2019 REGIONAL HEALTH ASSESSMENT:

MOUNTAIN VIEW COMMUNITY

January 2019

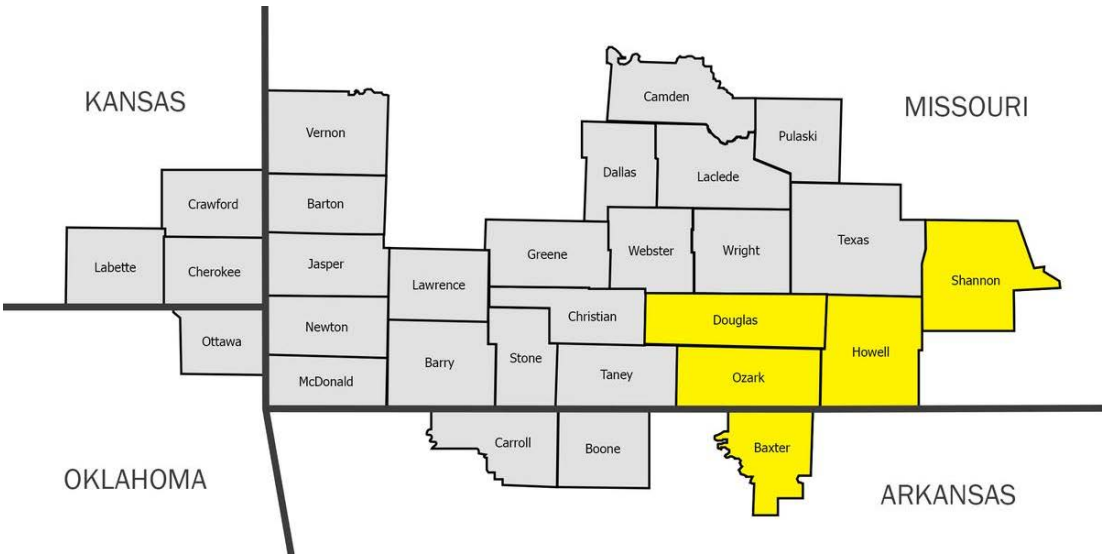
Table of Contents

Mountain View Community

In 2017, a variety of organizations across the Ozarks reconvened under the umbrella of the Ozarks Health Commission to assess the health needs of our region. Building upon the success of the 2016 Regional Health Assessment, partners again sought to better understand the health status, behaviors and needs of the populations they serve.

This 2019 Assessment combines more than 140 hospital and community data indicators as well as feedback from stakeholders and the broader community. This process resulted in three priorities: lung disease, cardiovascular disease and mental health. Weaving among the issues identified were six common threads: access to health care, mental health, physical activity, social determinants of health and tobacco use. Additionally, the health status of populations of interest—such as people in poverty, minorities and the elderly--were also analyzed.

For the purposes of this Assessment, the Mountain View Community is made up of Baxter, Douglas, Howell, Ozark, and Shannon counties.

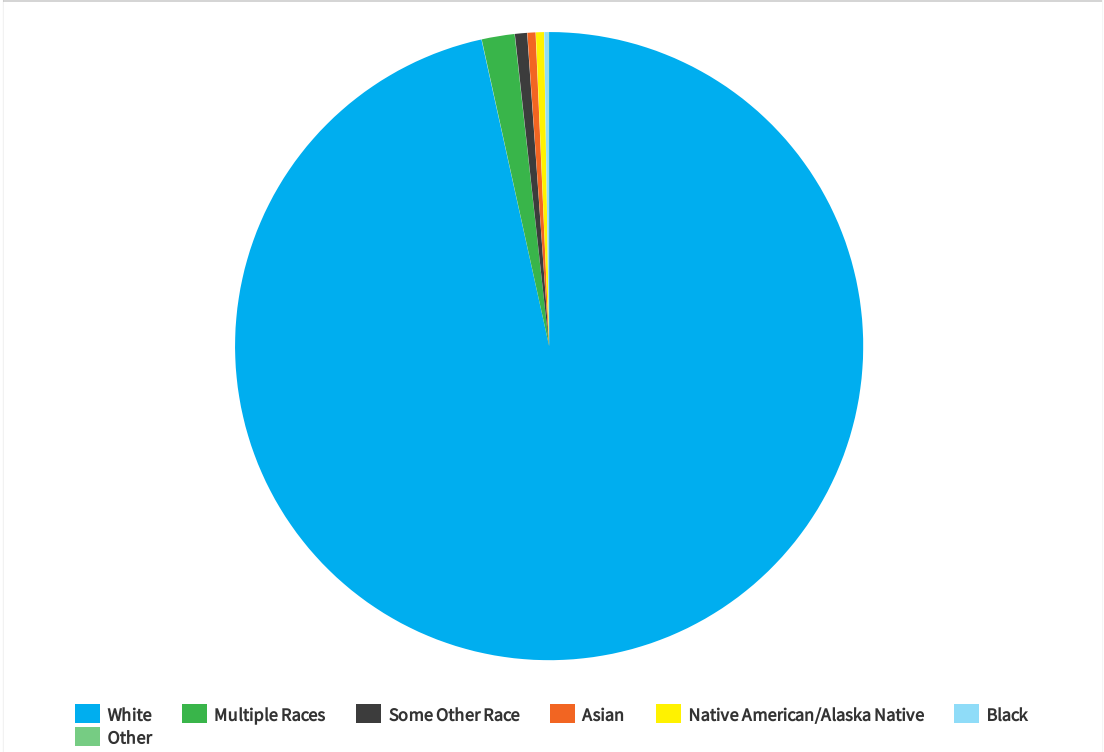


VIEW MOUNTAIN VIEW COMMUNITY SUMMARY

Health Priorities:

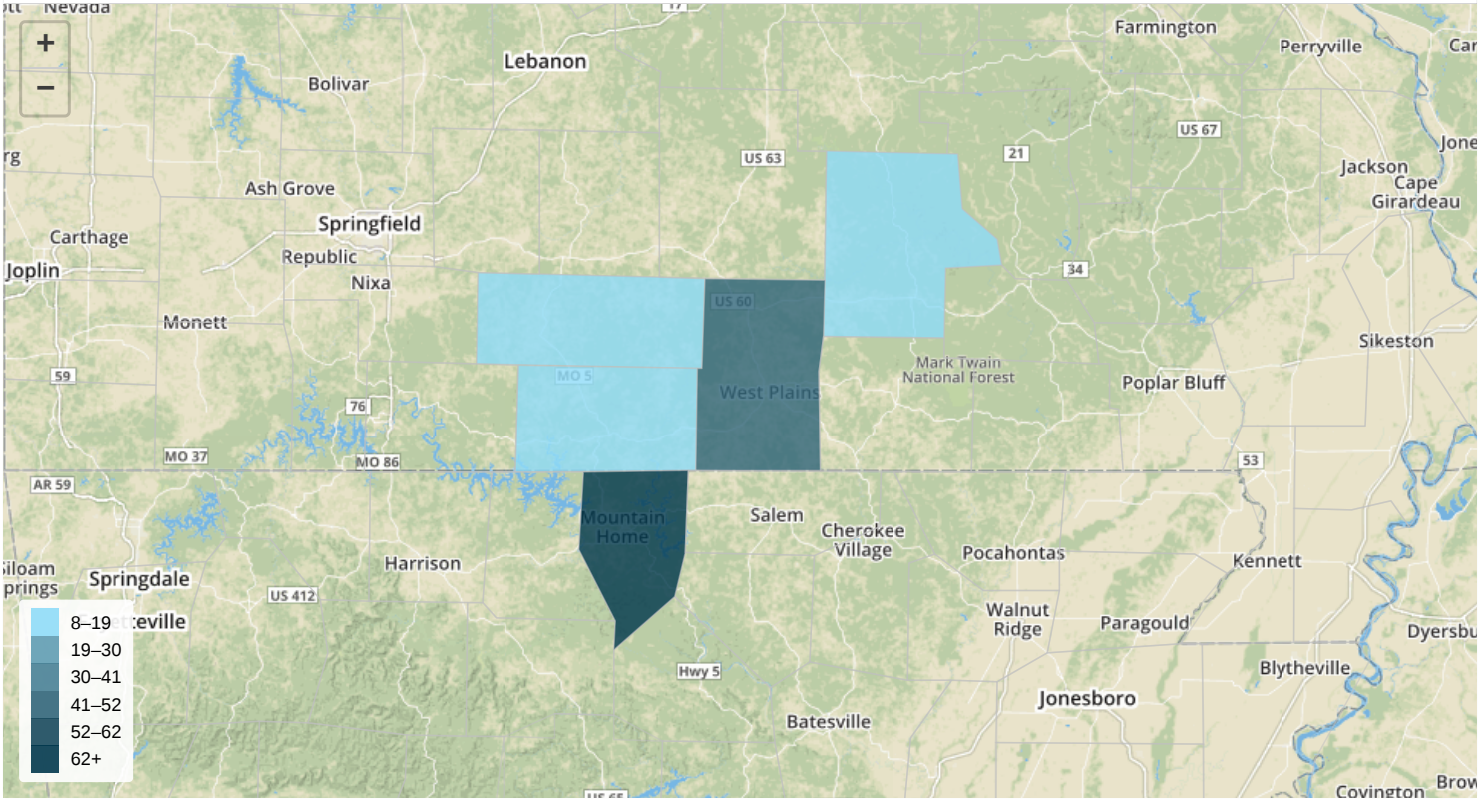
Demographics

Mountain View Community Population by Race



MORE DEMOGRAPHIC DATA

Population Density (per square mile) by County



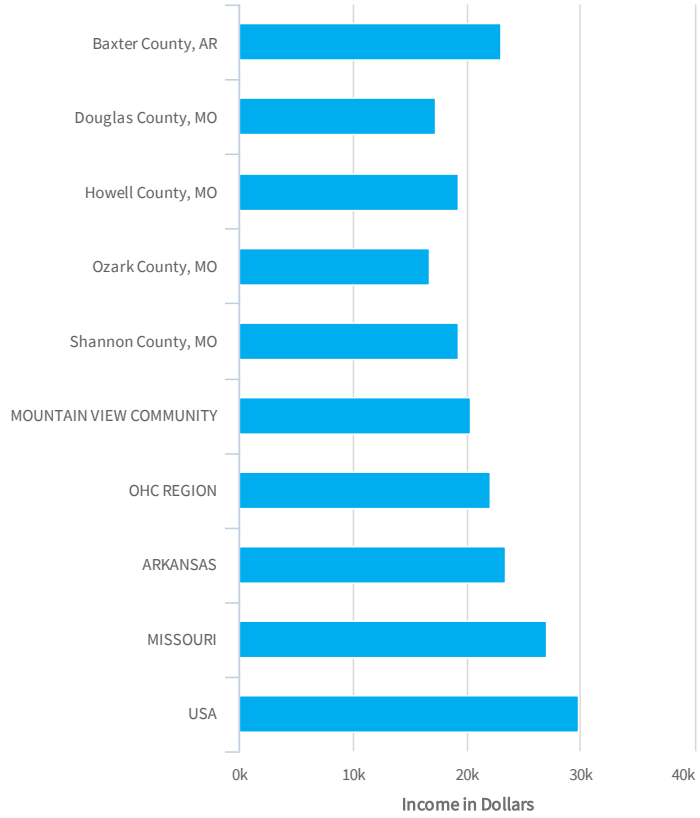
Populations of Interest

Vulnerable populations —such as people in poverty, minorities, and the elderly—often experience higher rates of chronic illness and worse health outcomes. This can create health disparities between various socioeconomic classes and/or demographic groups. In order to ensure vulnerable and at-risk populations were considered when identifying and addressing community health needs, the Ozarks Health Commission (OHC) developed a process to identify and understand vulnerable populations within each Community.

Using the Centers for Disease Control and Prevention (CDC) Social Vulnerability Index, the OHC identified nine key factors, or populations, to consider when developing actions to improve prioritized health needs. The table beside includes percentile rankings (values range from 0 – 1, with higher values indicative of greater vulnerability) for each population and highlights populations that are 80%, 85%, and 90% more vulnerable than the same population in other counties in its respective state. For example, Webster County has more youth than 92% of counties in Missouri. The needs of children age 18 years and younger should be considered when developing Community Health Improvement Plan (CHIP) strategies for this area.

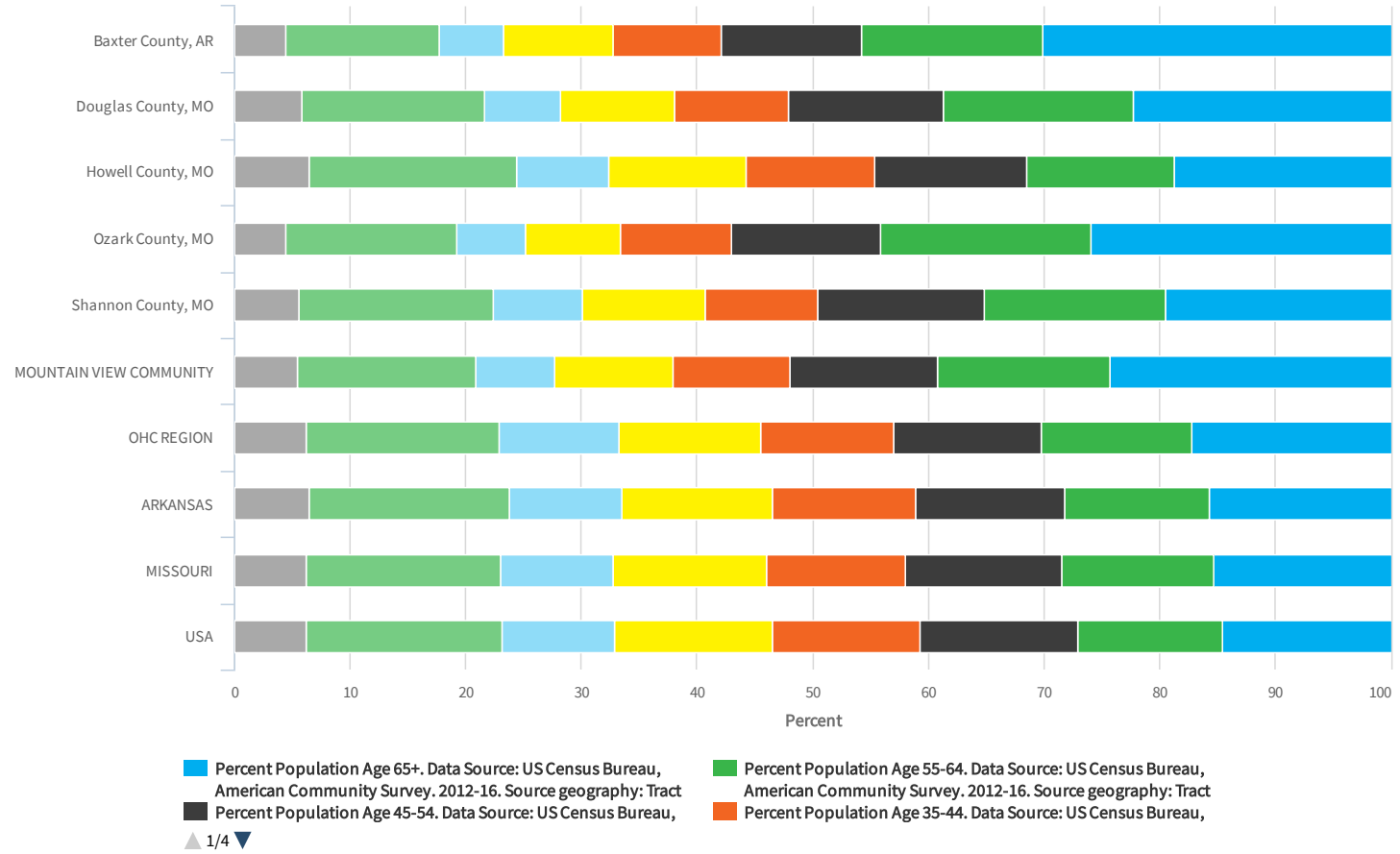
For more information about the methodology used in the CDC's Social Vulnerability Index, click here.

Per Capita Income



VIEW MORE INFO

Population by Age



HEALTH SERVICES AVAILABLE

Ozarks Health Commission

Recognizing the value of assessing and acting together on local health issues, key players from local hospital systems, public health entities, and others formed a working group to begin the task of a regional health assessment. This group grew under the umbrella of the local Ozarks Health Commission (OHC) and published the first assessments in 2016. Since that time, the process has been recognized at the annual meeting of the American Public Health Association, honored as a Promising Practice by the National Association of County and City Health Officials, and awarded the Group Merit Award from the Missouri Public Health Association.

Collectively, the assessments span four states—Missouri, Oklahoma, Arkansas, and Kansas—29 counties, and three hospital systems. This footprint will be referred to throughout the report as the OHC Region.

REPORT STEERING COMMITTEE

Questions? Comments? Feedback?

CONTACT OHC

Mountain View Community Summary

Howell County

West Plains

West Plains was selected as one of Americas 10 Best Small Towns in 2013 by Livability.com, a national website that ranks America's most livable small and mid-sized cities based on quality of life. Missouri State University-West Plains, a part of the Missouri State University System, is also located here. The two-year, open-admission institution has an enrollment of approximately 2,000 students.

Mountain View

Mountain View was established in 1878, although it is still debated as to who actually founded the town. Here is where to begin your family's Ozarks adventure, canoeing down one of the beautiful rivers, hiking to breathtaking ridges overlooking rolling hills and countryside. Mark Twain National Forest is just minutes from Mt. View.

Baxter County, AR

Mountain Home

Mountain Home has been named one of the best places to retire in America by Rand McNally and AARP. Located between two large lakes and with easy access to three major rivers, Mountain Home is known for providing abundant opportunities for the water sports enthusiast.

Ozark County

Gainesville

Opportunities for adventure in Gainesville abound for visitors of all ages and interests. History buffs will love taking the driving tour to the old grist mills. Fishing, Boating, Canoeing, and Kayaking are activities on nearby Bull Shoals Lake, Norfork Lake, The North Fork River and Bryant Creek. Caney Mountain was made for hiking and camping, with over 7000 acres ready to be explored!

Douglas County

Ava

Ava, which has formally adopted the motto “Treasure of the Ozarks”, is the county seat of Douglas County. Ava is the national headquarters of the Missouri Fox Trotting Horse Breed Association, which holds two annual festivals, spring and fall, drawing thousands to the community. Ava is also part of the Mark Twain National Forest.

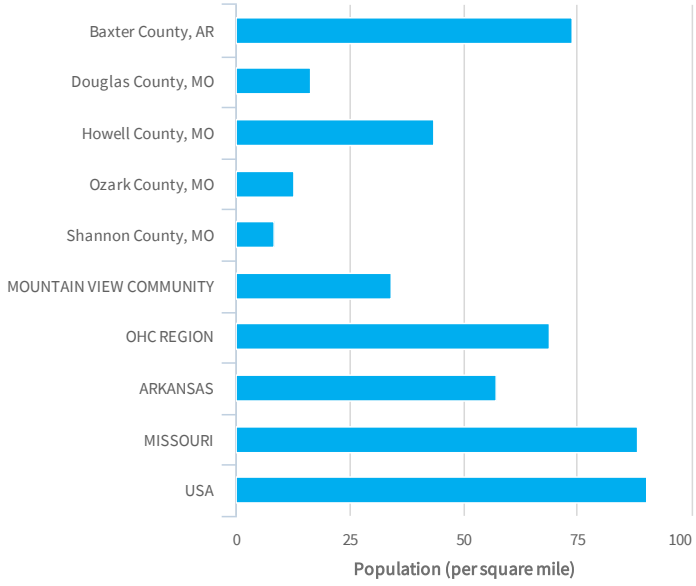
Shannon County

Shannon County is a county in the southern portion of Missouri. Its county seat is Eminence. The county was officially organized on January 29, 1841 and was named in honor of George F. "Peg-Leg" Shannon, a member of the Lewis and Clark Expedition. It is the second-largest county by area in Missouri. Missouri's first copper mine was opened in Shannon County in 1846 and Missouri's only manganese mine was opened here during World War II.

Shannon County is one of the poorest counties in Missouri with one of the lowest median household incomes in the United States.

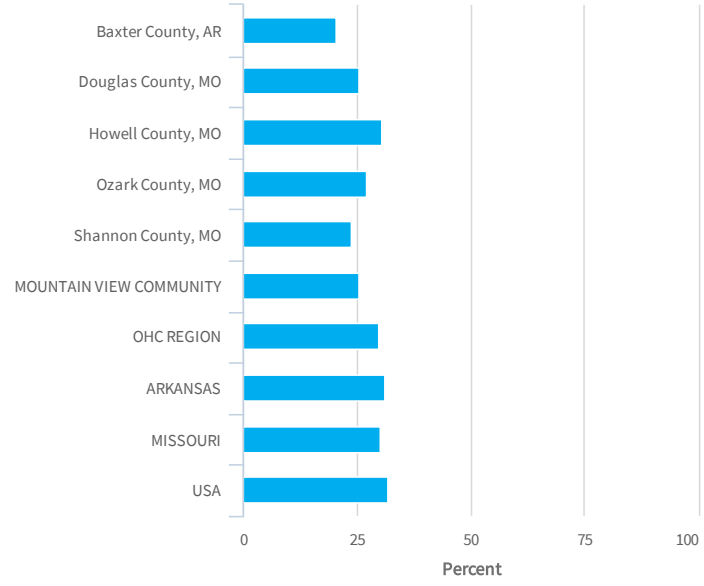
Demographics

Population Density



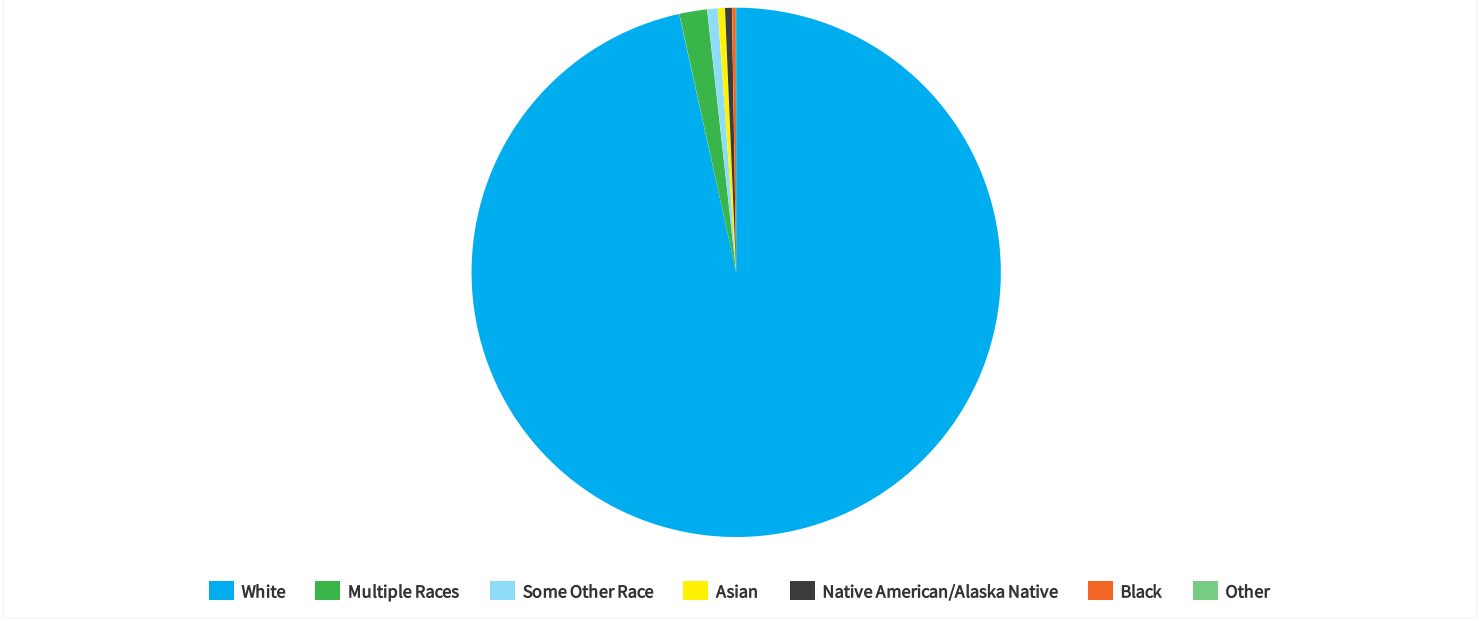
Population Density (Per Square Mile). Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Families With Children Under Age 18

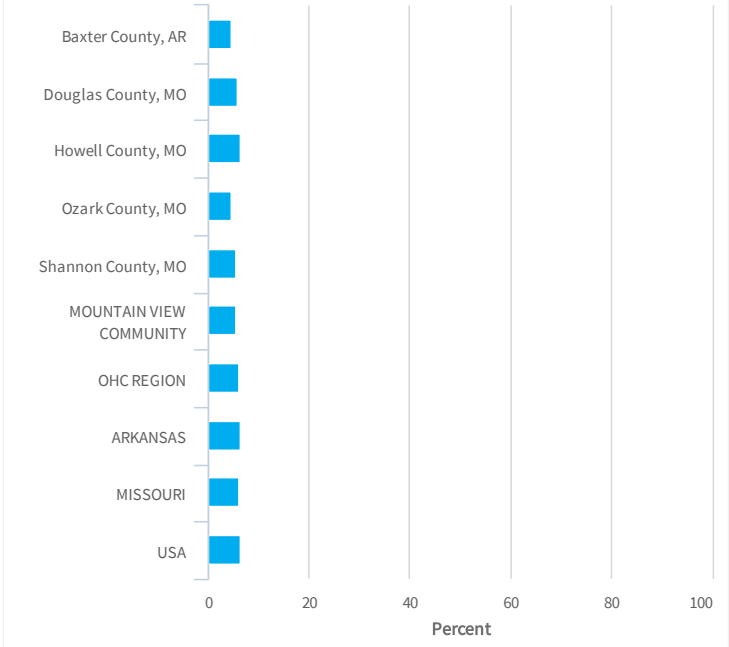


Families with Children (Under Age 18), Percent of Total Households. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Mountain View Community Population by Race

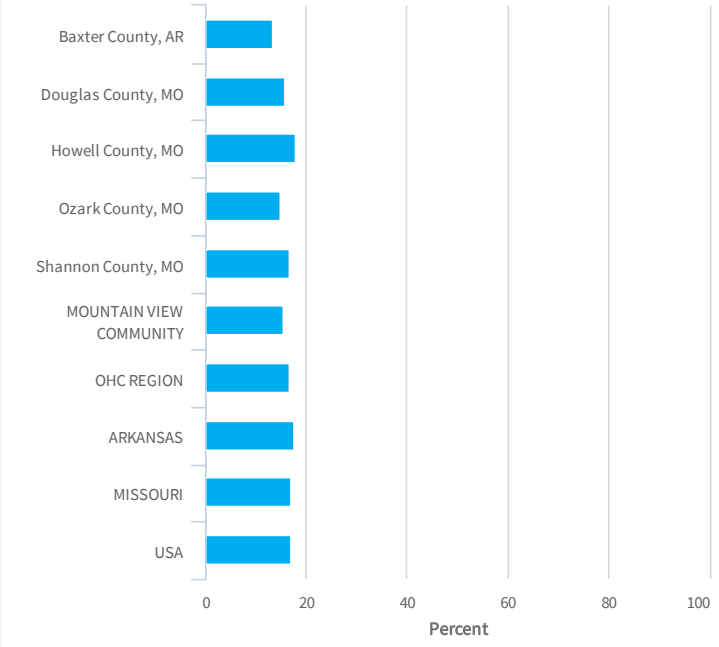


Population Age 0-4



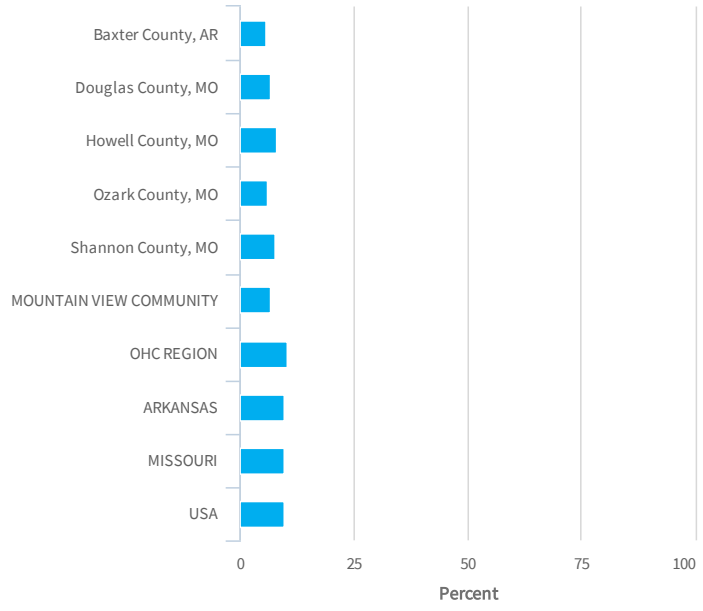
Percent Population Age 0-4. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Population Age 5-17



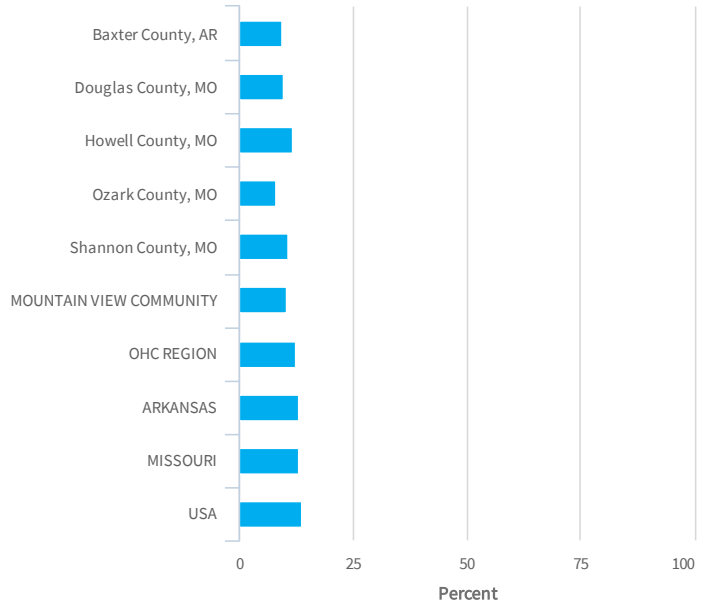
Percent Population Age 5-17. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Population Age 18-24



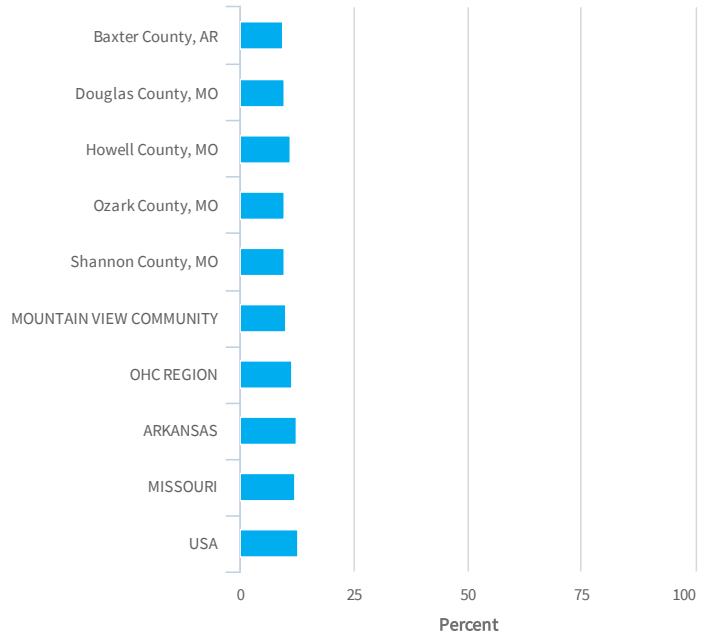
Percent Population Age 18-24. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Population Age 25-34



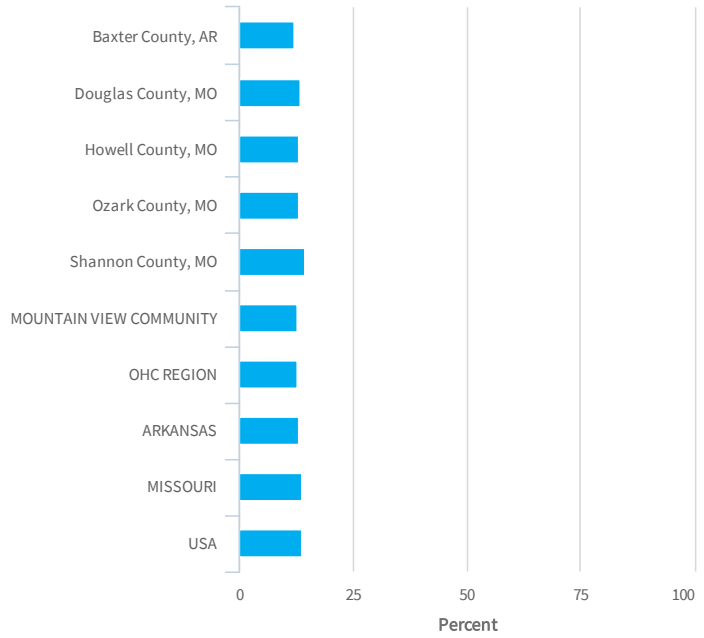
Percent Population Age 25-34. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Population Age 35-44



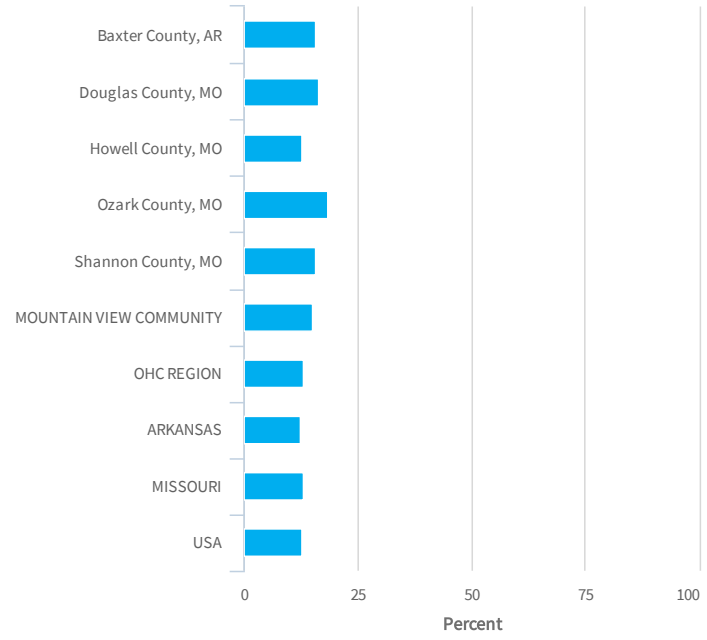
Percent Population Age 35-44. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Population Age 45-54



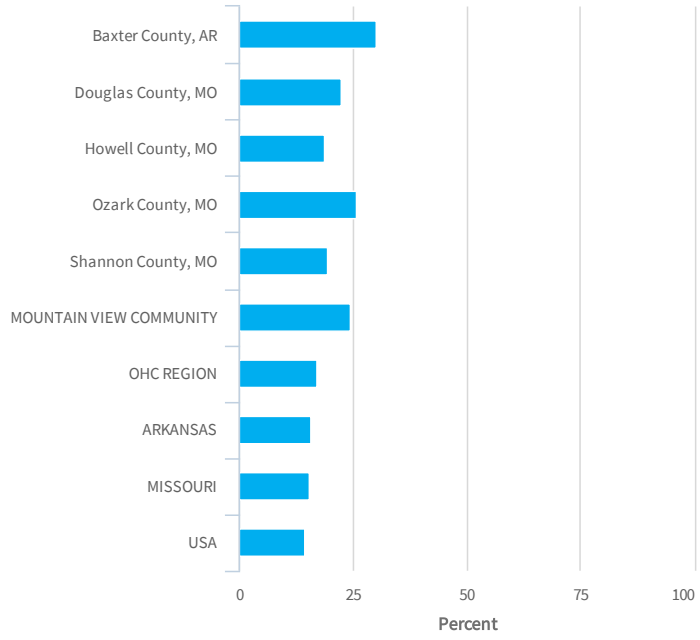
Percent Population Age 45-54. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Population Age 55-64



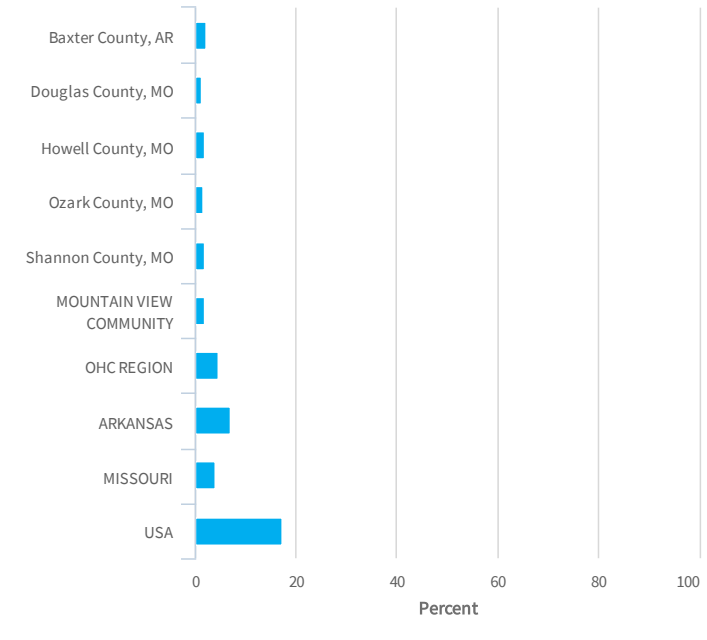
Percent Population Age 55-64. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Population Age 65+



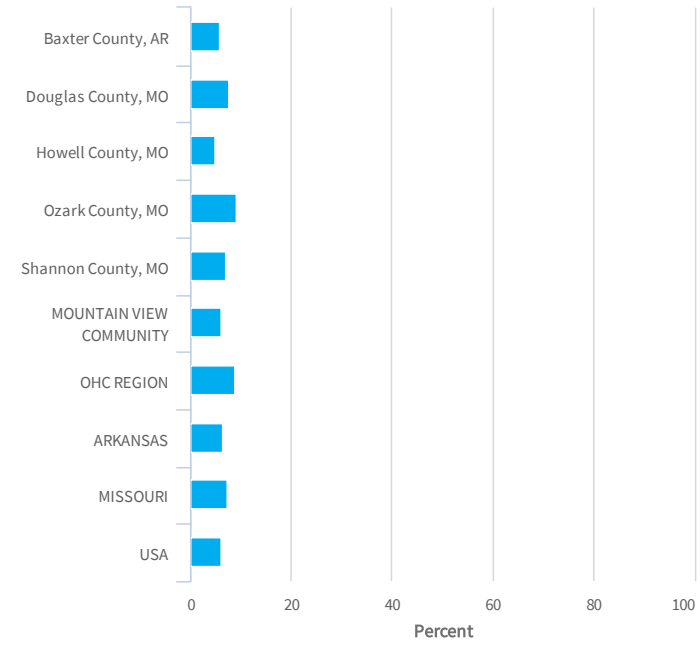
Percent Population Age 65+. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Hispanic Population



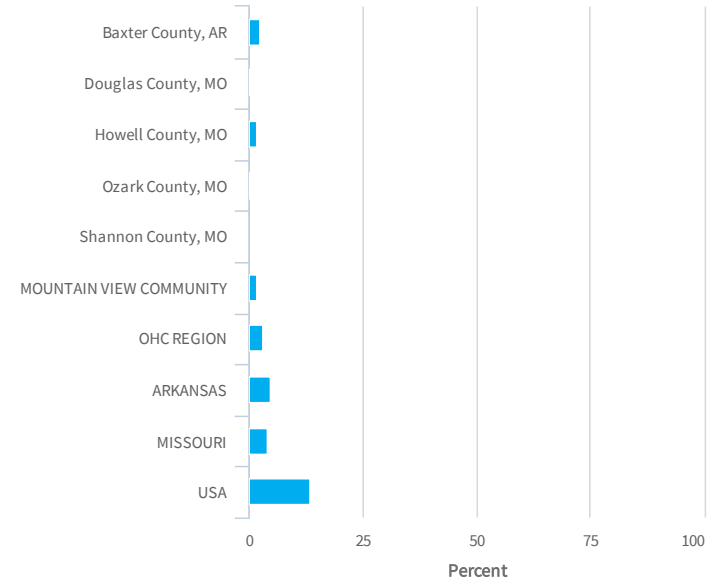
Percent Population Hispanic or Latino. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Geographic Mobility



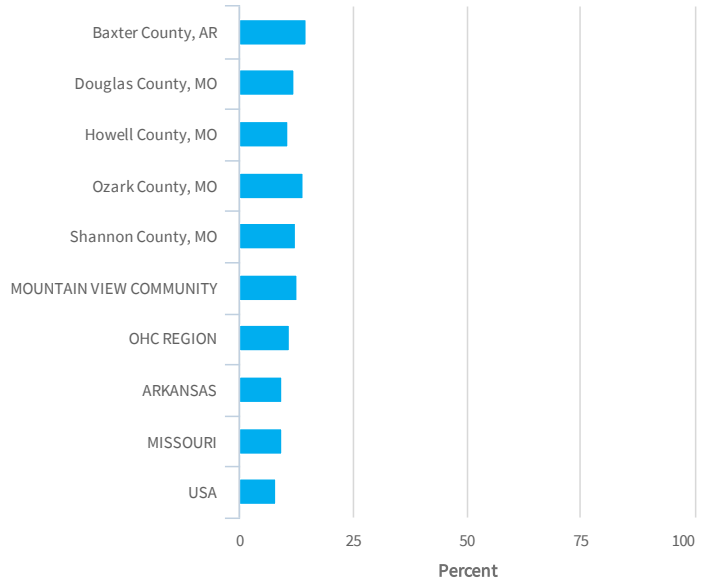
Percent Population In-Migration. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Foreign Birth Population



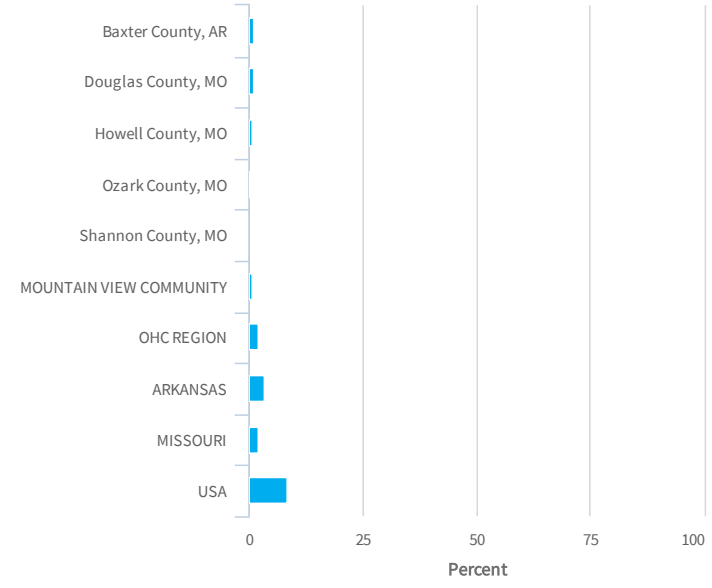
Foreign-Birth Population, Percent of Total Population. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Veteran Population



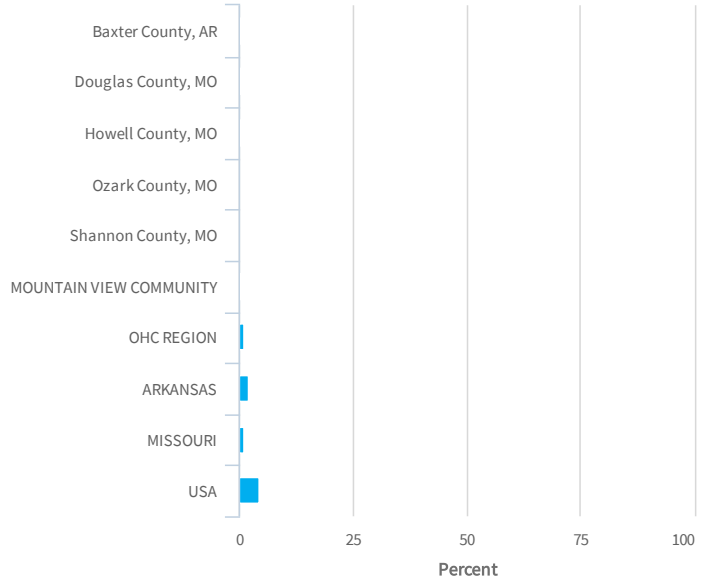
Veterans, Percent of Total Population. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Population with Limited English Proficiency



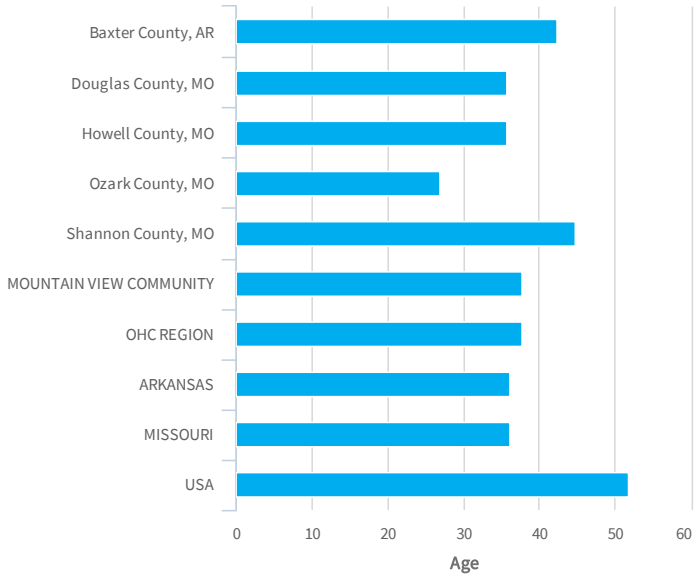
Percent Population Age 5+ with Limited English Proficiency. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Households with Limited English Use



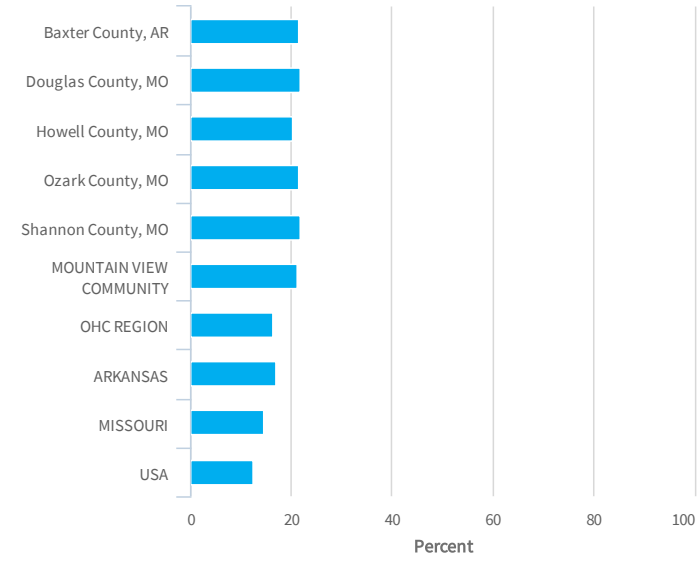
Percent Linguistically Isolated Population. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Median Age



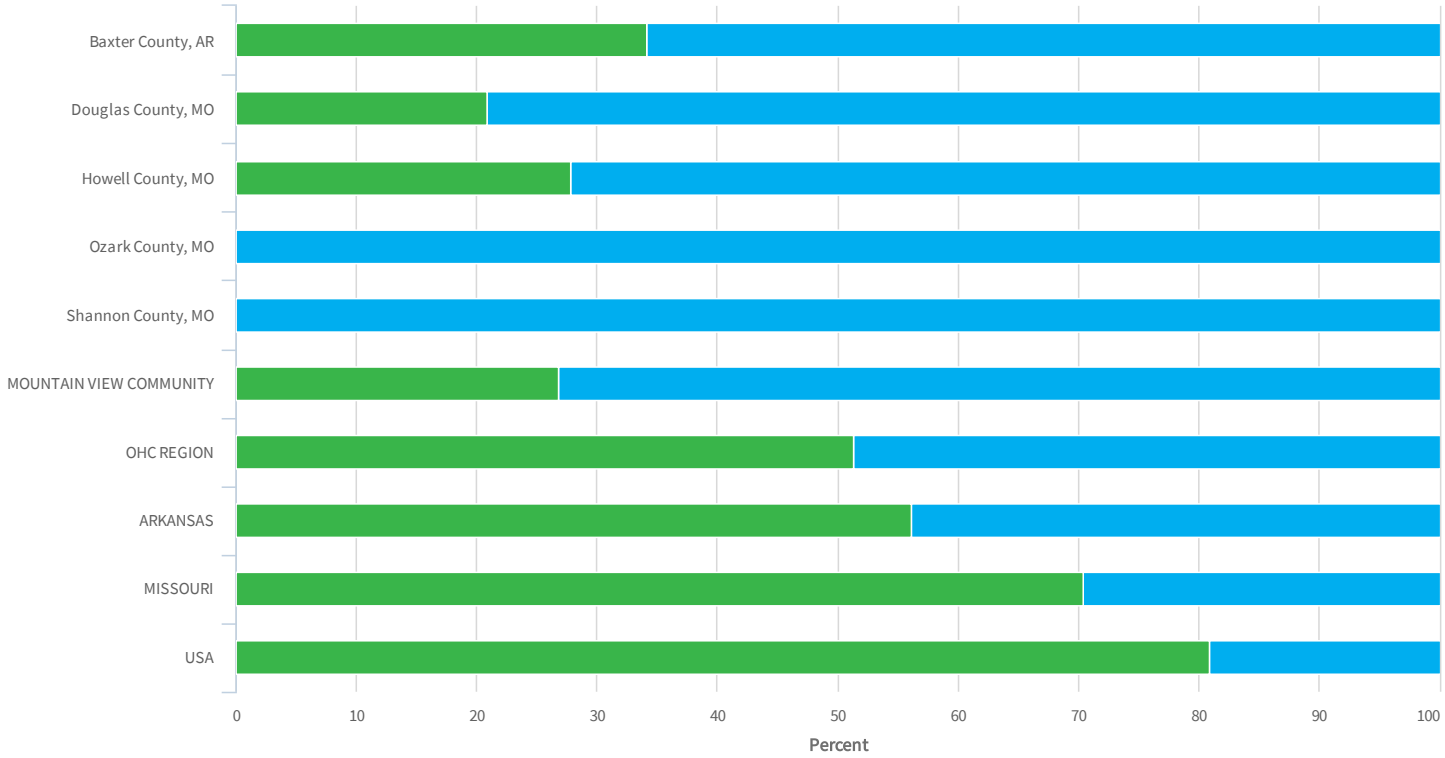
Median Age. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Population with a Disability



Percent Population with a Disability. Data Source: US Census Bureau, American Community Survey. 2012-16. Source geography: Tract

Urban and Rural Population



Percent Rural. Data Source: US Census Bureau, Decennial Census. 2010. Source geography: Tract

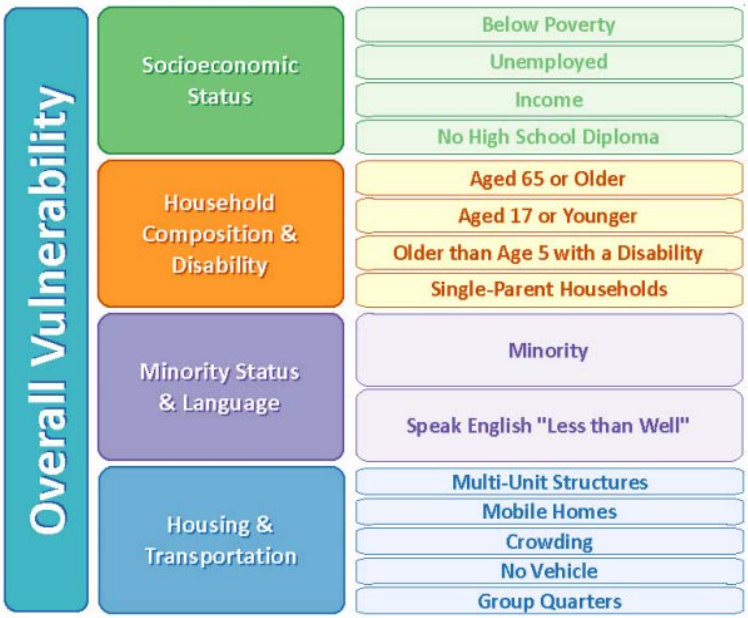
Percent Urban. Data Source: US Census Bureau, Decennial Census. 2010. Source geography: Tract

Populations of Interest

Methodology to Identify At-Risk Populations

The Ozarks Health Commission (OHC) wanted to ensure that vulnerable and at-risk populations were considered when identifying and addressing community health needs. Vulnerable populations, such as people in poverty, minorities, and the elderly, often experience higher rates of chronic illness and poorer healthy outcomes creating health disparities between various socioeconomic classes and/or demographic groups. Therefore, the OHC developed a committee to develop a process to identify and understand vulnerable populations within each Community.

The committee identified a CDC-developed tool called the Social Vulnerability Index (SVI),[1] which was created to assist emergency planners identify and map groups that may be most at-risk in the event of a disaster. The SVI uses U.S. Census and American Community Survey data to identify at-risk groups by ranking all census tracts on fifteen social factors. The factors are grouped into four main themes, as illustrated in the figure below.[2] [3] Since the SVI flags groups more vulnerable than 90% of all comparative census tracts, OHC applies the SVI to identify vulnerable groups within each county.



Additionally, the SVI tool identifies groups that are at-risk for being flagged, allowing OHC to identify

[1] https://svi.cdc.gov/Index.html
[2] https://gis.cdc.gov/grasp/svi/A%20Social%20Vulnerability%20Index%20for%20Disaster%20Management.pdf
[3] https://svi.cdc.gov/Documents/Publications/CDC_ATSDR_SVI_Materials/SVI_Poster_07032014_FINAL.pdf

potential emerging areas of concern.

For example, according to the most recent (2016) SVI data, Texas County, MO has three flagged groups: People living in poverty, low income, and those with a disability. Barry County, MO does not have any flagged groups. However, there are three groups that have the potential of being flagged (more vulnerable than 85% of other census tracts): unemployed, low income, and limited English proficiency.[4]

The committee determined that the assessment process would involve identifying groups that are flagged or have the potential to be flagged. Development of Community Health Improvement Plans could then include a prioritization process to identify and develop Community-specific strategies with special consideration of these populations.

The committee determined a limitation of the SVI tool is that it was specifically created for emergency planners, and the factors within the theme of "Housing and Transportation" did not have as direct of a connection to health as the other themes. The committee modified the SVI by assessing populations that live in substandard housing.

The committee completed a crosswalk between each SVI factor and the Assessed Health Issues (AHI) identified through public health data to ensure a connection between the factor and the AHIs. The group agreed to include measures that aligned with at least 50% of the AHI. This led to the removal of the following six measures:

- Single parent households
- Multi-unit structures
- Mobile homes
- Crowding
- No Vehicle
- Group quarters

Populations by Category

Socioeconomic Status

Poverty, Income, Employment and Education

Two SVI indicators measure the income status of the county population: Poverty and Per Capita Income. Poverty measures the proportion of the population living below 100% of the Federal Poverty

[4] Centers for Disease Control and Prevention/ Agency for Toxic Substances and Disease Registry/ Geospatial Research, Analysis, and Services Program. Social Vulnerability Index [2016] Database [State]. http://svi.cdc.gov/SVIDataToolsDownload.html. Accessed on [April 2018].

Level. Per Capita Income measures the average yearly income earned per person. A person's income status is closely tied to his or her health. Generally, people with a higher income have easier access to healthcare by means of transportation, health insurance, and finances to pay out-of-pocket expenses. Additionally, they are more likely to engage in healthy lifestyle behaviors, such as exercising, eating healthy food, and abstaining from tobacco use.[5] Therefore, their risk for acute and chronic illness is lower than that of those that live near or below poverty.

Two socioeconomic indicators closely tied to income are education and employment. The education indicator measures the prevalence of the population, age 25 and older, that does not have a high school diploma. The employment indicator measures the prevalence of the population, age 16 and older, that are unemployed. In general, people with a higher income are more educated, which means they typically 1) have increased knowledge of healthy lifestyle activities and 2) are better positioned for higher paying jobs which increases their means for participating in these activities[6]. Similarly, a person's employment status is closely tied to his or her access to health care.

Each of these socioeconomic indicators are predictive of behaviors that lead to poor health outcomes related to Cardiovascular Disease, Lung Disease, Mental Health, Oral Health, Diabetes and Cancer. Income and employment status are more directly tied to a person's mental health.[7] [8] Therefore, addressing populations that live near or below poverty, have low education levels, and/or are unemployed, will impact their health related to all Assessed Health Issues (AHI).

Household Composition and Disability

Age 17 or Younger

Children less than 18 years of age are generally dependent on a care giver to ensure their basic, educational and healthcare needs are met. If a parent is not able to nurture and protect his or her child, which is statistically evident in families facing the complexities of poverty, the child is more likely to participate in risky and unhealthy behavior.[9] Children living in poverty are more likely to experience abuse and neglect which can cause them to leave the house prematurely, have early pregnancies, and/or associate with inappropriate peers.[10] As the child gets older, low educational attainment can negatively affect employment possibilities, housing, access to health care, nutrition, and more.

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[5] https://www.cdc.gov/socialdeterminants/
[6] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.2.60
[7] https://www.cdc.gov/pcd/issues/2015/14_0451.htm
[8] http://www.apa.org/pubs/journals/releases/ort-7513.pdf
[9] G.W. Evans , "The Environment of Childhood Poverty," American Psychologist 59 , no. 2 (2004): 77 – 92. Crossref, Medline, Google Scholar
[10] G. Brown , "Mental Illness," Applications of Social Science to Clinical Medicine and Health Policy, ed. L.H. Aiken and D. Mechanic (New Brunswick: Rutgers University Press, 1986), 175–203. Google Scholar

Regardless of income, children are more susceptible to environmental risks due to developing immune systems. Yet, their risk increases if they live in poverty.[11] Health problems can result from contaminated water, poor sanitation, indoor smoke, and widespread disease vectors such as mosquitos and an unsafe food supply. In regard to the assessment's AHI, these conditions can increase the threat of a child developing lung related disease, as well as mental, behavioral and substance use issues while still in adolescence. Additionally, risky behaviors that develop during childhood years are likely to remain as an adult and/or affect their health status later in life. These may lead to poor health outcomes in all identified AHI: cardiovascular disease, lung disease, diabetes, oral health, and mental health.

Age 65 or Older

Oftentimes, adults age 65 and older experience risk factors that increase with age, such as decreased mobility, social isolation, chronic disease, financial decline, nutritional needs, and age-related illnesses. Living in poverty compounds the effect of these risk factors as it becomes more challenging to access available health and social resources. This population experiences an increased risk of dealing with one or more of all the AHI.

Persons with Disability

According to the International Classification of Functioning, Disability, and Health, a disability involves dysfunction of bodily function, limitations in activity, and/or restrictions in participating in life situations, and is the interaction between an individual with a health condition and personal and environmental factors.[12] Disability is diverse, with some health conditions requiring extensive attention and care while others do not. People with disabilities are vulnerable to insufficiencies in health care services, such as prohibitive costs, limited availability of services, physical barriers and inadequate skills and knowledge of health workers. Additionally, they may experience greater vulnerability to co-morbid conditions, age-related conditions, secondary conditions, engaging in risky health behaviors and higher rates of premature death.[13] Co-morbid, age-related and secondary conditions may include all of the AHI.

Minority Status and Language

Minority and Speak English "Less than Well"

Health disparities among racial and ethnic minorities are well-documented. Variations in health outcomes arise from factors such as lack of health insurance, limited access to health care, disparities

[11] G.W. Evans , "The Environment of Childhood Poverty," American Psychologist 59 , no. 2 (2004): 77 – 92. Crossref, Medline, Google Scholar

[12] http://www.who.int/classifications/icf/icfbeginnersguide.pdf?ua=1

[13] http://www.who.int/news-room/fact-sheets/detail/disability-and-health

in quality of care, inability of providers to recognize and address disparities, lack of data collection, analysis, and distribution of resources.[14] Because the social construct of one's environment can predict his or her health outcomes, it is important to understand the unique needs of diverse populations to ensure access to social and health services. Similarly, it is important to understand the health issues faced by specific racial and ethnic minorities. For example, there is a greater prevalence of hypertension among African Americans than Caucasians.[15] Additionally, Hispanics are burdened by asthma as they are more likely to work in environments that may make them sick and/or not provide access to health care. The risk for developing one or more of the AHI varies by race and ethnicity. Therefore, the first step in identifying unique health needs is to understand the ethnic and racial features of a Community.

Housing

Substandard Housing

The proportion of the population that lives in substandard housing is a predictor of health status and is also linked closely with socioeconomic status. Substandard Housing is defined by the U.S. Census Bureau as "the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1.01 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard".

These substandard housing units are more likely to contain physical hazards, lead-based paint, radon and mold and are often found in declining neighborhoods. Many times these neighborhoods lack the physical infrastructure to allow exercise and lack safe physical exercise opportunities. The Substandard Housing indicator is predictive of exposures that can lead to heart disease, lung disease, mental health disparities, diabetes and cancer.[16] Addressing substandard housing issues will impact resident health related to several Assessed Health Issues (AHI).

[14] https://minorityhealth.hhs.gov/Assets/pdf/2015_0916_Report_to_Congress_on_Minority_Health_Activities_FINAL.pdf
[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4108512/
[16] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447157/

Populations of Interest for Mountain View Community

Populations of Interest: Mountain View Community

COUNTY	Baxter	Ozark	Douglas	Howell	Community	OHC Region
Land Area in Square Miles (sq mi)	554.28	744.97	813.63	927.25	3040.13	**18459.54**
Total Population	40,992	9,450	13,467	40,265	104,174	**1,270,868**
Population Density (pop/sq mi)	73.95	12.69	16.55	43.42	34.27	**68.85**
Poverty	0.38	0.94	0.77	0.85	0.73	**0.67**
Unemployed	0.41	0.82	0.50	0.50	0.55	**0.54**
Per Capita Income	0.59	0.96	0.95	0.87	0.84	**0.75**
No High School Diploma	0.50	0.66	0.80	0.62	0.65	**0.57**
Age 65+	0.99	0.95	0.87	0.64	0.86	**0.57**
Age 17 or younger	0.06	0.13	0.36	0.75	0.33	**0.58**
Older than Age with a Disability	0.89	0.90	0.90	0.84	0.88	**0.69**
Minority	0.14	0.10	0.01	0.17	0.11	**0.32**
Non-English Speaking	0.29	0.14	0.21	0.21	0.21	**0.44**
Substandard Housing (%)	25.1%	29.8%	32.0%	28.6%	28.9%	**27.6%**

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

Red highlight	The population in this county is more vulnerable than 90% of all other counties in its respective state
Orange highlight	The population in this county is more vulnerable than 85% of all other counties in its respective state
Yellow highlight	The population in this county is more vulnerable than 80% of all other counties in its respective state

Health Services Available

2-1-1 MISSOURI

AUNT BERTHA

MERCY

Ozarks Health Commission Steering Committee Membership

Beyond just the numbers, Ozark Health Commission (OHC) members wanted input and buy-in from citizens in each Community. The steering committee of the OHC was composed of a variety of organizations representing multiple diverse perspectives.

Heather Coulter
CoxHealth

Jenalee Davidson
Springfield-Greene County Health Department

Danielle Dingman
Springfield-Greene County Health Department

Tara Hall
Springfield-Greene County Health Department

Molly Holtmann
Mercy

Nathan Koffarnus
Taney County Health Department

Aaron Lewis
Mercy

Morgan McDonald
Springfield-Greene County Health Department

Tony Moehr
Jasper County Health Department

Jon Mooney
Springfield-Greene County Health Department

Lisa Nelson
Freeman Health System

Emily Ogden
CoxHealth

Dan Pekarek
Joplin City Health Department

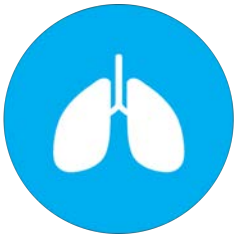
Jillian Pollard
Joplin Health Department

Julie Viele
Springfield-Greene County Health Department

Kathryn Wall
Springfield-Greene County Health Department

What is Lung Disease?

Lung disease is any problem in the lungs that prevents them from working properly.



Common lung diseases include:

- Asthma
- Bronchitis
- Chronic obstructive pulmonary disease (COPD)
- Pneumonia
- Pulmonary fibrosis

What causes Lung Disease?

The most common causes of lung disease include smoking, radon, asbestos, and air pollution (source).

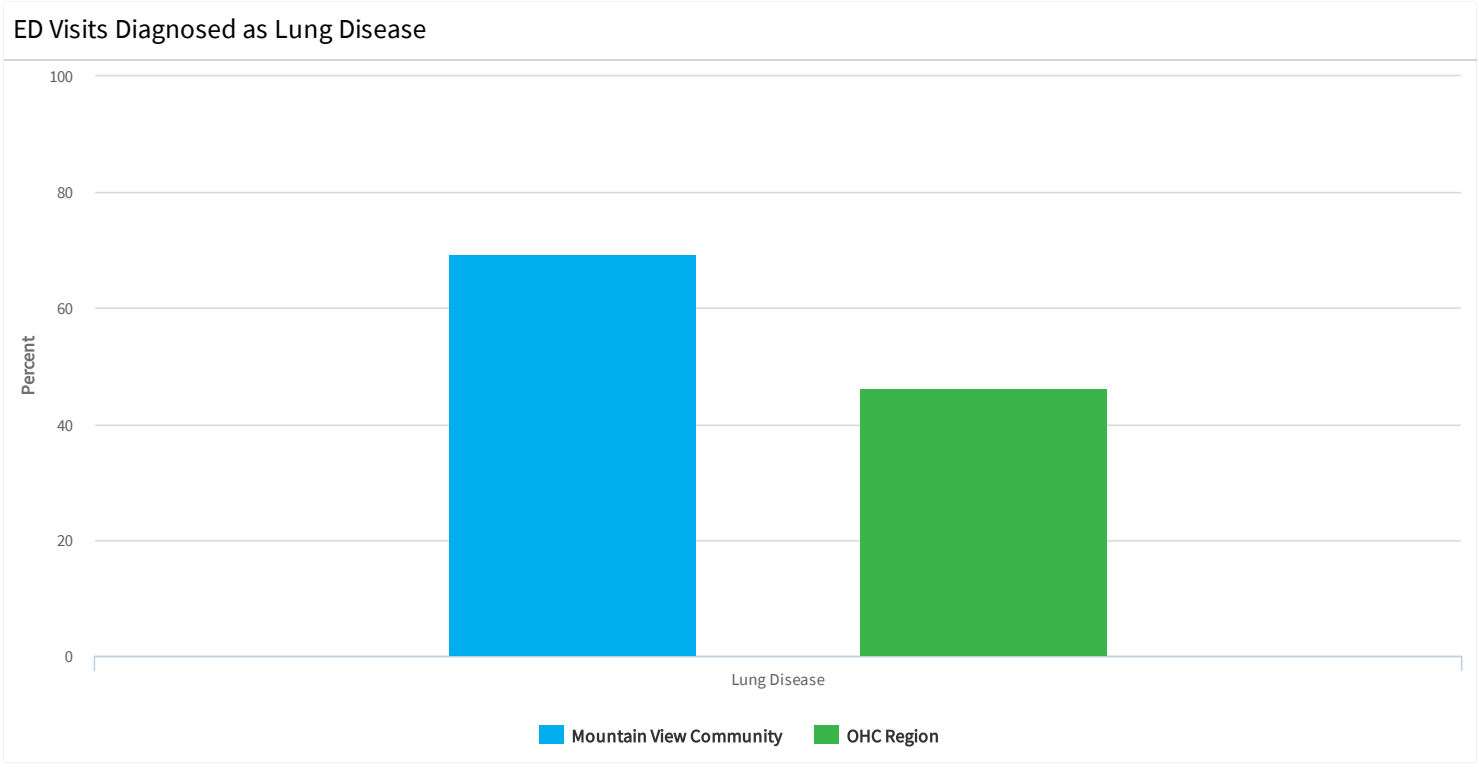
Why is this a priority?

There has been some improvement in the data surrounding lung disease since the 2016 Regional Health Assessment. However, all indicators for lung disease in the Ozarks Health Commission (OHC) Region perform worse than the nation.

What are our hospitals seeing?

In regard to hospital data, Emergency Departments (ED) across the OHC Region have experienced the burden of lung disease firsthand. Of all Assessed Health Issues (AHI), 46% of diagnoses are due to diseases of the respiratory system.

