Geary Community Hospital

Geary County Community Health Needs Assessment and Implementation Plan

September 2020
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Section 1:
Community Health Needs Assessment
Executive Summary

A comprehensive, six-step community health needs assessment ("CHNA") was conducted for Geary Community Hospital (GCH) by Community Hospital Consulting (CHC Consulting). This CHNA utilizes relevant health data and stakeholder input to identify the significant community health needs in Geary County, Kansas.

The CHNA Team, consisting of leadership from GCH, reviewed the research findings in March 2020 to prioritize the community health needs. Six significant community health needs were identified by assessing the prevalence of the issues identified from the health data findings combined with the frequency and severity of mentions in community input.

The CHNA Team participated in an electronic prioritization process to rank the community health needs based on three characteristics: size and prevalence of the issue, effectiveness of interventions and their capacity to address the need. Once this prioritization process was complete, GCH leadership discussed the results and decided to prioritize five of the identified needs in various capacities through the implementation plan.

The six most significant needs are listed below:
1.) Access to Primary and Specialty Care Services and Providers
2.) Access to Affordable Care and Reducing Health Disparities Among Specific Populations
3.) Increased Emphasis on Education and Awareness of Existing Health Care Resources
4.) Access to Mental and Behavioral Health Care Providers and Services
5.) Prevention, Education and Services to Address High Mortality Rates, Chronic Diseases, Preventable Conditions and Unhealthy Lifestyles
6.) Access to Dental Care Services and Providers

Once the prioritization process was complete, GCH leadership discussed the results and decided to address five of the six prioritized needs in various capacities through its implementation plan. While GCH acknowledges that this is a significant need in the community, "Access to Dental Care Services and Providers" is not addressed largely due to the fact that it is not a core business function of the hospital and the limited capacity of the hospital to address this need. GCH will continue to support local organizations and efforts to address this need in the community.

GCH leadership has developed the following implementation plan to identify specific activities and services which directly address the remaining identified priorities. The objectives were identified by studying the prioritized health needs, within the context of the hospital’s overall strategic plan and the availability of finite resources. The plan includes a rationale for each priority, followed by objectives, specific implementation activities, responsible leaders, annual updates and progress, and key results (as appropriate).

The GCH Board reviewed and adopted the 2020 Community Health Needs Assessment and Implementation Plan on September 29, 2020.
Priority #1: Access to Primary and Specialty Care Services and Providers

Geary County has a lower rate of primary care providers per 100,000 population than the state, as well as a higher rate of preventable hospitalizations than the state. Additionally, Geary County has several Health Professional Shortage Area and Medically Underserved Area/Population designations as defined by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA).

With regards to primary care access, interviewees noted limited availability of local resources that leads to outmigration of patients outside of Junction City. It was mentioned that there are challenges in seeking primary care services covered by insurance, particularly for KCare, military and military dependent and un/underinsured residents. One interviewee stated: “People with KCare are very limited in where they can go for primary care in Junction City.” Interviewees also noted outmigration of pediatric patients to Manhattan due to distrust in the longevity of new providers, with one interviewee specifically stating: “Most people go to Manhattan because there isn’t a pediatrician in Junction City. We have never had longevity of keeping pediatrics in Junction City. If a new doc comes in, nobody trusts that they’ll be long term here.”

A shortage of specialty care services in the community was brought up several times by interviewees, which may lead to long wait times; outmigration of patients to Kansas City, Wichita, Topeka, Selina or Manhattan; and delaying or foregoing care. Specific specialties mentioned as needed include Cardiology (full time), OB/GYN, Gastroenterology, Neurology (full time) and dialysis services.

Interviewees also discussed limited access to pediatric specialty services at Children’s Mercy, with one interviewee stating: “Specialty pediatric care is nonexistent. The hospital has partnered with Children’s Mercy to have some specialties here, but the waiting list to be able to see someone is absolutely crazy and they don’t cover all the specialties.”

Priority #2: Access to Affordable Care and Reducing Health Disparities Among Specific Populations

Geary County has a lower median household income and a higher unemployment rate than the state. Additionally, Geary County has a higher percentage of families and children living below poverty than the state, and higher food insecurity rates for the overall population and youth population than the state. There is a higher percentage of public school students eligible for free or reduced price lunch in the county, and a higher percentage of adolescents age 16-19 years old who are not in school and not employed.

The unmet needs of low income and un/underinsured residents in the community were brought up by interviewees. It was mentioned that there is a low prioritization of health care needs due to cost barriers to care, and vulnerable populations may leave the community to seek care in nearby clinics with more affordable services. One interviewee stated: “There’s a free clinic in Manhattan that has been very helpful for a lot of different things but we don’t have anything like that around here.”

Cost barriers to care were mentioned as leading to residents delaying and/or foregoing care. It was also mentioned that there is greater difficulty in placing low income and un/underinsured patients in appropriate mental health care settings, with one interviewee stating: “We serve a lot of people who are uninsured. Being able to get them somewhere for mental health, especially, more so than anything else is our biggest issue.” Interviewees also mentioned a challenge in navigating the health care system for military and military dependent families and homeless populations. One interviewee specifically stated: “Some of the Army connected people go to the Army hospital, some don’t. That also means we have a large population of retired military that have varying needs. Sometimes they go to the VA, sometimes they go to the hospital.”
Priority #2: Access to Affordable Care and Reducing Health Disparities Among Specific Populations (continued)

Interviewees discussed transportation barriers in getting to/from health care services, as well as a lack of a built environment that is conducive to transportation via biking, walking, etc. Though there is an existing transportation system in the community, interviewees mentioned challenges in navigating the service. One interviewee noted: “Most people have accepted the fact that Junction City isn’t walkable or bike friendly. There is a bus that will pick up 60+ adults and take them to the doctor’s office, but that’s hard to navigate.” Concern was raised surrounding the unmet transportation needs of families, seniors, low income and rural residents and veterans.

When asked which health disparities in Geary County, interviewees discussed the pediatric, elderly, teenagers/adolescents, racial/ethnic, low income/working poor, homeless and veterans/military dependent populations.

With regards to the pediatric population, interviewees discussed a lack of local developmental disability services and limited local access to pediatricians as challenges for this group. For elderly residents, interviewees mentioned transportation barriers and limited access to mental health resources and services as disproportionately challenging these residents.

Interviewees mentioned obesity, need for role models, mental health concerns (depression, anxiety), substance abuse education and rehab services and a need for domestic violence screenings as health disparities affecting the teenage/adolescent population in Geary County. It was noted that language barriers may specifically challenge racial/ethnic groups, and for the low income/working poor population, interviewees mentioned those residents are challenged by transportation barriers in the community.

With regards to the homeless population, interviewees discussed challenges associated with a lack of access to local shelters and difficulty getting into shelters, as well as a growing number of homeless persons. Lastly, interviewees mentioned limited access to mental health resources and services, a stigma associated with seeking mental health care services and difficulty accessing health care services due to insurance coverage barriers.

Priority #3: Increased Emphasis on Education and Awareness of Existing Health Care Resources

Interviewees raised concern surrounding the lack of education on the differences across health care settings in the community. One interviewee stated: “For a lot of people here, 911 is their primary access to health care. There’s no one there to educate the patient on where to go for certain types of care.”

Concern was raised surrounding communication across the continuum of care, and specifically the communication between AlphaCare and primary care providers to ensure information is shared appropriately. Interviewees also discussed misuse of the Emergency Room due to long wait times for an appointment with a primary care provider, long wait times in the waiting room of the primary care provider’s office and a desire to not miss work. One interviewee stated: “For the working poor, if an hour is taken off of work, that’s one less hour of pay they get. So sometimes they have to go to the ER because it’s after work hours and that’s when they can go.”

Priority #4: Access to Mental and Behavioral Health Care Providers and Services

Geary County has higher rates of adult depression than the state, as well as a higher percentage of residents who experienced 14+ days of poor mental health than the state.

Many interviewees mentioned a stigma associated with seeking mental and behavioral health care services, as well as cultural perspectives driving the use of those services. It was also mentioned that there is a greater challenge in seeking care for Medicare and TRICARE patients, with one interviewee stating...
Priority #4: Access to Mental and Behavioral Health Care Providers and Services (continued)

...“There are not a lot of mental health providers accepting Medicare and TRICARE patients. They require an additional level of credentialing, so that impacts access for those populations. We need mental health care for family members of veterans who don’t know how to manage the struggles that their loved one is experiencing.”

Limited local resources were also noted in the interviews, which may lead to the transferring of patients outside of the county. The shortage of providers results in long wait times and use of law enforcement to manage mental and behavioral-health related situations. One interviewee stated: “Wait times are way too long. People have PTSD issues and law enforcement have to deal with mental issues on a daily basis because all the providers are booked up. It’s an issue because it eats up time and resources.”

Interviewees raised concern surrounding significant recreational drug use (methamphetamine, opioids) and the lack of substance abuse treatment facilities in the community. Several individuals also discussed the lack of local developmental evaluations for pediatric patients, with one interviewee stating: “There are not any mental health professionals seeing pediatric patients. A lot of families have been referred to Children’s Mercy and they do not specifically provide autism evaluations or developmental evaluations.”

Priority #5: Prevention, Education and Services to Address High Mortality Rates, Chronic Diseases, Preventable Conditions and Unhealthy Lifestyles

Data suggests that higher rates of specific mortality causes and unhealthy behaviors warrants a need for increased preventive education and services to improve the health of the community. Heart disease and cancer are the two leading causes of death in Geary County and the state. Geary County has higher mortality rates than Kansas for diseases of heart; malignant neoplasms; cerebrovascular diseases; diabetes mellitus; Alzheimer disease; intentional self-harm (suicide); nephritis, nephrotic syndrome and nephrosis; certain conditions originating in the perinatal period; lung and bronchus cancer and colorectal cancer.

Geary County has higher rates of chronic conditions and unhealthy lifestyle behaviors than the state, such as diabetes (adult and Medicare populations), obesity, high blood pressure (adult and Medicare populations), asthma, arthritis and residents consuming fruit and vegetables less than one time per day. Data also suggests that residents may not be seeking necessary preventive care services, such as colon cancer screenings.

Geary County has higher rates of communicable diseases (chlamydia, gonorrhea) than the state. With regards to maternal and child health, specifically, Geary County has lower percentages of mothers receiving adequate prenatal care than the state.

Several interviewees noted limited health education and connection in the community that is evidenced by high rates of obesity and diabetes. It was also mentioned that obese and diabetic residents do not understand patient health information, with one interviewee stating: “There’s a rampant amount of obesity across the age spectrum with a crossover of diabetes, and there’s a real lack of education in this community about what their health numbers mean, like A1c. People get diagnosed with diabetes and they’re uninformed.”

The lack of built environment was mentioned as leading to residents not participating in healthy lifestyle behaviors, with perceived higher rates of obesity and poor lifestyle behaviors within the youth population. Interviewees also raised concern surrounding high rates of food insecurity and access to healthy, nutritious foods. One interviewee specifically stated: “Food insecurity and nutrition is a big health need because we have a lot of people who struggle financially and we all know that the cheap food is typically processed food. Having access to healthy nutritious food is a challenge in our county.” Interviewees also mentioned high rates of tobacco and vapor use, which is perceived to be a big health need in the community.
PROCESS AND METHODOLOGY
Process and Methodology

*Background & Objectives*

- This CHNA is designed in accordance with CHNA requirements identified in the Patient Protection and Affordable Care Act and further addressed in the Internal Revenue Service final regulations released on December 29, 2014. The objectives of the CHNA are to:
  - Meet federal government and regulatory requirements
  - Research and report on the demographics and health status of the study area, including a review of state and local data
  - Gather input, data and opinions from persons who represent the broad interest of the community
  - Analyze the quantitative and qualitative data gathered and communicate results via a final comprehensive report on the needs of the communities served by GCH
  - Document the progress of previous implementation plan activities
  - Prioritize the needs of the community served by the hospital
  - Create an implementation plan that addresses the prioritized needs for the hospital
Process and Methodology  

**Scope**

- The CHNA components include:
  - A description of the process and methods used to conduct this CHNA, including a summary of data sources used in this report
  - A biography of GCH
  - A description of the hospital’s defined study area
  - Definition and analysis of the communities served, including demographic and health data analyses
  - Findings from phone interviews collecting input from community representatives, including:
    - State, local, tribal or regional governmental public health department (or equivalent department or agency) with knowledge, information or expertise relevant to the health needs of the community;
    - Members of a medically underserved, low-income or minority populations in the community, or individuals or organizations serving or representing the interests of such populations
    - Community leaders
  - A description of the progress and/or completion of community benefit activities documented in the previous implementation plan
  - The prioritized community needs and separate implementation plan, which intend to address the community needs identified
  - A description of additional health services and resources available in the community
  - A list of information gaps that impact the hospital’s ability to assess the health needs of the community served
Process and Methodology

Methodology

• GCH worked with CHC Consulting in the development of its CHNA. GCH provided essential data and resources necessary to initiate and complete the process, including the definition of the hospital’s study area and the identification of key community stakeholders to be interviewed.

• CHC Consulting conducted the following research:
  – A demographic analysis of the study area, utilizing demographic data from Stratasan and local reports
  – A study of the most recent health data available
  – Conducted one-on-one phone interviews with individuals who have special knowledge of the communities, and analyzed results
  – Facilitated the prioritization process during the CHNA Team meeting on March 19, 2020.

• The methodology for each component of this study is summarized in the following section. In certain cases methodology is elaborated in the body of the report.
Process and Methodology

Methodology (continued)

- **GCH Biography**
  - Background information about GCH, mission, vision, motto and services provided were provided by the hospital or taken from its website

- **Study Area Definition**
  - The study area for GCH is based on hospital inpatient discharge data from May 1, 2018 – April 30, 2019 and discussions with hospital staff

- **Demographics of the Study Area**
  - Population demographics include population change by race, ethnicity, age, median income analysis, unemployment and economic statistics in the study area
  - Demographic data sources include, but are not limited to, Stratasan, the U.S. Census Bureau, the United States Bureau of Labor Statistics and Feeding America

- **Health Data Collection Process**
  - A variety of sources (also listed in the reference section) were utilized in the health data collection process
  - Health data sources include, but are not limited to, the Robert Wood Johnson Foundation, Kansas Department of Health and Environment, the CARES Engagement Network, United States Census Bureau, and the Centers for Disease Control and Prevention

- **Interview Methodology**
  - GCH provided CHC Consulting with a list of persons with special knowledge of public health in Geary County, including public health representatives and other individuals who focus specifically on underrepresented groups
  - From that list, 16 in depth phone interviews were conducted using a structured interview guide
  - Extensive notes were taken during each interview and then quantified based on responses, communities and populations (minority, elderly, un/underinsured, etc.) served, and priorities identified by respondents. Qualitative data from the interviews was also analyzed and reported.
Process and Methodology

Methodology (continued)

– Survey Methodology
  • CHC Consulting developed an electronic survey tool distributed by GCH via email, the GCH website and Facebook that was conducted between January 27, 2020 – February 17, 2020. The survey was sent via email to individuals or organizations representing the need of various community groups in Geary County, and was posted publicly on the hospital’s Facebook page for any community member to access. 55 individuals responded to the survey and those 55 responses were collected and analyzed.

– Evaluation of Hospital’s Impact
  • A description of the progress and/or completion of community benefit activities documented in the previous implementation plan
  • GCH provided CHC Consulting with a report of community benefit activity progress since the previous CHNA report

– Prioritization Strategy
  • Six significant needs were determined by assessing the prevalence of the issues identified in the health data findings, combined with the frequency and severity of mentions in the interviews
  • Three factors were used to rank those needs with the CHNA team in March 2020
  • See the prioritization section for a more detailed description of the prioritization methodology
HOSPITAL BIOGRAPHY
History

Born through the efforts of Drs. Walter Austin “W.A.” Carr and William Arthur “W.A.” Smiley, Junction City’s first hospital opened on September 9, 1913 in a large house located on the southwest corner of Second and Adams Streets.

After a few years, the hospital outgrew the old home and it became apparent that a new hospital should be built. The voters approved bonds and the new Junction City Municipal Hospital was completed at 900 S. Jefferson (at the corner of Ash Street and Jefferson Street) in 1920. It stands today as the Dreiling Arms Apartments. Dr. Carr admitted the first patient, August Neuber, in 1921 to the 25-to-30-bed facility. An addition was built in 1932 using federal funds.

Dr. Herb Bunker Jr., who practiced in Junction City for 43 years, recalled that the hospital on Jefferson Street was adequate, but had some obvious disadvantages. It had small rooms and only two operating rooms. Staff had to wheel the patient through the lobby to get to the operating rooms. He added that the emergency department consisted of one room with no additional room for storage or back up. Patients waited in the hall for their turn in the one room. The x-ray department was also only one room, which included a darkroom. The x-rays were hand developed from the hospital’s own film. The laboratory was assigned to one room as well.

In 1963, an election was held to change ownership of the hospital from the city to the county and on May 1, 1963, the hospital became known as Geary County Hospital.

A new hospital was planned at the southwest corner of Ash Street and St. Mary’s Road to replace the aging facility on South Jefferson Street. Geary County sold $1.1 million in bonds and received a matching sum from federal Hill-Burton grants. In return for the federal aid, the hospital promised to provide charity care to the indigent for the next 20 years. Although the debt has been retired, the hospital continues its commitment to those patients with little or no ability to pay.

The current hospital was completed in November 1966 and, in the summer of 1967, opened its doors to patients. Don Wise, administrator, dedicated the new hospital on June 4, 1967, which coincided with a name change to Geary Community Hospital to better reflect the hospital’s mission and vision. There were eight medical doctors and no specialists working in Junction City at the time.

Hospital Biography

About Geary Community Hospital (continued)

History (cont.)

Since its opening, the hospital campus at 1102 St. Mary’s Road has been improved upon and expanded many times. In order to attract and accommodate more physicians, the first of two medical arts buildings was constructed in two stages over nine years, beginning in 1974. 1987 brought a remodeled surgery center and in 1994 we expanded the emergency room and outpatient services. In September 1997, the hospital opened the Martha K. Hoover Women’s Health Center featuring 6 LDRP’s (Labor-Delivery-Recovery-Post Partum) Birthing Rooms and Basic Care and Special Care Nurseries (formerly called Level I and Level II),

In 2004, the first three floors of the Medical Arts II were completed. This space allowed for the relocation of administration, the business office and other non-medical offices to the new medical arts building and opened up prime space in the hospital for patient care functions. In 2006, a fourth floor was added to the Medical Arts II. It was soon occupied by most of the practitioners of the hospital’s rural health clinic.

By far the biggest construction project since the new hospital was built in 1966 was the $34 million, 110,000 sq. ft. expansion project that opened in February 2009. Essentially doubling the size of the hospital, the expansion included a new 36-bed, all-private-room medical/surgical unit, a new 6-bed, high-tech Thomas and Barbara Fegan Intensive Care Unit, and a new surgery center with four operating rooms, two procedure rooms, 16 private patient rooms and space for expansion. An auxiliary gift shop and a new chapel were included in the new wing.

Throughout the years Geary Community Hospital has been a leader in healthcare for our community and our region. GCH was the first facility in Kansas to do in vitro fertilization and in 2000 we began Kansas’ first bariatric program. From 1995 to 2012 GCH was home to The University of Kansas Family Practice Residency-Junction City Rural Track program, led by the late Dr. Ronald Mace. In 2015, GCH dedicated a wing on campus for resident and student housing in honor of Dr. Ron Mace. This free housing area is beneficial for students who do not have housing arrangements in the area but want to learn about rural healthcare in the Junction City area. GCH has also expanded to include a family medicine clinic in the neighboring community of Chapman, and established other programs, such as the Home Medical Equipment store and AlphaCare to better serve our patients and their families.

Today, Geary Community Hospital maintains its commitment to providing outstanding care to patients while providing an enjoyable work environment for our 400+ employees. GCH continues to explore ways to improve patient access to care, develop services that provide what our region needs and wants, and create programs that improve the wellness of our community. We’re proud that, for over a century, Geary County residents have made Geary Community Hospital their healthcare provider of choice.

Hospital Biography

Mission, Vision and Motto

Our Mission
Providing quality healthcare and promoting the well-being of those we serve.

Our Vision
To be the trusted choice for healthcare and wellness in our communities.

Our Motto
Progressive Healthcare, Hometown Compassion
# Hospital Biography

## Hospital Services

- **AlphaCare**
- **Audiology, Hearing Aids**
- **Cardiology**
- **Cardiopulmonary**
  - Cardiac Rehab
  - Pulmonary Rehab
  - Sleep Lab
- **Cardiovascular and Thoracic Surgery**
- **Case Management / Social Services**
- **Chapman Clinic**
- **Dermatology**
- **Diabetes Education**
- **Emergency Department**
- **Family Practice Clinics**
  - Dr. Marc Felts
  - Dr. Todd Frieze
  - Dr. Teran Naccarato
- **General Surgery**
  - Dr. Fouad Hachem
- **Gynecology & Obstetrics**
  - Dr. Anwar Khoury
  - Terrah Stroda, CNM
- **Home Medical Equipment**
- **Intensive Care Unit**
- **Internal Medicine Clinics**
  - Dr. Tom Craig
  - Dr. Richard Lochamy
- **Innovative Weight Loss Solutions**
- **Laboratory**
- **Medical/Surgical Care**
  - Swing Bed
- **Medical Records**
- **Nephrology**
- **Neurology**
- **Occupational Medicine**
- **Occupational Therapy**
- **Oncology, Hematology**
- **Ophthalmology**
- **Orthopedic Medicine**
- **Orthotics, Prosthetics**
- **Otolaryngology**
- **Pediatric Cardiology**
- **Pediatrics Clinic**
  - Dr. Tessa Bandhan
  - Dr. Rahel Getachew
- **Pediatric Endocrinology, Diabetes**
- **Pediatric Therapy**
- **Plastic Surgery**
- **Podiatry**
- **Pulmonology**
- **Radiology**
  - CT
  - MRI
  - PET
  - Nuclear Medicine
- **Sexual Assault Nurse Examiner (SANE)**
- **Surgery Center**
  - IV Therapy
- **Telemedicine**
- **Urology**
- **Women’s Health Center**
- **Wound Care**

STUDY AREA
Geary Community Hospital

Study Area

- Geary County comprises 72.5% of FY 2019 Inpatient Discharges
- Indicates the hospital

Geary Community Hospital
Patient Origin by County: May 1, 2018 – April 30, 2019

<table>
<thead>
<tr>
<th>County</th>
<th>State</th>
<th>FY 2019 Discharges</th>
<th>% of Total</th>
<th>Cumulative % of Total</th>
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<tbody>
<tr>
<td>Geary</td>
<td>KS</td>
<td>747</td>
<td>72.5%</td>
<td>72.5%</td>
</tr>
<tr>
<td>All Others</td>
<td></td>
<td>284</td>
<td>27.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>1,031</strong></td>
<td><strong>100.0%</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Hospital inpatient discharge data provided by Geary Community Hospital; May 2018 to April 2019; Normal Newborns excluded.
DEMOGRAPHIC OVERVIEW
## Population Health

### Population Growth

#### Projected 5-Year Population Growth

<table>
<thead>
<tr>
<th>Geographic Location</th>
<th>2019</th>
<th>2024</th>
<th>2019-2024 Change</th>
<th>2019-2024 % Change</th>
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</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>33,991</td>
<td>33,616</td>
<td>-375</td>
<td>-1.1%</td>
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<tr>
<td>Kansas</td>
<td>2,966,501</td>
<td>3,014,366</td>
<td>47,865</td>
<td>1.6%</td>
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</tbody>
</table>

Population Health

Population Composition by Race/Ethnicity

Geary County

Race/Ethnicity 2019 2024 2019‐2024 Change 2019‐2024 % Change
White 21,679 21,153 -526 -2.4%
Black 6,212 5,964 -248 -4.0%
Asian 1,126 1,123 -3 -0.3%
American Indian 387 423 36 9.3%
All Others 4,587 4,953 366 8.0%
Total 33,991 33,616 -375 -1.1%
Hispanic 6,140 7,191 1,051 17.1%

Kansas

Race/Ethnicity 2019 2024 2019‐2024 Change 2019‐2024 % Change
White 2,423,011 2,424,521 1,510 0.1%
Black 176,842 181,299 4,457 2.5%
Asian 93,784 109,176 15,392 16.4%
American Indian 29,532 30,230 698 2.4%
All Others 243,332 269,140 25,808 10.6%
Total 2,966,501 3,014,366 47,865 1.6%
Hispanic 366,644 409,175 42,531 11.6%

Race/Ethnicity Projected 5-Year Growth

2019‐2024

Geary County  Kansas

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2019</th>
<th>2024</th>
<th>2019‐2024 Change</th>
<th>2019‐2024 % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>0.1%</td>
<td>2.5%</td>
<td>16.4%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Black</td>
<td>-2.4%</td>
<td>-4.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>-0.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian</td>
<td>8.0%</td>
<td>10.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Others</td>
<td>-1.1%</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>17.1%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Hispanic</td>
<td></td>
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</table>

Population Health

Population Composition by Age Group

Geary County

- <18: 30.3%
- 18-44: 42.9%
- 45-64: 17.3%
- 65+: 9.5%

Kansas

- <18: 23.6%
- 18-44: 35.6%
- 45-64: 24.4%
- 65+: 16.3%

Age Projected 5-Year Growth

2019-2024

- <18: -1.2%
- 18-44: 0.5%
- 45-64: -8.5%
- 65+: -5.5%

- Geary County:
  - <18: 7.9%
  - 18-44: 14.1%

Population Health

Median Age

• The median age in Geary County and the state is expected to increase over the next five years (2019-2024).
• Geary County (29.3 years) has a younger median age than Kansas (37.3 years) (2019).

Median Age

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>29.3</td>
<td>29.4</td>
</tr>
<tr>
<td>Kansas</td>
<td>37.3</td>
<td>37.9</td>
</tr>
</tbody>
</table>

Population Health

*Median Household Income and Educational Attainment*

- The median household income in both Geary County and the state is expected to increase over the next five years (2019-2024).
- Geary County ($45,796) has a lower median household income than Kansas ($56,331) (2019).
- Geary County (23.0%) has a lower percentage of residents with a bachelor or advanced degree than the state (34.5%) (2019).

<table>
<thead>
<tr>
<th>Median Household Income</th>
<th>Education Bachelor / Advanced Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Geary County</strong></td>
<td>Geary County</td>
</tr>
<tr>
<td>$45,796</td>
<td>23.0%</td>
</tr>
<tr>
<td>$49,317</td>
<td>34.5%</td>
</tr>
<tr>
<td><strong>Kansas</strong></td>
<td>Kansas</td>
</tr>
<tr>
<td>$56,331</td>
<td></td>
</tr>
<tr>
<td>$62,582</td>
<td></td>
</tr>
</tbody>
</table>

Population Health

*Unemployment*

- Unemployment rates in Geary County and the state decreased between 2016 and 2018.
- In 2018, Geary County (4.8%) had a higher unemployment rate than the state (3.4%).
- Over the most recent 12-month time period, monthly unemployment rates in Geary County overall decreased. January 2019 had the highest unemployment rate (5.6) as compared to November 2019 with the lowest rate (3.9).

### Unemployment

*Rates by Year*

<table>
<thead>
<tr>
<th>Year</th>
<th>Geary County</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>5.6%</td>
<td>4.0%</td>
</tr>
<tr>
<td>2017</td>
<td>5.0%</td>
<td>3.7%</td>
</tr>
<tr>
<td>2018</td>
<td>4.8%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

### Geary County Unemployment

*Rates by Month*

<table>
<thead>
<tr>
<th>Month</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-18</td>
<td>5.6%</td>
<td>5.2%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Jan-19</td>
<td>5.6%</td>
<td>5.4%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Feb-19</td>
<td>5.4%</td>
<td>5.2%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Mar-19</td>
<td>4.2%</td>
<td>4.4%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Apr-19</td>
<td>4.4%</td>
<td>4.4%</td>
<td>4.0%</td>
</tr>
<tr>
<td>May-19</td>
<td>5.1%</td>
<td>5.3%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Jun-19</td>
<td>5.3%</td>
<td>4.9%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Jul-19</td>
<td>4.9%</td>
<td>4.1%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Aug-19</td>
<td>4.0%</td>
<td>5.1%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Sept-19</td>
<td>4.0%</td>
<td>5.3%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Oct-19</td>
<td>3.9%</td>
<td>4.9%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Nov-19</td>
<td>4.0%</td>
<td>4.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Dec-19</td>
<td>3.9%</td>
<td>4.0%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

Population Health

Poverty

- Geary County (19.8%) has a slightly higher percentage of families living below poverty as compared to the state (19.2%) (2019).
- Geary County (18.1%) has a higher percentage of children (<18 years) living in households with income below the Federal Poverty Level than Kansas (15.6%) and a slightly lower percentage than the nation (19.5%) (2014-2018).