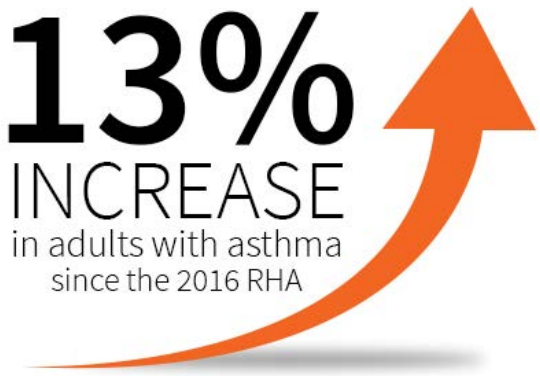
Mountain View Community ED have experienced a high rate of people presenting with lung disease. Of all AHI that present to area ED, diseases of the respiratory system account for 48% of diagnoses, which is the highest percentage of all AHI.

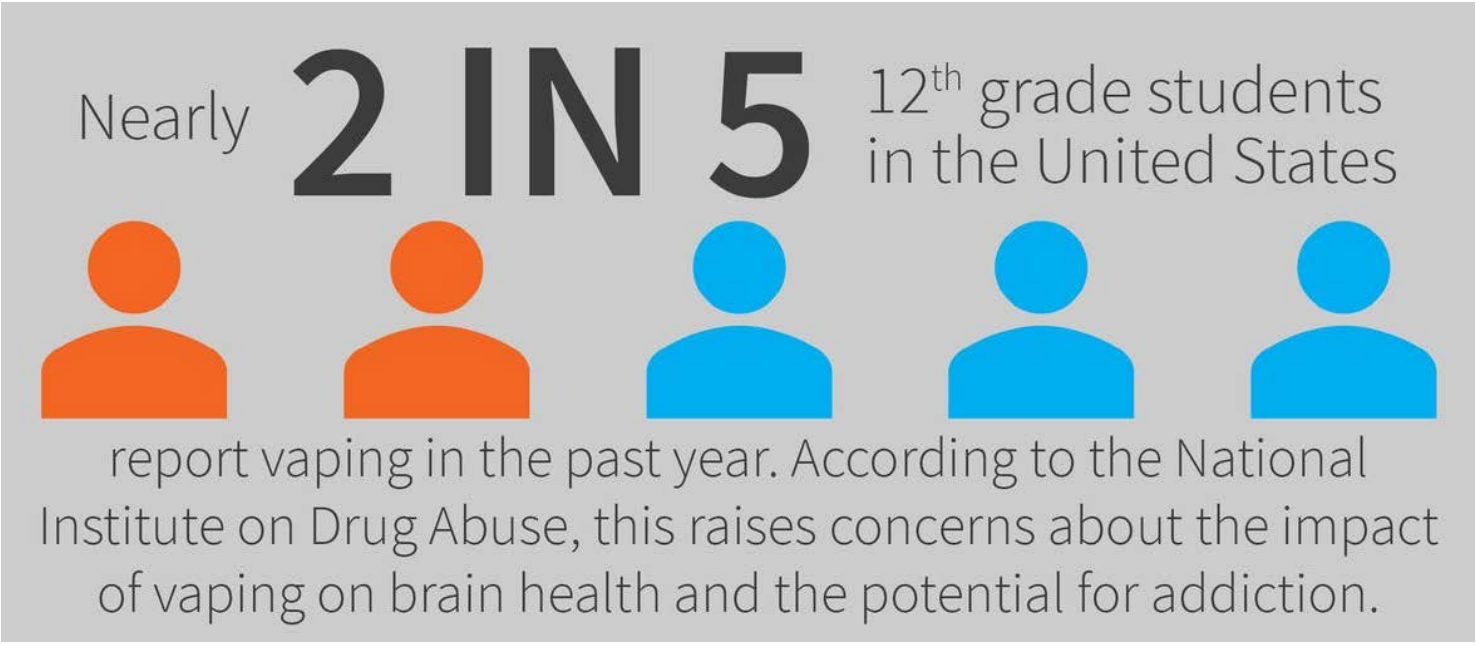


What is our community seeing?

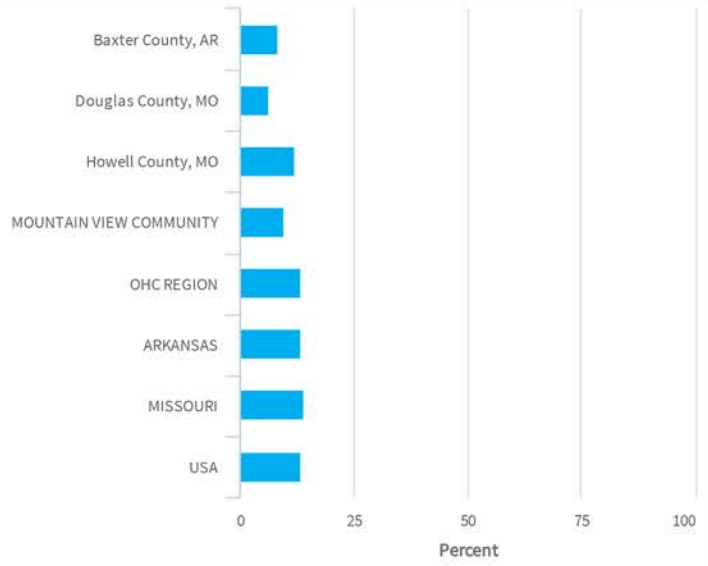
For the OHC Region overall, the secondary data indicators, except the percent of adults that live with asthma, have improved since the previous assessment. However, all still perform much worse than the nation.

Additionally, in a 2018 report on substance use among adolescents, the National Institute on Drug Abuse noted concern about the growing trend of vaping undermining progress on smoking rates. (source)



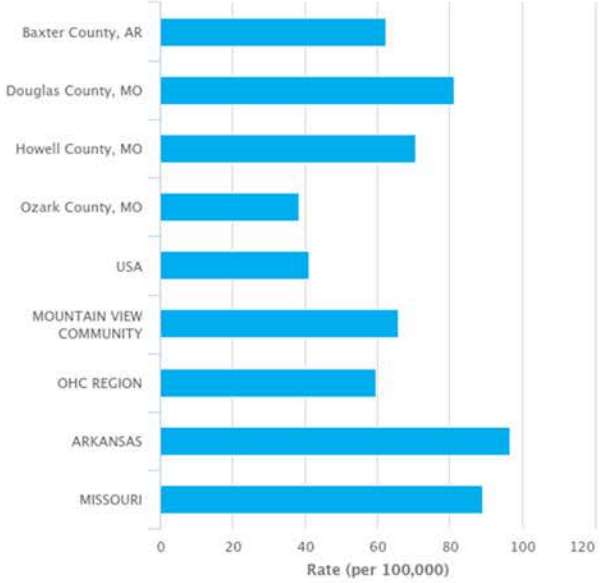


Asthma Prevalence



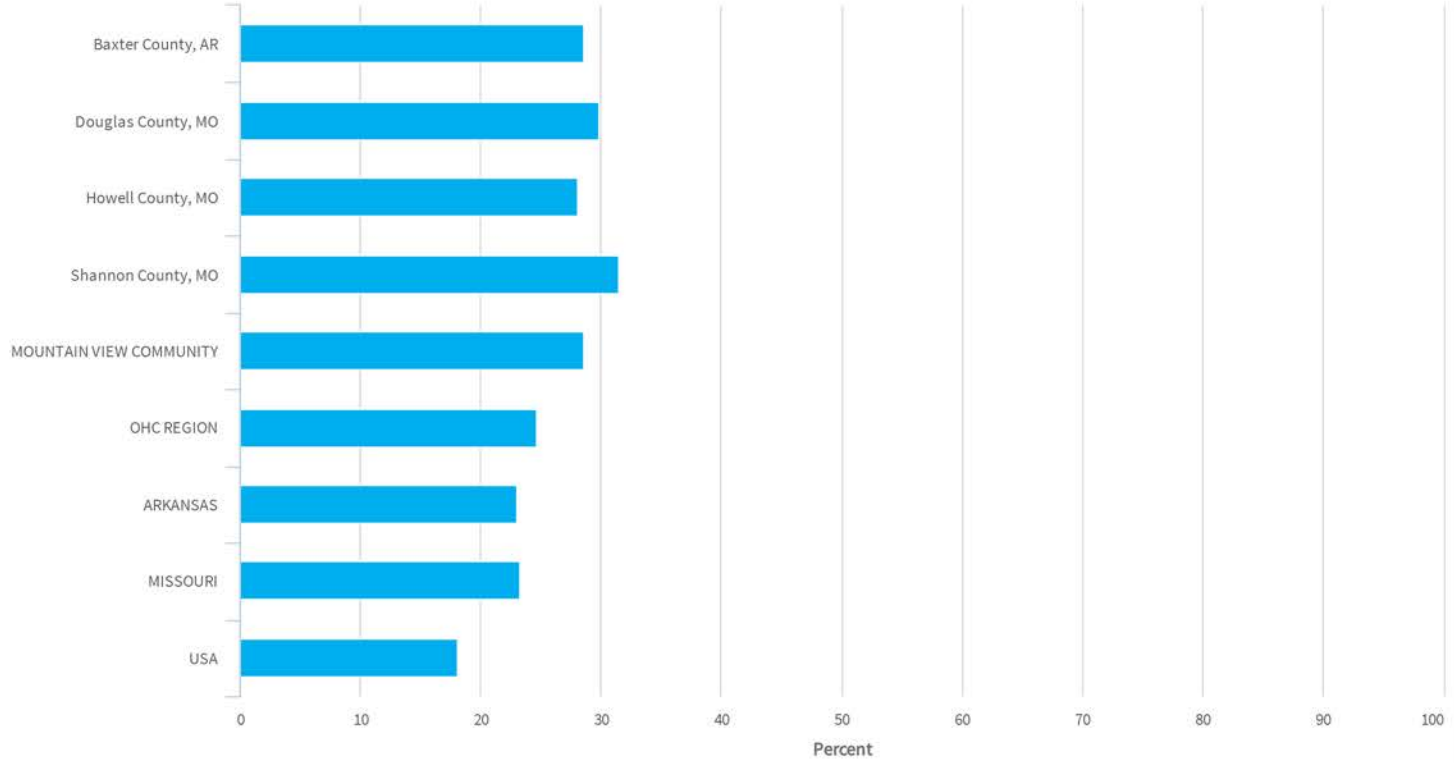
Percent Adults with Asthma. Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County

Lung Disease Mortality



Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

Current Tobacco Users



Percent Population Smoking Cigarettes(Age-Adjusted). Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health

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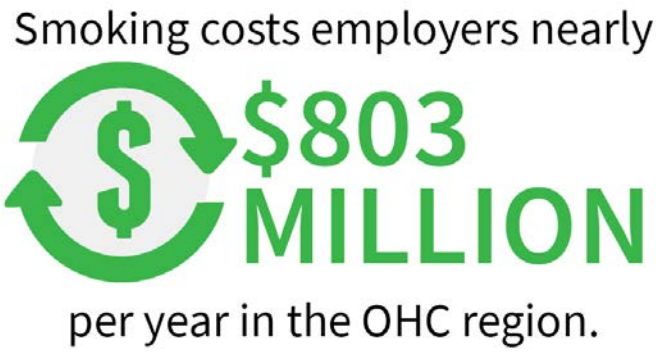
What does it cost?

One of the major contributors to lung disease is tobacco use. Not only does smoking affect the individual user, it also affects people around them, including employers. According to the U.S. Census Bureau, there were 440,038 employed individuals in the OHC Region in 2017. The smoking rate for the Region is 24.6%. Therefore, an estimated 108,249 people are employed and smoking. According to Berman, et al. (source), the annual cost to employers for a single smoker is $5,816.



What can communities do?

Communities can take an active role in reducing the impact of lung disease and its risk factors. The OHC encourages communities to adopt evidence-based strategies. Below are some ideas for communities to consider when addressing lung disease.

Improve access to appropriate care. Building a community that supports individuals to access the right care at the right time is critical. Efforts can focus on reducing barriers to care, improving referrals between community organizations, enhancing the healthcare workforce, and advocating for change that positively increases access to appropriate care.

Reduce tobacco use. Communities can take multiple actions to decrease the impact of tobacco use. Developing, implementing, and connecting people to smoking cessation programs can provide timely support for individuals seeking to quit. Implementing public policies, such as clean indoor air and raising the legal age to purchase tobacco, can limit access and exposure to tobacco products.

Focus on vulnerable populations. Some groups within a community may be more susceptible to lung disease or its effects. Communities should examine potentially vulnerable populations such as children, the poor, and particular racial groups. If disparities exist, community partners should determine appropriate approaches.

To see what our community is doing about this health priority, view our Community Health Improvement Plans:
Mercy CHIP

What can you do about Lung Disease?

What can you do?

First and foremost, don't smoke or stop smoking. Cigarette smoking is the most important risk factor for lung disease. If you want to keep your lungs at their healthiest, do not smoke. In addition, avoid secondhand smoke. Breathing the smoke from cigarettes, pipes, and vape pens enhances your risk for the same diseases that affect people who smoke. Don't allow smoking in your home, car, or work.

Exercise to work those lungs. Do something physically active for 30 minutes each day to increase the efficiency of your lungs. Walk around your neighborhood, take a bike ride, or even run in place for a bit.

Prevent infections. To help stop the spread of germs, cover your mouth and nose with a tissue when you cough or sneeze. Stay away from crowds during peak cold and flu season, get plenty of rest, eat well, and keep your stress levels under control. Make sure to get your flu shot during flu season. This is especially important if you have lung disease, though healthy people also benefit from getting vaccinated. If you have significant lung disease or are over 65, a pneumonia shot also is recommended.

Avoid exposure to pollutants. Wood burning heaters, mold, pet dander, and construction materials all pose a potential problem. Turn on the exhaust fan when you cook and avoid using aerosol products like hair spray. Change your furnace air filter seasonally. People with lung diseases such as asthma and chronic obstructive pulmonary disease (COPD) need to pay particular attention to the levels of air pollution called particulates — tiny solid or liquid particles — in the environment and limit their outdoor exposure when levels are high.

To see what our community is doing about this health priority, view our Community Health Improvement Plans through the links on the right.

Free Smoking Cessation Resources

SMOKE FREE

HOW TO QUIT SMOKING

BE TOBACCO FREE

TOBACCO CESSATION

Air Quality Improvement Resources

INDOOR AIR QUALITY

REDUCING AIR POLLUTION

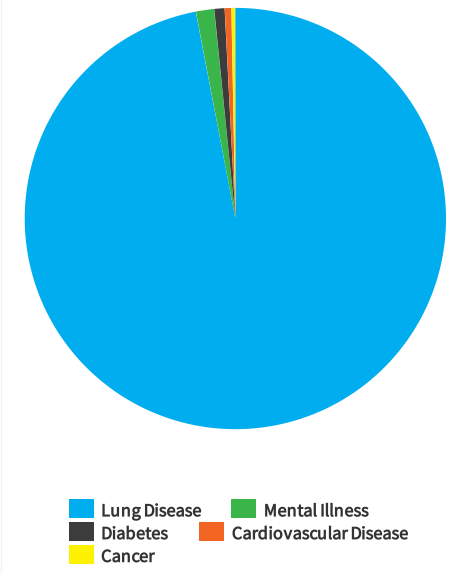
Community Health Improvement Plans

VIEW MERCY CHIP

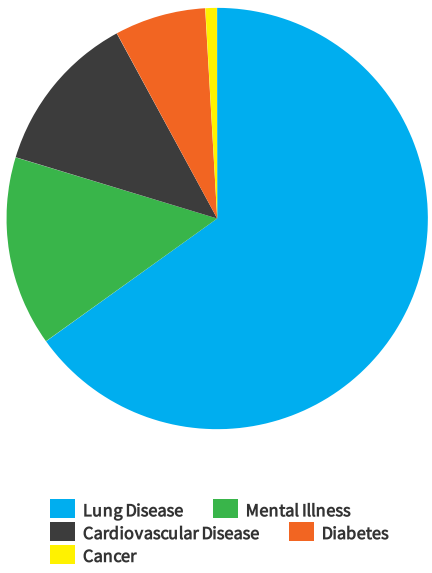
Lung Disease Data

Hospital Data

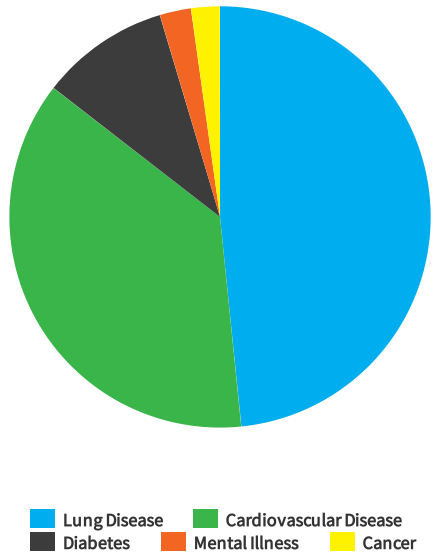
AHI-Related Diagnoses in Patients 0-17 Years Old in Mountain View Community ED



AHI-Related Diagnoses in Patients 18-64 Years Old in Mountain View Community ED

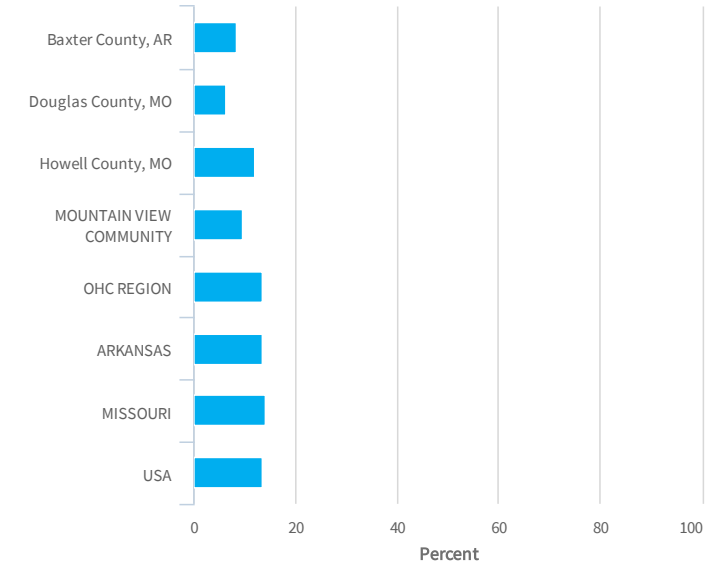


AHI-Related Diagnoses in Patients 65 and Older in Mountain View Community ED



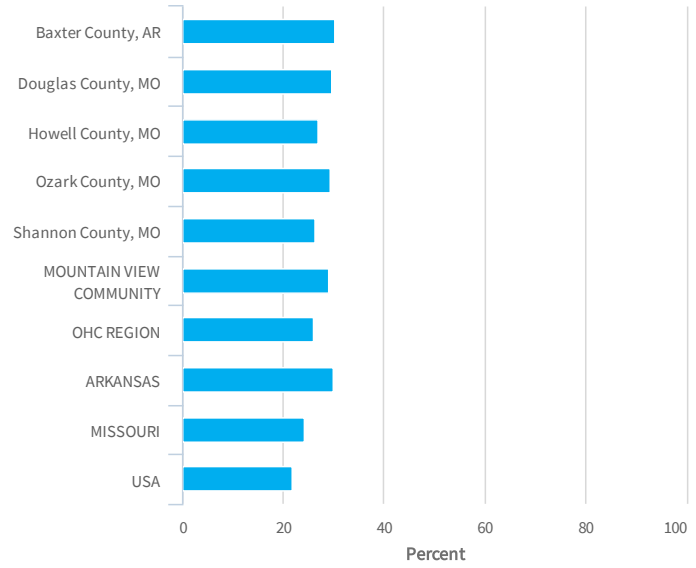
Community Data

Adults with Asthma



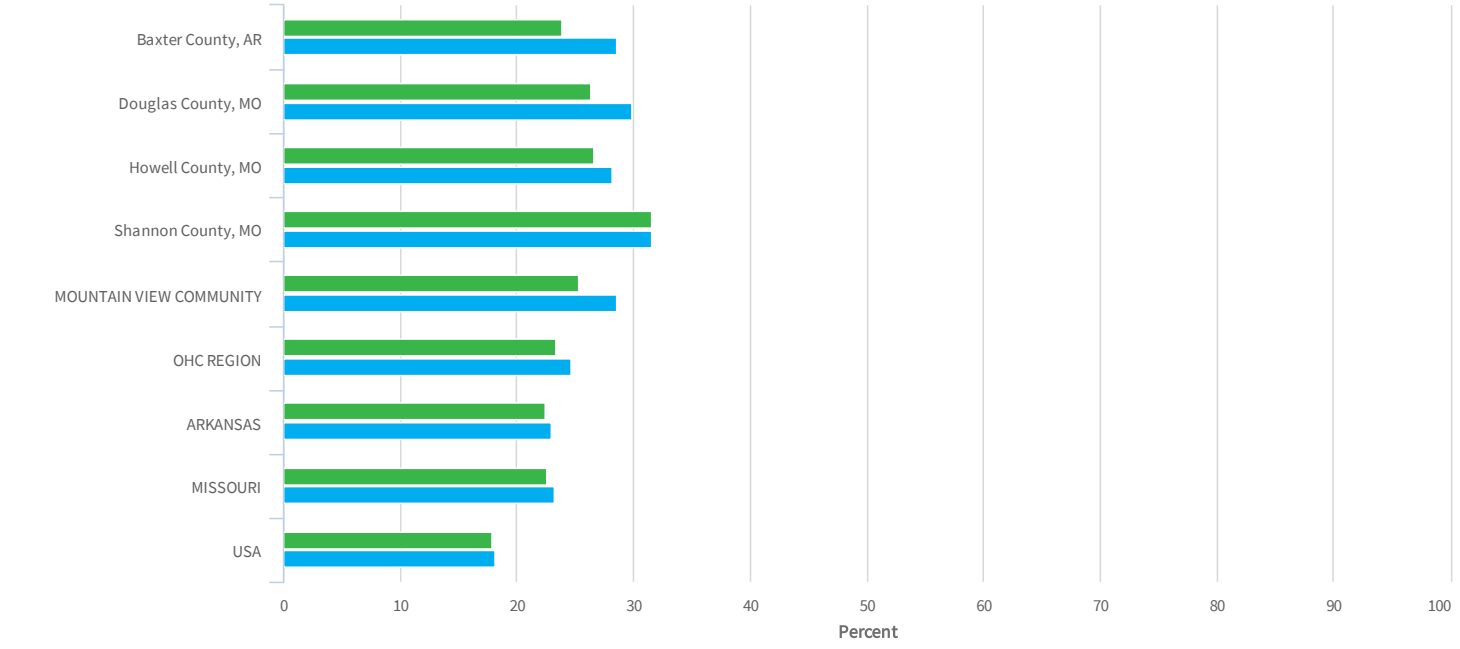
Percent Adults with Asthma. Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County

Physical Inactivity



Percent Population with no Leisure Time Physical Activity. Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013. Source geography: County

Population Using Tobacco (Crude Percentage & Age-Adjusted Percentage)



Percent Population Smoking Cigarettes(Age-Adjusted). Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health

Percent Population Smoking Cigarettes(Crude). Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators

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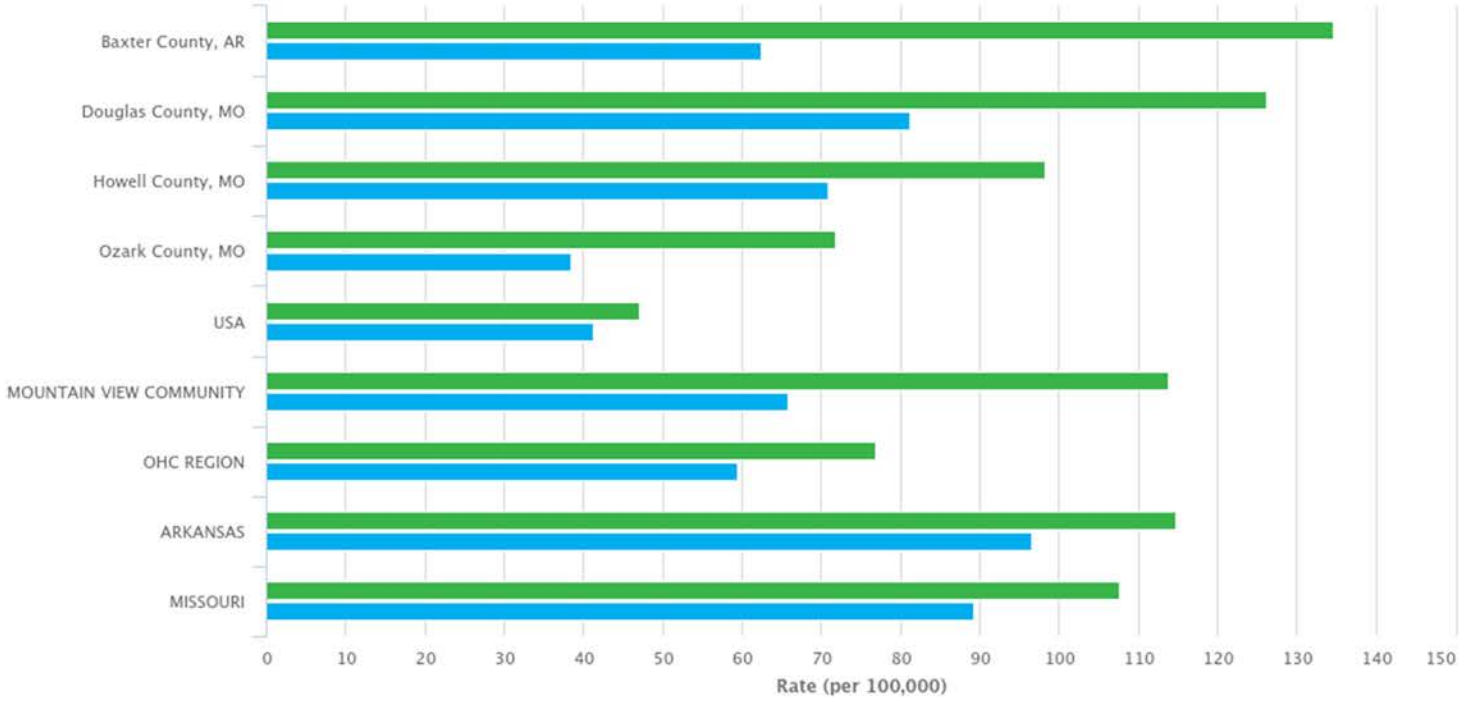
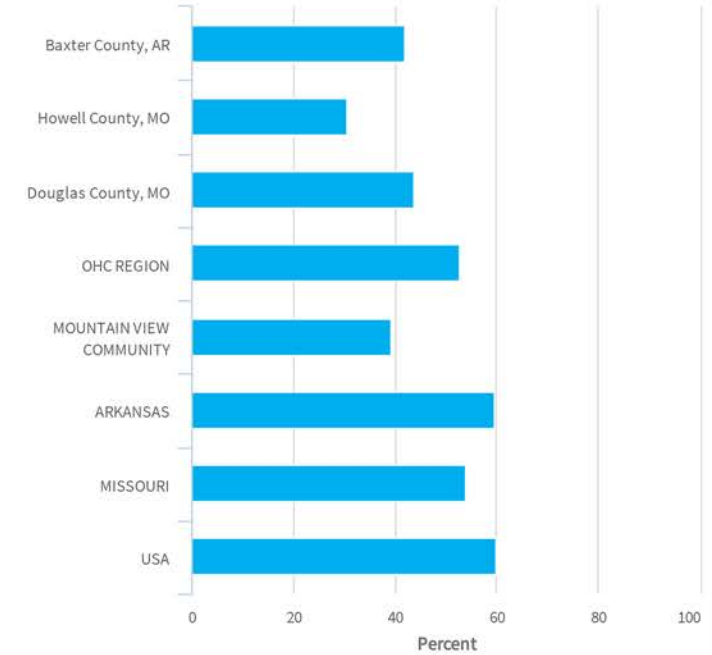
Lung Disease Mortality (Crude Death Rate & Age-Adjusted Death Rate)



Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

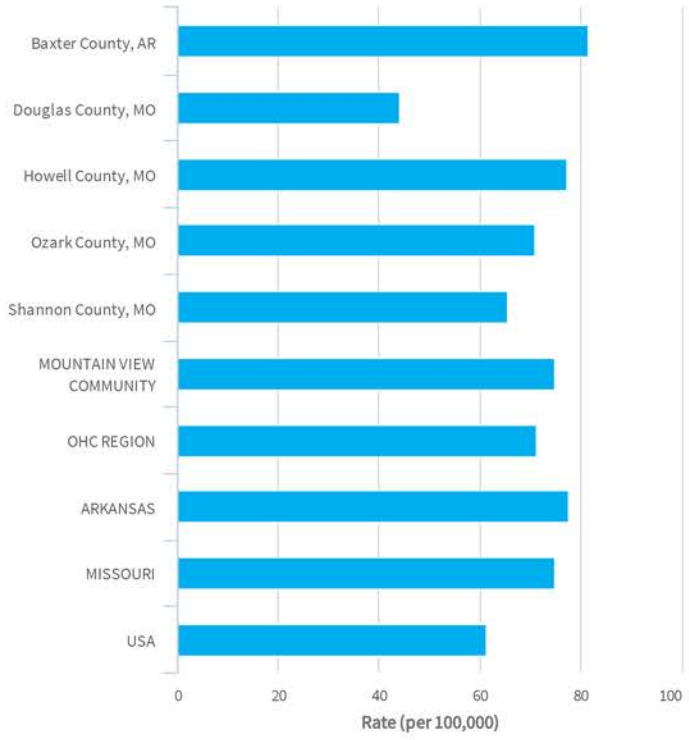
Crude Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

Adults Who Attempted to Quit Smoking in the Past 12 Months



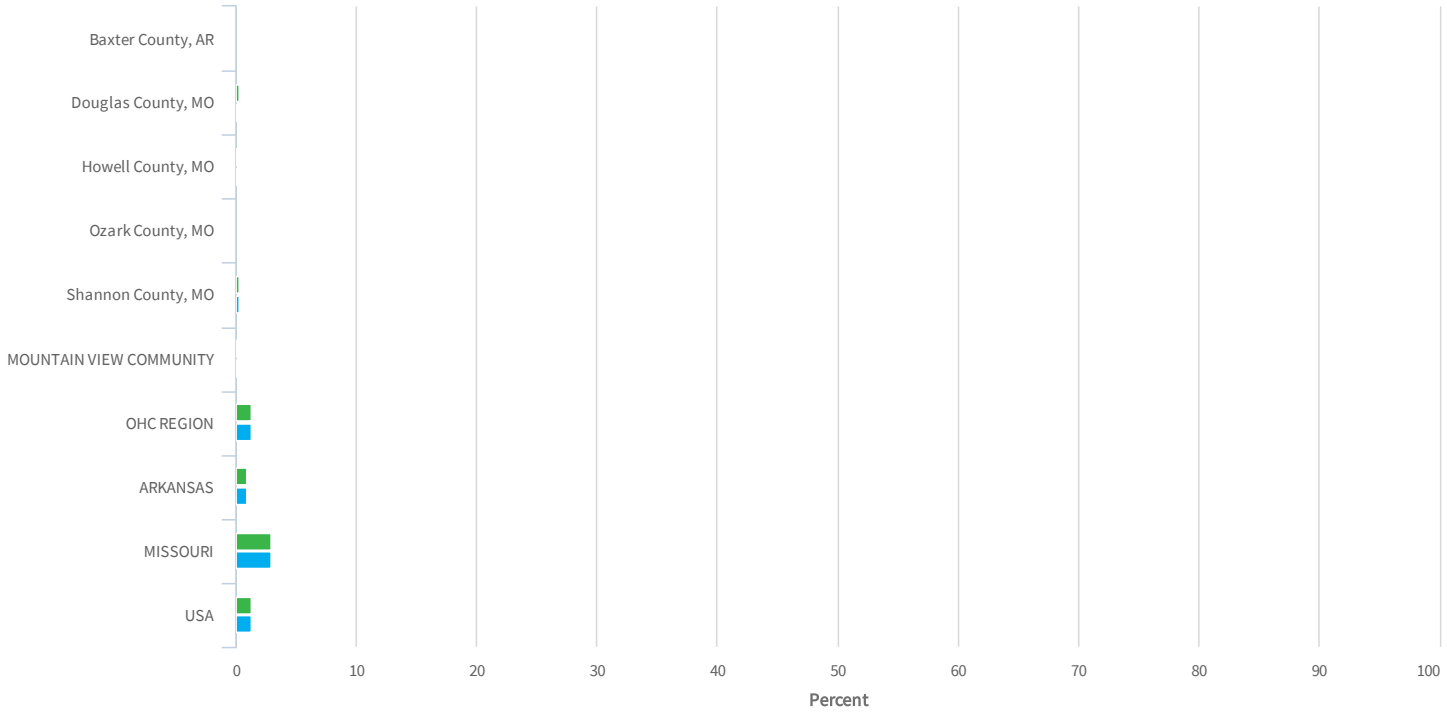
Percent Smokers with Quit Attempt in Past 12 Months. Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County

Lung Cancer Rate



Cancer Incidence Rate (Per 100,000 Pop.). Data Source: State Cancer Profiles. 2010-14. Source geography: County

Air Quality - Percentage of Days Exceeding Ozone Standards



Percentage of Days Exceeding Standards, Crude Average. Data Source: Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2012. Source geography: Tract

Percentage of Days Exceeding Standards, Pop. Adjusted Average. Data Source: Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2012. Source geography: Tract

Cardiovascular Disease

What is Cardiovascular Disease?

Cardiovascular disease refers to several types of heart conditions, including hypertension, high cholesterol, and congestive heart failure.

Cardiovascular disease is the leading cause of death in the United States, claiming more than 600,000 lives each year (source). The most common type of cardiovascular disease in the United States is coronary artery disease, which affects the blood flow to the heart (source).

The most common types of cardiovascular disease in the United States are:

- Congestive heart failure
- Coronary artery disease
- Myocardial infarction

What causes Cardiovascular Disease?

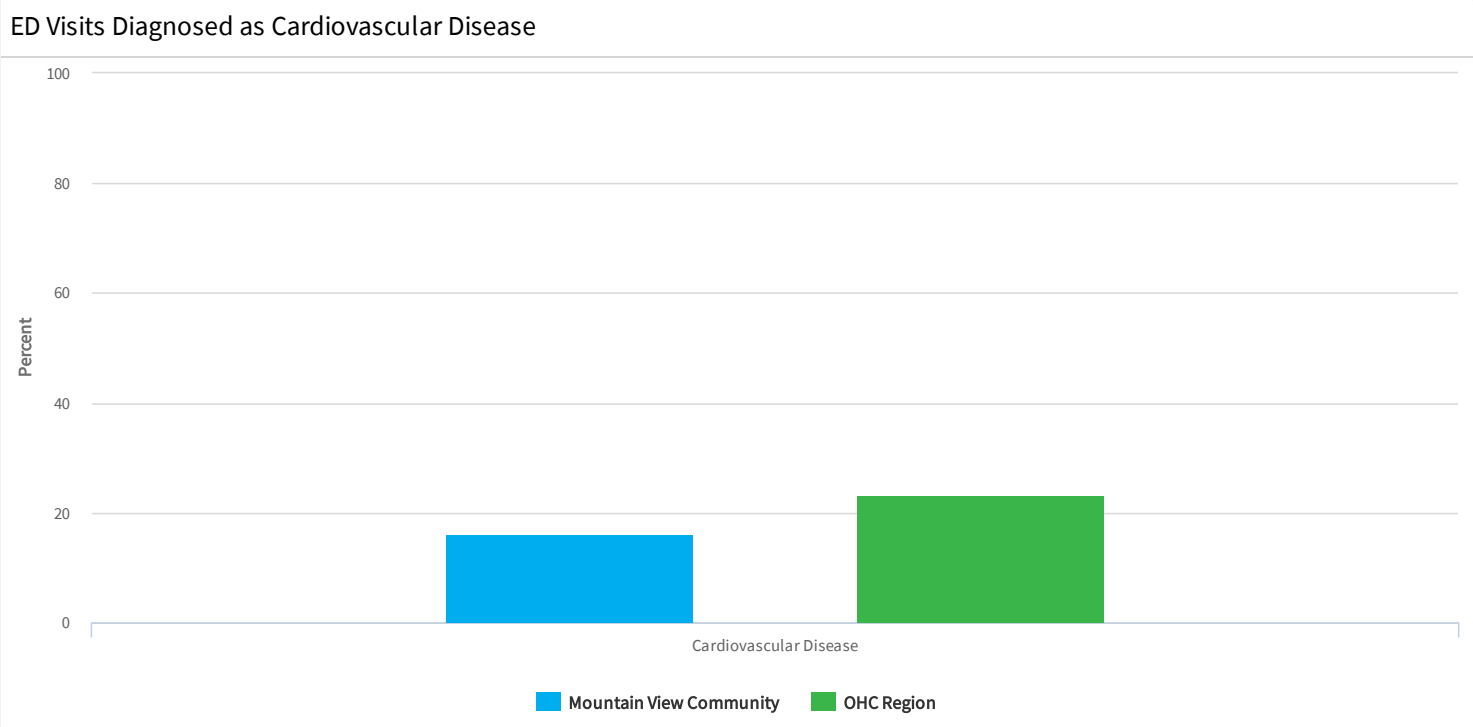
Cardiovascular disease can be the result of lifestyle choices, other health conditions, age, or family history. There are three key risk factors for heart disease: high blood pressure, high cholesterol, and smoking.

Why is this a priority?

Although there have been positive improvements in all data indicators used to assess cardiovascular disease, rates in the Ozarks Health Commission (OHC) Region remain significantly higher than national averages—showing that there is still a lot of work to be done to decrease the burden of this disease.

What are our hospitals seeing?

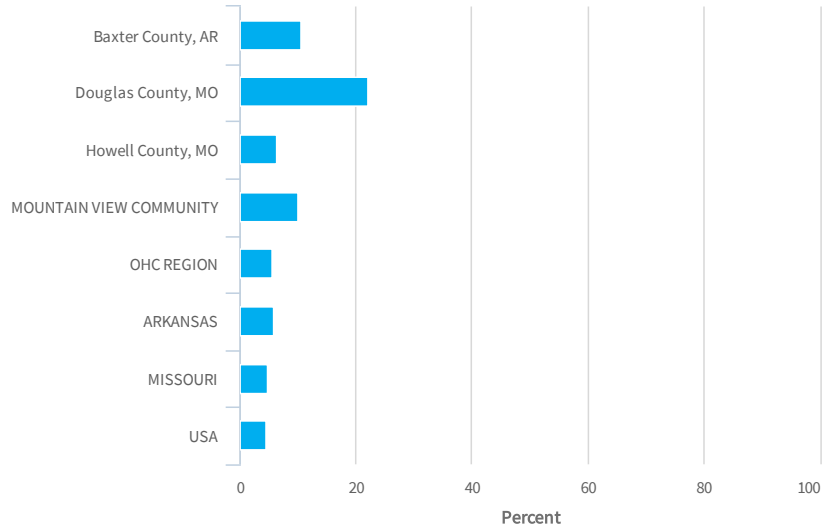
The burden of cardiovascular disease is evident in area Emergency Departments (ED). Of all the AHI, 23.3% of visits to the ED in the OHC Region are due to issues related to the circulatory system.



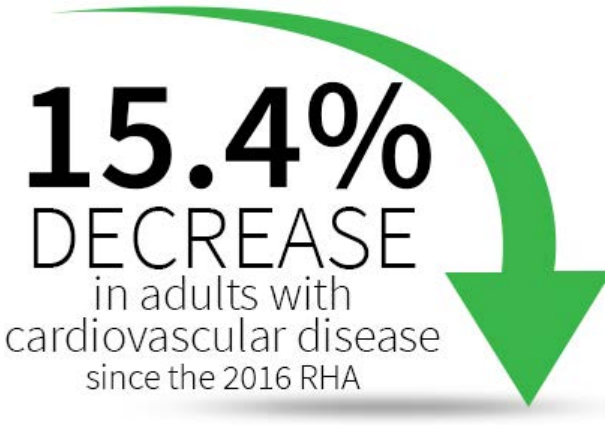
What is our community seeing?

Community data indicators used to understand the scope of cardiovascular disease include: how many people live with cardiovascular disease, use tobacco, do not engage in adequate physical activity, and die from heart disease or stroke each year.

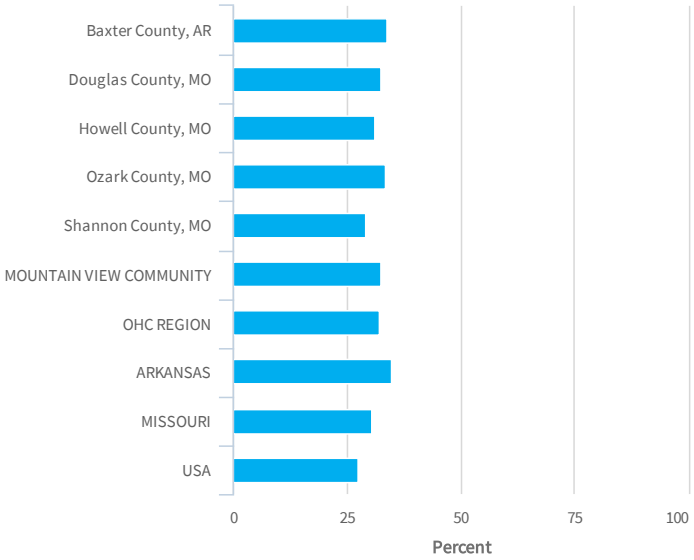
Adults with Cardiovascular Disease



Percent Adults with Heart Disease. Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County

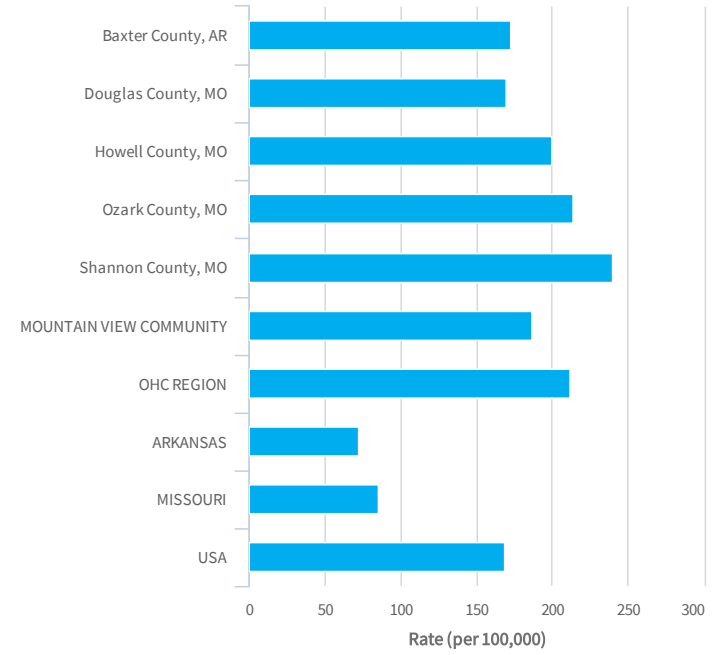


Population Considered Obese



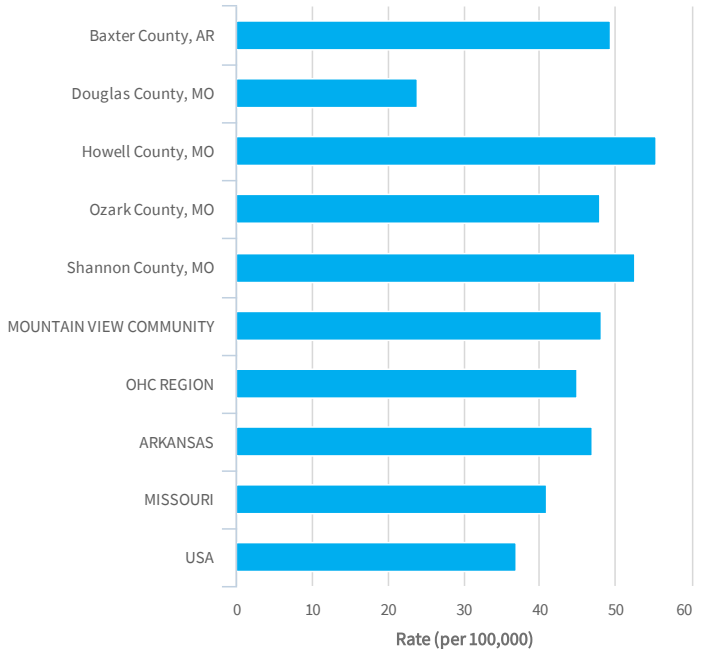
Percent Adults with BMI > 30.0 (Obese). Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013. Source geography: County

Cardiovascular Disease Mortality



Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

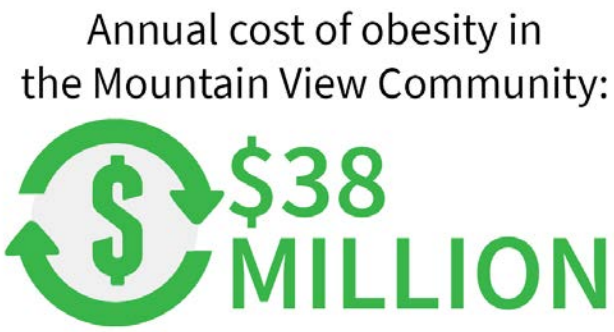
Stroke Mortality

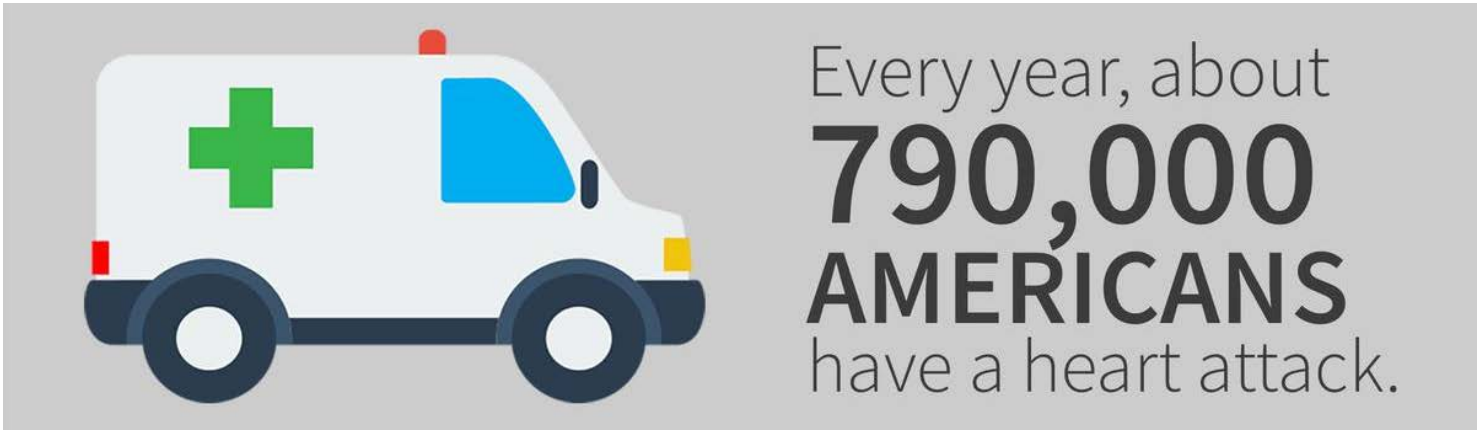


Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

What does it cost?

More work needs to be done to address cardiovascular disease in the OHC Region, specifically as it relates to obesity. Obesity is a serious health concern that increases a person's risk of cardiovascular disease, as well as other health issues. In the OHC Region, 32.2% of adults are obese (body mass index > 30). Medical spending for an obese person is $1,429 more per year than for someone of normal weight. (source)Thus, the OHC Region incurs $451 million in additional medical costs due to obesity.





What can communities do?

Communities can take an active role in reducing the impact of cardiovascular disease and its risk factors. The OHC encourages communities to adopt evidence-based strategies. Below are some ideas for communities to consider when addressing cardiovascular disease.

Improve access to appropriate care. Building a community that supports individuals to access the right care at the right time is critical. Efforts can focus on reducing barriers to care, improved referrals between community organizations, enhancing the healthcare workforce, and advocating for change that positively increases access to appropriate care.

Reduce tobacco use. Communities can take multiple actions to decrease the impact of tobacco use. Developing, implementing, and connecting people to smoking cessation programs can provide timely support for individuals seeking to quit. Implementing public policies, such as clean indoor air and raising the legal age to purchase tobacco, can limit access and exposure to tobacco products.

Improve active living and healthy eating. Increasing individuals' access to opportunities to be active and eat healthy are effective approaches to improving health. Efforts can focus on community programming to increase individual engagement in healthy living. Communities can also focus on building improved access to healthy living through efforts such as Complete Streets, increased access to active spaces like parks and greenways, and reducing food insecurity.

Focus on vulnerable populations. Some groups within a community may be more susceptible to cardiovascular disease or its effects. Communities should examine potentially vulnerable populations such as children, the poor, and certain racial groups. If disparities exist, community partners should determine appropriate approaches.

To see what our community is doing about this health priority, view our Community Health Improvement Plans:

Mercy CHIP

What can you do about Cardiovascular Disease?

What can you do?

Eat a healthy diet

A diet rich in fruits, vegetables, and whole grains can help protect your heart. Aim to eat beans, low-fat or fat-free dairy products, lean meats, and fish as part of a healthy diet. In addition, avoid too much salt and sugar in your diet.

Quit smoking

If you smoke, you are twice as likely to have a heart attack as a nonsmoker and more likely to die if you do have a heart attack. The effects of quitting smoking are quite sudden. Your blood pressure will decrease, your circulation will improve, and your oxygen supply will increase. Previous research has shown that when you quit smoking, your health starts to improve within days.

Exercise for at least 30 minutes daily

Getting regular exercise can reduce your risk of cardiovascular disease. According to the Mayo Clinic, experts recommend getting at least 30 minutes of exercise per day. The key is to stay active—remember that activities such as taking the stairs, housekeeping, gardening, and walking the dog all count toward your total.

Get enough quality sleep

According to a recent statement from the American Heart Association, an irregular sleep pattern (one that varies from the seven- to nine-hour nightly norm) is linked to a host of cardiovascular risks. Short sleep — less than six hours per night — appears to be especially hazardous to your heart health. Sleep-deprived people have higher blood levels of stress hormones and substances that indicate inflammation, a key player in cardiovascular disease. Even a single night of insufficient sleep can perturb your system. People who don't get enough sleep have a higher risk of obesity, high blood pressure, heart attack, diabetes, and depression.

Get regular health screenings

Another way to make a difference is through regular health screenings. With a couple of simple tests and physical examinations, you can detect the early onset of some serious medical conditions. Regular screenings can tell you what your numbers are and whether you need to take action.

Resources for a Heart Healthy Diet

DASH EATING PLAN

HEALTHY LIFESTYLE

Community Health Improvement Plan

VIEW MERCY CHIP

Blood pressure. The American Heart Association recommends keeping a record of your regular blood pressure readings.

Cholesterol levels. Keeping your cholesterol levels in check is another great way to stay healthy and lower your risks for cardiovascular disease and stroke. Simply put, cholesterol is a fat substance found in your blood and cells that is produced by your liver.

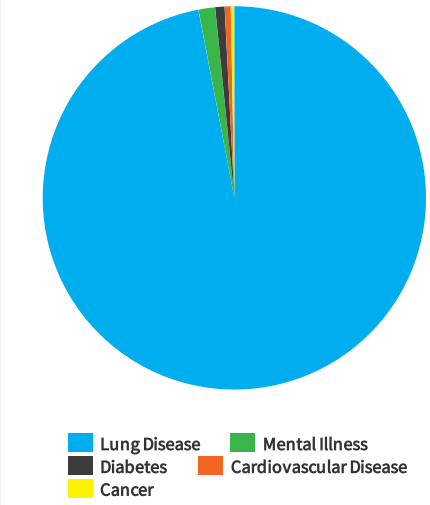
Diabetes screening. Since diabetes is a risk factor for developing cardiovascular disease, you may want to consider being screened for diabetes. Talk to your doctor about when you should have a fasting blood sugar test or hemoglobin A1C test to check for diabetes.

To see what our community is doing about this health priority, view our Community Health Improvement Plans through the links on the right.

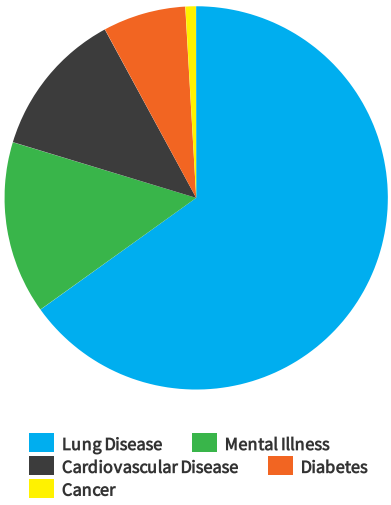
Cardiovascular Disease Data

Hospital Data

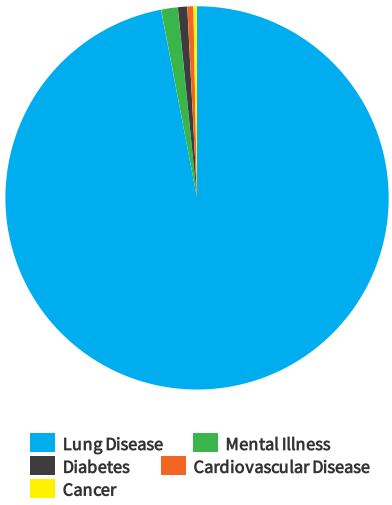
AHI-Related Diagnoses in Patients 0-17 Years Old in Mountain View Community ED



AHI-Related Diagnoses in Patients 18-64 Years Old in Mountain View Community ED

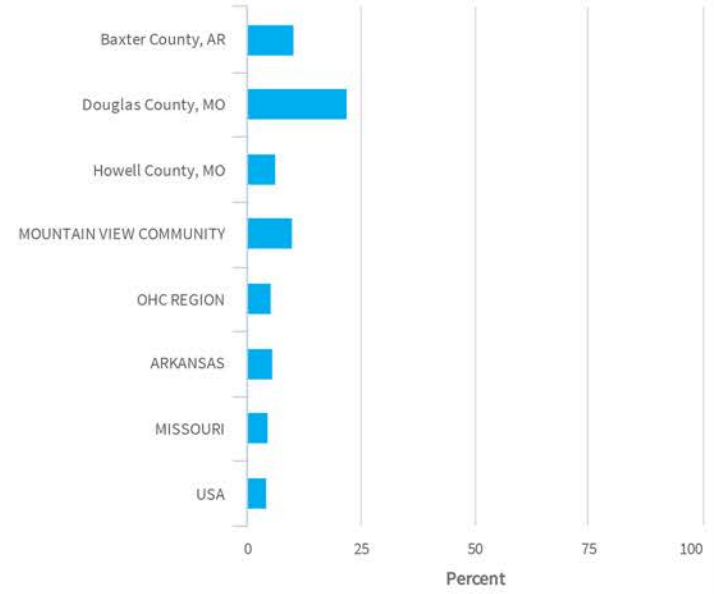


AHI-Related Diagnoses in Patients 65+ and Older in Mountain View Community ED



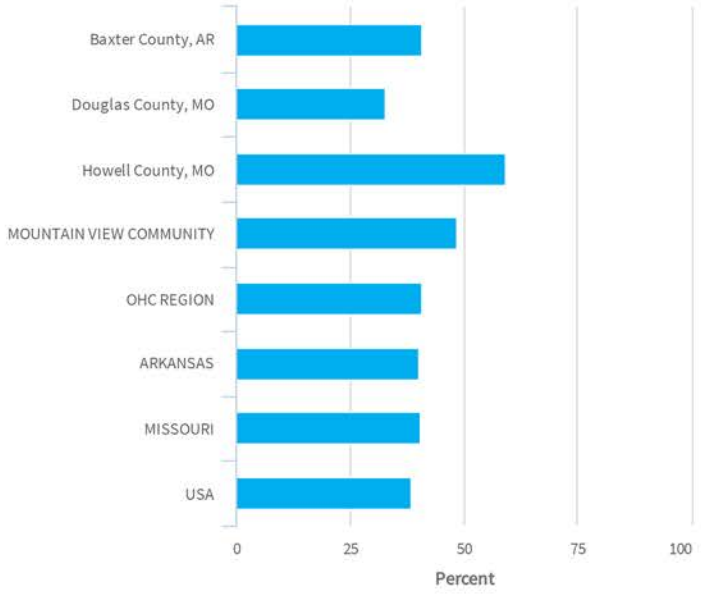
Community Data

Adults with Cardiovascular Disease



Percent Adults with Heart Disease. Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County

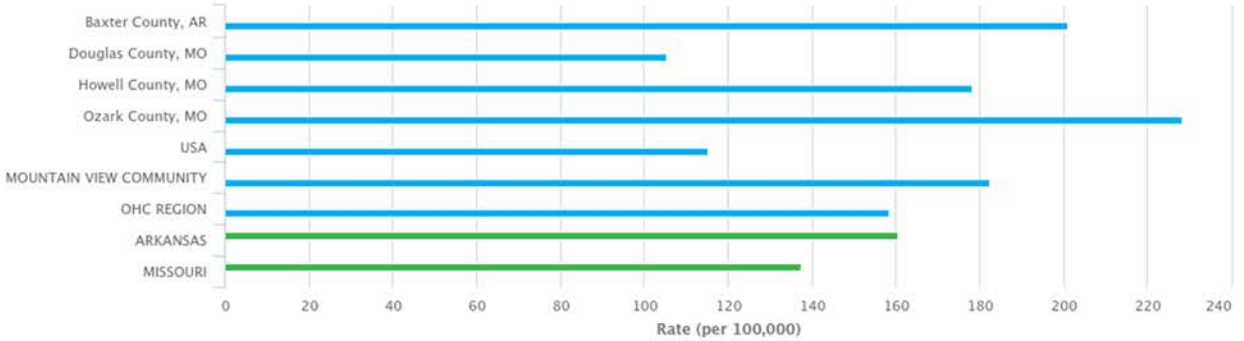
Adults with High Cholesterol



Percent Adults with High Cholesterol. Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County

Coronary Artery Disease (Crude Death Rate & Age-Adjusted Death Rate)

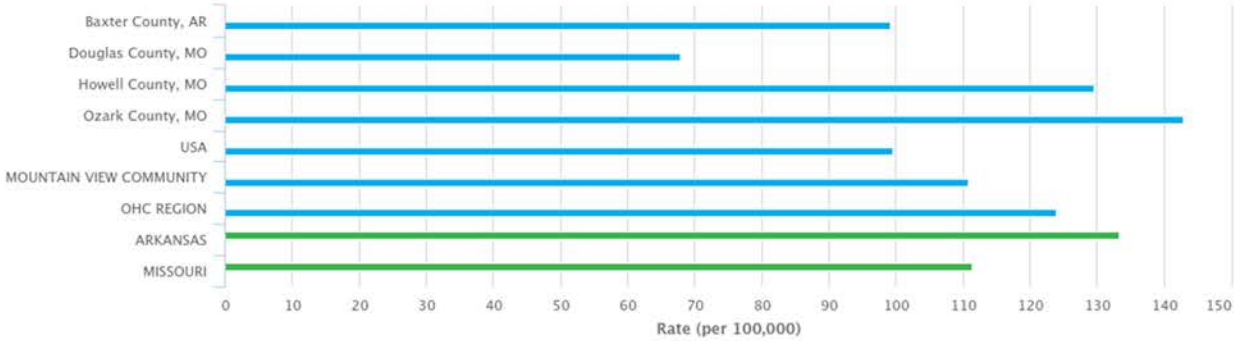
Crude Death Rate



Crude Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

Crude Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2013-17. Source geography: County

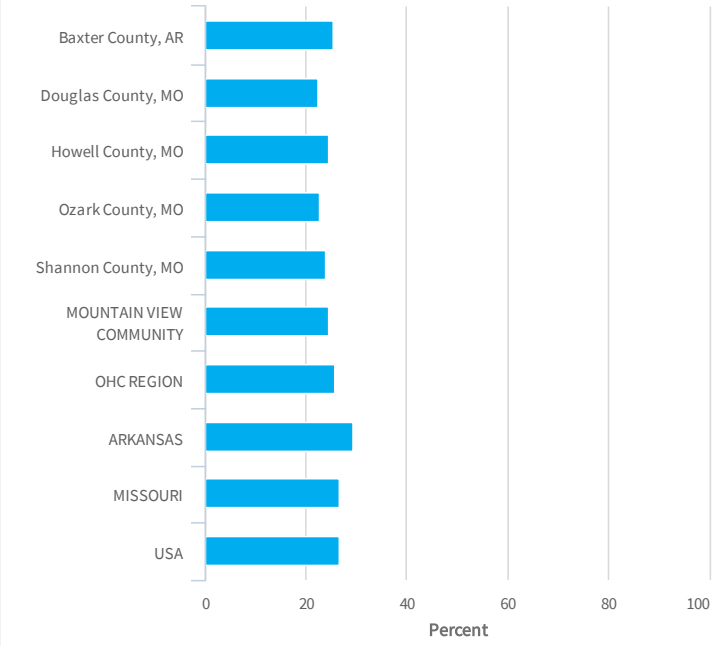
Age-Adjusted Death Rate



Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

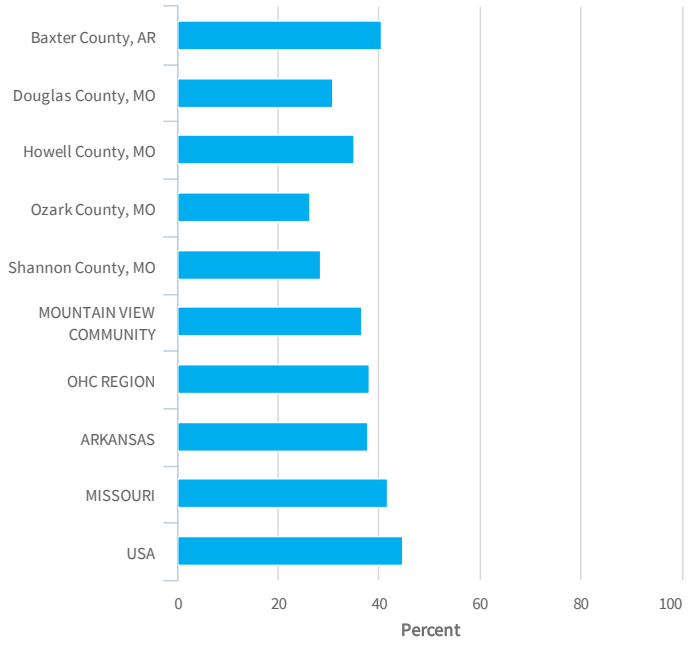
Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2013-17. Source geography: County

Medicare Population with Cardiovascular Disease



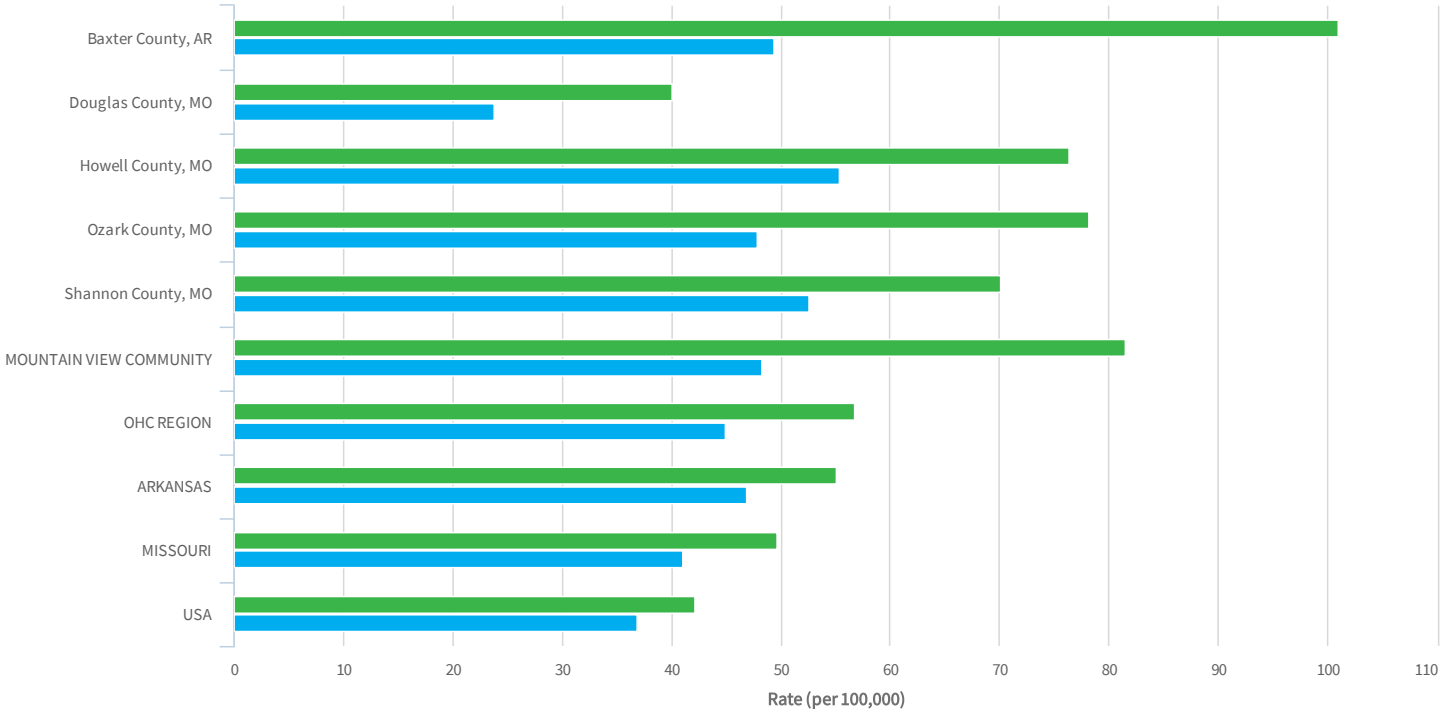
Percent with Heart Disease. Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County

Medicare Population with High Cholesterol



Percent with High Cholesterol. Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County

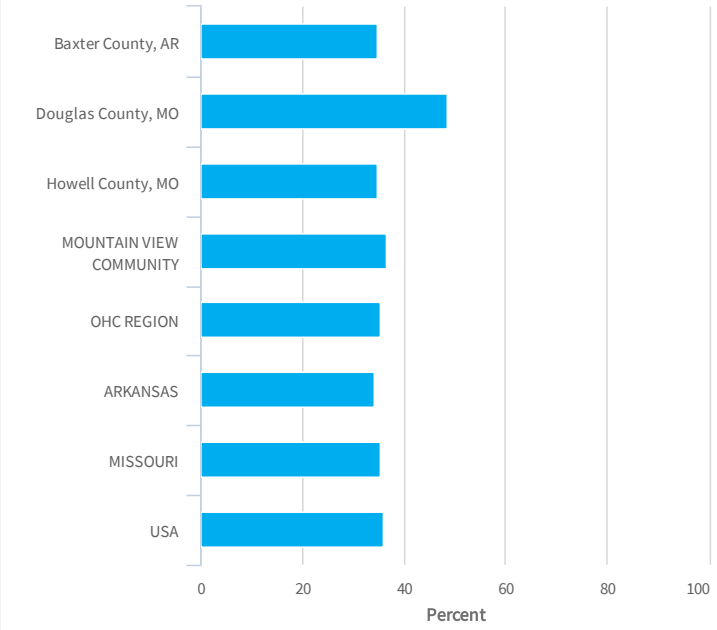
Stroke (Crude Death Rate & Age-Adjusted Death Rate)



Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

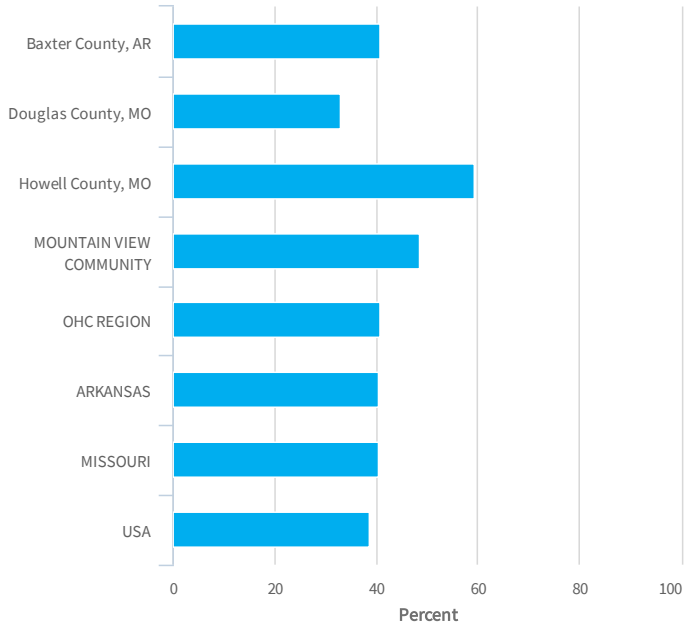
Crude Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

Overweight Adults



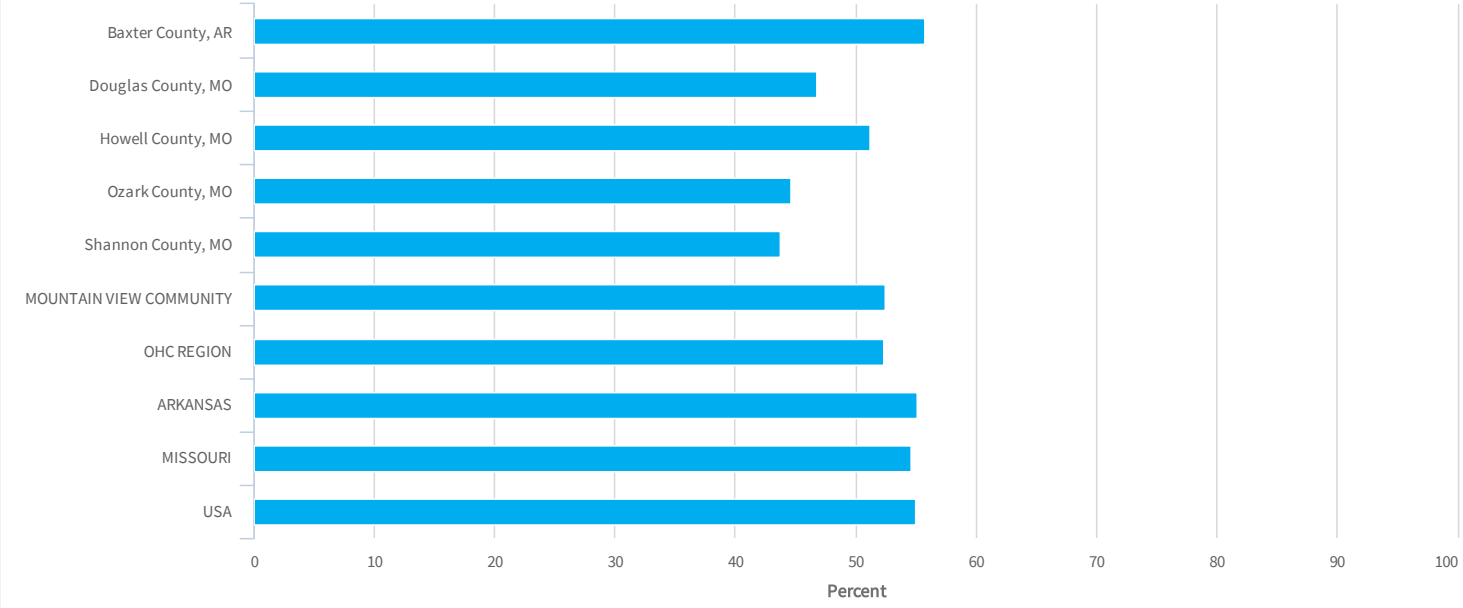
Percent Adults Overweight. Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County

Adults with High Blood Pressure



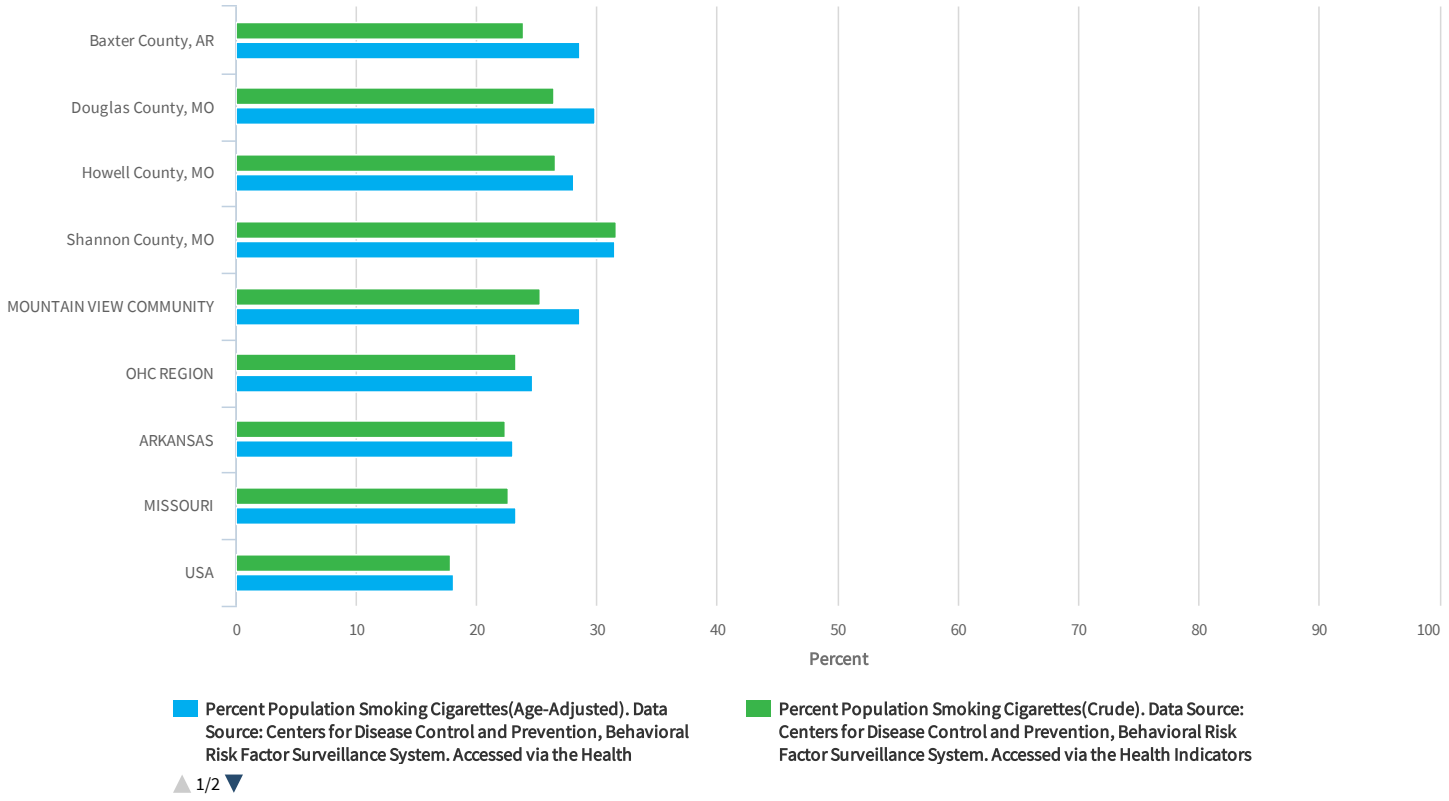
Percent Adults with High Cholesterol. Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County

Medicare Population with High Blood Pressure



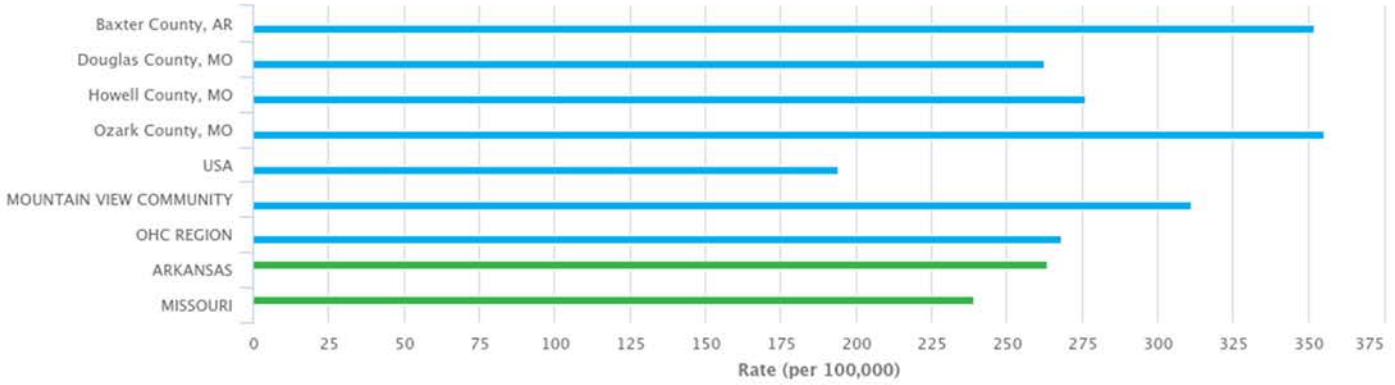
Percent with High Blood Pressure. Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County

Current Smokers (Crude Percentage & Age-Adjusted Percentage)



Cardiovascular Disease (Crude Death Rate & Age-Adjusted Rate)

Crude Death Rate



Crude Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

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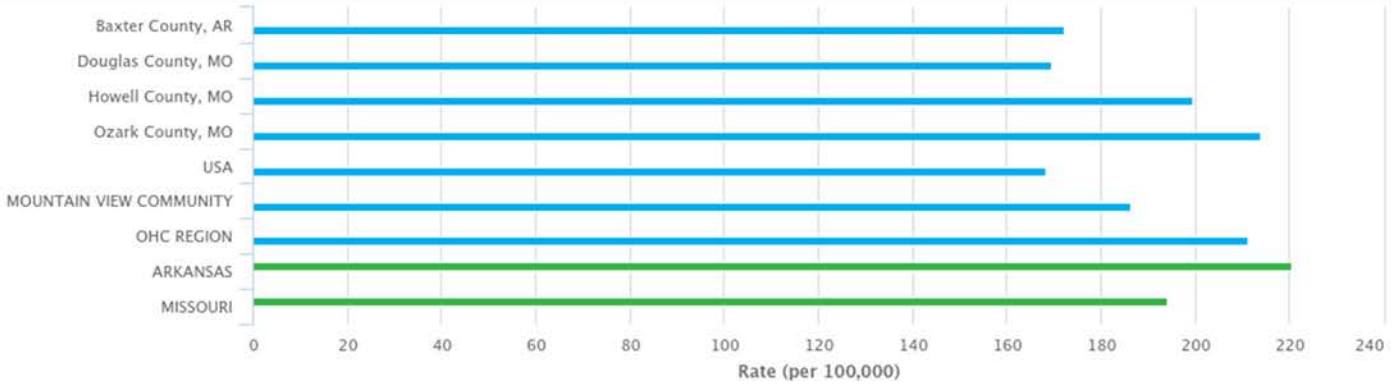
Age-Adjusted Death Rate



Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

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Mental Health

What is Mental Health?

Mental health includes a person's emotional, psychological, and social well-being. It affects how individuals think, feel, and act.

A person's mental health status also contributes to how to he or she handles stress, relates to others, and makes choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Within the broad category of mental health, mental illness specifically refers to all diagnosable mental disorders (source).

There are five main categories of mental illness (source):

- Anxiety disorder
- Dementia
- Eating disorders
- Mood disorders
- Schizophrenia and psychotic disorders

What Causes Mental Health Problems?

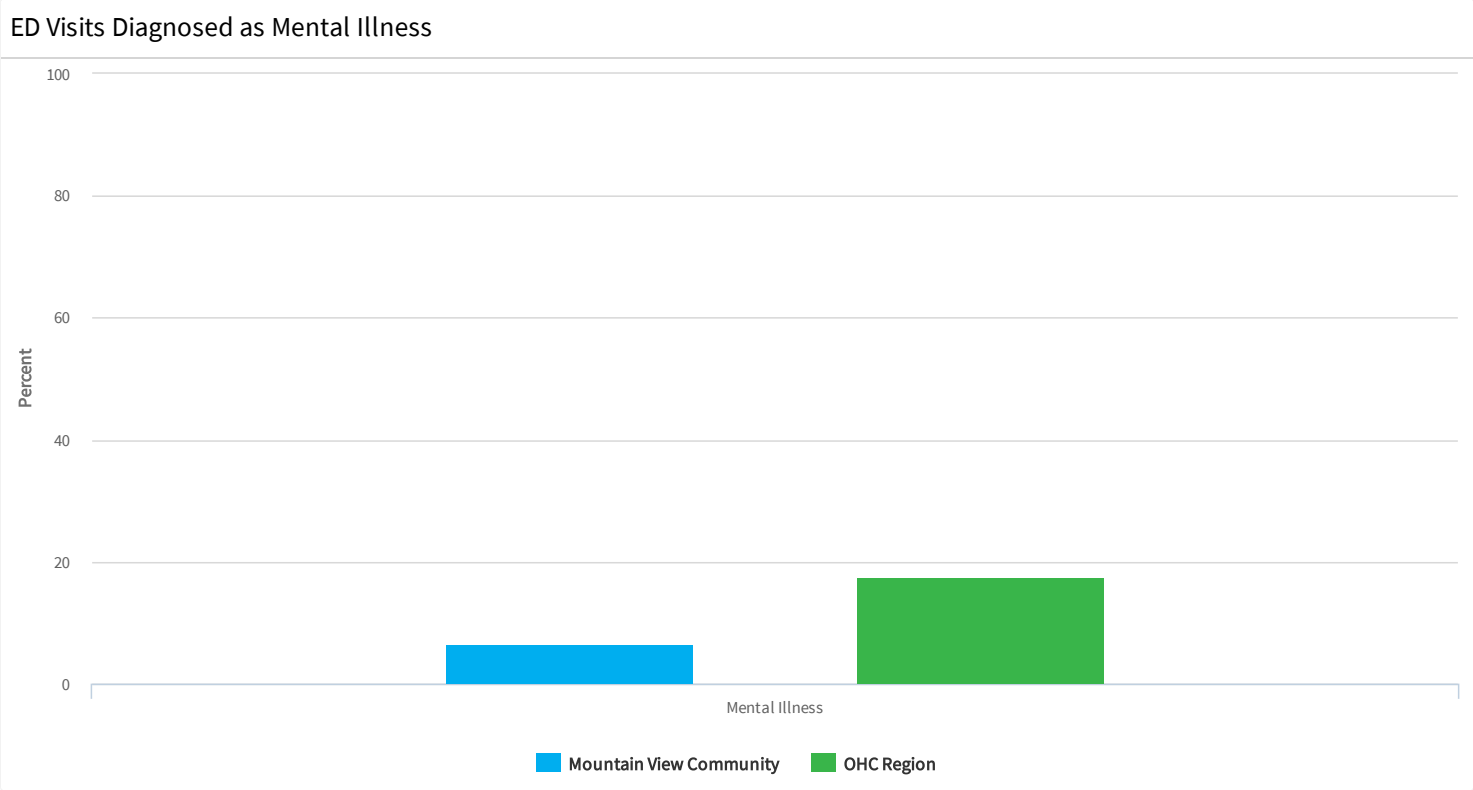
Many factors contribute to mental health problems, including: biology (factors such as genes or brain chemistry), life experiences (such as trauma or abuse), and family history (source).

Why is this a priority?

In the 2016 Regional Health Assessment, it was challenging to understand the full scope of mental health in the OHC region because data was limited. Much of the evidence was based on anecdotal feedback from community members who experienced mental illness firsthand from family, clients, or personally. The 2019 assessment is similar in that available data indicators are still limited. However, there has been much more conversation in the past three years about the burden of mental health on the OHC Region.

What are our hospitals seeing?

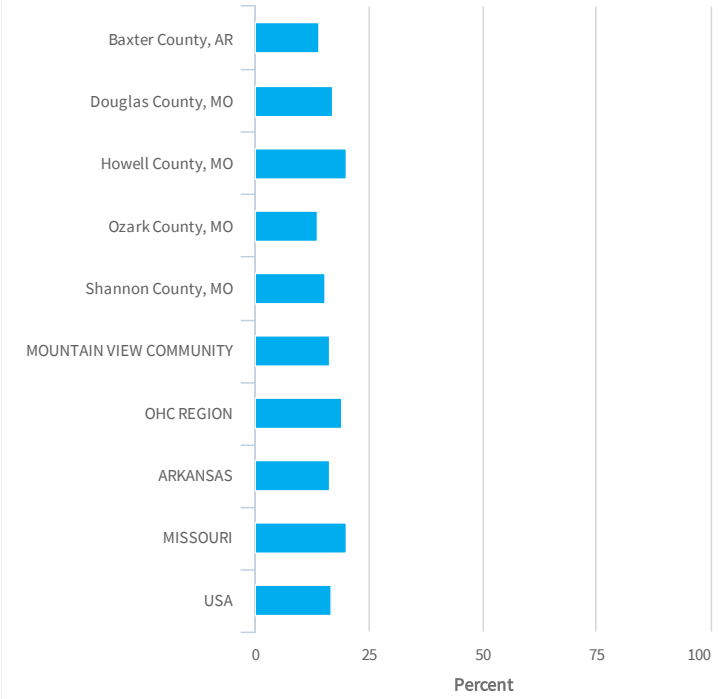
When evaluating hospital data, mental health rises to the surface, not only for AHI, but also for specific age groups and payer types. Of all AHI, 21.4% of visits in the OHC Region are due to mental, behavioral, and neurodevelopmental disorders. This rate jumps to over 33% for people 18 – 64 years of age, and nearly 41% for people without health insurance.



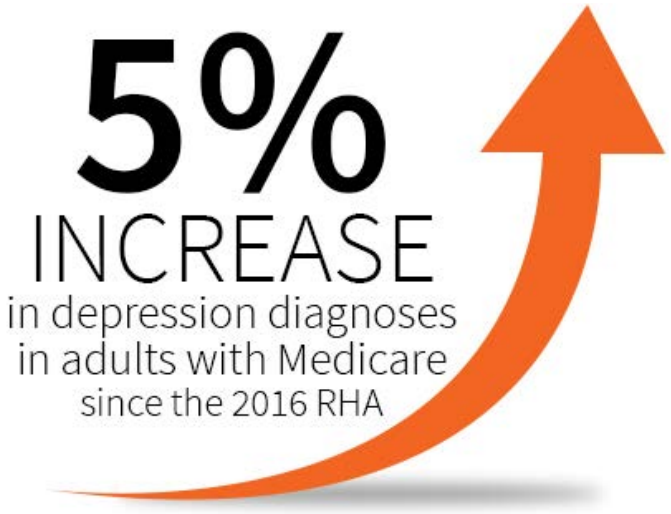
What is our community seeing?

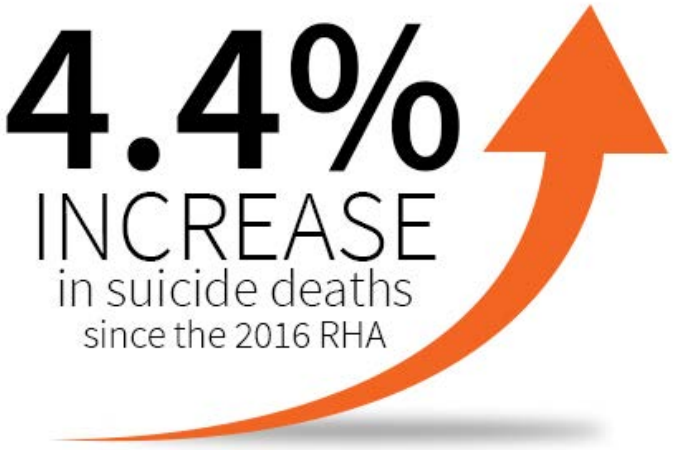
For the OHC Region overall, both indicators have gotten worse since the 2016 assessment and continue to be worse than the national data.

Depression Rate in the Medicare Population

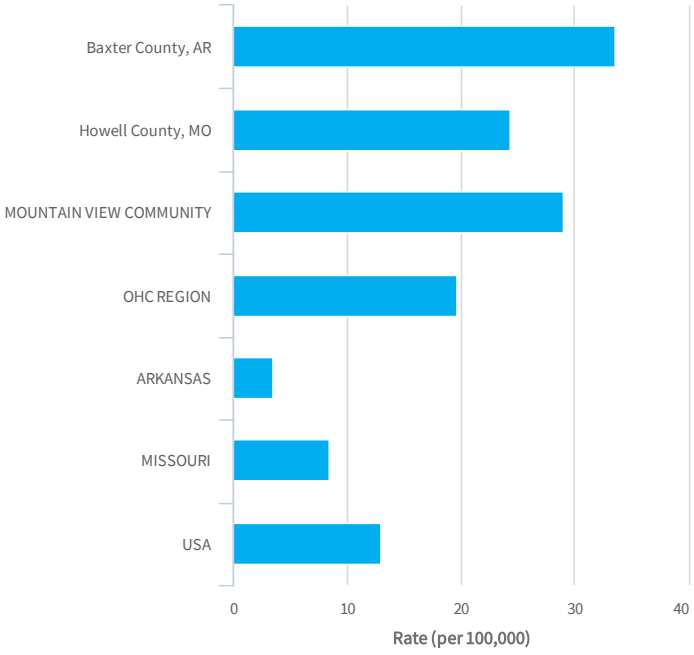


Percent with Depression. Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County





Suicide Mortality



Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

What does it cost?

According to data from the Bureau of Economic Analysis's Health Care Satellite Account, in 2013, $89 billion was spent for non-institutionalized mental illness, which accounts for 5% of total healthcare expenditures (source). Specific to major depressive disorder, the total cost of this illness is estimated at $210.5 billion per year. Half of this total is attributed to workplace costs—such as missed days from work and reduced productivity —about 45% of the costs are due to direct medical costs, and 5% are related to suicide, according to a 2015 study (source).

What can communities do?

Communities can take an active role in reducing the impact of mental illness and its risk factors. The OHC encourages communities to adopt evidence-based strategies. Below are some ideas for communities to consider when addressing mental health.

Improve access to appropriate care. Building a community that supports access the right care at the right time is critical. Efforts can focus on reducing barriers to care, improved referrals between community organizations, enhancing the healthcare workforce, and advocating for change that positively increases access to appropriate care.

Improve education and awareness. Mental illness is a disease that many in communities are still unfamiliar with. Efforts should be targeted at increasing awareness around mental health and substance misuse, as well as equipping people with the knowledge to provide support to others suffering from the diseases, such as programs like Mental Health First Aid.

Stabilize individuals in crisis. Individuals who are experiencing a mental health or substance misuse crisis are too often without appropriate community support. Community efforts should focus on increasing access to immediate care through direct service provision and improvement of community systems to offer assistance.

Focus on vulnerable populations. Some groups within a community may be more susceptible to mental health struggles. Communities should examine potentially vulnerable populations and, if disparities exist, community partners should determine appropriate approaches.

To see what our community is doing about this health priority, view our Community Health Improvement Plans:
Mercy CHIP

What can you do about Mental Health?

What can you do?

Awareness is the first step to educating the public, fighting stigma, and providing support to the nearly 60 million people in the U.S. who struggle with a mental illness. Most of us find ourselves personally connected with the topic of mental health. We may have had a loved one or known someone who has been affected. We might be the one who is struggling. Either way, knowing what to say, how to act, or what we can do to help is not always clear.

Communicating about mental health is one of the best ways to learn and build acceptance. Here are a few ideas that will help take the stigma out of illnesses such as depression, anxiety, and bipolar disorder and help public perception move in a more positive direction.

Learn the facts

Millions of people live with a mental illness or in a state of poor mental health. Educate yourself on the facts and then educate those around you. One in 5 Americans is affected by a mental illness. Stigma is toxic to good mental health because it creates an environment of shame, fear, and silence that prevents many people from seeking help and treatment. The perception of mental illness won't change unless we act to change it.

Learn the signs and symptoms mental health distress and know where to get help in your area. Take a mental health screening and share your results. Show others that checking up on your mental health is nothing to be ashamed of, it is okay to not be okay.

Talk and listen

Sometimes spreading mental health awareness can simply mean supporting and listening to those close to us. Be willing to ask people how they're doing and mean it. Don't be afraid to ask questions, but do not judge. Always be ready to listen and encourage. Try to educate those around you on how to talk about mental illness. Never use words like "crazy" or "insane" as insults . Talk to loved ones about how they are feeling. Regularly check in with those close to you, especially if you know they are dealing with a mental illness. Be a supportive friend. Talk about mental health with your children. Don't assume kids are too young to understand. Depression can affect children as young as elementary school.

Take to social

Share mental health awareness messages on Facebook, Twitter, and Instagram. While stigma is still a major barrier, seeing posts, and messages on social media allows those struggling with poor mental health to know that they have support. Advocating within our circles of influence helps ensure that these individuals have the same rights and opportunities as other members of our community. Showing respect and acceptance removes a significant barrier to successfully coping with their illness. Having people see them as people and not as an illness can make the biggest difference for someone who is struggling with their mental health.

To see what our community is doing about this health priority, view our Community Health Improvement Plan through the links on the right.

Mental Health Resources

HELP FOR MENTAL ILLNESS

FINDING HELP

GET HELP

Suicide Prevention Hotlines

LIFELINE

PREVENTION LIFELINE

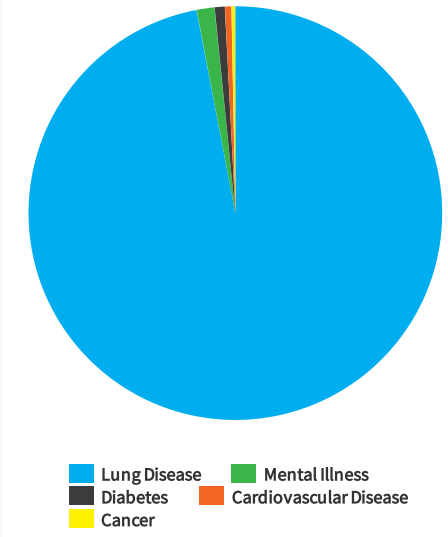
Community Health Improvement Plans

VIEW MERCY CHIP

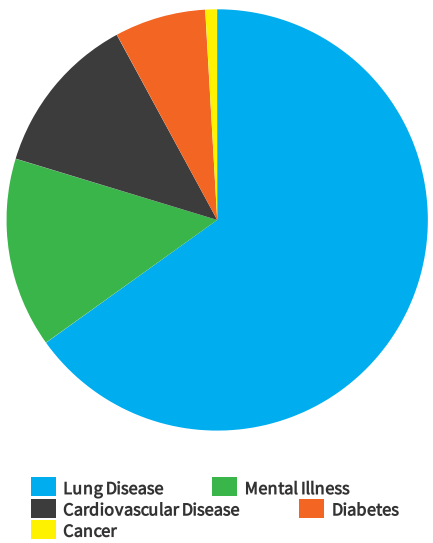
Mental Health Data

Hospital Data

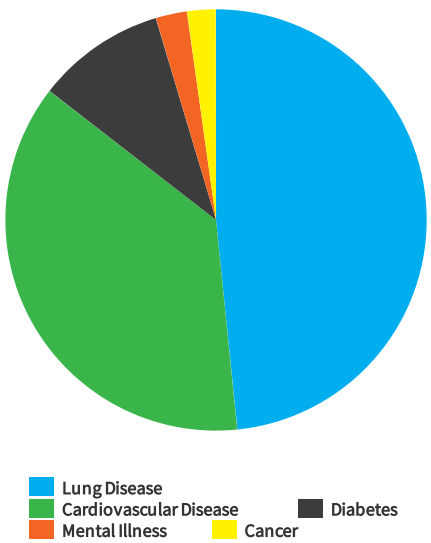
AHI-Related Diagnoses in Patients 0-17 Years Old in Mountain View Community ED



AHI-Related Diagnoses in Patients 18-64 Years Old in Mountain View Community ED

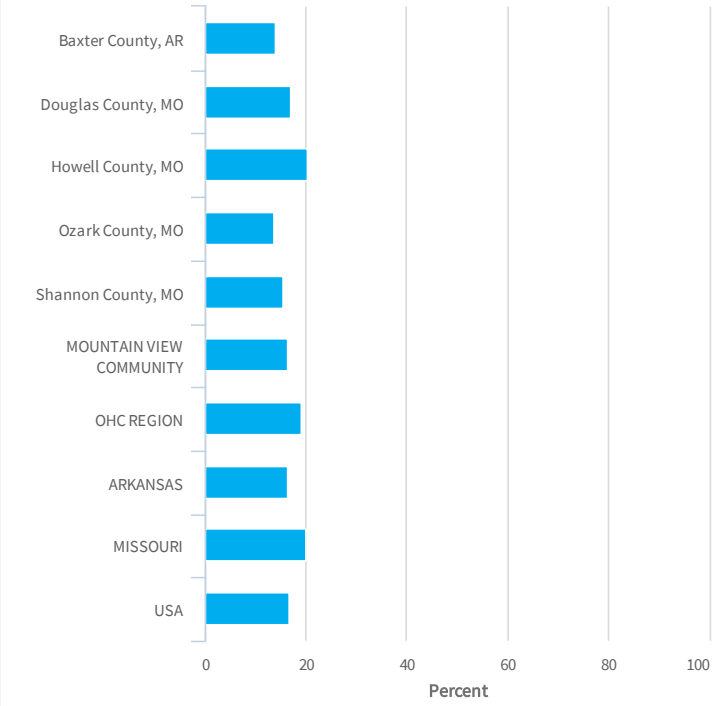


AHI-Related Diagnoses in Patients 65 and Older in Mountain View Community ED



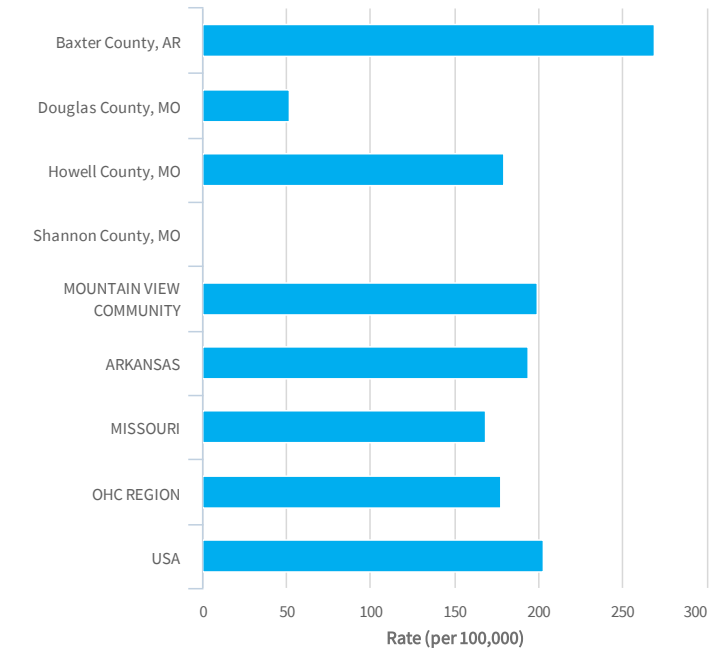
Community Data

Depression Rate in the Medicare Population



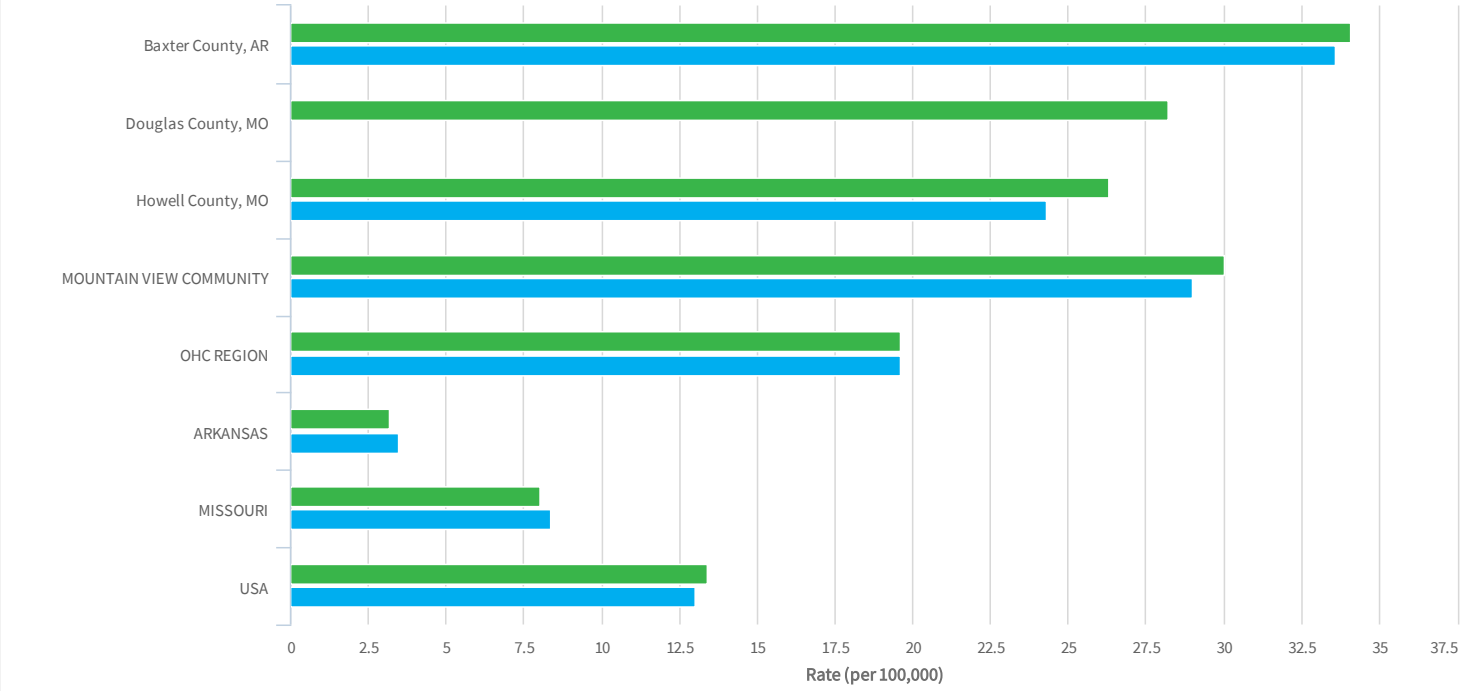
Percent with Depression. Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County

Access to a Mental Health Care Provider (Crude Rate & Age-Adjusted Rate)



Mental Health Care Provider Rate (Per 100,000 Population). Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2018. Source geography: County

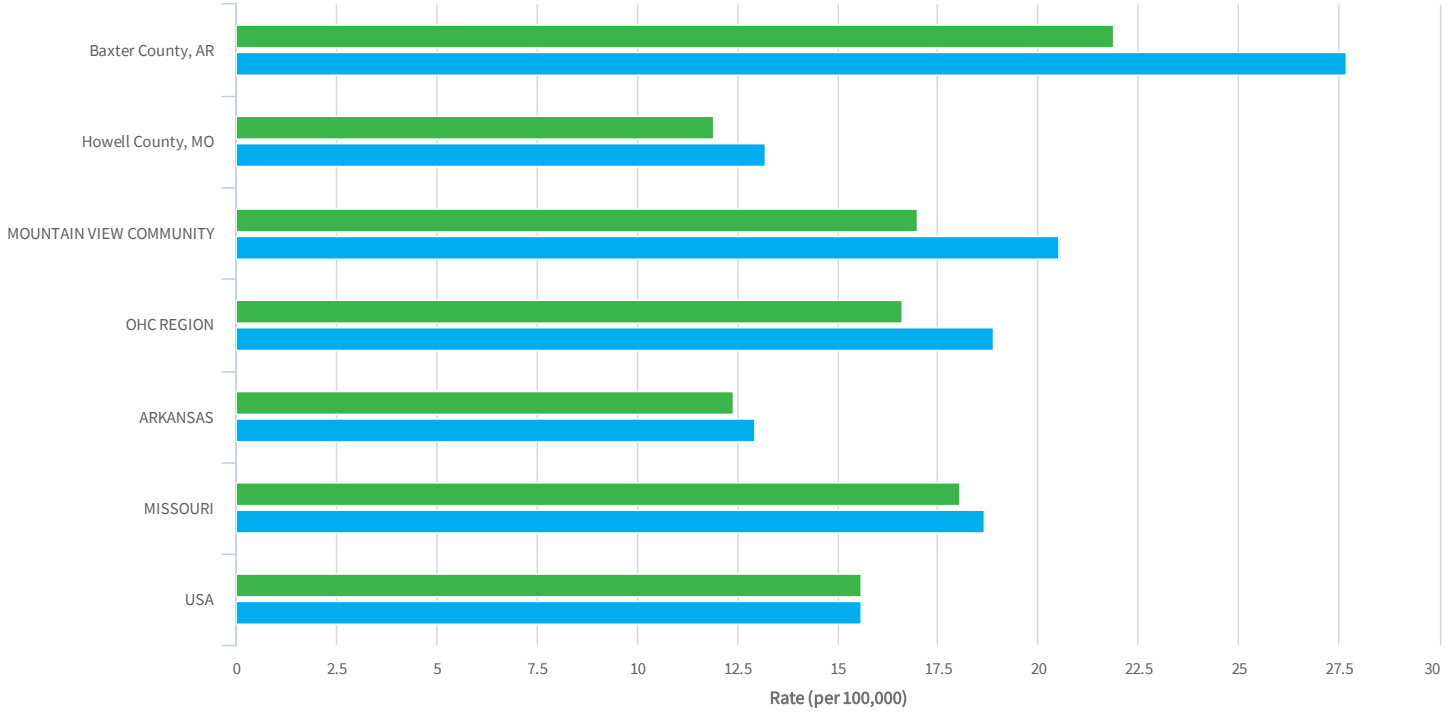
Suicide (Crude Death Rate & Age-Adjusted Death Rate)



Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

Crude Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

Drug Poisoning Mortality (Crude Death Rate & Age-Adjusted Death Rate)



Common Threads

Throughout this assessment, common threads often emerged in discussion around data and findings. While not explicitly identified as priority health issues, these common threads remained consistent across the Ozarks Health Commission (OHC) Region.

In studying these common threads, The Commission used the Socioecological Model[1] as a framework to examine the impact on health issues. The Socioecological Model recognizes a wide range of factors working together to impact health and includes influences at the individual, interpersonal, organizational, community, and policy levels. Each of these common threads can impact health issues at levels throughout the model. Community partners targeting to affect the common threads should consider action throughout the spectrum of the model. Throughout the common threads section, the Socioecological Model will be referenced to suggest possible strategies and provide context.

Socioecological Model[2]

[1] Centers for Disease Control and Prevention, http://www.cdc.gov/violenceprevention/overview/socialecologicalmodel.html
[2] Agency for Healthcare Research and Quality, http://www.ahrq.gov/professionals/prevention-chroniccare/resources/clinical-community-relationships-measures-atlas/ccrm-atlas3.html

Access to Appropriate Care

The understanding of and the ability to access appropriate care and treatment is critical to improve and maintain quality of life while reducing the burden of disease.

Accessing healthcare has always been a struggle within our country, and has long been recognized as an issue, especially for vulnerable populations. Out of this need, safety net providers, such as Federally Qualified Health Centers and Rural Health Clinics, have arisen. Additionally, various federal and state programs have been implemented and changed to provide increased access to care: most notably Medicare, Medicaid, and the Affordable Care Act. Despite numerous efforts, access to appropriate health care remains a concern for many. The OHC Region faces challenges to accessing care, with 16.84%—an estimated 576,000 people—without health insurance. Those without care face obvious health challenges since they are not as able to adequately treat acute issues or chronic diseases, resulting in further exacerbation of the condition, reducing quality of life, and resulting in early death.[3]

Accessing care can be a multi-faceted and complex challenge that spans all diseases and conditions and is closely connected with each of the six Assessed Health Issues. There is concerning data within the OHC Region. The rate of preventable hospital events considered to be ambulatory care sensitive in the OHC Region is 51.3 per 1,000 Medicare enrollees, compared with a national rate of 49.9. There are fewer primary care physicians in the OHC Region: 67.8 per 100,000, compared to the nation's rate of 87.8. Most alarming is the percent of people living in a designated Health Professional Shortage Area, which is 97.4%, compared to 33.1% of the national population.

The effect of a lack of access results in significant cost to both the individuals and communities. A 2014, Kaiser Family Foundation Report sums up the impact: "In 2013, the cost of 'uncompensated care' provided to uninsured individuals was $84.9 billon. Uncompensated care includes health care services without a direct source of payment. In addition, people who are uninsured paid an additional $25.8 billion out-of-pocket for their care."[4]

While having access to care is vital to improving treatment and health, accessing appropriate care is equally important. This certainly includes ensuring individuals have a plan to cover the cost of care and making sure that there is appropriate provider coverage in communities; however, another

[3] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
[4] Kaiser Family Foundation, http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-a-detailed-examination/

important component is changing the culture to understand how to access care appropriately. Too many times individuals are using the emergency department for non-emergent issues, as is shown in the primary hospital data. While everyone can use the emergency department for non-emergent issues, this makes the emergency department less efficient; the department, facility, and staff are designed to treat emergent health needs.

Improving access to appropriate care will require changes at multiple levels of influence, including individual, community, organizational, and policy levels, as indicated by the Socioecological Model. Efforts to address each assessed health issue should a) focus on improving the systems around the individual to improve health and access to appropriate care, and b) work to modify the way that individuals consume health services to ensure care is effective and efficient.

Social Determinants of Health

The interconnectedness of health, education, economic viability, housing, and quality of life impact an individual, family, and community's ability to thrive.

Throughout the world, our country, and in our own communities, there are factors existing that affect the ability of people to live a life that provides the best opportunity to be healthy. Health, as defined by the World Health Organization, can be considered a state of physical, mental, and social well-being and not merely the absence of disease or infirmity. In considering the interconnectedness of the multitude of factors that affect health for people, social determinants of health are often described. The Institute of Medicine suggests the following description:

> Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place."[5] In addition to the more material attributes of "place," the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable

[5] Gornick, Marian E., "Disparities in Health Care: Methods for Studying the Effects of Race, Ethnicity, and SES on Access, Use, and Quality of health care", http://www.iom.edu/~/media/Files/Activity%20Files/Quality/NHDRGuidance/DisparitiesGornick.pdf

housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

Improvements in population health may be achieved by assessing, understanding, and addressing root causes of poor health, which can often be traced to include the social determinants of health. This assessment analyzed the following social determinants of health:

- Unemployment
- Income level
- Poverty rate
- Population receiving SNAP benefits
- Population on Medicaid
- Free and reduced lunch rate
- Education level

Although there are other factors that affect health, these are some of the most widely used and accepted indicators of determining the health of a person. Achieving a state of health and desired quality of life requires economic stability, social and community connection, safe living arrangements, access to quality and appropriate health care, and much more. Just like many aspects of life that deal with resource availability, a good state of health is often associated with more readily available resources. Poor health or a lack of health affects each and every one of us by way of personal associations and community health achievement, which ultimately affects the ability of an individual and our community to thrive.

A good example of this is the employment sector. Employers struggle with recruiting and retaining individuals to work decent-waged jobs in some scenarios because potential employees struggle with unreliable transportation or health concerns caused by poor living conditions or lack of access to healthy foods. Communities can struggle to attract businesses that pay good wages and offer good jobs because employers do not want to reside in a place where the population is burdened by higher-than-average prevalence of poor health indicators such as high rates of tobacco use, obesity, heart disease, and lung disease. Businesses are attracted to communities where neighborhoods thrive, educational attainment is high, and employees are healthy and thriving—and therefore not a threat to the bottom line due to high health care costs as a result of preventable illness. The unemployment rate across the OHC Region (3.8%) varies by county, from 3% in Greene County, MO to 6.9% in Taney County, MO. For the OHC Region, the social determinants of health have improved since the previous report was published in 2016. The rate of families earning over 75,000 has increased from 25% to 29.29%. The rate of the population age 25 with an associate degree increased from 25% to 28.35%. The rate of the population age 25 or older without a high school diploma decreased from 16% to 12.83%.

Social determinants of health tell us a story about the way that people live and, by extension, how their lives affect the community. Ultimately, where we live, where we work, and our educational

attainment level have huge impacts on the quality and length of our lives. Communities that consider the health impacts of policy decisions can make a positive impact on the social determinants of health.

In considering how to apply the Socioecological Model to address the social determinants of health, it is important to understand that many of these factors are related, often in a cyclical fashion. For example, low education levels can lead to challenges finding and maintaining steady employment, which can lead to poverty, which can lead to a lack of access to educational opportunities. Armed with this understanding, the Socioecological Model can be applied to a single social determinant, such as education. Interventions should target multiple levels of influence. Yet, the greatest population health impact will be made when policy level changes are made to target the social determinants of health.

Tobacco Use

High prevalence in tobacco use results in some of the biggest health concerns related to lung disease, cardiovascular disease, and mental health. Interventions need to range from individual behavior change to policy change.

Awareness regarding the ill-health effects of tobacco use has grown significantly since the Surgeon General's Report on Smoking and Health published in 1964. The report laid the foundation for tobacco control efforts in the United States. However, as the leading cause of preventable death in the United States, there is still a great deal of work to be done.

According to the most recent Surgeon General's report published in 2014, smoking causes 87% of all lung cancer deaths, 32% of deaths due to coronary heart disease, and is responsible for 79% of all cases of chronic obstructive pulmonary disease. Nationally, 18% of adults are tobacco users. Within the OHC Region, 24.6% of residents use tobacco. Additionally, the prevalence in each of the six communities identified in this report is higher than the national average. In order to reduce the threat of death and poor quality of life among residents in the OHC Region, it is imperative that efforts are taken to reduce tobacco use.

While the evidence reveals that tobacco use can lead to complex physiological health issues, it can also complicate existing health issues. Those dealing with mental illness may smoke to curtail the severity of their mental health symptoms. According to the most recently published Centers for Disease Control and Prevention (CDC) vital sign report on smoking among adults with mental illness, 36% of adults with mental illness were current smokers, which is much higher than those without a

mental illness (21%). Additionally, 48% of people with a mental illness living below the poverty level smoke cigarettes.[6]

Although data does not currently exist for the OHC Region regarding tobacco use among adults with mental illness, it is safe to assume that smoking in this population is significantly high considering the high rates of depression (18.9% compared to 16.7% nationally) and poverty (18.09% compared to 15.11% nationally) in the region. People with mental illness may not have access to tobacco cessation services and may smoke more frequently than the general population. Therefore, it is important to monitor tobacco use across all subpopulations and use evidence–based interventions at multiple levels of influence.

According to the Socioecological Model, there are multiple levels of influence that affect a person's behavior. The levels of influence include individual, interpersonal, organizational, community, and public policy. Interventions targeting the individual level include: raising awareness about the harms of first, second, and third-hand smoke; providing tobacco cessation classes; and offering various modes of counseling to stay tobacco-free. Tobacco cessation classes may also serve as an interpersonal intervention because of the social support offered in a group setting. Organizational interventions may include tobacco-free workplace policies, as well as insurance companies increasing rates for tobacco users. At the community level, successful strategies include changing cultural norms through high-powered, cohesive, and consistent media campaigns. Finally, policy-level interventions have the greatest impact. Policy advocacy at the local, state, and national levels may include increasing tobacco tax, improving warning labels on tobacco products, implementing indoor air ordinances, regulating smoking in schools, and implementing comprehensive tobacco control programs.

Physical Activity and Nutrition

Good nutrition, regular physical activity, and a healthy body size are important in maintaining health and well-being and for preventing health conditions such as cardiovascular disease, diabetes, and cancer.

Obesity continues to be a growing issue for the physical and economic health of our nation. Currently, 27.5% of adults are obese, nationally. Within the OHC region, 32.2% of adults are obese.

[6] Centers for Disease Control and Prevention, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a2.htm?s_cid=mm6205a2_w

The ramifications for this can be severe. Obesity contributes to the exacerbation of many chronic conditions including cardiovascular disease, diabetes, and cancer. According to the CDC, chronic diseases are responsible for 7 out of 10 deaths each year and accounts for 86% of our nation's health care costs. The trending increase can be attributed to the American lifestyle, with most Americans eating more and moving less.

Regular physical activity improves overall health and well-being and reduces the risk of chronic diseases and obesity. More than 80% of adults and adolescents do not meet the guidelines for physical activity. People who are physically active tend to live longer and have lower risk for cardiovascular disease, diabetes, depression, and cancer. Physical activity can also help with weight control, and inactive adults have a higher risk for premature death.

Poor diets are not only a risk factor for obesity, but for other chronic diseases as well. For example, diets high in added sugar lead to health issues such as obesity, diabetes, and cardiovascular disease. High dietary fat intake is a risk factor for the development of high blood lipid levels, and high dietary salt intake is a risk factor for the development of high blood pressure. In turn, high blood lipid levels and high blood pressure are significant risk factors for cardiovascular disease and other chronic diseases. Fewer than 1 in 3 adults, and an even lower proportion of adolescents, eat the recommended amount of vegetables each day.

As the Socioecological Model describes, there are multiple levels of influence that affect a person's behavior. Interventions targeting the individual level include raising awareness about the harms of obesity, proper nutrition, and the importance of regular physical activity. Exercise and nutrition classes may also serve as an interpersonal intervention because of the social support offered in a group setting. Organizational interventions may include healthy food policies, such as vending machine policies. At the community level, successful strategies include changing cultural norms through a pedestrian-friendly community that encourages walking and biking to essential resources and addressing food access concerns. Finally, policy level interventions have the greatest impact. Policy advocacy at the local, states, and national levels may include increasing sugary beverage taxes, nutrition labeling, regulating food advertisement, regulating nutrition, and physical activity policies in schools, and implementing complete streets ordinances or bicycle and pedestrian friendly policies.

Mental Health

Mental health is inextricably linked to physical health. Poor mental health can have an impact on behaviors that result in poor physical health.

The linkages between mental health conditions and physical health are still not totally understood. It is tempting to make clear distinctions between the body and the mind, but evidence continues to emerge that we should not ignore this interconnectedness and that we must acknowledge that the two cannot be thought of as separate. We must also acknowledge that there is not a simple model that explains this relationship. Metaphorically, we cannot answer which comes first, the chicken or the egg. Poor physical health can lead to poor mental health. Conversely, poor mental health can contribute to behaviors that increase one's risk for chronic health conditions.

Mental health is a common thread in many chronic health conditions. Depression has been linked to higher rates of cardiovascular disease and diabetes. Additionally, persons with depression tend to engage in more risk behaviors for these diseases—such as smoking, poor diet or lack of exercise—than persons without depression.[7] A 2006 study suggests that 80% of those diagnosed with schizophrenia use tobacco products.[8] A growing body of evidence suggests that the lack of social connectedness, particularly in older adults, contributes to poor health outcomes.

While the relationship between mental health and physical health is becoming clearer, those connections remain murky and solutions to treating the mind and body together remain elusive. But what is becoming clear is that we can no longer largely rely on providing treatment for mental health issues through our emergency departments and our criminal justice system. Mental health issues need to be addressed before crisis is reached. Community leaders need to evaluate the causes of mental illness and take preventive measures to ensure that people live in an environment that contributes to stability of body and mind.

[7] Katon WJ., "Clinical and health services relationships between major depression, depressive symptoms, and general medical illness", http://www.ncbi.nlm.nih.gov/pubmed/12893098
[8] Keltner, Norman L.; Grant, Joan S., Perspectives in Psychiatric Care - "Smoke, Smoke, Smoke That Cigarette", http://onlinelibrary.wiley.com/doi/10.1111/j.1744-6163.2006.00085.x/abstract

Process

The assessment process builds on the methodology developed during the 2016 Regional Health Assessment. It includes more than 140 hospital and community data indicators. This data was compared to the nation and past performance and used to create the six Assessed Health Issues (AHI).

VIEW FULL METHODOLOGY

These Assessed Health Issues are:

VIEW AHI DATA

The hospital data, which includes information from both Emergency Departments and clinical quality measures, provides greater insight and understanding to the acuity and severity of the AHI within the community. The assessment also used broad-based community input via a survey. Those results are represented under Local Input below. With all of the data collected, as well as consideration for feasibility and readiness of the community to address those issues, local stakeholders decided upon community priorities.

Each of these elements is represented in a prioritization process, which examines 14 factors for each AHI. Community leaders used the information to build consensus while identifying the priority health issues.

VIEW PRIORITIZATION MATRIX

Hospital Data

One of the unique aspects of the Ozarks Health Commission (OHC) Regional Health Assessment (RHA) is the collection of data from partnering hospitals. Hospital data provides a more real-time evaluation of community health needs than secondary data, which lags three to five years.

VIEW HOSPITAL DATA

Additionally, it allows the OHC to study specific health needs in relation to the AHI in each community. This approach assists in determining priority health issues and developing strategic Community Health Improvement Plans (CHIPs) that align with the strengths of healthcare, public health, and community-based agencies.

To supplement population health data with more timely and in-depth information concerning the OHC Region populations, two types of primary hospital information were utilized: Emergency Department (ED) and Merit-Based Incentive Payment System (MIPS) data. This section of the report details demographic and payer information of all ED patients, as well as those presenting with health issues relating to the AHI.

Community Data

The compilation and analysis of secondary community health data was key to informing the selection of health issues to assess and prioritize. Key indicators that were identified through the 2016 assessment, as well as indicators that performed more poorly than the nation were reviewed and grouped accordingly. This process produced the same set of AHI and Common Threads as were identified in 2016. Data sources included the 2016 Missouri Student Survey County Reports, 2016 Arkansas Prevention Needs Assessment Survey, and the Department of Health and Senior Services – MOPHIMS, Cancer Incidence MICA. Community Commons served as a warehouse for much of the data used.

VIEW COMMUNITY DATA

Local Input

In addition to secondary and hospital data, the assessment garnered community feedback through the dissemination of a survey that captures perspective on the importance of the AHI to the community.

VIEW LOCAL INPUT DATA

Methodology

Introduction

For the 2019 assessment, the Ozarks Health Commission (OHC) built on the methodology developed for the 2016 assessment. The approach combines secondary data, hospital data, and community feedback on several levels to guide the prioritization process. The core data in the assessment is secondary community health indicators, which are available across various publicly available datasets. In addition to the secondary data, the hospital systems pulled data from their emergency departments and clinical quality measures to provide a more in-depth and timely examination of the Assessed Health Issues (AHI). The OHC then gathered community input and feedback by conducting a survey and hosting community key partner meetings to provide additional perspectives on the AHI.

Throughout the primary and secondary data collection, the OHC steering committee provided direction, feedback, and guidance; detailed research and analysis efforts took place within several subcommittees. The subcommittees completed work on secondary indicators, survey development, hospital data, and health issues and prioritization. The majority of the work completed by the subcommittees happened concurrently, between October 2017 and December 2018. The following sections detail these processes and findings of the data components of the assessment.

Secondary Data Process

A subcommittee on community health secondary data indicators was formed to identify indicators, collect and compile relevant data, and conduct a review of the findings. The subcommittee was comprised of public health partners from the steering committee. The subcommittee began their work in the Fall of 2017 and completed work in June 2018. The subcommittee focused on the primary collection point of data that was used for the first assessment, which was Community Commons, through the Community Health Needs Assessment portion of the website. A Community Health Needs Assessment report was run for each Community and the OHC Region in October 2017 and May 2018. Additional data was also collected from the 2016 Missouri Student Survey County Reports, 2016 Arkansas Prevention Needs Assessment Survey, and the Department of Health and Senior Services – MOPHIMS, Cancer Incidence MICA.

As the secondary data was collected and compiled, it was aggregated into the OHC Communities and placed into comparison charts to allow for a side-by-side examination of the data between Communities, the OHC Region and the nation. The subcommittee first reviewed the key indicators that were identified through the 2016 assessment. Then the subcommittee reviewed all other indicators that performed more poorly than the nation and examined the relevance and significance to determine if any key indicators should be added. The indicators were then grouped into related indicators. These produced the same set of AHI and Common Threads as were identified in 2016. After the data was

reviewed, the subcommittee provided their findings to the steering committee. The following are the key findings of the secondary community health indicators.

Identifying Health Issues

A subcommittee was formed to review, update, and finalize the process of identifying and prioritizing the health issues for the OHC Region and Communities. This subcommittee included representation from public health; they began meeting in January 2018 and concluded their work in April 2018. The secondary data key findings revealed that the OHC Region is under-performing in 37 indicators. These indicators highlight the areas of health and risk factors that the OHC Region experiences more challenges to improved health than the rest of the nation.

During the 2016 assessment, the under-performing indicators were examined and placed into similar groupings to create health issues. This process identified seven groupings that the OHC Region considered AHI and two additional groups for social determinants of health and access to care. Then the subcommittee identified associated indicators and placed them into their group. For example, high blood pressure and cholesterol, as well as other health issues related to the cardiovascular system, were collapsed into "cardiovascular disease". If relevant, an indicator was used in multiple groupings.

The seven AHI were: Cancer, Cardiovascular Disease, Lung Disease, Oral Health, Mental Health, Maternal and Child Health, and Diabetes. During this process, the subcommittee decided to remove the Maternal and Child Health grouping and place this category under population of interest.

The subcommittee concluded the process by reviewing the AHI scoring process. The scoring matrix includes key data points from secondary data, hospital data, and community perspective providing a more thorough examination of the AHI. The following sections outline the AHI and social determinants of health and the scoring process.

AHI Defined

Cancer

- Incidence-Lung, Colon & Rectum, and Cervical Cancer
- Mortality-Cancer
- Tobacco use
- Cancer screenings: mammograms, cervical, sigmoidoscopy or colonoscopy

Cardiovascular Disease

- Heart disease and stroke mortality
- Elevated blood pressure
- Elevated cholesterol levels

- Heart disease morbidity
- Obesity and Overweight
- Physical inactivity
- Fruit/veggie consumption
- Tobacco use (adult and youth)

Diabetes

- Diabetes prevalence
- Screening - A1c Test
- Obesity and Overweight
- Fruit/vegetable consumption
- Physical Inactivity

Lung Disease

- Mortality – Lung Disease
- Asthma prevalence
- Tobacco use (adult and youth)
- Physical Inactivity

Mental Health

- Suicide
- Depression
- Access to Mental Health Providers
- Mortality – Drug Poisoning

Oral Health

- Dental care utilization
- Poor dental health
- Access to dentists

Social Determinants of Health

- Families Earning Over $75,000
- Per Capital Income
- Poverty – Population Below 100% and 200% FPL
- Children Eligible for Free/Reduced Price Lunch
- Percent Population Age 25 with Associate Degree or Higher

- Percent Population Age 25 and older without a high school diploma

Access to Care

- Uninsured Adults
- Preventable Hospital Events
- Access to Primary Care
- Population Living in a Health Professional Shortage Area
- Lack of a consistent Source of Primary Care
- Access to Dentists
- Dental Care Utilization
- Access to Mental Health Providers

Hospital Data

One of the unique aspects of the Ozarks Health Commission (OHC) Regional Health Assessment (RHA) is the collection of data from partnering hospitals. Hospital data provides a more real-time evaluation of community health needs than secondary data, which lags three to five years. Additionally, it allows the OHC to study specific health needs in relation to the AHI in each community. This approach assists in determining priority health issues and developing strategic Community Health Implementation Plans (CHIPs) that align with the strengths of healthcare, public health, and community-based agencies.

To supplement population health data with more timely and in-depth information concerning the OHC Region populations, two types of primary hospital information were utilized: Emergency Department (ED) and Merit-Based Incentive Payment System (MIPS) data. This section of the report details demographic and payer information of all ED patients, as well as those presenting with health issues relating to the AHI.

The 29-county OHC Region is divided into six Communities, which each contain one or more hospitals. The table below outlines the counties and hospitals with an Emergency Department (ED) in each Community.

Community	**Counties**	**Hospital ED**
Branson	Boone, Carroll, Stone, Taney	CoxHealth Branson, Mercy Berryville
Joplin	Barton, Cherokee, Crawford, Jasper, Labette, McDonald, Newton, Ottawa, Vernon	Freeman Health System Joplin, Freeman Health System Neosho, Mercy Columbus, Mercy Carthage, Mercy Joplin
Lebanon	Camden, Dallas, Laclede, Pulaski, Texas, Wright	Mercy Lebanon

Monett	Barry, Lawrence	CoxHealth Monett, Mercy Aurora, Mercy Cassville
Mountain View	Baxter, Douglas, Howell, Ozark, Shannon	Mercy St. Francis
Springfield	Christian, Greene, Webster	CoxHealth South, CoxHealth North, Mercy Springfield

The RHA included the collection and analysis of hospital data which was aggregated. Findings are reported in the data and findings portion of the report. A subcommittee of the OHC, the primary data subcommittee, worked to identify and agree upon hospital datasets to include in the assessment. The primary data subcommittee—comprised of hospital representatives from all three partnering health systems and public health representatives—reviewed indicators and collection methods used in the 2016 RHA. To supplement population health data with more timely and in-depth information concerning the OHC Region populations, two types of primary hospital information were utilized: Emergency Department (ED) and Merit-Based Incentive Payment System (MIPS) data.

Emergency Department Data

The ED methodology is similar to that of the 2016 RHA, focusing on all visits by patients through emergency departments. This approach provides the opportunity to assess potential health disparities across patient groups, as well as assess the prevalence of mental illness within emergency departments.

The following ED visit data was collected for calendar year 2017:

- ED Only vs ED Admitted
- Top 20 Patient Home Zip Codes
- Emergency Severity Index
- Principal Diagnosis Group
- Age Groups
- Principal Diagnosis Group, Age 0-17
- Principal Diagnosis Group, Age 18-64
- Principal Diagnosis Group, Age 65+
- Payer Group
- Payer Group, by Principal Diagnosis Group
- Race
- Race Groups (Top 5) by Principal Diagnosis
- ED Visits with a Behavioral Health (BH) Principal Diagnosis by Top 20 Coded Diagnosis *(Repeat above for those with BH Principal Diagnosis)*
- ED Visits with a BH Secondary Diagnosis (non BH Principal) by Principal Diagnosis Group *(Repeat above for those with BH Secondary Diagnosis)*

The first three digits of ICD-10 diagnosis groups were used to ensure consistent data collection across health systems. Behavioral diagnoses were specified as ICD-10 Codes for Mental, Behavioral, and

Neurodevelopmental Disorders (F01-F99). In order to aid in efficient aggregation of ED data, each health system completed a standardized report template and submitted this to the Springfield-Greene County Health Department.

Clinical Data

The subcommittee determined that the addition of clinical data enhanced the assessment of health care utilization and established a baseline for quality improvement activities. After considering several nationally reported measures, Merit-Based Incentive Payment System (MIPS) data was selected.

Specifically, the following MIPS clinical quality indicators were selected for their alignment with the AHI identified by the secondary data subcommittee to be reported for calendar year 2017 by each health system:

- Cancer — Colorectal Cancer Screening (CMS 124)
- Cardiovascular Disease — Controlling High Blood Pressure (CMS 165)
- Diabetes — Diabetes HbA1c Poor Control (CMS 122)
- Lung Disease — Tobacco Use Screening and Cessation Intervention (CMS 138)
- Mental Health — Screening for Depression and Follow-Up Plan (CMS 2)

Aggregation & Analysis

SGCHD combined the health systems' ED data sets, and separately aggregated MIPS data sets. Data is reported for the entire OHC Region, as well for OHC Communities where more than one health system operates. In Communities where only one facility or one system is present, the information is reported alone. Community information is presented as a percent or rate, not as whole numbers or visit counts.

The primary data subcommittee analyzed the aggregated data for an improved understanding of population level health disparities, as well as the severity and impact of Assessed Health Issues on the region's EDs, as well as the quality emphasis of provider clinics. This data, along with community input, is combined with other data sources to help to determine health priority issues.

Local Input Survey

In order to engage community residents in the community health needs assessment process, Ozarks Health Commission partners agreed in May 2018 to administer a survey across the entire region. A subcommittee drafted the survey, which the steering committee reviewed to aid in a better understanding of the intent of the questions. For example, it was important to gain feedback on assessed health issues. So, respondents were asked to rate the importance, on a scale of one to four, of the following health issues addressed in each community: oral health, lung disease, mental illness, cancer, smoking, maternal and child health, and finally the opioid epidemic. The data received from that question was used in the prioritization process.

Over a two-month period the survey was refined with a focus on obtaining community feedback to address the assessed health issues identified through public health and hospital data. Basic demographic information collected included county, age, gender, race/ethnicity, educational attainment, employment status, household income, the presence of children in the home, housing status, and health rating and diagnosis information. To assure the survey was developed effectively, unbiased, and provided in both English and Spanish, the subcommittee received guidance and translation services from Drury University. The survey and its findings can be found in the data and findings portion of the report.

Survey Administration

Between June and August 2018, Survey Monkey was used to collect and compile the majority of survey data, and paper surveys were made available to those who faced electronic barriers to completing it online. The survey was developed not only to find geographical data, but to find data related to the respondent's health care needs and what the barriers to those needs might be. Individual partner organizations were asked to promote the survey via email, networking, social media, and point of service within facilities. Incentives were not offered to participants at any point of survey collection. Preliminary results were collected at the beginning of August, with final results analyzed later that month.

Health Indicator Scoring – Prioritization

To determine the process for prioritizing assessed health issues, the subcommittee began by reviewing the process that was developed for the 2016 assessment. For that assessment, information from Kaiser Permanente and the National Association of County and City Health Officials (NACCHO) were used as guides. The subcommittee identified Hanlon's Method as the best fit with the assessment process because it is ideal when health issues are considered against multiple criteria but recognized that modifications were needed to better fit the process, data, and Communities within the assessment. The resulting "Prioritization Matrix" was created to score the identified AHI.

Prioritization Matrix Components

The Prioritization Matrix consists of two scoring themes: data and input from the community. The data used includes morbidity and mortality data, morbidity and mortality trend data, morbidity and mortality comparison to national rates, hospital emergency department data, and clinical quality measure data. Community input includes broad-based community input on the AHI and community stakeholder input on the community feasibility and readiness to change the issue. With each factor that is mentioned, a score based on the data/feedback was given a score of 1-4, with the higher scores representing information that suggests the need for prioritization of the issue.

The AHI receives a rank between one and four, with a rank of one being the best performing and four being the worst performing in comparison to the national benchmarks. A regional MIPS measure receives the following rank if it falls in that ranks corresponding decile:

Regional MIPS Measure Rank	Benchmark Decile
4	4, 3, <3
3	5, 6
2	7, 8
1	9, 10

As indicated in the table above, the MIPS measures for each of the AHI received the highest or worse score in comparison to the national benchmarks.

Morbidity

Morbidity (also commonly referred to as prevalence) evaluates how common the health issue is in a population. Typically, it is represented as a percentage of the population with the health issue. For health issues without available prevalence data, the incidence rate was used. There are multiple indicators that are within the defined health issues. When multiple indicators define the health issue each indicator is scored and the average of all indicator scores create the overall morbidity score. The morbidity data is based on the NACCHO health assessment information[1]. Incidence data thresholds were created by the subcommittee, which based the top category on an incidence rate that would create a prevalence of five percent within a ten-year period.

Score	Prevalence	Incidence (per 100,000)
4	≥25%	> 500
3	10% - 24.5%	250 - 499
2	1% - 9.9%	100 - 249
1	<1%	< 100

Mortality

Death rates (mortality) are used to evaluate long-term impact and severity of a health issue to a community. As with prevalence, multiple indicators may be used to represent the health issue. The score was based on taking the region's highest mortality rate (heart disease 211 per 100,000) and creating quartiles.

Score	Severity/Seriousness
4	*>158.25*
3	*105.5 – 158.25*
2	*52.75 – 105.5*
1	*<52.75*

Morbidity and Mortality Trend

Examining the trend data for morbidity and mortality provides additional information on whether a health issue continues to be an issue in the communities and should be a priority. Percent difference

[(community rate 2015 – community rate 2018)/community rate 2018] is used to understand how the community rates have changed from 2015 to 2018. The 2015 data was recalculated to represent the current OHC Region footprint.

Score	Percent Difference
4	>10% Increase
3	<10% increase
2	<10% decrease
1	>10% decrease

Morbidity and Mortality Comparison to National Rate

In addition to knowing the morbidity and mortality rate in a community, further comparing the rate to the nation provides additional information on whether a health issue should be prioritized. Percent difference [(community rate – national rate)/national rate] is used to understand how the community rates differ from the national rates. Applying percent difference instead of simply relying on the difference between community and national rates provides more consistent and accurate comparisons across categories. The subcommittee developed the four thresholds and used a consensus approach to develop the thresholds.

Score	Percent Difference
4	>25% higher than national rates
3	11% - 24% higher than national rates
2	1% - 10% higher than national rates
1	≤ national rates

Hospital Data: Emergency Department

Secondary data provides a robust look at health indicators and health issues in a Community, but there are certain limitations to exclusively using secondary data to determine health priorities. Most notably, secondary data typically lags three to five years, raising concerns whether the data is too dated to fully represent the health issue. Layered primary data from hospital systems helps to provide greater confidence in the process and final conclusions/health priorities. The primary data used in this process comes from individual hospital Emergency Departments and Clinics from throughout the Region. Visits to the Emergency Department and Clinics were classified by the Principal Diagnosis Group (using ICD-10 coding). The visits based on Principal Diagnosis Group were tabulated for each Community. The Principal Diagnosis Groups were then associated with Health Issues (e.g. Diseases of the Respiratory System and Lung Disease). The primary data score was then based on the percent of Emergency Department visits and Clinical visits associated with identified AHI.