**Families Below Poverty**

2019

<table>
<thead>
<tr>
<th></th>
<th>Geary County</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>%</strong></td>
<td>19.8%</td>
<td>19.2%</td>
</tr>
</tbody>
</table>


Children Living Below Poverty Definition: children aged 0-17 are living in households with income below the Federal Poverty Level (FPL).

Note: The 2019 Federal Poverty Thresholds define a household size of 4 as living below 100% of the federal poverty level if the household income is less than $25,750, and less than 200% of the federal poverty level if the household income is less than $51,500. Please see the appendix for the full 2019 Federal Poverty Thresholds.
Population Health

*Food Insecurity*

- According to Feeding America, an estimated 17.4% of Geary County residents are food insecure as compared to 12.7% in Kansas. Additionally, 21.6% of the youth population (under 18 years of age) in Geary County are food insecure, as compared to 18.3% in Kansas (2017).

- The average meal cost for a Geary County resident is $3.07, as compared to $2.86 in Kansas (2017).

<table>
<thead>
<tr>
<th>Location</th>
<th>Overall Food Insecurity</th>
<th>Child Food Insecurity</th>
<th>Average Meal Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>17.4%</td>
<td>21.6%</td>
<td>$3.07</td>
</tr>
<tr>
<td>Kansas</td>
<td>12.7%</td>
<td>18.3%</td>
<td>$2.86</td>
</tr>
</tbody>
</table>


Food Insecure Definition (Adult): Lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods.

Food Insecure Definition (Child): Those children living in households experiencing food insecurity.

Average Meal Cost Definition: The average weekly dollar amount food-secure individuals report spending on food, as estimated in the Current Population Survey, divided by 21 (assuming three meals a day, seven days a week).
Population Health  
*Children in the Study Area*

- Geary County (60.7%) has a higher percentage of public school students eligible for free or reduced price lunch than the state (48.2%) and the nation (49.2%) (2016-2017).
- Geary County (87.1%) has a slightly higher high school graduation rate than the state (86.4%) but a slightly lower rate than the nation (86.8%) (2016-2017).
- Geary County (7.9%) has a higher percentage of youth age 16-19 who are not currently enrolled in school and who are not employed as compared to the state (5.6%) and the nation (6.8%) (2014-2018).

Definition: receiving a high school diploma within four years.
HEALTH DATA OVERVIEW
Health Status

Data Methodology

• The following information outlines specific health data:
  – Mortality, chronic diseases and conditions, health behaviors, natality, mental health and healthcare access

• Data Sources include, but are not limited to:
  – Kansas Department of State Health Services
  – Kansas Cancer Registry
  – Small Area Health Insurance Estimates (SAHIE)
  – CARES Engagement Network
  – The Behavioral Risk Factor Surveillance System (BRFSS)
    • The Behavioral Risk Factor Surveillance System (BRFSS) is the world’s largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Currently, information is collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.
    • It is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors.
    • States use BRFSS data to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs. Many states also use BRFSS data to support health-related legislative efforts.
  – The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute
  – United States Census Bureau

• Data Levels: Nationwide, state and county level data
Health Status

Count Health Rankings & Roadmaps - Geary County, Kansas

- The County Health Rankings rank 104 counties in Kansas (1 being the best, 104 being the worst).
- Many factors go into these rankings. A few examples include:
  - **Physical Environment:**
    - Air pollution – particulate matter
    - Drinking water violations
    - Severe housing problems
    - Driving alone to work
  - **Health Behaviors:**
    - Adult smoking
    - Adult obesity
    - Sexually transmitted infections
    - Teen births
  - **Clinical Care:**
    - Primary care physicians
    - Mammography screening
    - Flu vaccinations
    - Uninsured

<table>
<thead>
<tr>
<th>2020 County Health Rankings</th>
<th>Geary County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Outcomes</td>
<td>96</td>
</tr>
<tr>
<td>LENGTH OF LIFE</td>
<td>92</td>
</tr>
<tr>
<td>QUALITY OF LIFE</td>
<td>95</td>
</tr>
<tr>
<td>Health Factors</td>
<td>100</td>
</tr>
<tr>
<td>HEALTH BEHAVIORS</td>
<td>104</td>
</tr>
<tr>
<td>CLINICAL CARE</td>
<td>12</td>
</tr>
<tr>
<td>SOCIAL &amp; ECONOMIC FACTORS</td>
<td>85</td>
</tr>
<tr>
<td>PHYSICAL ENVIRONMENT</td>
<td>100</td>
</tr>
</tbody>
</table>

Note: Green represents the best ranking for the county, and red represents the worst ranking.

Note: Please see the appendix for full methodology.
Note: County Health Rankings ranks 104 of the 105 counties in Kansas.
# Health Status


<table>
<thead>
<tr>
<th>Rank</th>
<th>Geary County</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diseases of heart (I00-I09,I11,I13,I20-I51)</td>
<td>Malignant neoplasms (C00-C97)</td>
</tr>
<tr>
<td>2</td>
<td>Malignant neoplasms (C00-C97)</td>
<td>Diseases of heart (I00-I09,I11,I13,I20-I51)</td>
</tr>
<tr>
<td>3</td>
<td>Cerebrovascular diseases (I60-I69)</td>
<td>Chronic lower respiratory diseases (J40-J47)</td>
</tr>
<tr>
<td>4</td>
<td>Chronic lower respiratory diseases (J40-J47)</td>
<td>Accidents (unintentional injuries) (V01-X59,Y85-Y86)</td>
</tr>
<tr>
<td>5</td>
<td>Accidents (unintentional injuries) (V01-X59,Y85-Y86)</td>
<td>Cerebrovascular diseases (I60-I69)</td>
</tr>
<tr>
<td>6</td>
<td>Diabetes mellitus (E10-E14)</td>
<td>Alzheimer disease (G30)</td>
</tr>
<tr>
<td>7</td>
<td>Alzheimer disease (G30)</td>
<td>Diabetes mellitus (E10-E14)</td>
</tr>
<tr>
<td>8</td>
<td>Intentional self-harm (suicide) (*U03,X60-X84,Y87.0)</td>
<td>Intentional self-harm (suicide) (*U03,X60-X84,Y87.0)</td>
</tr>
<tr>
<td>9</td>
<td>Nephritis, nephrotic syndrome and nephrosis (N00-N07,N17-N19,N25-N27)</td>
<td>Influenza and pneumonia (J09-J18)</td>
</tr>
<tr>
<td>10</td>
<td>Certain conditions originating in the perinatal period (P00-P96)</td>
<td>Nephritis, nephrotic syndrome and nephrosis (N00-N07,N17-N19,N25-N27)</td>
</tr>
</tbody>
</table>


Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.
## Health Status


<table>
<thead>
<tr>
<th>Disease</th>
<th>Geary County</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Combined 5Yr. Rate</td>
<td>5Yr. Change</td>
</tr>
<tr>
<td>Diseases of heart (I00-I09,I11,I13,I20-I51)</td>
<td>202.0</td>
<td>▲</td>
</tr>
<tr>
<td>Malignant neoplasms (C00-C97)</td>
<td>190.8</td>
<td>▼</td>
</tr>
<tr>
<td>Cerebrovascular diseases (I60-I69)</td>
<td>50.8</td>
<td>▼</td>
</tr>
<tr>
<td>Chronic lower respiratory diseases (J40-J47)</td>
<td>49.5</td>
<td>▲</td>
</tr>
<tr>
<td>Accidents (unintentional injuries) (V01-X59,Y85-Y86)</td>
<td>40.5</td>
<td>▲</td>
</tr>
<tr>
<td>Diabetes mellitus (E10-E14)</td>
<td>35.8</td>
<td>▼</td>
</tr>
<tr>
<td>Alzheimer disease (G30)</td>
<td>29.6</td>
<td>-</td>
</tr>
<tr>
<td>Intentional self-harm (suicide) (*U03,X60-X84,Y87.0)</td>
<td>24.2</td>
<td>▲</td>
</tr>
<tr>
<td>Nephritis, nephrotic syndrome and nephrosis (N00-N07,N17-N19,N25-N27)</td>
<td>23.8</td>
<td>-</td>
</tr>
<tr>
<td>Certain conditions originating in the perinatal period (P00-P96)</td>
<td>6.6</td>
<td>-</td>
</tr>
</tbody>
</table>

- ▼ indicates that the county’s rate is lower than the state’s rate for that disease category.
- ▲ indicates that the county’s rate is higher than the state’s rate for that disease category.
- ▼ indicates that the rate is trending downwards.
- ▲ indicates that the rate is trending upwards.
- = Indicates that the rate remained consistent.


Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.
Health Status

Mortality – Overall

• Overall mortality rates in Geary County remained higher than the state between 2014 and 2018.

• Overall mortality rates in Geary County increased between 2014 and 2018, while rates in the state slightly increased.

• In 2016-2018, the overall mortality rate in Geary County (904.5 per 100,000) was higher than the state (766.4 per 100,000).

Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.
Health Status

Mortality – Diseases of the Heart

- Heart disease is the leading cause of death in Geary County and the second leading cause of death in the state (2014-2018).
- Between 2014 and 2018, heart disease mortality rates increased in Geary County and slightly increased in the state.
- In 2016-2018, the heart disease mortality rate in Geary County (224.4 per 100,000) was higher than the state rate (158.7 per 100,000).

Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.

Diseases of Heart
Age-adjusted Death Rates per 100,000, 2014-2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>124</td>
<td>179.3</td>
<td>143</td>
<td>210.1</td>
<td>149</td>
<td>224.4</td>
<td>227</td>
<td>202.0</td>
</tr>
<tr>
<td>Kansas</td>
<td>16,775</td>
<td>158.4</td>
<td>17,019</td>
<td>158.6</td>
<td>17,218</td>
<td>158.7</td>
<td>28,321</td>
<td>158.4</td>
</tr>
</tbody>
</table>
Health Status

*Mortality – Malignant Neoplasms*

- Cancer is the second leading cause of death in Geary County and the leading cause of death in the state (2014-2018).
- Between 2014 and 2018, cancer mortality rates decreased in Geary County and the state.
- In 2016-2018, the cancer mortality rate in Geary County (187.8 per 100,000) was higher than the state rate (157.4 per 100,000).


Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.
Health Status

Cancer Mortality by Type

Melanoma
Age-adjusted Rates per 100,000
2011-2015

Leukemia
Age-adjusted Rates per 100,000
2011-2015

Lung & Bronchus
Age-adjusted Rates per 100,000
2011-2015

Colorectal
Age-adjusted Rates per 100,000
2011-2015


Note: All rates are per 100,000. Rates are age-adjusted to the 2000 U.S. Standard Population. *Counts/rates are suppressed if fewer than 16 cases were reported in the specified category; Counts < 16 are too few to calculate a stable age-adjusted rate.
Health Status

Mortality – Cerebrovascular Disease

• Cerebrovascular disease is the third leading cause of death in Geary County the fifth leading cause of death in the state (2014-2018).

• Between 2014 and 2018, cerebrovascular disease mortality rates in Geary County and the state decreased.

• In 2016-2018, the cerebrovascular disease mortality rate in Geary County (45.5 per 100,000) was slightly higher than the state rate (37.3 per 100,000).


Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.
Health Status

**Mortality – Chronic Lower Respiratory Disease**

- Chronic lower respiratory disease (CLRD) is the fourth leading cause of death in Geary County and the third leading cause of death in the state (2014-2018).
- Between 2014 and 2018, CLRD mortality rates increased in Geary County and the state.
- In 2016-2018, the CLRD mortality rate in Geary County (53.3 per 100,000) was higher than the state rate (50.1 per 100,000).

### Chronic Lower Respiratory Diseases

*Age-adjusted Death Rates per 100,000, 2014-2018*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>30</td>
<td>45.8</td>
<td>30</td>
<td>46.6</td>
<td>34</td>
<td>53.3</td>
<td>53</td>
<td>49.5</td>
</tr>
<tr>
<td>Kansas</td>
<td>5,031</td>
<td>49.0</td>
<td>5,190</td>
<td>49.9</td>
<td>5,323</td>
<td>50.1</td>
<td>8,700</td>
<td>49.9</td>
</tr>
</tbody>
</table>

Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.
Health Status

*Mortality – Accidents*

- Fatal accidents are the fifth leading cause of death in Geary County and the fourth leading cause of death in the state (2014-2018).
- Between 2014 and 2018, accident mortality rates increased in Geary County and the state.
- In 2016-2018, the accident mortality rate in Geary County (43.2 per 100,000) was lower than the state rate (47.2 per 100,000).
- The leading cause of fatal accidents in Geary County is due to motor vehicle accidents (2016-2018).

![Accidents (Unintentional Injuries) Age-adjusted Death Rates per 100,000, 2014-2018](chart)


Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.

Accident mortality rates include: motor vehicle crashes, other land transport accidents, water transport accidents, air and space transport accidents, falls, accidental shootings, drownings, fire and smoke exposures, poisonings, suffocations, and all other unintentional injuries.
Health Status

*Mortality – Diabetes Mellitus*

- Diabetes mellitus is the sixth leading cause of death in Geary County and the seventh leading cause of death in the state (2014-2018).
- Between 2014 and 2018, diabetes mortality rates decreased in Geary County and increased in the state.
- In 2016-2018, the diabetes mortality rate in Geary County (34.8 per 100,000) was higher than the state rate (23.0 per 100,000).

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>DEATHS</th>
<th>AGE-ADJUSTED DEATH RATE</th>
<th>DEATHS</th>
<th>AGE-ADJUSTED DEATH RATE</th>
<th>DEATHS</th>
<th>AGE-ADJUSTED DEATH RATE</th>
<th>DEATHS</th>
<th>AGE-ADJUSTED DEATH RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>26</td>
<td>36.5</td>
<td>25</td>
<td>36.4</td>
<td>24</td>
<td>34.8</td>
<td>42</td>
<td>35.8</td>
</tr>
<tr>
<td>Kansas</td>
<td>2,054</td>
<td>20.2</td>
<td>2,285</td>
<td>22.2</td>
<td>2,404</td>
<td>23.0</td>
<td>3,731</td>
<td>21.7</td>
</tr>
</tbody>
</table>


Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.
Alzheimer’s disease is the seventh leading cause of death in Geary County and the sixth leading cause of death in the state (2014-2018).

Between 2014 and 2018, Alzheimer’s disease mortality rates increased in the state.

In 2014-2016, the Alzheimer’s disease mortality rate in Geary County (28.9 per 100,000) was higher than the rate in the state (22.8 per 100,000).


Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.
• Intentional self-harm (suicide) is the eighth leading cause of death in Geary County and the state (2014-2018).

• Between 2014 and 2018, intentional self-harm mortality rates increased in Geary County and the state.

• In 2016-2018, the intentional self-harm mortality rate in Geary County (28.8 per 100,000) was higher than the state (18.8 per 100,000).

Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.
Health Status

Mortality – Nephritis, Nephrotic Syndrome and Nephrosis

- Nephritis, nephrotic syndrome and nephrosis is the ninth leading cause of death in Geary County and the tenth leading cause of death in the state (2014-2018).

- Between 2014 and 2018, nephritis, nephrotic syndrome and nephrosis mortality rates decreased in the state.

Note: Age Adjustment Uses 2000 Standard Population. Rates calculated with small numbers are unreliable and should be used cautiously.
Health Status

Mortality – Certain Conditions Originating in the Perinatal Period

- Certain conditions originating in the perinatal period is the tenth leading cause of death in Geary County and is not a leading cause of death in the state (2014-2018).

- Between 2014 and 2018, certain conditions originating in the perinatal period mortality rates remained steady in the state.

### Certain Conditions Originating in the Perinatal Period

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>13</td>
<td>-</td>
<td>12</td>
<td>-</td>
<td>11</td>
<td>-</td>
<td>22</td>
<td>6.6</td>
</tr>
<tr>
<td>Kansas</td>
<td>336</td>
<td>4.0</td>
<td>325</td>
<td>3.9</td>
<td>323</td>
<td>4.0</td>
<td>553</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Health Status

**Communicable Diseases – Chlamydia, Gonorrhea, HIV**

**Chlamydia**
Rate per 100,000
2016-2018

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>521.2</td>
<td>491.8</td>
<td>844.8</td>
</tr>
<tr>
<td>Kansas</td>
<td>417.7</td>
<td>466.1</td>
<td>488.9</td>
</tr>
</tbody>
</table>

**Gonorrhea**
Rate per 100,000
2016-2018

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>110.7</td>
<td>143.3</td>
<td>197.9</td>
</tr>
<tr>
<td>Kansas</td>
<td>115.5</td>
<td>156.3</td>
<td>180.8</td>
</tr>
</tbody>
</table>

**People Living with HIV**
Number
2016-2018

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>31</td>
<td>37</td>
<td>35</td>
</tr>
<tr>
<td>Kansas</td>
<td>151</td>
<td>96</td>
<td>157</td>
</tr>
</tbody>
</table>


Note: People Living with HIV data reflects the number of persons living in Kansas who have been diagnosed with HIV. Last reported address was utilized to determine residency. If the last reported county variable was unknown, that individual is not reflected.
Health Status

Chronic Conditions – Diabetes

• In 2016, the percent of adults (age 20+) ever diagnosed with diabetes by a doctor in Geary County (12.2%) was higher than the state (9.1%) and national (9.3%) rates.

• In 2017, the percentage of Medicare Beneficiaries with diabetes in Geary County (30.2%) was higher than the state rate (25.4%) and the national rate (27.2%).

• Between 2013 and 2017, diabetes prevalence rates in adults (age 18+) in Geary County and Kansas increased.

• In 2017, Geary County (12.7%) had a higher percent of adults (age 18+) who had ever been diagnosed with diabetes than the state (10.5%).


Definition: Has a doctor, nurse, or other health professional ever told you that you have diabetes?

Note: a green dial indicates that the county has a better rate than the state, and a red dial indicates that the county has a worse rate than the state.

Diabetes Percentage, Adults (age 18+)
2013, 2015, 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Geary County</th>
<th>Kansas</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>8.3%</td>
<td>9.4%</td>
<td>12.7%</td>
</tr>
<tr>
<td>2015</td>
<td>9.6%</td>
<td>9.7%</td>
<td>10.5%</td>
</tr>
<tr>
<td>2017</td>
<td>10.5%</td>
<td>10.5%</td>
<td>10.5%</td>
</tr>
</tbody>
</table>
Health Status

Chronic Conditions – Obesity

• In 2016, Geary County (38.9%) had a higher percentage of adults (age 20+) who reported having a Body Mass Index (BMI) greater than 30.0 (obese) than the state (33.3%) and the nation (28.8%).

• Between 2013 and 2017, obesity prevalence rates in adults (age 18+) in Geary County and the state increased.

• In 2017, Geary County (42.1%) had a higher percentage of obese adults (age 18+) than the state (32.3%).


Definition: BMI is (weight in lbs. divided by (height in inches squared)) times 703. Recommended BMI is 18.5 to 24.9 Overweight is 25.0 to 29.9 Obese is => 30.0.

Note: a green dial indicates that the county has a better rate than the state, and a red dial indicates that the county has a worse rate than the state.
Health Status

High Blood Pressure

- Geary County (56.0%) has a slightly higher rate of Medicare fee-for-service residents with hypertension than the state (55.2%) and a higher rate than the nation (57.1%) (2017).
- Between 2013 and 2017, the percentage of adults (age 18+) with diagnosed hypertension in Geary County and the state increased.
- In 2017, the percentage of adults with diagnosed hypertension in Geary County (35.4%) was higher than the state (32.8%).

Note: a green dial indicates that the county has a better rate than the state, and a red dial indicates that the county has a worse rate than the state.
Health Status

_Chronic Conditions – Fruit & Vegetable Consumption_

- Between 2013 and 2017, the percent of adults (age 18+) that reported consuming fruit less than one time per day in Geary County and the state decreased.
- In 2017, Geary County (37.7%) had a consistent percentage of adults (age 18+) that reported consuming fruit less than one time per day with the state (37.5%).
- Between 2013 and 2017, the percent of adults (age 18+) that reported consuming vegetables less than one time per day in Geary County and the state decreased.
- In 2017, Geary County (18.2%) had a slightly higher percentage of adults (age 18+) that reported consuming vegetables less than one time per day than the state (17.3%).

<table>
<thead>
<tr>
<th>Geary County</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2015</td>
</tr>
<tr>
<td>42.9%</td>
<td>45.3%</td>
</tr>
<tr>
<td>41.7%</td>
<td>43.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Geary County</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2015</td>
</tr>
<tr>
<td>24.5%</td>
<td>31.0%</td>
</tr>
<tr>
<td>22.9%</td>
<td>22.3%</td>
</tr>
</tbody>
</table>


Definition: Respondents who reported they consumed fruit or vegetables less than 1 time per day.
Health Status

*Chronic Conditions – Asthma*

- Between 2013 and 2017, asthma prevalence rates in adults (age 18+) in Geary County and the state increased.
- In 2017, Geary County (12.8%) had a higher percentage of adults (age 18+) ever diagnosed with asthma than the state (9.1%).

<table>
<thead>
<tr>
<th>Geary County</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.3%</td>
<td>8.9%</td>
</tr>
<tr>
<td>15.0%</td>
<td>8.7%</td>
</tr>
<tr>
<td>12.8%</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

*Current Asthma Percentage, Adults (age 18+)*

2013, 2015, 2017

Definition: Has a doctor, nurse, or other health professional ever told you that you had asthma?
Health Status

Chronic Conditions – Arthritis

• Between 2013 and 2017, arthritis prevalence rates in adults (age 18+) in Geary County and the state increased.

• In 2017, Geary County (29.4%) had a higher percentage of adults (age 18+) ever diagnosed with arthritis than the state (24.1%).


Definition: Has a doctor, nurse, or other health professional ever told you that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?
Health Status

Health Behaviors – Physical Inactivity

- In 2016, the percent of the adult population (age 20+) in Geary County (24.5%) that self-reported no leisure time for physical activity was slightly higher than the state rate (24.2%) and higher than the national rate (22.8%).

- The percent of adults (age 18+) that did not participate in leisure time physical activity in Geary County decreased between 2013 and 2017, while rates in the state increased.

- In 2017, the percentage of adults (age 18+) that did not participate in physical activity in Geary County (26.1%) was lower than the state (27.9%).
Health Status

Health Behaviors – Binge Drinking

- Between 2013 and 2017, the percentage of adults (age 18+) at risk of binge drinking in Geary County fluctuated while rates in the state increased.
- In 2017, Geary County (15.0%) had a lower percentage of adults (age 18+) at risk of binge drinking than the state (17.2%).

Binge Drinking
Percentage At Risk, Adults (age 18+)
2013, 2015, 2017

Definition: During the past 30 days, what is the largest number of drinks you had on any occasion? Respondents are classified as “at risk” for binge drinking if males reported consuming 5 or more and females reported consuming 4 or more alcoholic beverages at one time.
Health Status

Health Behaviors – Smoking

- Between 2013 and 2017, the percent of adults (age 18+) that self-reported currently smoking cigarettes in Geary County decreased, while rates in the state increased.

- In 2017, the prevalence of current smokers in Geary County (17.4%) was lower than the state (32.2%).

Current Cigarette Smokers
Percentage, Adults (age 18+)
2013, 2015, 2017

<table>
<thead>
<tr>
<th></th>
<th>Geary County</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>45.6%</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>25.4%</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>17.4%</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>20.0%</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>17.7%</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>32.2%</td>
<td></td>
</tr>
</tbody>
</table>

Frequency of Smoking Definition: Respondents who reported they have smoked at least 100 cigarettes in their entire life and that they now smoke some days or every day.
Note: smoking refers to cigarettes, and does not include electronic cigarettes (e-cigarettes, NJOY, Bluetip), herbal cigarettes, cigars, cigarillos, little cigars, pipes, bidis, kreteks, water pipes (hookahs), marijuana, chewing tobacco, snuff, or snus.
Health Status

Maternal & Child Health Indicators

• Between 2016 and 2018, the percent of live births to mothers receiving adequate prenatal care in Geary County decreased, while rates in the state remained steady.

• In 2018, Geary County (71.4%) had a lower percentage of live births to mothers receiving adequate prenatal care than the state (83.4%).

• Between 2016 and 2018, the percent of low birthweight births in Geary County and the state increased.

• In 2018, Geary County (7.1%) had a slightly lower percentage of low birthweight births than the state (7.4%).

**Mothers Receiving Adequate Prenatal Care**

<table>
<thead>
<tr>
<th>Percentage, Live births</th>
<th>2016-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>73.6%</td>
</tr>
<tr>
<td>Kansas</td>
<td>83.4%</td>
</tr>
</tbody>
</table>

**Low Birthweight Births (<2.500g)**

<table>
<thead>
<tr>
<th>Percentage, Live births</th>
<th>2016-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>6.5%</td>
</tr>
<tr>
<td>Kansas</td>
<td>7.4%</td>
</tr>
</tbody>
</table>


Note: Data are reported by mother’s place of residence, not infant’s place of birth.

Adequate Prenatal Care Definition: Percent births where birth certificate indicates mother with less than adequate prenatal care as measured by the Kessner Index. The Kessner Index measures levels of prenatal care as determined by the trimester that prenatal care begins, the number of prenatal care visits, and the period of gestation.
Health Status

Mental Health – Depressive Disorders

- In 2017, the percentage of Medicare Beneficiaries in Geary County (15.8%) with depression was lower than the state (18.9%) and national rates (17.9%).

- Between 2013 and 2017, the rate of adults (age 18+) ever diagnosed with a depressive disorder in Geary County decreased, while rates in the state increased.

- In 2017, Geary County (22.8%) had a higher percentage of adults (age 18+) ever diagnosed with a depressive disorder than the state (20.9%).


Definition: Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder including depression, major depression, dysthymia, or minor depression?
Health Status

*Mental Health – 14+ Days of Poor Mental Health*

- Between 2013 and 2017, the percent of adults (age 18+) that reported experiencing 14 or more days of poor mental health in Geary County decreased, while rates in the state increased.
- In 2017, Geary County (11.9%) had a consistent percent of adults (age 18+) that reported experiencing 14 or more days of poor mental health with the state (11.4%).

**Days of Poor Mental Health - 14+**

**Percentage, Adults (age 65+)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Geary County</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>20.4%</td>
<td>9.7%</td>
</tr>
<tr>
<td>2015</td>
<td>13.8%</td>
<td>9.7%</td>
</tr>
<tr>
<td>2017</td>
<td>11.9%</td>
<td>11.4%</td>
</tr>
</tbody>
</table>


Definition: Days mental health not good - 14 days
### Health Status

**Screenings – Mammography, Prostate Screening, Pap Test, Colorectal (Medicare)**

#### Received Mammography Screening

<table>
<thead>
<tr>
<th>Received Mammography Screening</th>
<th>Percent, Females (age 35+)</th>
<th>2015-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>40.0%</td>
<td>38.0%</td>
</tr>
<tr>
<td>Kansas</td>
<td>33.0%</td>
<td>34.0%</td>
</tr>
<tr>
<td>United States</td>
<td>32.0%</td>
<td>32.0%</td>
</tr>
</tbody>
</table>

#### Received Prostate Cancer Screening

<table>
<thead>
<tr>
<th>Received Prostate Cancer Screening</th>
<th>Percent, Males (age 50+)</th>
<th>2015-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>24.0%</td>
<td>22.0%</td>
</tr>
<tr>
<td>Kansas</td>
<td>17.0%</td>
<td>17.0%</td>
</tr>
<tr>
<td>United States</td>
<td>15.0%</td>
<td>16.0%</td>
</tr>
</tbody>
</table>

#### Received Pap Test Screening

<table>
<thead>
<tr>
<th>Received Pap Test Screening</th>
<th>Percent, Females (all ages)</th>
<th>2015-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>5.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Kansas</td>
<td>5.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>United States</td>
<td>6.0%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

#### Received Colorectal Cancer Screening

<table>
<thead>
<tr>
<th>Received Colorectal Cancer Screening</th>
<th>Percent, Adults (age 50+)</th>
<th>2015-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>3.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Kansas</td>
<td>4.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>United States</td>
<td>6.0%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>


Mammography Screening Definition: percentages are identified using the HCPCS/CPT codes present in the Medicare administrative claims. The uptake rate for mammography services is calculated as the percentage of beneficiaries that received at least one of the services (defined by HCPCS/CPT codes) in a given year. Number of beneficiaries for mammography services excludes: beneficiaries without Part B enrollment for at least one month; beneficiaries with enrollment in Medicare Advantage; male beneficiaries; and female beneficiaries aged less than 35.