Score	Percent of Visits Associated with Health Issues
4	>25% of visits

3	11% - 24% of visits
2	1% - 10% of visits
1	< 1% of visits

Hospital Data: Clinical Quality

Metrics from the Merit-Based Incentive Payment System (MIPS) were selected to enhance the assessment of health care utilization and establish a baseline for quality improvement activities across the region. The table below outlines the selected MIPS clinical quality indicators, their alignment with the AHI, and their descriptions. To align with the ED data analysis, oral health was not included in the selection and evaluation of MIPS measures.

Score	Measure	Measure Description
Cancer	Colorectal Cancer Screening (CMS 130)	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
Diabetes	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (CMS 122)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
Mental Disorders	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan (CMS 2)	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen
Lung Disease	Preventative Care & Screening: Tobacco Use: Screening and Cessation Intervention (CMS 138)	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
Cardiovascular Disease	Controlling Hypertension (CMS 165)	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period

Each OHC partnering health system provided the selected MIPS metrics for their service area within the Region. The metrics were aggregated to create scores for the Region and then ranked according to their performance in comparison to national benchmarks. The table below outlines the following:

- AHI
- MIPS Quality Measure corresponding to selected AHI
- MIPS score for the Region
- MIPS national average
- Decile range and decile in which the Region MIPS score falls

- Benchmark range, or the score for the tenth decile for its respective measure
- Rank of the AHI

AHI	MIPS Quality Measure	Region (%)	MIPS Average (%)	Decile Range	Decile	Benchmark (BM) Range	Rank
Cancer	Colorectal Cancer Screening	46.55	60.90	46.82 - 51.65	<3	>= 80.95	4
Cardiovascular Disease	Controlling Hypertension	63.33	66.50	60.41 - 64.27	4	>= 79.74	4
Diabetes	Hemoglobin A1c Poor Control (>9%)	28.19	22.00	33.33 - 23.54	3	<=3.33	4
Lung Disease	Tobacco Use: Screening and Cessation Intervention	70.96	86.20	82.06 - 86.04	<3	>= 99.32	4
Mental/ Behavioral Health	Screening for Clinical Depression and Follow-up Plan	29.94	65.30	29.28 - 65.00	4	100.00	4

Local Input Data

The survey had a total of 2,525 responses. Of these responses, 2,478 (98%) were in English and 44 (2%) were in Spanish. Respondents were asked to indicate the county where they receive the majority of their health care. Three counties: Jasper County, MO (38%); Greene County, MO (26%); and Newton County, MO (16%) led the way with a combined 81% of the overall total. Note that this is not necessarily indicative of which county these individuals actually reside in, as both the Springfield and Joplin areas are home to large regional health care providers.

The following is a brief review of survey findings. Of the respondents, 83% were female; 58% were 46 years of age or older; 91% identified themselves as white, 4% as Hispanic or Latino; 39% reported having children under the age of 18; 66% were married or in a domestic partnership; and, overall, the group was highly educated with 51% having a Bachelor's degree or higher compared to 15% with a high school diploma or less. Only 5% of those taking the survey reported themselves as unemployed and self-pay/uninsured. Home ownership was reported by 76% of those surveyed.

- Mental illness (75%), maternal and child health (64%) and opioid abuse (63%) were the top three health issues rated as "really important" that survey participants felt needed to be addressed in their community.

- When asked to list their three most important factors for a "Healthy Community" respondents most often selected access to health care (49%), low crime/safe neighborhoods (47%) and good jobs and healthy economy (47%). Other factors scoring high included good schools (32%) and healthy behaviors and lifestyles (29%).
- The large majority (88%) of respondents rated their own health as either healthy or very healthy. Only 1% of those surveyed rated themselves as very unhealthy.
- The primary barrier preventing respondents from using health services was cost (43%), with insurance doesn't cover service (21%) and lack of providers (10%) also frequently cited.
- A total of 4% of respondents reported living without stable housing either currently or at some point within the past two years.
- The majority of those surveyed (77%) denied any exposure to secondhand smoke. When exposure was reported, 15% of the time it was attributed to exposure from restaurants and other businesses. Secondhand smoke exposure at home was reported by only 9% of those surveyed.

Feasibility to Change the Issue

Feasibility to change evaluates the complexity of the issue, the control the community has over the issue, and the understanding of a path for implementation. Issues with a clear, evidence-based approach and those which can be solved by addressing a single issue are viewed as more feasible to change, whereas ones that are multi-faceted or with no clear approach to change are viewed less feasible. To illustrate, mental health is a multi-faceted health issue with no clearly defined path to make significant improvements in a limited time frame. The subcommittee based the categories on information found within the NACCHO Guide to Prioritization Techniques[1] and used community experience of subcommittee members to determine definitions and thresholds for the categories. Contrary to the first two ranking criteria, "Feasibility to Change the Issue" and "Community Readiness to Change" are to use a more broad and inclusive examination of the health issue in the community, rather than focusing on a single indicator.

Score	Feasibility – Complexity of the Issue
4	Single health issue that can be improved in 2-3 years
3	Multi-faceted health issue that can be improved in 2-3 years
2	Single health issue that cannot be improved in 2-3 years
1	Multi-faceted health issue that cannot be improved in 2-3 years

[1] https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

Issues that can be addressed at a local level are viewed to be more feasible to change, whereas issues that are not controlled by the community are viewed as less feasible to change. To further illustrate, access to care is largely impacted by whether or not a community has expanded Medicaid, which is not feasible for an individual community to change.

Score	Feasibility – Level of Control at Local Level
4	Local control to create policy or system change
3	Some local control to create policy or system change
2	Little local control to create policy or system change
1	Unknown level of control

A community that has developed a clear path based off of their understanding of the issue is viewed to be more likely to change, whereas a community with no understanding or path are less likely to change.

Score	Feasibility – Clear Path for Implementation
4	Clear path of what is needed and is currently in place or development
3	Clear path of what is needed, but no current efforts in development or early in development
2	Moderate understanding of what is needed, but no efforts are in development
1	Unknown or no understanding about what efforts are needed

Community Readiness to Change

Community readiness to change evaluates both the community and organizations within the community's readiness to impact the issue. Organizations that have efforts or funding already in place to address an issue are more ready to impact change. Communities that have both key organizations serving as a backbone for a health issue and community collaboration that is moving in parallel and coordinated fashion are more closely following the Collective Impact Model[3], which provides an effective approach to advance progress around community issues. This approach was developed by the steering committee, which based the standard on the Collective Impact Model and used a consensus approach determine the breakpoints for scoring.

Score	Readiness – Current Organizational Leadership
4	Current community organizational leading with the capacity and experience in addressing the issue
3	Current community organization leading but with limited capacity and experience in addressing the issue
2	No current community organization leading the effort
1	Organization leadership unknown

A community with collaborative efforts already underway is more likely to adopt health priorities and impact change. Priority was placed on having community collaboration already in place due to the fact that this component of change can take longer and be more challenging to put into place that an organization's focus.

Score	Readiness – Coordinated Community Efforts
4	Formal community partnership in place with evidence of success
3	Formal community partnership in place but with limited success
2	Informal community partnership or no community coordinated efforts
1	Community partnership unknown

These criteria provide the scores for each health issues, which were then used by community stakeholders to build consensus and select priority health issues. For the factors related to feasibility and readiness to change, Communities used a consistent process to collect input from partners and build consensus. The subsequent section outlines this process.

Process to Build Consensus of the Feasibility and Readiness for Assessed Health Issues and the Selection of Priority Health Issues

There are two main components of the prioritization process: a quantitative element that includes data from secondary, hospital data sources, local input survey, and a qualitative element that includes community perception on the feasibility and readiness for community change. Within each of these elements in the prioritization process, multiple factors are included and are used to create scores based on the data and perceptions of need. While the quantitative elements of this process are collected through the compilation and analysis of data, the qualitative elements needed to be collected through discussion and gathered input from the community. By engaging with a group of community stakeholders, the objective process for determining priorities includes community perspective, which helps ensure that the best fit priorities are selected. The following process describes how the Ozarks Health Commission collected input and perspective in various communities on feasibility and readiness to change, as well as building consensus for the health priorities.

Gathering & Informing the Stakeholders

Communities with the Ozarks Health Commission region used a variety of approaches to determine and assemble stakeholders. The most common approaches were to use an existing group of community members and/or leaders that are already meeting to focus on health, and to recruit a group of community members and/or leaders to meet. In either approach, a group of stakeholders were sought out, including members of various sectors and demographic groups. Groups typically consist of ten to twenty-five individuals.

As the groups were convened the first priority is to describe the purpose and assessment processes that have been used to identify the assess health issues and inform the stakeholders of the quantitative results that inform the prioritization process. These results focus on key indicators and their ranked score associated with each assessed health issue. The presentation of the results included both handouts and/or presentations describing these elements.

Facilitating Discussion around Feasibility and Readiness

A member of the Ozarks Health Commission or close community partner facilitated discussion with the gathered stakeholders around the issues of feasibility and readiness with each of the assessed health issue. The following was the discussion guide and questions to prompt discussion.

There are five components that will be rated by the community stakeholders for each of the six assessed health issues identified within the Ozarks Health Commission region. Within Feasibility to Change there are three components to be rated: Complexity of the Issue, Level of Control and the Local Level, and a Clear Path for Implementation. Within Readiness to Change there are two components to be rated: Current Organizational Leadership and Coordinated Community Efforts. Each of the five components were described and then discussion around each component for each health issue will be discussed. The following descriptions from the process for prioritization matrix were used:

Complexity of the Issue: Feasibility to change evaluates the complexity of the issue, the control the community has over the issue, and the understanding of a path for implementation. Issues with a clear, evidence-based approach and those which can be solved by addressing a single issue are viewed as more feasible to change, whereas ones that are multi-faceted or with no clear approach to change are viewed less feasible. To illustrate, mental health is a multi-faceted health issue with no clearly defined path to make significant improvements in a limited time frame. The subcommittee based the categories on information found within the NACCHO Guide to Prioritization Techniques[2] and used community experience of subcommittee members to determine definitions and thresholds for the categories. Contradictory to the first two ranking criteria, “Feasibility to Change the Issue” and “Community Readiness to Change” are to use a more broad and inclusive examination of the health issue in the community, rather than focusing on a single indicator.

Level of Control at Local Level: Issues that can be addressed at a local level are viewed to be more feasible to change, whereas issues that are not controlled by the community are viewed as less feasible to change. To further illustrate, access to care is largely impacted by whether or not a community has expanded Medicaid, which is not feasible for an individual community to change.

[2] National Association of County & City Health Officials, http://archived.naccho.org/topics/infrastructure/CHAIP/upload/Final-Issue-Prioritization-Resource-Sheet.pdf

Clear Path for Implementation: A community that has developed a clear path based off of their understanding of the issue is viewed to be more likely to change, whereas a community with no understanding or path are less likely to change.

Current Organizational Leadership: The community readiness to change evaluates both the community and organizations within the community's readiness to impact the issue. Organizations that have efforts or funding already in place to address an issue are more ready to impact change. Communities that have both key organizations serving as a backbone for a health issue and community collaboration that is moving in parallel and coordinated fashion are more closely following the Collective Impact Model[3], which provides an effective approach to advance progress around community issues. This approach was developed by the steering committee, which based the standard on the Collective Impact Model and used a consensus approach determine the breakpoints for scoring.

Coordinated Community Efforts: A community with collaborative efforts already underway is more likely to adopt health priorities and impact change. Priority was placed on having community collaboration already in place due to the fact that this component of change can take longer and be more challenging to put into place that an organization's focus.

Rating Feasibility and Readiness

As the facilitated discussion takes place around each health issue, community stakeholders individually rate the varying factors on the scale provided earlier in this section of the report. This rating was performed either as each individual component (e.g. complexity of health issue) was discussed, as each element was discussed (e.g. all components within feasibility), or at the end of the entire discussion for a health issue. To collect the ratings, communities could use a variety of methods including paper rating sheets or completion of an online survey, such as Survey Monkey or Kahoot. Additionally, Communities could receive this feedback from stakeholders either at the meeting or via online survey prior to the meeting. The individual ratings for each component were then compiled and averaged during the meeting. These averaged scores were then entered into the Prioritization Matrix and displayed for community stakeholders.

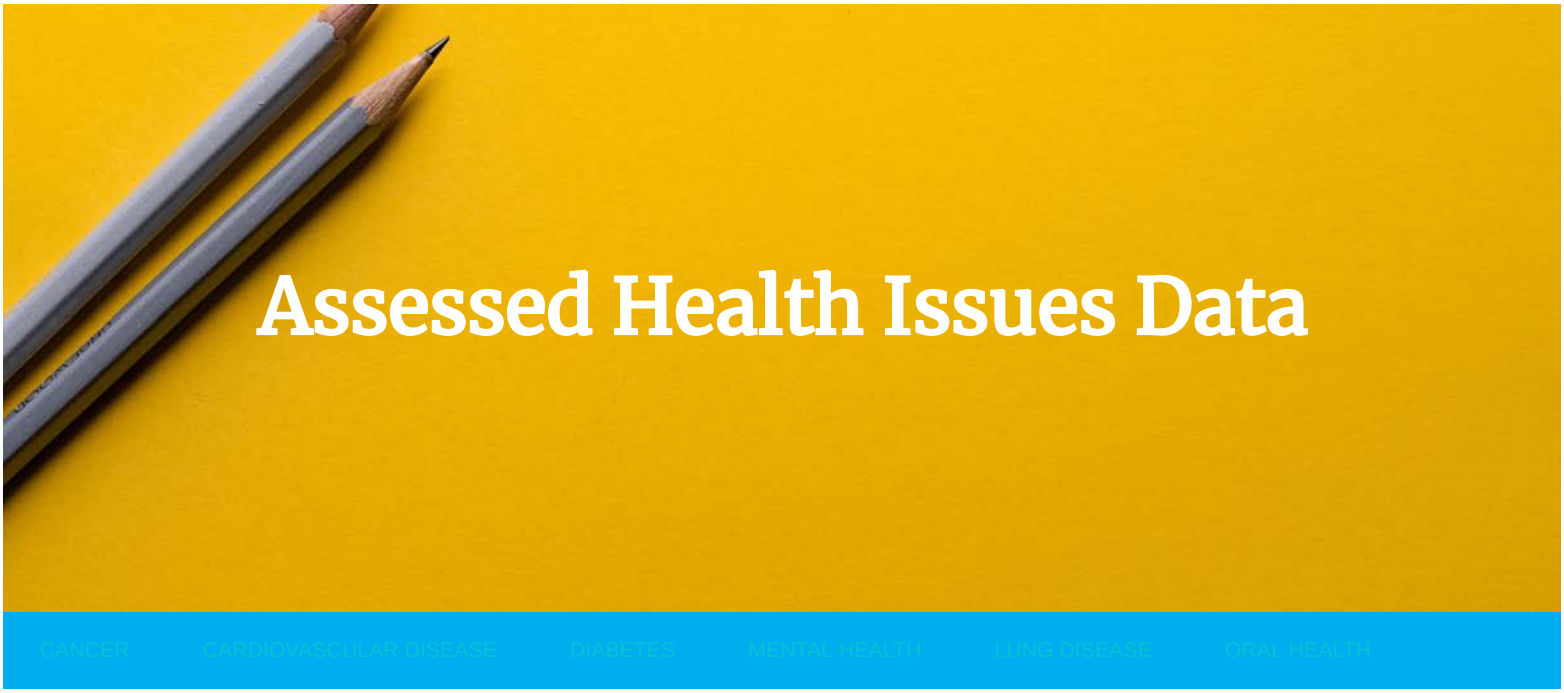
Building Consensus for Health Priorities

After the community stakeholders were shown the final scores for each health issue in the prioritization matrix, the facilitator(s) led a discussion to build consensus around the final health priorities. This final selection could occur either at the same meeting or at a follow up meeting. It also could have included the same group of stakeholders or a different group of stakeholders. For instance, in the Springfield Community, the initial discussion and rating of feasibility and readiness occurred with stakeholders that focused on implementation of strategies to address health issues. Final consensus and selection of

[3] Collective Impact Forum, https://collectiveimpactforum.org/what-collective-impact

health priorities was made by another group consistently of executive leadership from throughout the community.

The product of these meetings created the draft health priorities for each Community within the region. These priorities were then taken to the executive boards for all participating health systems and local public health agencies within the community for review and final approval.

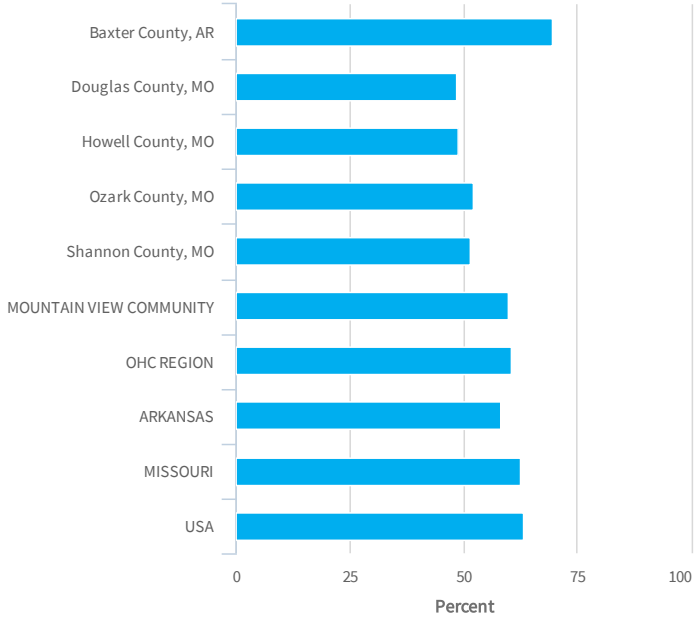


Assessed Health Issues Data

CANCER CARDIOVASCULAR DISEASE DIABETES MENTAL HEALTH LUNG DISEASE ORAL HEALTH

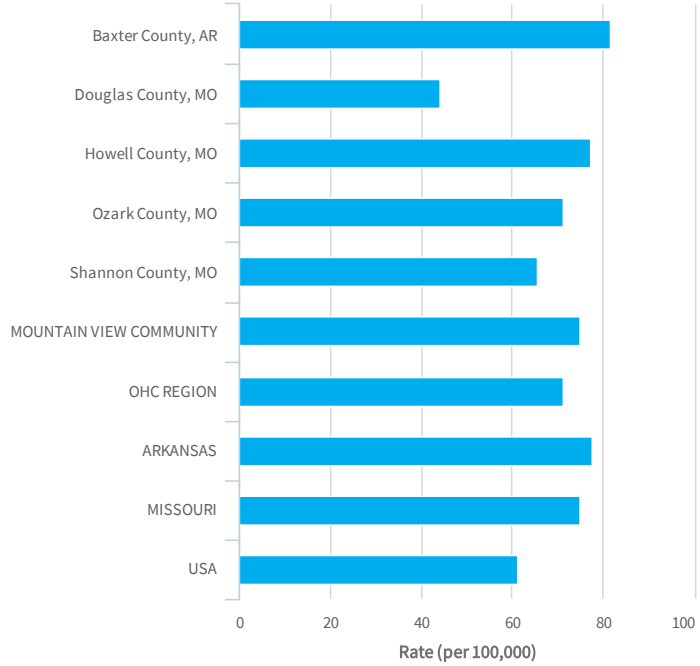
Cancer

Cancer-Screening Mammogram



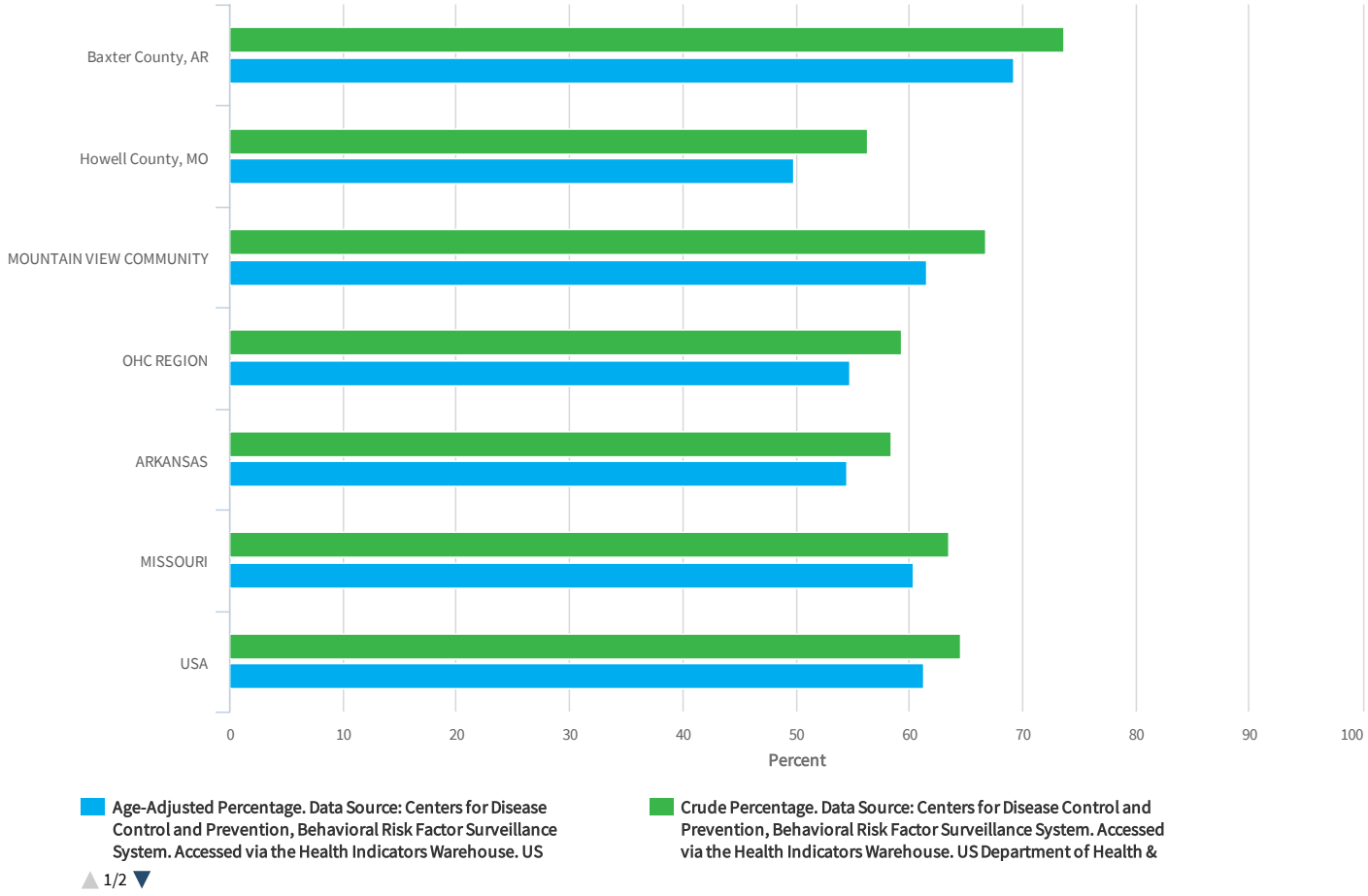
Percent Female Medicare Enrollees with Mammogram in Past 2 Year. Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2014. Source geography: County

Lung Cancer Incidence

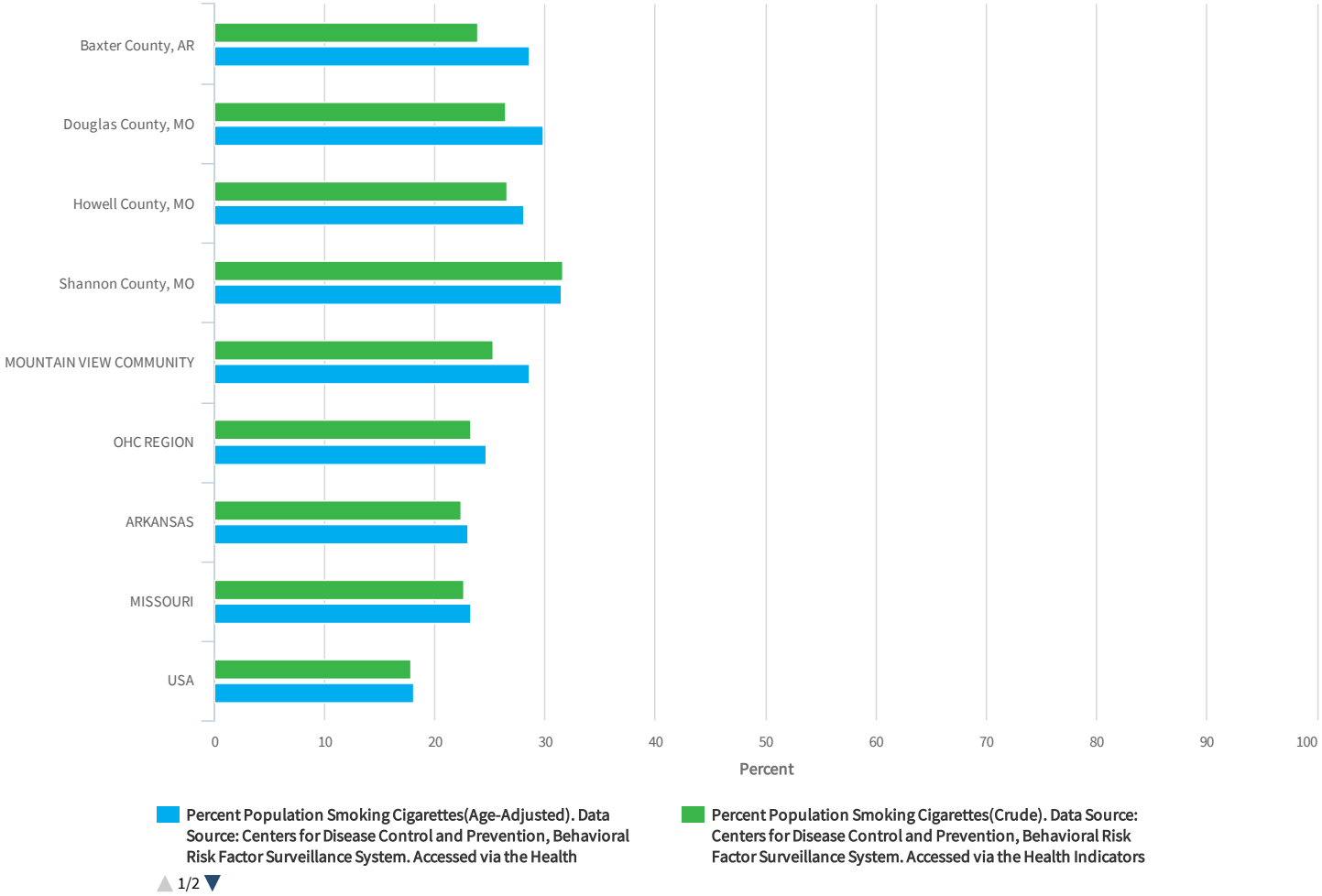


Cancer Incidence Rate (Per 100,000 Pop.). Data Source: State Cancer Profiles. 2010-14. Source geography: County

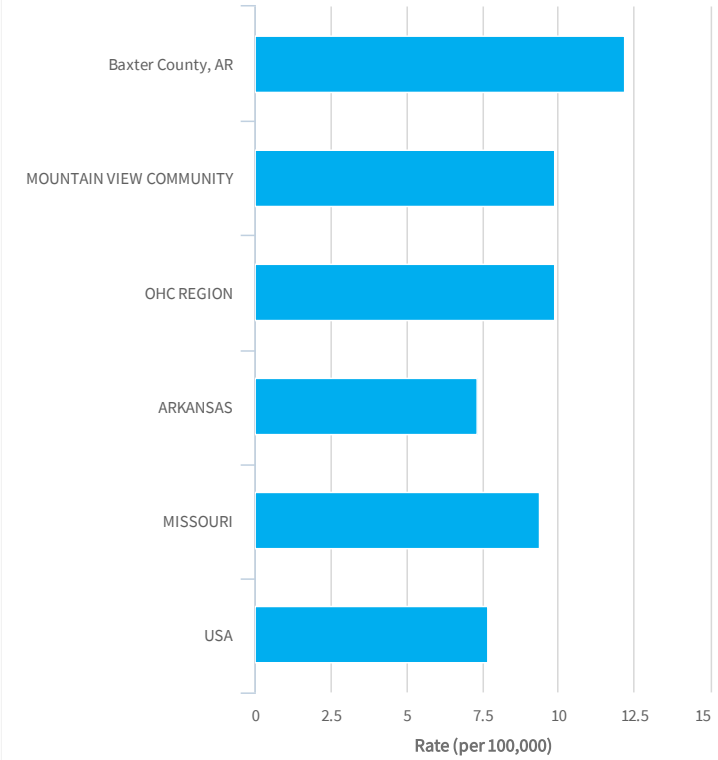
Cancer Screening - Sigmoidoscopy or Colonoscopy (Crude Percentage & Age-Adjusted Percentage)



Current Smokers (Crude Percentage & Age-Adjusted Percentage)

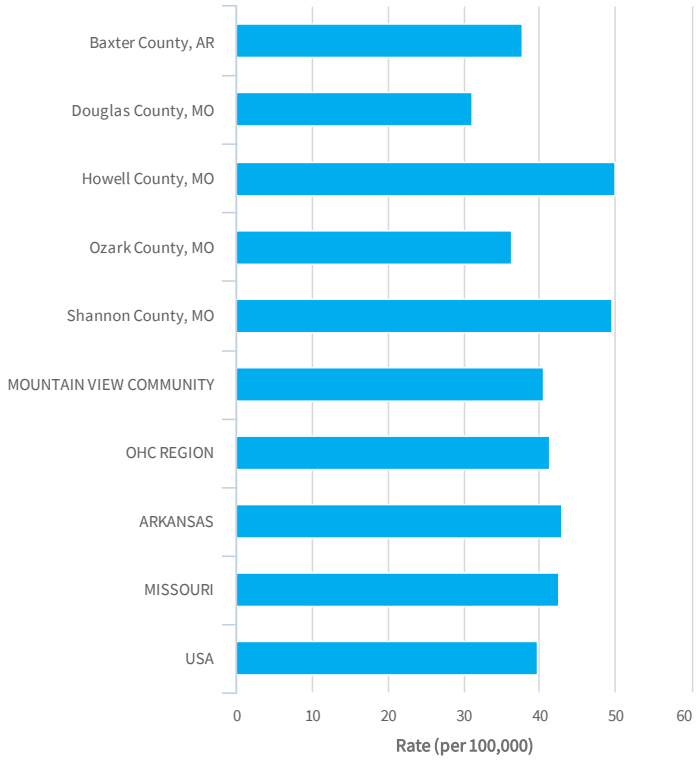


Cervical Cancer Incidence



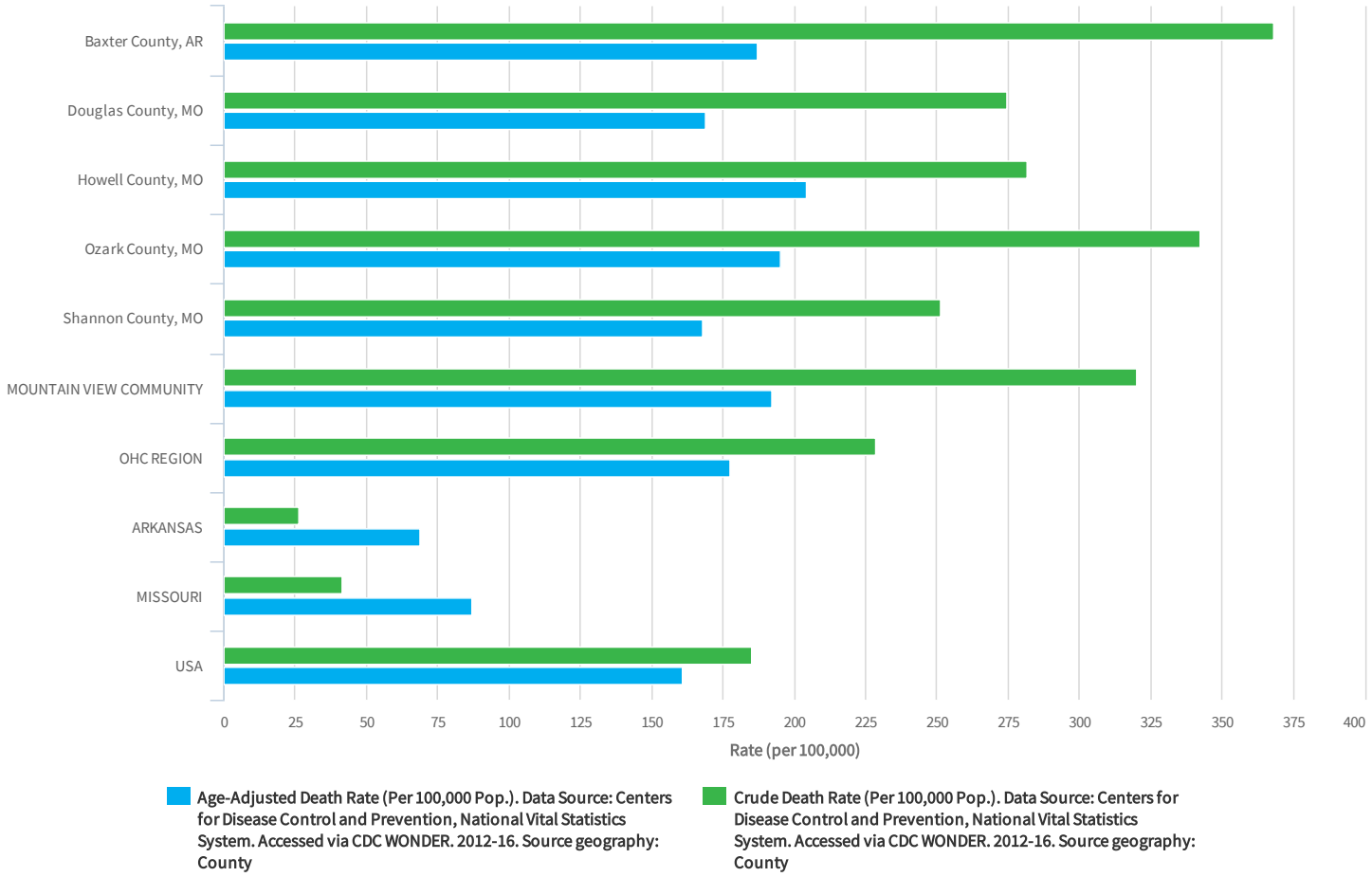
Cancer Incidence Rate (Per 100,000 Pop.). Data Source: State Cancer Profiles. 2009-13. Source geography: County

Colon and Rectum Cancer Incidence



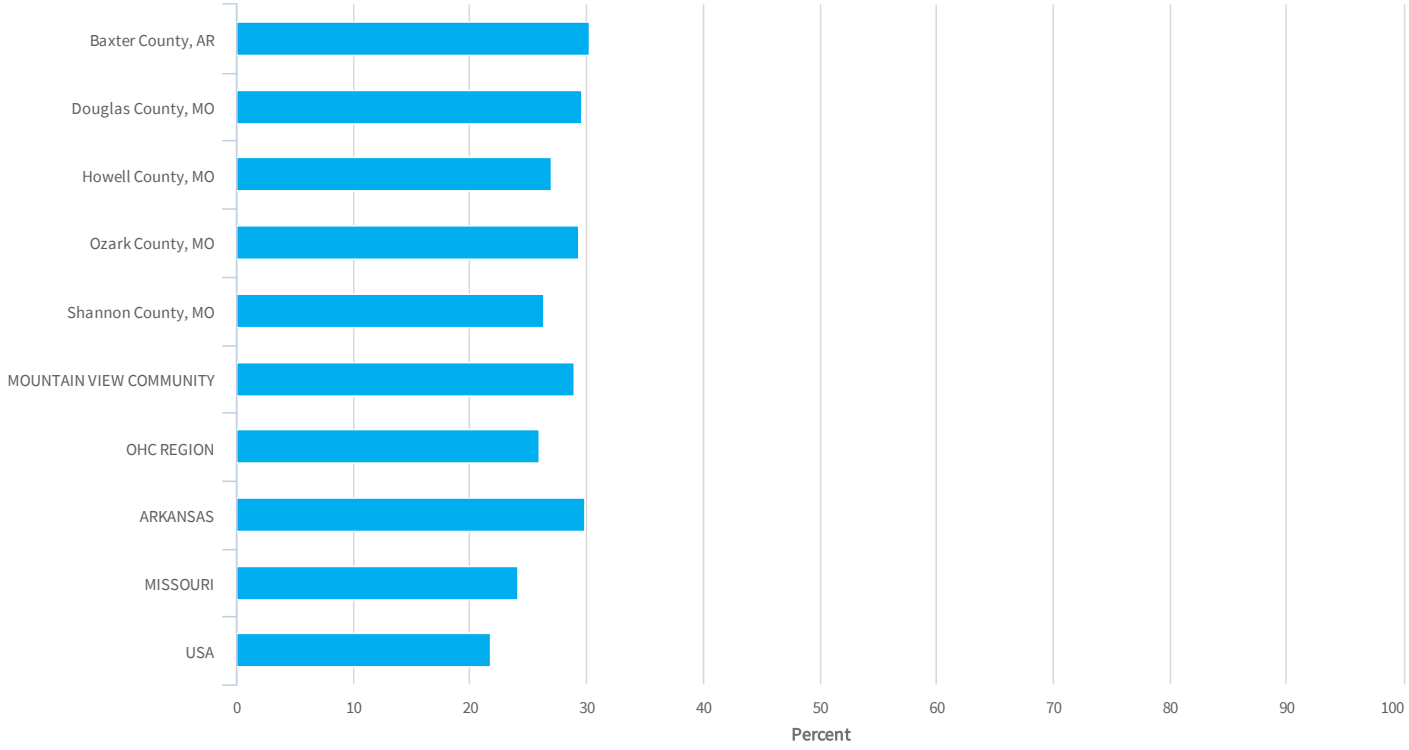
Cancer Incidence Rate (Per 100,000 Pop.). Data Source: State Cancer Profiles. 2010-14. Source geography: County

Cancer Mortality (Crude Death Rate & Age-Adjusted Death Rate)



Cardiovascular Disease

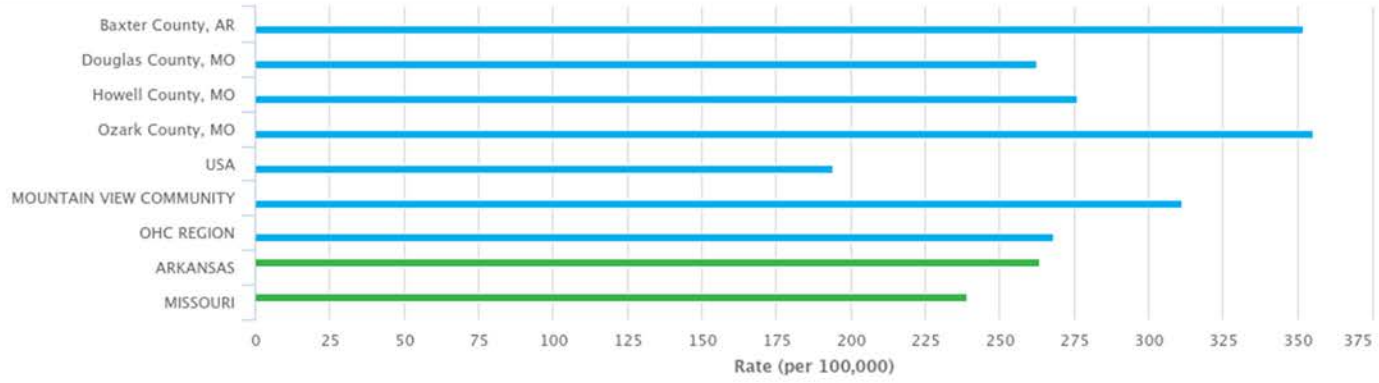
Physical Inactivity



Percent Population with no Leisure Time Physical Activity. Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013. Source geography: County

Cardiovascular Disease Mortality (Crude Death Rate & Age-Adjusted Death Rate)

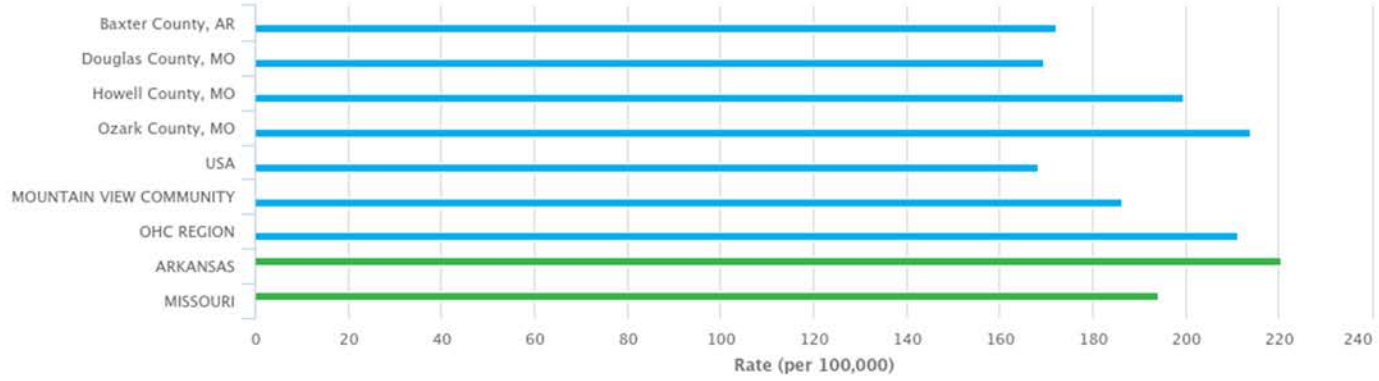
Crude Death Rate



Crude Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

Crude Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2013-17. Source geography: County

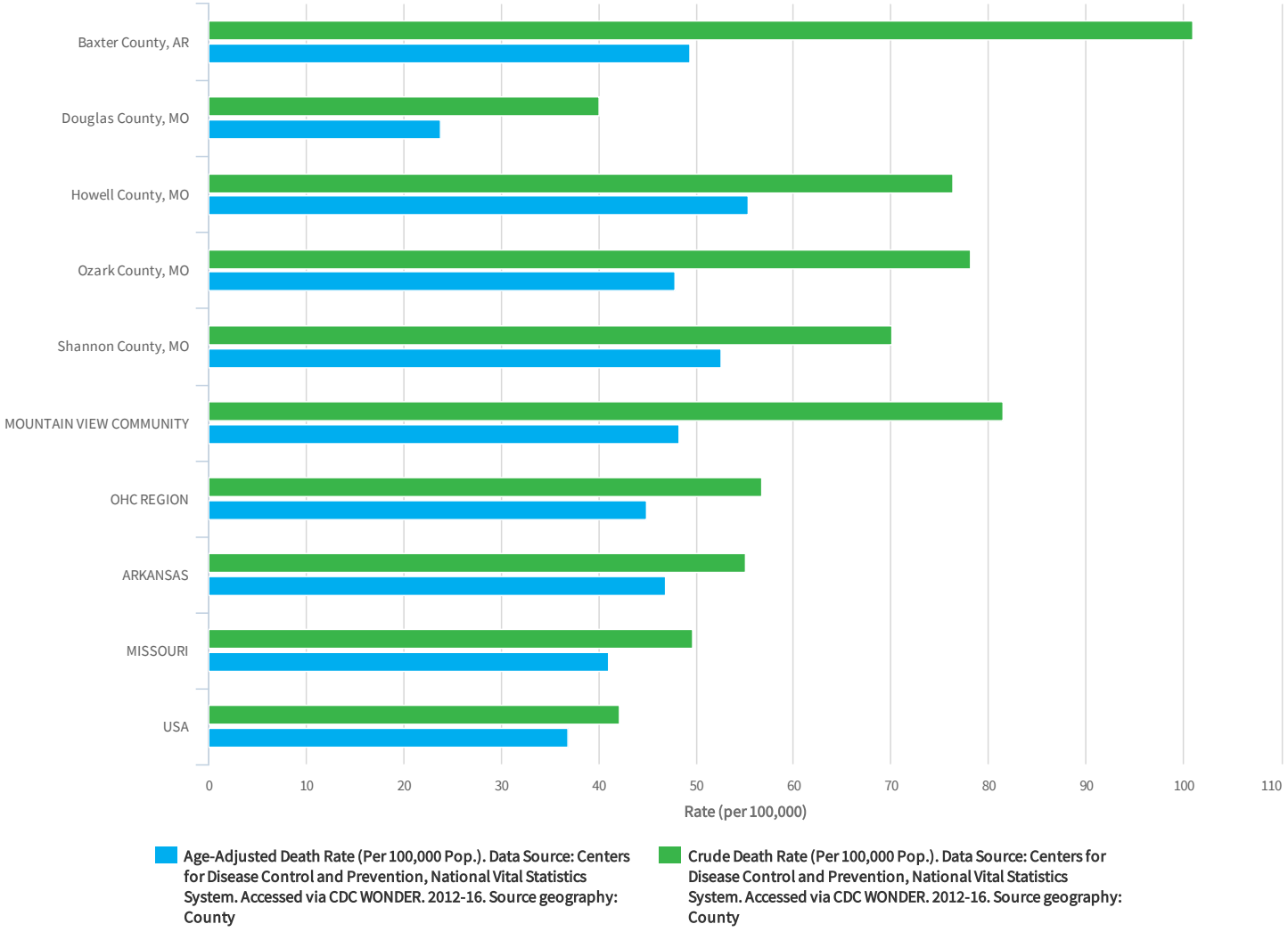
Age-Adjusted Death Rate



Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

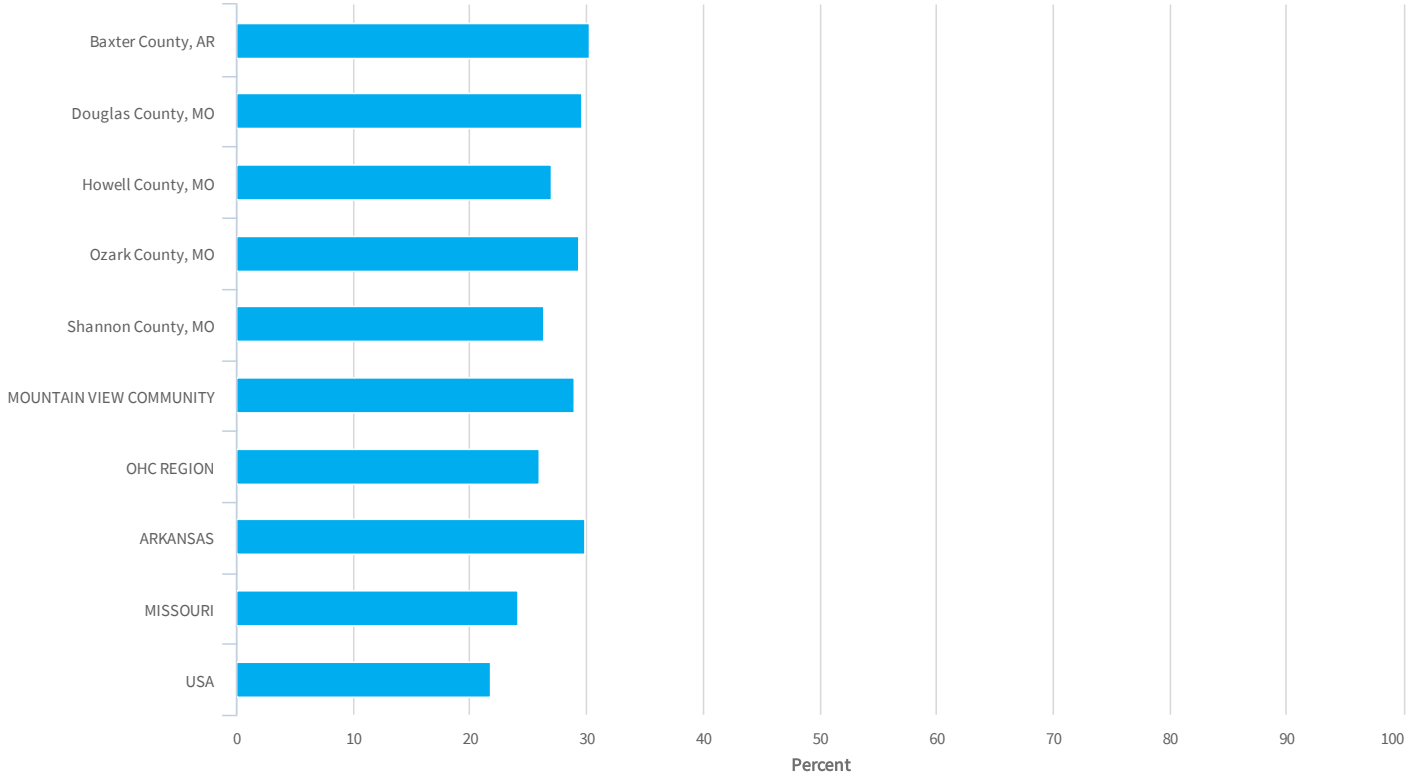
Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2013-17. Source geography: County

Stroke Mortality (Crude Death Rate & Age-Adjusted Death Rate)



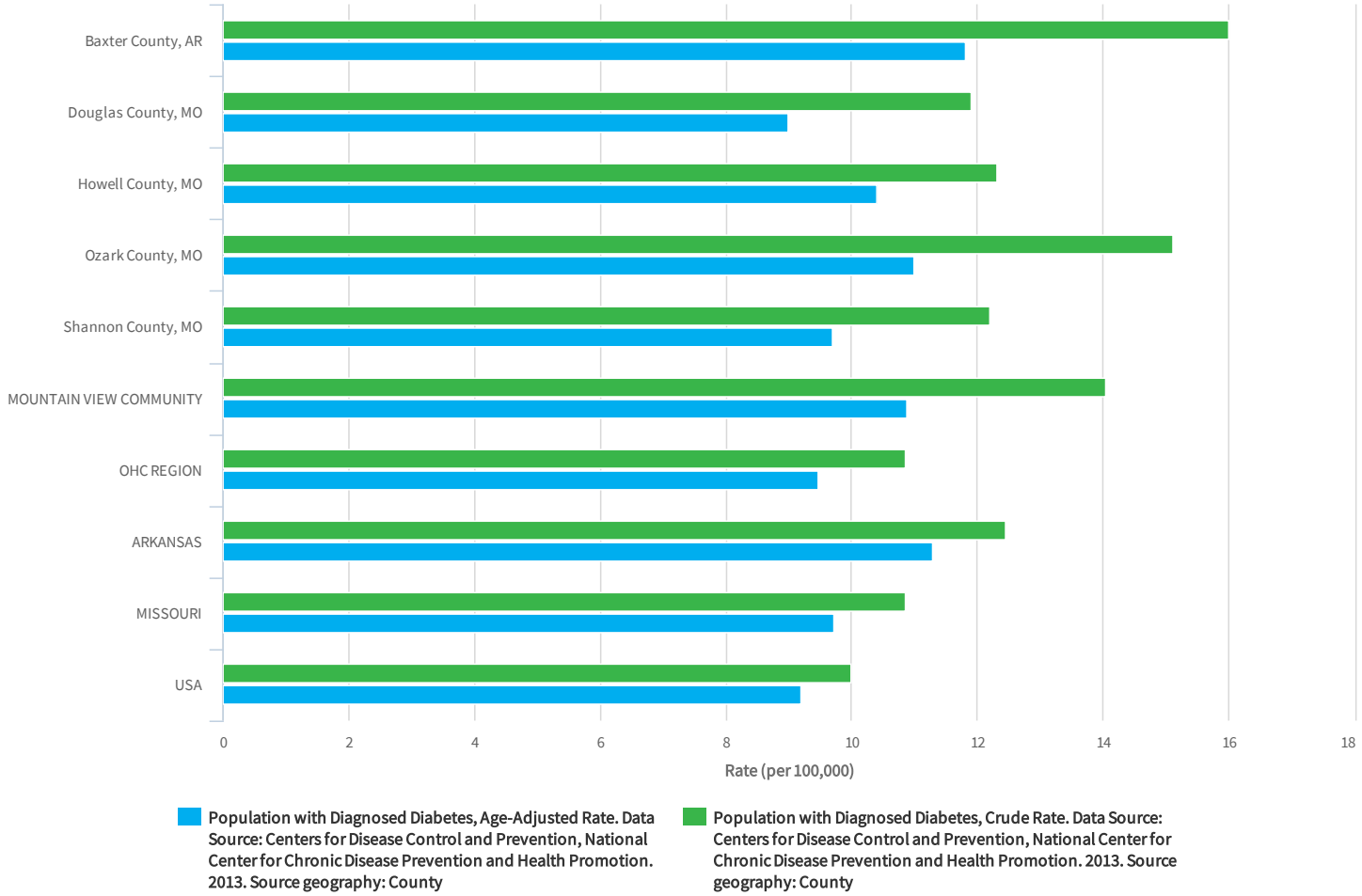
Diabetes

Physical Inactivity



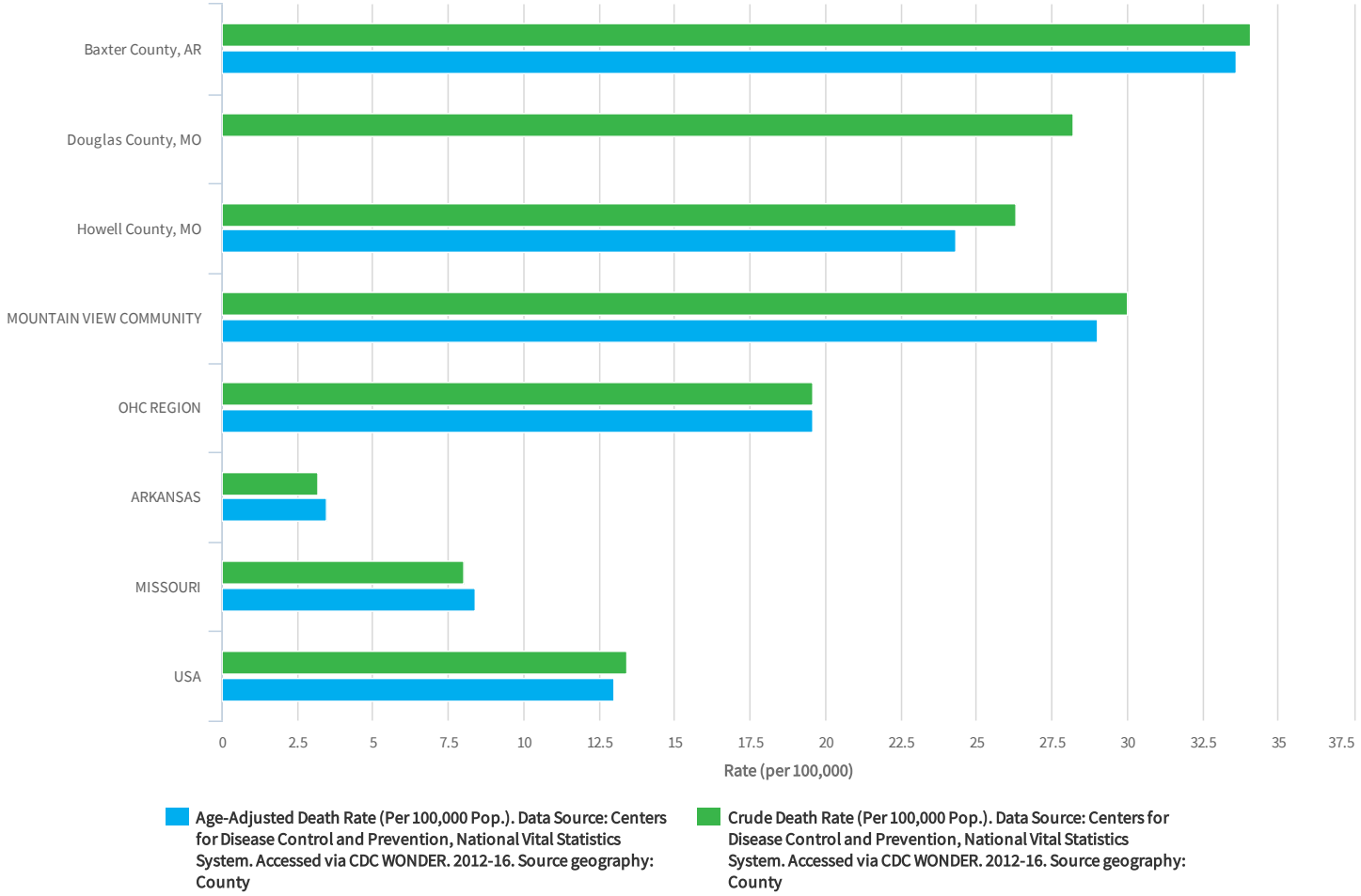
Percent Population with no Leisure Time Physical Activity. Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013. Source geography: County

Adult Diabetes (Crude Rate & Age-Adjusted Rate)

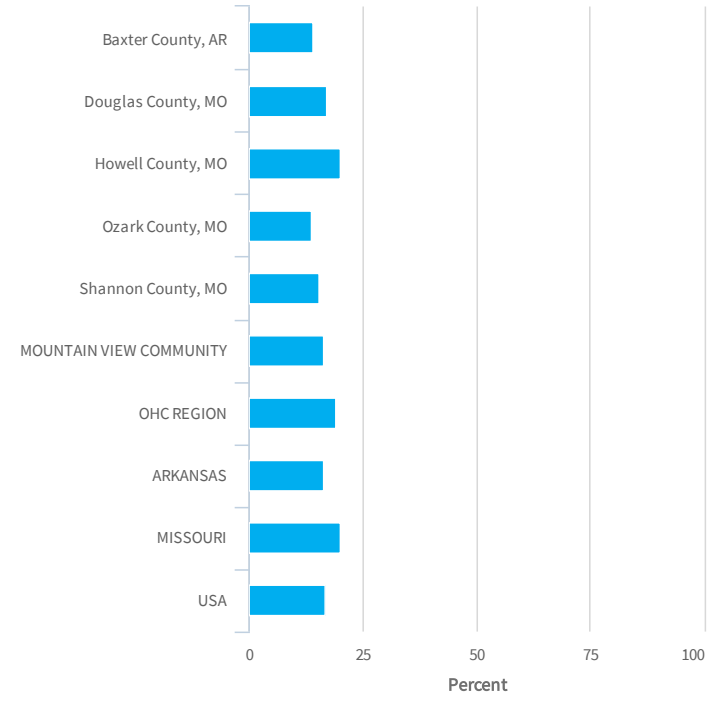


Mental Health

Suicide Mortality (Crude Death Rate & Age-Adjusted Death Rate)

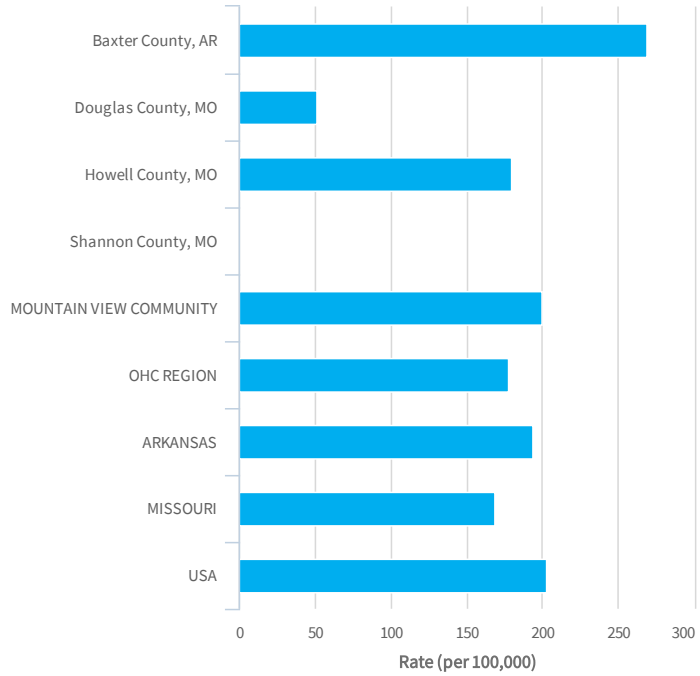


Depression in the Medicare Population



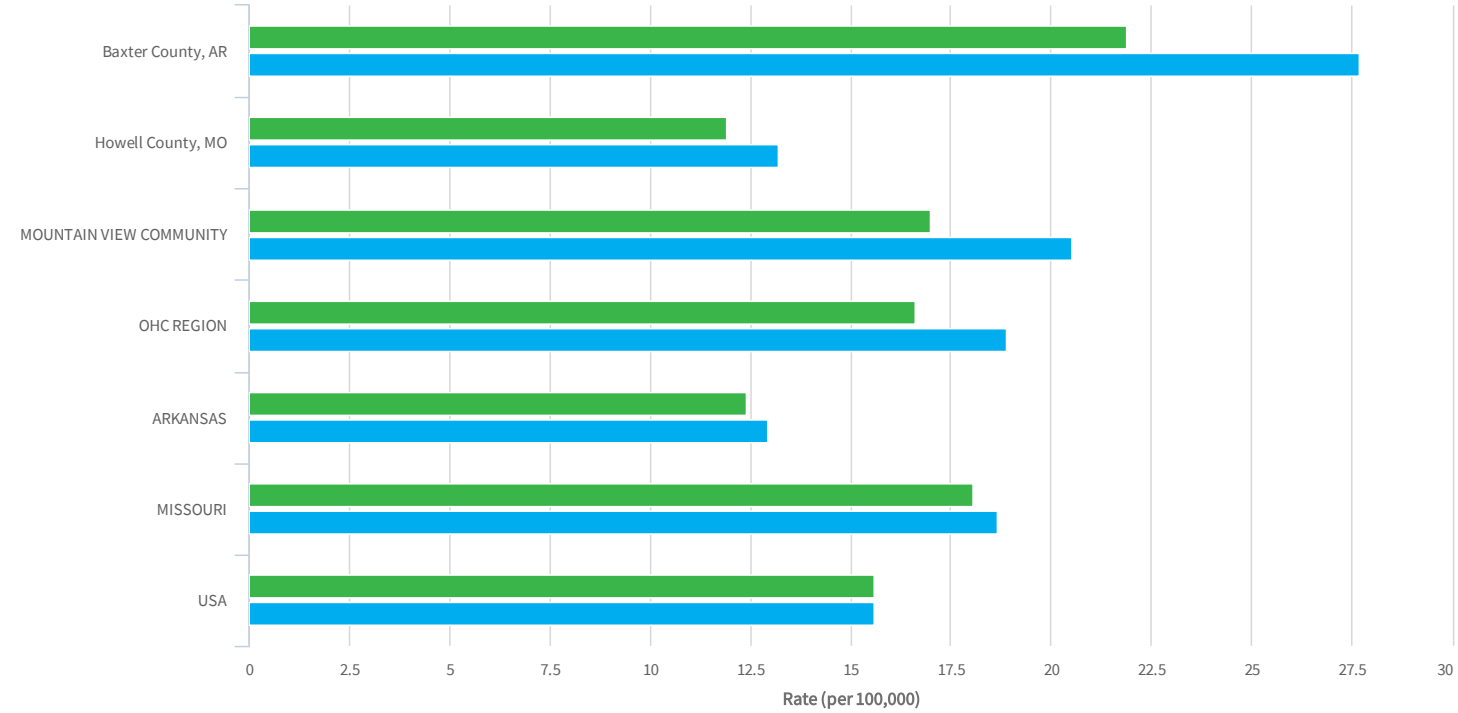
Percent with Depression. Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County

Access to a Mental Health Care Provider Rate



Mental Health Care Provider Rate (Per 100,000 Population). Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2018. Source geography: County

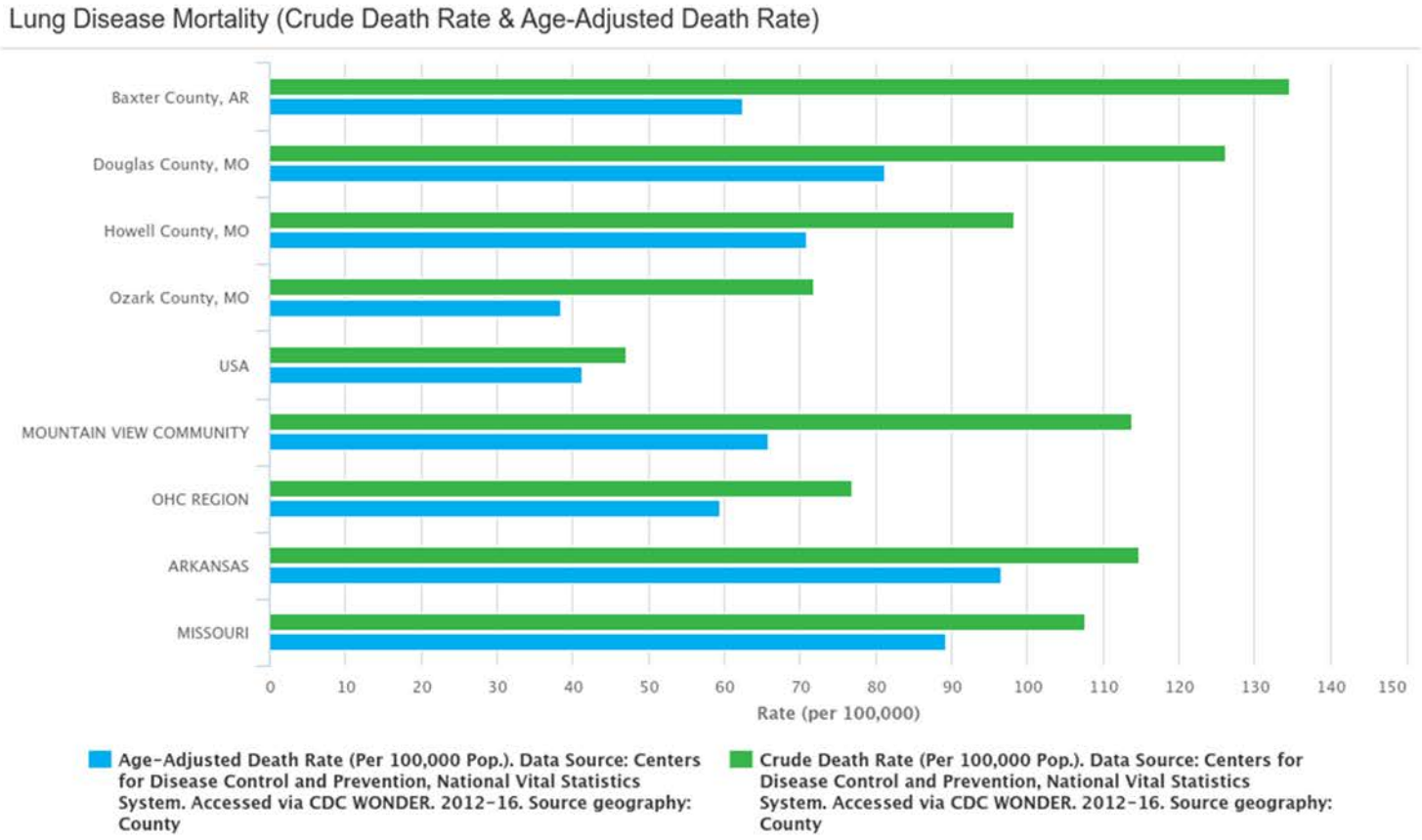
Drug Poisoning Mortality (Crude Death Rate & Age-Adjusted Death Rate)



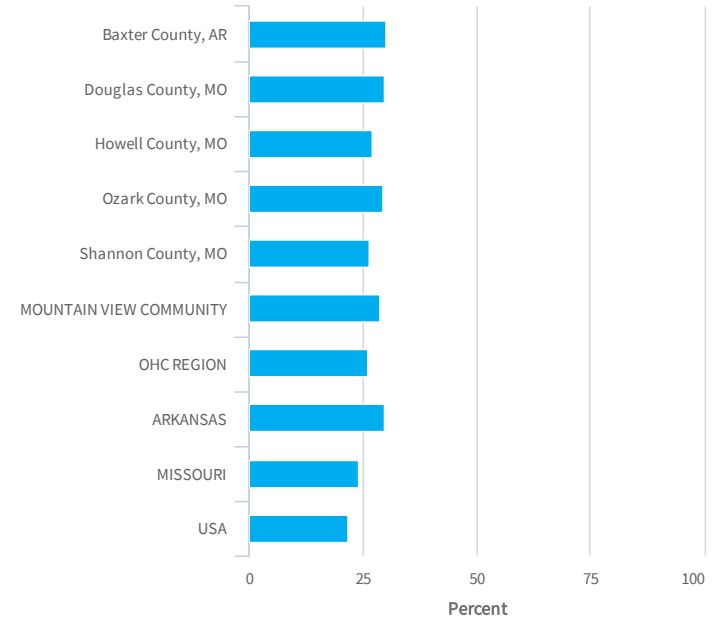
Age-Adjusted Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

Crude Death Rate (Per 100,000 Pop.). Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County