Colorectal Cancer Screening Definition: percentages are identified using the HCPCS/CPT codes present in the Medicare administrative claims. The uptake rate for colorectal cancer services is calculated as the percentage of beneficiaries that received at least one of the services (defined by HCPCS/CPT codes) in a given year. Number of beneficiaries for colorectal cancer screening services excludes: beneficiaries without Part B enrollment for at least one month; beneficiaries with enrollment in Medicare Advantage; and beneficiaries aged less than 50.

Pap Test Screening Definition: percentages are identified using the HCPCS/CPT codes present in the Medicare administrative claims. The uptake rate for pap test services is calculated as the percentage of beneficiaries that received at least one of the services (defined by HCPCS/CPT codes) in a given year. Number of beneficiaries for pap test services excludes: beneficiaries without Part B enrollment for at least one month; beneficiaries with enrollment in Medicare Advantage; and male beneficiaries.

Prostate Cancer Screening Definition: percentages are identified using the HCPCS/CPT codes present in the Medicare administrative claims. The uptake rate for prostate cancer services is calculated as the percentage of beneficiaries that received at least one of the services (defined by HCPCS/CPT codes) in a given year. Number of beneficiaries for prostate cancer screening services excludes: beneficiaries without Part B enrollment for at least one month; beneficiaries with enrollment in Medicare Advantage; female beneficiaries; and male beneficiaries aged less than 50.
Health Status

Preventive Care – Influenza Vaccine

• Between 2013 and 2017, the percent of adults (age 18-64) that did not receive a flu shot in Geary County and the state increased.
• In 2017, Geary County (58.0%) had a lower percentage of adults (age 18-64) that did not receive a flu shot than the state (61.6%).

No Flu Shot in Past Year
Percentage, Adults (age 18+)
2013, 2015, 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Geary County</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>51.1%</td>
<td>57.8%</td>
</tr>
<tr>
<td>2015</td>
<td>59.9%</td>
<td>57.4%</td>
</tr>
<tr>
<td>2017</td>
<td>58.0%</td>
<td>61.6%</td>
</tr>
</tbody>
</table>


Definition: During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?
Health Status

Health Care Access – Uninsured

• As of 2017, Geary County (10.2%) has a lower rate of uninsured adults (age 18-64) as compared to the state (12.3%).

• Geary County and the state experienced declines in the percentage of uninsured adults (age 18-64) between 2013 and 2017 (9.1% and 5.2%, respectively).

Uninsured Percent, Adults (age 18-64) 2013-2017

Health Status

**Health Care Access – Medical Cost Barrier & No Personal Doctor**

- Between 2013 and 2017, the percent of adults (age 18+) that needed medical care but could not receive it due to cost in Geary County and the state decreased.
- In 2017, the percent of adults (age 18+) that reported experiencing a medical cost barrier in the past 12 months in Geary County (12.2%) was consistent with the state (12.1%).
- Between 2013 and 2017, the percent of adults (age 18+) in Geary County that reported having no personal doctor decreased, while rates in the state slightly increased.
- In 2017, Geary County (30.6%) had a higher percent of adults (age 18+) that had no personal doctor than the state (22.4%).

### Medical Cost Barrier to Care

<table>
<thead>
<tr>
<th>Percentage, Adults (age 18+)</th>
<th>2013, 2015, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>14.2%, 10.9%, 12.2%</td>
</tr>
<tr>
<td>Kansas</td>
<td>13.6%, 11.0%, 12.1%</td>
</tr>
</tbody>
</table>

### No Personal Doctor

<table>
<thead>
<tr>
<th>Percentage, Adults (age 18+)</th>
<th>2013, 2015, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geary County</td>
<td>36.9%, 31.9%, 30.6%</td>
</tr>
<tr>
<td>Kansas</td>
<td>21.5%, 20.1%, 22.4%</td>
</tr>
</tbody>
</table>


**Definition:** Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?

**Definition:** Do you have one person you think of as your personal doctor or health care provider?
Health Status

*Health Care Access – Providers*

- In 2014, the rate of primary care physicians per 100,000 population in Geary County (35.7 per 100,000) was lower than the state (38.7 per 100,000) and national rates (38.3 per 100,000).

- In 2015, the rate of dental care providers per 100,000 population in Geary County (132.3 per 100,000) was higher than the state (55.4 per 100,000) and national rates (65.6 per 100,000).

- In 2017, the rate of mental health care providers per 100,000 population in Geary County (289.5 per 100,000) was higher than the state rate (192.9 per 100,000) and the national rate (202.8 per 100,000).


Definition: “Primary care physicians” classified by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Definition: All dentists qualified as having a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry and who practice within the scope of that license.

Definition: Psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

Note: a green dial indicates that the county has a better rate than the state, and a red dial indicates that the county has a worse rate than the state.
Health Status

Health Care Access – Common Barriers to Care

• Lack of available primary care resources for patients to access may lead to increased preventable hospitalizations.
  – In 2015, the rate of preventable hospital events in Geary County (54.6 per 1,000 Medicare Enrollees) was higher than the state (51.3 per 1,000) and the nation (49.4 per 1,000).

• Lack of transportation is frequently noted as a potential barrier to accessing and receiving care.
  – In 2014-2018, 4.6% of households in Geary County had no motor vehicle, as compared to 5.4% in Kansas and 8.7% in the nation.


Definition: Ambulatory Care Sensitive (ACS) conditions include pneumonia, dehydration, asthma, diabetes, and other conditions which could have been prevented if adequate primary care resources were available and accessed by those patients.
PHONE INTERVIEW FINDINGS
Overview

• Conducted 16 interviews with the two groups outlined in the IRS Final Regulations
• Discussed the health needs of the community, access issues, barriers and issues related to specific populations
• Gathered background information on each interviewee
Interviewee Information

- **Richard Burnett**: Owner/Director, Family Care Center of Junction City
- **Allen Dinkel**: City Manager, Junction City
- **Maria Ellis, LSCSW**: Counselor, Pawnee Mental Health
- **Joseph Handlos**: Chair, Live Well Geary County
- **Ted Hayden**: Executive Director, YMCA
- **Kelly Heindel**: Office Manager, Junction City Fire Department
- **Danielle Holliday**: Community Development Coordinator, Konza Prairie Community Health Center
- **Terry Johnson**: Fire Chief, Junction City Fire Department
- **Linda Kidd**: Program Assistant, Geary County Schools Infant Toddler Services (0-3)
- **Erica Lee**: Senior Case Advocate, Crisis Center, Inc.
- **Nichole Mader**: Director, United Way of Junction City/Geary County
- **Chuck Otte**: Agent, KSU Extension
- **Stephanie Peterson**: Director, Flint Hills Metropolitan Planning Organization
- **Charles Stimatze**: County Commissioner, Junction City
- **Tammy Vonbusch**: Director, Geary County Health Department
- **Kent Vosburg**: Division EMS/Training Chief, Junction City Fire Department

Source: Geary Community Hospital Community Health Needs Assessment Interviews conducted by Community Hospital Consulting; August 5, 2019 – August 16, 2019.
Interviewee Characteristics

- Work for a State, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community
  - 6.3%

- Member of a medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations
  - 56.3%

- Community leaders
  - 37.5%

Note: Interviewees may provide information for several required groups.
Community Needs Summary

• Interviewees discussed the following as the most significant health issues:
  – Insurance Coverage & Affordability of Care
  – Transportation
  – Access to Primary Care
  – Access to Specialty Care
  – Access to Mental and Behavioral Health Care
  – Access to Dental Care
  – Community Education & Preventive Care

Source: Geary Community Hospital Community Health Needs Assessment Interviews conducted by Community Hospital Consulting; August 5, 2019 – August 16, 2019.
Insurance Coverage & Affordability of Care

**Issues:**
- Concern surrounding the unmet needs of the low income, un/underinsured populations
- Low prioritization of health care needs due to cost barriers to care
- Outmigration of vulnerable populations to nearby clinics for more affordable services
- Cost barriers to care leading to delaying and/or foregoing care
- Greater difficulty placing low income, un/underinsured patients requiring mental health services
- Challenge in navigating health care system for military/military dependent families, homeless

**Needs:**
- Efforts to promote financial assistance, support programs, discounted services in the community
- Greater access to affordable healthcare coverage and services for underserved populations
- Education concerning the importance of seeking preventive care services

“There’s a lot of low income people that come in here and they don’t always receive all the care that they need.”

“A lot of the people here cannot afford health insurance, even through the ACA. It is absolutely insanely expensive to have health insurance. And if you don’t have health insurance, you’re looking at a $1,000 bill for even just a cold.”

“When families can’t afford to pay their rent, they sure as heck can’t afford to pay insurance.”

“There are a couple of clinics here but from experience, they’re not affordable if you don’t have insurance. Especially for low income. If you’re unable to pay it, they take you to court.”

“There’s a free clinic in Manhattan that has been very helpful for a lot of different things but we don’t have anything like that around here.”

“The uninsured just aren’t going to the doctor very much until it’s absolutely necessary. They get sicker and sicker until it’s a full blown emergency.”

“We serve a lot of people who are uninsured. Being able to get them somewhere for mental health, especially, more so than anything else is our biggest issue.”

“We see a lot of homelessness and tied to that is lack of insurance, lack of identification, and so they drop between the cracks as far as care goes.”

“Some of the army connected people go to the army hospital, some don’t. That also means we have a large population of retired military that have varying needs. Sometimes they go to the VA, sometimes they go to the hospital.”
Transportation

• **Issues:**
  – Transportation barriers in getting to/from health care services
  – Lack of built environment conducive to transportation via biking, walking, etc.
  – Challenges with existing transportation system
  – Concern surrounding the unmet transportation needs of the following:
    ▪ Families
    ▪ Elderly
    ▪ Low income
    ▪ Rural
    ▪ Veterans

• **Needs:**
  – Efforts to improve local public transit system availability
  – Emphasis on the transportation needs for underserved populations
  – Focus on efforts to enhance built environment to encourage other modes of transportation (walking, biking)

“We need to think about the biggest question. How do we get vulnerable populations to providers and appointments?”

“We need access to the health care system and different providers, and again it can’t just be by vehicle, we need to be providing access via transit, walking, biking…”

“Most people have accepted the fact that Junction City isn’t walkable or bike friendly. There is a bus that will pick up 60+ adults and take them to the doctor’s office, but that’s hard to navigate.”

“Even though we have one, there are still a lot of people who don’t know how to use our existing public transit system.”

“A lot of families have transportation issues and don’t have a way to get to the hospital or to doctors…that can be an issue with a lot of families here. The ATA bus has certain stops and routes that some families utilize, but several families have several kids and that can be inconvenient for them.”

“We need transportation for older, lower income populations that live a far distance from the hospital. We don’t have really good public transportation, it’s getting better, but people can’t afford a taxi. But if the entire population had transportation, we wouldn’t have enough providers. We’re keeping heads above water because people aren’t going and getting care they way really should.”

“For Veterans, it’s very difficult to get to Topeka and the quality care is not the greatest over there. They’re limited to where they can go because they are vets, but there have been some that have not gotten the greatest care through the VA.”

Source: Geary Community Hospital Community Health Needs Assessment Interviews conducted by Community Hospital Consulting; August 5, 2019 – August 16, 2019.
Access to Primary Care

• Issues:
  – Limited availability of local resources leading to outmigration of patients outside of Junction City
  – Challenges in seeking primary care services covered by insurance, particularly for:
    ▪ KCare
    ▪ Military and military dependents
    ▪ Un/underinsured
  – Concern surrounding communication across the continuum of care
  – Misuse of the Emergency Room due to:
    ▪ Long wait times for an appointment with a PCP
    ▪ Long wait time in waiting room of PCP office
    ▪ Desire to not miss work
  – Lack of education on the difference across health care settings
  – Outmigration of pediatric patients to Manhattan, distrust in longevity of new providers

• Needs:
  – Continued efforts towards recruitment of physicians
  – Education regarding importance in establishing relationship with primary care providers
  – Emphasis on the primary care needs of all insurance types
  – Focus on retention of pediatricians

“The challenge with access to care comes back to hours people are open. Many people go out of town because there are providers that have extended hours.”

“People with KCare are very limited in where they can go for primary care in Junction City.”

“Military dependents are limited on who they can see because a lot of providers don’t accept Tricare. Those who do accept Tricare…the billing never seems to be correct, fees change all the time.”

“Un/underinsured people don’t have the financial resources to pay for follow up testing or medications that are recommended.”

“How does AlphaCare communicate with primary care providers to make sure information is passed along? It’s a continuity of care issue.”

“What happens is that their primary care doc says they’re busy and can’t see them, so people go to the ER because they want to be seen fairly quickly.”

“If you have an appointment for 9am, you might be seen by 11am.”

“For the working poor, if an hour is taken off of work, that’s one less hour of pay they get. So sometimes they have to go to the ER because it’s after work hours and that’s when they can go.”

“For a lot of people here, 911 is their primary access to health care. There’s no one there to educate the patient on where to go for certain types of care.”

“Most people go to Manhattan because there isn’t a pediatrician in Junction City. We have never had longevity of keeping pediatrics in Junction City. If a new doc comes in, nobody trusts that they’ll be long term here.”
Access to Specialty Care

• Issues:
  – Shortage of specialty care services
  – Lack of local services leading to:
    ▪ Long wait times
    ▪ Outmigration of patients to Kansas City, Wichita, Topeka, Selina, Manhattan
    ▪ Delaying/foregoing care
  – Specific specialties mentioned as needed include:
    ▪ Cardiology (FT)
    ▪ OB/GYN
    ▪ Neurology (FT)
    ▪ Dialysis
    ▪ Gastroenterology
  – Limited access to pediatric specialty services at Children’s Mercy
  – Concern surrounding negative public commentary leading to outmigration

• Needs:
  – Continued efforts towards recruitment efforts for specialty care providers
  – Emphasis on availability of local specialty care services for residents

“We need more access to specialty services. A lot of people have to drive all the way to Kansas City or Wichita to get specialty care. And it’s unaffordable.”

“We have some visiting cardiologists, visiting neurologists...but nobody seems to be here full time in that respect.”

“People leave for cardiac care. We have a few specialists who come here, but when it comes to doing the procedure, people go to Topeka or Selina.”

“Cardiology is something we just don’t have, and we have a lot of people with heart problems and heart conditions. With OB/GYN, there’s only one provider around in Geary County and so typically people go to Manhattan.”

“We only have one OB/GYN in Geary County which is concerning. Most specialists just come a few days a week. No one sets up shop here.”

“There’s only one dialysis center here. Heart patients have to travel to get care, anything involving cardiac, stroke, respiratory...those things require traveling.”

“People have to go to Manhattan or somewhere else for gastroenterology.”

“Specialty pediatric care is nonexistent. The hospital has partnered with Children’s Mercy to have some specialties here, but the waiting list to be able to see someone is absolutely crazy and they don’t cover all the specialties.”

Source: Geary Community Hospital Community Health Needs Assessment Interviews conducted by Community Hospital Consulting; August 5, 2019 – August 16, 2019.

Geary Community Hospital Community Health Needs Assessment and Implementation Plan
Community Hospital Consulting

September 2020
Access to Mental & Behavioral Health Care

**Issues:**
- Stigma associated with seeking mental and behavioral health care
- Cultural perspectives driving use of mental and behavioral health care services
- Limited local resources leading to transferring of patients outside of the county
- Shortage of providers resulting in long wait times, use of law enforcement to manage mental and behavioral health-related situations
- Lack of substance abuse treatment facilities, developmental evaluations for pediatric patients
- Significant recreational drug use (methamphetamine, opioids)
- Greater challenge in seeking care for Medicare, TriCare patients

**Needs:**
- Efforts to reduce stigma associated with seeking care
- Increased access to local mental and behavioral health services, particularly for underserved populations
- Increased emphasis on need for primary prevention for mental and behavioral health
- Promotion and generation of substance abuse programs and services

“Mental health issues are the most undertreated problem and that gets back to the perception that people have about that. If you have high blood pressure, you take medication for it. There’s this mental stigma. We’ve got to get past the mental stigma.”

“The African American population will go to families and pastors as support sources instead of getting mental health services for themselves. From a cultural perspective, there are factors that influence people reaching out to access care and who they’re reaching out to.”

“Wait times are way too long. People have PTSD issues and law enforcement have to deal with mental issues on a daily basis because all the providers are booked up. It’s an issue because it eats up time and resources.”

“It’s a matter of having enough providers for people who need help now, not in 2 weeks or in a month. We need more resources for those crisis mental health needs in our community.”

“There are not any mental health professionals seeing pediatric patients. A lot of families have been referred to Children’s Mercy and they do not specifically provide autism evaluations or developmental evaluations.”

“There are no detox facilities here, and there is a tremendous substance abuse problem. A large part of it is meth and opioids.”

“There are not a lot of mental health providers accepting Medicare and TriCare patients. They require an additional level of credentialing, so that impacts access for those populations. We need mental health care for family members of veterans who don’t know how to manage the struggles that their loved one is experiencing.”

Source: Geary Community Hospital Community Health Needs Assessment Interviews conducted by Community Hospital Consulting; August 5, 2019 – August 16, 2019.
Access to Dental Care

• **Issues:**
  – Limited local resources leading to transferring of patients outside of the county, long wait times for appointments
  – Insurance coverage as determinant in ability to receive local care
  – Perceived lack of emphasis on preventive dental care services
  – Concern surrounding oral health issues due to tobacco use
  – Lack of affordable services leading to low prioritization of oral health

• **Needs:**
  – Continued support towards recruitment efforts for dental care providers
  – Emphasis on increased access to affordable dental care services for low income pediatric residents
  – Focus on the importance of dental care coverage, preventive care

“There is a tremendous need for dental care in our community. Oral surgery and implant services for dental care are really lacking in Geary County. Insurance doesn’t always cover some of those things but they are very needed, and people have to leave the county to access them.”

“It’s difficult to get an appointment in there, the wait is long. Sometimes they can get you in if it’s an emergency but a lot of people are on state insurance so they’re going outside Geary County for that as well.”

“It takes forever to get into a dentist and we've lost several dentists in town.”

“We are lacking communication in the importance of preventive dental care services. The resources are there, it’s a matter of communicating it appropriately.”

“Dental care is just so, so expensive...especially for a community that has the kind of smoking and tobacco issues that we have. All those kinds of oral health. We have great needs here and to fix things in your mouth costs a lot of money.”

“Preventive dental care is a large health need here. It’s not being accessed and utilized, but a lot of people have oral problems. When you’re worried about not having enough food and not being able to pay your rent, you’re not going to the dentist.”
Community Education & Preventive Care

• Issues:
  – Limited health education and connection in the community
  – High rates of obesity, diabetes worsened by lack of understanding of patient health information
  – Lack of built environment leading to lower rates of healthy lifestyle behaviors
  – Perceived higher rates of obesity, poor lifestyle behavior for youth
  – Concern surrounding high rates of food insecurity and access to healthy, nutritious foods
  – High rates of tobacco, vapor use

• Needs:
  – Targeted healthy lifestyle education towards underserved populations
  – Increased access to healthy food options, healthy lifestyle opportunities
  – Efforts to emphasize the health risks of tobacco use, vaping

“People have to get reconnected with their food. We have a terrible disconnect.”

“There’s a rampant amount of obesity across the age spectrum with a crossover of diabetes, and there’s a real lack of education in this community about what their health numbers mean, like a1c. People get diagnosed with diabetes and they’re uninformed.”

“Obesity is a big issue. Diabetes is a big issue. There’s not good sidewalks throughout the city, that kind of thing.”

“Everybody’s seeing that kids are getting larger waisted and bigger, they’re wanting to spend more time in front of a screen.”

“I am baffled by the type of food offered in our school vending machines. Candy, chips, sugary stuff...it seems like you have a kid sitting in school all day who needs peanut butter/celery, something with protein, to help get their brain thinking instead of a sugar high.”

“Geary County is one of the most food insecure counties in Kansas. How do they get there to get access to healthy foods?”

“Food insecurity and nutrition is a big health need because we have a lot of people who struggle financially and we all know that the cheap food is typically processed food. Having access to healthy nutritious food is a challenge in our county.”

“The biggest health need is smoking cessation. I am in a parking lot right now and sitting in between a vaper and a smoker.”
Populations Most at Risk

Interviewees expressed concern surrounding health disparities disproportionately affecting specific populations, including:

• **Pediatric**
  - Lack of local developmental disability services
  - Limited local access to pediatricians

• **Elderly**
  - Transportation barriers
  - Limited access to mental health resources and services

• **Teenagers/Adolescents**
  - Obesity
  - Need for role models
  - Depression, anxiety
  - Substance abuse education, rehab services
  - Need for domestic violence screenings

• **Homeless**
  - Lack of access to local shelters, difficulty getting into shelters
  - Growing population

• **Veterans/Military Dependents**
  - Limited access to mental health resources and services
  - Stigma associated with seeking mental health care services
  - Difficulty accessing health care services due to insurance coverage barriers

• **Racial/Ethnic Groups**
  - Language barriers

• **Low Income/Working Poor**
  - Transportation barriers

Source: Geary Community Hospital Community Health Needs Assessment Interviews conducted by Community Hospital Consulting; August 5, 2019 – August 16, 2019.
COMMUNITY SURVEY FINDINGS
Survey Methodology

• Survey developed by CHC Consulting and distributed on behalf of Geary Community Hospital
• Emailed as an invitation from former interim CEO Don Smithburg and posted onto the GCH website, Facebook page
• Survey sent to identified individuals/organizations in the community, GCH staff, and posted for public commentary
  – Survey conducted between January 27, 2020 – February 17, 2020
  – 55 respondents serving a multi-county area around Geary County
• Respondents allowed to take survey only once but were encouraged to forward the survey to additional community leaders
  – We were not able to track the number of times the survey was forwarded so it is difficult to calculate an overall response rate
  – It should be noted that not all survey questions were answered by all of those submitting surveys
  – The percentages reflected in the following summary were calculated using the actual number of respondents to the specific survey question
Organizations Responding to Survey

- Junction City Fire Department
- Junction City
- Family Care Center of Junction City
- Flint Hills Metropolitan Planning Organization
- Fort Riley Irwin Community Hospital
- Geary Community Hospital
- Geary County Health Department
- Konza Prairie Community Health Center
- Geary County Convention & Visitors Bureau
- Kansas State University
- Memorial Health System
- Morrison Healthcare
- United Way of Junction City/Geary County

Note: not all respondents provided an organization.
Organization Type

• CHNA regulations require input from two specific groups and input was gained from each
  – State, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community – **41.5% (22 of 53)**
  – Member of a medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations – **20.8% (11 of 53)**

• Majority of respondents (71.2%) work for a health care facility followed by governmental agencies (13.5%)

• Respondents who indicated “Other” for their company/organization include retirees and propane business

Counties Served

- In addition to Geary County, respondents indicated serving the following communities:
  - Riley County
  - Dickinson
  - Topeka
  - Wabaunsee
  - Marion
  - Saline
  - Clay
  - Washington
  - Shawnee
  - Pottawatomie
  - Morris
Health Need Adequacy for Specific Populations

- More than one-third of respondents indicated “Very Inadequate or Inadequate” services for persons with mental illness, working poor, persons with no social or emotional support, homeless, and low income groups.

Health Need Adequacy for Specific Populations

• More than one-third of respondents indicated “Very Inadequate or Inadequate” services for persons with mental illness, working poor, persons with no social or emotional support, homeless, and low income groups

• Survey respondents indicated the following regarding “Very Inadequate or Inadequate” services:
  – We do not have enough mental health providers or inpatient beds in Kansas and hold them in the ER for days at a time. There is NO homeless shelter or resources for homeless in our community at all.
  – Junction City has low paying jobs and much of the population do not have sufficient income to pay for medical care which makes that a low priority in suffering households.
  – We have a very high rate of poverty in Geary County. Individuals/families are either under-insured or have no insurance. They do not use services in fear of creating bills that they cannot pay.
Health Need Adequacy for Specific Populations: Very Inadequate/Inadequate Detail

• Contributing factors indicated by respondents on open ended questions:
  – We need to expand Medicaid to provide insurance for the working poor and underinsured.
  – We have a very high rate of poverty in Geary County. Individuals/families are either under-insured or have no insurance. They do not use services in fear of creating bills that they cannot pay.
  – Need more for the less fortunate, it’s bad when people have to choose between eating and health care!
  – We do not have enough mental health providers or inpatient beds in Kansas and hold [those patients] in the ER for days at a time. There is NO homeless shelter or resources for homeless in our community at all
  – Access to care is hard for people with no insurance. They are not aware of the resources we have and the ability to receive care despite no insurance.
  – Junction City has low paying jobs and much of the population do not have sufficient income to pay for medical care which makes that a low priority in suffering households.
  – There is no inpatient care for psychiatric needs, nor is there a physician on staff. There is a lack of general social support functions, i.e. Social Workers, Outpatient Counseling, nor support groups for Alcoholism, or Addiction issues.
  – Geary County’s disparate rate of hypertension, obesity, and diabetes are compounded by a variety of social determinants of health including under-employment, underinsured status, low-socioeconomic status, high-housing costs, and racial disparities. Geary County’s uniquely diverse and transient community increases language and communication barriers, while relatively young, inadequate resources exist to serve the aging population. Organizations serving the uninsured/underinsured populations are under resourced and unable to meet the needs of the growing population of working poor and middle class that are falling between the gaps in safety net programming and funding.
  – People who don’t speak English or are undocumented really are at a disadvantage.

Geary Community Hospital Community Health Needs Assessment and Implementation Plan
Community Hospital Consulting
Most Important Health Initiatives

Respondents ranked the following health care initiatives for all residents from most important to least important:

1. Improving access to preventive care (screenings for chronic diseases, immunizations)
2. Promoting behavior change in unhealthy lifestyles
3. Health promotion and preventive education
4. Recruiting more health care providers
5. Recruiting specialists who can provide services that are not currently available
6. Improving access to health care for populations with limited services
7. Promoting chronic disease management
8. Improving access to dental care for populations with limited services
9. Increasing the proportion of residents who have access to health coverage
10. Promoting provider connectedness
11. Helping ensure the availability of cutting edge treatments
**Most Important Health Problems**

- Respondents were asked to select the five most important issues in the community for the categories listed below:

<table>
<thead>
<tr>
<th>Health Problems</th>
<th>Chronic Diseases</th>
<th>Preventable Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mental Health Problems (66.7%)</td>
<td>1. Diabetes (71.4%)</td>
<td>1. Mental Illness (56.3%)</td>
</tr>
<tr>
<td>2. Obesity (adult) (52.8%)</td>
<td>2. Mental Illness (71.4%)</td>
<td>2. Chronic Obstructive Pulmonary Disease (COPD) (46.9%)</td>
</tr>
<tr>
<td>3. Substance Abuse (50.0%)</td>
<td>3. Obesity (60.0%)</td>
<td>3. Uncontrolled Diabetes (46.9%)</td>
</tr>
<tr>
<td>4. Suicide (41.7%)</td>
<td>4. Hypertension (high blood pressure) (54.3%)</td>
<td>4. Influenza (43.8%)</td>
</tr>
<tr>
<td>5. Obesity (children) (36.1%)</td>
<td>5. Chronic Obstructive Pulmonary Disease (COPD) (42.9%)</td>
<td>5. Congestive Heart Failure (43.8%)</td>
</tr>
</tbody>
</table>

Note: Respondents allowed to select multiple items. Percentages are greater than 100% due to multiple responses.

Barriers for Low Income Residents

- Respondents asked to rank barriers related to access to primary/preventative care for low income residents in the community which include (in rank order):
  1. Lack of access due to provider distance
  2. Language barriers
  3. Lack of providers accepting Medicaid/Medicare
  4. Lack of capacity (e.g. insufficient providers/extended wait times)
  5. Delays or complications in referrals to services
  6. Lack of child care
  7. Scheduling (system inefficiency/non-standardized process)
  8. Lack of transportation resource
  9. Difficulty navigating system/lack of awareness of available resources
  10. Eligibility screening process for benefits/covered services
  11. Delays in authorization/referral approval
  12. Lack of coverage/financial hardship

Access for Low Income Residents

- Respondents asked to rate the level of difficulty low income residents face when trying to access specific health related services
  - Most difficulty accessing mental and behavioral health care services, substance abuse services, and routine specialty care
  - Easier access to emergency services, urgent care services, prenatal care and routine hospital services
Barriers to Care Coordination

- Below are barriers to effective care coordination
  1. Limited health IT infrastructure and interoperability
  2. Lack of staff and time for investment in coordination (at the practice and broader community levels)
  3. Complexity of coordination for patients with high levels of need and/or with frequent hospital and clinic visits
  4. Practice norms that encourage clinicians to act in silos rather than coordinate with each other
  5. Limited financial integration across most providers
  6. No (or few) financial incentives or requirements for care coordination for providers
  7. Fragmented, stand-alone services, rather than an integrated delivery system
  8. Lack of partnerships across community organizations
  9. Lack of communication between health care facilities and providers
  10. Lack of community involvement
  11. Limited Primary Care provider involvement in inpatient care
  12. Competition between facilities
  13. Transition from hospital setting to primary care provider
  14. Misconception regarding privacy laws and limits to information sharing/access (HIPAA)

Source: Geary Community Hospital Community Health Needs Assessment Survey conducted by CHC Consulting; January 27, 2020 – February 17, 2020.
Barriers to Effective Care Coordination: Major Barrier Detail

- When asked to elaborate, respondents indicated the following factors as the top barriers of care coordination most affecting patients:
  - There are a lot of communication barriers between agencies and organizations as well as competition between each other.
  - Our system needs updating so that patients can access new patient info online and access more information and paperwork to limit time spent in offices. Partnerships with other facilities to offer healthy choices and incentives for healthy choices!
  - Community as a whole is not a willing participant for [their] care. They do not work on preventative measures. I feel we lack providers and that they may have a difficult time coordinating care for their patients when they are not willing to participate in their own care.
  - Need more coordination of services and flow of services and communication
  - Getting a person admitted to the hospital is a major hurdle. The ER is frequently transferring a patient out, as the primary provider does not want to come in to admit a patient. Allow the hospitalist to admit patients. Little communication between departments, and sometimes in the same department.
  - Geary County has a multitude of community coalitions and partnerships that assist in increasing collaboration and communication. Complex coordination of high-need patients would be an idea output of that collaboration, but due to limited IT interoperability and lack of staff time and resources dedicated, electronic referrals are as far as that collaboration has gotten instead of true integrated service delivery.


Geary Community Hospital Community Health Needs Assessment and Implementation Plan
Community Hospital Consulting
Health Care Service Adequacy

• Respondents asked to rate services adequately provided in the community
  – More than one-third of survey respondents indicated “very inadequate or inadequate” services provided for mental health screenings, substance abuse treatment and tobacco cessation programs
  – More than 50% of respondents feel women’s health exams, routine physical exams, vision/hearing exams and prenatal health care services are “very adequate or adequate”

Adequacy of Health Services

Health Care Service Adequacy:
Very Inadequate and Inadequate Detail

• When asked to give their thoughts on issues of service inadequacy, respondents commented most on the following areas:
  – High poverty rate. Services are not free. Most are uninsured and do not want to put themselves into financial hardship or cannot afford to miss work.
  – Not a whole lot of access to substance abuse treatment or resources for patients. Access to dental care for people without insurance is very difficult to find. Mental health is very hard to get into and established and meds managed.
  – Seems to be issues in mental health patients and trying to get them the support that they need.
  – No mental health services. Contract with Pawnee Mental Health, but it appears a battle with administrations has resulted in that a weak process in place, and no one wants to fix it due to "its the other person’s fault". If you know the process is broken, fix it to help people. Telling a person that your hospital is a major leader in weight loss surgery, and to not worry about other programs is not acceptable. Help people make healthy choices so that maybe they don't have to have surgery.
  – Not enough facilities for proper care.
Health Education

• More than 50% of respondents believe that community members get their health-related education from the internet or friends and family

• Less than 20% of respondents believe that community members are accessing health-related education from area schools, books/magazines, pharmacists, churches, faith based institutions, libraries or help lines

Final Comments

- It's a frightening time. So much is out of control and everything is money-based, not patient care-based.
- Geary County has a tremendous number of strengths but also many challenges, as related to community health. Steps to integrate healthcare services, collaborate across agency lines, and resource comprehensive, affordable, and quality dental, medical, and behavioral health care are necessary to improve community health outcomes.
LOCAL COMMUNITY HEALTH REPORTS
Riley County

2020 Community Needs Assessment – Background

• In an effort to gain insights from the community for the purposes of planning and community improvement, Wichita State University’s Center for Applied Research and Evaluation (CARE) was contracted by the Flint Hills Wellness Coalition to conduct a communitywide needs assessment for Riley County, which included the compilation of selected secondary data, administration of a community survey, community member interviews, and focus groups.

• Secondary data, which is publicly available data such as the Census, Kansas Behavioral Risk Factor Surveillance System (BRFSS), and others, were compiled for the most recent years available.

• The community survey was conducted online and through administration at public locations or meetings to gather input from residents regarding their perceptions of community strengths and needs in 10 topic areas (Quality of Life, Physical Health, Mental Health, Social Issues, Children and Youth, Education, Aging, Housing, Transportation, and Economics/Personal Finance).

• A total of 1,229 surveys were completed. Although significant efforts were made to solicit participation by a representative sample of community members, survey respondents were largely white, female, middle-aged or older, educated, with higher incomes than average.

• In order to gain additional insight on the issues addressed in the survey as well as any other concerns, 25 community members representing a wide range of interests, ages, length of residency, and professions were interviewed. Additionally, two focus groups were held for populations that were underrepresented in the survey – persons with low income and Hispanics/Latinos – as well as an additional group with community/governmental organization representatives.

• The strengths and needs that were identified for Riley County were remarkably consistent across all methods of data collection.

Riley County

2020 Community Needs Assessment – Primary Findings

- Similar to the findings of the community needs assessment conducted in 2014-2015, the overarching themes for all of the data collected are that Riley County is a community that enjoys a high quality of life and vibrancy, but is beginning to show more negative signs of growth, such as increased housing and property costs, too few living wage jobs, and an expanding gap between “haves” and “have nots” with a resulting need for more resources for those in need. More specifically, the primary findings across all methods are:

  - **HIGH QUALITY OF LIFE**
    - As in 2014-2015, the high quality of life of Riley County remains a primary theme for the survey and interviews/focus groups. Riley County has a reputation as a good place to raise a family, with good schools, including Kansas State University as an anchor for education as well as culture/ activity, good size, good physical and natural environment, and a strong sense of community and collaboration. While the diversity fostered by the university and larger businesses was noted as a key element of the quality of life, discrimination regarding race/ethnicity, income, sexual orientation/ gender identity, and disability was also noted as an issue.

  - **GROWTH AS BOTH A STRENGTH AND A CHALLENGE**
    - While nearly all participants in interviews and focus groups acknowledged that growth in Riley County, and Manhattan especially, has brought good things like increased diversity and new businesses, they also frequently connected this growth with increasing problems such as higher than average housing costs and property taxes, a lack of living wage jobs, and concerns about insufficient infrastructure. In a domino effect, increasing costs to live amidst such growth has created greater needs for services such as food pantries/community meals and other services for persons with lower and even moderate incomes. Some participants felt the community is prematurely preparing for an influx of higher incomes while forgetting about the needs of those who currently live and struggle there. Additionally, the growth of “big box” stores has primarily brought minimum wage jobs, not the living wage jobs that are considered a primary need and economic catalyst in the community.

Riley County

2020 Community Needs Assessment – Primary Findings (continued)

– LACK OF AFFORDABLE HOUSING
  • Affordable housing remains a major issue across the community with the median value being $194,800 in Riley County and $200,400 for Manhattan versus $145,400 in Kansas (2014-2018 estimate). The current median rent is $938 for Riley County and $908 for Manhattan ($831 for Kansas). As noted above, many participants feel the cost of housing is being driven by current or expected growth, which is in turn increasing property taxes and the need for services to help those who are falling behind economically due to these costs. Additionally, residents are finding that new housing is primarily for those with higher incomes while those with moderate or lower incomes are priced out of the market, even for older or less desirable properties. A lack of accountability for landlords is also an issue as deficient properties are not properly addressed, but are often the only affordable options for students and those with lower incomes.

– LACK OF ACCESSIBLE & AFFORDABLE MEANTL HEALTH SERVICES
  • In the 2014-2015 assessment, mental health services emerged as one of the primary issues. Although the lack of mental health services remains a concern, the recent addition of the Pawnee Mental Health Crisis Stabilization Center has helped address at least some of the need. However, the lack of adequate and affordable healthcare has risen to the top for 2019-2020, most particularly related to the hospital. A number of participants noted the limited services offered through the hospital means that many Riley residents must travel or be transported to other hospitals for issues as common as heart attacks. Additionally, it was noted that the community lacks specialists and affordable options for those with lower incomes. Although participants in focus groups noted a few clinics that provide affordable, accessible services, an issue still remains with some providers requiring full payment for services up front, which is typically not an option for lower income persons.

– LACK OF LIVING WAGE JOBS
  • As noted previously, this issue is tied to growth, housing, and the expanding need for services for persons with low income in the community. This issue was brought up across all data collection methods, and a number of interview participants noted the difficulty of keeping talented people in Manhattan unless they are being brought in for the National Bio and Agro-defense Facility (NBAF) or similar high-paying, but highly targeted positions. And even though there may be a reasonable number of job opportunities in the community, a large number are minimum wage or are filled by students. This leaves few employment options beyond entry level and which allow people to have a decent standard of living.
INPUT REGARDING THE HOSPITAL’S PREVIOUS CHNA
Consideration of Previous Input

• IRS Final Regulations require a hospital facility to consider written comments received on the hospital facility’s most recently conducted CHNA and most recently adopted Implementation Strategy in the CHNA process.
• The hospital made every effort to solicit feedback from the community by providing a feedback mechanism on the hospital’s website. However, at the time of this publication, written feedback has not been received on the hospital’s most recently conducted CHNA and Implementation Strategy.
• To provide input on this CHNA please see details at the end of this report or respond directly to the hospital online at the site of this download.
EVALUATION OF HOSPITAL’S IMPACT
Evaluation of Hospital’s Impact

• IRS Final Regulations require a hospital facility to conduct an evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital’s prior CHNA.

• This section includes activities completed based on the 2017 to 2019 Implementation Plan.
Pathway: Community Policy

Work at the community level to create conditions that improve community design and access to healthy places through Built Environment, Food Policy or Tobacco Policy. This may be a new effort or communities may select to enhance policy work already underway in their community. Coordination funding may be used for convening, assessments and consulting.

- Once a policy is enacted, Implementation Grants will be available, with award dependent on the size and scale of the project.

Pathway expectations: Work at the community level to create conditions that improve community design and access to healthy places through built environment, food policy or tobacco control policy. This may be a new effort or communities may select to enhance and build upon policy work already underway in their community. The community is only required to work on one policy related to healthy eating, active living or tobacco during the course of the three-year grant period.

<table>
<thead>
<tr>
<th>Measured Output</th>
<th>Policy Description</th>
<th>Work Prior to 8/1/1</th>
<th>Proposed (Date)</th>
<th>Adopted (Date)</th>
<th>Progress Since Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health policy proposed (at least 1 required)</td>
<td>Prohibiting tobacco use in public play areas: parks with playgrounds, school grounds and sports fields</td>
<td>N/A</td>
<td>17-Jul-18</td>
<td>7-Aug-18</td>
<td>Resolution for Tobacco Free Youth Recreation Areas on City owned property with the exception of Heritage Park and Rolling Meadows Golf Course approved August 7, 2018</td>
</tr>
<tr>
<td>Health policy proposed (additional optional)</td>
<td>Community policy to support installation of bike lanes in areas identified in MPO Master Plan.</td>
<td>Master Plan created by MPO that included a bike plan.</td>
<td>5-Mar-19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Focus | Action Items/Next Steps | Partners | Responsible Party | Start Date (Month-Yr.) | End Date (Month-Yr.) | Status |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>Research Kansas Public Health Laws about legality of policy</td>
<td>KPHL, LWGC</td>
<td>Paula Dinkel, Susan Moyer, Jared Tremblay</td>
<td>Jan-18</td>
<td>Mar-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Research impact of 2nd hand smoke on youth</td>
<td>GCHD, LWGC</td>
<td>Charles Martinez, Paula Dinkel</td>
<td>Mar-18</td>
<td>Jun-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Research and discussion with PHLC to determine steps necessary to enact a policy prohibiting tobacco use in identified areas.</td>
<td>LWGC, GCPHD, Delivering Change, GCH, USD 475, PHLC</td>
<td>Paula Dinkel, Susan Moyer, Jared Tremblay</td>
<td>Mar-18</td>
<td>May-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Discussions with USD 475 about issues with current policies for tobacco use on school grounds</td>
<td>GCHD, LWGC</td>
<td>Charles Martinez, Paula Dinkel</td>
<td>Mar-18</td>
<td>Apr-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Contact Parks and Recreation about current policies for tobacco use in parks and rec areas.</td>
<td>GCHD, LWGC</td>
<td>Charles Martinez, Paula Dinkel</td>
<td>Mar-18</td>
<td>Apr-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Conversations with community members to gain support for policy</td>
<td>GCHD, LWGC</td>
<td>Charles Martinez, Paula Dinkel</td>
<td>May-18</td>
<td>Jun-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Conversations with City and County officials to gain support for policy</td>
<td>LWCG</td>
<td>Paula Dinkel, Susan Moyer, Jared Tremblay</td>
<td>Mar-18</td>
<td>May-18</td>
<td>Complete</td>
</tr>
</tbody>
</table>
**Pathway: Community Policy**

Work at the community level to create conditions that improve community design and access to healthy places through Built Environment, Food Policy or Tobacco Policy. This may be a new effort or communities may select to enhance policy work already underway in their community. Coordination funding may be used for convening, assessments and consulting.

- Once a policy is enacted, Implementation Grants will be available, with award dependent on the size and scale of the project.

**Pathway expectations:** Work at the community level to create conditions that improve community design and access to healthy places through built environment, food policy or tobacco control policy. This may be a new effort or communities may select to enhance and build upon policy work already underway in their community. The community is only required to work on one policy related to healthy eating, active living or tobacco during the course of the three-year grant period.

<table>
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<tr>
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<th>Action Items/Next Steps</th>
<th>Partners</th>
<th>Responsible Party</th>
<th>Start Date (Month-Yr.)</th>
<th>End Date (Month-Yr.)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Obtain documentation necessary for support of tobacco policy from City Commission</td>
<td>LWGC, GCHD, Delivering Change, GCH, USD 475</td>
<td>Paula Dinkel, Susan Moyer, Jared Tremblay</td>
<td>Jun-18</td>
<td>Aug-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Obtain documentation necessary for support of tobacco policy from County Commission</td>
<td>LWGC, GCHD, Delivering Change, GCH, USD 476</td>
<td>Paula Dinkel, Susan Moyer, Jared Tremblay</td>
<td>Jun-18</td>
<td>Aug-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Present Tobacco Free proposal to City Commission and City Officials</td>
<td>LWGC</td>
<td>Susan Jagerson, Joe Handlos</td>
<td>Jul-18</td>
<td>Aug-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>TF Policy approved for Junction City</td>
<td>LWGC</td>
<td>Susan Jagerson, Joe Handlos</td>
<td>Aug-18</td>
<td>Aug-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Obtain TF signage from KDHE for parks, athletic fields and youth recreation areas</td>
<td>LWGC</td>
<td>Susan Jagerson, Joe Handlos</td>
<td>Aug-18</td>
<td>Aug-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Using community policy grant funds, partner with area agencies to create Tobacco Free JC marketing campaign to promote Tobacco Free parks and tobacco cessation programs.</td>
<td>LWGC, Delivering Change and GCPHD</td>
<td>Susan Jagerson, Dani Holliday &amp; Jill Nelson</td>
<td>September-18</td>
<td>November-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Tobacoffeejc. Launch website, collateral pieces and advertising campaign for community tobacco free initiatives</td>
<td>LWGC, Delivering Change and GCPHD</td>
<td>Susan Jagerson, Dani Holliday &amp; Jill Nelson</td>
<td>September-18</td>
<td>November-18</td>
<td>Complete</td>
</tr>
<tr>
<td>Active Living</td>
<td>Partner with MPO and City of Junction City to implement bicycle routes as identified in MPO Master Plan.</td>
<td>LWGC, FHMPO, City of Junction City</td>
<td>FHMPO</td>
<td>November-18</td>
<td>August-20</td>
<td>In-Progress</td>
</tr>
<tr>
<td></td>
<td>Develop MOU to create community policy to support installation of bike lanes in areas identified in MPO Master Plan.</td>
<td>LWGC, FHMPO, City of Junction City</td>
<td>FHMPO</td>
<td>December-18</td>
<td>March-19</td>
<td>Complete</td>
</tr>
</tbody>
</table>

**Messaging / Communication efforts**

Radio - JC Now, Social Media, JC Post, Daily Union, Kick-off event, Signage, Tobacco Free JC marketing campaign

**Pathway Connectivity**

Community Resident Well Being
## Pathway: Community Policy

Work at the community level to create conditions that improve community design and access to healthy places through Built Environment, Food Policy or Tobacco Policy. This may be a new effort or communities may select to enhance policy work already underway in their community. Coordination funding may be used for convening, assessments and consulting.

- Once a policy is enacted, Implementation Grants will be available, with award dependent on the size and scale of the project.

### Pathway expectations:

Work at the community level to create conditions that improve community design and access to healthy places through built environment, food policy or tobacco control policy. This may be a new effort or communities may select to enhance and build upon policy work already underway in their community. The community is only required to work on one policy related to healthy eating, active living or tobacco during the course of the three-year grant period.

### Achievement Grant Status:

Received $5,000 grant to promote Tobacco Free Policy
Pathway: Resident-Community Wellbeing

**Community Project** – Establish one community project per year to engage individuals, increase awareness of healthy lifestyles and share your successes. Funding may be used to coordinate and promote these events. Additionally, through the technical assistance component, BCBSKS will work with communities to assist with identifying and providing access to subject matter experts as appropriate.

**Mobilize residents** Engage residents in the community to sign the Pathways to a Healthy You Pledge to make improvements in their own health, and to participate in community events and other healthy eating, active living and tobacco-free activities.

Coordination grant funds should be used for event planning, communications and marketing in the community. Additional funding is available for community well-being projects through Implementation Grants, with award dependent on the size and scale of the project.

**Pathway expectations:** The community project should incorporate a minimum of one community event per year, and the event should align with the focus area that is being worked on in the other pathways during the same time period. This pathways is intended for coalitions to select a project that is designed to get community members engaged and promote your work. Examples of types of community events: a one-day event, such as a healthy food festival; coordination of an activity, such as a walking group; implementation of a community resource, such as a community garden. Use this pathway as outreach to get more individual community members involved in your work.

<table>
<thead>
<tr>
<th>Measured Output</th>
<th>Project/Event Description</th>
<th>Work Prior to 8/1/17</th>
<th>Output Target</th>
<th>Output to Date</th>
<th>Progress Since Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Pathways to a Healthy You pledges signed (required)</td>
<td>N/A</td>
<td>N/A</td>
<td>200</td>
<td>88</td>
<td>After seeing the level of responses in year one the Pledge goal was adjusted to a more realistic goal.</td>
</tr>
<tr>
<td>Community Project (1 per year required)</td>
<td>Year 1: Partner with I.C.A.R.E. Center on their initiative to install multi-generational fitness playground equipment in City-owned 5th St. Park to promote healthy activities in our community.</td>
<td>N/A</td>
<td>1 per year</td>
<td>1</td>
<td>Received Pathways grant. Equipment ordered and playground is expected to be ready for Kick-off event on September 15.</td>
</tr>
<tr>
<td>Community Event (1 per year required)</td>
<td>Year 1: Kick-off event to promote healthy activity and awareness of new equipment. Open to the public</td>
<td>N/A</td>
<td>1 per year</td>
<td>1</td>
<td>Pathways to Fitness event to include community race, dedicate multi-generational playground and introduce Tobacco Free Resolution is scheduled for September 15.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus</th>
<th>Action Items/Next Steps</th>
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<th>Responsible Party</th>
<th>Start Date (Month-Yr.)</th>
<th>End Date (Month-Yr.)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Living</td>
<td>Conversations with community agencies to determine involvement and plan for obtaining funding, purchasing and installing equipment</td>
<td>LWGC, I.C.A.R.E. Center</td>
<td>LWGC</td>
<td>January-18</td>
<td>December-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Encourage LWGC and Pathways members to submit Healthy Pledge</td>
<td>LWGC</td>
<td>LWGC</td>
<td>March-18</td>
<td>May-18</td>
<td>In-Progress</td>
</tr>
<tr>
<td></td>
<td>Obtain signed pledges at community events. The first one will be Go Red for Women on March 8. Other events will include the Hospital’s annual Chase for a Cause, School Wellness Committee, Community Connections event, Fort Riley events.</td>
<td>LWGC, GCHD</td>
<td>LWGC</td>
<td>February-18</td>
<td>August-20</td>
<td>In-Progress</td>
</tr>
<tr>
<td></td>
<td>Make Health Pledges available at local Farmers Market SNAP-Ed tent.</td>
<td>LWGC, KSRE</td>
<td>LWGC</td>
<td>June-18</td>
<td>September-18</td>
<td>Complete</td>
</tr>
</tbody>
</table>
### Community Project

**Community Project** – Establish one community project per year to engage individuals, increase awareness of healthy lifestyles and share your successes. Funding may be used to coordinate and promote these events. Additionally, through the technical assistance component, BCBSKS will work with communities to assist with identifying and providing access to subject matter experts as appropriate.

### Mobilize residents

Engage residents in the community to sign the *Pathways to a Healthy You Pledge* to make improvements in their own health, and to participate in community events and other healthy eating, active living and tobacco-free activities.

Coordination grant funds should be used for event planning, communications and marketing in the community. Additional funding is available for community well-being projects through Implementation Grants, with award dependent on the size and scale of the project.

### Pathway expectations:

The community project should incorporate a minimum of one community event per year, and the event should align with the focus area that is being worked on in the other pathways during the same time period. This pathways is intended for coalitions to select a project that is designed to get community members engaged and promote your work. Examples of types of community events: a one-day event, such as a healthy food festival; coordination of an activity, such as a walking group; implementation or a community resource, such as a community garden. Use this pathway as outreach to get more individual community members involved in your work.

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<th>End Date (Month-Yr.)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work with ICARE to order and schedule installation of multi-generational playground equipment. Schedule for first week of September</strong></td>
<td>LWGC, I.C.A.R.E. Center</td>
<td>I.C.A.R.E.</td>
<td>18 July</td>
<td>18 September</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td><strong>Partner with USD 475 and other entities for Community Race and Pathways to Fitness Event to kick-off Multi-generational playground and introduce TFP policy.</strong></td>
<td>LWGC, I.C.A.R.E. Center, Geary Co. Ext,</td>
<td>LWGC</td>
<td></td>
<td>18 April</td>
<td>18 September</td>
<td>Complete</td>
</tr>
<tr>
<td><strong>Submit Pathways grant to host community race and Pathways to Fitness on September 15.</strong></td>
<td>LWGC</td>
<td>LWGC</td>
<td></td>
<td>18 July</td>
<td>18 August</td>
<td>Complete</td>
</tr>
<tr>
<td><strong>Hosted Pathways to Fitness Event on September 15, 2018 that covered all three focus areas. Community Race, and multigenerational fitness area groundbreaking, fitness vendors and bicycle/scooter giveaways (active living) Free healthy snacks and recipe cards provided by SNAP-Ed and Geary County extension agents, information about meals at home planning provided by Konza Health Clinic (healthy eating), and reading of resolution and unveiling the first Tobacco Free park sign in Playground Park where the Fitness event was held (tobacco cessation)</strong></td>
<td>LWGC, USD 475, Konza Clinic, SNAP-Ed, City of Junction City</td>
<td>LWGC</td>
<td>March-18</td>
<td>18 September</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco</strong></td>
<td>Tobacco Free JC partnership, collateral pieces, media blitz and website, tobaccofreejc.org</td>
<td>LWGC, Konza Clinic, GCH and Delivering Change</td>
<td>LWGC</td>
<td>September-18</td>
<td>November-18</td>
<td>Complete</td>
</tr>
<tr>
<td><strong>Healthy Eating</strong></td>
<td>Year 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Pathway: Resident-Community Wellbeing

**Community Project** – Establish one community project per year to engage individuals, increase awareness of healthy lifestyles and share your successes. Funding may be used to coordinate and promote these events. Additionally, through the technical assistance component, BCBSKS will work with communities to assist with identifying and providing access to subject matter experts as appropriate.

**Mobilize residents** Engage residents in the community to sign the Pathways to a Healthy You Pledge to make improvements in their own health, and to participate in community events and other healthy eating, active living and tobacco-free activities.

Coordination grant funds should be used for event planning, communications and marketing in the community. Additional funding is available for community well-being projects through Implementation Grants, with award dependent on the size and scale of the project.

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**Pathway expectations:**

The community project should incorporate a minimum of one community event per year, and the event should align with the focus area that is being worked on in the other pathways during the same time period. This pathways is intended for coalitions to select a project that is designed to get community members engaged and promote your work. Examples of types of community events: a one-day event, such as a healthy food festival; coordination of an activity, such as a walking group; implementation or a community resource, such as a community garden. Use this pathway as outreach to get more individual community members involved in your work.

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<th>End Date (Month-Yr.)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Work with USD 475 and Community Garden committee to maintain community garden and develop an overall plan for providing gardening education and increasing locations for locally grown produce.</td>
<td>LWGC, USD 475, Konza Clinic, Community Garden, Residents</td>
<td>LWGC</td>
<td>December-18</td>
<td>August-19</td>
<td>In-Progress</td>
</tr>
</tbody>
</table>

**Messaging / Communication efforts**

Social media, radio, online advertising, flyers to USD 475.

**Pathway Connectivity**

Community Policy

**Achievement Grant Status:**

Received implementation grant for I.C.A.R.E. Multi-generational fitness playground foundation and equipment for $30,749.00. Total project cost $43,655.00. Requested grant for September 15 event. Received $12,400 grant for Pathways to Fitness event held on September 15 and Tobacco Free marketing campaign.
Pathway: Food Retail

Work with the local grocery store(s) (if applicable) and/or other food retail locations, including but not limited to gas stations, dollar stores and corner stores, in the community. The coalition will identify a target retail store engagement goal in the Action Plan. The store owner or manager will sign the Pathways to Healthy Foods Pledge to complete a store assessment and adopt assessment recommendations.

- From the assessment, work with the store owner/manager to identify recommendations that can be implemented to increase healthy shopping behavior for residents. Changes can range from very simple, inexpensive solutions to costlier solutions to implement.
- Implementation Grants up to $20,000 per community are available for stores interested in carrying out costlier changes.
- Stores will receive recognition and promotional support for signing the pledge and participating.

Pathway expectations: Recruit one or more food retail store to work with. The store owner/manager will be asked to sign the pledge and complete the type of assessment they select in the pledge. The assessment should be completed to identify recommendations for changes. Recommendations to implement should be selected. If implementation funds are required, an implementation plan and funding request should be submitted for an Implementation Grant. Once the implementation is complete, the store can submit an application for an Achievement Grant.