Lung Disease

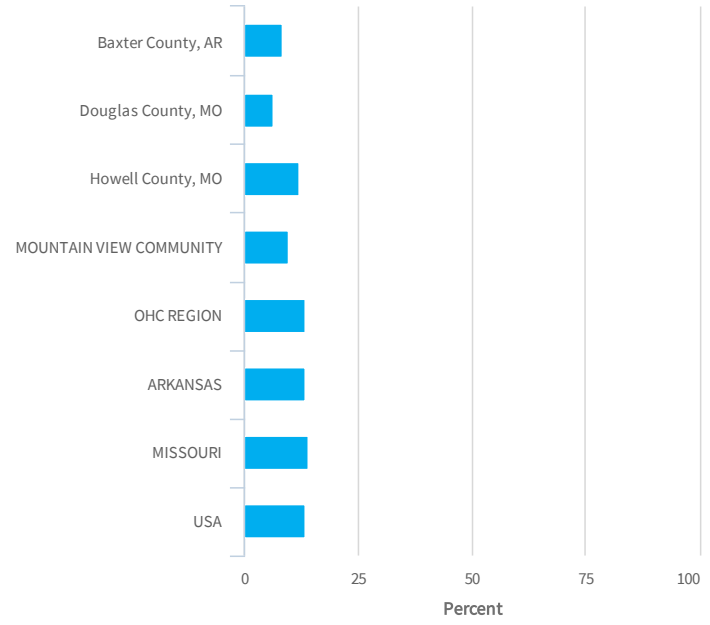


Physical Inactivity



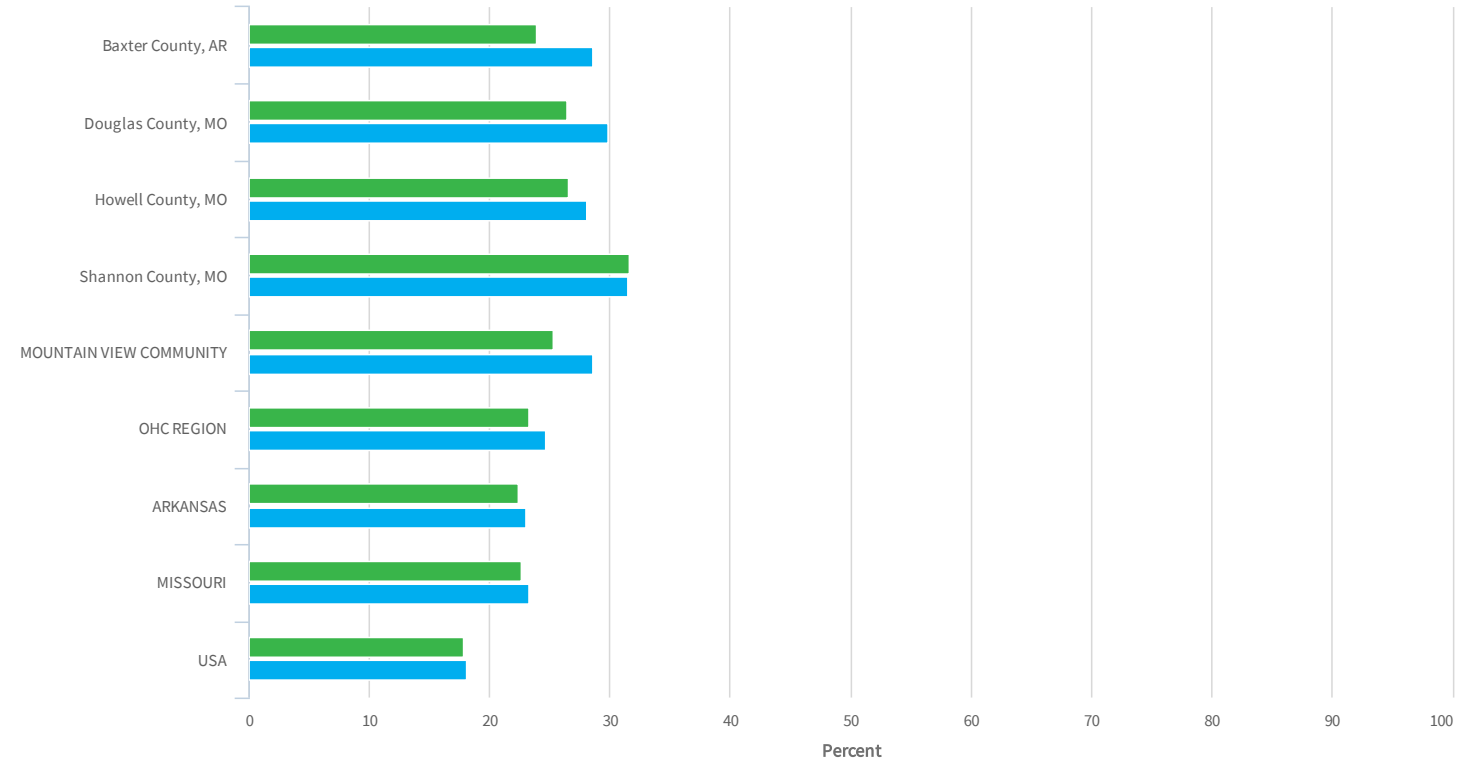
Percent Population with no Leisure Time Physical Activity. Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2013. Source geography: County

Asthma Prevalence



Percent Adults with Asthma. Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County

Current Smokers (Crude Percentage & Age-Adjusted Percentage)



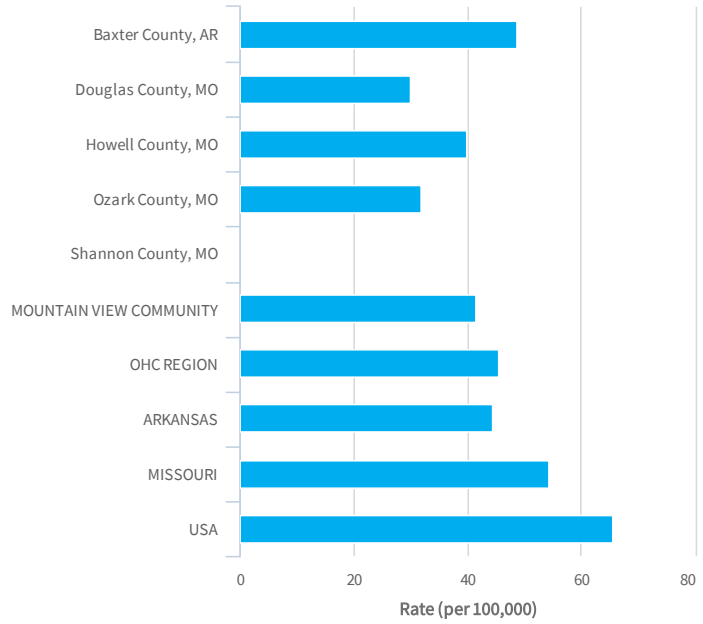
Percent Population Smoking Cigarettes(Age-Adjusted). Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health

Percent Population Smoking Cigarettes(Crude). Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators

1/2

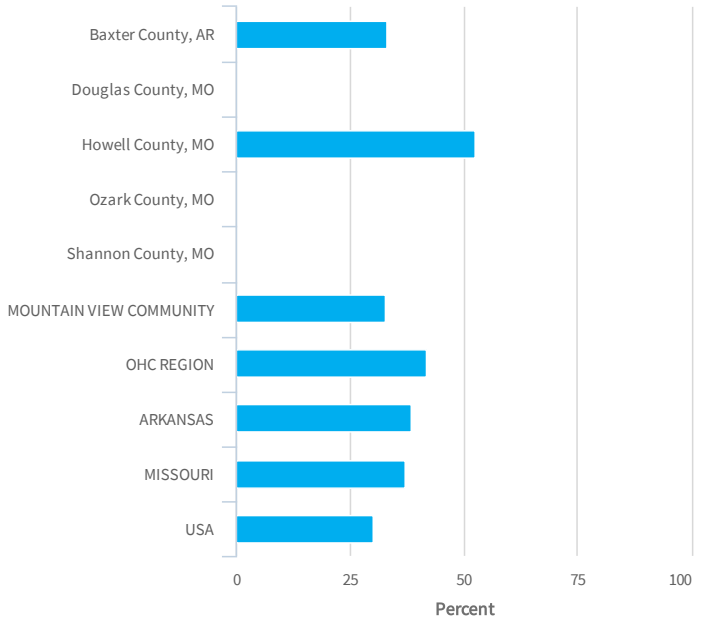
Oral Health

Access to Dentists



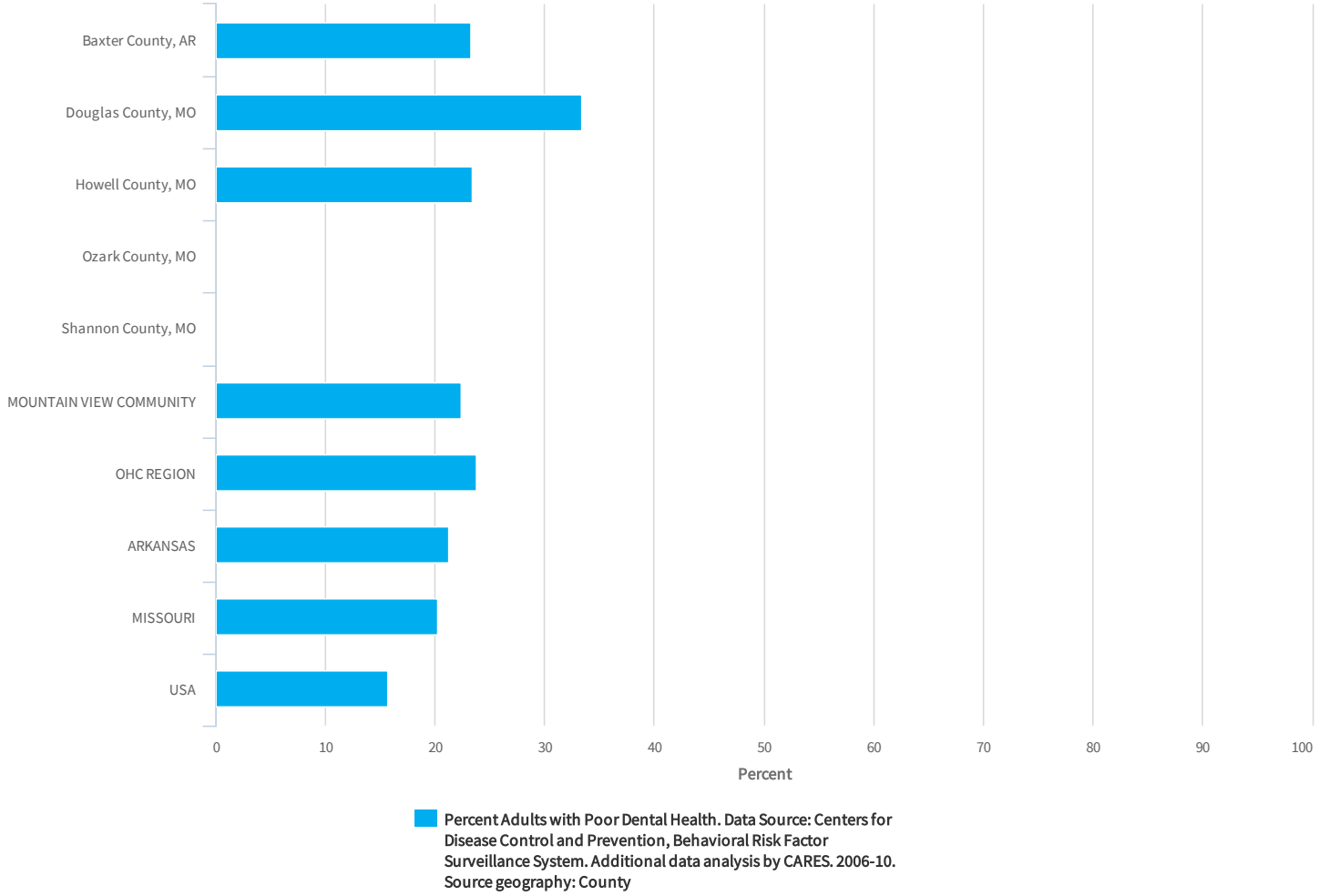
Dentists, Rate per 100,000 Pop. Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2015. Source geography: County

Adults with No Dental Exam



Percent Adults with No Dental Exam. Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10. Source geography: County

Poor Dental Health



Prioritization Process

To begin the process, the Stakeholder Survey was sent to the Mercy Mt. View Board which includes representatives from the Red Cross, The Good Samaritan Board, Jacks Fork Community Foundation, The Agape House, the Mountain View Chamber of Commerce, and South Central Missouri Community Action Agency. This survey was designed by the Ozarks Health Commission (OHC) to receive input from stakeholders in each community in the Region to establish the prioritization of the six Assessed Health Issues (AHI). Questions asked in the survey were designed to assist communities in determining the community's readiness and feasibility to change concerning each AHI. Survey data was received and compiled by staff at Springfield-Greene County Health Department. The Mercy Mt. View Board voted for Mental Health, Lung Disease and Heart Disease as top three priorities.

	Mental Health	Lung Disease	Cancer	Heart Disease	Diabetes	Oral Health
Prevalence	1	2	3	3	3	3
Prevalence Trend	2	1	4	2	1	3
Prevalence Comparison to Nation	3	1	4	1	4	3
Mortality (Score)	4	2	4	1	1	1
Mortality Trend	3	3	1	4	1	1
Mortality Comparison to Nation	3	4	2	4	1	1
Hospital ED Data	2	4	3	2	1	2
Hospital Clinic Data	4	4	4	4	1	4
Regional Survey Results	3.52	3.24	3.46	3.68	3.29	3.41
Feasibility - Complexity of The Issues	1.67	1.67	1.67	1.67	1.67	1.67
Feasibility - Level of Control at Local Level	2.33	2.67	2.67	2.00	2.00	2.67
Feasibility - Clear Path for Implementation	2.33	2.33	2.33	2.33	2.33	2.33
Readiness - Current Organizational Leadership	2.67	2.67	2.67	2.67	3.0	3.33
Readiness - Coordinated Community Efforts	2.33	2.33	2.33	2.33	2.33	2.67
Total Score	36.85	35.91	40.13	35.68	27.62	34.08
Priority Rank	**2**	**3**	**1**	**4**	**6**	**5**

Community Data

Community Comparisons

DATA CATEGORY	DATA INDICATOR	INDICATOR ATTRIBUTE	Branson	Joplin	Lebanon	Monett	Mt. View	Springfield	Regional	USA	Arkansas	Kansas	Missouri	Oklahoma
Demographics	Total Population	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Total Land Area(Square Miles)	2316.79	5514.49	4367.63	1389.99	3040.13	1830.53	18459.55	3532068.6	52035.57	81758.39	68746.51	68596.35
		Population Density (Per Square Mile)	64.76	62.49	44.31	53.18	34.27	221.02	68.85	90.19	57.05	35.45	88.14	56.5
Demographics	Change in Total Population	Total Population, 2000 Census	127668	328874	167348	69214	98250	324411	1115765	280405781	2673398	2688419	5591987	3450653
		Total Population, 2010 Census	148226	346354	193447	74231	105320	388798	1256376	307745539	2915918	2853118	5988927	3751351
		Total Population Change, 2000-2010	20558	17480	26099	5017	7070	64387	140611	27339758	242520	164699	396940	300698
		Percent Population Change, 2000-2010	16.10%	5.32%	15.60%	7.25%	7.20%	19.85%	12.60%	9.75%	9.07%	6.13%	7.10%	8.71%
Demographics	Families with Children	Total Households	60193	132344	68211	27822	43652	162356	494578	117716237	1141480	1115858	2372362	1461500
		Total Family Households	40989	88497	47271	19487	29373	102006	327623	77608829	757729	729881	1529363	967783
		Families with Children (Under Age 18)	16236	42651	20727	8528	11100	48129	147371	37299113	356822	357123	714287	472912
		Families with Children (Under Age 18), Percent of Total Households	26.97%	32.23%	30.39%	30.65%	25.43%	29.64%	29.80%	31.69%	31.26%	32.00%	30.11%	32.36%
Demographics	Female Population	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Female Population	76601	174616	93281	36883	53221	206649	641251	161792840	1511778	1456380	3086334	1955594
		Percent Female Population	51.05%	50.67%	48.20%	49.90%	51.09%	51.08%	50.46%	50.79%	50.93%	50.25%	50.93%	50.46%
Demographics	Male Population	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Male Population	73440	170005	100254	37037	50953	197928	629617	156765322	1456694	1441912	2973317	1919995
		Percent Male Population	48.95%	49.33%	51.80%	50.10%	48.91%	48.92%	49.54%	49.21%	49.07%	49.75%	49.07%	49.54%
Demographics	Median Age	Total Population	2968472	2898292	6059651	6059651	2968472	6059651	2968472	37301	6059651	6059651	318558162	318558162
		Median Age	37.7	36.2	38.3	38.3	37.7	38.3	37.7	42.4	38.3	38.3	37.7	37.7
Demographics	Population Under Age 18	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589

		Population Age 0-17	31315	84639	43558	17935	21777	91571	290795	73612438	707234	721347	1395124	952325
		Percent Population Age 0-17	20.87%	24.56%	22.51%	24.26%	20.90%	22.63%	22.88%	23.11%	23.82%	24.89%	23.02%	24.57%
Demographics	Population Age 0-4	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Population Age 0-4	8284	22562	11706	4585	5635	25424	78196	19866960	190884	198915	374010	265818
		Percent Population Age 0-4	5.52%	6.55%	6.05%	6.20%	5.41%	6.28%	6.15%	6.24%	6.43%	6.86%	6.17%	6.86%
Demographics	Population Age 5-17	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Population Age 5-17	23031	62077	31852	13350	16142	66147	212599	53745478	516350	522432	1021114	686507
		Percent Population Age 5-17	15.35%	18.01%	16.46%	18.06%	15.50%	16.35%	16.73%	16.87%	17.39%	18.03%	16.85%	17.71%
Demographics	Population Age 18-64	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Population Age 18-64	86434	205573	117586	42334	57107	252349	761383	198765092	1796251	1761418	3734593	2361379
		Percent Population Age 18-64	57.61%	59.65%	60.76%	57.27%	54.82%	62.37%	59.91%	62.40%	60.51%	60.77%	61.63%	60.93%
Demographics	Population Age 18-24	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Population Age 18-24	12271	35194	22767	5785	7015	49068	132100	31296577	287647	298450	591150	388986
		Percent Population Age 18-24	8.18%	10.21%	11.76%	7.83%	6.73%	12.13%	10.39%	9.82%	9.69%	10.30%	9.76%	10.04%
Demographics	Population Age 25-34	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Population Age 25-34	15618	41987	24373	7902	10697	55051	155628	43397907	385316	384327	800229	533743
		Percent Population Age 25-34	10.41%	12.18%	12.59%	10.69%	10.27%	13.61%	12.25%	13.62%	12.98%	13.26%	13.21%	13.77%
Demographics	Population Age 35-44	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Population Age 35-44	16544	40745	20641	8484	10565	49129	146108	40548400	367023	345603	731234	473291
		Percent Population Age 35-44	11.03%	11.82%	10.67%	11.48%	10.14%	12.14%	11.50%	12.73%	12.36%	11.92%	12.07%	12.21%
Demographics	Population Age 45-54	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Population Age 45-54	19837	44421	24589	9974	13308	50825	162954	43460466	385891	370189	820875	490534
		Percent Population Age 45-54	13.22%	12.89%	12.71%	13.49%	12.77%	12.56%	12.82%	13.64%	13.00%	12.77%	13.55%	12.66%
Demographics	Population Age 55-64	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Population Age 55-64	22164	43226	25216	10189	15522	48276	164593	40061742	370374	362849	791105	474825
		Percent Population Age 55-64	14.77%	12.54%	13.03%	13.78%	14.90%	11.93%	12.95%	12.58%	12.48%	12.52%	13.06%	12.25%

Demographics	Population Age 65+	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Population Age 65+	32292	54409	32391	13651	25290	60657	218690	46180632	464987	415527	929934	561885
		Percent Population Age 65+	21.52%	15.79%	16.74%	18.47%	24.28%	14.99%	17.21%	14.50%	15.66%	14.34%	15.35%	14.50%
Demographics	Population with Any Disability	Total Population (For Whom Disability Status Is Determined)	148642	340580	177437	73037	103115	399311	1242122	313576137	2915402	2839352	5946094	3794815
		Total Population with a Disability	28122	54318	33898	12162	21708	53709	203917	39272529	492769	353735	858449	594454
		Percent Population with a Disability	18.92%	15.95%	19.10%	16.65%	21.05%	13.45%	16.42%	12.52%	16.90%	12.46%	14.44%	15.66%
Demographics	Population in Limited English Households	Total Population Age 5+	141757	322059	181829	69335	98539	379153	1192672	298691202	2777588	2699377	5685641	3609771
		Linguistically Isolated Population	1791	4295	806	1160	387	3341	11780	13393615	51735	69514	63881	85264
		Percent Linguistically Isolated Population	1.26%	1.33%	0.44%	1.67%	0.39%	0.88%	0.99%	4.48%	1.86%	2.58%	1.12%	2.36%
Demographics	Population with Limited English Proficiency	Population Age 5+	141757	322059	181829	69335	98539	379153	1192672	298691202	2777588	2699377	5685641	3609771
		Population Age 5+ with Limited English Proficiency	3067	8175	2477	2605	721	6344	23389	25440956	89615	120905	120716	146023
		Percent Population Age 5+ with Limited English Proficiency	2.16%	2.54%	1.36%	3.76%	0.73%	1.67%	1.96%	8.52%	3.23%	4.48%	2.12%	4.05%
Demographics	Population Geographic Mobility	Total Population	148128	340337	191383	73144	103030	399851	1255873	314813229	2931330	2861053	5989469	3825777
		Population In-Migration	12587	23064	27919	5240	6147	35714	110671	19417258	189103	204203	431416	288725
		Percent Population In-Migration	8.50%	6.78%	14.59%	7.16%	5.97%	8.93%	8.81%	6.17%	6.45%	7.14%	7.20%	7.55%
Demographics	Foreign-Born Population	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Naturalized U.S. Citizens	1700	3672	2272	981	969	5256	14850	19979407	44575	73866	106455	75889
		Population Without U.S. Citizenship	3156	8381	1997	1989	696	5816	22035	22214947	94459	126903	129624	149627
		Total Foreign-Birth Population	4856	12053	4269	2970	1665	11072	36885	42194354	139034	200769	236079	225516

		Foreign-Birth Population, Percent of Total Population	3.24%	3.50%	2.21%	4.02%	1.60%	2.74%	2.90%	13.25%	4.68%	6.93%	3.90%	5.82%
Demographics	Hispanic Population	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Non-Hispanic Population	141653	324459	184877	68166	102222	391949	1213326	263359055	2761423	2570553	5822367	3494122
		Percent Population Non-Hispanic	94.41%	94.15%	95.53%	92.22%	98.13%	96.88%	95.47%	82.67%	93.03%	88.69%	96.08%	90.16%
		Hispanic or Latino Population	8388	20162	8658	5754	1952	12628	57542	55199107	207049	327739	237284	381467
		Percent Population Hispanic or Latino	5.59%	5.85%	4.47%	7.78%	1.87%	3.12%	4.53%	17.33%	6.97%	11.31%	3.92%	9.84%
Demographics	Urban and Rural Population	Total Population	148226	346354	193447	74231	105320	388798	1256376	312471327	2915918	2853118	5988927	3751351
		Urban Population	54059	186471	62277	25478	28279	288834	645398	252746527	1637589	2116961	4218371	2485029
		Rural Population	94167	159883	131170	48753	77041	99964	610978	59724800	1278329	736157	1770556	1266322
		Percent Urban	36.47%	53.84%	32.19%	34.32%	26.85%	74.29%	51.37%	80.89%	56.16%	74.20%	70.44%	66.24%
		Percent Rural	63.53%	46.16%	67.81%	65.68%	73.15%	25.71%	48.63%	19.11%	43.84%	25.80%	29.56%	33.76%
Demographics	Veteran Population	Total Population Age 18+	118708	259845	136764	55981	82367	312784	966449	243935157	2256793	2159618	4644895	2905409
		Total Veterans	14345	24269	19789	6272	10598	29906	105179	19535341	213949	192340	438100	286926
		Veterans, Percent of Total Population	12.08%	9.34%	14.47%	11.20%	12.87%	9.56%	10.88%	8.01%	9.48%	8.91%	9.43%	9.88%
Social & Economic Factors	Children Eligible for Free/Reduced Price Lunch	Total Students	22027	58553	29360	12483	14160	60501	197084	50611787	492132	488568	918254	692878
		Number Free/Reduced Price Lunch Eligible	13486	34328	17212	7504	8842	27470	108842	25893504	312477	240209	460004	424665
		Percent Free/Reduced Price Lunch Eligible	61.22%	58.63%	58.62%	60.11%	62.44%	45.40%	55.23%	52.61%	63.58%	49.17%	50.12%	62.24%
Social & Economic Factors	Food Insecurity Rate	Total Population	149474	345567	193753	73987	104810	396974	1264565	318198163	2966369	2904021	6063589	3878051
		Food Insecure Population, Total	25200	53820	32430	10840	17710	62240	202240	47448890	567250	413560	1019350	652090
		Food Insecurity Rate	16.86%	15.57%	16.74%	14.65%	16.90%	15.68%	15.99%	14.91%	19.10%	14.20%	16.80%	16.80%
Social & Economic Factors	Head Start	Total Children Under Age 5	8431	24458	12698	4966	6188	25553	82294	20426118	197689	205492	390237	264126
		Total Head Start Programs	8	60	14	6	9	12	109	18886	274	195	379	442

		Head Start Programs, Rate (Per 10,000 Children)	8.3	10.63	10.24	10.07	12.93	4.3	8.51	7.18	10.12	7.35	7.28	11.17
Social & Economic Factors	High School Graduation Rate (EdFacts)	Total Student Cohort	1671	4217	2128	919	1081	4171	14187	3135216	34699	35465	64203	45499
		Estimated Number of Diplomas Issued	1517	3701	2002	845	989	3815	12869	2700120	30300	30297	58434	37721
		Cohort Graduation Rate	90.8	87.8	94.1	91.9	91.5	91.5	90.7	86.1	87.3	85.4	91	82.9
Social & Economic Factors	High School Graduation Rate (NCES)	Average Freshman Base Enrollment	1755	4545	2474	1110	1232	4592	15708	4024345	37912	37847	75801	48143
		Estimated Number of Diplomas Issued	1465	3871	2196	961	1024	4007	13524	3039015	28057	30368	62969	37219
		On-Time Graduation Rate	83.4	85.2	88.8	86.6	83.1	87.2	86.1	75.5	74	80.2	83.1	77.3
Social & Economic Factors	Households with No Motor Vehicle	Total Occupied Households	60193	132344	68211	27822	43652	162356	494578	117716237	1141480	1115858	2372362	1461500
		Households with No Motor Vehicle	3312	8447	3996	1514	2282	9521	29072	10562847	72981	61262	172972	82935
		Percentage of Households with No Motor Vehicle	5.50%	6.38%	5.86%	5.44%	5.23%	5.86%	5.88%	8.97%	6.39%	5.49%	7.29%	5.67%
Social & Economic Factors	Housing Cost Burden (30%)	Total Households	60193	132344	68211	27822	43652	162356	494578	117716237	1141480	1115858	2372362	1461500
		Cost Burdened Households (Housing Costs Exceed 30% of Income)	16517	34688	18470	6981	11289	47477	135422	38719430	295330	286885	658995	376490
		Percentage of Cost Burdened Households(Over 30% of Income)	27.44%	26.21%	27.08%	25.09%	25.86%	29.24%	27.38%	32.89%	25.87%	25.71%	27.78%	25.76%
Social & Economic Factors	Income - Families Earning Over $75,000	Total Familes	40989	88497	47271	19487	29373	102006	327623	77608829	757729	729881	1529363	967783
		Families with Income Over $75,000	10402	26138	12624	5041	6541	35209	95955	35073881	248268	326894	615255	366025

		Percent Families with Income Over $75,000	25.38%	29.54%	26.71%	25.87%	22.27%	34.52%	29.29%	45.19%	32.76%	44.79%	40.23%	37.82%
Social & Economic Factors	Income - Inequality (GINI Index)	Total Households	60193	132344	68211	27822	43652	162356	494578	117716237	1141480	1115858	2372362	1461500
		Gini Index Value	no data	no data	no data	no data	no data	no data	no data	0.48	0.47	0.46	0.46	0.47
Social & Economic Factors	Income - Median Family Income	Total Family Households	40989	88497	47271	19487	29373	102006	327623	77608829	757729	729881	1529363	967783
		Average Family Income	$60,708.00	$65,276.00	$60,332.00	$58,189.00	$56,488.00	$70,858.00	$64,520.00	$90,960.00	$69,867.00	$86,732.00	$80,299.00	$77,212.00
		Median Family Income								$67,871.00	$53,123.00	$68,231.00	$62,285.00	$59,742.00
Social & Economic Factors	Income - Per Capita Income	Total Population	150041	344621	193535	73920	104174	404577	1270868	318558162	2968472	2898292	6059651	3875589
		Total Income ($)	$3,255,149,400.00	$7,495,876,000.00	$3,939,053,600.00	$1,457,053,600.00	$2,112,736,700.00	$9,840,709,900.00	$28,100,579,200.00	$9,502,305,741,900.00	$69,464,226,500.00	$82,536,574,200.00	$163,880,073,200.00	$99,323,689,000.00
		Per Capita Income ($)	$21,695.00	$21,751.00	$20,353.00	$19,711.00	$20,280.00	$24,323.00	$22,111.00	$29,829.00	$23,400.00	$28,477.00	$27,044.00	$25,628.00
Social & Economic Factors	Income - Public Assistance Income	Total Households	60193	132344	68211	27822	43652	162356	494578	117716237	1141480	1115858	2372362	1461500
		Households with Public Assistance Income	1304	3324	1838	628	1533	3557	12184	3147577	25749	20645	52988	45251
		Percent Households with Public Assistance Income	2.17%	2.51%	2.69%	2.26%	3.51%	2.19%	2.46%	2.67%	2.26%	1.85%	2.23%	3.10%
Social & Economic Factors	Insurance - Population Receiving Medicaid	Total Population(For Whom Insurance Status is Determined)	148642	340580	177437	73037	103115	399311	1242122	313576137	2915402	2839352	5946094	3794815
		Population with Any Health Insurance	125287	289490	149205	60794	90480	347909	1063165	276875891	2555830	2541808	5272765	3200667
		Population Receiving Medicaid	29353	62551	34285	13652	22982	57719	220542	59874221	683151	387712	877803	664227
		Percent of Insured Population Receiving Medicaid	23.43%	21.61%	22.98%	22.46%	25.40%	16.59%	20.74%	21.62%	26.73%	15.25%	16.65%	20.75%
Social & Economic Factors	Insurance - Uninsured Adults	Total Population Age 18 - 64	84361	200652	105480	41810	56551	245236	734090	194584952	1738806	1714756	3626537	2294130

		Population with Medical Insurance	68698	165386	87124	33566	47757	207915	610446	168884012	1502431	1495631	3131839	1841266
		Percent Population With Medical Insurance	81.43%	82.42%	82.60%	80.28%	84.45%	84.78%	83.16%	86.79%	86.41%	87.22%	86.36%	80.26%
		Population Without Medical Insurance	15663	35266	18356	8244	8794	37321	123644	25700940	236375	219125	494698	452864
		Percent Population Without Medical Insurance	18.57%	17.58%	17.40%	19.72%	15.55%	15.22%	16.84%	13.21%	13.59%	12.78%	13.64%	19.74%
Social & Economic Factors	Insurance - Uninsured Children	Total Population Under Age 19	32191	86209	43306	18131	22010	94296	296143	76217025	726232	742382	1429136	990472
		Population with Medical Insurance	29805	79835	39883	16523	20487	87746	274279	72369595	689930	704377	1341542	914708
		Percent Population With Medical Insurance	92.59%	92.61%	92.10%	91.13%	93.08%	93.05%	92.62%	94.95%	95.00%	94.88%	93.87%	92.35%
		Population Without Medical Insurance	2386	6374	3423	1608	1523	6550	21864	3847430	36302	38005	87594	75764
		Percent Population Without Medical Insurance	7.41%	7.39%	7.90%	8.87%	6.92%	6.95%	7.38%	5.05%	5.00%	5.12%	6.13%	7.65%
Social & Economic Factors	Insurance - Uninsured Population	Total Population (For Whom Insurance Status is Determined)	148642	340580	177437	73037	103115	399311	1242122	313576137	2915402	2839352	5946094	3794815
		Total Uninsured Population	23355	51090	28232	12243	12635	51402	178957	36700246	359572	297544	673329	594148
		Percent Uninsured Population	15.71%	15.00%	15.91%	16.76%	12.25%	12.87%	14.41%	11.70%	12.33%	10.48%	11.32%	15.66%
Social & Economic Factors	Lack of Social or Emotional Support	Total Population Age 18+	114819	257971	146743	55072	82478	296593	953676	232556016	2187717	2112400	4532155	2793624
		Estimated Population Without Adequate Social / Emotional Support	22035	46664	24842	8705	14732	47553	164531	48104656	455045	331647	865642	561518
		Crude Percentage	19.20%	18.80%	18.50%	32.60%	23.00%	16.00%	18.60%	20.70%	20.80%	15.70%	19.10%	20.10%
		Age-Adjusted Percentage	20.30%	18.70%	18.40%	35.60%	22.30%	16.10%	18.70%	20.70%	20.90%	15.70%	19.10%	20.10%
Social & Economic Factors	Population Receiving SNAP Benefits (ACS)	Total Households	60193	132344	68211	27822	43652	162356	494578	117716237	1141480	1115858	2372362	1461500
		Households Receiving SNAP Benefits	8652	19566	11027	4473	7612	18574	69904	15360951	163102	101588	308375	199662

		Percent Households Receiving SNAP Benefits	14.37%	14.78%	16.17%	16.08%	17.44%	11.44%	14.13%	13.05%	14.29%	9.10%	13.00%	13.66%
Social & Economic Factors	Population Receiving SNAP Benefits (SAIPE)	Total Population	150461	345094	193282	74009	103952	408834	1275632	321396328	2978204	2911641	6083672	3911338
		Population Receiving SNAP Benefits	20194	55663	28669	12425	17995	51341	186287	44567069	440641	258971	827095	610150
		Percent Population Receiving SNAP Benefits	13.40%	16.10%	14.80%	16.80%	17.30%	12.60%	14.60%	13.90%	14.80%	8.90%	13.60%	15.60%
Social & Economic Factors	Population with Associate's Level Degree or Higher	Total Population Age 25+	106455	224788	127210	50200	75382	263938	847973	213649147	1973591	1878495	4073377	2534278
		Population Age 25+ with Associate's Degree or Higher	25207	62126	32076	10492	17379	93131	240411	82237511	551450	746764	1433231	808078
		Percent Population Age 25+ with Associate's Degree or Higher	23.68%	27.64%	25.21%	20.90%	23.05%	35.29%	28.35%	38.49%	27.94%	39.75%	35.19%	31.89%
Social & Economic Factors	Population with Bachelor's Degree or Higher	Total Population Age 25+	106455	224788	127210	50200	75382	263938	847973	213649147	1973591	1878495	4073377	2534278
		Population Age 25+ with Bachelor's Degree or Higher	18203	44192	22434	7298	11210	73722	177059	64767787	424446	593801	1125665	620115
		Percent Population Age 25+ with Bachelor's Degree or Higher	17.10%	19.66%	17.64%	14.54%	14.87%	27.93%	20.88%	30.32%	21.51%	31.61%	27.63%	24.47%
Social & Economic Factors	Population with No High School Diploma	Total Population Age 25+	106455	224788	127210	50200	75382	263938	847973	213649147	1973591	1878495	4073377	2534278
		Population Age 25+ with No High School Diploma	14597	30865	19030	8495	11242	24540	108769	27818380	292228	182049	454882	322890
		Percent Population Age 25+ with No High School Diploma	13.71%	13.73%	14.96%	16.92%	14.91%	9.30%	12.83%	13.02%	14.81%	9.69%	11.17%	12.74%
Social & Economic Factors	Poverty - Children Below 100% FPL	Total Population	146893	335780	180602	72771	102523	390888	1229457	310629645	2881404	2816191	5876366	3760050

		Population Under Age 18	30522	82589	42298	17611	21206	89334	283560	72456096	694104	710859	1364095	934217
		Population Under Age 18 in Poverty	7326	20341	11739	5437	6189	18965	69997	15335783	186130	122480	287147	215690
		Percent Population Under Age 18 in Poverty	24.00%	24.63%	27.75%	30.87%	29.19%	21.23%	24.69%	21.17%	26.82%	17.23%	21.05%	23.09%
Social & Economic Factors	Poverty - Children Below 200% FPL	Total Population Under Age 18	30522	82589	42298	17611	21206	89334	283560	72456096	694104	710859	1364095	934217
		Population Under Age 18 at or Below 200% FPL	17011	44173	24502	11454	12540	43255	152935	31364270	369570	287206	597599	456466
		Percent Population Under Age 18 at or Below 200% FPL	55.73%	53.49%	57.93%	65.04%	59.13%	48.42%	53.93%	43.29%	53.24%	40.40%	43.81%	48.86%
Social & Economic Factors	Poverty - Population Below 100% FPL	Total Population	146893	335780	180602	72771	102523	390888	1229457	310629645	2881404	2816191	5876366	3760050
		Population in Poverty	24601	61691	34844	14679	19830	66817	222462	46932225	542431	373162	897755	621155
		Percent Population in Poverty	16.75%	18.37%	19.29%	20.17%	19.34%	17.09%	18.09%	15.11%	18.83%	13.25%	15.28%	16.52%
Social & Economic Factors	Poverty - Population Below 185% FPL	Total Population	146893	335780	180602	72771	102523	390888	1229457	310629645	2881404	2816191	5876366	3760050
		Population with Income at or Below 185% FPL	57663	134330	73844	31754	43811	140056	481458	96139377	1118877	816882	1864503	1314248
		Percent Population with Income at or Below 185% FPL	39.26%	40.01%	40.89%	43.64%	42.73%	35.83%	39.16%	30.95%	38.83%	29.01%	31.73%	34.95%
Social & Economic Factors	Poverty - Population Below 200% FPL	Total Population	146893	335780	180602	72771	102523	390888	1229457	310629645	2881404	2816191	5876366	3760050
		Population with Income at or Below 200% FPL	63445	146025	80396	34931	48047	152801	525645	104390198	1211947	893570	2033050	1424632
		Percent Population with Income at or Below 200% FPL	43.19%	43.49%	44.52%	48.00%	46.86%	39.09%	42.75%	33.61%	42.06%	31.73%	34.60%	37.89%

Social & Economic Factors	Poverty - Population Below 50% FPL	Total Population	146893	335780	180602	72771	102523	390888	1229457	310629645	2881404	2816191	5876366	3760050
		Population with Income at or Below 50% FPL	9440	24494	13262	5101	7316	29391	89004	20787162	226272	158397	395468	270732
		Percent Population with Income at or Below 50% FPL	6.43%	7.29%	7.34%	7.01%	7.14%	7.52%	7.24%	6.69%	7.85%	5.62%	6.73%	7.20%
Social & Economic Factors	Student Reading Proficiency (4th Grade)	Total Students with Valid Test Scores	1623	4288	2210	875	1129	4514	14639	3393582	34557	34051	66036	46634
		Percentage of Students Scoring 'Proficient' or Better	48.00%	57.56%	56.33%	51.43%	46.24%	58.97%	55.51%	49.67%	33.84%	55.27%	58.79%	69.75%
		Percentage of Students Scoring 'Not Proficient' or Worse	52	42.44	43.67	48.57	53.76	41.03	44.49	45.61	66.16	44.73	41.21	30.25
Social & Economic Factors	Teen Births	Female Population Age 15 - 19	4561	12486	6324	2517	3031	13869	42788	10736677	99627	98459	206847	128840
		Births to Mothers Age 15 - 19	248	695	302	138	171	489	2043	392962	5519	3929	8170	6932
		Teen Birth Rate (Per 1,000 Population)	54.37	55.66	47.75	54.83	56.42	35.26	47.75	36.6	55.4	39.9	39.5	53.8
Social & Economic Factors	Unemployment Rate	Labor Force	67685	163290	71370	32944	40195	207751	583235	162635301	1349290	1468404	3037457	1856982
		Number Employed	64045	157614	68029	31669	38466	201274	561097	155857594	1296850	1417876	2922605	1785530
		Number Unemployed	3640	5676	3341	1275	1729	6477	22138	6777707	52440	50528	114852	71452
		Unemployment Rate	5.4	3.5	4.7	3.9	4.3	3.1	3.8	4.2	3.9	3.4	3.8	3.8
Social & Economic Factors	Violent Crime	Total Population	150174	344396	194007	73946	104869	399254	1266646	311082592	2811942	2858500	6040967	3847536
		Violent Crimes	586	1203	505	256	208	2149	4907	1181036	13437	9966	26745	16951
		Violent Crime Rate (Per 100,000 Pop.)	389.8	349.2	260.1	347.1	198.3	538.3	387.3	379.7	477.9	348.7	442.8	440.5
Physical Environment	Air Quality - Ozone	Total Population	148226	346354	193447	74231	105320	388798	1256376	312471327	2915918	2853118	5988927	3751351
		Average Daily Ambient Ozone Concentration	43.45	44.62	43.35	44.33	42.91	43.54	43.82	38.95	42.52	43.65	42.45	45.05

		Number of Days Exceeding Emissions Standards	1.43	8.46	3	4.71	0.27	4.17	4.73	4.46	3.02	7.9	10.46	8.35
		Percentage of Days Exceeding Standards, Crude Average	0.39%	2.32%	0.82%	1.29%	0.07%	1.14%	1.30%	1.22%	0.83%	2.16%	2.87%	2.29%
		Percentage of Days Exceeding Standards, Pop. Adjusted Average	0.40%	2.37%	0.78%	1.34%	0.08%	1.13%	1.26%	1.24%	0.84%	2.20%	2.87%	2.27%
Physical Environment	Air Quality - Particulate Matter 2.5	Total Population	148226	346354	193447	74231	105320	388798	1256376	312471327	2915918	2853118	5988927	3751351
		Average Daily Ambient Particulate Matter 2.5	9.12	9.44	9.08	9.24	8.99	9.6	9.36	9.1	9.96	9.17	10.2	9.38
		Number of Days Exceeding Emissions Standards	0	0	0	0	0	0	0	0.35	0	0	0	0
		Percentage of Days Exceeding Standards, Crude Average	0	0	0	0	0	0	0	0.1	0	0	0	0
		Percentage of Days Exceeding Standards, Pop. Adjusted Average	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.10%	0.00%	0.00%	0.00%	0.00%
Physical Environment	Climate & Health - Drought Severity	Percentage of Weeks in D0 (Abnormally Dry)	21.74%	20.52%	19.31%	27.88%	11.61%	19.71%	19.91%	16.96%	18.67%	21.71%	21.93%	18.70%
		Percentage of Weeks in D1 (Moderate Drought)	8.64%	18.53%	13.57%	14.63%	10.79%	17.22%	15.32%	12.59%	8.92%	18.01%	14.83%	18.82%
		Percentage of Weeks in D2 (Severe Drought)	9.68%	14.33%	7.20%	9.40%	5.53%	7.45%	9.53%	8.84%	6.81%	15.95%	8.81%	15.45%
		Percentage of Weeks in D3 (Extreme Drought)	4.48%	3.69%	3.96%	2.25%	6.41%	3.76%	3.99%	4.92%	6.71%	16.34%	3.97%	17.76%
		Percentage of Weeks in D4 (Exceptional Drought)	4.24%	2.16%	0.01%	2.13%	2.63%	0.06%	1.46%	2.54%	2.92%	3.70%	0.86%	4.30%
		Percentage of Weeks in Drought (Any)	48.77%	59.24%	44.06%	56.29%	36.97%	48.19%	50.21%	45.85%	44.02%	75.71%	50.39%	75.03%

Physical Environment	Climate & Health - High Heat Index Days	Total Weather Observations	15695	31755	28470	8395	19345	10585	114245	19094610	319010	509540	438730	420480
		Average Heat Index Value	96.61	98.16	96.35	96.75	97.07	96.16	97.08	91.82	97.3	95.02	96.92	97.11
		Observations with High Heat Index Values	1891	5057	3206	1044	2475	1163	14836	897155	57240	51866	52450	80717
		Observations with High Heat Index Values, Percentage	12.00%	15.90%	11.30%	12.40%	12.80%	11.00%	13.00%	4.70%	17.90%	10.20%	12.00%	19.20%
Physical Environment	Food Access - Fast Food Restaurants	Total Population	148226	346354	193447	74231	105320	388798	1256376	312846570	2915918	2853118	5988927	3751351
		Number of Establishments	113	212	93	36	60	333	847	233392	1979	2036	4153	2752
		Establishments, Rate per 100,000 Population	76.23	61.21	48.08	48.5	56.97	85.65	67.42	74.6	67.87	71.36	69.34	73.36
Physical Environment	Food Access - Food Desert Census Tracts	Total Population (2010)	148226	346354	193447	74231	105320	388798	1256376	308745538	2915918	2853118	5988927	3751351
		Food Desert Census Tracts	15	42	23	6	12	30	128	27527	341	373	638	466
		Other Census Tracts	13	39	14	8	10	54	138	45337	345	397	755	580
		Food Desert Population	87042	189143	131963	32236	59064	165083	664531	129885212	1511826	1469254	3071039	1792846
		Other Population	61184	157211	61484	41995	46256	223715	591845	178860326	1404092	1383864	2917888	1958505
Physical Environment	Food Access - Grocery Stores	Total Population	148226	346354	193447	74231	105320	388798	1256376	312846570	2915918	2853118	5988927	3751351
		Number of Establishments	28	41	31	18	22	55	195	66284	477	516	1061	639
		Establishments, Rate per 100,000 Population	18.89	11.84	16.03	24.25	20.89	14.15	15.52	21.19	16.36	18.09	17.72	17.03
Physical Environment	Food Access - Low Food Access	Total Population	148226	346354	193447	74231	105320	388798	1256376	308745538	2915918	2853118	5988927	3751351
		Population with Low Food Access	39444	89511	71573	13507	26149	83325	323509	69266771	698771	752888	1531368	993419
		Percent Population with Low Food Access	26.61%	25.84%	37.00%	18.20%	24.83%	21.43%	25.75%	22.43%	23.96%	26.39%	25.57%	26.48%

Physical Environment	Food Access - Low Income & Low Food Access	Total Population	148226	346354	193447	74231	105320	388798	1256376	308745538	2915918	2853118	5988927	3751351
		Low Income Population	71933	146424	82775	38762	47286	153941	541121	106758543	1266307	928552	2144902	1445224
		Low Income Population with Low Food Access	17877	36583	28483	5295	12447	28196	128881	20221368	291773	253257	463471	362477
		Percent Low Income Population with Low Food Access	24.85%	24.98%	34.41%	13.66%	26.32%	18.32%	23.82%	18.94%	23.04%	27.27%	21.61%	25.08%
Physical Environment	Food Access - Modified Retail Food Environment Index	Total Population	148223	346354	193447	74231	105320	388801	1256376	312474470	2915918	2853118	5988926	3751351
		Percent Population in Tracts with No Food Outlet	0.00%	1.08%	0.56%	0.00%	5.30%	1.73%	1.36%	0.99%	0.50%	1.48%	0.64%	1.96%
		Percent Population in Tracts with No Healthy Food Outlet	23.21%	41.84%	35.92%	35.48%	37.50%	21.64%	31.74%	18.63%	26.96%	25.43%	21.82%	37.41%
		Percent Population in Tracts with Low Healthy Food Access	41.02%	27.61%	23.99%	18.71%	19.74%	35.76%	29.97%	30.89%	24.07%	23.45%	27.45%	30.39%
		Percent Population in Tracts with Moderate Healthy Food Access	29.00%	25.99%	27.95%	45.81%	32.36%	40.86%	32.96%	43.28%	44.26%	42.66%	45.26%	26.74%
		Percent Population in Tracts with High Healthy Food Access	6.77%	3.49%	11.57%	0.00%	5.11%	0.00%	3.97%	5.02%	4.22%	6.99%	4.83%	3.51%
Physical Environment	Food Access - SNAP-Authorized Food Stores	Total Population	148226	346354	193447	74231	105320	388798	1256376	312411142	2915918	2853118	5988927	3751351
		Total SNAP-Authorized Retailers	150	349	190	78	120	313	1200	257596	2810	2036	4996	3598
		SNAP-Authorized Retailers, Rate per 10,000 Population	10.12	10.08	9.82	10.51	11.39	8.05	9.55	8.25	9.64	7.14	8.34	9.59
Physical Environment	Food Access - WIC-Authorized Food Stores	Total Population (2011 Estimate)	149562	347093	193892	73942	105344	392224	1262058	318921538	2956882	2884614	6036320	3814128

		Number WIC-Authorized Food Stores	23	50	31	14	15	47	180	50042	438	382	722	850
		WIC-Authorized Food Store Rate (Per 100,000 Pop.)	15.3	14.4	15.9	18.9	14.2	11.9	14.2	15.6	14.8	13.2	11.9	22.2
Physical Environment	Housing - Assisted Housing	Total Housing Units (2010)	80014	151844	102912	34172	52772	171380	593094	133341676	1316299	1233215	2712729	1664378
		Total HUD-Assisted Housing Units	1380	4984	1743	252	1420	3046	12825	5005789	51029	34926	90864	53223
		HUD-Assisted Units, Rate per 10,000 Housing Units	172.47	328.23	169.37	73.74	269.08	177.73	216.24	375.41	387.67	283.21	334.95	319.78
Physical Environment	Housing - Housing Unit Age	Total Housing Units	1341391	1248955	2738774	2738774	1341391	2738774	1341391	16908	2738774	2738774	134054899	134054899
		Median Year Structures Built	1983	1972	1976	1976	1983	1976	1983	1979	1976	1976	1977	1977
Physical Environment	Housing - LIHTC	LIHTC Properties	45	103	37	18	34	89	326	43092	589	608	1713	531
		LIHTC Units	1625	4186	1190	654	1054	4004	12713	2784155	29513	29905	63615	27814
Physical Environment	Housing - Mortgage Lending	Total Population (2010)	148226	346354	193447	74231	105320	388798	1256376	312470869	2915918	2853118	5988927	3751351
		Number of Home Loans Originated	2984	5368	3766	1167	1539	9422	24246	5959108	52608	53511	119207	75530
		Loans Originations, Approval Rate	53.12%	51.58%	51.60%	49.58%	53.12%	55.80%	53.34%	51.57%	49.03%	56.41%	52.31%	52.11%
		Loan Originations, Rate per 100,000 Population	201.31	154.99	194.68	157.21	146.13	242.34	192.98	190.71	180.42	187.55	199.05	201.34
Physical Environment	Housing - Overcrowded Housing	Total Occupied Housing Units	57699	121263	63770	26728	42564	152974	464998	90970439	914347	981294	2007863	1130101
		Overcrowded Housing Units	1537	3709	1763	793	970	2713	11485	3932606	29803	22647	38588	40671
		Percentage of Housing Units Overcrowded	2.66%	3.06%	2.76%	2.97%	2.28%	1.77%	2.47%	4.32%	3.26%	2.31%	1.92%	3.60%
Physical Environment	Housing - Substandard Housing	Total Occupied Housing Units	60193	132344	68211	27822	43652	162356	494578	117716237	1141480	1115858	2372362	1461500

		Occupied Housing Units with One or More Substandard Conditions	17063	36391	19184	7389	12065	47334	139426	39729263	310386	293940	663290	396712
		Percent Occupied Housing Units with One or More Substandard Conditions	28.35%	27.50%	28.12%	26.56%	27.64%	29.15%	28.19%	33.75%	27.19%	26.34%	27.96%	27.14%
Physical Environment	Housing - Vacancy Rate	Total Housing Units	81080	152457	103468	33987	52725	176451	600168	134054899	1341391	1248955	2738774	1699462
		Vacant Housing Units	20887	20113	35257	6165	9073	14095	105590	16338662	199911	133097	366412	237962
		Vacant Housing Units, Percent	25.76%	13.19%	34.08%	18.14%	17.21%	7.99%	17.59%	12.19%	14.90%	10.66%	13.38%	14.00%
Physical Environment	Liquor Store Access	Total Population	148226	346354	193447	74231	105320	388798	1256376	312846570	2915918	2853118	5988927	3751351
		Number of Establishments	16	48	12	9	18	24	127	33692	344	637	381	431
		Establishments, Rate per 100,000 Population	10.79	13.86	6.2	12.12	17.09	6.17	10.11	10.77	11.8	22.33	6.36	11.49
Physical Environment	Recreation and Fitness Facility Access	Total Population	148226	346354	193447	74231	105320	388798	1256376	312846570	2915918	2853118	5988927	3751351
		Number of Establishments	8	17	18	5	9	46	103	32712	222	256	585	304
		Establishments, Rate per 100,000 Population	5.4	4.91	9.3	6.74	8.55	11.83	8.2	10.46	7.61	8.97	9.77	8.1
Physical Environment	Use of Public Transportation	Total Population Employed Age 16+	61306	153593	80652	29636	39104	186525	550816	145861221	1247999	1402677	2803637	1720575
		Population Using Public Transit for Commute to Work	168	391	161	57	94	946	1817	7476312	5112	7169	41741	7924
		Percent Population Using Public Transit for Commute to Work	0.27%	0.25%	0.20%	0.19%	0.24%	0.51%	0.33%	5.13%	0.41%	0.51%	1.49%	0.46%
Clinical Care	Access to Dentists	Total Population, 2015	150461	345094	193282	74009	103952	408834	1275632	321418820	2978204	2911641	6083672	3911338
		Dentists, 2015	48	131	100	25	43	235	582	210832	1318	1614	3299	2250
		Dentists, Rate per 100,000 Pop.	31.9	38	51.7	33.8	41.4	57.5	45.6	65.6	44.3	55.4	54.2	57.5
Clinical Care	Access to Mental Health Providers	Estimated Population	150272	345145	193216	73683	94576	404849	1261741	317105555	2952717	2835271	6017783	3853992

		Number of Mental Health Providers	98	624	252	80	189	1002	2245	643219	5731	5265	10147	14454
		Ratio of Mental Health Providers to Population(1 Provider per x Persons)	1533.4	553.1	766.7	921	500.4	404	562	493	515.2	538.5	593.1	266.6
		Mental Health Care Provider Rate (Per 100,000 Population)	65.2	180.7	130.4	108.5	199.8	247.4	177.9	202.8	194	185.6	168.6	375
Clinical Care	Access to Primary Care	Total Population, 2014	150274	345141	193218	73685	104068	404854	1271240	318857056	2966369	2904021	6063589	3878051
		Primary Care Physicians, 2014	99	188	99	47	77	352	862	279871	2229	2457	5072	2764
		Primary Care Physicians, Rate per 100,000 Pop.	65.9	54.5	51.2	63.8	74	86.9	67.8	87.8	75.1	84.6	83.6	71.3
Clinical Care	Cancer Screening - Mammogram	Total Medicare Enrollees	20714	40363	22492	6906	16806	29885	137166	26753396	335922	316321	581575	405789
		Female Medicare Enrollees Age 67-69	1910	3607	2157	580	1457	2639	12350	2395946	30761	26965	52310	38135
		Female Medicare Enrollees with Mammogram in Past 2 Years	1182	2063	1282	351	872	1733	7487	1510847	17866	16987	32760	21211
		Percent Female Medicare Enrollees with Mammogram in Past 2 Year	61.90%	57.20%	59.50%	60.70%	59.90%	65.70%	60.60%	63.10%	58.10%	63.00%	62.60%	55.60%
Clinical Care	Cancer Screening - Pap Test	Female Population Age 18+	105848	234695	134529	52531	80303	278333	886239	176847182	1763631	1838372	3846348	2154209
		Estimated Number with Regular Pap Test	70239	126412	71215	32954	42427	198981	542228	137191142	1275105	1400839	2877068	1525180
		Crude Percentage	66.40%	64.60%	65.50%	62.70%	68.00%	71.50%	67.50%	77.60%	72.30%	76.20%	74.80%	70.80%
		Age-Adjusted Percentage	68.50%	66.30%	69.30%	66.40%	75.20%	72.70%	69.90%	78.50%	74.00%	77.80%	76.60%	72.60%
Clinical Care	Cancer Screening - Sigmoidoscopy or Colonoscopy	Total Population Age 50+	49407	90883	52712	21412	38527	95188	348129	75116406	758335	693824	1532083	930101
		Estimated Population Ever Screened for Colon Cancer	28856	37300	26862	10473	20056	60717	184264	48549269	442868	439884	972873	536668

		Crude Percentage	58.40%	49.30%	56.40%	48.90%	66.70%	70.30%	59.30%	64.60%	58.40%	63.40%	63.50%	57.70%
		Age-Adjusted Percentage	50.60%	46.30%	53.90%	45.80%	61.50%	64.70%	54.70%	61.30%	54.50%	60.30%	60.30%	54.20%
Clinical Care	Dental Care Utilization	Total Population(Age 18+)	113132	256714	144880	54878	81978	292256	943838	235375690	2187717	2112400	4532155	2793624
		Total Adults Without Recent Dental Exam	50000	114807	60143	33160	26903	108897	393910	70965788	839735	597011	1681987	1181932
		Percent Adults with No Dental Exam	44.20%	44.70%	41.50%	60.40%	32.80%	37.30%	41.70%	30.20%	38.40%	28.30%	37.10%	42.30%
Clinical Care	Diabetes Management - Hemoglobin A1c Test	Total Medicare Enrollees	20714	40363	22492	6906	16806	29885	137166	26753396	335922	316321	581575	405789
		Medicare Enrollees with Diabetes	2445	5481	2876	819	1918	3491	17030	3314834	42560	36855	74009	56401
		Medicare Enrollees with Diabetes with Annual Exam	2076	4561	2441	714	1691	3124	14608	2822996	35815	31820	63678	44194
		Percent Medicare Enrollees with Diabetes with Annual Exam	84.90%	83.20%	84.90%	87.30%	88.20%	89.50%	85.80%	85.20%	84.20%	86.30%	86.00%	78.40%
Clinical Care	Facilities Designated as Health Professional Shortage Areas	Primary Care Facilities	1	22	6	1	3	5	38	3599	25	69	103	106
		Mental Health Care Facilities	0	19	7	0	3	4	33	3171	31	46	87	103
		Dental Health Care Facilities	0	21	5	0	2	6	34	3071	21	47	79	96
		Total HPSA Facility Designations	1	62	18	1	8	15	105	9836	77	162	269	305
Clinical Care	Federally Qualified Health Centers	Total Population	148226	346354	193447	74231	105320	388798	1256376	312471327	2915918	2853118	5988927	3751351
		Number of Federally Qualified Health Centers	6	19	10	3	3	7	48	8329	124	70	202	104
		Rate of Federally Qualified Health Centers per 100,000 Population	4.05	5.49	5.17	4.04	2.85	1.8	3.82	2.67	4.25	2.45	3.37	2.77

Clinical Care	High Blood Pressure Management	Total Population(Age 18+)	113132	256714	144880	54878	81978	292256	943838	235375690	2187717	2112400	4532155	2793624
		Total Adults Not Taking Blood Pressure Medication (When Needed)	11408	40852	0	0	8101	63289	123650	51175402	417130	429337	957912	565511
		Percent Adults Not Taking Medication	10.10%	15.90%	0.00%	0.00%	9.90%	21.70%	13.10%	21.70%	19.10%	20.30%	21.10%	20.20%
Clinical Care	HIV Screenings	Survey Population(Adults Age 18+)	107382	219443	126862	53696	66790	247807	821980	214984421	1993401	2031579	4226096	2671944
		Total Adults Never Screened for HIV / AIDS	80053	161477	84505	42877	49764	170651	589327	134999025	1342774	1420739	2840197	1857242
		Percent Adults Never Screened for HIV / AIDS	74.50%	73.60%	66.60%	79.90%	74.50%	68.90%	71.70%	62.79%	67.36%	69.93%	67.21%	69.51%
Clinical Care	Lack of a Consistent Source of Primary Care	Survey Population(Adults Age 18+)	116114	233513	130970	56977	73625	262390	873589	236884668	2185490	2136402	4560355	2843159
		Total Adults Without Any Regular Doctor	32081	56326	32101	6701	12309	65624	205142	52290932	500175	432196	938202	686103
		Percent Adults Without Any Regular Doctor	27.60%	24.10%	24.50%	11.80%	16.70%	25.00%	23.50%	22.07%	22.89%	20.23%	20.57%	24.13%
Clinical Care	Lack of Prenatal Care	Total Births		7293				14505	21798	16693978	160395	165882	318557	217637
		Mothers Starting Prenatal Care in First Semester		1244				2549	3793	7349554		117513	56322	33170
		Mothers with Late or No Prenatal Care		531				810	1341	2880098		41231	16666	17443
		Prenatal Care Not Reported		5518				11146	16664	6464326	160395	7138	245569	167024
		Percentage Mothers with Late or No Prenatal Care	suppressed	7.30%	suppressed	suppressed	suppressed	5.60%	6.20%	17.30%		24.90%	5.20%	8.00%
Clinical Care	Pneumonia Vaccination	Total Population Age 65+	27989	50576	28835	12279	23266	51793	194738	39608820	413544	372044	826139	499547
		Estimated Population with Annual Pneumonia Vaccination	18010	29452	13603	9019	12104	36618	118806	26680462	273353	257454	572514	360673

		Crude Percentage	64.30%	69.80%	71.10%	73.50%	65.80%	77.70%	71.10%	67.40%	66.10%	69.20%	69.30%	72.20%
		Age-Adjusted Percentage	65.20%	69.70%	71.80%	74.10%	65.90%	77.00%	71.10%	67.50%	66.30%	68.80%	69.40%	72.70%
Clinical Care	Population Living in a Health Professional Shortage Area	Total Area Population	148226	346354	193447	74231	105320	388798	1256376	308745538	2915918	2853118	5988927	3751351
		Population Living in a HPSA	116024	346354	193447	74231	105320	388798	1224174	102289607	1325988	1418050	3266848	1680905
		Percentage of Population Living in a HPSA	78.28%	100.00%	100.00%	100.00%	100.00%	100.00%	97.44%	33.13%	45.47%	49.70%	54.55%	44.81%
Clinical Care	Preventable Hospital Events	Total Medicare Part A Enrollees	21825	42843	23503	7383	17452	32222	145228	29649023	357377	341565	628274	437663
		Ambulatory Care Sensitive Condition Hospital Discharges	949	2503	1250	386	903	1452	7446	1479545	22139	17732	35569	25928
		Ambulatory Care Sensitive Condition Discharge Rate	43.5	58.4	53.2	52.4	51.8	45.1	51.3	49.9	62	51.9	56.6	59.2
Clinical Care	Recent Primary Care Visit	Total Population (2010)	2915918	2853118	5988927	5988927	2915918	352596	352596		5988927	5988927	308745538	308745538
		Total Population in the 500 Cities (2010)	490373	1042514	1411382	1411382	490373	159498	159498		1411382	1411382	103020808	103020808
		Percentage of Adults with Routine Checkup in Past 1 Year	68.90%	68.20%	68.80%	68.80%	68.90%	67.54%	67.54%		68.80%	68.80%	67.90%	67.90%
Health Behaviors	Alcohol Consumption	Total Population Age 18+	114819	257971	146743	55072	82478	296593	953676	232556016	2187717	2112400	4532155	2793624
		Estimated Adults Drinking Excessively	12406	32370	15906	4246	8454	35347	108729	38248349	275652	323197	770466	368758
		Estimated Adults Drinking Excessively(Crude Percentage)	10.80%	13.90%	17.00%	15.90%	13.20%	13.10%	13.60%	16.40%	12.60%	15.30%	17.00%	13.20%
		Estimated Adults Drinking Excessively(Age-Adjusted Percentage)	9.30%	14.50%	17.10%	17.80%	15.20%	13.70%	14.10%	16.90%	13.20%	15.90%	17.90%	13.90%
Health Behaviors	Alcohol Expenditures	State Rank	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	no data	no data	no data	no data	no data
		Z-Score (US)	-0.61	-0.7	0.06	-0.11	0.14	-0.83	-0.51	no data	0.16	0.4	0.36	0.58
		Z-Score (State)	-1.31	-1.91	-0.49	-0.7	-0.39	-1.59	-1.68	no data	0	0	0	0

		Average Expenditures (USD)	$711.09	$731.23	$807.90	$808.62	$775.68	$697.39	$737.39	$839.54	$764.85	$868.57	$849.54	$864.68
		Percentage of Food-At-Home Expenditures	13.31%	13.16%	14.38%	14.11%	14.52%	12.94%	13.47%	14.29%	14.45%	15.15%	15.03%	15.67%
Health Behaviors	Fruit/Vegetable Consumption	Total Population(Age 18+)	109164	254130	136296	53801	80556	285279	919226	227279010	2136963	2079386	4473226	2709105
		Total Adults with Inadequate Fruit / Vegetable Consumption	39714	169831	76214	0	26656	212019	524434	171972118	1686064	1682223	3538322	2289194
		Percent Adults with Inadequate Fruit / Vegetable Consumption	81.10%	79.50%	84.00%		78.80%	81.60%	81.10%	75.70%	78.90%	80.90%	79.10%	84.50%
Health Behaviors	Fruit/Vegetable Expenditures	State Rank	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	no data	no data	no data	no data	no data
		Z-Score (US)	-1.47	-1.75	-1.26	-1.2	-1.02	-2.11	-1.66	no data	-0.7	-0.57	-0.61	-0.49
		Z-Score (State)	-0.23	-1.71	0.31	0.51	0.83	-2.16	-1.19	no data	0	0	0	0
		Average Expenditures (USD)	$625.22	$640.30	$665.26	$681.10	$641.05	$607.67	$633.97	$744.71	$616.25	$677.50	$665.08	$657.14
		Percentage of Food-At-Home Expenditures	11.70%	11.52%	11.84%	11.89%	12.00%	11.28%	11.58%	12.68%	11.65%	11.81%	11.77%	11.91%
Health Behaviors	Physical Inactivity	Total Population Age 20+	114897	250068	143242	54086	80365	298818	941476	234207619	2171944	2090037	4486311	2801368
		Population with no Leisure Time Physical Activity	34244	73149	38522	15343	25271	69943	256472	52147893	671796	490569	1120890	814440
		Percent Population with no Leisure Time Physical Activity	27.60%	28.20%	25.70%	26.50%	28.90%	22.90%	26.00%	21.80%	29.90%	23.00%	24.10%	28.30%
Health Behaviors	Soda Expenditures	State Rank	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	no data	no data	no data	no data	no data
		Z-Score (US)	1.99	2.09	1.49	1.49	1.46	2.44	2.01	no data	0.89	0.75	0.74	0.8
		Z-Score (State)	0.9	1.5	0.33	0.34	-0.36	2.71	0.95	no data	0	0	0	0
		Average Expenditures (USD)	$252.17	$264.41	$255.54	$260.57	$242.39	$263.10	$259.02	$236.04	$242.97	$258.63	$254.50	$250.46
		Percentage of Food-At-Home Expenditures	4.72%	4.76%	4.55%	4.55%	4.54%	4.88%	4.73%	4.02%	4.59%	4.51%	4.50%	4.54%
Health Behaviors	Tobacco Expenditures	State Rank	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	no data	no data	no data	no data	no data
		Z-Score (US)	2.11	1.81	1.69	1.88	2.19	1.52	1.77	no data	0.71	0.03	0.31	0.56
		Z-Score (State)	0.97	0.86	1.23	1.49	1.08	0.99	0.47	no data	0	0	0	0

		Average Expenditures (USD)	$1,034.80	$1,040.74	$1,026.45	$1,051.25	$1,031.00	$999.17	$1,024.26	$822.70	$968.13	$896.37	$935.41	$982.97
		Percentage of Food-At-Home Expenditures	2.40%	2.28%	2.23%	2.30%	2.43%	2.16%	2.26%	1.56%	2.13%	1.73%	1.89%	2.04%
Health Behaviors	Tobacco Usage - Current Smokers	Total Population Age 18+	114819	257971	146743	55072	82478	296593	953676	232556016	2187717	2112400	4532155	2793624
		Total Adults Regularly Smoking Cigarettes	27698	55639	39437	15996	18930	60189	217889	41491223	490049	369670	1024267	673263
		Percent Population Smoking Cigarettes(Crude)	24.10%	22.40%	26.90%	29.00%	25.30%	20.30%	23.30%	17.80%	22.40%	17.50%	22.60%	24.10%
		Percent Population Smoking Cigarettes(Age-Adjusted)	26.20%	23.00%	29.50%	30.10%	28.60%	20.90%	24.60%	18.10%	23.00%	17.70%	23.20%	24.50%
Health Behaviors	Tobacco Usage - Former or Current Smokers	Survey Population(Adults Age 18+)	114989	232456	131191	56726	73453	261818	870633	235151778	2170901	2127142	4535528	2828524
		Total Adults Ever Smoking 100 or More Cigarettes	61505	117290	68934	27904	42270	131895	449798	103842020	1100570	931965	2224446	1392091
		Percent Adults Ever Smoking 100 or More Cigarettes	53.49%	50.46%	52.54%	49.19%	57.55%	50.38%	51.66%	44.16%	50.70%	43.81%	49.04%	49.22%
Health Behaviors	Tobacco Usage - Quit Attempt	Survey Population(Smokers Age 18+)	30553	65473	37284	12611	14936	67182	228039	45526654	563311	438742	1109658	696201
		Total Smokers with Quit Attempt in Past 12 Months	14801	32554	20401	6453	5848	40012	120069	27323073	336085	246642	596738	418156
		Percent Smokers with Quit Attempt in Past 12 Months	48.44%	49.72%	54.72%	51.17%	39.15%	59.56%	52.65%	60.02%	59.66%	56.22%	53.78%	60.06%
Health Behaviors	Walking or Biking to Work	Population Age 16+	61306	153593	80652	29636	39104	186525	550816	145861221	1247999	1402677	2803637	1720575
		Population Walking or Biking to Work	1646	3393	1493	659	899	4212	12302	4908725	23754	38101	60671	34573
		Percentage Walking or Biking to Work	2.68%	2.21%	1.85%	2.22%	2.30%	2.26%	2.23%	3.37%	1.90%	2.72%	2.16%	2.01%
Health Outcomes	Asthma Prevalence	Survey Population(Adults Age 18+)	116002	232835	130541	56824	74053	262891	873146	237197465	2186289	2133641	4553696	2840351

		Total Adults with Asthma	16114	36672	14166	8462	7116	35404	117934	31697608	291927	264243	644403	403172
		Percent Adults with Asthma	13.90%	15.80%	10.90%	14.90%	9.60%	13.50%	13.50%	13.40%	13.40%	12.40%	14.20%	14.20%
Health Outcomes	Cancer Incidence - Breast	Estimated Total Population (Female)	10927	15883	11999	4975	8578	23526	75891	18515303	179591	164858	368864	222495
		New Cases (Annual Average)	120	165	133	48	86	285	837	228664	2024	2036	4644	2621
		Cancer Incidence Rate (Per 100,000 Pop.)	109.82	103.88	110.84	96.47	100.25	121.14	110.29	123.5	112.7	123.5	125.9	117.8
Health Outcomes	Cancer Incidence - Cervical	Estimated Total Population (Female)	148484	139726	312941	312941	148484	312941	148484		312941	312941	16137921	16137921
		New Cases (Annual Average)	147	102	266	266	147	266	147		266	266	12299	12299
		Cancer Incidence Rate (Per 100,000 Pop.)	9.9	7.3	8.5	8.5	9.9	8.5	9.9		8.5	8.5	7.62	7.62
Health Outcomes	Cancer Incidence - Colon and Rectum	Estimated Total Population	21339	31385	22768	10119	16520	43580	145714	34945477	343953	318932	700941	423696
		New Cases (Annual Average)	86	140	103	39	67	166	601	139083	1479	1314	2979	1788
		Cancer Incidence Rate (Per 100,000 Pop.)	40.3	44.61	45.24	38.54	40.56	38.09	41.25	39.8	43	41.2	42.5	42.2
Health Outcomes	Cancer Incidence - Lung	Estimated Total Population	22946	31838	24356	10299	17600	45068	152110	35229411	354768	321428	714419	432768
		New Cases (Annual Average)	164	244	186	73	132	285	1084	215604	2753	1980	5351	3064
		Cancer Incidence Rate (Per 100,000 Pop.)	71.47	76.64	76.37	70.87	75	63.24	71.26	61.2	77.6	61.6	74.9	70.8
Health Outcomes	Cancer Incidence - Prostate	Estimated Total Population (Male)	11650	14612	12120	4979	8738	21341	73442	16980487	169096	153467	345148	205632
		New Cases (Annual Average)	115	107	107	38	77	218	662	194936	2041	1903	3486	2227
		Cancer Incidence Rate (Per 100,000 Pop.)	98.71	73.22	88.28	76.32	88.12	102.15	90.14	114.8	120.7	124	101	108.3

Health Outcomes	Depression (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	25144	54610	27917	9727	21988	42541	181927	34118227	454228	402096	767306	535844
		Beneficiaries with Depression	3794	11098	4979	1638	3605	9265	34379	5695629	73888	71709	153690	103338
		Percent with Depression	15.10%	20.30%	17.80%	16.80%	16.40%	21.80%	18.90%	16.70%	16.30%	17.80%	20.00%	19.30%
Health Outcomes	Diabetes (Adult)	Total Population Age 20+	114647	249449	143252	54129	80343	297427	939247	236919508	2172116	2085770	4478513	2798712
		Population with Diagnosed Diabetes	13848	28460	15357	5679	11273	27410	102027	23685417	270151	205369	486462	326404
		Population with Diagnosed Diabetes, Crude Rate	12.08	11.41	10.72	10.49	14.03	9.22	10.86	10	12.44	9.85	10.86	11.66
		Population with Diagnosed Diabetes, Age-Adjusted Rate	9.67%	10.11%	9.35%	8.55%	10.88%	8.57%	9.46%	9.19%	11.28%	9.07%	9.71%	10.73%
Health Outcomes	Diabetes (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	25144	54610	27917	9727	21988	42541	181927	34118227	454228	402096	767306	535844
		Beneficiaries with Diabetes	5691	14742	6758	2271	5108	9618	44188	9057809	110901	99599	198285	144313
		Percent with Diabetes	22.60%	27.00%	24.20%	23.30%	23.20%	22.60%	24.30%	26.55%	24.42%	24.77%	25.84%	26.93%
Health Outcomes	Heart Disease (Adult)	Survey Population(Adults Age 18+)	115045	232377	129796	56462	73484	260695	867859	236406904	2170495	2127276	4527296	2825960
		Total Adults with Heart Disease	4447	13384	7248	4067	7452	10761	47359	10407185	126048	96196	218318	143494
		Percent Adults with Heart Disease	3.90%	5.80%	5.60%	7.20%	10.10%	4.10%	5.50%	4.40%	5.80%	4.50%	4.80%	5.10%
Health Outcomes	Heart Disease (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	25144	54610	27917	9727	21988	42541	181927	34118227	454228	402096	767306	535844
		Beneficiaries with Heart Disease	6215	16412	7538	2179	5389	8952	46685	9028604	132518	102633	204290	163747
		Percent with Heart Disease	24.70%	30.10%	27.00%	22.40%	24.50%	21.00%	25.70%	26.46%	29.17%	25.52%	26.62%	30.56%
Health Outcomes	High Blood Pressure (Adult)	Total Population(Age 18+)	114819	257971	146743	55072	82478	296593	953676	232556016	2187717	2112400	4532155	2793624
		Total Adults with High Blood Pressure	30569	65064	45434	18737	19920	79517	259241	65476522	697882	578798	1336986	902341
		Percent Adults with High Blood Pressure	26.62%	30.04%	33.90%	34.02%	31.06%	26.81%	29.42%	28.16%	31.90%	27.40%	29.50%	32.30%

Health Outcomes	High Blood Pressure (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	25144	54610	27917	9727	21988	42541	181927	34118227	454228	402096	767306	535844
		Beneficiaries with High Blood Pressure	12610	31101	14111	4713	11544	21049	95128	18761681	250397	213741	419133	308910
		Percent with High Blood Pressure	50.20%	57.00%	50.50%	48.50%	52.50%	49.50%	52.30%	54.99%	55.13%	53.16%	54.62%	57.65%
Health Outcomes	High Cholesterol (Adult)	Survey Population(Adults Age 18+)	89324	157576	95990	39182	49318	198770	630160	180861326	1558602	1570832	3449710	2020634
		Total Adults with High Cholesterol	34396	60260	42880	18832	23948	76590	256906	69662357	628092	604594	1394360	844648
		Percent Adults with High Cholesterol	38.51%	38.24%	44.67%	48.06%	48.56%	38.53%	40.77%	38.52%	40.30%	38.49%	40.42%	41.80%
Health Outcomes	High Cholesterol (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	25144	54610	27917	9727	21988	42541	181927	34118227	454228	402096	767306	535844
		Beneficiaries with High Cholesterol	9394	22539	10220	3330	8016	15733	69232	15219766	171745	160836	320577	215698
		Percent with High Cholesterol	37.40%	41.30%	36.60%	34.20%	36.50%	37.00%	38.10%	44.61%	37.81%	40.00%	41.78%	40.25%
Health Outcomes	Infant Mortality	Total Births	8655	24670	12610	5105	6025	26440	83505	20913535	200675	207475	399460	272495
		Total Infant Deaths	58	159	93	29	41	170	550	136369	1545	1473	2876	2125
		Infant Mortality Rate (Per 1,000 Births)	6.7	6.4	7.4	5.7	6.8	6.4	6.6	6.5	7.7	7.1	7.2	7.8
Health Outcomes	Low Birth Weight	Total Live Births	11984	34433	17150	7231	8316	35210	114324	29300495	278383	285236	556612	372505
		Low Weight Births (Under 2500g)	836	2474	1202	528	617	2403	8060	2402641	25054	20537	44529	30918
		Low Weight Births, Percent of Total	6.98%	7.18%	7.01%	7.30%	7.42%	6.82%	7.05%	8.20%	9.00%	7.20%	8.00%	8.30%
Health Outcomes	Mortality - Cancer	Total Population	150201	344735	193466	73915	104235	404584	1271136	318689254	209087	329065	239305	381575
		Average Annual Deaths, 2010-2014	385	821	436	172	334	757	2905	590634	55	149	99	143
		Crude Death Rate (Per 100,000 Pop.)	256.5	238.1	225.6	232.2	320.2	187.1	228.5	185.3	26.4	45.28	41.29	37.58
		Age-Adjusted Death Rate (Per 100,000 Pop.)	169.4	194.3	185	166.6	192.1	160.7	177.4	160.9	68.97	110.62	87.2	99.84

Health Outcomes	Mortality - Coronary Heart Disease	Total Population	150201	344735	193466	73915	104235	404584	1271136	318689254	209087	329065	239305	381575
		Average Annual Deaths, 2010-2014	294	642	304	159	190	424	2012	367306	28	69	55	86
		Crude Death Rate (Per 100,000 Pop.)	195.9	186.1	156.9	214.6	182.3	104.8	158.3	115.3	160.39	107.1	137.33	158.63
		Age-Adjusted Death Rate (Per 100,000 Pop.)	132.7	153.4	133.4	158	110.9	88.5	124	99.6	133.36	88.83	111.45	139.77
Health Outcomes	Mortality - Drug Poisoning	Total Population	150201	344735	193466	73915	104235	404584	1271136	318689254	2968265	2900563	6061284	3875668
		Average Annual Deaths, 2010-2014	22	41	26	11	14	85	200	49715	368	325	1094	775
		Crude Death Rate (Per 100,000 Pop.)	14.9	12.4	16.5	14.3	17	21.1	16.6	15.6	12.4	11.19	18.05	20
		Age-Adjusted Death Rate (Per 100,000 Pop.)	17.1	14.1	23.4	15.9	20.5	21.5	18.9	15.6	12.92	11.6	18.67	20.44
Health Outcomes	Mortality - Heart Disease	Total Population	150201	344735	193466	73915	104235	404584	1271136	318689254	209087	329065	239305	381575
		Average Annual Deaths, 2010-2014	508	1004	479	243	325	852	3410	618853	47	116	94	146
		Crude Death Rate (Per 100,000 Pop.)	338.3	291.2	247.4	328.2	311.4	210.5	268.2	194.2	263.53	191.75	238.96	261
		Age-Adjusted Death Rate (Per 100,000 Pop.)	234.7	240	213	239.3	186.2	178.6	211.3	168.2	220.54	157.89	194.12	231.25
Health Outcomes	Mortality - Homicide	Total Population	150201	344735	193466	73915	104235	404584	1271136	318689254	209087	329065	239305	381575
		Average Annual Deaths, 2010-2014	2	7	8			15	33	17167	10	19	15	29
		Crude Death Rate (Per 100,000 Pop.)	5.9	4.2	10.6			4.1	5	5.4	4.88	5.65	6.35	7.55
		Age-Adjusted Death Rate (Per 100,000 Pop.)	no data	4.1	11.3	no data	no data	4.5	5.2	5.5	4.5	5.77	6.47	7.11
Health Outcomes	Mortality - Lung Disease	Total Population	150201	344735	193466	73915	104235	404584	1271136	318689254	209087	329065	239305	381575
		Average Annual Deaths, 2007-2011	112	278	154	61	119	252	976	149886	6	14	12	21
		Crude Death Rate (Per 100,000 Pop.)	74.3	80.7	79.5	82.8	113.8	62.4	76.8	47	114.7	100	107.7	104.5

		Age-Adjusted Death Rate (Per 100,000 Pop.)	48.6	65.9	67.5	58.9	65.9	52.6	59.5	41.3	220.54	157.89	194.12	231.25
Health Outcomes	Mortality - Motor Vehicle Crash	Total Population	150201	344735	193466	73915	104235	404584	1271136	318689254	209087	329065	239305	381575
		Average Annual Deaths, 2010-2014	32	66	37	18	23	58	234	37053	22	39	18	42
		Crude Death Rate (Per 100,000 Pop.)	21.2	19.1	19	24.6	22.1	14.3	18.4	11.6	10.52	11.97	7.61	10.9
		Age-Adjusted Death Rate (Per 100,000 Pop.)	21	19.4	20.2	24.6	21.6	14.1	18.4	11.3	12.07	13.87	8.43	12.19
Health Outcomes	Mortality - Pedestrian Motor Vehicle Crash	Total Population (2010)	148226	346354	193447	74231	105320	388798	1256376	312732537	2915918	2853118	5988927	3751351
		Total Pedestrian Deaths, 2011-2015	14	34	9	4	7	28	96	28832	246	141	431	324
		Average Annual Deaths, Rate per 100,000 Pop.	3.1	3.3	1.6	1.8	2.2	2.4	2.5	3.1	2.8	1.6	2.4	2.9
Health Outcomes	Mortality - Premature Death	Total Population	237437	479715	639673	113551	128661	147977	1747014	896379917	9375719	7714271	16130328	11260973
		Total Premature Death, 2014-2016	2440	5487	2891	1201	1868	5112	18999	3642755	46702	32726	81491	58956
		Total Years of Potential Life Lost,2014-2016 Average	20773	46408	52958	9984	12096	10947	153165	64739406	993489	538237	1224219	1093711
		Years of Potential Life Lost, Rate per 100,000 Population	8749	9674	8279	8793	9401	7398	8767	7222	10596	6977	7590	9712
Health Outcomes	Mortality - Stroke	Total Population	150201	344735	193466	73915	104235	404584	1271136	318689254	2968265	2900563	6061284	3875668
		Average Annual Deaths, 2010-2014	86	194	97	42	85	219	722	134618	1636	1351	3012	1872
		Crude Death Rate (Per 100,000 Pop.)	57.3	56.2	49.9	57.4	81.5	54.1	56.8	42.2	55.12	46.56	49.69	48.3
		Age-Adjusted Death Rate (Per 100,000 Pop.)	40	45.5	43.2	41	48.2	46.7	44.9	36.9	46.9	38.71	41.02	43.6
Health Outcomes	Mortality - Suicide	Total Population	150201	344735	193466	73915	104235	404584	1271136	318689254	209087	329065	239305	381575

		Average Annual Deaths, 2010-2014	35	67	35	11	28	72	248	42747	7	28	19	28
		Crude Death Rate (Per 100,000 Pop.)	23	19.4	18	15.2	30	17.7	19.6	13.4	3.16	8.39	8.02	7.34
		Age-Adjusted Death Rate (Per 100,000 Pop.)	22.1	20.2	18.9	15.2	29	17.5	19.6	13	3.45	8.53	8.38	8.05
Health Outcomes	Mortality - Unintentional Injury	Total Population	150201	344735	193466	73915	104235	404584	1271136	318689254	3177352	3229627	6300589	4257242
		Average Annual Deaths, 2010-2014	82	182	100	45	63	214	687	140444	1537	1472	3254	2557
		Crude Death Rate (Per 100,000 Pop.)	54.9	52.9	51.6	60.9	60.4	52.9	54	44.1	48.38	45.59	51.64	60.07
		Age-Adjusted Death Rate (Per 100,000 Pop.)	52.5	51.3	53.1	58.4	56.6	50.9	52.4	41.9	47.03	43.7	49.38	59.56
Health Outcomes	Obesity	Total Population Age 20+	114898	249820	143119	54037	80266	298609	940749	234188203	2172420	2089430	4487602	2801466
		Adults with BMI > 30.0 (Obese)	37957	84000	43253	16849	25793	94344	302196	64884915	747964	642606	1380352	916887
		Percent Adults with BMI > 30.0 (Obese)	33.40%	33.60%	30.10%	31.00%	32.60%	31.70%	32.20%	27.50%	34.70%	30.70%	30.60%	32.60%
Health Outcomes	Overweight	Survey Population(Adults Age 18+)	109306	223700	126729	53314	72530	252396	837975	224991207	2093351	2026269	4363655	2730646
		Total Adults Overweight	41675	77616	46926	19785	26417	82157	294576	80499532	712017	715654	1541649	954311
		Percent Adults Overweight	38.10%	34.70%	37.00%	37.10%	36.40%	32.60%	35.20%	35.80%	34.00%	35.30%	35.30%	34.90%
Health Outcomes	Poor Dental Health	Total Population(Age 18+)	113132	256714	144880	54878	81978	292256	943838	235375690	2187717	2112400	4532155	2793624
		Total Adults with Poor Dental Health	26806	61627	40660	18454	18373	58918	224838	36842620	462882	303584	915359	608605
		Percent Adults with Poor Dental Health	23.70%	24.00%	28.10%	33.60%	22.40%	20.20%	23.80%	15.70%	21.20%	14.40%	20.20%	21.80%
Health Outcomes	Poor General Health	Total Population Age 18+	114819	257971	146743	55072	82478	296593	953676	232556016	2187717	2112400	4532155	2793624
		Estimated Population with Poor or Fair Health	22861	47790	31181	10839	17690	46904	177265	37766703	446294	278837	765934	547550
		Crude Percentage	19.90%	19.20%	21.20%	19.70%	21.40%	15.80%	18.80%	16.20%	20.40%	13.20%	16.90%	19.60%
		Age-Adjusted Percentage	18.50%	18.00%	21.10%	17.90%	19.10%	15.10%	17.70%	15.70%	19.40%	12.70%	16.00%	18.70%

Health Outcomes	STI - Chlamydia Incidence	Total Population	150076	344442	193921	73757	104425	401235	1267856	316128839	2959188	2894038	6044718	3850326
		Total Chlamydia Infections	361	1264	596	150	205	1754	4330	1441789	15589	11116	27981	20657
		Chlamydia Infection Rate (Per 100,000 Pop.)	240.54	366.97	307.34	203.37	196.31	437.15	341.52	456.08	526.8	384.1	462.9	536.5
Health Outcomes	STI - Gonorrhea Incidence	Total Population	150076	344442	193921	73757	104425	401235	1267856	316128839	2958931	2895152	6045008	3850063
		Total Gonorrhea Infections	67	112	89	12	19	456	755	350062	4539	2568	7387	6137
		Gonorrhea Infection Rate (Per 100,000 Pop.)	44.64	32.52	45.89	16.27	18.19	113.65	59.55	110.73	153.4	88.7	122.2	159.4
Health Outcomes	STI - HIV Prevalence	Population Age 13+	127620	273442	162428	61052	88659	335219	1048420	263765822	2448582	2370043	5043482	3162620
		Population with HIV / AIDS	125	264	87	27	65	586	1154	931526	5006	2807	11968	5433
		Population with HIV / AIDS, Rate (Per 100,000 Pop.)	97.95	96.55	53.56	44.22	73.31	174.81	110.07	353.16	204.44	118.44	237.3	171.79

Community Data

Mountain View Community

DATA CATEGORY	DATA INDICATOR	INDICATOR ATTRIBUTE	MOUNTAIN VIEW COMMUNITY	Arkansas	Missouri	USA	Baxter County, AR	Douglas County, MO	Howell County, MO	Ozark County, MO
Demographics	Total Population	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Total Land Area(Square Miles)	3040.13	52035.57	68746.5	3532068.58	554.28	813.63	927.25	744.97
		Population Density (Per Square Mile)	34.27	57.05	88.14	90.19	73.95	16.55	43.42	12.69
Demographics	Change in Total Population	Total Population, 2000 Census	98250	2673398	5591987	280405781	38386	13084	37238	9542
		Total Population, 2010 Census	105320	2915918	5988927	307745539	41513	13684	40400	9723
		Total Population Change, 2000-2010	7070	242520	396940	27339758	3127	600	3162	181
		Percent Population Change, 2000-2010	7.20%	9.07%	7.10%	9.75%	8.15%	4.59%	8.49%	1.90%
Demographics	Families with Children	Total Households	43652	1141480	2372362	117716237	18061	5110	16214	4267
		Total Family Households	29373	757729	1529363	77608829	11862	3595	11023	2893
		Families with Children (Under Age 18)	11100	356822	714287	37299113	3700	1296	4948	1156

		Families with Children (Under Age 18), Percent of Total Households	25.43%	31.26%	30.11%	31.69%	20.49%	25.36%	30.52%	27.09%
Demographics	Female Population	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Female Population	53221	1511778	3086334	161792840	21144	6718	20648	4711
		Percent Female Population	51.09%	50.93%	50.93%	50.79%	51.58%	49.88%	51.28%	49.85%
Demographics	Male Population	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Male Population	50953	1456694	2973317	156765322	19848	6749	19617	4739
		Percent Male Population	48.91%	49.07%	49.07%	49.21%	48.42%	50.12%	48.72%	50.15%
Demographics	Median Age	Total Population	2968472	6059651	3.2E+08	40992	13467	40265	9450	
		Median Age	37.7	38.3	37.7	51.8	47.4	40.5	51	
Demographics	Population Under Age 18	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Population Age 0-17	21777	707234	1395124	73612438	7250	2904	9806	1817
		Percent Population Age 0-17	20.90%	23.82%	23.02%	23.11%	17.69%	21.56%	24.35%	19.23%
Demographics	Population Age 0-4	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Population Age 0-4	5635	190884	374010	19866960	1825	782	2610	418
		Percent Population Age 0-4	5.41%	6.43%	6.17%	6.24%	4.45%	5.81%	6.48%	4.42%
Demographics	Population Age 5-17	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Population Age 5-17	16142	516350	1021114	53745478	5425	2122	7196	1399

		Percent Population Age 5-17	15.50%	17.39%	16.85%	16.87%	13.23%	15.76%	17.87%	14.80%
Demographics	Population Age 18-64	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Population Age 18-64	57107	1796251	3734593	198765092	21415	7559	22945	5188
		Percent Population Age 18-64	54.82%	60.51%	61.63%	62.40%	52.24%	56.13%	56.98%	54.90%
Demographics	Population Age 18-24	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Population Age 18-24	7015	287647	591150	31296577	2307	900	3245	563
		Percent Population Age 18-24	6.73%	9.69%	9.76%	9.82%	5.63%	6.68%	8.06%	5.96%
Demographics	Population Age 25-34	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Population Age 25-34	10697	385316	800229	43397907	3854	1324	4750	769
		Percent Population Age 25-34	10.27%	12.98%	13.21%	13.62%	9.40%	9.83%	11.80%	8.14%
Demographics	Population Age 35-44	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Population Age 35-44	10565	367023	731234	40548400	3833	1318	4504	910
		Percent Population Age 35-44	10.14%	12.36%	12.07%	12.73%	9.35%	9.79%	11.19%	9.63%
Demographics	Population Age 45-54	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Population Age 45-54	13308	385891	820875	43460466	5000	1803	5284	1221

		Percent Population Age 45-54	12.77%	13.00%	13.55%	13.64%	12.20%	13.39%	13.12%	12.92%
Demographics	Population Age 55-64	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Population Age 55-64	15522	370374	791105	40061742	6421	2214	5162	1725
		Percent Population Age 55-64	14.90%	12.48%	13.06%	12.58%	15.66%	16.44%	12.82%	18.25%
Demographics	Population Age 65+	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Population Age 65+	25290	464987	929934	46180632	12327	3004	7514	2445
		Percent Population Age 65+	24.28%	15.66%	15.35%	14.50%	30.07%	22.31%	18.66%	25.87%
Demographics	Population with Any Disability	Total Population (For Whom Disability Status Is Determined)	103115	2915402	5946094	313576137	40535	13346	39841	9393
		Total Population with a Disability	21708	492769	858449	39272529	8722	2911	8050	2025
		Percent Population with a Disability	21.05%	16.90%	14.44%	12.52%	21.52%	21.81%	20.21%	21.56%
Demographics	Population in Limited English Households	Total Population Age 5+	98539	2777588	5685641	298691202	39167	12685	37655	9032
		Linguistically Isolated Population	387	51735	63881	13393615	192	57	138	0

		Percent Linguistically Isolated Population	0.39%	1.86%	1.12%	4.48%	0.49%	0.45%	0.37%	0.00%
Demographics	Population with Limited English Proficiency	Population Age 5+	98539	2777588	5685641	298691202	39167	12685	37655	9032
		Population Age 5+ with Limited English Proficiency	721	89615	120716	25440956	382	106	217	16
		Percent Population Age 5+ with Limited English Proficiency	0.73%	3.23%	2.12%	8.52%	0.98%	0.84%	0.58%	0.18%
Demographics	Population Geographic Mobility	Total Population	103030	2931330	5989469	314813229	40563	13345	39752	9370
		Population In-Migration	6147	189103	431416	19417258	2347	1015	1949	836
		Percent Population In-Migration	5.97%	6.45%	7.20%	6.17%	5.79%	7.61%	4.90%	8.92%
Demographics	Foreign-Born Population	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Naturalized U.S. Citizens	969	44575	106455	19979407	707	15	232	15
		Population Without U.S. Citizenship	696	94459	129624	22214947	258	46	377	15
		Total Foreign-Birth Population	1665	139034	236079	42194354	965	61	609	30

		Foreign-Birth Population, Percent of Total Population	1.60%	4.68%	3.90%	13.25%	2.35%	0.45%	1.51%	0.32%
Demographics	Hispanic Population	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Non-Hispanic Population	102222	2761423	5822367	263359055	40156	13296	39477	9293
		Percent Population Non-Hispanic	98.13%	93.03%	96.08%	82.67%	97.96%	98.73%	98.04%	98.34%
		Hispanic or Latino Population	1952	207049	237284	55199107	836	171	788	157
		Percent Population Hispanic or Latino	1.87%	6.97%	3.92%	17.33%	2.04%	1.27%	1.96%	1.66%
Demographics	Urban and Rural Population	Total Population	105320	2915918	5988927	312471327	41513	13684	40400	9723
		Urban Population	28279	1637589	4218371	252746527	14180	2857	11242	0
		Rural Population	77041	1278329	1770556	59724800	27333	10827	29158	9723
		Percent Urban	26.85%	56.16%	70.44%	80.89%	34.16%	20.88%	27.83%	0.00%
		Percent Rural	73.15%	43.84%	29.56%	19.11%	65.84%	79.12%	72.17%	100.00%
Demographics	Veteran Population	Total Population Age 18+	82367	2256793	4644895	243935157	33718	10563	30453	7633
		Total Veterans	10598	213949	438100	19535341	4952	1278	3305	1063
		Veterans, Percent of Total Population	12.87%	9.48%	9.43%	8.01%	14.69%	12.10%	10.85%	13.93%
Social & Economic Factors	Children Eligible for Free/Reduced Price Lunch	Total Students	14160	492132	918254	50611787	5073	1524	6034	1529
		Number Free/Reduced Price Lunch Eligible	8842	312477	460004	25893504	3109	1041	3599	1093

		Percent Free/Reduced Price Lunch Eligible	62.44%	63.58%	50.12%	52.61%	61.29%	68.31%	59.65%	71.48%
Social & Economic Factors	Food Insecurity Rate	Total Population	104810	2966369	6063589	318198163	41154	13575	40469	9612
		Food Insecure Population, Total	17710	567250	1019350	47448890	6740	2270	7070	1630
		Food Insecurity Rate	16.90%	19.10%	16.80%	14.91%	16.38%	16.72%	17.47%	16.96%
Social & Economic Factors	Head Start	Total Children Under Age 5	6188	197689	390237	20426118	2020	811	2862	495
		Total Head Start Programs	9	274	379	18886	4	1	3	1
		Head Start Programs, Rate (Per 10,000 Children)	12.93	10.12	7.28	7.18	14.85	12.33	10.48	20.2
Social & Economic Factors	High School Graduation Rate (EdFacts)	Total Student Cohort	1081	34699	64203	3135216	419	128	423	111
		Estimated Number of Diplomas Issued	989	30300	58434	2700120	365	124	397	103
		Cohort Graduation Rate	91.5	87.3	91	86.1	87.1	96.9	93.9	92.8
Social & Economic Factors	High School Graduation Rate (NCES)	Average Freshman Base Enrollment	1232	37912	75801	4024345	427	131	534	140
		Estimated Number of Diplomas Issued	1024	28057	62969	3039015	320	126	446	131

		On-Time Graduation Rate	83.1	74	83.1	75.5	75	96.2	83.6	93.9
Social & Economic Factors	Households with No Motor Vehicle	Total Occupied Households	43652	1141480	2372362	117716237	18061	5110	16214	4267
		Households with No Motor Vehicle	2282	72981	172972	10562847	743	187	1038	314
		Percentage of Households with No Motor Vehicle	5.23%	6.39%	7.29%	8.97%	4.11%	3.66%	6.40%	7.36%
Social & Economic Factors	Housing Cost Burden (30%)	Total Households	43652	1141480	2372362	117716237	18061	5110	16214	4267
		Cost Burdened Households (Housing Costs Exceed 30% of Income)	11289	295330	658995	38719430	4369	1528	4343	1049
		Percentage of Cost Burdened Households(Over 30% of Income)	25.86%	25.87%	27.78%	32.89%	24.19%	29.90%	26.79%	24.58%
Social & Economic Factors	Income - Families Earning Over $75,000	Total Familes	29373	757729	1529363	77608829	11862	3595	11023	2893
		Families with Income Over $75,000	6541	248268	615255	35073881	2874	602	2567	498
		Percent Families with Income Over $75,000	22.27%	32.76%	40.23%	45.19%	24.23%	16.75%	23.29%	17.21%
Social & Economic Factors	Income - Inequality (GINI Index)	Total Households	43652	1141480	2372362	117716237	18061	5110	16214	4267
		Gini Index Value	no data	0.47	0.46	0.48	0.44	0.45	0.46	0.41

Social & Economic Factors	Income - Median Family Income	Total Family Households	29373	757729	1529363	77608829	11862	3595	11023	2893
		Average Family Income	$56,488.00	$69,867.00	$80,299.00	$90,960.00	$62,764.00	$50,679.00	$54,678.00	$44,871.00
		Median Family Income		$53,123.00	$62,285.00	$67,871.00	$47,559.00	$38,961.00	$41,902.00	$37,206.00
Social & Economic Factors	Income - Per Capita Income	Total Population	104174	2968472	6059651	318558162	40992	13467	40265	9450
		Total Income ($)	$2,112,736,700.00	$69,464,226,500.00	$163,880,073,200.00	$9,502,305,741,900.00	$945,606,000.00	$232,447,300.00	$776,815,500.00	$157,867,900.00
		Per Capita Income ($)	$20,280.00	$23,400.00	$27,044.00	$29,829.00	$23,068.00	$17,260.00	$19,292.00	$16,705.00
Social & Economic Factors	Income - Public Assistance Income	Total Households	43652	1141480	2372362	117716237	18061	5110	16214	4267
		Households with Public Assistance Income	1533	25749	52988	3147577	511	170	634	218
		Percent Households with Public Assistance Income	3.51%	2.26%	2.23%	2.67%	2.83%	3.33%	3.91%	5.11%
Social & Economic Factors	Insurance - Population Receiving Medicaid	Total Population(For Whom Insurance Status is Determined)	103115	2915402	5946094	313576137	40535	13346	39841	9393
		Population with Any Health Insurance	90480	2555830	5272765	276875891	36800	11076	34697	7907

		Population Receiving Medicaid	22982	683151	877803	59874221	8026	3130	9491	2335
		Percent of Insured Population Receiving Medicaid	25.40%	26.73%	16.65%	21.62%	21.81%	28.26%	27.35%	29.53%
Social & Economic Factors	Insurance - Uninsured Adults	Total Population Age 18 - 64	56551	1738806	3626537	194584952	21263	7410	22837	5041
		Population with Medical Insurance	47757	1502431	3131839	168884012	18753	5899	19097	4008
		Percent Population With Medical Insurance	84.45%	86.41%	86.36%	86.79%	88.20%	79.61%	83.62%	79.51%
		Population Without Medical Insurance	8794	236375	494698	25700940	2510	1511	3740	1033
		Percent Population Without Medical Insurance	15.55%	13.59%	13.64%	13.21%	11.80%	20.39%	16.38%	20.49%
Social & Economic Factors	Insurance - Uninsured Children	Total Population Under Age 19	22010	726232	1429136	76217025	7553	2852	9747	1858
		Population with Medical Insurance	20487	689930	1341542	72369595	7186	2642	8993	1666
		Percent Population With Medical Insurance	93.08%	95.00%	93.87%	94.95%	95.14%	92.64%	92.26%	89.67%
		Population Without Medical Insurance	1523	36302	87594	3847430	367	210	754	192

		Percent Population Without Medical Insurance	6.92%	5.00%	6.13%	5.05%	4.86%	7.36%	7.74%	10.33%
Social & Economic Factors	Insurance - Uninsured Population	Total Population (For Whom Insurance Status is Determined)	103115	2915402	5946094	313576137	40535	13346	39841	9393
		Total Uninsured Population	12635	359572	673329	36700246	3735	2270	5144	1486
		Percent Uninsured Population	12.25%	12.33%	11.32%	11.70%	9.21%	17.01%	12.91%	15.82%
Social & Economic Factors	Lack of Social or Emotional Support	Total Population Age 18+	82478	2187717	4532155	232556016	34007	10570	30119	7782
		Estimated Population Without Adequate Social / Emotional Support	14732	455045	865642	48104656	8196	no data	6536	no data
		Crude Percentage	23.00%	20.80%	19.10%	20.70%	24.10%	suppressed	21.70%	suppressed
		Age-Adjusted Percentage	22.30%	20.90%	19.10%	20.70%	22.60%	suppressed	21.90%	suppressed
Social & Economic Factors	Population Receiving SNAP Benefits (ACS)	Total Households	43652	1141480	2372362	117716237	18061	5110	16214	4267
		Households Receiving SNAP Benefits	7612	163102	308375	15360951	1994	1129	3451	1038
		Percent Households Receiving SNAP Benefits	17.44%	14.29%	13.00%	13.05%	11.04%	22.09%	21.28%	24.33%

Social & Economic Factors	Population Receiving SNAP Benefits (SAIPE)	Total Population	103952	2978204	6083672	321396328	41053	13373	40117	9409
		Population Receiving SNAP Benefits	17995	440641	827095	44567069	5272	2554	8482	1687
		Percent Population Receiving SNAP Benefits	17.30%	14.80%	13.60%	13.90%	12.80%	19.10%	21.10%	17.90%
Social & Economic Factors	Population with Associate's Level Degree or Higher	Total Population Age 25+	75382	1973591	4073377	213649147	31435	9663	27214	7070
		Population Age 25+ with Associate's Degree or Higher	17379	551450	1433231	82237511	8181	1623	6314	1261
		Percent Population Age 25+ with Associate's Degree or Higher	23.05%	27.94%	35.19%	38.49%	26.03%	16.80%	23.20%	17.84%
Social & Economic Factors	Population with Bachelor's Degree or Higher	Total Population Age 25+	75382	1973591	4073377	213649147	31435	9663	27214	7070
		Population Age 25+ with Bachelor's Degree or Higher	11210	424446	1125665	64767787	5576	911	3912	811
		Percent Population Age 25+ with Bachelor's Degree or Higher	14.87%	21.51%	27.63%	30.32%	17.74%	9.43%	14.37%	11.47%

Social & Economic Factors	Population with No High School Diploma	Total Population Age 25+	75382	1973591	4073377	213649147	31435	9663	27214	7070
		Population Age 25+ with No High School Diploma	11242	292228	454882	27818380	4018	1924	4154	1146
		Percent Population Age 25+ with No High School Diploma	14.91%	14.81%	11.17%	13.02%	12.78%	19.91%	15.26%	16.21%
Social & Economic Factors	Poverty - Children Below 100% FPL	Total Population	102523	2881404	5876366	310629645	40473	13188	39509	9353
		Population Under Age 18	21206	694104	1364095	72456096	7161	2746	9522	1777
		Population Under Age 18 in Poverty	6189	186130	287147	15335783	1591	848	3143	607
		Percent Population Under Age 18 in Poverty	29.19%	26.82%	21.05%	21.17%	22.22%	30.88%	33.01%	34.16%
Social & Economic Factors	Poverty - Children Below 200% FPL	Total Population Under Age 18	21206	694104	1364095	72456096	7161	2746	9522	1777
		Population Under Age 18 at or Below 200% FPL	12540	369570	597599	31364270	3489	1945	6006	1100
		Percent Population Under Age 18 at or Below 200% FPL	59.13%	53.24%	43.81%	43.29%	48.72%	70.83%	63.07%	61.90%
Social & Economic Factors	Poverty - Population Below 100% FPL	Total Population	102523	2881404	5876366	310629645	40473	13188	39509	9353
		Population in Poverty	19830	542431	897755	46932225	5600	2704	8980	2546

		Percent Population in Poverty	19.34%	18.83%	15.28%	15.11%	13.84%	20.50%	22.73%	27.22%
Social & Economic Factors	Poverty - Population Below 185% FPL	Total Population	102523	2881404	5876366	310629645	40473	13188	39509	9353
		Population with Income at or Below 185% FPL	43811	1118877	1864503	96139377	14411	6327	18191	4882
		Percent Population with Income at or Below 185% FPL	42.73%	38.83%	31.73%	30.95%	35.61%	47.98%	46.04%	52.20%
Social & Economic Factors	Poverty - Population Below 200% FPL	Total Population	102523	2881404	5876366	310629645	40473	13188	39509	9353
		Population with Income at or Below 200% FPL	48047	1211947	2033050	104390198	15804	7207	19925	5111
		Percent Population with Income at or Below 200% FPL	46.86%	42.06%	34.60%	33.61%	39.05%	54.65%	50.43%	54.65%
Social & Economic Factors	Poverty - Population Below 50% FPL	Total Population	102523	2881404	5876366	310629645	40473	13188	39509	9353
		Population with Income at or Below 50% FPL	7316	226272	395468	20787162	1860	854	3825	777
		Percent Population with Income at or Below 50% FPL	7.14%	7.85%	6.73%	6.69%	4.60%	6.48%	9.68%	8.31%

Social & Economic Factors	Student Reading Proficiency (4th Grade)	Total Students with Valid Test Scores	1129	34557	66036	3393582	420	139	458	112
		Percentage of Students Scoring 'Proficient' or Better	46.24%	33.84%	58.79%	49.67%	26.78%	60.86%	55.63%	62.82%
		Percentage of Students Scoring 'Not Proficient' or Worse	53.76	66.16	41.21	45.61	73.22	39.14	44.37	37.18
Social & Economic Factors	Teen Births	Female Population Age 15 - 19	3031	99627	206847	10736677	1023	427	1311	270
		Births to Mothers Age 15 - 19	171	5519	8170	392962	49	22	88	12
		Teen Birth Rate (Per 1,000 Population)	56.42	55.4	39.5	36.6	47.6	50.7	66.8	43.4
Social & Economic Factors	Unemployment Rate	Labor Force	40195	1349290	3037457	162635301	16466	4961	15270	3498
		Number Employed	38466	1296850	2922605	155857594	15757	4755	14619	3335
		Number Unemployed	1729	52440	114852	6777707	709	206	651	163
		Unemployment Rate	4.3	3.9	3.8	4.2	4.3	4.2	4.3	4.7
Social & Economic Factors	Violent Crime	Total Population	104869	2811942	6040967	311082592	41120	13556	40620	9573
		Violent Crimes	208	13437	26745	1181036	51	26	104	27
		Violent Crime Rate (Per 100,000 Pop.)	198.3	477.9	442.8	379.7	123.2	194.3	256	282

Physical Environment	Air Quality - Ozone	Total Population	105320	2915918	5988927	312471327	41513	13684	40400	9723
		Average Daily Ambient Ozone Concentration	42.91	42.52	42.45	38.95	42.82	43.02	43	42.8
		Number of Days Exceeding Emissions Standards	0.27	3.02	10.46	4.46	0	0.67	0.5	0
		Percentage of Days Exceeding Standards, Crude Average	0.07%	0.83%	2.87%	1.22%	0.00%	0.18%	0.14%	0.00%
		Percentage of Days Exceeding Standards, Pop. Adjusted Average	0.08%	0.84%	2.87%	1.24%	0.00%	0.20%	0.13%	0.00%
Physical Environment	Air Quality - Particulate Matter 2.5	Total Population	105320	2915918	5988927	312471327	41513	13684	40400	9723
		Average Daily Ambient Particulate Matter 2.5	8.99	9.96	10.2	9.1	8.99	8.96	9.03	8.9
		Number of Days Exceeding Emissions Standards	0	0	0	0.35	0	0	0	0
		Percentage of Days Exceeding Standards, Crude Average	0	0	0	0.1	0	0	0	0

		Percentage of Days Exceeding Standards, Pop. Adjusted Average	0.00%	0.00%	0.00%	0.10%	0.00%	0.00%	0.00%	0.00%
Physical Environment	Climate & Health - Drought Severity	Percentage of Weeks in D0 (Abnormally Dry)	11.61%	18.67%	21.93%	16.96%	14.87%	17.42%	6.51%	10.69%
		Percentage of Weeks in D1 (Moderate Drought)	10.79%	8.92%	14.83%	12.59%	6.22%	15.79%	12.81%	14.85%
		Percentage of Weeks in D2 (Severe Drought)	5.53%	6.81%	8.81%	8.84%	2.92%	6.04%	7.50%	7.77%
		Percentage of Weeks in D3 (Extreme Drought)	6.41%	6.71%	3.97%	4.92%	10.74%	3.30%	3.86%	2.92%
		Percentage of Weeks in D4 (Exceptional Drought)	2.63%	2.92%	0.86%	2.54%	6.57%	0.00%	0.00%	0.43%
		Percentage of Weeks in Drought (Any)	36.97%	44.02%	50.39%	45.85%	41.33%	42.55%	30.68%	36.65%
Physical Environment	Climate & Health - High Heat Index Days	Total Weather Observations	19345	319010	438730	19094610	3650	6205	5840	3650
		Average Heat Index Value	97.07	97.3	96.92	91.82	97.49	96.62	96.78	97.37
		Observations with High Heat Index Values	2475	57240	52450	897155	600	731	624	520

		Observations with High Heat Index Values, Percentage	12.80%	17.90%	12.00%	4.70%	16.44%	11.78%	10.68%	14.25%
Physical Environment	Food Access - Fast Food Restaurants	Total Population	105320	2915918	5988927	312846570	41513	13684	40400	9723
		Number of Establishments	60	1979	4153	233392	31	4	24	1
		Establishments, Rate per 100,000 Population	56.97	67.87	69.34	74.6	74.68	29.23	59.41	10.28
Physical Environment	Food Access - Food Desert Census Tracts	Total Population (2010)	105320	2915918	5988927	308745538	41513	13684	40400	9723
		Food Desert Census Tracts	12	341	638	27527	3	3	4	2
		Other Census Tracts	10	345	755	45337	6	0	4	0
		Food Desert Population	59064	1511826	3071039	129885212	14250	13684	21407	9723
		Other Population	46256	1404092	2917888	178860326	27263	0	18993	0
Physical Environment	Food Access - Grocery Stores	Total Population	105320	2915918	5988927	312846570	41513	13684	40400	9723
		Number of Establishments	22	477	1061	66284	7	2	11	2
		Establishments, Rate per 100,000 Population	20.89	16.36	17.72	21.19	16.86	14.62	27.23	20.57
Physical Environment	Food Access - Low Food Access	Total Population	105320	2915918	5988927	308745538	41513	13684	40400	9723
		Population with Low Food Access	26149	698771	1531368	69266771	6957	5147	8680	5365
		Percent Population with Low Food Access	24.83%	23.96%	25.57%	22.43%	16.76%	37.61%	21.49%	55.18%

Physical Environment	Food Access - Low Income & Low Food Access	Total Population	105320	2915918	5988927	308745538	41513	13684	40400	9723
		Low Income Population	47286	1266307	2144902	106758543	17892	7089	17502	4803
		Low Income Population with Low Food Access	12447	291773	463471	20221368	2590	2595	4565	2697
		Percent Low Income Population with Low Food Access	26.32%	23.04%	21.61%	18.94%	14.48%	36.61%	26.08%	56.15%
Physical Environment	Food Access - Modified Retail Food Environment Index	Total Population	105320	2915918	5988926	312474470	41513	13684	40400	9723
		Percent Population in Tracts with No Food Outlet	5.30%	0.50%	0.64%	0.99%	0.00%	40.78%	0.00%	0.00%
		Percent Population in Tracts with No Healthy Food Outlet	37.50%	26.96%	21.82%	18.63%	40.17%	59.22%	36.41%	0.00%
		Percent Population in Tracts with Low Healthy Food Access	19.74%	24.07%	27.45%	30.89%	11.20%	0.00%	39.95%	0.00%
		Percent Population in Tracts with Moderate Healthy Food Access	32.36%	44.26%	45.26%	43.28%	48.63%	0.00%	10.33%	100.00%

		Percent Population in Tracts with High Healthy Food Access	5.11%	4.22%	4.83%	5.02%	0.00%	0.00%	13.31%	0.00%
Physical Environment	Food Access - SNAP-Authorized Food Stores	Total Population	105320	2915918	5988927	312411142	41513	13684	40400	9723
		Total SNAP-Authorized Retailers	120	2810	4996	257596	40	10	57	13
		SNAP-Authorized Retailers, Rate per 10,000 Population	11.39	9.64	8.34	8.25	9.64	7.31	14.11	13.37
Physical Environment	Food Access - WIC-Authorized Food Stores	Total Population (2011 Estimate)	105344	2956882	6036320	318921538	41536	13548	40665	9595
		Number WIC-Authorized Food Stores	15	438	722	50042	5	2	7	1
		WIC-Authorized Food Store Rate (Per 100,000 Pop.)	14.2	14.8	11.9	15.6	12	14.8	17.2	10.4
Physical Environment	Housing - Assisted Housing	Total Housing Units (2010)	52772	1316299	2712729	133341676	22580	6519	18021	5652
		Total HUD-Assisted Housing Units	1420	51029	90864	5005789	452	13	839	116
		HUD-Assisted Units, Rate per 10,000 Housing Units	269.08	387.67	334.95	375.41	200.18	19.94	465.57	205.24
Physical Environment	Housing - Housing Unit Age	Total Housing Units	1341391	2738774	1.3E+08	22588	6458	18065	5614	

		Median Year Structures Built	1983	1976	1977	1985	1981	1980	1981	
Physical Environment	Housing - LIHTC	LIHTC Properties	34	589	1713	43092	21	0	11	2
		LIHTC Units	1054	29513	63615	2784155	683	0	309	62
Physical Environment	Housing - Mortgage Lending	Total Population (2010)	105320	2915918	5988927	312470869	41513	13684	40400	9723
		Number of Home Loans Originated	1539	52608	119207	5959108	870	175	403	91
		Loans Originations, Approval Rate	53.12%	49.03%	52.31%	51.57%	53.28%	64.34%	48.79%	54.82%
		Loan Originations, Rate per 100,000 Population	146.13	180.42	199.05	190.71	209.57	127.89	99.75	93.59
Physical Environment	Housing - Overcrowded Housing	Total Occupied Housing Units	42564	914347	2007863	90970439	17688	5046	15637	4193
		Overcrowded Housing Units	970	29803	38588	3932606	271	149	348	202
		Percentage of Housing Units Overcrowded	2.28%	3.26%	1.92%	4.32%	1.53%	2.95%	2.23%	4.82%
Physical Environment	Housing - Substandard Housing	Total Occupied Housing Units	43652	1141480	2372362	117716237	18061	5110	16214	4267
		Occupied Housing Units with One or More Substandard Conditions	12065	310386	663290	39729263	4524	1637	4631	1273

		Percent Occupied Housing Units with One or More Substandard Conditions	27.64%	27.19%	27.96%	33.75%	25.05%	32.04%	28.56%	29.83%
Physical Environment	Housing - Vacancy Rate	Total Housing Units	52725	1341391	2738774	134054899	22588	6458	18065	5614
		Vacant Housing Units	9073	199911	366412	16338662	4527	1348	1851	1347
		Vacant Housing Units, Percent	17.21%	14.90%	13.38%	12.19%	20.04%	20.87%	10.25%	23.99%
Physical Environment	Liquor Store Access	Total Population	105320	2915918	5988927	312846570	41513	13684	40400	9723
		Number of Establishments	18	344	381	33692	13	1	4	0
		Establishments, Rate per 100,000 Population	17.09	11.8	6.36	10.77	31.32	7.31	9.9	0
Physical Environment	Recreation and Fitness Facility Access	Total Population	105320	2915918	5988927	312846570	41513	13684	40400	9723
		Number of Establishments	9	222	585	32712	3	0	6	0
		Establishments, Rate per 100,000 Population	8.55	7.61	9.77	10.46	7.23	0	14.85	0
Physical Environment	Use of Public Transportation	Total Population Employed Age 16+	39104	1247999	2803637	145861221	15045	4887	16125	3047
		Population Using Public Transit for Commute to Work	94	5112	41741	7476312	64	10	14	6

		Percent Population Using Public Transit for Commute to Work	0.24%	0.41%	1.49%	5.13%	0.43%	0.20%	0.09%	0.20%
Clinical Care	Access to Dentists	Total Population, 2015	103952	2978204	6083672	321418820	41053	13373	40117	9409
		Dentists, 2015	43	1318	3299	210832	20	4	16	3
		Dentists, Rate per 100,000 Pop.	41.4	44.3	54.2	65.6	48.72	29.91	39.88	31.88
Clinical Care	Access to Mental Health Providers	Estimated Population	94576	2952717	6017783	317105555	40857	13545	40174	0
		Number of Mental Health Providers	189	5731	10147	643219	110	7	72	0
		Ratio of Mental Health Providers to Population(1 Provider per x Persons)	500.4	515.2	593.1	493	371.4	1935	558	
		Mental Health Care Provider Rate (Per 100,000 Population)	199.8	194	168.6	202.8	269.2	51.6	179.2	
Clinical Care	Access to Primary Care	Total Population, 2014	104068	2966369	6063589	318857056	40857	13546	40173	9492
		Primary Care Physicians, 2014	77	2229	5072	279871	37	2	36	2
		Primary Care Physicians, Rate per 100,000 Pop.	74	75.1	83.6	87.8	90.56	14.76	89.61	21.07
Clinical Care	Cancer Screening - Mammogram	Total Medicare Enrollees	16806	335922	581575	26753396	8455	1203	5715	1433
		Female Medicare Enrollees Age 67-69	1457	30761	52310	2395946	750	107	472	128

		Female Medicare Enrollees with Mammogram in Past 2 Years	872	17866	32760	1510847	522	52	231	67
		Percent Female Medicare Enrollees with Mammogram in Past 2 Year	59.90%	58.10%	62.60%	63.10%	69.70%	48.60%	48.90%	52.30%
Clinical Care	Cancer Screening - Pap Test	Female Population Age 18+	80303	1763631	3846348	176847182	33115	10356	29283	7549
		Estimated Number with Regular Pap Test	42427	1275105	2877068	137191142	24008	no data	18419	no data
		Crude Percentage	68.00%	72.30%	74.80%	77.60%	72.50%	suppressed	62.90%	suppressed
		Age-Adjusted Percentage	75.20%	74.00%	76.60%	78.50%	79.90%	suppressed	69.90%	suppressed
Clinical Care	Cancer Screening - Sigmoidoscopy or Colonoscopy	Total Population Age 50+	38527	758335	1532083	75116406	18110	4630	11949	3838
		Estimated Population Ever Screened for Colon Cancer	20056	442868	972873	48549269	13329	no data	6727	no data
		Crude Percentage	66.70%	58.40%	63.50%	64.60%	73.60%	suppressed	56.30%	suppressed
		Age-Adjusted Percentage	61.50%	54.50%	60.30%	61.30%	69.20%	suppressed	49.80%	suppressed
Clinical Care	Dental Care Utilization	Total Population(Age 18+)	81978	2187717	4532155	235375690	33865	10506	29837	7770
		Total Adults Without Recent Dental Exam	26903	839735	1681987	70965788	11245	0	15658	0

		Percent Adults with No Dental Exam	32.80%	38.40%	37.10%	30.20%	33.20%	0.00%	52.50%	0.00%
Clinical Care	Diabetes Management - Hemoglobin A1c Test	Total Medicare Enrollees	16806	335922	581575	26753396	8455	1203	5715	1433
		Medicare Enrollees with Diabetes	1918	42560	74009	3314834	967	120	668	163
		Medicare Enrollees with Diabetes with Annual Exam	1691	35815	63678	2822996	874	107	564	144
		Percent Medicare Enrollees with Diabetes with Annual Exam	88.20%	84.20%	86.00%	85.20%	90.40%	89.20%	84.60%	89.00%
Clinical Care	Facilities Designated as Health Professional Shortage Areas	Primary Care Facilities	3	25	103	3599	0	1	2	0
		Mental Health Care Facilities	3	31	87	3171	0	1	2	0
		Dental Health Care Facilities	2	21	79	3071	0	1	1	0
		Total HPSA Facility Designations	8	77	269	9836	0	3	5	0
Clinical Care	Federally Qualified Health Centers	Total Population	105320	2915918	5988927	312471327	41513	13684	40400	9723

		Number of Federally Qualified Health Centers	3	124	202	8329	0	1	1	1
		Rate of Federally Qualified Health Centers per 100,000 Population	2.85	4.25	3.37	2.67	0	7.31	2.48	10.28
Clinical Care	High Blood Pressure Management	Total Population(Age 18+)	81978	2187717	4532155	235375690	33865			
		Total Adults Not Taking Blood Pressure Medication (When Needed)	8101	417130	957912	51175402	8101			
		Percent Adults Not Taking Medication	9.90%	19.10%	21.10%	21.70%	23.90%			
Clinical Care	HIV Screenings	Survey Population(Adults Age 18+)	66790	1993401	4226096	214984421	29850	8447	28493	no data
		Total Adults Never Screened for HIV / AIDS	49764	1342774	2840197	134999025	23036	7065	19663	no data
		Percent Adults Never Screened for HIV / AIDS	74.50%	67.36%	67.21%	62.79%	77.17%	83.64%	69.01%	no data
Clinical Care	Lack of a Consistent Source of Primary Care	Survey Population(Adults Age 18+)	73625	2185490	4560355	236884668	34687	9043	29895	no data
		Total Adults Without Any Regular Doctor	12309	500175	938202	52290932	3668	2697	5944	no data

		Percent Adults Without Any Regular Doctor	16.70%	22.89%	20.57%	22.07%	10.58%	29.83%	19.88%	no data
Clinical Care	Lack of Prenatal Care	Total Births		160395	318557	16693978				
		Mothers Starting Prenatal Care in First Semester			56322	7349554				
		Mothers with Late or No Prenatal Care			16666	2880098				
		Prenatal Care Not Reported		160395	245569	6464326				
		Percentage Mothers with Late or No Prenatal Care	suppressed		5.20%	17.30%	suppressed	suppressed	suppressed	suppressed
Clinical Care	Pneumonia Vaccination	Total Population Age 65+	23266	413544	826139	39608820	11524	2648	6868	2226
		Estimated Population with Annual Pneumonia Vaccination	12104	273353	572514	26680462	7502	no data	4602	no data
		Crude Percentage	65.80%	66.10%	69.30%	67.40%	65.10%	suppressed	67.00%	suppressed
		Age-Adjusted Percentage	65.90%	66.30%	69.40%	67.50%	65.60%	suppressed	66.40%	suppressed
Clinical Care	Population Living in a Health Professional Shortage Area	Total Area Population	105320	2915918	5988927	308745538	41513	13684	40400	9723
		Population Living in a HPSA	105320	1325988	3266848	102289607	41513	13684	40400	9723

		Percentage of Population Living in a HPSA	100.00%	45.47%	54.55%	33.13%	100.00%	100.00%	100.00%	100.00%
Clinical Care	Preventable Hospital Events	Total Medicare Part A Enrollees	17452	357377	628274	29649023	8730	1257	5965	1500
		Ambulatory Care Sensitive Condition Hospital Discharges	903	22139	35569	1479545	439	63	325	74
		Ambulatory Care Sensitive Condition Discharge Rate	51.8	62	56.6	49.9	50.3	50.7	54.6	49.8
Clinical Care	Recent Primary Care Visit	Total Population (2010)	2915918	5988927	3.1E+08					
		Total Population in the 500 Cities (2010)	490373	1411382	1E+08					
		Percentage of Adults with Routine Checkup in Past 1 Year	68.90%	68.80%	67.90%					
Health Behaviors	Alcohol Consumption	Total Population Age 18+	82478	2187717	4532155	232556016	34007	10570	30119	7782
		Estimated Adults Drinking Excessively	8454	275652	770466	38248349	4659	no data	3795	no data
		Estimated Adults Drinking Excessively(Crude Percentage)	13.20%	12.60%	17.00%	16.40%	13.70%	suppressed	12.60%	suppressed

		Estimated Adults Drinking Excessively(Age-Adjusted Percentage)	15.20%	13.20%	17.90%	16.90%	16.40%	suppressed	13.90%	suppressed
Health Behaviors	Alcohol Expenditures	State Rank	suppressed	no data	no data	no data	67	26	44	41
		Z-Score (US)	0.14	0.16	0.36	no data	0.69	-0.4	-0.16	-0.19
		Z-Score (State)	-0.39	0	0	no data	0.78	-1.06	-0.76	-0.79
		Average Expenditures (USD)	$775.68	$764.85	$849.54	$839.54	suppressed	suppressed	suppressed	suppressed
		Percentage of Food-At-Home Expenditures	14.52%	14.45%	15.03%	14.29%	suppressed	suppressed	suppressed	suppressed
Health Behaviors	Fruit/Vegetable Consumption	Total Population(Age 18+)	80556	2136963	4473226	227279010	33827	10299	28933	7497
		Total Adults with Inadequate Fruit / Vegetable Consumption	26656	1686064	3538322	171972118	26656	no data	no data	no data
		Percent Adults with Inadequate Fruit / Vegetable Consumption	78.80%	78.90%	79.10%	75.70%	78.80%	suppressed	suppressed	suppressed
Health Behaviors	Fruit/Vegetable Expenditures	State Rank	suppressed	no data	no data	no data	1	33	75	6
		Z-Score (US)	-1.02	-0.7	-0.61	no data	-0.69	-1.18	-1.33	-0.99
		Z-Score (State)	0.83	0	0	no data	2.03	0.57	0.13	1.1
		Average Expenditures (USD)	$641.05	$616.25	$665.08	$744.71	suppressed	suppressed	suppressed	suppressed

		Percentage of Food-At-Home Expenditures	12.00%	11.65%	11.77%	12.68%	suppressed	suppressed	suppressed	suppressed
Health Behaviors	Physical Inactivity	Total Population Age 20+	80365	2171944	4486311	234207619	32952	10301	29584	7528
		Population with no Leisure Time Physical Activity	25271	671796	1120890	52147893	11039	3317	8461	2454
		Percent Population with no Leisure Time Physical Activity	28.90%	29.90%	24.10%	21.80%	30.20%	29.60%	27.00%	29.40%
Health Behaviors	Soda Expenditures	State Rank	suppressed	no data	no data	no data	17	80	76	71
		Z-Score (US)	1.46	0.89	0.74	no data	1.13	1.7	1.67	1.61
		Z-Score (State)	-0.36	0	0	no data	-1.16	0.85	0.78	0.64
		Average Expenditures (USD)	$242.39	$242.97	$254.50	$236.04	suppressed	suppressed	suppressed	suppressed
		Percentage of Food-At-Home Expenditures	4.54%	4.59%	4.50%	4.02%	suppressed	suppressed	suppressed	suppressed
Health Behaviors	Tobacco Expenditures	State Rank	suppressed	no data	no data	no data	38	102	83	101
		Z-Score (US)	2.19	0.71	0.31	no data	1.99	2.6	2.2	2.58
		Z-Score (State)	1.08	0	0	no data	0.88	2.53	1.95	2.5
		Average Expenditures (USD)	$1,031.00	$968.13	$935.41	$822.70	suppressed	suppressed	suppressed	suppressed
		Percentage of Food-At-Home Expenditures	2.43%	2.13%	1.89%	1.56%	suppressed	suppressed	suppressed	suppressed
Health Behaviors	Tobacco Usage - Current Smokers	Total Population Age 18+	82478	2187717	4532155	232556016	34007	10570	30119	7782

		Total Adults Regularly Smoking Cigarettes	18930	490049	1024267	41491223	8128	2790	8012	no data
		Percent Population Smoking Cigarettes(Crude)	25.30%	22.40%	22.60%	17.80%	23.90%	26.40%	26.60%	suppressed
		Percent Population Smoking Cigarettes(Age-Adjusted)	28.60%	23.00%	23.20%	18.10%	28.60%	29.80%	28.10%	suppressed
Health Behaviors	Tobacco Usage - Former or Current Smokers	Survey Population(Adults Age 18+)	73453	2170901	4535528	235151778	34559	8573	30321	no data
		Total Adults Ever Smoking 100 or More Cigarettes	42270	1100570	2224446	103842020	21408	5416	15446	no data
		Percent Adults Ever Smoking 100 or More Cigarettes	57.55%	50.70%	49.04%	44.16%	61.95%	63.18%	50.94%	no data
Health Behaviors	Tobacco Usage - Quit Attempt	Survey Population(Smokers Age 18+)	14936	563311	1109658	45526654	7677	3188	4071	no data
		Total Smokers with Quit Attempt in Past 12 Months	5848	336085	596738	27323073	3208	1398	1242	no data
		Percent Smokers with Quit Attempt in Past 12 Months	39.15%	59.66%	53.78%	60.02%	41.79%	43.84%	30.51%	no data
Health Behaviors	Walking or Biking to Work	Population Age 16+	39104	1247999	2803637	145861221	15045	4887	16125	3047

		Population Walking or Biking to Work	899	23754	60671	4908725	423	193	234	49
		Percentage Walking or Biking to Work	2.30%	1.90%	2.16%	3.37%	2.81%	3.95%	1.45%	1.61%
Health Outcomes	Asthma Prevalence	Survey Population(Adults Age 18+)	74053	2186289	4553696	237197465	34688	9044	30321	no data
		Total Adults with Asthma	7116	291927	644403	31697608	2928	572	3616	no data
		Percent Adults with Asthma	9.60%	13.40%	14.20%	13.40%	8.40%	6.30%	11.90%	no data
Health Outcomes	Cancer Incidence - Breast	Estimated Total Population (Female)	8578	179591	368864	18515303	3948	1116	2736	777
		New Cases (Annual Average)	86	2024	4644	228664	49	7	24	6
		Cancer Incidence Rate (Per 100,000 Pop.)	100.25	112.7	125.9	123.5	124.1	62.7	87.7	77.2
Health Outcomes	Cancer Incidence - Cervical	Estimated Total Population (Female)	148484	312941	1.6E+07					
		New Cases (Annual Average)	147	266	12299					
		Cancer Incidence Rate (Per 100,000 Pop.)	9.9	8.5	7.62					
Health Outcomes	Cancer Incidence - Colon and Rectum	Estimated Total Population	16520	343953	700941	34945477	7692	2250	5200	1377
		New Cases (Annual Average)	67	1479	2979	139083	29	7	26	5

		Cancer Incidence Rate (Per 100,000 Pop.)	40.56	43	42.5	39.8	37.7	31.1	50	36.3
Health Outcomes	Cancer Incidence - Lung	Estimated Total Population	17600	354768	714419	35229411	8445	2040	5426	1687
		New Cases (Annual Average)	132	2753	5351	215604	69	9	42	12
		Cancer Incidence Rate (Per 100,000 Pop.)	75	77.6	74.9	61.2	81.7	44.1	77.4	71.1
Health Outcomes	Cancer Incidence - Prostate	Estimated Total Population (Male)	8738	169096	345148	16980487	4152	1037	2640	907
		New Cases (Annual Average)	77	2041	3486	194936	49	8	15	5
		Cancer Incidence Rate (Per 100,000 Pop.)	88.12	120.7	101	114.8	118	77.1	56.8	55.1
Health Outcomes	Depression (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	21988	454228	767306	34118227	10426	1495	8153	1914
		Beneficiaries with Depression	3605	73888	153690	5695629	1451	253	1640	261
		Percent with Depression	16.40%	16.30%	20.00%	16.70%	13.90%	16.90%	20.10%	13.60%
Health Outcomes	Diabetes (Adult)	Total Population Age 20+	80343	2172116	4478513	236919508	32988	10252	29553	7550
		Population with Diagnosed Diabetes	11273	270151	486462	23685417	5278	1220	3635	1140
		Population with Diagnosed Diabetes, Crude Rate	14.03	12.44	10.86	10	16	11.9	12.3	15.1

		Population with Diagnosed Diabetes, Age-Adjusted Rate	10.88%	11.28%	9.71%	9.19%	11.80%	9.00%	10.40%	11.00%
Health Outcomes	Diabetes (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	21988	454228	767306	34118227	10426	1495	8153	1914
		Beneficiaries with Diabetes	5108	110901	198285	9057809	2405	332	1968	403
		Percent with Diabetes	23.20%	24.42%	25.84%	26.55%	23.07%	22.21%	24.14%	21.06%
Health Outcomes	Heart Disease (Adult)	Survey Population(Adults Age 18+)	73484	2170495	4527296	236406904	34552	9044	29888	no data
		Total Adults with Heart Disease	7452	126048	218318	10407185	3593	1997	1862	no data
		Percent Adults with Heart Disease	10.10%	5.80%	4.80%	4.40%	10.40%	22.10%	6.20%	no data
Health Outcomes	Heart Disease (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	21988	454228	767306	34118227	10426	1495	8153	1914
		Beneficiaries with Heart Disease	5389	132518	204290	9028604	2631	333	1993	432
		Percent with Heart Disease	24.50%	29.17%	26.62%	26.46%	25.23%	22.27%	24.44%	22.57%
Health Outcomes	High Blood Pressure (Adult)	Total Population(Age 18+)	82478	2187717	4532155	232556016	34007	10570	30119	7782
		Total Adults with High Blood Pressure	19920	697882	1336986	65476522	10372	no data	9548	no data
		Percent Adults with High Blood Pressure	31.06%	31.90%	29.50%	28.16%	30.50%	suppressed	31.70%	suppressed

Health Outcomes	High Blood Pressure (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	21988	454228	767306	34118227	10426	1495	8153	1914
		Beneficiaries with High Blood Pressure	11544	250397	419133	18761681	5819	699	4172	854
		Percent with High Blood Pressure	52.50%	55.13%	54.62%	54.99%	55.81%	46.76%	51.17%	44.62%
Health Outcomes	High Cholesterol (Adult)	Survey Population(Adults Age 18+)	49318	1558602	3449710	180861326	20380	5834	23104	no data
		Total Adults with High Cholesterol	23948	628092	1394360	69662357	8318	1916	13714	no data
		Percent Adults with High Cholesterol	48.56%	40.30%	40.42%	38.52%	40.81%	32.86%	59.36%	no data
Health Outcomes	High Cholesterol (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	21988	454228	767306	34118227	10426	1495	8153	1914
		Beneficiaries with High Cholesterol	8016	171745	320577	15219766	4208	459	2847	502
		Percent with High Cholesterol	36.50%	37.81%	41.78%	44.61%	40.36%	30.70%	34.92%	26.23%
Health Outcomes	Infant Mortality	Total Births	6025	200675	399460	20913535	1965	770	2795	495
		Total Infant Deaths	41	1545	2876	136369	15	6	17	3
		Infant Mortality Rate (Per 1,000 Births)	6.8	7.7	7.2	6.5	7.8	7.9	6.1	6.2
Health Outcomes	Low Birth Weight	Total Live Births	8316	278383	556612	29300495	2716	1078	3787	735

		Low Weight Births (Under 2500g)	617	25054	44529	2402641	196	92	273	56
		Low Weight Births, Percent of Total	7.42%	9.00%	8.00%	8.20%	7.20%	8.50%	7.20%	7.60%
Health Outcomes	Mortality - Cancer	Total Population	104235	209087	239305	318689254	40995	13475	40304	9460
		Average Annual Deaths, 2010-2014	334	55	99	590634	151	37	114	32
		Crude Death Rate (Per 100,000 Pop.)	320.2	26.4	41.29	185.3	367.9	274.6	281.9	342.5
		Age-Adjusted Death Rate (Per 100,000 Pop.)	192.1	68.97	87.2	160.9	187.1	168.9	204.2	195
Health Outcomes	Mortality - Coronary Heart Disease	Total Population	104235	209087	239305	318689254	40995	13475	40304	9460
		Average Annual Deaths, 2010-2014	190	28	55	367306	82	14	72	22
		Crude Death Rate (Per 100,000 Pop.)	182.3	160.39	137.33	115.3	201	105.4	178.1	228.3
		Age-Adjusted Death Rate (Per 100,000 Pop.)	110.9	133.36	111.45	99.6	99.2	67.9	129.6	142.8
Health Outcomes	Mortality - Drug Poisoning	Total Population	104235	2968265	6061284	318689254	40995	13475	40304	9460
		Average Annual Deaths, 2010-2014	14	368	1094	49715	9		5	

		Crude Death Rate (Per 100,000 Pop.)	17	12.4	18.05	15.6	21.9	suppressed	11.9	suppressed
		Age-Adjusted Death Rate (Per 100,000 Pop.)	20.5	12.92	18.67	15.6	27.7	suppressed	13.2	suppressed
Health Outcomes	Mortality - Heart Disease	Total Population	104235	209087	239305	318689254	40995	13475	40304	9460
		Average Annual Deaths, 2010-2014	325	47	94	618853	144	35	111	34
		Crude Death Rate (Per 100,000 Pop.)	311.4	263.53	238.96	194.2	352.2	262.7	275.9	355.2
		Age-Adjusted Death Rate (Per 100,000 Pop.)	186.2	220.54	194.12	168.2	172.3	169.4	199.6	213.8
Health Outcomes	Mortality - Homicide	Total Population	104235	209087	239305	318689254	40995	13475	40304	9460
		Average Annual Deaths, 2010-2014		10	15	17167				
		Crude Death Rate (Per 100,000 Pop.)		4.88	6.35	5.4	suppressed	suppressed	suppressed	suppressed
		Age-Adjusted Death Rate (Per 100,000 Pop.)	no data	4.5	6.47	5.5	suppressed	suppressed	suppressed	suppressed
Health Outcomes	Mortality - Lung Disease	Total Population	104235	209087	239305	318689254	40995	13475	40304	9460
		Average Annual Deaths, 2007-2011	119	6	12	149886	55	17	40	7

		Crude Death Rate (Per 100,000 Pop.)	113.8	114.7	107.7	47	134.7	126.2	98.3	71.9
		Age-Adjusted Death Rate (Per 100,000 Pop.)	65.9	96.6	89.2	41.3	62.5	81.2	70.8	38.5
Health Outcomes	Mortality - Motor Vehicle Crash	Total Population	104235	209087	239305	318689254	40995	13475	40304	9460
		Average Annual Deaths, 2010-2014	23	22	18	37053	7	3	11	2
		Crude Death Rate (Per 100,000 Pop.)	22.1	10.52	7.61	11.6	17.6	23.8	26.3	21.1
		Age-Adjusted Death Rate (Per 100,000 Pop.)	21.6	12.07	8.43	11.3	16.4	suppressed	26.8	suppressed
Health Outcomes	Mortality - Pedestrian Motor Vehicle Crash	Total Population (2010)	105320	2915918	5988927	312732537	41513	13684	40400	9723
		Total Pedestrian Deaths, 2011-2015	7	246	431	28832	2	1	3	1
		Average Annual Deaths, Rate per 100,000 Pop.	2.2	2.8	2.4	3.1	1.6	2.4	2.5	3.4
Health Outcomes	Mortality - Premature Death	Total Population	128661	9375719	1.6E+07	896379917	51417	35370	11991	29883
		Total Premature Death, 2014-2016	1868	46702	81491	3642755	767	240	689	172
		Total Years of Potential Life Lost,2014-2016 Average	12096	993489	1224219	64739406	4977	3057	1184	2878

		Years of Potential Life Lost, Rate per 100,000 Population	9401	10596	7590	7222	9680	8643	9874	9630
Health Outcomes	Mortality - Stroke	Total Population	104235	2968265	6061284	318689254	40995	13475	40304	9460
		Average Annual Deaths, 2010-2014	85	1636	3012	134618	41	5	31	7
		Crude Death Rate (Per 100,000 Pop.)	81.5	55.12	49.69	42.2	101	40.1	76.4	78.2
		Age-Adjusted Death Rate (Per 100,000 Pop.)	48.2	46.9	41.02	36.9	49.3	23.8	55.4	47.9
Health Outcomes	Mortality - Suicide	Total Population	104235	209087	239305	318689254	40995	13475	40304	9460
		Average Annual Deaths, 2010-2014	28	7	19	42747	14	4	11	
		Crude Death Rate (Per 100,000 Pop.)	30	3.16	8.02	13.4	34.1	28.2	26.3	suppressed
		Age-Adjusted Death Rate (Per 100,000 Pop.)	29	3.45	8.38	13	33.6	suppressed	24.3	suppressed
Health Outcomes	Mortality - Unintentional Injury	Total Population	104235	3177352	6300589	318689254	40995	13475	40304	9460
		Average Annual Deaths, 2010-2014	63	1537	3254	140444	27	8	22	6
		Crude Death Rate (Per 100,000 Pop.)	60.4	48.38	51.64	44.1	65.9	59.4	55.6	59.2

		Age-Adjusted Death Rate (Per 100,000 Pop.)	56.6	47.03	49.38	41.9	58.6	54.6	53.1	66
Health Outcomes	Obesity	Total Population Age 20+	80266	2172420	4487602	234188203	32938	10277	29521	7530
		Adults with BMI > 30.0 (Obese)	25793	747964	1380352	64884915	10639	3340	9299	2515
		Percent Adults with BMI > 30.0 (Obese)	32.60%	34.70%	30.60%	27.50%	33.80%	32.30%	31.20%	33.40%
Health Outcomes	Overweight	Survey Population(Adults Age 18+)	72530	2093351	4363655	224991207	33897	8939	29694	no data
		Total Adults Overweight	26417	712017	1541649	80499532	11802	4349	10266	no data
		Percent Adults Overweight	36.40%	34.00%	35.30%	35.80%	34.80%	48.60%	34.60%	no data
Health Outcomes	Poor Dental Health	Total Population(Age 18+)	81978	2187717	4532155	235375690	33865	10506	29837	7770
		Total Adults with Poor Dental Health	18373	462882	915359	36842620	7882	3509	6982	0
		Percent Adults with Poor Dental Health	22.40%	21.20%	20.20%	15.70%	23.30%	33.40%	23.40%	0.00%
Health Outcomes	Poor General Health	Total Population Age 18+	82478	2187717	4532155	232556016	34007	10570	30119	7782
		Estimated Population with Poor or Fair Health	17690	446294	765934	37766703	7039	2368	6867	1416
		Crude Percentage	21.40%	20.40%	16.90%	16.20%	20.70%	22.40%	22.80%	18.20%
		Age-Adjusted Percentage	19.10%	19.40%	16.00%	15.70%	17.50%	21.30%	20.90%	15.70%

Health Outcomes	STI - Chlamydia Incidence	Total Population	104425	2959188	6044718	316128839	40957	13515	40393	9560
		Total Chlamydia Infections	205	15589	27981	1441789	80	16	104	5
		Chlamydia Infection Rate (Per 100,000 Pop.)	196.31	526.8	462.9	456.08	195.33	118.39	257.47	52.3
Health Outcomes	STI - Gonorrhea Incidence	Total Population	104425	2958931	6045008	316128839	40957	13515	40393	9560
		Total Gonorrhea Infections	19	4539	7387	350062	9	1	9	0
		Gonorrhea Infection Rate (Per 100,000 Pop.)	18.19	153.4	122.2	110.73	21.97	7.4	22.28	0
Health Outcomes	STI - HIV Prevalence	Population Age 13+	88659	2448582	5043482	263765822	35767	11400	33234	8258
		Population with HIV / AIDS	65	5006	11968	931526	23	7	26	9
		Population with HIV / AIDS, Rate (Per 100,000 Pop.)	73.31	204.44	237.3	353.16	64.31	61.4	78.23	108.99

OHC Region Secondary Data Findings

Social Determinants of Health

The OHC Region tends to have lower income and higher rates of poverty compared to the nation.