<table>
<thead>
<tr>
<th>Measured Output</th>
<th>Work Prior to 8/1/17</th>
<th>Output Target</th>
<th>Output to Date</th>
<th>Progress Since Last update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of food retailer pledges signed (required)</td>
<td>N/A</td>
<td>4</td>
<td>1</td>
<td>Handys Convenience store signed food retailer pledge</td>
</tr>
<tr>
<td>Number of grocery store assessments completed (required)</td>
<td>N/A</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of built environment projects (if applicable)</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of organizational health policies adopted (if applicable)</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Focus**

- **Healthy Eating**
  - Identified local store for initial partnership by polling LWGC members for ideas
    - Partners: LWGC
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): September-17
    - End Date (Month-Yr.): September-17
    - Status: Complete
  - Met with convenience store COO, Angie Wallace for initial conversation
    - Partners: Handy's LLC
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): September-17
    - End Date (Month-Yr.): October-17
    - Status: Complete
  - Conducted In-Store Evaluation of Health Food Choices (Pre-Eval)
    - Partners: Handy's LLC - Grandview Plaza
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): November-17
    - End Date (Month-Yr.): November-17
    - Status: Complete
  - On-site food tasting to promote existing options for healthy food choices - yogurt parfaits
    - Partners: Handy's LLC - Grandview Plaza
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): January-18
    - End Date (Month-Yr.): January-18
    - Status: Complete
  - food tasting using existing options for healthy food choices w a few additions - sweet/sour rice
    - Partners: Handy's LLC - Grandview Plaza
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): January-18
    - End Date (Month-Yr.): January-18
    - Status: Complete
  - food tasting using existing options for healthy food choices w a few additions - trail mix
    - Partners: Handy's LLC - Grandview Plaza
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): January-18
    - End Date (Month-Yr.): January-18
    - Status: Complete
  - Presented to Grandview Plaza City Commission about partnership with Handy's, BCBS, and LWGC
    - Partners: Grandview Plaza City Commission, Handy's
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): January-18
    - End Date (Month-Yr.): January-18
    - Status: Complete
  - Requested permission for door to door distribution of information about project
    - Partners: Grandview Plaza City Commission, Handy's
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): January-18
    - End Date (Month-Yr.): January-18
    - Status: Complete
  - Canvassed neighborhood with informational material about partnership with Handy's - 80 reach
    - Partners: Grandview Plaza City Commission, Handy's
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): January-18
    - End Date (Month-Yr.): January-18
    - Status: Complete
  - Signage to promote the availability of healthy foods at local Handy's convenience store.
    - Partners: Handy's LLC - Grandview Plaza
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): February-18
    - End Date (Month-Yr.): June-19
    - Status: In-Progress
  - Establish a local community "advisory group" to help increase the reach of our work
    - Partners: volunteers - TBD
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): January-18
    - End Date (Month-Yr.): March-19
    - Status: In-Progress
  - Met with owner Flagstop Campground convenience store in Milford. Requested revisit discussion in January when gearing up for new season.
    - Partners: LWGC, Flagstop Campground
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): June-18
    - End Date (Month-Yr.): June-18
    - Status: In-Progress
  - Meet with owner Acorns Resort convenience store in Milford.
    - Partners: LWGC, GE. Co. SNAP/Ed
    - Responsible Party: Geary County Research & Extension
    - Start Date (Month-Yr.): March-19
    - End Date (Month-Yr.): June-19
    - Status: In-Progress

**Messaging / Communication efforts**

We have done 2 live interviews related to this Pathway’s Specific Work and the work of Geary County Research & Extension SNAP-Ed. Door-to-door neighborhood canvass, communication with city council, and local elementary school have also been initiated. To expand our reach we are seeking local community members to serve as an informal sounding board for our efforts and next steps.

**Pathway Connectivity**

Working with local convenience store since there is no grocery store in the Grandview Plaza community. We intend to expand this reach to other grocery stores in our county over the next several months. We are using a SNAP-Ed curriculum, Stock Healthy/Shop Healthy to help provide structure to our efforts. As summer approaches, we will explore making connections with vendors from the local farmer’s market to assist in stocking fresh fruits and vegetables.
Pathway: Food Retail

Work with the local grocery store(s) (if applicable) and/or other food retail locations, including but not limited to gas stations, dollar stores and corner stores, in the community. The coalition will identify a target retail store engagement goal in the Action Plan. The store owner or manager will sign the Pathways to Healthy Foods Pledge to complete a store assessment and adopt assessment recommendations.

- From the assessment, work with the store owner/manager to identify recommendations that can be implemented to increase healthy shopping behavior for residents. Changes can range from very simple, inexpensive solutions to costlier solutions to implement.
- Implementation Grants up to $20,000 per community are available for stores interested in carrying out costlier changes.
- Stores will receive recognition and promotional support for signing the pledge and participating.

| Pathway expectations: | Recruit one or more food retail store to work with. The store owner/manager will be asked to sign the pledge and complete the type of assessment they select in the pledge. The assessment should be completed to identify recommendations for changes. Recommendations to implement should be selected. If implementation funds are required, an implementation plan and funding request should be submitted for an Implementation Grant. Once the implementation is complete, the store can submit an application for an Achievement Grant. |

| Achievement Grant Status: | |
Engage the hospital (if applicable) and primary care health care providers to sign the Pathways to a Healthy Provider Pledge. This coalition will identify a target provider engagement goal in the Action Plan.

1. Hospitals should establish, implement or enhance campus policies related to healthy eating, active living and tobacco-free campus.
2. Individual providers should implement a process or protocol to increase patient engagement around physical activity, healthy eating and tobacco-cessation, through health action planning, a wellness contract or health coaching. This should align with or enhance existing quality improvement efforts.
3. Hospitals and providers will receive recognition and promotional support for signing the pledge and participating.

Implementation Grants and Achievement Grants up to $10,000 per community will be available for participating providers.

Pathway expectations: This pathway has a strategy for hospitals and one for providers, though the pledge applies to both entities. Hospitals should chose to implement one or more new policies or update existing policies on healthy eating. Primary care providers should look at processes or protocols that can be put in place that addresses all three focus areas. The idea is to improve patient engagement while also aligning the work with any existing quality improvement efforts the clinic is already engaged in.

<table>
<thead>
<tr>
<th>Measured Output</th>
<th>Work Prior to 8/1/17</th>
<th>Output Target</th>
<th>Output to Date</th>
<th>Progress Since Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Pathways to a Healthy Provider pledges signed (required)</td>
<td>N/A</td>
<td>2</td>
<td>1</td>
<td>Geary Community Hospital Pediatrics Clinic has completed the pledge and received funding for WWAD</td>
</tr>
<tr>
<td>Number of Pathways to a Healthy Hospital pledges signed (required)</td>
<td>N/A</td>
<td>1</td>
<td>1</td>
<td>Geary Community Hospital completed the pledge.</td>
</tr>
<tr>
<td>Number of organizational health policies implemented (at least 1 required)</td>
<td>N/A</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus</th>
<th>Action Items/Next Steps</th>
<th>Partners</th>
<th>Responsible Party</th>
<th>Start Date (Month-Yr.)</th>
<th>End Date (Month-Yr.)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathways to a Healthy Hospital Pledge</td>
<td>Geary Community Hospital</td>
<td>Nikki Davies</td>
<td>February-18</td>
<td>July-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Hospital will present information to it’s physicians about the opportunities associated with the Healthy provider pledges and policies.</td>
<td>GCH, LWGC</td>
<td>Nikki Davies</td>
<td>March-18</td>
<td>May-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Konza Prairie Health Clinic will be invited to attend and partner in Pathways initiatives. Will receive information about Healthy provider pledges and availability of funding.</td>
<td>GCH, KPH</td>
<td>Nikki Davies, Charles Martinez</td>
<td>March-18</td>
<td>August-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Pathways to a Healthy Provider Referrals</td>
<td>Geary Community Hospital / Geary County Health Department</td>
<td>Charles Martinez / Nikki Davies</td>
<td>February-18</td>
<td>July-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Meet with Konza Community Health to discuss pledges and provider opportunities. Discuss Contracting with their dietician.</td>
<td>LWGC, Konza Community Health</td>
<td>Charles Matinez, Susan Jagerson</td>
<td>August-18</td>
<td>August-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Geary Community Hospital Provider pledge received</td>
<td>LWGC, GCH</td>
<td>GCH</td>
<td>December-18</td>
<td>December-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Partner with Geary Community Hospital to implement WWAD program hosted by Pediatric clinic.</td>
<td>LWGC, GCH, Pediatrics Clinic</td>
<td>GCH</td>
<td>December-18</td>
<td>May-19</td>
<td>In-Progress</td>
<td></td>
</tr>
<tr>
<td>Submit achievement grant application for Geary Community Hospital to implement WWAD program</td>
<td>LWGC, GCH, Pediatrics Clinic</td>
<td>GCH</td>
<td>December-18</td>
<td>January-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Contracting with Konza Prairie Health Clinic dietician to work with restaurant partners</td>
<td>LWGC, Konza Community Health</td>
<td>LWGC</td>
<td>October-18</td>
<td>September-19</td>
<td>In-Progress</td>
<td></td>
</tr>
</tbody>
</table>

| Messaging / Communication efforts                                      |                                                                                       |                                              |
|----------------------------------------------------------------------|---------------------------------------------------------------------------------------|                                              |
| Pathway Connectivity                                                  |                                                                                       |                                              |
| Achievement Grant Status:                                            | Geary Community Hospital Pediatrics Clinic has been approved for $5,000 achievement grant to implement a WWAD program. |
Pathway: Restaurants

Engage restaurants owners to sign the Pathways to a Healthy Restaurant Pledge to complete restaurant assessment and adopt healthy strategies. The coalition will identify a target restaurant engagement goal in the Action Plan, and may choose to do work with restaurants individually or implement a Healthy Restaurants Program. Communities should also consider including caterers.

- From the assessment findings, identify changes that can be implemented by the restaurant to increase healthy eating behavior for residents. Changes in the assessment will range from very simple, inexpensive solutions, to costlier solutions.
- Restaurants will receive recognition and promotional support for signing the pledge and participating.
- Implementation Grants are available for restaurant owners interested in carrying out costlier changes (up to $20,000 per community).
- Upon implementation of the recommendations, the restaurant owner is eligible for an Achievement Grant to go toward energy efficiency or facade improvements. Communities are eligible for up to $38,000 in grant funds.

Pathway expectations: Recruit one or more restaurants to work with (the goal number of restaurants should be set by the coalition). The restaurant owner/manager will be asked to sign the pledge and complete the type of assessment they select in the pledge. The assessment should be completed to identify recommendations for changes. Recommendations to implement should be selected. If implementation funds are required, an implementation plan and funding request should be submitted for an implementation Grant. Once the implementation is complete, the restaurant can submit an application for an Achievement Grant.

<table>
<thead>
<tr>
<th>Measured Output</th>
<th>Work Prior to 8/1/17</th>
<th>Output Target</th>
<th>Output to Date</th>
<th>Progress Since Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Pathways to a Healthy Restaurant pledges signed (required)</td>
<td>N/A</td>
<td>4</td>
<td>5</td>
<td>Munson’s Prime, Hot Roz BBQ, Negril, Cynthia’s One Bite Delight, and Tyme Out Steakhouse signed the Pathways to a Healthy Restaurant pledge</td>
</tr>
<tr>
<td>Number of restaurant assessments completed (required)</td>
<td>N/A</td>
<td>2</td>
<td>3</td>
<td>Munson’s Prime, Hot Rodz BBQ, and Tyme Out Steakhouse completed the restaurant assessment.</td>
</tr>
<tr>
<td>Number of built environment projects (if applicable)</td>
<td>N/A</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of organizational health policies adopted (if applicable)</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus</th>
<th>Action Items/Next Steps</th>
<th>Partners</th>
<th>Responsible Party</th>
<th>Start Date (Month-Yr.)</th>
<th>End Date (Month-Yr.)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Eating</td>
<td>One on one in person conversations with locally owned restaurants; Munson’s Prime, Ikes, Coaches, Thomas Taste of Chicago, Bellas, Cynthia’s, Stacy’s, Tyme Out, Rodz BBQ, and The Cove regarding Healthy Restaurant Pledges.</td>
<td>LWGC, Geary County Research &amp; Extension</td>
<td>LWGC, Pathways Restaurant Committee</td>
<td>March-18</td>
<td>December-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Meetings with Munson’s Prime and Coaches restaurants</td>
<td>LWGC, Munson’s Prime</td>
<td>LWGC</td>
<td>March-18</td>
<td>July-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Munson’s Prime signed Restaurant pledge</td>
<td>LWGC, Munson’s Prime</td>
<td>LWGC</td>
<td>June-18</td>
<td>June-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Munson’s Prime completed Restaurant Assessment</td>
<td>LWGC, Munson’s Prime</td>
<td>LWGC</td>
<td>July-18</td>
<td>July-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Request from Munson’s Prime to provide dietician to create new menus with nutritional information and designate healthier options as &quot;Live Well&quot; choices.</td>
<td>LWGC, Munson’s Prime</td>
<td>LWGC</td>
<td>July-18</td>
<td>March-19</td>
<td>In-Progress</td>
</tr>
<tr>
<td></td>
<td>Partner with Munson’s Prime to submit Pathways grant to obtain funding for coolers and prep-table to be able to store and prepare fresh fruits and vegetables.</td>
<td>LWGC, Munson’s Prime</td>
<td>Munson’s Prime</td>
<td>August-18</td>
<td>August-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Sent letters to all locally owned restaurants in regarding funding and assessment opportunities</td>
<td>Susan Jagerson</td>
<td>Susan Jagerson</td>
<td>December-18</td>
<td>December-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Meetings with Hot Rodz BBQ and Tyme Out Steakhouse to complete pledges and assessments</td>
<td>LWGC, Hot Rodz BBQ, Tyme Out</td>
<td>LWGC</td>
<td>December-18</td>
<td>December-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Follow up meetings with Munson’s, Hot Rodz and Tyme Out with dietician to review and help implement healthier menu selections</td>
<td>LWGC, Munson’s, Hot Rodz BBQ, Tyme Out, Tracy Sabo</td>
<td>Tracy Sabo Dietician</td>
<td>August-18</td>
<td>February-19</td>
<td>In-Progress</td>
</tr>
<tr>
<td></td>
<td>Purchase Nutri-hand Nutrition Analyzer with Coordination Funds to assist with menu reviews and suggested changes</td>
<td>LWGC, Munson’s, Hot Rodz BBQ, Tyme Out, Tracy Sabo</td>
<td>LWGC</td>
<td>December-18</td>
<td>December-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Additional meetings held with Negril Caribbean Restaurant and Cynthia’s One Bite Delight</td>
<td>LWGC, Cynthia’s, Negril, Tracy Sabo</td>
<td>LWGC</td>
<td>January-19</td>
<td>March-19</td>
<td>In-Progress</td>
</tr>
<tr>
<td></td>
<td>Tracy Sabo is working with Kansas State University dietitian students to assist in menu development and environment assessments.</td>
<td>LWGC, Tracy Sabo, KSU Students</td>
<td>Tracy Sabo Dietician</td>
<td>January-19</td>
<td>March-19</td>
<td>In-Progress</td>
</tr>
</tbody>
</table>

Messaging / Communication efforts

Letters to all locally owned restaurants to inform them about funding and assessment opportunities. Press release, radio news and social media updates regarding partnership with Munson’s Prime.
Engage restaurant owners to sign the Pathways to a Healthy Restaurant Pledge to complete restaurant assessment and adopt healthy strategies. The coalition will identify a target restaurant engagement goal in the Action Plan, and may choose to do work with restaurants individually or implement a Healthy Restaurants Program. Communities should also consider including caterers.

- From the assessment findings, identify changes that can be implemented by the restaurant to increase healthy eating behavior for residents. Changes in the assessment will range from very simple, inexpensive solutions, to costlier solutions.
- Restaurants will receive recognition and promotional support for signing the pledge and participating.
- Implementation Grants are available for restaurant owners interested in carrying out costlier changes (up to $20,000 per community).
- Upon implementation of the recommendations, the restaurant owner is eligible for an Achievement Grant to go toward energy efficiency or facade improvements. Communities are eligible for up to $38,000 in grant funds.

<table>
<thead>
<tr>
<th>Pathway: Restaurants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pathway expectations:</strong> Recruit one or more restaurants to work with (the goal number of restaurants should be set by the coalition). The restaurant owner/manager will be asked to sign the pledge and complete the type of assessment they select in the pledge. The assessment should be completed to identify recommendations for changes. Recommendations to implement should be selected. If implementation funds are required, an implementation plan and funding request should be submitted for an Implementation Grant. Once the implementation is complete, the restaurant can submit an application for an Achievement Grant.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pathway Connectivity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Munson’s Prime received a $5,000 implementation to purchase equipment. Hot Rodz BBQ submitted $5,000 implementation grant request for equipment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Achievement Grant Status:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Munson’s Prime received a $5,000 implementation to purchase equipment. Hot Rodz BBQ submitted $5,000 implementation grant request for equipment.</td>
<td></td>
</tr>
</tbody>
</table>
Pathway: Schools

Work with schools to reach “Modeling” level for at least one wellness policy in each of the following categories: Physical Activity or Integrated School Based Wellness AND Nutrition or Nutrition Promotion and Education, as outlined in the Kansas State Department of Education’s (KSDE) Kansas School Wellness Policy Model Guidelines (www.kn-eat.org). Implement for a minimum of one elementary school, one middle school/junior high school, and one high school* in the community’s school district(s). Activities that address similar policies in preschools may be included under this section, in addition to the school wellness policy work outlined above. *Or one per school building regardless of configuration (example: K-2 or K-5 or K-8)

Once policies are enacted, schools will be eligible to apply for Implementation Grants of up to $10,000 per school (limit of $60,000 per community) with the submission of a policy implementation plan.

Pathway expectations:
The main intent of this pathways is to help schools get modeling wellness policies in writing and the policy implemented in the school. The coalition should work directly with the existing school wellness teams on this pathway. Only the healthy eating and active living policies are required, but a tobacco policy may be addressed too. It is important to note that wellness policies are often at the district level. Should they be done at the school level, there does need to be at least two policies affecting youth at every grade level in the community, both policies do not have to be implemented in the same school for each grade level. Once the policy is approved and an implementation plan is decided upon they may be submitted for an Implementation Grant.

<table>
<thead>
<tr>
<th>Measured Output</th>
<th>School/District</th>
<th>Original Policy</th>
<th>New Model Practice</th>
<th>Completion Date</th>
<th>Progress Since Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modeling nutrition policies at elementary/middle/high schools</td>
<td>USD 475</td>
<td>Students have access to free drinking water throughout the day, including during meal service. Hygiene standards for all methods delivering drinking water will be maintained.</td>
<td>Students have clear/translucent individual water bottles in the classroom where appropriate.</td>
<td>Aug-19</td>
<td>Bids have been received and implementation grant has been written to purchase Retro Kits to convert drinking fountains to water bottle filling stations at every school at each level elementary, middle and high school.</td>
</tr>
<tr>
<td>Modeling nutrition promotion policies at elementary/middle/high schools</td>
<td>USD 475</td>
<td>School promotes participation in the National School Lunch Program (NSLP) and School Breakfast Program (SBP) if applicable and to choose nutritious foods and beverages throughout the day. Menus are posted on school website and/or distributed to families via another method.</td>
<td>Marketing and advertising of nutritious foods and beverages is implemented consistently through a comprehensive and multi-channel approach to the community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modeling physical activity policies at elementary/middle/high schools</td>
<td>USD 475</td>
<td>School policy outlines guidance on conditions regulating indoor and outdoor recess and physical education, are encouraged for all students.</td>
<td>Students that participate in indoor recess are provided moderate to vigorous physical activity opportunities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modeling physical activity policies at elementary/middle/high schools</td>
<td>USD 475</td>
<td>Extracurricular physical activity programs, such as a physical activity club or intramural programs, such as physical activity club or intramurals programs are offered.</td>
<td>Extracurricular physical activity programs, such as physical activity club or intramural programs are offered through partnerships with community organizations and resources.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modeling physical activity policies at elementary/middle/high schools</td>
<td>USD 475</td>
<td>Professional development on integrating physical activity into core/non-core subjects is provided to licensed physical education teachers, school nurses, and building administrators.</td>
<td>Professional development on integrating physical activity into core/non-core subjects is provided to all staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Built environment projects (if applicable)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Focus | Action Items/Next Steps | Partners | Responsible Party | Start Date (Month-Yr.) | End Date (Month-Yr.) | Status |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Conversations with USD 475 Wellness Coordinator Joe Handlos to determine focus for policies for schools within the KSWP Guidelines for Nutrition, and physical activity.</td>
<td>USD 475, LWGC</td>
<td>Susan Jagerson, Nikki Davies</td>
<td>January-18</td>
<td>January-18</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Conversations with USD 475 Wellness Coordinator Joe Handlos and USD 475 Administrator Beth Hudson to approve focus for policies for schools within the KSWP Guidelines for Nutrition, and physical activity.</td>
<td>USD 475, LWGC</td>
<td>Joe Handlos</td>
<td>January-18</td>
<td>January-18</td>
<td>Complete</td>
</tr>
<tr>
<td>Healthy Eating</td>
<td>All Schools - Nutrition - Water Bottle Filling Stations - Secure bids to purchase water bottle filling stations and insure schools will allow students to bring clear water bottles.</td>
<td>USD 475, LWGC, St. Xavier’s</td>
<td>Joe Handlos</td>
<td>February-18</td>
<td>August-18</td>
<td>Complete</td>
</tr>
<tr>
<td>Healthy Eating</td>
<td>All Schools - Nutrition Promotion - Secure a dietician and other appropriate staff to provide guidance to families on health, nutrition and planning nutritious meals.</td>
<td>USD 475, LWGC</td>
<td>Joe Handlos</td>
<td>June-18</td>
<td></td>
<td>Not Started</td>
</tr>
<tr>
<td>Active Living</td>
<td>Elementary - Increase the opportunity for students to participate in moderate/vigorous physical activity. Licensed Physical Education teachers provide guidance on how to use GoNoodle Plus videos which engage students in the moderate/vigorous physical activity levels. Meet with staff to determine the most appropriate equipment for engaging students in moderate/vigorous physical activity levels.</td>
<td>USD 475, LWGC</td>
<td>Joe Handlos, USD 475 Wellness Team</td>
<td>August-18</td>
<td>August-20</td>
<td>Not Started</td>
</tr>
</tbody>
</table>
Pathway: Schools

Work with schools to reach "Modeling" level for at least one wellness policy in each of the following categories: Physical Activity or Integrated School Based Wellness AND Nutrition or Nutrition Promotion and Education, as outlined in the Kansas State Department of Education’s (KSDE) Kansas School Wellness Policy Model Guidelines (www.kn-eat.org). Implement for a minimum of one elementary school, one middle school/junior high school, and one high school* in the community’s school district(s). Activities that address similar policies in preschools may be included under this section, in addition to the school wellness policy work outlined above.

*Or one per school building regardless of configuration (example: K-2 or K-5 or K-8)

Once policies are enacted, schools will be eligible to apply for Implementation Grants of up to $10,000 per school (limit of $60,000 per community) with the submission of a policy implementation plan.

Pathway expectations: The main intent of this pathways is to help schools get modeling wellness policies in writing and the policy implemented in the school. The coalition should work directly with the existing school wellness teams on this pathway. Only the healthy eating and active living policies are required, but a tobacco policy may be addressed too. It is important to note that wellness policies are often at the district level. Should they be done at the school level, there does need to be at least two policies affecting youth at every grade level in the community, both policies do not have to be implemented in the same school for each grade level. Once the policy is approved and an implementation plan is decided upon they may be submitted for an Implementation Grant.

<table>
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<tr>
<th>Focus</th>
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<th>Partners</th>
<th>Responsible Party</th>
<th>Start Date (Month-Yr.)</th>
<th>End Date (Month-Yr.)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Living</td>
<td>All Schools - Increase physical activity opportunities for all students by partnering with other community organizations. Survey students to determine interest level in the type of physical activity club or intramurals. Survey and select staff to supervise the activity club/intramurals. Meet with community partners to explore cooperative use options.</td>
<td>USD 475, LWGC</td>
<td>Joe Handlos</td>
<td>August-18</td>
<td>August-20</td>
<td>Not Started</td>
</tr>
<tr>
<td>Active Living</td>
<td>All Schools - Professional development on integrating physical activity into core/non-core subjects. Meet with Teaching and Learning staff to place this training on the professional development calendar and develop a plan for training staff each year.</td>
<td>USD 475, LWGC</td>
<td>Joe Handlos</td>
<td>September-18</td>
<td>August-20</td>
<td>Not Started</td>
</tr>
<tr>
<td>Healthy Eating</td>
<td>MOU with USD 475 to purchase greenhouse and develop/maintain gardens throughout the school district and community to educate students about growing produce. This would be through Schools Nutrition Education and Resident-Community Well-Being Pathway</td>
<td>USD 475, LWGC, Community Garden</td>
<td>Joe Handlos</td>
<td>January-18</td>
<td>August-20</td>
<td>In-Progress</td>
</tr>
<tr>
<td>Active Living</td>
<td>Work with USD 475 to purchase bicycle fleet and implement bicycle training program.</td>
<td>USD 475, LWGC</td>
<td>Joe Handlos</td>
<td>March-18</td>
<td>October-19</td>
<td>In-Progress</td>
</tr>
</tbody>
</table>

Messaging / Communication efforts:

Pathway Connectivity

Achievement Grant Status: USD 475 submitted request for implementation grant to purchase retro kits to convert select drinking fountains to water bottle filling stations.
### Pathway: Worksites

Engage employers in the community to sign the Pathways to a Healthy Workplace Pledge. The pledge will require that companies:

- Complete WorkWell Kansas “Foundations” and additional Focus area workshops for physical activity, nutrition, and tobacco cessation.
- Implement worksite wellness plan developed at each workshop to progress toward comprehensive worksite wellness.

Upon implementation of a comprehensive worksite wellness plan, employers will be eligible for Achievement Grants to go towards additional worksite wellness efforts; up to $100,000 per community with a limit of $10,000 for any individual worksite.

**Pathway expectations:**

The coalition should work with the WorkWell Kansas staff to determine a date and location for a Foundations workshop, then recruit employers in their community to sign the pledge and attend the workshop. If your community already has a group of employers engaged in WWKS there may be an opportunity to hold one of they physical activity, nutrition or tobacco workshops. The employers will complete the workshop and have a plan to implement at their worksite. Once an employer can show they have completed a comprehensive approach to worksite wellness in one of the framework columns, that employer is eligible to apply for an Achievement Grant. WWKS will continue to be available to work with the employers on the next workshops and enhancing their worksite wellness.

<table>
<thead>
<tr>
<th>Measured Output</th>
<th>Work Prior to 8/1/17</th>
<th>Output Target</th>
<th>Output to Date</th>
<th>Progress Since Last Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Pathways to a Healthy Workplace pledges signed (required)</td>
<td>N/A</td>
<td>10</td>
<td>3</td>
<td>Three organizations have signed pledges, USD 475, Konza Prairie Community Health, and Dorothy Bramlage Public Library.</td>
</tr>
<tr>
<td>Number of Worksites Trained--“foundations” workshop and additional focus area workshops (required)</td>
<td>N/A</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of worksite wellness plans adopted (required)</td>
<td>N/A</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of worksite health policies adopted (if applicable)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus</th>
<th>Action Items/Next Steps</th>
<th>Partners</th>
<th>Responsible Party</th>
<th>Start Date (Month-Yr.)</th>
<th>End Date (Month-Yr.)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Work Well Kansas to schedule Work Well Foundation Workshop in Geary County</td>
<td>LWGC, Work Well, GCH</td>
<td>Susan Jagerson, Nikki Davies, Joe Handlos</td>
<td>March-18</td>
<td>April-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Plan workshop, Identify and invite local employers</td>
<td>LWGC, Junction City Area Chamber of Commerce</td>
<td>Susan Jagerson</td>
<td>March-18</td>
<td>October-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Host workshop, request employers to sign pledge, identify employers willing to adopt work wellness plan and institute new policies.</td>
<td>LWGC, Work Well, GCH</td>
<td>Susan Jagerson, Nikki Davies, Joe Handlos</td>
<td>June-18</td>
<td>October-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Work Site Wellness Foundation Workshop presented on Oct. 17. Seven organizations attended the workshop.</td>
<td>LWGC, WorkWell</td>
<td>Susan Jagerson</td>
<td>August-18</td>
<td>October-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Dorothy Bramlage Public Library has completed and received approval for their Foundation Development plan.</td>
<td>DBPL</td>
<td>Donna Porter, DBPL</td>
<td>November-18</td>
<td>January-18</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Active Living</td>
<td>Arrangements for 2nd WorkWell Workshop in March or April</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Active Living</td>
<td>Host Physical Activity Workshop for participating WorkWell worksites that completed Foundation workshop and Foundation Development Plan, Geary Community Hospital, Konza Prairie Health Clinic, City of Junction City, Restoration Center, USD 475, Dorothy Bramlage Public Library</td>
<td>LWGC, WorkWell KS</td>
<td>Susan</td>
<td>April-19</td>
<td>May-19</td>
<td>Complete</td>
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<tr>
<td>Messaging / Communication efforts</td>
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<td></td>
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<td></td>
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<tr>
<td>Pathway Connectivity</td>
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</table>
Pathway: Worksites

Engage employers in the community to sign the Pathways to a Healthy Workplace Pledge. The pledge will require that companies:

- Complete WorkWell Kansas “Foundations” and additional Focus area workshops for physical activity, nutrition, and tobacco cessation.
- Implement worksite wellness plan developed at each workshop to progress toward comprehensive worksite wellness.