- *Families Earning Over $75,000*: 29.29% (US: 45.19%); ranges from Springfield: 34.52% to Mountain Home: 22.27%
- *Per Capita Income*: $22,111 (US: $29,829); ranges from Springfield: $24,323 to Monett: $20,280
- *Poverty – Population Below 100% FPL*: 18.09% (US: 15.11%); ranges from Branson: 16.75% to Monett: 20.17%
- *Poverty – Population Below 200% FPL*: 42.75% (US: 33.61%); ranges from Springfield: 39.09% to Monett: 48.00%
- *Children Eligible for Free/Reduced Price Lunch*: 55.23% (US: 52.61%); ranges from Springfield: 45.40% to Mountain Home: 62.44%

Education

The OHC Region tends to have a lower percentage than the nation of the population with an associate degree or higher; however, the proportion of the population with a High School Diploma is slightly higher.

- *Percent Population Age 25 with Associate Degree or Higher*: 28.35% (US: 38.49%); ranges from Springfield: 35.29% to Monett: 20.90%
- *Percent Population Age 25 and Older without a High School Diploma*: 12.83% (US: 13.02%); ranges from Springfield: 9.30% to Monett: 16.92%

Nutrition, Physical Activity, and Obesity

The OHC Region tends to have more residents reporting inadequate fruit/vegetable consumption, inadequate physical activity, and a higher proportion of obese adults than the nation. The region does have a slightly lower proportion of residents in the overweight category.

- *Inadequate Fruit/Vegetable Consumption*: 81.10% (US: 75.70%); ranges from Joplin: 79.50% to Lebanon: 84.00%
- *Inadequate Physical Activity*: 26.00% (US: 21.80%); ranges from Springfield: 22.90% to Mountain Home: 28.90%
- *Obese Adults*: 32.20% (US: 27.50%); ranges from Lebanon: 30.10% to Joplin 33.60%
- *Overweigh*t: 35.20% (US: 35.80%); ranges from Springfield: 32.60% to Branson: 38.10%

Access to Care

In general, the OHC Region has less access to care in the three key areas of primary care, dental care, and mental health. This lack of access is driven by the level of uninsured individuals as well as shortages of providers in these key areas.

- *Uninsured Adults*: 16.84% (US: 13.21%); ranges from Springfield: 15.22% to Monett: 19.72%
- *Access to Primary Care [/100,000]*: 67.8 (US: 87.8); ranges from Springfield: 86.9 to Lebanon: 51.2
- *Access to Dentists [/100,000]*: 45.6 (US: 65.6); ranges from Springfield: 57.5 to Branson: 31.9
- *Population Living in a Health Professional Shortage Area*: 97.44% (US: 33.13%); ranges from Branson: 78.28% to 100% in all other communities
- *Access to Mental Health Providers [/100,000]*: 177.9 (US:202.8); ranges from Springfield: 247.4 to Branson: 65.2
- *Lack of a Consistent Source of Primary Care*: 23.50% (US: 22.07%); ranges from Monett: 11.80% to Branson: 27.60%

Clinical Preventative Services

In most indicators, the OHC Region has lower clinical preventive screenings and services compared to the nation; however, in diabetic screening hemoglobin A1c testing, the OHC Region is slightly better than the nation.

- *Cancer Screening-Mammogram*: 60.60% (US:63.10%); ranges from Springfield: 65.70% to Joplin: 57.20%
- *Cervical Screening*: 69.90% (US: 78.50%); ranges from Mt. Home: 75.20% to Joplin: 66.30%
- *Cancer Screening-Sigmoidoscopy or Colonoscopy*: 54.70% (US: 61.30%); ranges from Springfield: 64.70% to Monett: 45.80%
- *Diabetic Screening Hemoglobin A1c Test*: 85.80% (US: 85.20%); ranges from Springfield: 89.50% to Joplin: 83.20%
- *Dental Care Utilization (No Dental Exam)*: 41.70% (US: 30.20%); ranges from Mt. Home: 32.80% to Monett: 60.40%

Tobacco

The rate of tobacco use in the OHC Region is higher than the nation, with all Communities above the national rate.

- *Tobacco Use-Current Smokers*: 24.60% (US: 18.10%); ranges from Springfield: 20.90% to Monett: 30.1%
- *Youth Tobacco Use*: 12.94%; ranges from Branson: 9.28% to Lebanon: 18.94%

Mental Health

The OHC Region has higher rates of depression in the Medicare population compared to the nation; however, two communities perform better than the nation.

- *Depression (Medicare Population)*: 18.90% (US: 16.70%); ranges from Branson: 15.10% to Springfield: 21.80%

Oral Health

The rate of poor dental health in the OHC Region is higher than the nation, with all Communities above the national rate.

- *Poor Dental Health*: 23.80% (US: 15.70%); ranges from Springfield: 20.20% to Monett: 33.60%

Hospitalizations

As a Region, we are performing worse than the nation in preventable hospital events, two of the six Communities have a lower rate than the nation.

- *Preventable Hospital Events*: 51.3/1,000 (US: 49.9/1,000); ranges from Branson: 43.5 to Joplin: 58.4

Chronic Disease

The chronic disease morbidity rates for the OHC Region are higher than the national rates. The incidence rates for lung, cervical, and colon and rectum cancer are also higher than the nation.

- Cervical Cancer Incidence: 9.9/100,000 (US: 7.62/100,000); ranges from Joplin: 7.3 to Branson and Mountain Home: 9.9
- Colon and Rectum Cancer Incidence: 41.25/100,000 (US: 39.8); ranges from Springfield: 38.09 to Lebanon: 45.24
- Lung Cancer Incidence: 71.26/100,000 (US: 61.2); ranges from Springfield: 63.24 to Joplin: 76.64
- Asthma Prevalence: 13.5% (US: 13.4%); ranges from Mountain Home 9.19% to Joplin 15.8%
- Blood Pressure Morbidity: 29.42% (28.16%): ranges from Branson: 26.62% to Monett 34.02%
- Diabetes (Adult) Morbidity: 9.46% (9.19%); ranges from Springfield 8.57% to Mountain Home 10.88%
- Heart Disease (Adult) Morbidity: 5.5% (US: 4.4%); ranges from Branson: 3.9% to Mountain Home: 10.1%

- High Cholesterol (Adult) Morbidity: 40.77% (US: 38.52%); ranges from Joplin 38.24% to Mountain Home: 48.56%

Death and Mortality

The OHC Region performs more poorly in all listed mortality rates than the nation. The region has more than 1,500 premature deaths than the national average.

- *Premature Death*: 8767/100,000 (US: 7,222/100,000); ranges from Springfield: 7,398 to Joplin: 8,279
- Cancer Mortality: 177.4/100,000 (US: 160.9/100,000); ranges from Springfield: 160.9 to Joplin: 194.3
- *Coronary Heart Disease*: 124/100,000 (US: 99.6/100,00); ranges from Springfield: 88.5 to Monett: 158
- *Drug Poisoning Mortality*: 18.9/100,000 (US: 15.6/100,000); ranges from Joplin: 14.1 to Lebanon: 23.4
- *Heart Disease Mortality*: 211.3/100,000 (US: 168.2/100,000); ranges from Springfield: 178.6 to Joplin: 240
- *Lung Disease Mortality*: 59.5/100,000 (US: 41.3/100,000); ranges from Branson: 48.6 to Lebanon: 67.5
- *Stroke Mortality*: 44.9/100,000 (US: 36.9/100,000); ranges from Branson: 40 to Mountain Home: 48.2
- *Suicide*: 19.6/100,000 (US: 13/100,000); ranges from Monett: 15.2 to Branson: 22.1

OHC Region Secondary Trend Data Findings

In addition to the OHC Region Secondary Data Findings, the secondary data subcommittee compared the OHC Region data from the 2016 assessment to the most recent data. The committee focused on the key indicators that were identified through the secondary data review. The data was compiled and placed into comparison charts to allow for side-by-side examination of the data. The committee identified key trend findings by selecting indicators that had a percentage change greater than one percentage point and/or a mortality/morbidity indicator that is included in the prioritization matrix. Then, the selected trend indicators were re-calculated based off of the current OHC Region footprint to have a more accurate trend comparison. The OHC Region footprint has changed from the 2016 assessment with 51 counties to the current OHC Region with 29 counties. After the trend data was reviewed, the committee provided their findings to the steering committee. The following are the secondary trend data key findings.

Cancer

Cancer mortality, tobacco use, colon & rectum cancer incidence, and cancer screening have all improved for the OHC Region. The incidence for both lung and cervical cancer have increased.

- *Cancer Screening – Mammogram:* 57.0% (2016 Assessment data) to 60.6% (2018 Assessment data)
- *Cancer Screening – Sigmoidoscopy or Colonoscopy:* 52.0% to 54.7%
- *Cancer Incidence – Cervical (/100,000):* 8.0 to 9.1
- *Cancer Mortality (/100,000):* 188.1 to 177.4
- *Tobacco Use:* 26.0% to 24.6%
- *Cancer Incidence – Lung (/100,000)*: 69.2 to 71.3
- *Cancer Incidence – Colon & Rectum (/100,000):* 43.5 to 41.3

Diabetes

Adult diabetes and physical inactivity rates have improved overall for the OHC region.

- *Diabetes (Adult)*: 10.0% to 9.5%
- *Physical Inactivity:* 28.0% to 26.0%

Mental Disorders

The OHC region has seen an increase in both suicide rates and depression.

- *Suicide (/100,000):* 18.8 to 19.6
- *Depression:* 18.0% to 18.9%

Lung Disease

Health behavior factors affecting lung disease, such as tobacco use and physical inactivity rates, have improved overall for the OHC Region; however, at this time, lung disease mortality has stayed the same. In the region, asthma prevalence has increased.

- *Mortality-Lung Disease (/100,000):* 59.6 to 59.5
- *Tobacco Use:* 26.0% to 24.6%
- *Physical Inactivity:* 28.0% to 26.0%
- *Asthma Prevalence*: 13.0% to 13.5%

Cardiovascular Disease

Behaviors that effect cardiovascular disease, such as physical activity and tobacco, have improved. Morbidity and mortality measures of cardiovascular disease, such as the rate of heart disease and death rates from stroke and heart disease, have also improved. Overall, the OHC Region has improved in every indicator of cardiovascular disease.

- *Mortality-Stroke (/100,000):* 45.5 to 44.9
- *Mortality-Heart Disease (/100,000):* 215.1 to 211.3
- *Physical Inactivity:* 28.0% to 26.0%
- *Tobacco Use:* 26.0% to 24.6%
- *Morbidity-Heart Disease (Adult):* 6.5% to 5.5%

Oral Health

Overall, the oral health of the OHC Region has improved with less poor dental health days reported and improved access to dental care.

- *Dental Care Utilization (No Dental Exam):* 43.0% to 23.8%
- *Access to Dentists (/100,000):* 35.8 to 45.6
- *Poor Dental Health:* 27.0% to 23.8%

Social Determinants of Health

For the OHC Region, the social determinants of health have improved. The population is more educated and earning more money.

- *Families Earning Over $75,000:* 25.0% to 29.3%
- *Children Eligible for Free/Reduced Price Lunch:* 60.0% to 55.2%
- *Percent Population Age 25 with Associate Degree or Higher:* 25.0% to 28.4%
- *Percent Population Age 25 and older without a High School Diploma:* 16.0% to 12.8%

Access to Care

The uninsured adult population and preventable hospital events have decreased; however, the percentage of the population living in a Health Professional Shortage Area has increased.

- *Uninsured Adults:* 25.0% to 16.8%
- *Preventable Hospital Events (/1,000)*: 66.9 to 51.3
- *Population Living in a Health Professional Shortage Area:* 85.0% to 97.4%

Hospital Data

Mountain View Community

Emergency Department Visits	
Cancer	1.10%
Diabetes	6.10%
Mental Illness	7.50%
Cardiovascular Disease	16.00%
Lung Disease	69.30%
Emergency Department by Payor	
Medicare	22.30%
Commercial	33.10%
Medicaid	27.10%
Self Pay	17.40%
Other	0.00%
Emergency Department by Age Groups	
0-17	23.80%
18-64	55.90%
65+	20.30%
Assessed Health Issues, 0-17 years old	
Cancer	0.30%
Diabetes	0.80%
Mental Illness	1.40%
Cardiovascular Disease	0.50%
Lung Disease	97.00%
Assessed Health Issues, 18-64 years old	
Cancer	0.90%
Diabetes	7.00%
Mental Illness	14.60%
Cardiovascular Disease	12.40%
Lung Disease	65.10%
Assessed Health Issues, 65+ years old	
Cancer	2.20%
Diabetes	9.90%
Mental Illness	2.40%
Cardiovascular Disease	37.10%
Lung Disease	48.40%
Emergency Department by Patient Race	
Caucasian	94.10%
Black or African American	0.50%
Hispanic	0.80%
Unknown/Refused	0.70%
Multi_Racial	0.50%
Other	2.90%
American Indian / Alaska Native	0.30%
Asian	0.10%
Remaining Race Groups	0.00%
Other Pacific Islander	0.00%

Hospital Data

OHC Region

Emergency Department Visits	
Cancer	1.70%
Diabetes	7.40%
Mental Illness	21.40%
Cardiovascular Disease	23.30%
Lung Disease	46.30%
Emergency Department by Payor	
Medicare	24.10%
Commercial	32.70%
Medicaid	23.00%
Self Pay	19.00%
Other	1.10%
Emergency Department by Age Groups	
0-17	17.00%
18-64	61.60%
65+	21.40%
Assessed Health Issues, 0-17 years old	
Cancer	0.10%
Diabetes	2.40%
Mental Illness	10.80%
Cardiovascular Disease	1.50%
Lung Disease	85.30%
Assessed Health Issues, 18-64 years old	
Cancer	1.40%
Diabetes	8.50%
Mental Illness	33.10%
Cardiovascular Disease	17.50%
Lung Disease	39.60%
Assessed Health Issues, 65+ years old	
Cancer	3.30%
Diabetes	8.20%
Mental Illness	4.40%
Cardiovascular Disease	48.70%
Lung Disease	35.40%
Emergency Department by Patient Race	
Caucasian	90.40%
Black or African American	3.60%
Hispanic	2.40%
Unknown/Refused	0.50%
Multi_Racial	1.00%
Other	1.00%
American Indian / Alaska Native	0.40%
Asian	0.20%
Remaining Race Groups	0.40%
Other Pacific Islander	0.00%

OHC Region Primary Data Findings

ED by Top 20 Patient Home Zip Codes

There are 14 Emergency Departments (ED) in the OHC Region. Below are the top 20 patient home zip codes for each Community.

Lebanon			
Zip	**City**	**State**	**Percent**
65536	Lebanon	Missouri	56.8%
65583	Waynesville	Missouri	5.6%
65556	Richland	Missouri	5.1%
65584	St Robert	Missouri	2.8%
65632	Conway	Missouri	2.6%
65722	Phillipsburg	Missouri	2.2%
65463	Eldridge	Missouri	1.5%
65667	Hartville	Missouri	1.4%
65662	Grovespring	Missouri	1.3%
65020	Camdenton	Missouri	1.3%
65567	Stoutland	Missouri	1.3%
65459	Dixon	Missouri	1.3%
65452	Crocker	Missouri	1.2%
65534	Laquey	Missouri	1.2%
65713	Niangua	Missouri	1.1%
65706	Marshfield	Missouri	1.1%
65470	Falcon	Missouri	1.1%
65590	Long Lane	Missouri	0.8%
65552	Plato	Missouri	0.7%
65622	Buffalo	Missouri	0.6%
Remaining Zip Codes			9.1%
All ED			100.0%

Mountain View			
Zip	**City**	**State**	**Percent**
65548	Mountain View	Missouri	33.4%
65438	Birch Tree	Missouri	12.6%

65588	Winona	Missouri	12.1%
65793	Willow Springs	Missouri	9.5%
65571	Summersville	Missouri	6.6%
65775	West Plains	Missouri	4.9%
65466	Eminence	Missouri	4.4%
65606	Alton	Missouri	2.4%
65789	Pomona	Missouri	1.8%
63965	Van Buren	Missouri	1.2%
65479	Hartshorn	Missouri	1.0%
65711	Mountain Grove	Missouri	1.0%
63941	Fremont	Missouri	0.9%
65689	Cabool	Missouri	0.6%
65791	Thayer	Missouri	0.4%
65788	Peace Valley	Missouri	0.4%
65804	Springfield	Missouri	0.3%
65483	Houston	Missouri	0.2%
65560	Salem	Missouri	0.2%
65638	Trail	Missouri	0.2%
Remaining Zip Codes			Missouri
All ED			100.0%

Springfield			
Zip	**City**	**State**	**Percent**
65803	Springfield	Missouri	14.3%
65802	Springfield	Missouri	13.9%
65807	Springfield	Missouri	10.0%
65804	Springfield	Missouri	6.5%
65714	Nixa	Missouri	4.1%
65721	Ozark	Missouri	3.8%
65806	Springfield	Missouri	3.7%
65738	Republic	Missouri	2.7%
65706	Marshfield	Missouri	2.4%
65810	Springfield	Missouri	2.2%
65742	Rogersville	Missouri	1.5%
65781	Willard	Missouri	1.5%
65608	Ava	Missouri	1.3%
65757	Strafford	Missouri	1.1%

65809	Springfield	Missouri	1.1%
65746	Seymour	Missouri	1.0%
65619	Brookline	Missouri	1.0%
65536	Lebanon	Missouri	0.6%
65753	Sparta	Missouri	0.5%
65605	Aurora	Missouri	0.5%
Remaining Zip Codes			26.3%
All ED			100.0%

Branson			
Zip	**City**	**State**	**Percent**
65616	Branson	Missouri	25.7%
72616	Berryville	Missouri	8.2%
65672	Hollister	Missouri	6.9%
65737	Reeds Spring	Missouri	5.1%
65653	Forsyth	Missouri	4.7%
65740	Rockaway Beach	Missouri	4.7%
72638	Green Forest	Missouri	3.9%
65686	Kimberling City	Missouri	2.5%
65679	Kirbyville	Missouri	2.2%
65611	Blue Eye	Missouri	1.6%
65656	Galena	Missouri	1.6%
72601	Harrison	Arkansas	1.4%
72662	Omaha	Arkansas	1.2%
65681	Lampe	Missouri	1.1%
72632	Eureka Springs	Missouri	1.1%
65673	Hollister	Missouri	1.1%
65615	Branson	Missouri	1.0%
65680	Kissee Mills	Missouri	0.9%
72631	Eureka Springs	Missouri	0.9%
65739	Ridgedale	Missouri	0.8%
Remaining Zip Codes			23.2%
All ED			100.0%

Monett			
Zip	**City**	**State**	**Percent**

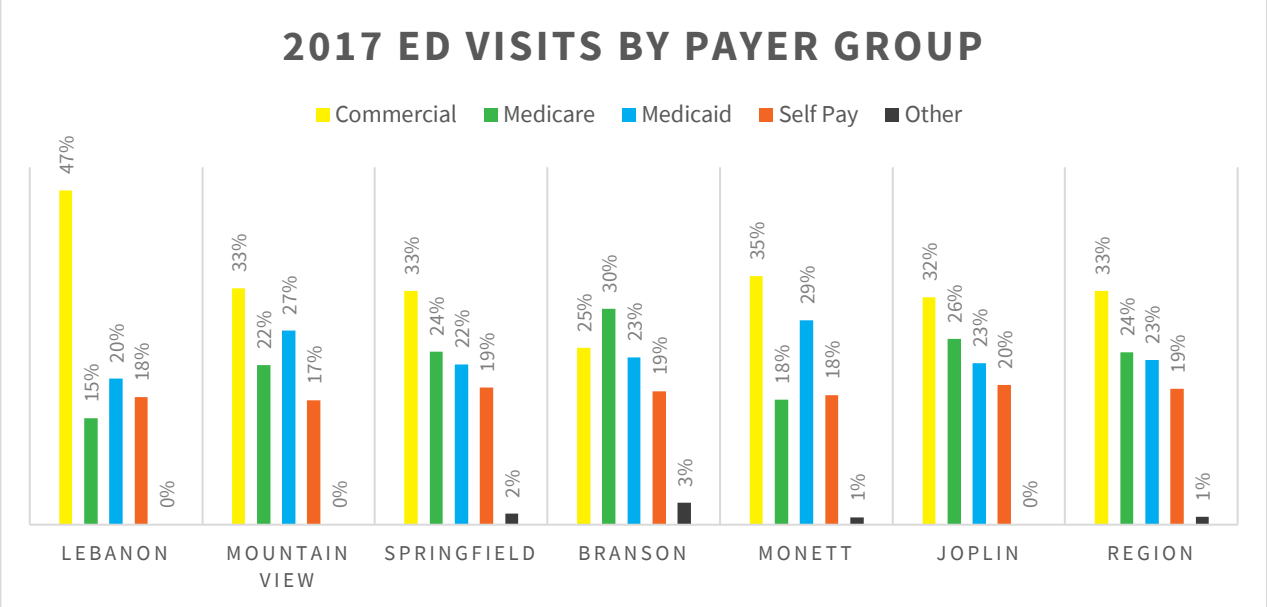
65605	Aurora	Missouri	17.5%
65708	Monett	Missouri	16.5%
65625	Cassville	Missouri	14.8%
65712	Mount Vernon	Missouri	5.9%
65734	Purdy	Missouri	4.8%
65647	Exeter	Missouri	3.9%
65723	Pierce City	Missouri	3.9%
65705	Marionville	Missouri	3.4%
65769	Verona	Missouri	3.3%
65745	Seligman	Missouri	3.1%
65633	Crane	Missouri	2.2%
65772	Washburn	Missouri	2.2%
65747	Shell Knob	Missouri	1.7%
64874	Wheaton	Missouri	1.3%
65707	Miller	Missouri	1.2%
65641	Eagle Rock	Missouri	0.8%
65610	Billings	Missouri	0.7%
64873	Wentworth	Missouri	0.6%
65756	Stotts City	Missouri	0.6%
64842	Fairview	Missouri	0.6%
Remaining Zip Codes			10.7%
All ED			100.0%

Joplin			
Zip	**City**	**State**	**Percent**
64801	Joplin	Missouri	16.6%
64804	Joplin	Missouri	13.5%
64836	Carthage	Missouri	12.3%
64850	Neosho	Missouri	11.0%
64870	Webb City	Missouri	5.3%
64834	Carl Junction	Missouri	2.5%
64865	Seneca	Missouri	2.2%
66739	Galena	Kansas	2.2%
66725	Columbus	Kansas	2.1%
64831	Anderson	Missouri	2.0%
66713	Baxter Springs	Kansas	1.9%
64844	Granby	Missouri	1.9%

64862	Sarcoxie	Missouri	1.5%
64843	Goodman	Missouri	1.5%
64835	Carterville	Missouri	1.4%
74354	Miami	Oklahoma	1.4%
64840	Diamond	Missouri	1.0%
64855	Oronogo	Missouri	0.8%
64755	Jasper	Missouri	0.8%
74363	Quapaw	Oklahoma	0.7%
Remaining Zip Codes			17.4%
Total			100.0%

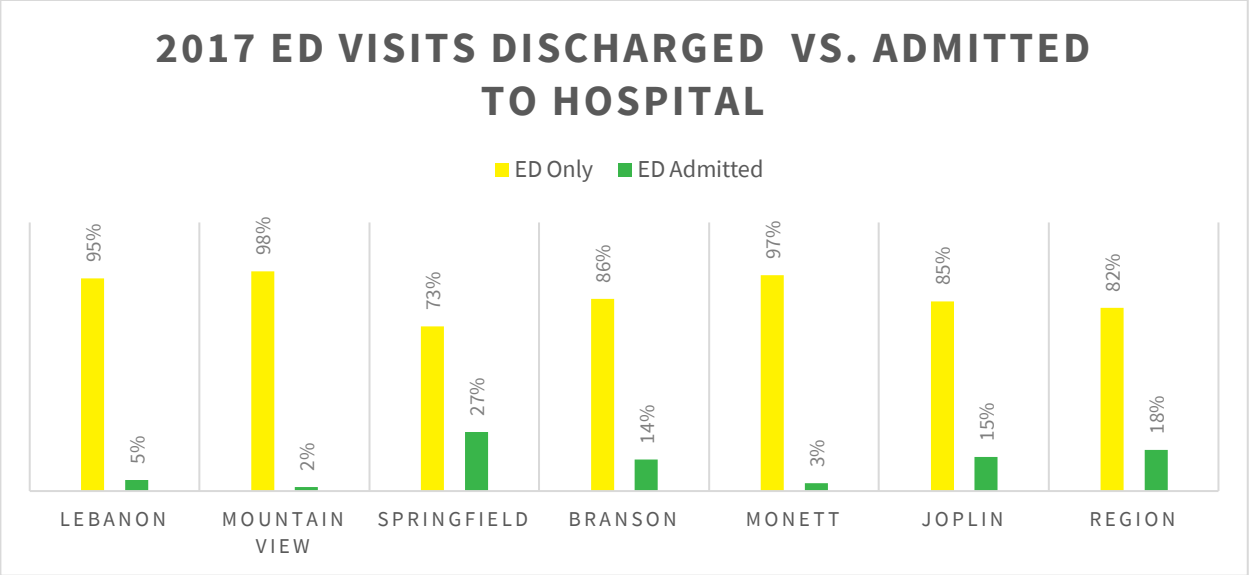
ED by Payer Group

Of all ED patients, 33% had Commercial insurance, had 24% Medicare, 23% had Medicaid, and 19% did not have health insurance. Understanding the payer mix of ED patients is important when assessing access to appropriate care in the community.



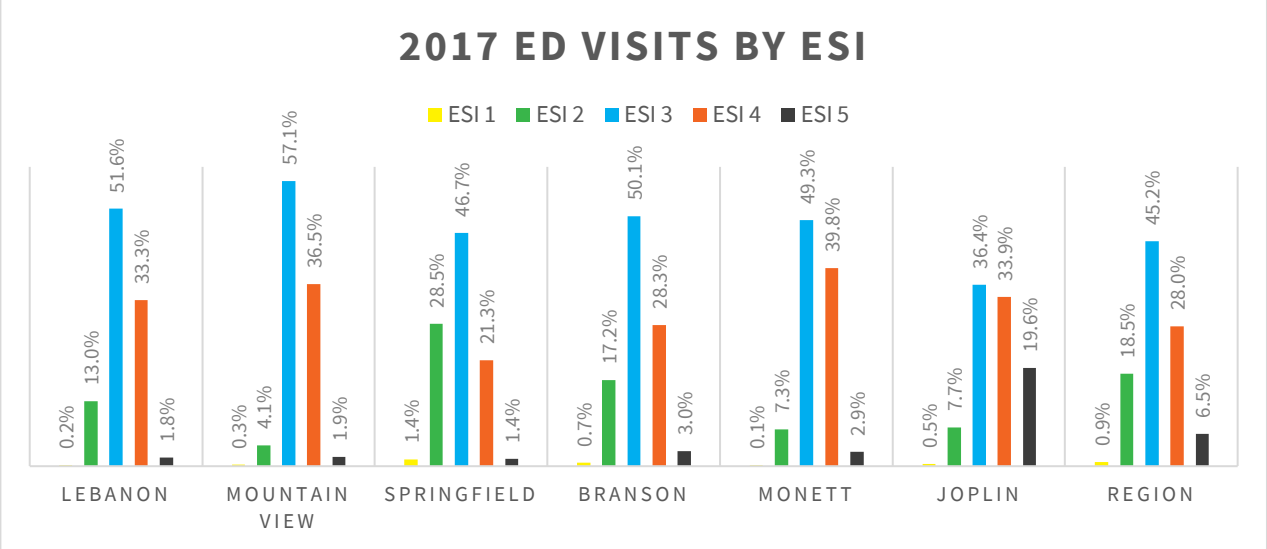
ED Only vs ED Admitted

Approximately 82% of patients presenting to all OHC Region EDs were discharged after being treated, while 18% were admitted to the hospital. Generally, communities with major trauma centers will have higher admittance rates than communities with EDs that treat lower acuity injury and illness.



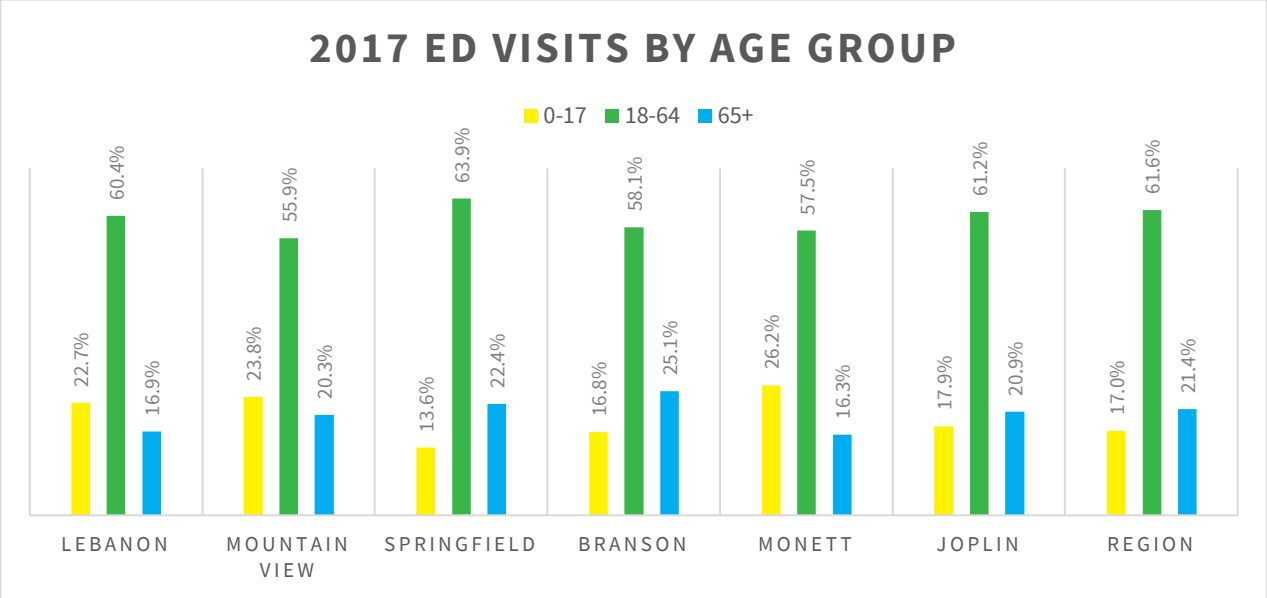
ED by Emergency Severity Index

The Emergency Severity Index (ESI) is a score assigned to a patient after being evaluated by a nurse shortly after entering the ED. A score of 1 indicates the highest acuity level, whereas a score of 5 indicates the lowest acuity level. For example, a minor, non-life-threatening laceration requiring stitches may receive an ESI of 5, whereas a patient experiencing cardiac arrest may receive an ESI of 1. Understanding the ESI breakdown of ED visits is helpful when assessing access to appropriate care in a community. Approximately, 0.9% of patients presenting to OHC Region EDs received an ESI of 1, 18.5% received ESI of 2, 45.2% received an ESI of 3, 28% received an ESI of 4, and 6.5% received an ESI of 5.



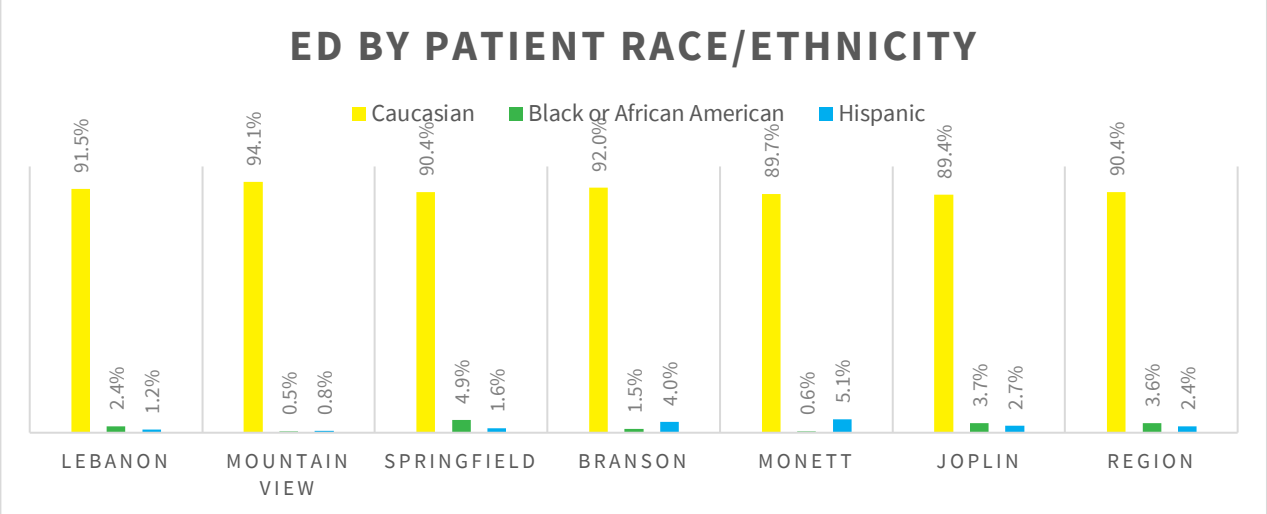
ED by Age Groups

Three age groups were evaluated: 0-17, 18-64, and 65 and older. In the OHC Region, 61.6% of ED patients are between 18 to 64 years of age. Children 0-17 years of age account for 17% of ED visits. The presentation of people 65 years and older in the OHC Region is 21.4%.



ED by Patient Race/Ethnicity

In the OHC Region, approximately 90% of ED patients are Caucasian, 4% are Black or African American, and 3% are Hispanic or multiracial.



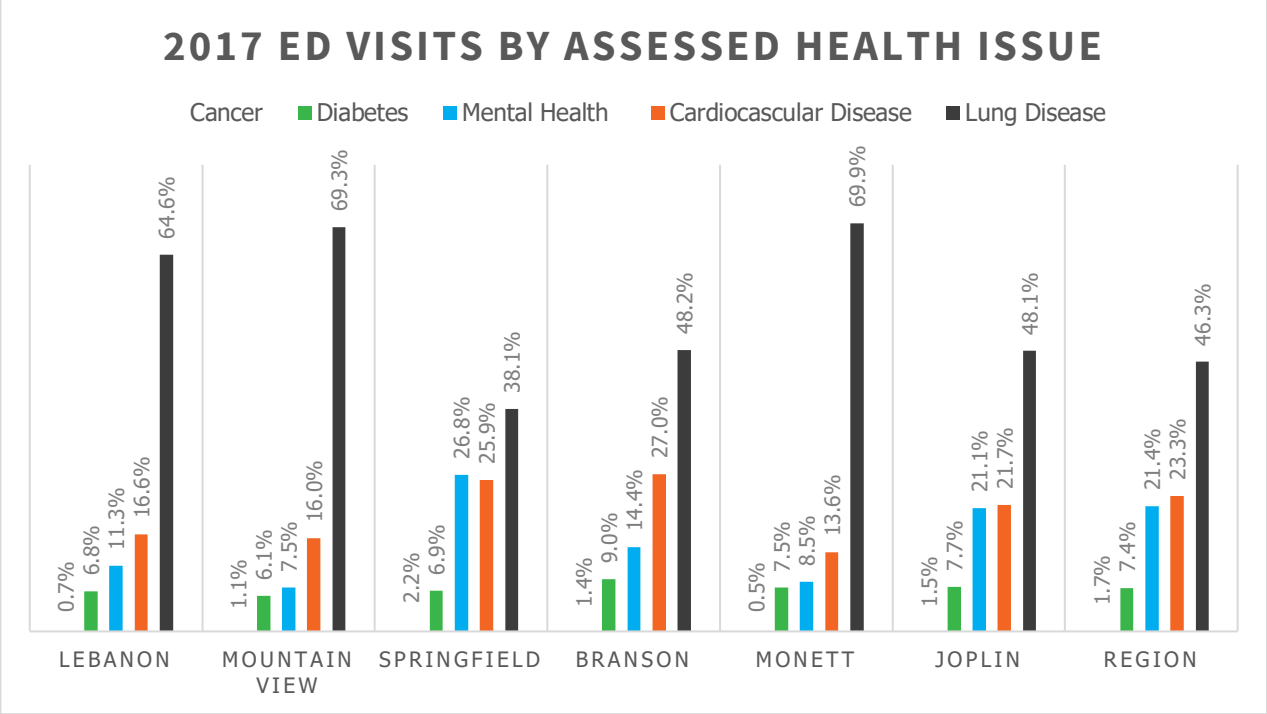
Presentation of Assessed Health Issues in the ED

For the purposes of the Regional Health Assessment, the Hospital Data Committee analyzed Principal Diagnosis Groups that specifically related to five of the six Assessed Health Issues (AHI): Cancer, Diabetes, Mental Health, Cardiovascular Disease, and Lung Disease. Because only the first three digits of ICD-10 codes were pulled for the report, Oral Health was not easily segmented in the primary hospital data. In this section of the narrative, we will discuss the hospital primary data findings of these specific issues.

The table below lists the ICD-10 diagnosis code groups and diagnosis group descriptions that align with the five AHI analyzed.

Assessed Health Issue	Dx Code Groups	Diagnosis Group Descriptions
Cancer	C00-D49	Neoplasms
Diabetes	E00-E89	Endocrine, nutritional and metabolic diseases
Mental Health	F01-F99	Mental, Behavioral and Neurodevelopmental disorders
Cardiovascular Disease	I00-I99	Diseases of the circulatory system
Lung Disease	J00-J99	Diseases of the respiratory system

In the OHC Region, 25% of total ED visits are related to the AHI.

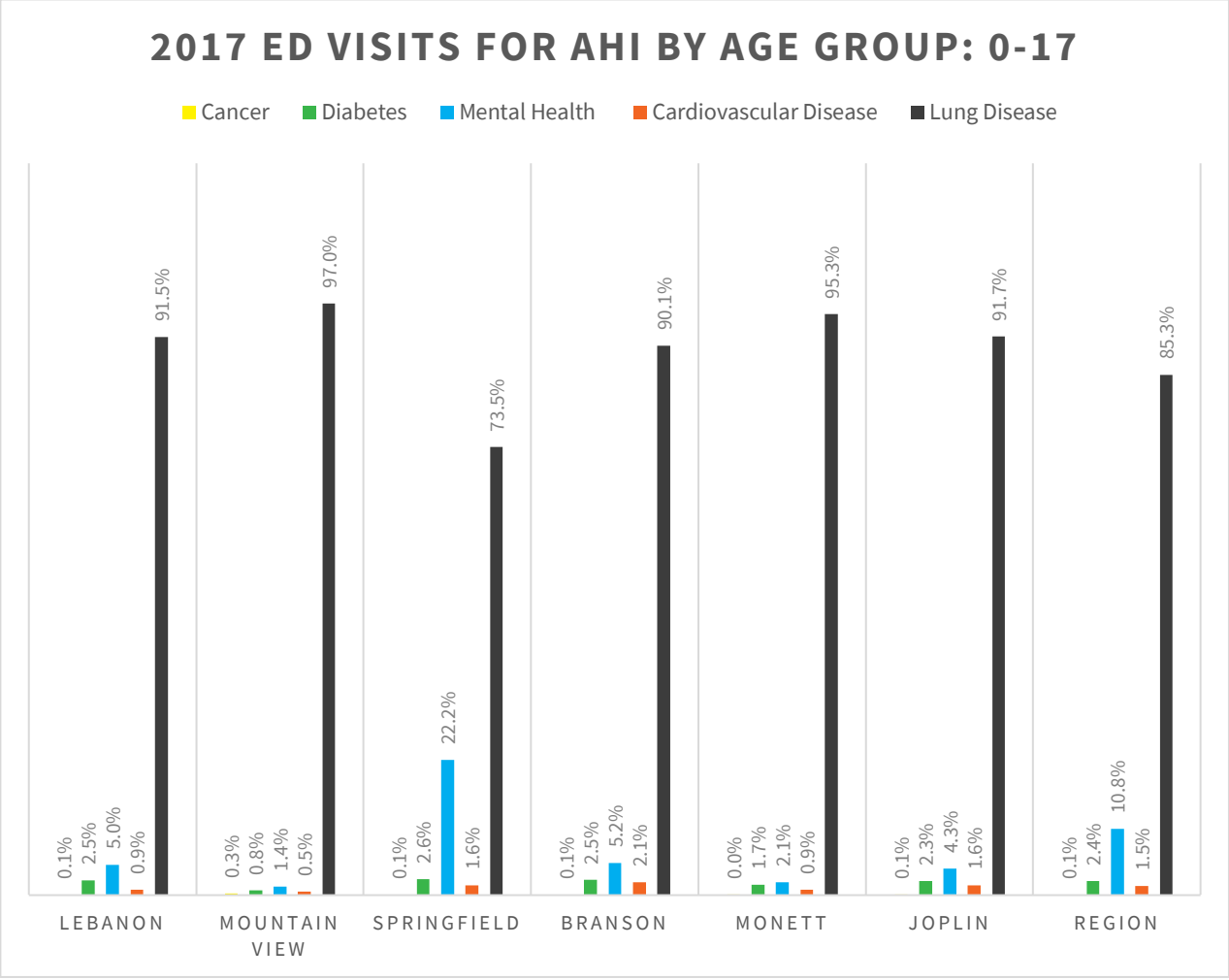


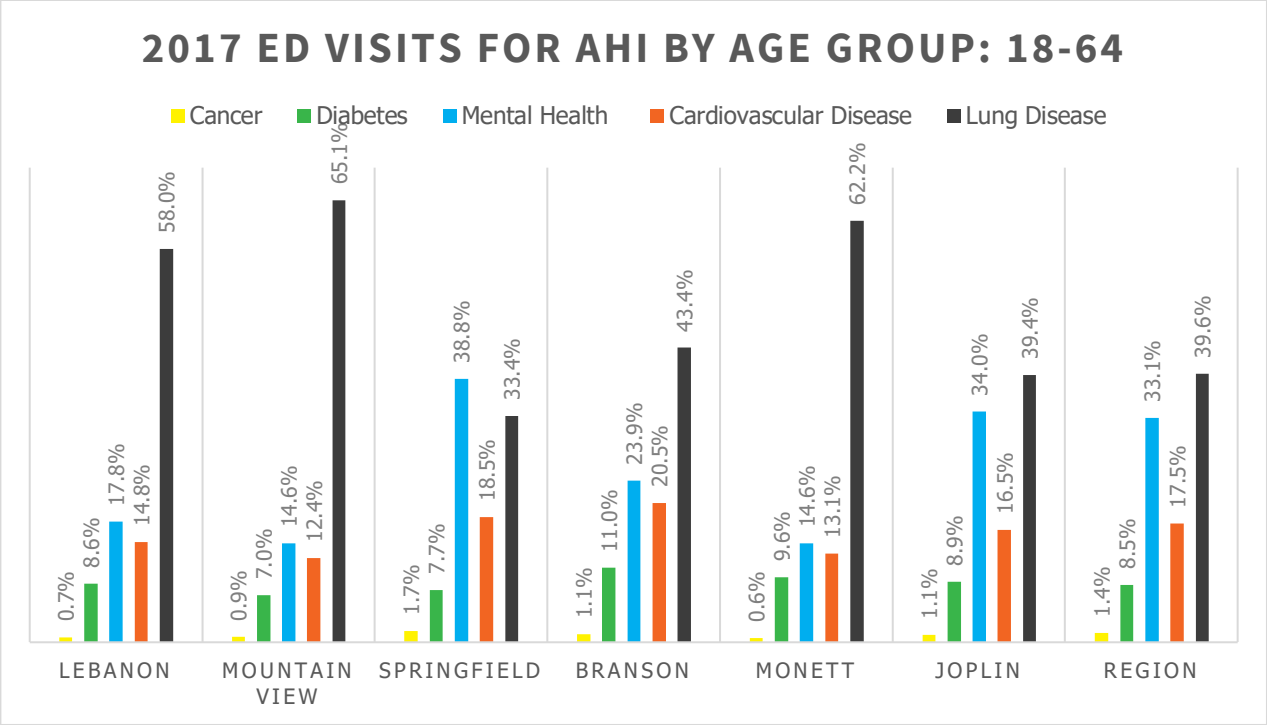
Demographics of ED Patients Presenting with one of the AHI

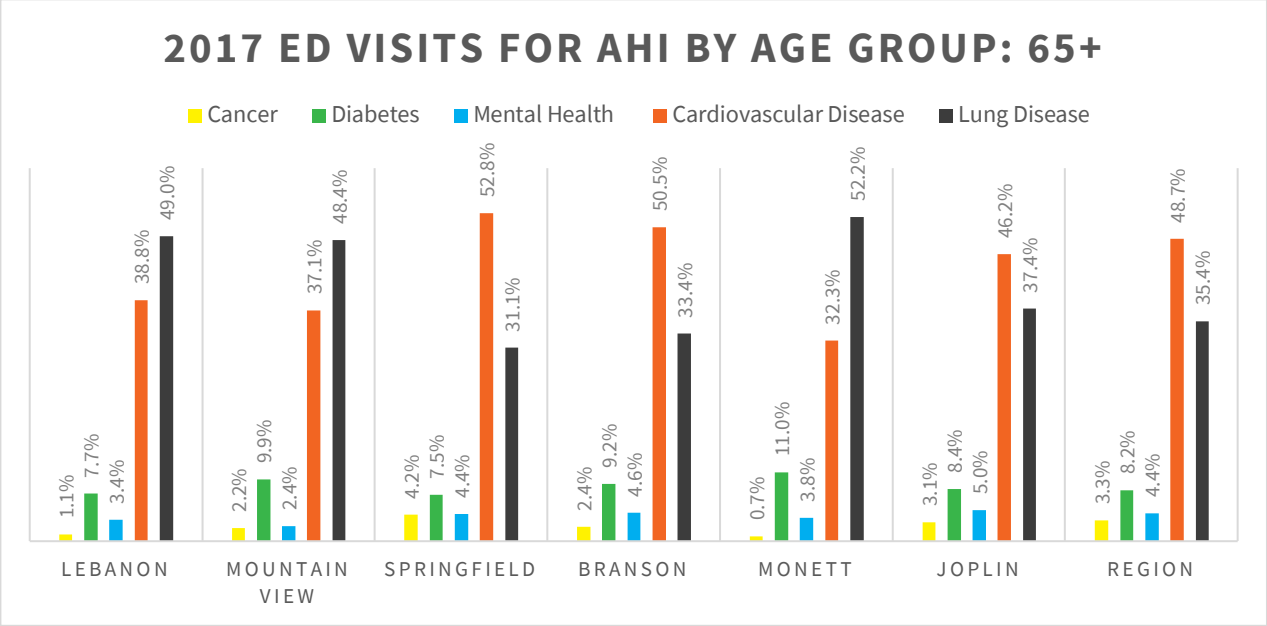
To develop strategic initiatives to address prioritized health issues, it is important identify and understand needs of specific populations. The following sections assess age groups, gender, race, and payer types of patients that visit EDs in the OHC Region.

ED Visits for AHI by Age Group

There are noticeable differences in visits due to specific AHI across age groups. Over 85% of visits by children are due to lung related disease, while 39.6% and 35.4% of similar visits are by those age 18-64 and 65+, respectively. Additionally, visits due to cardiovascular disease increase with age. Among adults 65 and older, visits due to cardiovascular disease are almost 49%. Also of note, ED visits by children for mental health issues are 11% for the OHC Region.



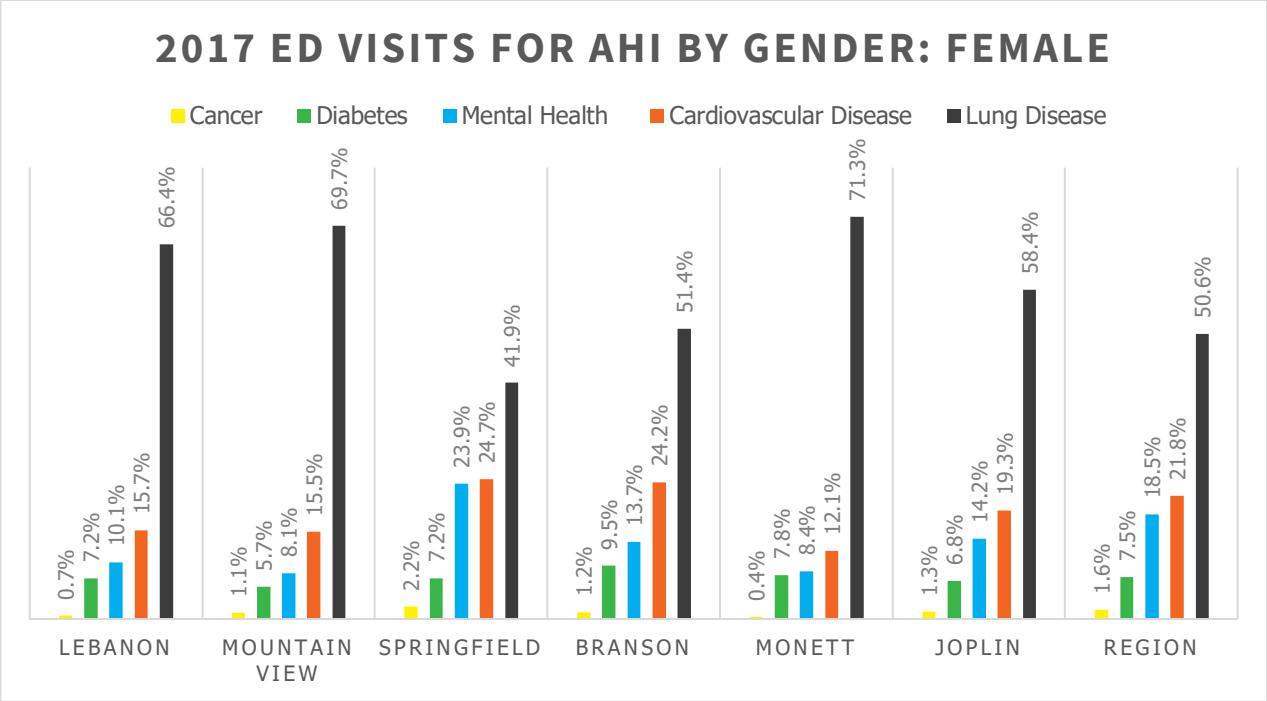


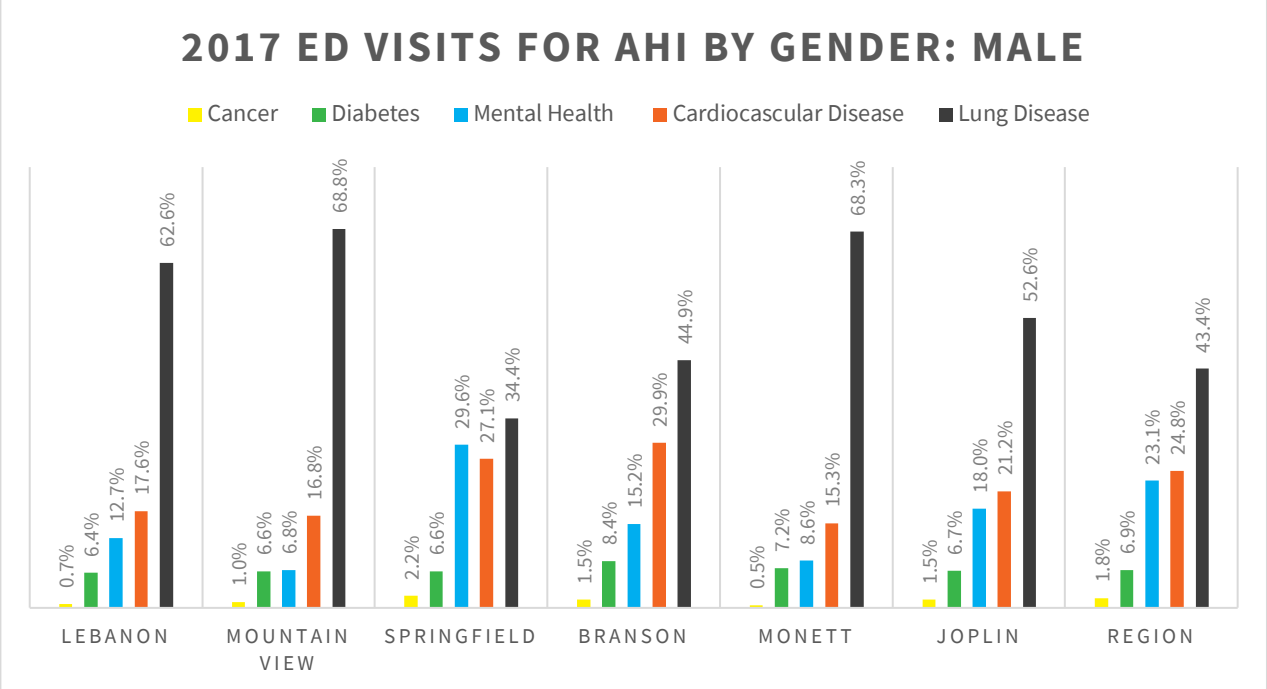


ED Visits for AHI by Gender

In the OHC Region, women presented to the ED more than men for diabetes and lung related diseases, men presented to the ED more than women for mental health and cardiovascular related illnesses, and

the presentation for cancer was equal. The most notable disparities across gender are related to Mental Health. Approximately 23% of visits by males were for mental health related illness, while 18.5% of similar visits were by females.

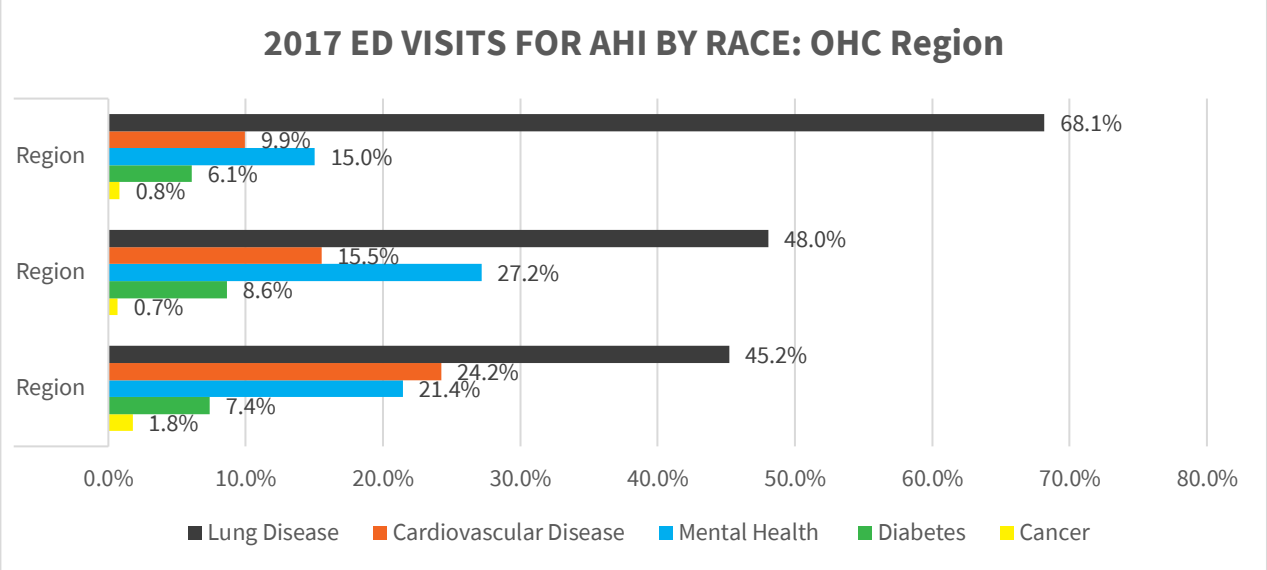


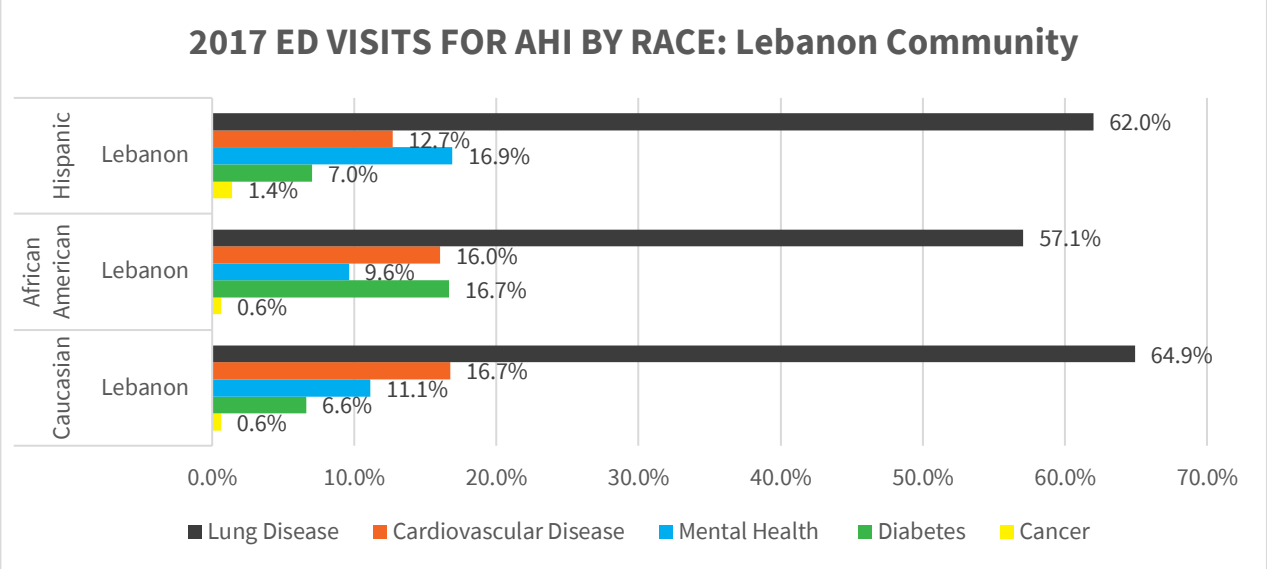


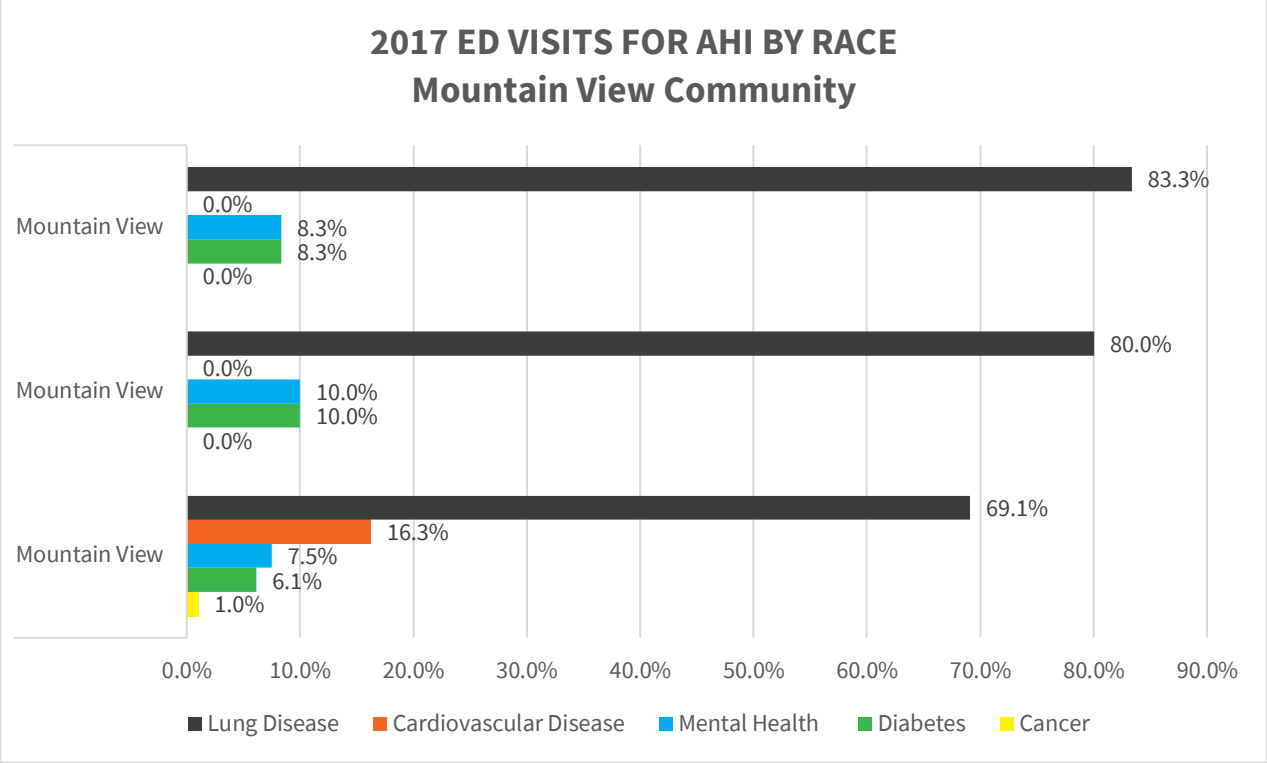
ED Visits for AHI by Race

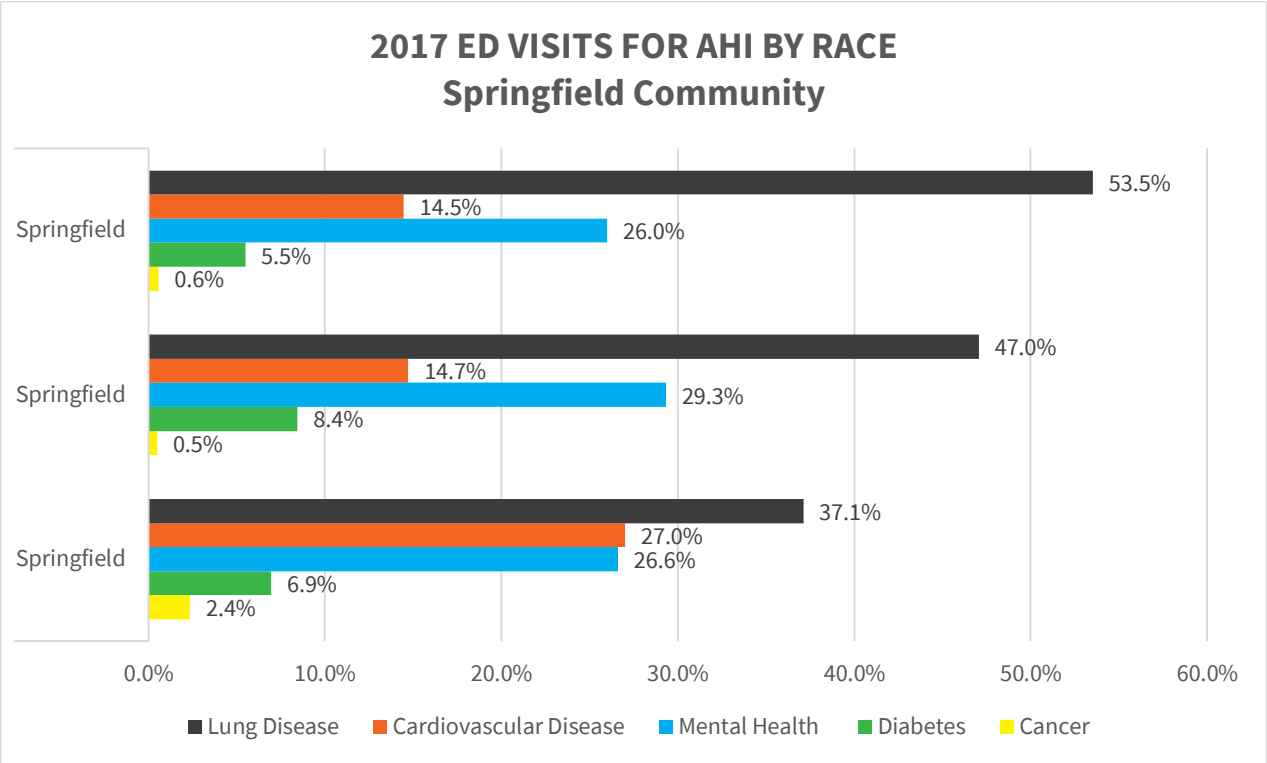
For the purposes of this report, the top three presenting races are included in the analysis.