Upon implementation of a comprehensive worksite wellness plan, employers will be eligible for Achievement Grants to go towards additional worksite wellness efforts; up to $100,000 per community with a limit of $10,000 for any individual worksite.

Pathway expectations:

The coalition should work with the WorkWell Kansas staff to determine a date and location for a Foundations workshop, then recruit employers in their community to sign the pledge and attend the workshop. If your community already has a group of employers engaged in WWKS there may be an opportunity to hold one of they physical activity, nutrition or tobacco workshops. The employers will complete the workshop and have a plan to implement at their worksite. Once an employer can show they have completed a comprehensive approach to worksite wellness in one of the framework columns, that employer is eligible to apply for an Achievement Grant. WWKS will continue to be available to work with the employers on the next workshops and enhancing their worksite wellness.

Achievement Grant Status:
PREVIOUS PRIORITIZED NEEDS
## Previous Prioritized Needs

### 2014 Prioritized Needs

1. Lack of available and affordable healthy food options.
2. Few environments that support physical activity.
3. Transportation barriers create poor access to healthcare services.

### 2017 Prioritized Needs

1. Lack of available, affordable, quality healthy food options.
2. Few environments that support physical activity.
3. Quality of life is perceived as worse for individuals and families with lower incomes.
4. Lack of access to healthcare services.
5. Transportation has improved but barriers still exist and limit access to healthcare and employment.
6. Too much access to alcohol and tobacco.
7. Lack of public education about resources and services available in the community.
2020 Preliminary Health Needs

- Access to Affordable Care and Reducing Health Disparities Among Specific Populations
- Access to Dental Care Services and Providers
- Access to Mental and Behavioral Health Care Services and Providers
- Access to Primary and Specialty Care Services and Providers
- Increased Emphasis on Education and Awareness of Existing Health Care Resources
- Prevention, Education and Services to Address High Mortality Rates, Chronic Diseases, Preventable Conditions and Unhealthy Lifestyles
PRIORITIZATION
The Prioritization Process

• In March 2020, leadership from GCH met with CHC Consulting to review findings and prioritize the community’s health needs.

• Leadership ranked the health needs based on three factors:
  – Size and Prevalence of Issue
  – Effectiveness of Interventions
  – Hospital’s Capacity

• See the following page for a more detailed description of the prioritization process.
# The Prioritization Process

The CHNA Team utilized the following factors to evaluate and prioritize the significant health needs.

1. **Size and Prevalence of the Issue**
   - a. How many people does this affect?
   - b. How does the prevalence of this issue in our communities compare with its prevalence in other counties or the state?
   - c. How serious are the consequences? (urgency; severity; economic loss)

2. **Effectiveness of Interventions**
   - a. How likely is it that actions taken will make a difference?
   - b. How likely is it that actions will improve quality of life?
   - c. How likely is it that progress can be made in both the short term and the long term?
   - d. How likely is it that the community will experience reduction of long-term health cost?

3. **Geary Community Hospital Capacity**
   - a. Are people at Geary Community Hospital likely to support actions around this issue? (ready)
   - b. Will it be necessary to change behaviors and attitudes in relation to this issue? (willing)
   - c. Are the necessary resources and leadership available to us now? (able)
Health Needs Ranking

• Hospital leadership participated in an electronic ballot process to rank the health needs in order of importance, resulting in the following order:

1. Access to Primary and Specialty Care Services and Providers
2. Access to Affordable Care and Reducing Health Disparities Among Specific Populations
3. Increased Emphasis on Education and Awareness of Existing Health Care Resources
4. Access to Mental and Behavioral Health Care Providers and Services
5. Prevention, Education and Services to Address High Mortality Rates, Chronic Diseases, Preventable Conditions and Unhealthy Lifestyles
6. Access to Dental Care Services and Providers
Final Priorities

- Hospital leadership decided to address five of the ranked health needs. The final health priorities that GCH will address through its Implementation Plan are listed below:

1. Access to Primary and Specialty Care Services and Providers
2. Access to Affordable Care and Reducing Health Disparities Among Specific Populations
3. Increased Emphasis on Education and Awareness of Existing Health Care Resources
4. Access to Mental and Behavioral Health Care Providers and Services
5. Prevention, Education and Services to Address High Mortality Rates, Chronic Diseases, Preventable Conditions and Unhealthy Lifestyles
PRIORITIES THAT WILL NOT BE ADDRESSED
Priorities That Will Not Be Addressed

• GCH decided not to specifically address “Access to Dental Care Services and Providers.”

• While GCH acknowledges that this is a significant need in the community, "Access to Dental Care Services and Providers" is not addressed largely due to the fact that it is not a core business function of the hospital and the limited capacity of the hospital to address this need.

• GCH will continue to support local organizations and efforts to address this need in the community.
RESOURCES IN THE COMMUNITY
Additional Resources in the Community

- In addition to the services provided by GCH, other charity care services and health resources that are available in Geary County are included in this section.
**Adult Day Care**
Chapman Valley Manor
Chapman, 785-922-6525

Deseret Health & Rehab
Onaga, 785-889-4227

Enterprise Estates
Nursing Center
Enterprise, 785-263-8278

Interim Healthcare, Inc.
Manhattan, 785-320-7600

Leonardville Nursing Home
Leonardville, 785-293-5244

Sterling House of Junction City
Brookdale Senior Living
Junction City, 785-762-3123

**Aging and Disability Resource Center**
855-200-2372

**Attendant / Personal Care**
Advocate
Wamego, 785-456-8910

At Home Assisted Care
Manhattan, 785-473-7007

Comfort Keepers
Salina, 877-224-3968
785-825-1055

Consumer Directed Services, Inc.
Wichita, 888-821-2493 or
316-838-0780

Deseret Health & Rehab
Onaga, 785-889-4227

Home Health and Hospice at Geary Community Hospital
Junction City, 785-762-2653

**Caregiver Training**
At Home Assisted Care
Manhattan, 785-473-7007

Brookdale Home Health
Salina, 785-825-8500

Deseret Health & Rehab
Onaga, 785-889-4227

Home Sweet Home
Health Care
Salina, 785-309-6081

Three Rivers, Inc.
Wamego, 785-456-9915 or
800-555-3994

**Chore Services**
At Home Assisted Care
Manhattan, 785-473-7007

Clutter Proz
Wamego, 785-456-1828

Home Health and Hospice
At Geary Community Hospital
Junction City, 785-762-2653

**Credit Counseling**
Consumer Credit Counseling Services, Inc.
Salina, 785-827-6731

Housing & Credit Counseling Inc.
Topeka, 785-234-0217

**Home Health and Hospice at Geary Community Hospital**
Junction City, 785-762-2653

**Homecare & Hospice, Inc.**
Manhattan, 785-537-0688

**Home Sweet Home**
Health Care
Salina, 785-309-6081

**Interim Healthcare, Inc.**
Manhattan, 785-320-7600

**Meadowlark Hills**
Home Health
Manhattan, 785-537-9497

**Three Rivers, Inc.**
Wamego, 785-456-9915 or
800-555-3994
<table>
<thead>
<tr>
<th><strong>Durable Medical Equipment</strong></th>
<th><strong>Employment Assistance</strong></th>
<th><strong>Home Health Care-Licensed</strong></th>
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<tbody>
<tr>
<td>Geary Community Hospital - Home Medical Equipment Junction City, 785-762-2983</td>
<td>Older Kansans Employment Program Manhattan, 785-776-9294</td>
<td>Angels Care Home Health Salina, 785-826-9600</td>
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<tr>
<td>Jay Hatfield Mobility Salina, 785-452-9888</td>
<td></td>
<td>Brookdale Home Health Salina, 785-825-8500</td>
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<tr>
<td>North Central-Flint Hills Area Agency on Aging Manhattan, 785-776-9294 or 800-432-2703</td>
<td></td>
<td>Caregivers Home Health Manhattan, 785-776-9911</td>
</tr>
<tr>
<td>Positive Air, LLC Manhattan, 785-320-7622</td>
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<td>Home Health and Hospice at Geary Community Hospital Junction City, 785-762-2653</td>
</tr>
<tr>
<td>Salina Regional Home Medical Services Salina, 785-823-8770</td>
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<td>Homecare &amp; Hospice, Inc. Manhattan, 785-537-0688</td>
</tr>
<tr>
<td>Three Rivers, Inc. Wamego, 785-456-9915 or 800-555-3994</td>
<td></td>
<td>Interim Healthcare, Inc. Manhattan, 785-320-7600</td>
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<tr>
<td><strong>Emergency Alert Systems</strong></td>
<td><strong>Homemaker Services</strong></td>
<td><strong>Housing - Information</strong></td>
</tr>
<tr>
<td>Alert 1 Medical Alert Systems Williamsport, PA 800-693-5433</td>
<td>Advocare Wamego, 785-456-8910</td>
<td>North Central-Flint Hills Area Agency on Aging Manhattan, 785-776-9294 or 800-432-2703</td>
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<td>At Home Assisted Care Manhattan, 785-473-7007</td>
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<td>Home Buddy Wichita, 866-922-8339</td>
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<td>Life Assisted Services of Cloud County Health Center Concordia, 785-243-8508</td>
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<td>LifeStation, Inc. Union, NJ 877-288-4956</td>
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<td>Salina Regional Home Medical Services - Lifeline Salina, 785-823-8770</td>
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<td>Trust Home Care Wichita, 316-683-7700</td>
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<tr>
<td><strong>Information &amp; Assistance</strong></td>
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<tr>
<td>Geary County Senior Center Junction City, 785-238-4015</td>
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<tr>
<td>Kansas Advocates for Better Care (Care home information) Lawrence, 800-525-1782 or 785-842-3088</td>
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<tr>
<td>At Home Assisted Care Manhattan, 785-473-7007</td>
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<td>Caregivers Home Health Manhattan, 785-776-9911</td>
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<td>Comfort Keepers Salina, 785-825-1055</td>
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<td>Consumer Directed Services, Inc. Wichita, 888-821-2493 or 316-838-0780</td>
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<tr>
<td>Home Health and Hospice at Geary Community Hospital Junction City, 785-762-2653</td>
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<tr>
<td>Homecare &amp; Hospice, Inc. Manhattan, 785-537-0688</td>
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<tr>
<td>Home Sweet Home Health Care Salina, 785-309-6081</td>
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<td>Interim Healthcare, Inc. Manhattan, 785-320-7600</td>
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<tr>
<td>Three Rivers, Inc. Wamego, 785-456-9915 or 800-555-3994</td>
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</tbody>
</table>
Information - Dental Health
Konza Prairie Community Health and Dental Center
Junction City, 785-238-1829

Information - Vision Impaired
Envision
Wichita, 316-440-1600

Three Rivers, Inc.
Wamego, 785-456-9915 or 800-555-3994

Legal Services
Kansas Legal Services
Topeka, 888-353-5337 or 800-723-6953

Meals
Geary County Senior Center
Junction City, 785-238-4015

Mental Health Services
Pawnee Mental Health Services
Junction City, 785-762-5250

Rehabilitation Services
Brookdale Home Health
Salina, 785-825-8500 or 800-875-8510

Caregivers Home Health
Manhattan, 785-776-9911

Deseret Health & Rehab
Onaga, 785-889-4227

Enterprise Estates Nursing Center
Enterprise, 785-263-8278

Leonardville Nursing Home
Leonardville, 785-293-5244

Senior Health Insurance Counseling for Kansas
Statewide 800-860-5260

North Central-Flint Hills Area Agency on Aging
Manhattan, 785-776-9294 or 800-432-2703

Telemedicine Services
Deseret Health & Rehab
Onaga, 785-889-4227

Transportation
Flint Hills Area Transportation Agency
Manhattan, 785-537-6345 or 877-551-6345

Veterans’ Services
Kansas Commission on Veterans’ Affairs
Junction City, 785-238-4522

Weatherization
North Central Regional Planning Commission
Beloit, 800-432-0303

Kansas Housing Resources Corporation
Topeka, 785-217-2048

Homecare & Hospice, Inc.
Manhattan, 785-537-0688

Home Sweet Home Health Care
Salina, 785-309-6081

Leonardville Nursing Home
Leonardville, 785-293-5244

Meadowlark Hills Home Health
Manhattan, 785-537-9497

PRN Home Health and Hospice
Wamego, 785-456-7764

Comfort Keepers
Salina, 785-825-1055

Deseret Health & Rehab
Onaga, 785-889-4227

Enterprise Estates Nursing Center
Enterprise, 785-263-8278

Senior Center
Geary County Senior Center
Junction City, 785-238-4015

Sterling House of Junction City
Brookdale Senior Living
Junction City, 785-762-3123

Three Rivers, Inc.
Wamego, 785-456-9915 or 800-555-3994
## Free Emergency Food

<table>
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<th></th>
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<tbody>
<tr>
<td><strong>Geary County Food Pantry</strong></td>
<td>Anyone in need</td>
<td>Food pantry -may be utilized only once per month</td>
<td>Monday and Thursday, 9 am-12:45 pm Tuesday, 5:30-7 pm Prior to first pick-up, must complete paperwork: Tuesdays, 3-5 pm</td>
<td>First visit: -original social security card -valid photo identification After first visit: -original social security card -valid photo ID -proof of income -proof of residence in Geary County</td>
</tr>
<tr>
<td><strong>Emergency Food Pantry--First United Methodist Church</strong></td>
<td>Anyone in need</td>
<td>Emergency food pantry -may be utilized once per month</td>
<td>Tuesday - Friday, 9 am-3 pm</td>
<td>Valid photo ID and/or proof of Geary County address</td>
</tr>
<tr>
<td><strong>Caring Place</strong></td>
<td>Anyone in need</td>
<td>Pre-made food bags to support a family of four for one week -may be utilized once per three months</td>
<td>Tuesday 10 am -1 pm</td>
<td>Valid photo ID</td>
</tr>
<tr>
<td><strong>Wheels of Hope</strong></td>
<td>Grant Avenue mobile home residents and families living in transition</td>
<td>Food distribution</td>
<td>Fourth Thursday monthly, 5-6 pm</td>
<td>Children must attend USD 475 or have prescreen from school McKinney-Vento Coordinator</td>
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</tbody>
</table>
## Reduced-Cost Food for Purchase

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<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Bread of Hope</strong></td>
<td>Anyone in need</td>
<td>Quality food for a low price</td>
<td>Church of the Nazarene’s House of Hope 1025 South Washington, (785)-762-4402</td>
<td>Order reduced-cost food package online at <a href="http://www.breadofhope.net">www.breadofhope.net</a> or with the Church of the Nazarene. Packages are available for pick-up on Saturday once per month.</td>
<td>None</td>
</tr>
<tr>
<td><strong>Bountiful Baskets Food Cooperative</strong></td>
<td>Anyone</td>
<td>A produce basket filled with fruits and vegetables</td>
<td>Location alternates weekly: Parking lots of VFW Post #8773 1215 S. Washington St and Geary Community Hospital 1102 St. Mary’s Road</td>
<td>Orders for purchase are taken online at <a href="http://www.bountifulbaskets.org">www.bountifulbaskets.org</a> Weekly pick up on Saturday</td>
<td>$3 set up fee plus $15 contribution per basket</td>
</tr>
<tr>
<td><strong>Geary County Senior Center</strong></td>
<td>Anyone</td>
<td>Hot lunch</td>
<td>1025 S. Spring Valley Rd. (785)-238-4015</td>
<td>Monday-Friday, 12 pm</td>
<td>Suggested donation of $3.50/meal for seniors, $5.25 for all others. If possible, make reservation one day prior</td>
</tr>
</tbody>
</table>
Advocacy Organizations

Search | Advanced Search | New Members | Coupons and Discounts | All Categories

Related Categories

Advocacy Organizations

Sort alphabetically by...

Aging Well, Inc

816 N. Washington Street
Junction City, KS

Learn More

Big Lakes Developmental Center Inc.

1416 Hayes Drive
Manhattan, KS 66502

(785) 776-9201

Learn More

CASA of the 8th Judicial District

801 N. Washington, Ste. C
Junction City, KS 66441

(785) 762-3907
<table>
<thead>
<tr>
<th>Address</th>
<th>City, State, Zip</th>
<th>Phone</th>
<th>Learn More</th>
</tr>
</thead>
<tbody>
<tr>
<td>610 Rockledge Dr</td>
<td>Junction City, KS 66441</td>
<td>(785) 226-1879</td>
<td></td>
</tr>
<tr>
<td>4620 Eureka Dr.</td>
<td>Manhattan, KS 66503</td>
<td>(785) 564-4907</td>
<td></td>
</tr>
</tbody>
</table>

If your business isn't here, contact us today to get listed!

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Learn More

Wamego Area Chamber of Commerce
529 Lincoln Ave
Wamego, KS 66547
(785) 456-7849
Learn More

If your business isn't here, contact us today to get listed!

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Churches

Related Categories

Churches
Education
K-12 Schools

Faith Evangelical Lutheran Church

212 N. Eisenhower
P.O. Box 181
Junction City, KS 66441
(785) 238-6567

Learn More

Flint Hills Church Junction City

337 W. 7th Street
Junction City, KS 66441
(785) 762-3292
Employee-owned Bayer Construction is always looking for qualified applicants! Contact Stan Hambright at 785-776-8839 or visit www.bayerconst.com/human-resources

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Clubs

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Fort Riley Spouses Club

PO Box 2254
Fort Riley, KS 66442
(785) 309-0572

Learn More

Junction City Community Baseball Club

PO Box 828
Junction City, KS 66441

Learn More

Junction City Little Theater

P O Box 305
Junction City, KS 66441
(785) 238-3871
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Community Events/Activites

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Related Categories

Community Events/Activites

Sort alphabetically by...

Junction City Rodeo Association

2655 Paint Road
Chapman, KS 67431

(785) 210-6536

Learn More

Juneteenth Association

1803 N. Madison St.
Junction City, KS 66441

(785) 226-2750

Learn More

Sundown Salute Inc.

PO Box 287
Junction City, KS 66441

(785) 762-2632

Learn More
Dentists/Orthodontists

Search | Advanced Search | New Members | Coupons and Discounts | All Categories

Related Categories
Dentists/Orthodontists

David Craft, D.D.S
3810 Vanesta Dr.
Suite 120
Manhattan, KS 66503
☎ (785) 223-4210
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Barton County Community College

211 Custer Avenue #211
Fort Riley, KS 66442
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Central Michigan University

211 Custer Avenue
Building 211
Fort Riley, KS
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Geary Rehab & Fitness Center

104 S. Washington Street
Junction City, KS 66441
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<td>1703 McFarland Rd, Junction City, KS 66441</td>
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<td>Jimi Parker Fitness</td>
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<td>Junction City Athletic Training Facility</td>
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<tr>
<td>Planet Fitness</td>
<td>435 E Chestnut St, Junction City, KS 66441</td>
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Hartland Hearing Care Centers

1005 W. 6th St.
Junction City, KS 66441
(785) 223-9952

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We are a proud part of the largest and only American owned and innovated hearing aid company. For more than 30 years, we've been proudly providing better hearing as individualized as the people who wear our hearing aids. Our staff has been serving the hearing impaired since 1987 and look forward to meeting you! ~ Easy on-site parking ~ Wheel chair accessible ~ Cheerful and competent staff ~ Enjoy our hot Keurig coffee and fresh treats daily ~

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Heart and Vascular Clinics
1104 W Ash
Junction City, KS 66441
(785) 539-4644

Heart and Vascular Clinics diagnoses and treats patients with cardiovascular disease in Junction City, Manhattan and the surrounding area.

Jimi Parker Fitness

JUNCTION CITY, KS 66441
(785) 375-6649

Learn More
# Health Clinics

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<td>Heart and Vascular Clinics diagnoses and treats patients with cardiovascular disease in Junction City, Manhattan and the surrounding area.</td>
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<tr>
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Homecare & Hospice

Homecare & Hospice proudly provides hospice, home health and home care services to Junction City and surrounding communities. Caring for individuals in their homes, nursing homes or our hospice house.
Home Health Services

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Suite C
Junction City, KS 66441
(785) 783-4311

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(785) 537-0688

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2019 PARTNER AGENCIES

ARMSERVICE YMCA

111 E. 16th St. Provides support and services for active duty personnel, their families, and the surrounding community. "Operation Wheels" provides transportation to military dependent families needing transportation to limited locations to meet family needs. This includes doctor appointments, mental health services, WIC appointments, etc.

BIG BROTHERS/BIG SISTERS

132 N. Eisenhower. Serves children in the USD 475 area from age 6-17 by providing adults who act as mentors and role models. When children and teens have the influence of a caring adult, they are more likely to avoid risky behaviors and to focus on academics. Today's youth face a variety of challenges, and being matched with a Big Brother or Big Sister can help them navigate these challenges and reach their potential.

CASA OF THE 8TH JUDICIAL DISTRICT

801 N Washington St. Ste C. The primary goal of CASA programs is to assist in securing permanency for children who are in the child welfare system due to abuse and/or neglect. The presiding judge in such a case may appoint a volunteer CASA who is responsible for advocating on behalf of the child's best interests and helping them obtain a safe, permanent, and homelike placement. CASA volunteers can also be appointed to work with children in the juvenile justice system and children involved in domestic relations cases.

CRISIS CENTER

24-Hour Hotlines, 24-Hour Crisis Intervention, Safe Shelter, Food and Subsistence, Advocacy, Referrals, Children's Services, Support Groups for Women and Children, Supportive Counseling, Assistance with Protection Orders. COMMUNITY EDUCATION AND TRAINING The Crisis Center provides educational programs to churches, schools, and civic groups, as well as specialized training to professional associations and employee groups. For information call 785-539-7935. WE CAN HELP Manhattan 785-579-2785, Junction City 785-762-8835. Outside Manhattan and Junction City 1-800-727-2785.

DELIVERING CHANGE - SLEEP SACK PROGRAM

1102 St. Mary's Rd. Ste 106. Delivering Change is a non-profit project of the local Geary County Perinatal Coalition, made up of individuals and organizations that impact the health of mothers and their infants in Geary County. This exciting project was created in response to a growing need for the improved health of women of childbearing age, and improved outcomes for the infants born in our community. Delivering Change creates a community-wide collaborative that aims to increase or improve the tools necessary for improving maternal health and decreasing morbidity and mortality. Delivering Change creates an environment for healthy moms and their babies right here in Geary County.

If you would like to help in our effort, would like to contribute financially to the project, or would be interested in having a representative speak to your group or organization, please contact Delivering Change at 785-238-0300. Find us on Twitter.

FOOD PANTRY OF GEARY COUNTY INC.

136 W 3rd St. Strives to minimize hunger in the community, raise community awareness of hunger among low income families, transients, and encourage the donation of surplus food.

GIRL SCOUTS OF NORTHEAST KANSAS & NORTHWEST MISSOURI

921 W. 4th St. Dedicated solely to girls where, in partnership with adults, girls develop strong values, social conscience, and conviction about their self-worth.

HOUSING & CREDIT COUNSELING

A non-profit agency founded in 1972. HCCI provides counseling and education about budgeting, credit and credit building, debt payment, mortgage delinquency, rental housing issues, student loan payment options, homeownership opportunities and reverse mortgages for persons age 62 and older. HCCI is approved by HUD and accredited by the Council on Accreditation. HCCI is a member of the National Foundation for Credit Counseling and is licensed and regulated in Kansas by the Office of the State Bank Commissioner (License #000003).

The Better Business Bureau of the Great Plains named HCCI as the BBB Integrity Award Winner for a four-state region in recognition of excellence in customer service. In 2017 HCCI received the first Innovative Program Award from the National Foundation for Credit Counseling for HCCI's TOTO Program, an affordable housing project that counsels families earning lower incomes to pre-qualify for home mortgages and gives Down Payment Assistance cash awards to qualifying households.

Call 1-800-383-0217 or visit www.hcci-ks.org.

JUNCTION CITY FAMILY YMCA

1703 McFarland Rd. Provides sports, fitness, recreation programs, and social services for all regardless of their ability to pay, in the Junction City, Ft. Riley, Geary County area. The Learn to Swim program is funded by United Way of Junction City/Geary County, so that all students in USD 475 have the opportunity to learn water safety.
KANSAS LEGAL SERVICES

Kansas Legal Services is a nonprofit law firm. It specializes in providing legal representation to the most vulnerable in your community, including victims of domestic violence, children, crime victims, the elderly, and the disabled. Attorneys with KLS practice general poverty law; they use the courts to help low-income individuals break down legal barriers preventing them from being more economically stable. Success happens when KLS helps the individual increase their ability to be more self-sufficient so that they can overcome poverty on their own. In many cases the individual will remain in poverty but their quality of life will be increased; this often happens with disabled and elderly clients. For example, KLS might help them obtain benefits like housing, access to healthcare or other financial assistance they were being wrongly denied. KLS's mission is to provide legal representation to those who cannot otherwise afford an attorney, especially in situations where a legal solution will provide a positive impact. You can find us on Facebook or Twitter.

OPEN DOOR COMMUNITY HOUSE, INC.

136 W. 3rd St. Local emergency shelter designed to help individuals and families who need a temporary place to stay. Help encourage self-sufficiency; assist the needy with temporary management.

SALVATION ARMY

Provides emergency services that include rent assistance, utility assistance, prescriptions, vision needs, etc.

JC PACESETTERS/SPECIAL OLYMPICS

The Junction City Pacesetters is a local Kansas Special Olympics sports team for individuals with intellectual and physical disabilities. The Pacesetters started over 30 years ago on Ft. Riley (at Camp Funston), Kansas. We currently have about 30 special athletes. These special athletes come from Junction City and Ft. Riley. We bowl, play basketball, participate in track and field events, and in social activities year round. Special Olympics give these athletes a chance to compete in different sports at their skill level and feel good about their accomplishments. This special athlete must be at least 8 years old and have a current physical. There is NO COST to the athlete after their physical. Questions: call Coach John at 785-209-1996 or email jtgjeh2015@yahoo.com.

SUNFLOWER BRIDGE/CASA PROJECT

Sunflower Bridge Child Visit & Exchange is a program that provides a safe, nonconfrontational location where parents can drop off and pick up their children for visitation with the noncustodial parent. It also offers supervised visitation for noncustodial parents. These services must be court ordered.
INFORMATION GAPS
Information Gaps

While the following information gaps exist in the health data section of this report, please note that every effort was made to compensate for these gaps in the interviews conducted by Community Hospital Consulting.

– This assessment seeks to address the community’s health needs by evaluating the most current data available. However, published data inevitably lags behind due to publication and analysis logistics.

– Due to smaller population numbers and the general rural nature of Geary County, 1-year estimates for a few data indicators are statistically unreliable. Therefore, sets of years were combined to increase the reliability of the data while maintaining the county-level perspective.

– It is important to note that this study was conducted prior to the awareness and impact of COVID-19. Therefore, the virus was not mentioned in the qualitative data and was not analyzed in the quantitative data. Hospital activities as a result of COVID-19 will be included and tracked in the Implementation Plan as appropriate.
ABOUT COMMUNITY HOSPITAL CONSULTING
About CHC Consulting

- Community Hospital Corporation owns, manages and consults with hospitals through three distinct organizations – CHC Hospitals, CHC Consulting and CHC ContinueCare, which share a common purpose of preserving and protecting community hospitals.

- Based in Plano, Texas, CHC provides the resources and experience community hospitals need to improve quality outcomes, patient satisfaction and financial performance. For more information about CHC, please visit the website at: [www.communityhospitalcorp.com](http://www.communityhospitalcorp.com)
APPENDIX

- SUMMARY OF DATA SOURCES
- DATA REFERENCES
- MUA/P AND HPSA INFORMATION
- INTERVIEWEE INFORMATION
- ELECTRONIC COMMUNITY SURVEY RESULTS
- PRIORITY BALLOT
SUMMARY OF DATA SOURCES
Summary of Data Sources

- **Demographics**
  - This study utilized demographic data from *Stratasan*.
  - Food insecurity information is pulled from *Feeding America’s Map the Meal Gap*, which provides food insecurity data by county, congressional district and state; [http://map.feedingamerica.org/](http://map.feedingamerica.org/).
  - This study also used health data collected by the *CARES Engagement Network*, a national platform that provides public and custom tools produced by the Center for Applied Research and Engagement Systems (CARES) at the University of Missouri. Data can be accessed at [https://engagementnetwork.org/](https://engagementnetwork.org/).
  - The *Annie E. Casey Foundation* is a private charitable organization, dedicated to helping build better futures for disadvantaged children in the United States. One of their initiatives is the Kids Count Data Center, which provides access to hundreds of measures of child well-being by county and state; [http://datacenter.kidscount.org/](http://datacenter.kidscount.org/).

- **Health Data**
  - The *County Health Rankings* are made available by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The Rankings measure the health of nearly all counties in the nation and rank them within states. The Rankings are compiled using county-level measures from a variety of national and state data sources. These measures are standardized and combined using scientifically-informed weights. The Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. Building on the work of America’s Health Rankings, the University of Wisconsin Population Health Institute has used this model to rank the health of Wisconsin’s counties every year since 2003; [http://wwwCountyHealthRankings.org/](http://wwwCountyHealthRankings.org/).
  - The *Centers for Disease Control and Prevention National Center for Health Statistics WONDER Tool* provides access to public health statistics and community health data including, but not limited to, mortality, chronic conditions, and communicable diseases; [http://wonder.cdc.gov/ucd-icd10.html](http://wonder.cdc.gov/ucd-icd10.html).
  - This study utilizes county level data from the *Behavioral Risk Factor Surveillance System (BRFSS)*, provided by the : Kansas Department of Health and Environment; [http://www.kdheks.gov/brfss/HRSReports/local_hrs_reports_index.htm](http://www.kdheks.gov/brfss/HRSReports/local_hrs_reports_index.htm).
Summary of Data Sources

**Health Data (continued)**
- This study also used health data collected by the CARES Engagement Network, a national platform that provides public and custom tools produced by the Center for Applied Research and Engagement Systems (CARES) at the University of Missouri. Data can be accessed at [https://engagementnetwork.org/](https://engagementnetwork.org/).
- The U.S. Census Bureau’s Small Area Health Insurance Estimates program produces the only source of data for single-year estimates of health insurance coverage status for all counties in the U.S. by selected economic and demographic characteristics. Data can be accessed at [https://www.census.gov/data-tools/demo/sahie/index.html](https://www.census.gov/data-tools/demo/sahie/index.html).
- The U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) provides Medically Underserved Area / Population and Health Professional Shortage Area scores, and can be accessed at: [https://datawarehouse.hrsa.gov/tools/analyzers.aspx](https://datawarehouse.hrsa.gov/tools/analyzers.aspx).

**Phone Interviews**
- CHC Consulting conducted interviews on behalf of GCH from August 5, 2019 – August 16, 2019.
- Interviews were conducted and summarized by Valerie Hayes, Planning Manager.

**Survey**
- CHC Consulting developed an electronic survey tool distributed by GCH via email, the GCH website and Facebook that was conducted between January 27, 2020 – February 17, 2020.
- The survey was sent via email to individuals or organizations representing the need of various community groups in Geary County, and was posted publicly on the hospital’s Facebook page for any community member to access.
DATA REFERENCES
### 2020 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

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For families/households with more than 8 persons, add $4,480 for each additional person.
MUA/P AND HPSA INFORMATION
Medically Underserved Areas/Populations

*Background*

• Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population.

• MUAs have a shortage of primary care services for residents within a geographic area such as:
  - A whole county
  - A group of neighboring counties
  - A group or urban census tracts
  - A group of county or civil divisions

• MUPs are specific sub-groups of people living in a defined geographic area with a shortage of primary care services. These groups may face economic, cultural, or linguistic barriers to health care. Examples include, but are not limited to:
  - Homeless
  - Low income
  - Medicaid eligible
  - Native American
  - Migrant farmworkers

Medically Underserved Areas/Populations

Background (continued)

• The Index of Medical Underservice (IMU) is applied to data on a service area to obtain a score for the area. IMU is calculated based on four criteria:
  1. Population to provider ratio
  2. Percent of the population below the federal poverty level
  3. Percent of the population over age 65
  4. Infant mortality rate

• The IMU scale is from 1 to 100, where 0 represents ‘completely underserved’ and 100 represents ‘best served’ or ‘least underserved.’

• Each service area or population group found to have an IMU of 62.0 or less qualifies for designation as a Medically Underserved Area or Medically Underserved Population.

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| Primary Care | 01180   | Law Inc - Junction City Service Area | Medically Underserved Population | Kansas | Geary County, KS | 51.6 | Designated | Rural        | 04/22/1994 | 07/13/1994 |

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Health Professional Shortage Areas

Background

• Health Professional Shortage Areas (HPSAs) are designations that indicate health care provider shortages in:
  - Primary care
  - Dental health
  - Mental health

• These shortages may be geographic-, population-, or facility-based:
  - Geographic Area: A shortage of providers for the entire population within a defined geographic area.
  - Population Groups: A shortage of providers for a specific population group(s) within a defined geographic area (e.g., low income, migrant farmworkers, and other groups)
  - Facilities:
    - Other Facility (OFAC)
    - Correctional Facility
    - State Mental Hospitals
    - Automatic Facility HPSAs (FQHCs, FQHC Look-A-Likes, Indian Health Facilities, HIS and Tribal Hospitals, Dual-funded Community Health Centers/Tribal Clinics, CMS-Certified Rural Health Clinics (RHCs) that meet National Health Service Corps (NHSC) site requirements)

Health Professional Shortage Areas

*Background (continued)*

- HRSA reviews these applications to determine if they meet the eligibility criteria for designation. The main eligibility criterion is that the proposed designation meets a threshold ratio for population to providers.

- Once designated, HRSA scores HPSAs on a scale of 0-25 for primary care and mental health, and 0-26 for dental health, with higher scores indicating greater need.
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<td>Richard Burnett</td>
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<td>Danielle Holliday</td>
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A: Work for a State, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community

B: Member of a medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations

C: Community Leaders

Source: Geary Community Hospital Community Health Needs Assessment Interviews conducted by Community Hospital Consulting; August 5, 2019 – August 16, 2019.
ELECTRONIC COMMUNITY SURVEY RESULTS
Q1 Keeping your background and the organization you work for in mind, please select all of the following that apply:

Answered: 53  Skipped: 2

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<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
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<td>You work for a state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community</td>
<td>41.51%   22</td>
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<td>You are a member of a medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations</td>
<td>20.75%   11</td>
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<td>None of the above</td>
<td>45.28%   24</td>
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Total Respondents: 53
Q2 What type of company/organization do you work for?

Answered: 52  Skipped: 3

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Q3 What is the name of the organization/company you work for? (optional)

Answered: 33    Skipped: 22
Q4 In which county(ies) does your organization assist residents? Please list all that apply.

Answered: 44    Skipped: 11
Q5 How would you categorize the following groups with respect to how well each population's health needs are currently being met? Please select N/A if you do not know or it does not apply.

Answered: 42  Skipped: 13
- Immigrants
- Lesbian, Gay, Bi-sexual, ...
- Low Income
- Persons with Chronic...
Persons with No Social or...
Pregnant Women
Young Mothers
Single Parents
Substance Abuse
Undocumented Persons
Unemployed
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<td>Persons with Limited/Non-English Proficiency</td>
<td>9.52%</td>
<td>26.19%</td>
<td>30.95%</td>
<td>9.52%</td>
<td>7.14%</td>
<td>3</td>
<td>16.67%</td>
</tr>
<tr>
<td>Persons with Mental Illness</td>
<td>7.32%</td>
<td>19.51%</td>
<td>9.76%</td>
<td>29.27%</td>
<td>24.39%</td>
<td>10</td>
<td>9.76%</td>
</tr>
<tr>
<td>Persons with No Social or Emotional Support</td>
<td>12.20%</td>
<td>12.20%</td>
<td>19.51%</td>
<td>31.71%</td>
<td>7.32%</td>
<td>3</td>
<td>17.07%</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>30.95%</td>
<td>45.24%</td>
<td>9.52%</td>
<td>2.38%</td>
<td>0.00%</td>
<td>0</td>
<td>11.90%</td>
</tr>
<tr>
<td>Young Mothers</td>
<td>21.43%</td>
<td>50.00%</td>
<td>14.29%</td>
<td>4.76%</td>
<td>0.00%</td>
<td>0</td>
<td>9.52%</td>
</tr>
<tr>
<td>Senior Citizens</td>
<td>11.90%</td>
<td>50.00%</td>
<td>19.05%</td>
<td>11.90%</td>
<td>0.00%</td>
<td>0</td>
<td>7.14%</td>
</tr>
<tr>
<td>Retirees</td>
<td>12.50%</td>
<td>50.00%</td>
<td>20.00%</td>
<td>5.00%</td>
<td>0.00%</td>
<td>0</td>
<td>12.50%</td>
</tr>
<tr>
<td>Veterans</td>
<td>14.29%</td>
<td>40.48%</td>
<td>19.05%</td>
<td>9.52%</td>
<td>4.76%</td>
<td>2</td>
<td>11.90%</td>
</tr>
<tr>
<td>Working Poor</td>
<td>9.52%</td>
<td>23.81%</td>
<td>14.29%</td>
<td>35.71%</td>
<td>7.14%</td>
<td>3</td>
<td>9.52%</td>
</tr>
<tr>
<td>Single Parents</td>
<td>12.50%</td>
<td>40.00%</td>
<td>22.50%</td>
<td>15.00%</td>
<td>0.00%</td>
<td>0</td>
<td>10.00%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>9.52%</td>
<td>16.67%</td>
<td>21.43%</td>
<td>26.19%</td>
<td>4.76%</td>
<td>2</td>
<td>21.43%</td>
</tr>
<tr>
<td>Undocumented Persons</td>
<td>4.76%</td>
<td>14.29%</td>
<td>33.33%</td>
<td>4.76%</td>
<td>11.90%</td>
<td>5</td>
<td>30.95%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>9.52%</td>
<td>26.19%</td>
<td>23.81%</td>
<td>16.67%</td>
<td>7.14%</td>
<td>3</td>
<td>16.67%</td>
</tr>
<tr>
<td>Uninsured/Underinsured</td>
<td>7.14%</td>
<td>30.95%</td>
<td>11.90%</td>
<td>16.67%</td>
<td>14.29%</td>
<td>6</td>
<td>19.05%</td>
</tr>
</tbody>
</table>
Q6 If you selected inadequate or very inadequate for any of the above groups, please elaborate:

Answered: 18   Skipped: 37
Q7 Please rate the importance of the following health care initiatives for residents in your community. Please select N/A if you do not know or it does not apply.

Answered: 35  Skipped: 20
Increasing the proportion of ...

Promoting behavior change ...

Health promotion and ...

Improving access to ...
Promoting chronic disease prevention

Recruiting more healthcare providers

Recruiting specialists and experts
## Survey Results

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Very Important</th>
<th>Important</th>
<th>Neutral</th>
<th>Unimportant</th>
<th>Very Unimportant</th>
<th>N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving access to health care for populations with limited services</td>
<td>42.86%</td>
<td>45.71%</td>
<td>5.71%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>5.71%</td>
<td>35</td>
</tr>
<tr>
<td>Improving access to dental care for populations with limited services</td>
<td>45.71%</td>
<td>37.14%</td>
<td>8.57%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>8.57%</td>
<td>35</td>
</tr>
<tr>
<td>Helping ensure the availability of cutting edge treatments</td>
<td>37.14%</td>
<td>31.43%</td>
<td>28.57%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>2.86%</td>
<td>35</td>
</tr>
<tr>
<td>Increasing the proportion of residents who have access to health coverage</td>
<td>45.71%</td>
<td>37.14%</td>
<td>8.57%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>8.57%</td>
<td>35</td>
</tr>
<tr>
<td>Promoting behavior change in unhealthy lifestyles</td>
<td>45.71%</td>
<td>48.57%</td>
<td>2.86%</td>
<td>2.86%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>35</td>
</tr>
<tr>
<td>Health promotion and preventive education</td>
<td>45.71%</td>
<td>45.71%</td>
<td>8.57%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>35</td>
</tr>
<tr>
<td>Improving access to preventive care (screenings for chronic diseases, immunizations)</td>
<td>42.86%</td>
<td>51.43%</td>
<td>5.71%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>35</td>
</tr>
<tr>
<td>Promoting chronic disease management</td>
<td>45.71%</td>
<td>40.00%</td>
<td>11.43%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>2.86%</td>
<td>35</td>
</tr>
<tr>
<td>Recruiting more health care providers</td>
<td>48.57%</td>
<td>42.86%</td>
<td>8.57%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>35</td>
</tr>
<tr>
<td>Recruiting specialists who can provide services that are not currently available</td>
<td>48.57%</td>
<td>42.86%</td>
<td>5.71%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>2.86%</td>
<td>35</td>
</tr>
<tr>
<td>Promoting provider connectedness</td>
<td>31.43%</td>
<td>45.71%</td>
<td>14.29%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>8.57%</td>
<td>35</td>
</tr>
</tbody>
</table>
Q8 In the following list, please mark what you think are the FIVE MOST IMPORTANT “Health Problems” in our community (those problems that have the greatest impact on overall community health). Check only five:

Answered: 36  Skipped: 19
<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging Problems (e.g. arthritis, hearing/vision loss, etc.)</td>
<td>5.56% 2</td>
</tr>
<tr>
<td>Asthma/Allergies</td>
<td>13.89% 5</td>
</tr>
<tr>
<td>Availability of ambulance services</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>Cancer</td>
<td>11.11% 4</td>
</tr>
<tr>
<td>Child Abuse/Neglect</td>
<td>22.22% 8</td>
</tr>
<tr>
<td>Dementia/Alzheimer's</td>
<td>8.33% 3</td>
</tr>
<tr>
<td>Dental Problems</td>
<td>11.11% 4</td>
</tr>
<tr>
<td>Diabetes</td>
<td>33.33% 12</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>11.11% 4</td>
</tr>
<tr>
<td>Elder Abuse/Neglect</td>
<td>13.89% 5</td>
</tr>
<tr>
<td>Firearm Related Injuries</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>HIV</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>Heart Disease/Stroke</td>
<td>13.89% 5</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>16.67% 6</td>
</tr>
<tr>
<td>Industrial/Farming Injuries</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>Infectious Diseases (Hepatitis, TB, etc.)</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>Lead Poisoned Children</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>Mental Health Problems</td>
<td>66.67% 24</td>
</tr>
<tr>
<td>Motor Vehicle Crash Injuries</td>
<td>2.78% 1</td>
</tr>
<tr>
<td>Obesity (adult)</td>
<td>52.78% 19</td>
</tr>
<tr>
<td>Obesity (children)</td>
<td>36.11% 13</td>
</tr>
<tr>
<td>Poor Birth Outcomes (prematurity, low birth weight, birth defects, etc.)</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>Rape/Sexual Assault</td>
<td>11.11% 4</td>
</tr>
<tr>
<td>Respiratory/Lung Disease</td>
<td>25.00% 9</td>
</tr>
<tr>
<td>School Violence/Bullying</td>
<td>19.44% 7</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases/Infections</td>
<td>11.11% 4</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>50.00% 18</td>
</tr>
<tr>
<td>Suicide</td>
<td>41.67% 15</td>
</tr>
<tr>
<td>Teenage Pregnancy</td>
<td>5.56% 2</td>
</tr>
<tr>
<td>Underage Drinking</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>Total Respondents: 36</td>
<td></td>
</tr>
</tbody>
</table>
Q9 Please select the TOP FIVE MOST PREVALENT CHRONIC DISEASES in your community. Check only five:

Answered: 35  Skipped: 20

- Diabetes
- Heart Failure
- Chronic Obstructive...
- Mental Illness
- End stage renal...
- Hepatitis
- Hypertension (high blood...)
- Obesity
- Cancer
- Hyperlipidemia (high lipid...)
- Stroke
- Asthma
- Hypercholesterolemia (high ...)
- Arthritis
- Poor Oral Health
- Chronic Liver Disease/Cirr...
<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>71.43%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>31.43%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>42.86%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>71.43%</td>
</tr>
<tr>
<td>End stage renal disease/Chronic Kidney Disease</td>
<td>5.71%</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>0.00%</td>
</tr>
<tr>
<td>Hypertension (high blood pressure)</td>
<td>54.29%</td>
</tr>
<tr>
<td>Obesity</td>
<td>60.00%</td>
</tr>
<tr>
<td>Cancer</td>
<td>34.29%</td>
</tr>
<tr>
<td>Hyperlipidemia (high lipid levels in the bloodstream)</td>
<td>5.71%</td>
</tr>
<tr>
<td>Stroke</td>
<td>22.86%</td>
</tr>
<tr>
<td>Asthma</td>
<td>14.29%</td>
</tr>
<tr>
<td>Hypercholesterolemia (high LDL cholesterol levels)</td>
<td>8.57%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>14.29%</td>
</tr>
<tr>
<td>Poor Oral Health</td>
<td>25.71%</td>
</tr>
<tr>
<td>Chronic Liver Disease/Cirrhosis</td>
<td>5.71%</td>
</tr>
</tbody>
</table>

Total Respondents: 35
Q10 Please select the TOP FIVE CONDITIONS associated with PREVENTABLE HOSPITALIZATIONS in your community. Check only five:

- Bacterial Pneumonia
- Dehydration
- Urinary Tract Infection
- Perforated Appendix
- Low Birth Weight
- Mental Illness
- Angina (without...)
- Influenza
- Congestive Heart Failure
- Hypertension (high blood...)
- Pregnancy Complications
- Adult Asthma
- Viral Infections
- Chronic Obstructive...
- Diabetes Short-Term...
- Diabetes Long-Term...
- Uncontrolled Diabetes
- Lower-Extremity Amputation...
<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial Pneumonia</td>
<td>3.13%</td>
</tr>
<tr>
<td>Dehydration</td>
<td>18.75%</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>21.88%</td>
</tr>
<tr>
<td>Perforated Appendix</td>
<td>6.25%</td>
</tr>
<tr>
<td>Low Birth Weight</td>
<td>3.13%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>56.25%</td>
</tr>
<tr>
<td>Angina (without procedures)</td>
<td>3.13%</td>
</tr>
<tr>
<td>Influenza</td>
<td>43.75%</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>43.75%</td>
</tr>
<tr>
<td>Hypertension (high blood pressure)</td>
<td>43.75%</td>
</tr>
<tr>
<td>Pregnancy Complications</td>
<td>12.50%</td>
</tr>
<tr>
<td>Adult Asthma</td>
<td>21.88%</td>
</tr>
<tr>
<td>Viral Infections</td>
<td>34.38%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>46.88%</td>
</tr>
<tr>
<td>Diabetes Short-Term Complications</td>
<td>21.88%</td>
</tr>
<tr>
<td>Diabetes Long-Term Complications</td>
<td>28.13%</td>
</tr>
<tr>
<td>Uncontrolled Diabetes</td>
<td>46.88%</td>
</tr>
<tr>
<td>Lower-Extremity Amputation Among Patients with Diabetes</td>
<td>15.63%</td>
</tr>
<tr>
<td><strong>Total Respondents: 32</strong></td>
<td></td>
</tr>
</tbody>
</table>
Q11 Please rank the TOP BARRIERS related to access to primary/preventative care for LOW INCOME residents on a scale of 1 to 8. Rank in order of importance with 1 being the most important and 8 being the least important. Each number can be selected only once. Please select N/A if you do not know or it does not apply.
Language barriers
Delays or complication...
Lack of providers...
<table>
<thead>
<tr>
<th>Lack of coverage/financial hardship</th>
<th>11</th>
<th>4</th>
<th>2</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>1</th>
<th>0</th>
<th>22</th>
<th>50.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty navigating system/lack of awareness of available resources</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>19</td>
<td>21.05%</td>
</tr>
<tr>
<td>Lack of access due to provider distance</td>
<td>0</td>
<td>0</td>
<td>26.67%</td>
<td>6.67%</td>
<td>20.00%</td>
<td>13.33%</td>
<td>20.00%</td>
<td>13.33%</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Lack of capacity (e.g. insufficient providers/extended wait times)</td>
<td>2</td>
<td>1</td>
<td>16.67%</td>
<td>11.11%</td>
<td>11.11%</td>
<td>11.11%</td>
<td>0</td>
<td>22.22%</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Scheduling (system inefficiency/non-standardized process)</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>30.77%</td>
<td>7.69%</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>0.00%</td>
</tr>
<tr>
<td>Eligibility screening process for benefits/covered services</td>
<td>1</td>
<td>6</td>
<td>0.00%</td>
<td>13.33%</td>
<td>6.67%</td>
<td>13.33%</td>
<td>6.67%</td>
<td>6.67%</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Lack of child care</td>
<td>1</td>
<td>0</td>
<td>12.50%</td>
<td>43.75%</td>
<td>12.50%</td>
<td>6.25%</td>
<td>12.50%</td>
<td>6.25%</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Delays in authorization/referral approval</td>
<td>3</td>
<td>4</td>
<td>17.39%</td>
<td>4.35%</td>
<td>17.39%</td>
<td>13.04%</td>
<td>4.35%</td>
<td>4.35%</td>
<td>0</td>
<td>23</td>
</tr>
<tr>
<td>Lack of transportation resource</td>
<td>1</td>
<td>1</td>
<td>5.88%</td>
<td>17.65%</td>
<td>23.53%</td>
<td>0.00%</td>
<td>5.88%</td>
<td>11.76%</td>
<td>5.88%</td>
<td>17</td>
</tr>
<tr>
<td>Language barriers</td>
<td>2</td>
<td>0</td>
<td>5.88%</td>
<td>5.88%</td>
<td>11.76%</td>
<td>17.65%</td>
<td>11.76%</td>
<td>11.76%</td>
<td>23.53%</td>
<td>4</td>
</tr>
<tr>
<td>Delays or complications in referrals to services</td>
<td>1</td>
<td>3</td>
<td>20.00%</td>
<td>6.67%</td>
<td>6.67%</td>
<td>0.00%</td>
<td>20.00%</td>
<td>20.00%</td>
<td>0.00%</td>
<td>15</td>
</tr>
<tr>
<td>Lack of providers accepting Medicaid/Medicare</td>
<td>1</td>
<td>1</td>
<td>15.00%</td>
<td>25.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>20.00%</td>
<td>15.00%</td>
<td>15.00%</td>
<td>3</td>
</tr>
<tr>
<td>Other (specify below)</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>75.00%</td>
<td>3</td>
</tr>
</tbody>
</table>
Q12 Please rate the level of difficulty low income patients face when trying to ACCESS health care services. Please select N/A if you do not know or it does not apply.

Answered: 30    Skipped: 25
<table>
<thead>
<tr>
<th>Service</th>
<th>VERY EASY</th>
<th>EASY</th>
<th>NEUTRAL</th>
<th>DIFFICULT</th>
<th>VERY DIFFICULT</th>
<th>N/A</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Primary/Preventative Care</td>
<td>6.67%</td>
<td>33.33%</td>
<td>30.00%</td>
<td>23.33%</td>
<td>3.33%</td>
<td>3.33%</td>
<td>30</td>
</tr>
<tr>
<td>Routine Hospital Services</td>
<td>7.14%</td>
<td>42.86%</td>
<td>21.43%</td>
<td>17.86%</td>
<td>7.14%</td>
<td>3.57%</td>
<td>28</td>
</tr>
<tr>
<td>Routine Specialty Care</td>
<td>6.67%</td>
<td>13.33%</td>
<td>20.00%</td>
<td>40.00%</td>
<td>13.33%</td>
<td>6.67%</td>
<td>30</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>37.93%</td>
<td>24.14%</td>
<td>20.69%</td>
<td>6.90%</td>
<td>6.90%</td>
<td>3.45%</td>
<td>29</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>34.48%</td>
<td>24.14%</td>
<td>20.69%</td>
<td>13.79%</td>
<td>3.45%</td>
<td>3.45%</td>
<td>29</td>
</tr>
<tr>
<td>Mental/Behavioral Health Care Services</td>
<td>0.00%</td>
<td>3.33%</td>
<td>26.67%</td>
<td>30.00%</td>
<td>30.00%</td>
<td>10.00%</td>
<td>30</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>17.24%</td>
<td>41.38%</td>
<td>24.14%</td>
<td>10.34%</td>
<td>0.00%</td>
<td>6.90%</td>
<td>29</td>
</tr>
<tr>
<td>Pediatric/Well-child Services</td>
<td>17.24%</td>
<td>24.14%</td>
<td>41.38%</td>
<td>13.79%</td>
<td>0.00%</td>
<td>3.45%</td>
<td>29</td>
</tr>
<tr>
<td>Dental Care</td>
<td>3.33%</td>
<td>16.67%</td>
<td>26.67%</td>
<td>23.33%</td>
<td>13.33%</td>
<td>16.67%</td>
<td>30</td>
</tr>
<tr>
<td>Substance Abuse Services</td>
<td>0.00%</td>
<td>6.90%</td>
<td>17.24%</td>
<td>27.59%</td>
<td>31.03%</td>
<td>17.24%</td>
<td>29</td>
</tr>
</tbody>
</table>
Q13 Please rate the following barriers to effective care coordination in your community (1 as not a barrier, 5 as a major barrier). Please select N/A if you do not know or it does not apply.

Answered: 29  Skipped: 26
Lack of communication...

Transition from hospital...

Competition between...

Lack of partnerships...
Limited health IT...
Limited financial...
Fragmented stand-alone...
Primary Care...
Limited
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
<th>TOTAL</th>
<th>WEIGHTED AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>No (or few) financial incentives or requirements for care coordination for providers</td>
<td>6.90%</td>
<td>2</td>
<td>17.24%</td>
<td>5</td>
<td>20.69%</td>
<td>6</td>
<td>13.79%</td>
<td>6</td>
</tr>
<tr>
<td>Lack of staff and time for investment in coordination (at the practice and broader community levels)</td>
<td>6.90%</td>
<td>2</td>
<td>13.79%</td>
<td>4</td>
<td>13.79%</td>
<td>4</td>
<td>27.59%</td>
<td>8</td>
</tr>
<tr>
<td>Lack of community involvement</td>
<td>10.34%</td>
<td>3</td>
<td>24.14%</td>
<td>7</td>
<td>17.24%</td>
<td>5</td>
<td>13.79%</td>
<td>4</td>
</tr>
<tr>
<td>Lack of communication between health care facilities and providers</td>
<td>10.34%</td>
<td>3</td>
<td>20.69%</td>
<td>6</td>
<td>20.69%</td>
<td>6</td>
<td>34.48%</td>
<td>10</td>
</tr>
<tr>
<td>Transition from hospital setting to primary care provider</td>
<td>6.90%</td>
<td>2</td>
<td>31.03%</td>
<td>9</td>
<td>20.69%</td>
<td>6</td>
<td>17.24%</td>
<td>5</td>
</tr>
<tr>
<td>Competition between facilities</td>
<td>20.69%</td>
<td>6</td>
<td>13.79%</td>
<td>4</td>
<td>20.69%</td>
<td>6</td>
<td>20.69%</td>
<td>6</td>
</tr>
<tr>
<td>Lack of partnerships across community organizations</td>
<td>17.24%</td>
<td>5</td>
<td>6.90%</td>
<td>2</td>
<td>20.69%</td>
<td>6</td>
<td>20.69%</td>
<td>6</td>
</tr>
<tr>
<td>Limited Primary Care provider involvement in inpatient care</td>
<td>10.34%</td>
<td>3</td>
<td>13.79%</td>
<td>4</td>
<td>27.59%</td>
<td>8</td>
<td>13.79%</td>
<td>4</td>
</tr>
<tr>
<td>Fragmented, stand-alone services, rather than an integrated delivery system</td>
<td>6.90%</td>
<td>2</td>
<td>6.90%</td>
<td>2</td>
<td>34.48%</td>
<td>10</td>
<td>20.69%</td>
<td>6</td>
</tr>
<tr>
<td>Limited financial integration across most providers</td>
<td>3.45%</td>
<td>1</td>
<td>17.24%</td>
<td>5</td>
<td>20.69%</td>
<td>6</td>
<td>10.34%</td>
<td>3</td>
</tr>
<tr>
<td>Limited health IT infrastructure and interoperability</td>
<td>6.90%</td>
<td>2</td>
<td>0.00%</td>
<td>0</td>
<td>27.59%</td>
<td>8</td>
<td>20.69%</td>
<td>6</td>
</tr>
<tr>
<td>Practice norms that encourage clinicians to act in silos rather than coordinate with each other</td>
<td>3.57%</td>
<td>1</td>
<td>10.71%</td>
<td>3</td>
<td>28.57%</td>
<td>8</td>
<td>21.43%</td>
<td>6</td>
</tr>
<tr>
<td>Complexity of coordination for patients with high levels of need and/or with frequent hospital and clinic visits</td>
<td>6.90%</td>
<td>2</td>
<td>27.59%</td>
<td>8</td>
<td>31.03%</td>
<td>9</td>
<td>31.03%</td>
<td>9</td>
</tr>
<tr>
<td>Misconception regarding privacy laws and limits to information sharing/access (HIPAA)</td>
<td>41.38%</td>
<td>12</td>
<td>17.24%</td>
<td>5</td>
<td>13.79%</td>
<td>4</td>
<td>10.34%</td>
<td>3</td>
</tr>
</tbody>
</table>
Q14 If you selected 4 or 5 (substantial barriers) for any of the above groups, please elaborate:

Answered: 8    Skipped: 47
Q15 Please indicate whether you feel the following services are adequately provided in your community, or if they need to be improved to advance the health and safety of residents in your community. Please select N/A if you do not know or it does not apply.

Answered: 30  Skipped: 25
<table>
<thead>
<tr>
<th>Service</th>
<th>VERY ADEQUATE</th>
<th>ADEQUATE</th>
<th>NEUTRAL</th>
<th>INADEQUATE</th>
<th>VERY INADEQUATE</th>
<th>N/A</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease Screenings</td>
<td>10.34%</td>
<td>36.48%</td>
<td>41.38%</td>
<td>6.90%</td>
<td>0.00%</td>
<td>6.90%</td>
<td>29</td>
</tr>
<tr>
<td>Dental Exams</td>
<td>6.90%</td>
<td>24.14%</td>
<td>27.59%</td>
<td>27.59%</td>
<td>3.45%</td>
<td>10.34%</td>
<td>3</td>
</tr>
<tr>
<td>Women's Health Exams</td>
<td>31.03%</td>
<td>31.03%</td>
<td>20.69%</td>
<td>6.90%</td>
<td>3.45%</td>
<td>6.90%</td>
<td>29</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>3.57%</td>
<td>7.14%</td>
<td>28.57%</td>
<td>32.14%</td>
<td>21.43%</td>
<td>7.14%</td>
<td>28</td>
</tr>
<tr>
<td>Mental Health Screenings</td>
<td>6.90%</td>
<td>3.45%</td>
<td>24.14%</td>
<td>37.93%</td>
<td>20.69%</td>
<td>6.90%</td>
<td>29</td>
</tr>
<tr>
<td>Prenatal Health Care</td>
<td>41.38%</td>
<td>34.88%</td>
<td>10.34%</td>
<td>3.45%</td>
<td>0.00%</td>
<td>3.45%</td>
<td>1</td>
</tr>
<tr>
<td>Tobacco Cessation Programs</td>
<td>6.90%</td>
<td>13.79%</td>
<td>27.59%</td>
<td>27.59%</td>
<td>13.79%</td>
<td>10.34%</td>
<td>3</td>
</tr>
<tr>
<td>Routine Physical Exams</td>
<td>17.24%</td>
<td>48.28%</td>
<td>24.14%</td>
<td>6.90%</td>
<td>0.00%</td>
<td>3.45%</td>
<td>29</td>
</tr>
<tr>
<td>Vision/Hearing Exams</td>
<td>10.00%</td>
<td>46.67%</td>
<td>30.00%</td>
<td>6.67%</td>
<td>0.00%</td>
<td>6.67%</td>
<td>30</td>
</tr>
<tr>
<td>Nutrition and Weight Management Programs</td>
<td>3.45%</td>
<td>20.69%</td>
<td>41.38%</td>
<td>20.69%</td>
<td>6.90%</td>
<td>6.90%</td>
<td>29</td>
</tr>
</tbody>
</table>
Q16 If you selected inadequate or very inadequate for any of the above groups, please elaborate:

Answered: 5   Skipped: 50
Q17 Based on your experience, where are patients getting their health-related education (e.g., preventative information)? Please select all that apply.

Answered: 29  Skipped: 26
### Answer Choices

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends and Family</td>
<td>62.07%</td>
</tr>
<tr>
<td>Hospital</td>
<td>27.59%</td>
</tr>
<tr>
<td>Doctor</td>
<td>41.38%</td>
</tr>
<tr>
<td>Health Department</td>
<td>37.93%</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>13.79%</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>20.69%</td>
</tr>
<tr>
<td>Help Lines</td>
<td>3.45%</td>
</tr>
<tr>
<td>Church</td>
<td>10.34%</td>
</tr>
<tr>
<td>Books/Magazines</td>
<td>17.24%</td>
</tr>
<tr>
<td>Internet</td>
<td>75.86%</td>
</tr>
<tr>
<td>Child's School</td>
<td>17.24%</td>
</tr>
<tr>
<td>Television Advertisements</td>
<td>20.69%</td>
</tr>
<tr>
<td>Nursing and Allied Health Staff</td>
<td>24.14%</td>
</tr>
<tr>
<td>Faith Based Institutions</td>
<td>6.90%</td>
</tr>
<tr>
<td>Library</td>
<td>3.45%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>20.69%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Respondents: 29</strong></td>
<td></td>
</tr>
</tbody>
</table>
Q18 At this time please provide any additional comments you would like to share regarding the community's health.

Answered: 3  Skipped: 52
PRIORITY BALLOT
Upon reviewing the comprehensive preliminary findings report for the 2020 GCH Community Health Needs Assessment (CHNA), we have identified the following needs for the GCH CHNA Team to prioritize in order of importance.

Please review the following criteria (Size and Prevalence of the Issue, Effectiveness of Interventions and GCH Capacity) that we would like for you to use when identifying the top community health priorities for GCH, then cast 3 votes for each priority.

1. Size and Prevalence of the Issue
In thinking about the “Size and Prevalence” of the health need identified, ask yourself the following questions listed below to figure out if the overall magnitude of the health issue should be ranked as a "1" (least important) or a "5" (most important).
   a. How many people does this affect?
   b. How does the prevalence of this issue in our communities compare with its prevalence in other counties or the state?
   c. How serious are the consequences? (urgency; severity; economic loss)

2. Effectiveness of Interventions
In thinking about the “Effectiveness of Interventions” of the health need identified, ask yourself the following questions listed below to figure out if the overall magnitude of the health issue should be ranked as a "1" (least important) or a "5" (most important).
   a. How likely is it that actions taken by GCH will make a difference?
   b. How likely is it that actions taken by GCH will improve quality of life?
   c. How likely is it that progress can be made in both the short term and the long term?
   d. How likely is it that the community will experience reduction of long-term health cost?

3. GCH Capacity
In thinking about the Capacity of GCH to address the health need identified, ask yourself the following questions listed below to figure out if the overall magnitude of the health issue should be ranked as a "1" (least important) or a "5" (most important).
   a. Are people at GCH likely to support actions around this issue? (ready)
   b. Will it be necessary to change behaviors and attitudes in relation to this issue? (willing)
   c. Are the necessary resources and leadership available to us now? (able)

*Please note that the identified health needs below are in alphabetical order for now, and will be shifted in order of importance once they are ranked by the CHNA Team.
| *1. Access to Affordable Care and Reducing Health Disparities Among Specific Populations* |
|--------------------------------------------------|---|---|---|---|---|
| 1 (Least Important) | 2 | 3 | 4 | 5 (Most Important) |
| Size and Prevalence of the Issue | | | | |
| Effectiveness of Interventions | | | | |
| GCH Capacity | | | | |

| *2. Access to Dental Care Services and Providers* |
|--------------------------------------------------|---|---|---|---|---|
| 1 (Least Important) | 2 | 3 | 4 | 5 (Most Important) |
| Size and Prevalence of the Issue | | | | |
| Effectiveness of Interventions | | | | |
| GCH Capacity | | | | |

| *3. Access to Mental and Behavioral Health Care Services and Providers* |
|--------------------------------------------------|---|---|---|---|---|
| 1 (Least Important) | 2 | 3 | 4 | 5 (Most Important) |
| Size and Prevalence of the Issue | | | | |
| Effectiveness of Interventions | | | | |
| GCH Capacity | | | | |

| *4. Access to Primary and Specialty Care Services and Providers* |
|--------------------------------------------------|---|---|---|---|---|
| 1 (Least Important) | 2 | 3 | 4 | 5 (Most Important) |
| Size and Prevalence of the Issue | | | | |
| Effectiveness of Interventions | | | | |
| GCH Capacity | | | | |

| *5. Increased Emphasis on Education and Awareness of Existing Health Care Resources* |
|--------------------------------------------------|---|---|---|---|---|
| 1 (Least Important) | 2 | 3 | 4 | 5 (Most Important) |
| Size and Prevalence of the Issue | | | | |
| Effectiveness of Interventions | | | | |
| GCH Capacity | | | | |
### 6. Prevention, Education and Services to Address High Mortality Rates, Chronic Diseases, Preventable Conditions and Unhealthy Lifestyles

<table>
<thead>
<tr>
<th></th>
<th>1 (Least Important)</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 (Most Important)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size and Prevalence of the Issue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effectiveness of Interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCH Capacity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 7. When thinking about the above needs, are there any on this list that you DO NOT feel that GCH could/would work on over the next 3 years?

<table>
<thead>
<tr>
<th></th>
<th>Yes, we could/should work on this issue.</th>
<th>No, we cannot/should not work on this issue.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Affordable Care and Reducing Health Disparities Among Specific Populations</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Access to Dental Care Services and Providers</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Access to Mental and Behavioral Health Care Services and Providers</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Access to Primary and Specialty Care Services and Providers</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Increased Emphasis on Education and Awareness of Existing Health Care Resources</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Prevention, Education and Services to Address High Mortality Rates, Chronic Diseases, Preventable Conditions and Unhealthy Lifestyles</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Section 2: 
Implementation Plan
A comprehensive, six-step community health needs assessment ("CHNA") was conducted for Geary Community Hospital (GCH) by Community Hospital Consulting (CHC Consulting). This CHNA utilizes relevant health data and stakeholder input to identify the significant community health needs in Geary County, Kansas.

The CHNA Team, consisting of leadership from GCH, reviewed the research findings in March 2020 to prioritize the community health needs. Six significant community health needs were identified by assessing the prevalence of the issues identified from the health data findings combined with the frequency and severity of mentions in community input.

The CHNA Team participated in an electronic prioritization process to rank the community health needs based on three characteristics: size and prevalence of the issue, effectiveness of interventions and their capacity to address the need. Once this prioritization process was complete, GCH leadership discussed the results and decided to prioritize five of the identified needs in various capacities through the implementation plan.

The six most significant needs are listed below:
1.) Access to Primary and Specialty Care Services and Providers
2.) Access to Affordable Care and Reducing Health Disparities Among Specific Populations
3.) Increased Emphasis on Education and Awareness of Existing Health Care Resources
4.) Access to Mental and Behavioral Health Care Providers and Services
5.) Prevention, Education and Services to Address High Mortality Rates, Chronic Diseases, Preventable Conditions and Unhealthy Lifestyles
6.) Access to Dental Care Services and Providers

Once the prioritization process was complete, GCH leadership discussed the results and decided to address five of the six prioritized needs in various capacities through its implementation plan. While GCH acknowledges that this is a significant need in the community, "Access to Dental Care Services and Providers" is not addressed largely due to the fact that it is not a core business function of the hospital and the limited capacity of the hospital to address this need. GCH will continue to support local organizations and efforts to address this need in the community.

GCH leadership has developed the following implementation plan to identify specific activities and services which directly address the remaining identified priorities. The objectives were identified by studying the prioritized health needs, within the context of the hospital’s overall strategic plan and the availability of finite resources. The plan includes a rationale for each priority, followed by objectives, specific implementation activities, responsible leaders, annual updates and progress, and key results (as appropriate).

The GCH Board reviewed and adopted the 2020 Community Health Needs Assessment and Implementation Plan on September 29, 2020.
## Priority #1: Access to Primary and Specialty Care Services and Providers

**Rationale:**
Geary County has a lower rate of primary care providers per 100,000 population than the state, as well as a higher rate of preventable hospitalizations than the state. Additionally, Geary County has several Health Professional Shortage Area and Medically Underserved Area/Population designations as defined by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA).

With regards to primary care access, interviewees noted limited availability of local resources that leads to outmigration of patients outside of Junction City. It was mentioned that there are challenges in seeking primary care services covered by insurance, particularly for KCare, military and military dependents and un/underinsured residents. One interviewee stated: “People with KCare are very limited in where they can go for primary care in Junction City.” Interviewees also noted outmigration of pediatric patients to Manhattan due to distrust in the longevity of new providers, with one interviewee specifically stating: “Most people go to Manhattan because there isn’t a pediatrician in Junction City. We have never had longevity of keeping pediatrics in Junction City. If a new doc comes in, nobody trusts that they’ll be long term here.”

A shortage of specialty care services in the community was brought up several times by interviewees, which may lead to long wait times; outmigration of patients to Kansas City, Wichita, Topeka, Selina or Manhattan; and delaying or foregoing care. Specific specialties mentioned as needed include Cardiology (full time), OB/GYN, Gastroenterology, Neurology (full time) and dialysis services.

Interviewees also discussed limited access to pediatric specialty services at Children’s Mercy, with one interviewee stating: “Specialty pediatric care is nonexistent. The hospital has partnered with Children’s Mercy to have some specialties here, but the waiting list to be able to see someone is absolutely crazy and they don’t cover all the specialties.”

**Objective:**
Provide and promote access to primary and specialty health care services in the community

<table>
<thead>
<tr>
<th>Implementation Activity</th>
<th>Responsible Leader(s)</th>
<th>FY 2021 Progress</th>
<th>FY 2022 Key Results (As Appropriate)</th>
<th>FY 2023 Progress</th>
<th>FY 2023 Key Results (As Appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.A. GCH will continue to consult its Medical Staff Development Plan report to determine the physician needs of the county and consider the recruitment of providers accordingly.</td>
<td>CEO, Practice Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.B. GCH will continue to strengthen the continuum of care by increasing health information exchange opportunities, such as electronically exchanging patient summaries of care with other physicians to reconcile any medication concerns and conducting routine follow-up phone calls with discharged patients. In addition, efforts to shift the clinic record system to an electronic system are underway.</td>
<td>Practice Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1.C. GCH will continue to serve as a clinical site for health care students from local academic institutions to rotate through the facility, and will continue to provide scholarship opportunities for eligible students pursuing degrees in nursing. Non-Clinical internships and job shadowing opportunities are also provided for high school students. | Education Coordinator | **Current Examples Include:**  
LaVerne Allen Scholarship Program, Health Care Scholarship; students rotate from KU, Washburn, Wichita State, Manhattan Area Technical College, Cloud County Community College | | | |
| 1.D. GCH will continue to provide full time and rotating specialty services in order to increase access to specialty care providers and services in the community. Additional specialty providers and rotating coverage opportunities are continuously evaluated. | CEO, Practice Manager | **Current Examples Include:**  
General Surgery, Bariatric Surgery, Cardiopulmonary, Intensive/Critical Care, Nephrology, Orthopedic Surgery, OB/GYN, Ophthalmology (opportunity) | | | |
<table>
<thead>
<tr>
<th>Implementation Activity</th>
<th>Responsible Leader(s)</th>
<th>FY 2021</th>
<th>FY 2022</th>
<th>FY 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Progress</td>
<td>Key Results</td>
<td>Progress</td>
</tr>
<tr>
<td>1.E. GCH will continue to increase access to care through the provision of extended-hours access to primary care services through the rural health clinic, as well as telehealth services.</td>
<td>Practice Manager</td>
<td>Current Examples include: Intensive Care, Primary Care, Telestroke</td>
<td></td>
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### Priority #2: Access to Affordable Care and Reducing Health Disparities Among Specific Populations

**Rationale:**
Geary County has a lower median household income and a higher unemployment rate than the state. Additionally, Geary County has a higher percentage of families and children living below poverty than the state, and higher food insecurity rates for the overall population and youth population than the state. There is a higher percentage of public school students eligible for free or reduced price lunch in the county, and a higher percentage of adolescents age 16-19 years old who are not in school and not employed.

The unmet needs of low income and un/underinsured residents in the community were brought up by interviewees. It was mentioned that there is a low prioritization of health care needs due to cost barriers to care, and vulnerable populations may leave the community to seek care in nearby clinics with more affordable services. One interviewee stated: “There’s a free clinic in Manhattan that has been very helpful for a lot of different things but we don’t have anything like that around here.”

Cost barriers to care were mentioned as leading to residents delaying and/or foregoing care. It was also mentioned that there is greater difficulty in placing low income and un/underinsured patients in appropriate mental health care settings, with one interviewee stating: “We serve a lot of people who are uninsured. Being able to get them somewhere for mental health, especially, more so than anything else is our biggest issue.”

Interviewees also mentioned a challenge in navigating the health care system for military and military dependent families and homeless populations. One interviewee specifically stated: “Some of the Army connected people go to the Army hospital, some don’t. That also means we have a large population of retired military that have varying needs. Sometimes they go to the VA, sometimes they go to the hospital."

Interviewees discussed transportation barriers in getting to/from health care services, as well as a lack of a built environment that is conducive to transportation via biking, walking, etc. Though there is an existing transportation system in the community, interviewees mentioned challenges in navigating the service. One interviewee noted: “Most people have accepted the fact that Junction City isn’t walkable or bike friendly. There is a bus that will pick up 60+ adults and take them to the doctor’s office, but that’s hard to navigate.” Concern was raised surrounding the unmet transportation needs of families, seniors, low income and rural residents and veterans.

When asked which health disparities in Geary County, interviewees discussed the pediatric, elderly, teenagers/adolescents, racial/ethnic, low income/working poor, homeless and veterans/military dependent populations.

With regards to the pediatric population, interviewees discussed a lack of local developmental disability services and limited local access to pediatricians as challenges for this group. For elderly residents, interviewees mentioned transportation barriers and limited access to mental health resources and services as disproportionately challenging these residents.

Interviewees mentioned obesity, need for role models, mental health concerns (depression, anxiety), substance abuse education and rehab services and a need for domestic violence screenings as health disparities affecting the teenage/adolescent population in Geary County. It was noted that language barriers may specifically challenge racial/ethnic groups, and for the low income/working poor population, interviewees mentioned those residents are challenged by transportation barriers in the community.

With regards to the homeless population, interviewees discussed challenges associated with a lack of access to local shelters and difficulty getting into shelters, as well as a growing number of homeless persons. Lastly, interviewees mentioned limited access to mental health resources and services, a stigma associated with seeking mental health care services and difficulty accessing health care services due to insurance coverage barriers.

**Objective:**
Implement and offer programs that aim to reduce health disparities by targeting specific populations

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<tr>
<th>Implementation Activity</th>
<th>Responsible Leader(s)</th>
<th>FY 2021 Progress</th>
<th>FY 2022 Key Results (As Appropriate)</th>
<th>FY 2023 Progress</th>
<th>Key Results (As Appropriate)</th>
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<tbody>
<tr>
<td>2.A. GCH will continue to host and/or participate in fundraising events and donation drives to benefit underserved organizations in the community, as well as educational events.</td>
<td>Director of Human Resources and External Relations</td>
<td>Current Examples Include: JC Strong Benefit Run, Artrageous, Chase For A Cause, GCH Foundation Events</td>
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<td>2.B. GCH will continue to work with self pay patients on payment plans and/or insurance coverage through financial counseling.</td>
<td>Assistant CFO/Controller</td>
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<td>2.C. GCH will continue to provide translation services and resources in multiple languages, including services for those who may be vision and/or hearing impaired.</td>
<td>Director of Quality Management</td>
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<td>2.D. GCH is exploring participation in the 340b Pharmacy Program which provides discounted pharmacy pricing to indigent patients.</td>
<td>Pharmacy</td>
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<td>2.E. GCH will execute a detailed cost reduction strategy for patient services to ensure and improve affordability of care.</td>
<td>Practice Manager</td>
<td>Current Examples Include: IV Therapy, Medicaid</td>
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### Priority #3: Increased Emphasis on Education and Awareness of Existing Health Care Resources

**Rationale:**
- Interviewees raised concern surrounding the lack of education on the difference across health care settings in the community. One interviewee stated: “For a lot of people here, 911 is their primary access to health care. There’s no one there to educate the patient on where to go for certain types of care.”
- Concern was raised surrounding communication across the continuum of care, and specifically the communication between AlphaCare and primary care providers to ensure information is shared appropriately. Interviewees also discussed misuse of the Emergency Room due to long wait times for an appointment with a primary care provider, long wait times in the waiting room of the primary care provider’s office and a desire to not miss work. One interviewee stated: “For the working poor, if an hour is taken off of work, that’s one less hour of pay they get. So sometimes they have to go to the ER because it’s after work hours and that’s when they can go.”

**Objective:**
*Engage in efforts to increase education and awareness of existing health care resources*

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<td>Progress</td>
<td>Key Results (As Appropriate)</td>
<td>Progress</td>
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<td><strong>3.A.</strong> GCH will continue to promote and increase awareness of its service offerings in the community through local media outlets, such as the radio, billboards, direct mail advertisements, Facebook and updating the hospital’s website.</td>
<td>Communications Director</td>
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<td><strong>3.B.</strong> GCH case managers and social workers will continue to provide a brochure of community resources to appropriate services for applicable patients, and will work to update the information based on new agencies in the area.</td>
<td>Case Management, Communications Director</td>
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### Priority #4: Access to Mental and Behavioral Health Care Providers and Services

**Rationale:**
Geary County has higher rates of adult depression than the state, as well as a higher percentage of residents who experienced 14+ days of poor mental health than the state. Many interviewees mentioned a stigma associated with seeking mental and behavioral health care services, as well as cultural perspectives driving the use of those services. It was also mentioned that there is a greater challenge in seeking care for Medicare and TRICARE patients, with one interviewee stating: “There are not a lot of mental health providers accepting Medicare and TRICARE patients. They require an additional level of credentialing, so that impacts access for those populations. We need mental health care for family members of veterans who don’t know how to manage the struggles that their loved one is experiencing.”

Limited local resources were also noted in the interviews, which may lead to the transferring of patients outside of the county. The shortage of providers results in long wait times and use of law enforcement to manage mental and behavioral-health related situations. One interviewee stated: “Wait times are way too long. People have PTSD issues and law enforcement have to deal with mental issues on a daily basis because all the providers are booked up. It’s an issue because it eats up time and resources.”

Interviewees raised concern surrounding significant recreational drug use (methamphetamine, opioids) and the lack of substance abuse treatment facilities in the community. Several individuals also discussed the lack of local developmental evaluations for pediatric patients, with one interviewee stating: “There are not any mental health professionals seeing pediatric patients. A lot of families have been referred to Children’s Mercy and they do not specifically provide autism evaluations or developmental evaluations.”

**Objective:**
Provide and promote access to mental and behavioral health care services in the community

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<td>4.A.</td>
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<td>4.B.</td>
<td>ER Director</td>
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<td>4.C.</td>
<td>ER Director</td>
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Priority #5: Prevention, Education and Services to Address High Mortality Rates, Chronic Diseases, Preventable Conditions and Unhealthy Lifestyles

Rationale:
Data suggests that higher rates of specific mortality causes and unhealthy behaviors warrants a need for increased preventive education and services to improve the health of the community. Heart disease and cancer are the two leading causes of death in Geary County and the state. Geary County has higher mortality rates than Kansas for diseases of heart; malignant neoplasms; cerebrovascular diseases; diabetes mellitus; Alzheimer disease; intentional self-harm (suicide); nephritis, nephrotic syndrome and nephrosis; certain conditions originating in the perinatal period; lung and bronchus cancer and colorectal cancer.

Geary County has higher rates of chronic conditions and unhealthy behaviors than the state, such as diabetes (adult and Medicare populations), obesity, high blood pressure (adult and Medicare populations), asthma, arthritis and residents consuming fruit and vegetables less than one time per day. Data also suggests that residents may not be seeking necessary preventive care services, such as colon cancer screenings.

Geary County has higher rates of communicable diseases (chlamydia, gonorrhea) than the state. With regards to maternal and child health, specifically, Geary County has lower percentages of mothers receiving adequate prenatal care than the state.

Several interviewees noted limited health education and connection in the community that is evidenced by high rates of obesity and diabetes. It was also mentioned that obese and diabetic residents do not understand patient health information, with one interviewee stating: “There’s a rampant amount of obesity across the age spectrum with a crossover of diabetes, and there’s a real lack of education in this community about what their health numbers mean, like A1c. People get diagnosed with diabetes and they’re uninformed.”

The lack of built environment was mentioned as leading to residents not participating in healthy lifestyle behaviors, with perceived higher rates of obesity and poor lifestyle behaviors within the youth population. Interviewees also raised concern surrounding high rates of food insecurity and access to healthy, nutritious foods. One interviewee specifically stated: “Food insecurity and nutrition is a big health need because we have a lot of people who struggle financially and we all know that the cheap food is typically processed food. Having access to healthy nutritious food is a challenge in our county.” Interviewees also mentioned high rates of tobacco and vapor use, which is perceived to be a big health need in the community.

Objective:
Implement programs and provide educational opportunities that seek to address unhealthy lifestyles and behaviors in the community

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<td>Key Results</td>
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<tr>
<td>5.A. GCH will continue to host and/or participate in local health-related events to offer a variety of health screenings to the community, support or partner with local organizations that provide services to vulnerable populations and promote healthy behaviors.</td>
<td>Director of Human Resources and External Communications</td>
<td>Current Examples include: Farmers Market, COVID-19 testing, Konza, Walk with a Doc, USD 475</td>
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<td>5.B. GCH will remain connected to key areas of public health needs, address risk concerns, and provide access to support programs to educate our most vulnerable population. We will continue to focus on the reduction of area infant mortality rates, better parenting solutions, and healthy families by increasing the availability of all aspects of the Delivery Change program.</td>
<td>Delivering Change Director, Clinical Dietitian, Flint Hills Surgery</td>
<td>Current Examples include: Becoming A Mom &amp; Breastfeeding Support Group (Delivery Change Program), Conscious Fathering, Diabetes Education &amp; Support Group, Grief Support Group, Innovative Weight Loss Seminar &amp; Support Group, USD 475 texting and driving safety education</td>
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<td>5.C. GCH personnel will continue to serve in leadership roles and as volunteers with many agencies and committees in the community. Additionally, GCH will continue to provide staff representation at various conferences and in local consortiums focused around its patient population’s needs. Opportunities to pursue professional development and volunteer at organizations are continuously evaluated.</td>
<td>Director of Human Resources and External Communications</td>
<td>Current Examples include: MITCC, Rotary Club, Konza</td>
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<td>5.D. GCH will continue to provide medication management resources to patients upon discharge as needed.</td>
<td>Nursing, Pharmacy</td>
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Section 3:
Feedback, Comments and Paper Copies
INPUT REGARDING THE HOSPITAL’S CURRENT CHNA
CHNA Feedback Invitation

• GCH invites all community members to provide feedback on its previous and existing CHNA and Implementation Plan.

• To provide input on this or the previous CHNA, please see details at the end of this report or respond directly to the hospital online at the site of this download.
Feedback, Questions or Comments?

Please address any written comments on the CHNA and Implementation Plan and/or requests for a copy of the CHNA and Implementation Plan to:

**Geary Community Hospital – CHNA Feedback**

ATTN: Administration
1102 St. Mary’s Road
Junction City, KS 66441

Please find the most up to date contact information on the Geary Community Hospital homepage:

http://gearycommunityhospital.org/
Thank you!

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