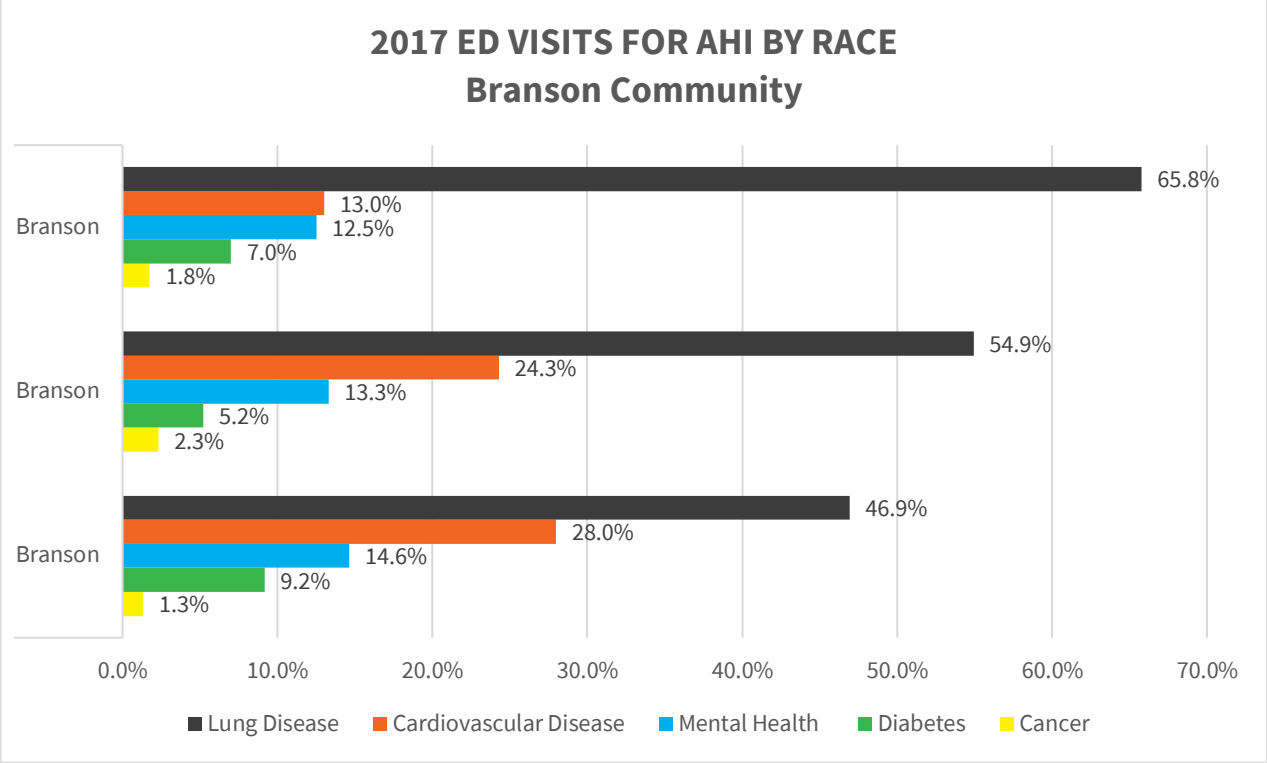
As presented in the chart below, health disparities exist between Caucasian, African American and Hispanic race groups. Most notably, the prevalence of ED visits due to lung disease is highest in the Region among the Hispanic population, second highest in Black/African Americans and lowest in Caucasians. Those that classify as Black or African American have the highest presentation of mental health issues in OHC area ED (27.2%). Regarding Cardiovascular Disease, Caucasians present to the ED more than African Americans and Hispanics at 24.2%, 15.5%, and 9.9%, respectively.

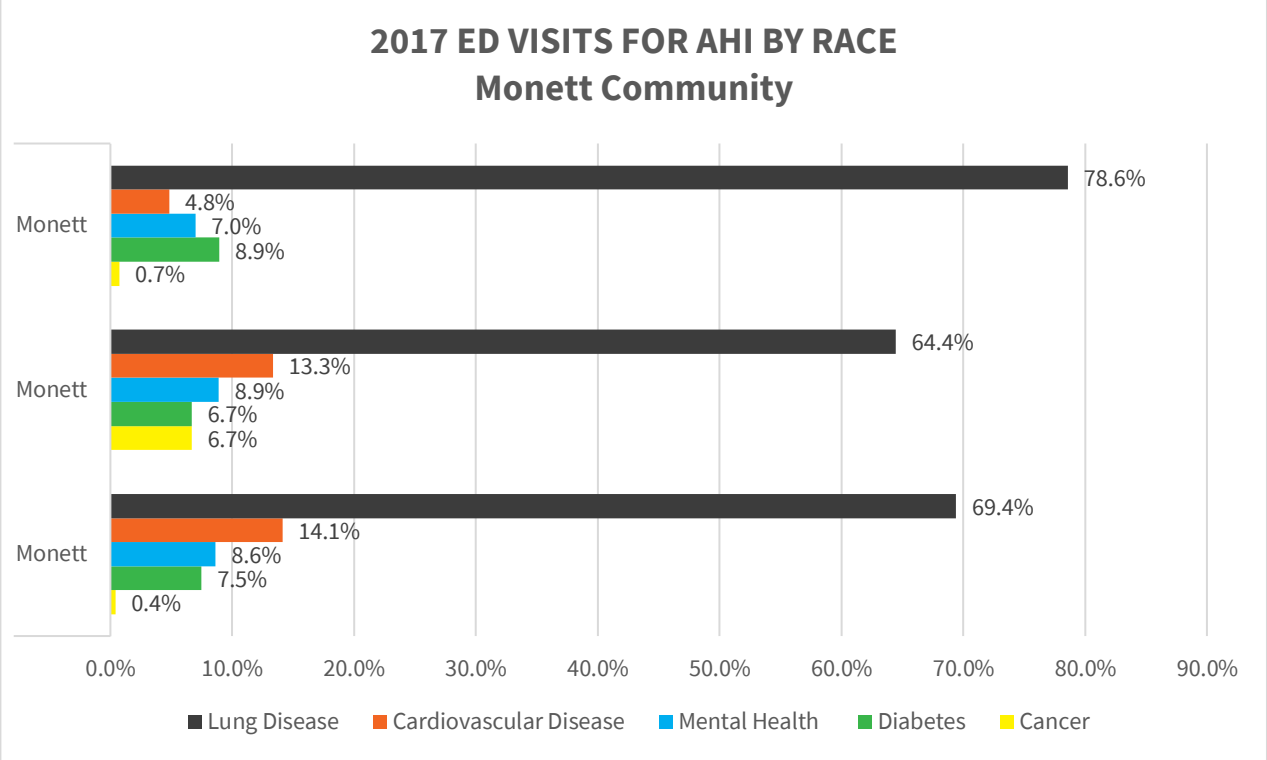


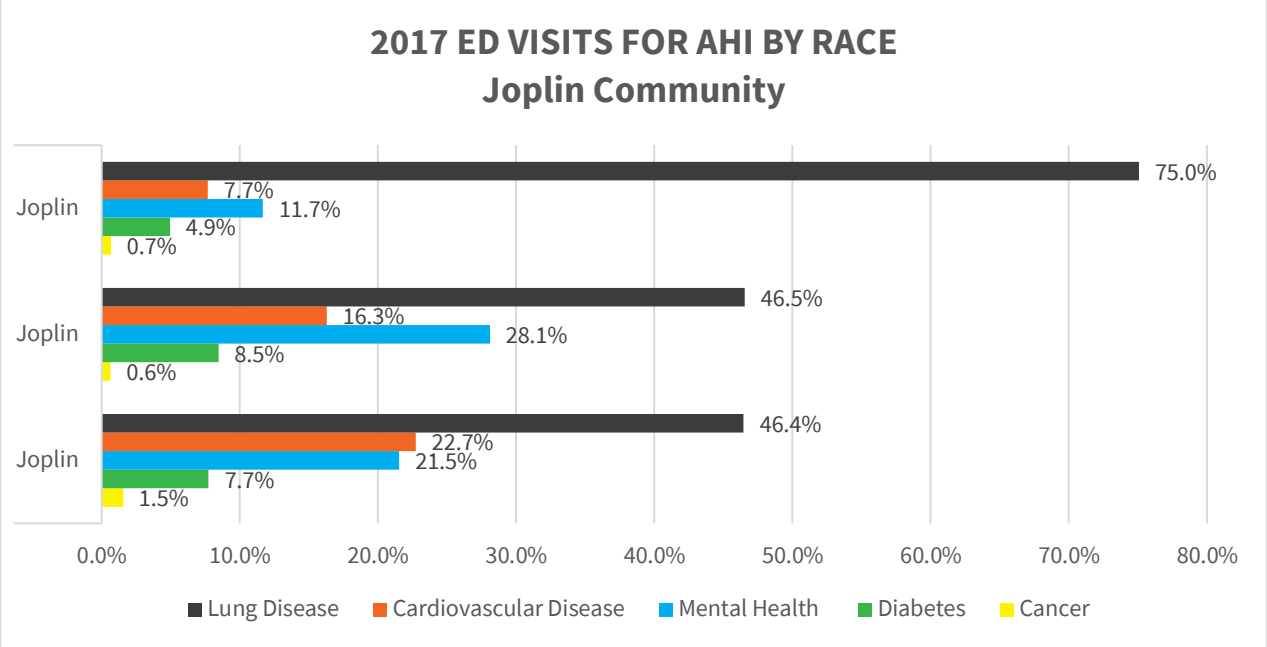



2017 ED VISITS FOR AHI BY RACE
Mountain View Community
Mountain View
Mountain View
Mountain View
83.3%
0.0%
8.3%
8.3%
0.0%
80.0%
0.0%
10.0%
10.0%
0.0%
69.1%
16.3%
7.5%
6.1%
1.0%
0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0%
Lung Disease
Cardiovascular Disease
Mental Health
Diabetes
Cancer


2017 ED VISITS FOR AHI BY RACE
Springfield Community
Springfield
Springfield
Springfield
53.5%
14.5%
26.0%
5.5%
0.6%
47.0%
14.7%
29.3%
8.4%
0.5%
37.1%
27.0%
26.6%
6.9%
2.4%
0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0%
Lung Disease
Cardiovascular Disease
Mental Health
Diabetes
Cancer

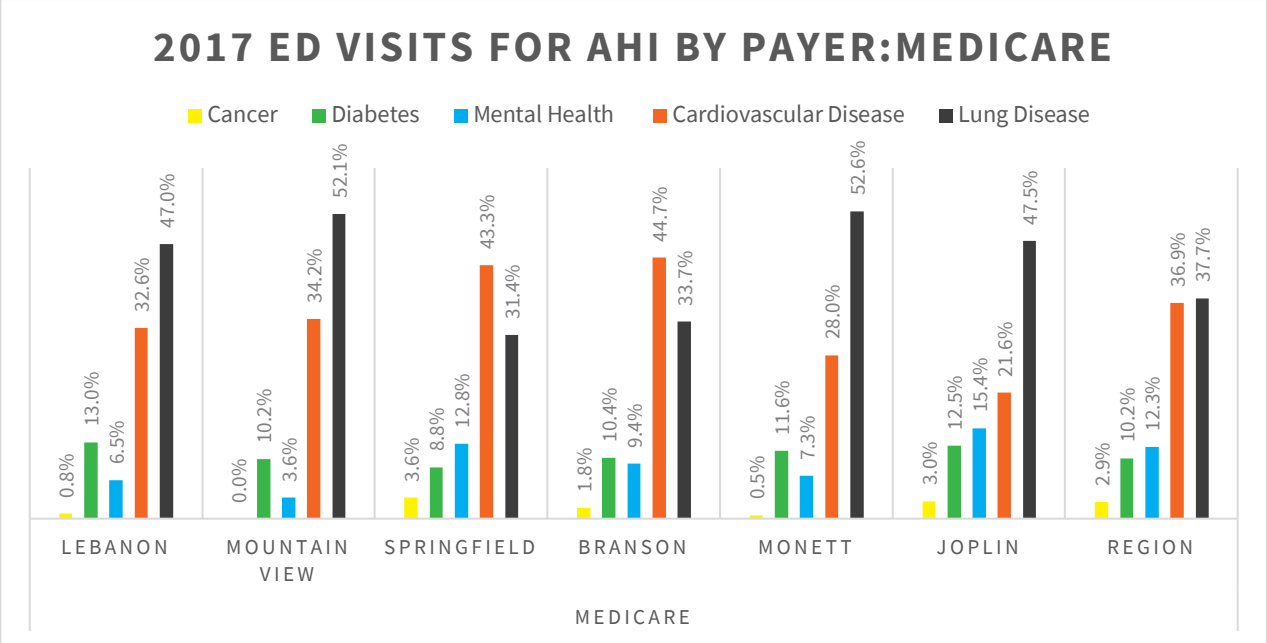

2017 ED VISITS FOR AHI BY RACE
Branson Community
Branson
65.8%
13.0%
12.5%
7.0%
1.8%
Branson
54.9%
24.3%
13.3%
5.2%
2.3%
Branson
46.9%
28.0%
14.6%
9.2%
1.3%
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
Lung Disease
Cardiovascular Disease
Mental Health
Diabetes
Cancer

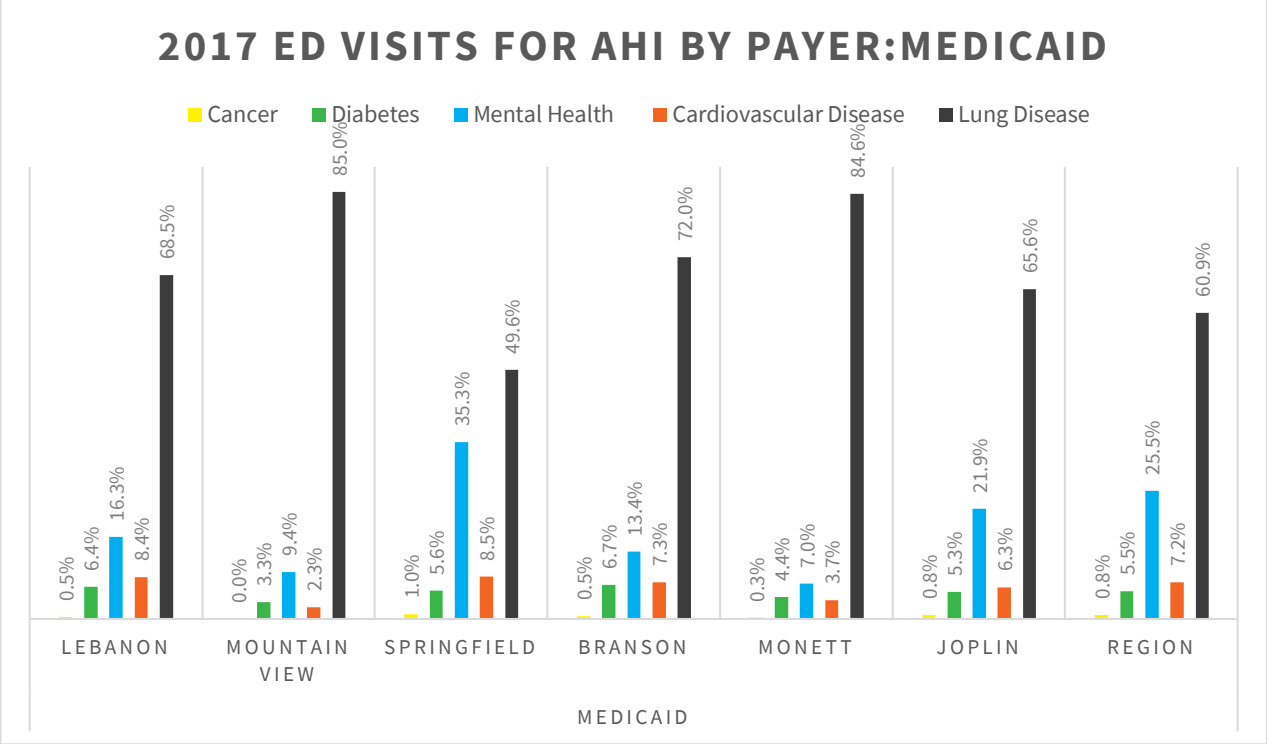

2017 ED VISITS FOR AHI BY RACE
Monett Community
Monett
78.6%
4.8%
7.0%
8.9%
0.7%
Monett
64.4%
13.3%
8.9%
6.7%
6.7%
Monett
69.4%
14.1%
8.6%
7.5%
0.4%
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
80.0%
90.0%
Lung Disease
Cardiovascular Disease
Mental Health
Diabetes
Cancer

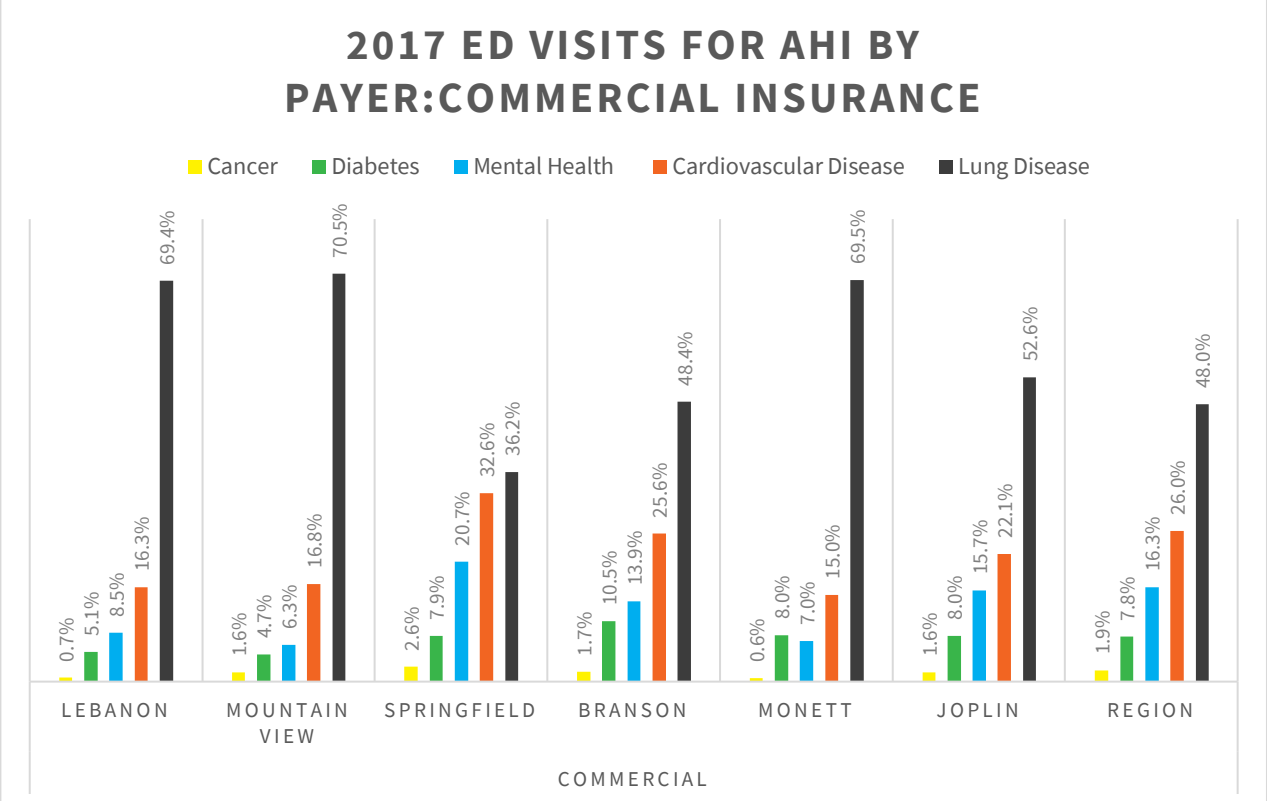


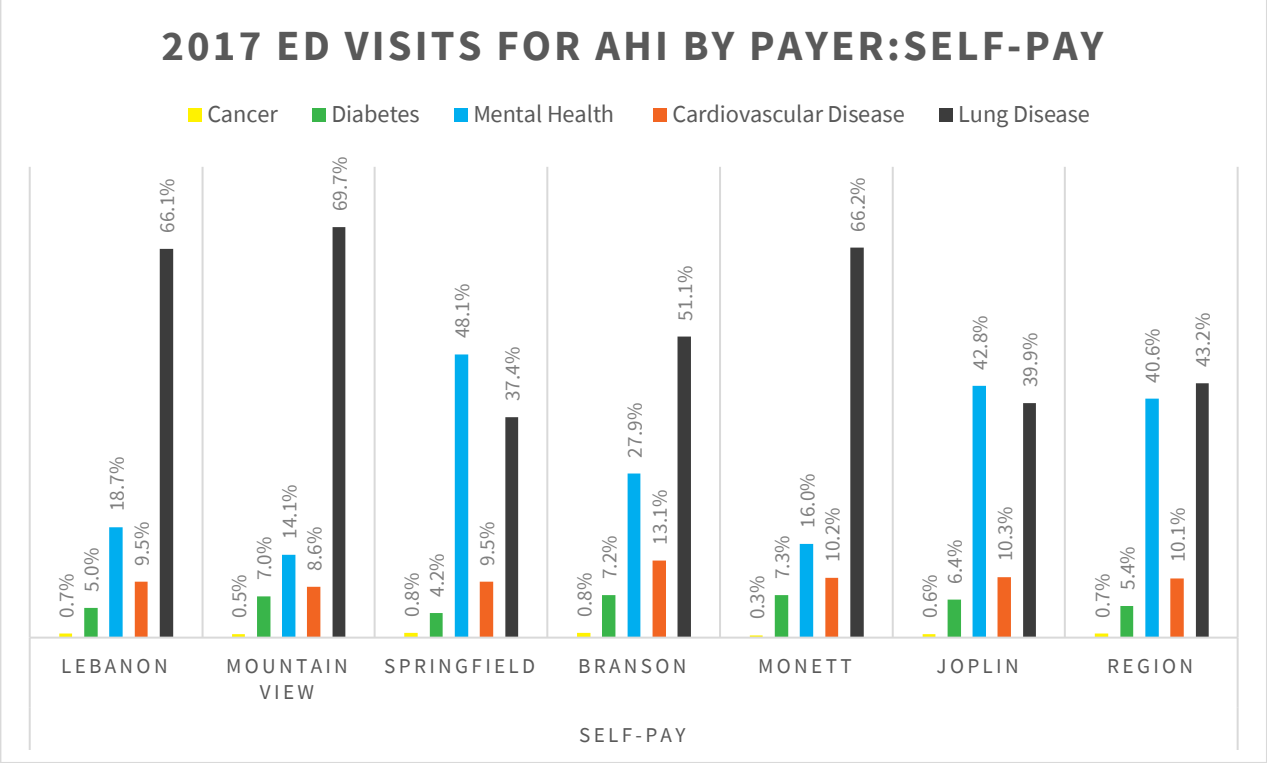
ED Visits for AHI by Payer

In the OHC Region, visits for issues related to mental health are more common among those without health insurance at 41%, and those with Medicaid at 26%. In the OHC Region, visits due to lung related disease are most common among those with Medicaid (61%), closely followed by those with commercial insurance (48%).




2017 ED VISITS FOR AHI BY PAYER:MEDICAID
Cancer
Diabetes
Mental Health
Cardiovascular Disease
Lung Disease
0.5%
6.4%
16.3%
8.4%
68.5%
0.0%
3.3%
9.4%
2.3%
85.0%
1.0%
5.6%
35.3%
8.5%
49.6%
0.5%
6.7%
13.4%
7.3%
72.0%
0.3%
4.4%
7.0%
3.7%
84.6%
0.8%
5.3%
21.9%
6.3%
65.6%
0.8%
5.5%
25.5%
7.2%
60.9%
LEBANON
MOUNTAIN VIEW
SPRINGFIELD
BRANSON
MONETT
JOPLIN
REGION
MEDICAID


2017 ED VISITS FOR AHI BY PAYER:COMMERCIAL INSURANCE
Cancer
Diabetes
Mental Health
Cardiovascular Disease
Lung Disease
0.7%
5.1%
8.5%
16.3%
69.4%
1.6%
4.7%
6.3%
16.8%
70.5%
2.6%
7.9%
20.7%
32.6%
36.2%
1.7%
10.5%
13.9%
25.6%
48.4%
0.6%
8.0%
7.0%
15.0%
69.5%
1.6%
8.0%
15.7%
22.1%
52.6%
1.9%
7.8%
16.3%
26.0%
48.0%
LEBANON
MOUNTAIN VIEW
SPRINGFIELD
BRANSON
MONETT
JOPLIN
REGION
COMMERCIAL



MIPS Data

Metrics from the Merit-Based Incentive Payment System (MIPS) was selected to enhance the assessment of health care utilization and establish a baseline for quality improvement activities across the region. The table below outlines the selected MIPS clinical quality indicators, their alignment with the AHI, and their descriptions.

Assessed Health Issue	Measure	Measure Description
Cancer	Colorectal Cancer Screening (CMS 130)	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
Diabetes	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (CMS 122)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
Mental Disorders	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan (CMS 2)	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

Lung Disease	Preventative Care & Screening: Tobacco Use: Screening and Cessation Intervention (CMS 138)	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
Cardiovascular Disease	Controlling Hypertension (CMS 165)	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period

Each OHC partnering health system provided the selected MIPS metrics for their service area within the OHC Region. The metrics were aggregated to create scores for the OHC Region and then ranked according to their performance in comparison to national benchmarks. The table below outlines the following:

- Assessed Health Issue (AHI)
- MIPS Quality Measure corresponding to selected AHI
- MIPS score for the OHC Region
- MIPS national average
- Decile range and decile in which the Region MIPS score falls
- Benchmark range, or the score for the tenth decile for its respective measure
- Rank of the AHI

The AHI receives a rank between one to four, with a rank of one being the best performing and four being the worst performing in comparison to the national benchmarks. A regional MIPS measure receives the following rank if it falls in that ranks corresponding decile:

REGIONAL MIPS MEASURE RANK	BENCHMARK DECILE
4	4, 3, <3
3	5, 6
2	7, 8
1	9, 10

Assessed Health Issue	MIPS Quality Measure	Region (%)	MIPS Average (%)	Decile Range	Decile	Benchmark (BM) Range	BM Decile	Rank
Cancer	Colorectal Cancer Screening	46.55	60.90	46.82 - 51.65	<3	>= 80.95	10	4
Cardiovascular Disease	Controlling Hypertension	63.33	66.50	60.41 - 64.27	4	>= 79.74	10	4

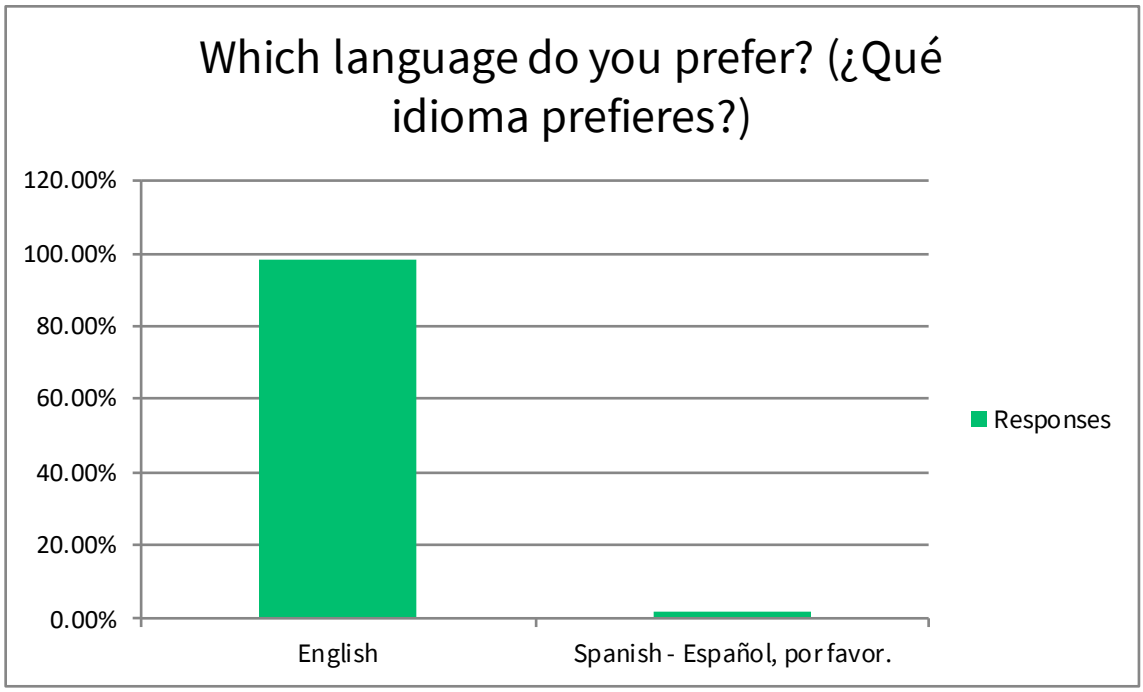
Diabetes	Hemoglobin A1c Poor Control (>9%)	28.19	22.00	33.33 - 23.54	3	<=3.33	10	4
Lung Disease	Tobacco Use: Screening and Cessation Intervention	70.96	86.20	82.06 - 86.04	<3	>= 99.32	10	4
Mental/Behavioral Health	Screening for Clinical Depression and Follow-up Plan	29.94	65.30	29.28 - 65.00	4	100.00	10	4

Ozarks Health Commission - Community Survey

Question 1

Which language do you prefer? (¿Qué idioma prefieres?)

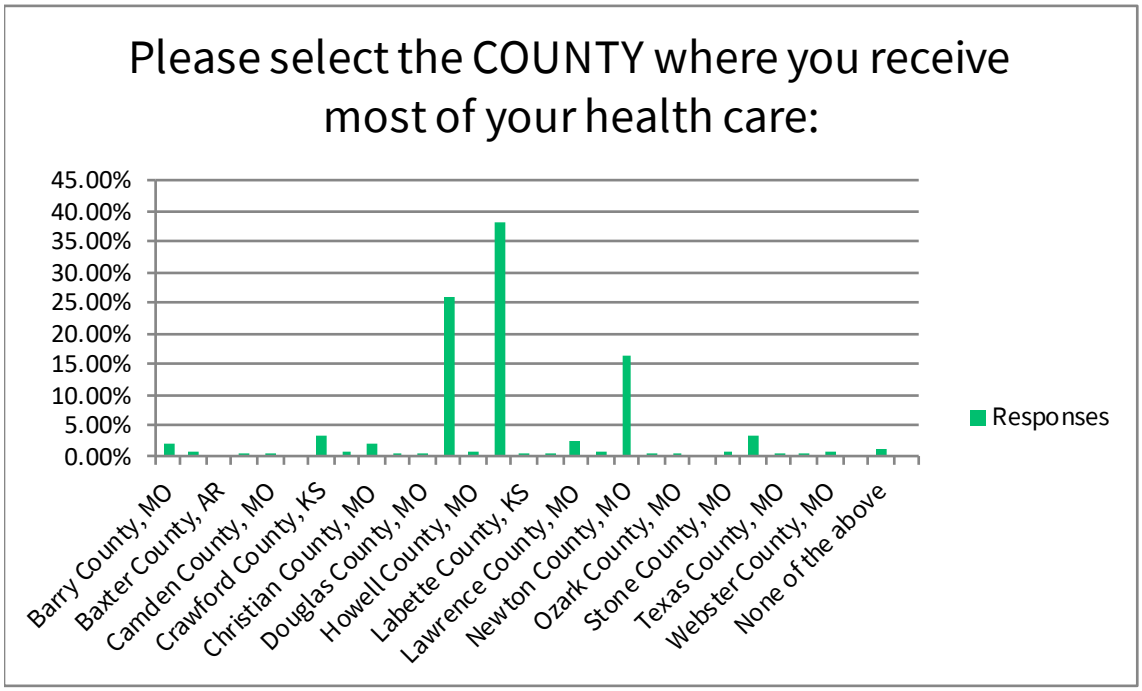
Answer Choices	Responses	
English	98.26%	2478
Spanish - Español, por favor.	1.74%	44
	Answered	**2522**
	Skipped	**2**



Question 2

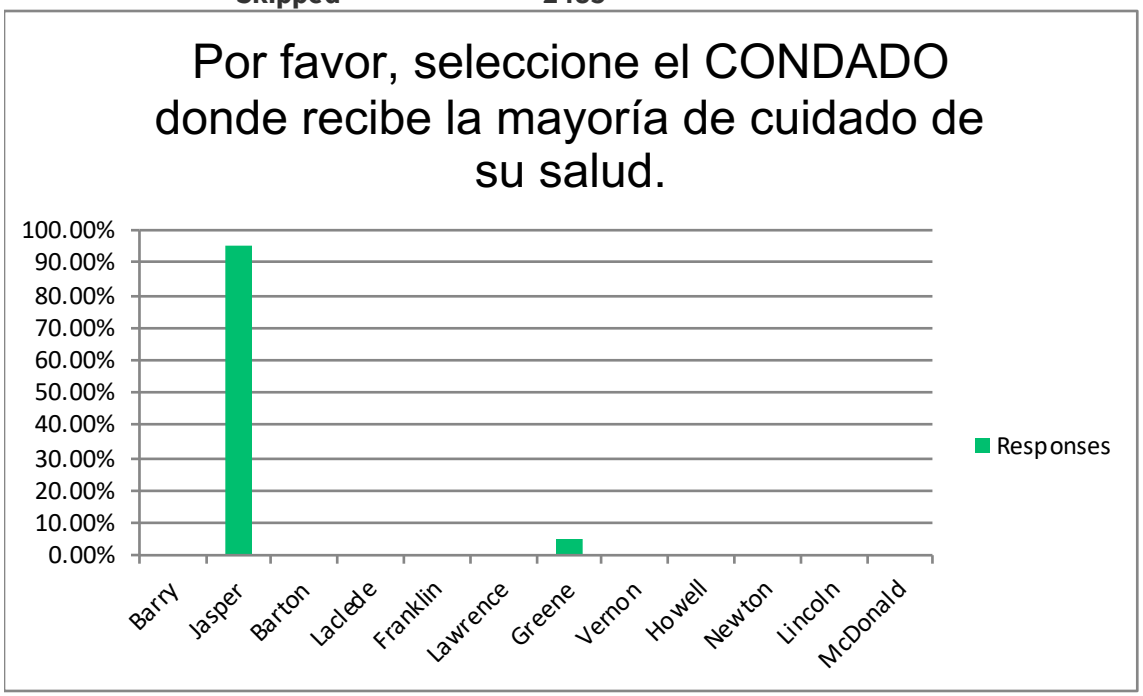
Please select the COUNTY where you receive most of your health care:

Answer Choices	Responses	
Barry County, MO	2.08%	46
Barton County, MO	0.68%	15
Baxter County, AR	0.00%	0
Boone County, AR	0.05%	1
Camden County, MO	0.05%	1
Carroll County, AR	0.00%	0
Crawford County, KS	3.13%	69
Cherokee County, KS	0.72%	16
Christian County, MO	1.99%	44
Dallas County, MO	0.14%	3
Douglas County, MO	0.14%	3
Greene County, MO	26.01%	574
Howell County, MO	0.50%	11
Jasper County, MO	38.29%	845
Labette County, KS	0.14%	3
Laclede County, MO	0.36%	8
Lawrence County, MO	2.67%	59
McDonald County, MO	0.50%	11
Newton County, MO	16.40%	362
Ottawa County, OK	0.18%	4
Ozark County, MO	0.05%	1
Pulaski County, MO	0.00%	0
Stone County, MO	0.54%	12
Taney County, MO	3.44%	76
Texas County, MO	0.05%	1
Vernon County, MO	0.18%	4
Webster County, MO	0.59%	13
Wright County, MO	0.00%	0
None of the above	1.13%	25
Other (please specify)	0.00%	0
	Answered	**2207**
	Skipped	**317**


Please select the COUNTY where you receive most of your health care:
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Barry County, MO
Baxter County, AR
Camden County, MO
Crawford County, KS
Christian County, MO
Douglas County, MO
Howell County, MO
Labette County, KS
Lawrence County, MO
Newton County, MO
Ozark County, MO
Stone County, MO
Texas County, MO
Webster County, MO
None of the above
Responses

Por favor, seleccione el CONDADO donde recibe la mayoría de cuidado de su salud.

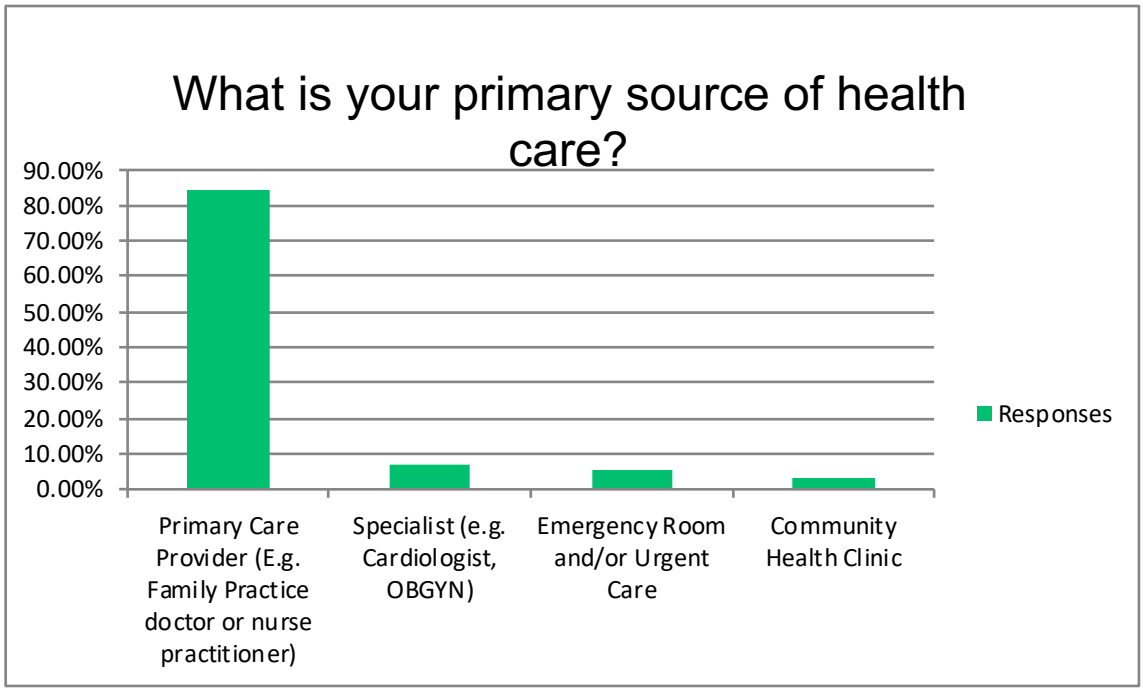
Answer Choices	Responses	
Barry	0.00%	0
Jasper	94.87%	37
Barton	0.00%	0
Laclede	0.00%	0
Franklin	0.00%	0
Lawrence	0.00%	0
Greene	5.13%	2
Vernon	0.00%	0
Howell	0.00%	0
Newton	0.00%	0
Lincoln	0.00%	0
McDonald	0.00%	0
	Answered	**39**
	Skipped	**2485**



Question 3

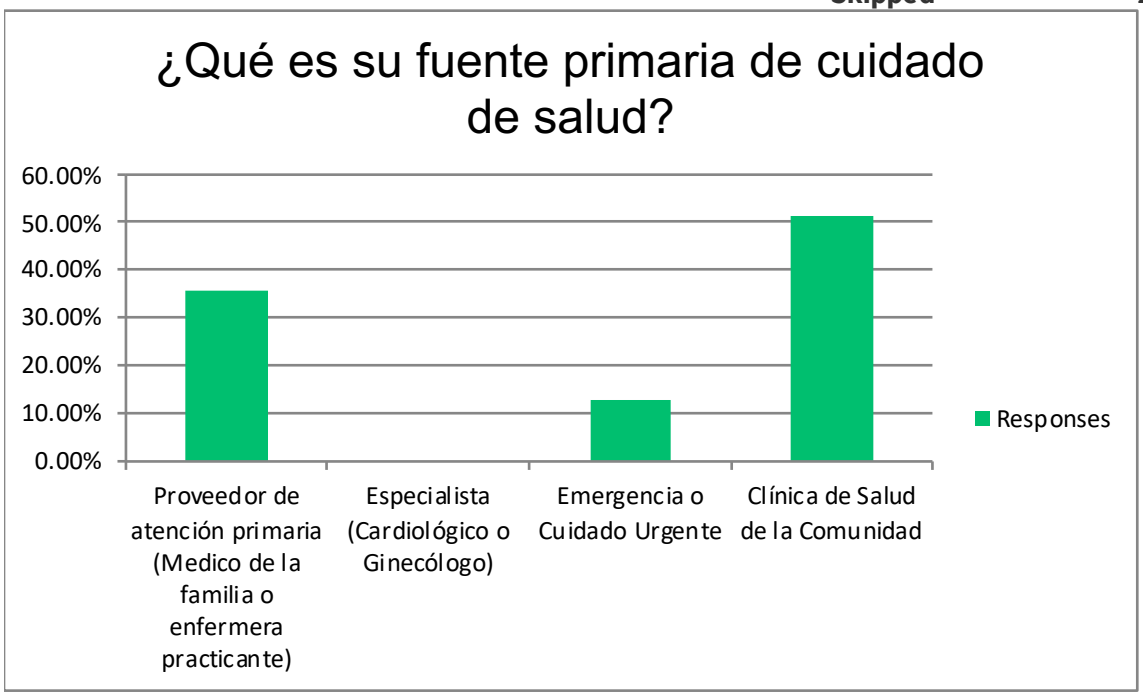
What is your primary source of health care?

Answer Choices	Responses	
Primary Care Provider (E.g. Family Practice doctor or nurse practitioner)	84.63%	1872
Specialist (e.g. Cardiologist, OBGYN)	7.01%	155
Emergency Room and/or Urgent Care	5.15%	114
Community Health Clinic	3.21%	71
	Answered	**2212**
	Skipped	**312**



¿Qué es su fuente primaria de cuidado de salud?

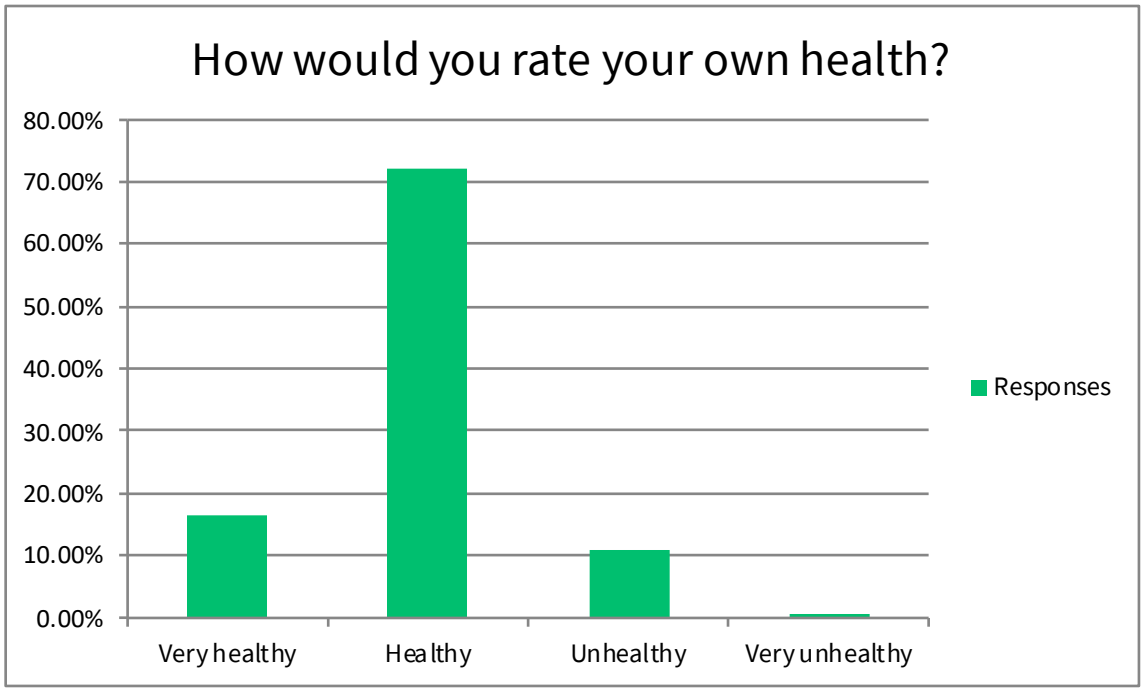
Answer Choices	Responses	
Proveedor de atención primaria (Medico de la familia o enfermera practicante)	35.48%	11
Especialista (Cardiológico o Ginecólogo)	0.00%	0
Emergencia o Cuidado Urgente	12.90%	4
Clínica de Salud de la Comunidad	51.61%	16
	Answered	**31**
	Skipped	**2493**



Question 4

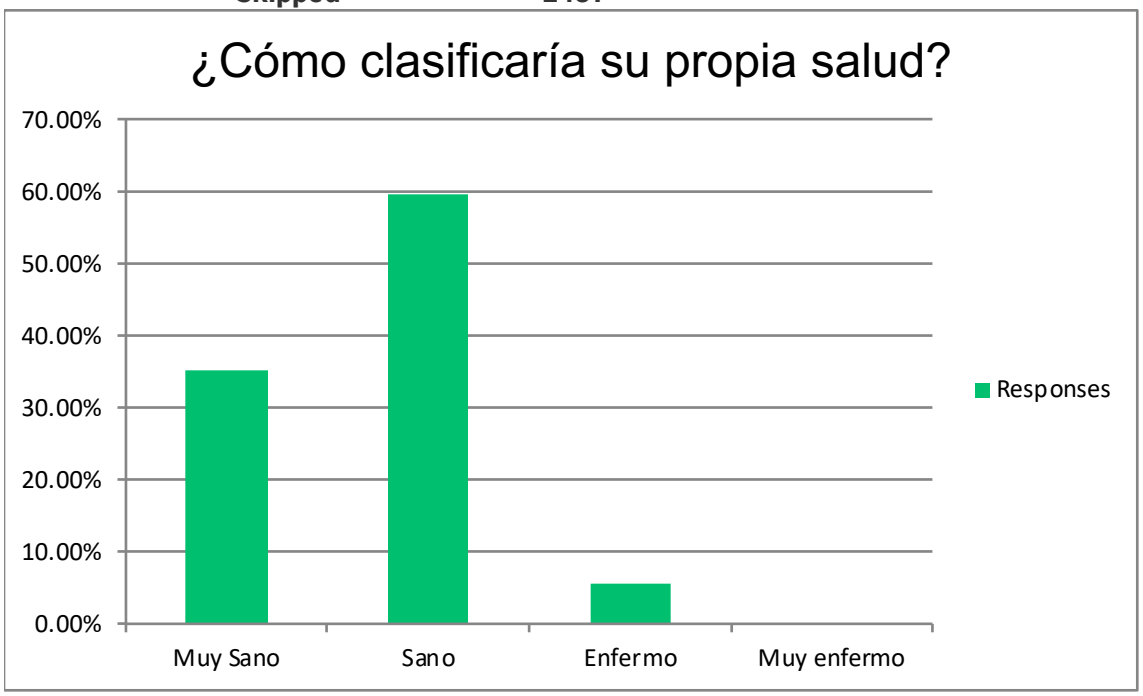
How would you rate your own health?

Answer Choices	Responses	
Very healthy	16.33%	362
Healthy	71.99%	1596
Unhealthy	10.87%	241
Very unhealthy	0.81%	18
	Answered	**2217**
	Skipped	**307**



¿Cómo clasificaría su propia salud?

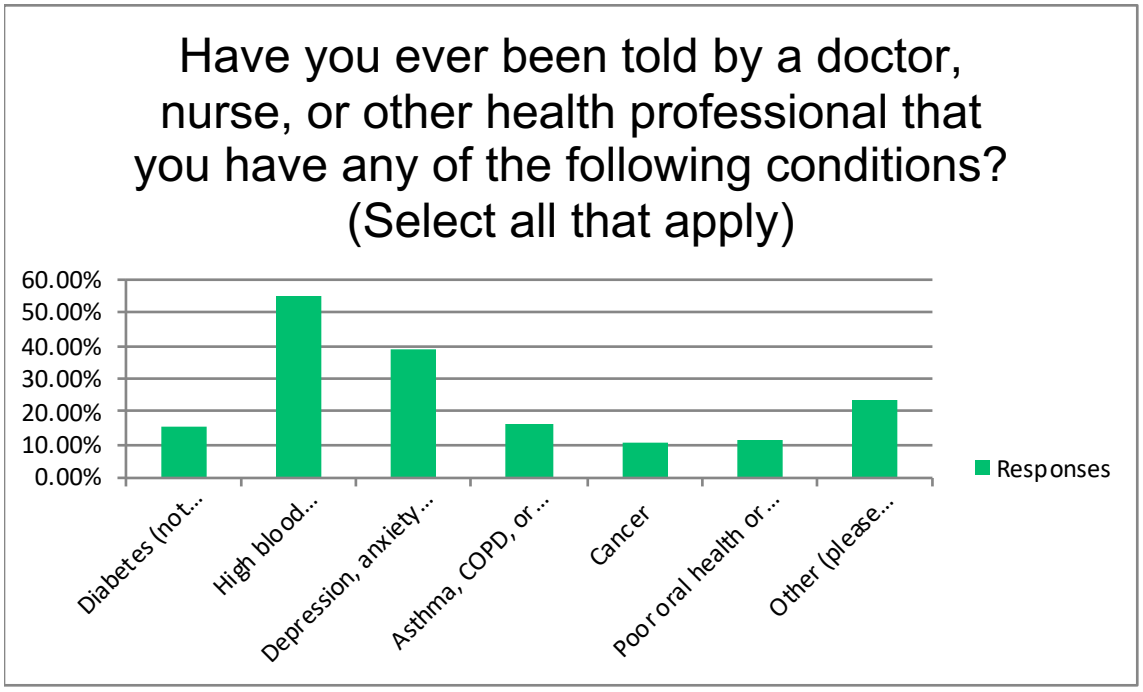
Answer Choices	Responses	
Muy Sano	35.14%	13
Sano	59.46%	22
Enfermo	5.41%	2
Muy enfermo	0.00%	0
	Answered	**37**
	Skipped	**2487**



Question 5

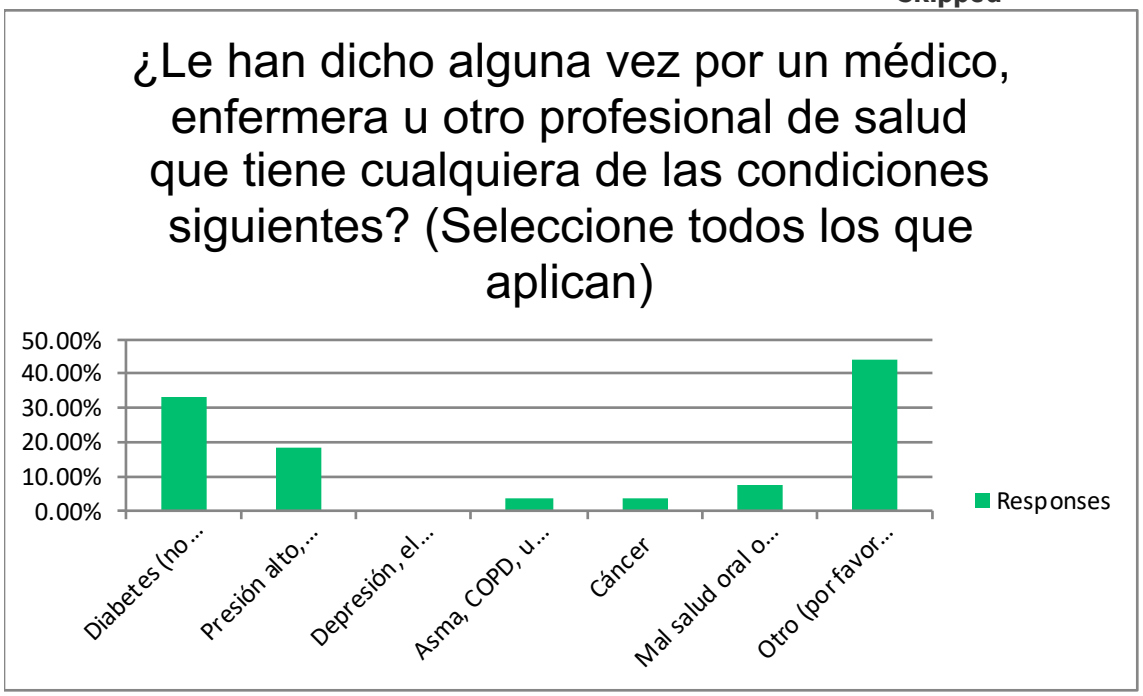
Have you ever been told by a doctor, nurse, or other health professional that you have any of the following conditions? (Select all that apply)

Answer Choices	Responses	
Diabetes (not during pregnancy)	15.50%	269
High blood pressure, high cholesterol OR other heart disease	55.01%	955
Depression, anxiety disorder, or other mental health issues	39.06%	678
Asthma, COPD, or other lung disease	15.96%	277
Cancer	10.37%	180
Poor oral health or dental issues	11.23%	195
Other (please specify)	23.39%	406
	Answered	**1736**
	Skipped	**788**



¿Le han dicho alguna vez por un médico, enfermera u otro profesional de salud que tiene cualquiera de las condiciones siguientes? (Seleccione todos los que aplican)

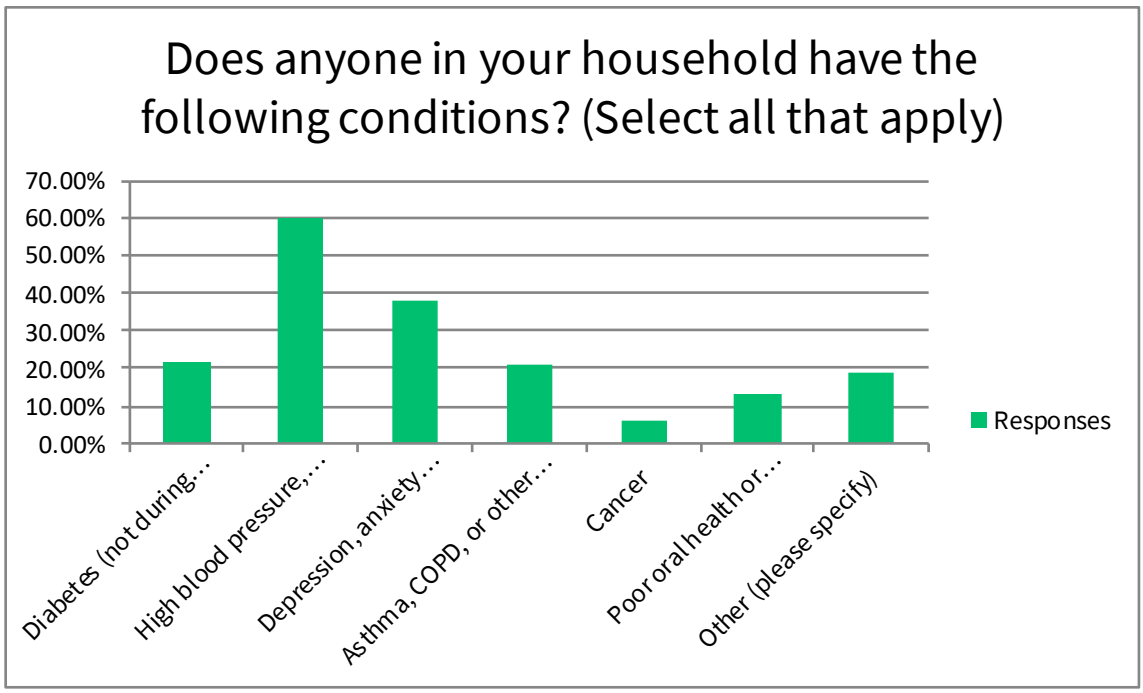
Answer Choices	Responses	
Diabetes (no durante embarazo)	33.33%	9
Presión alto, colesterol alto u otra enfermedad de corazón	18.52%	5
Depresión, el trastorno de ansiedad, u otros problemas de salud	0.00%	0
Asma, COPD, u otra enfermedad de pulmones	3.70%	1
Cáncer	3.70%	1
Mal salud oral o problemas con los dientes	7.41%	2
Otro (por favor especifique)	44.44%	12
	Answered	**27**
	Skipped	**2497**



Question 6

Does anyone in your household have the following conditions? (Select all that apply)

Answer Choices	Responses	
Diabetes (not during pregnancy)	21.71%	347
High blood pressure, high cholesterol OR other heart disease	60.14%	961
Depression, anxiety disorder, or other mental health issues	38.11%	609
Asthma, COPD, or other lung disease	20.71%	331
Cancer	6.26%	100
Poor oral health or dental issues	13.45%	215
Other (please specify)	18.77%	300
	Answered	**1598**
	Skipped	**926**



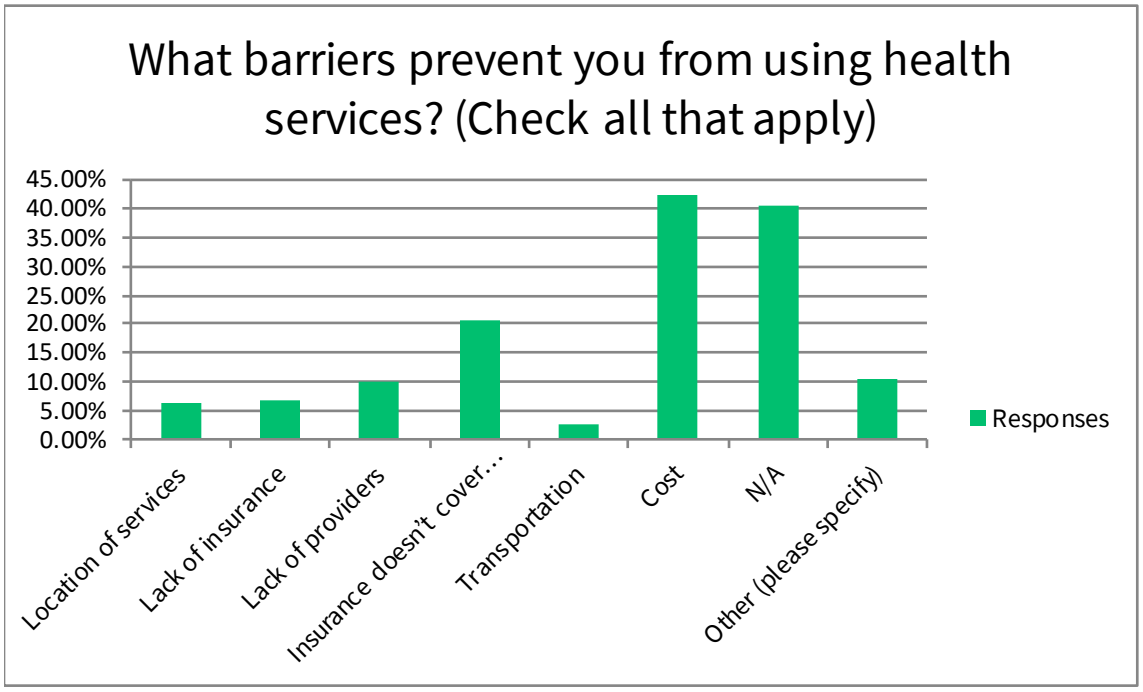
¿Hay alguien en su casa tiene las condiciones siguientes? (Seleccione todos los que aplican)

Answer Choices	Responses	
Diabetes (no durante embarazo)	28.00%	7
Presión alto, colesterol alto u otra enfermedad de corazón	16.00%	4
Depresión, el trastorno de ansiedad, u otros problemas de salud mental	4.00%	1
Asma, COPD, u otra enfermedad de pulmones	20.00%	5
Cáncer	0.00%	0
Mal salud oral o problemas con los dientes	12.00%	3
Otro (por favor especifique)	44.00%	11
	Answered	**25**
	Skipped	**2499**

Question 7

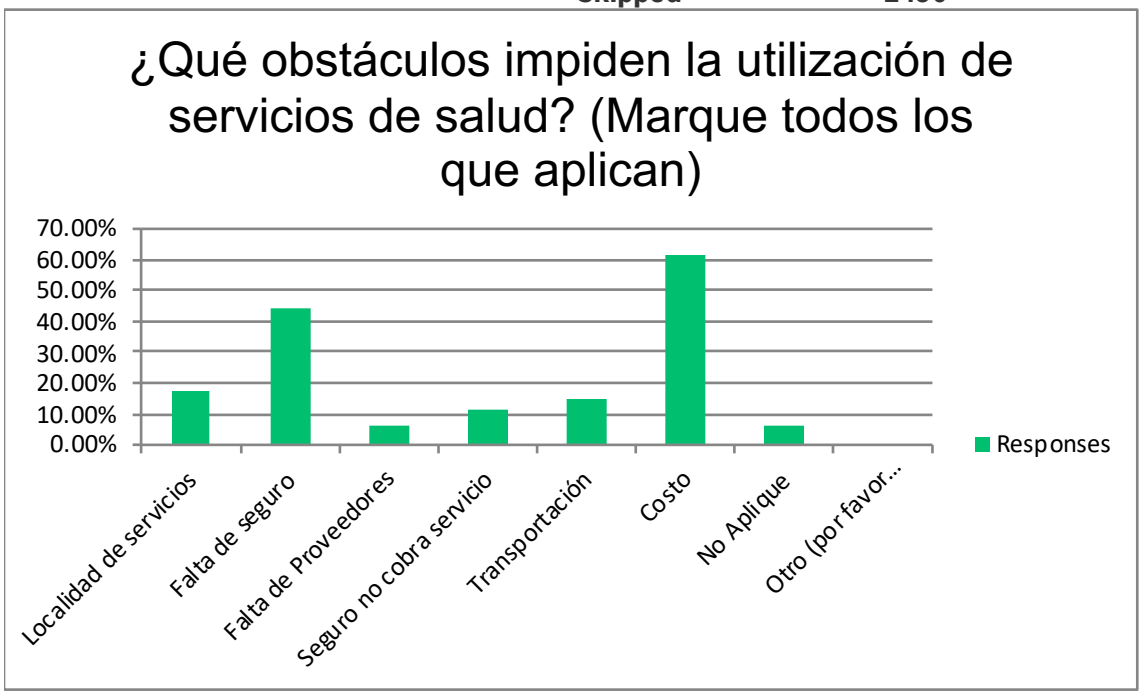
What barriers prevent you from using health services? (Check all that apply)

Answer Choices	Responses	
Location of services	6.35%	134
Lack of insurance	6.92%	146
Lack of providers	10.14%	214
Insurance doesn't cover service	20.84%	440
Transportation	2.37%	50
Cost	42.25%	892
N/A	40.41%	853
Other (please specify)	10.37%	219
	Answered	**2111**
	Skipped	**413**



¿Qué obstáculos impiden la utilización de servicios de salud? (Marque todos los que aplican)

Answer Choices	Responses	
Localidad de servicios	17.65%	6
Falta de seguro	44.12%	15
Falta de Proveedores	5.88%	2
Seguro no cobra servicio	11.76%	4
Transportación	14.71%	5
Costo	61.76%	21
No Aplique	5.88%	2
Otro (por favor especifique)	0.00%	0
	Answered	**34**
	Skipped	**2490**



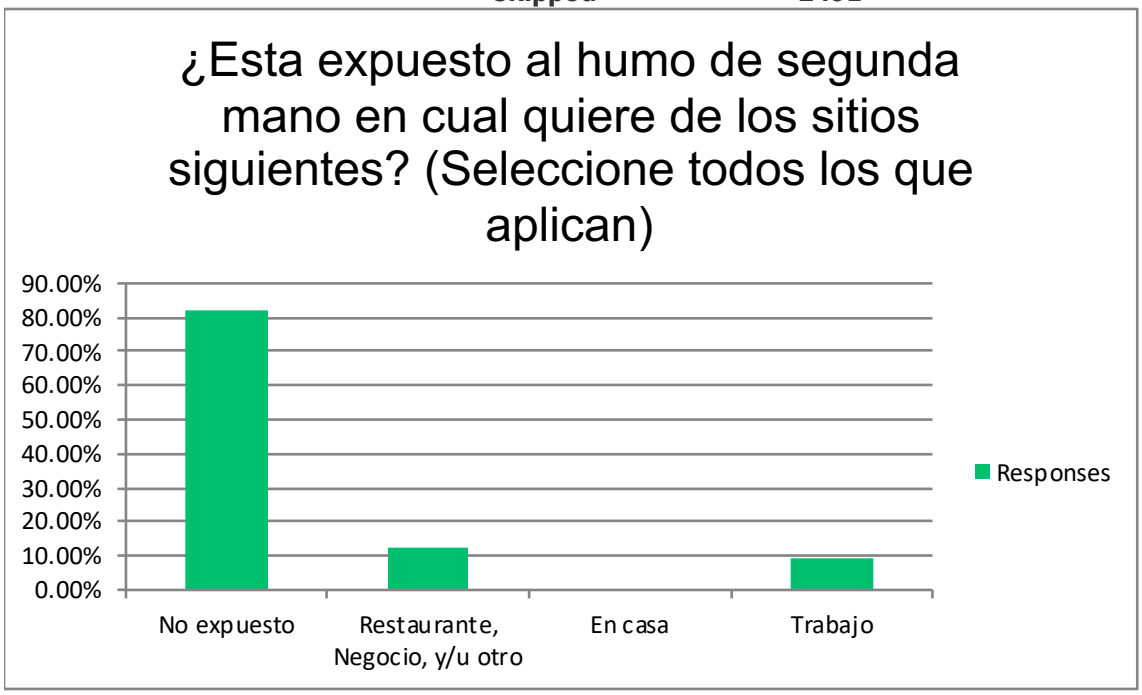
Question 8

Are you exposed to secondhand smoke in any of the following places? (Select all that apply)

Answer Choices	Responses	
I am not exposed	76.88%	1666
Restaurant, Business, and/or Other	14.91%	323
Home	8.72%	189
Workplace	3.18%	69
	Answered	**2167**
	Skipped	**357**

¿Esta expuesto al humo de segunda mano en cual quiere de los sitios siguientes? (Seleccione todos los que aplican)

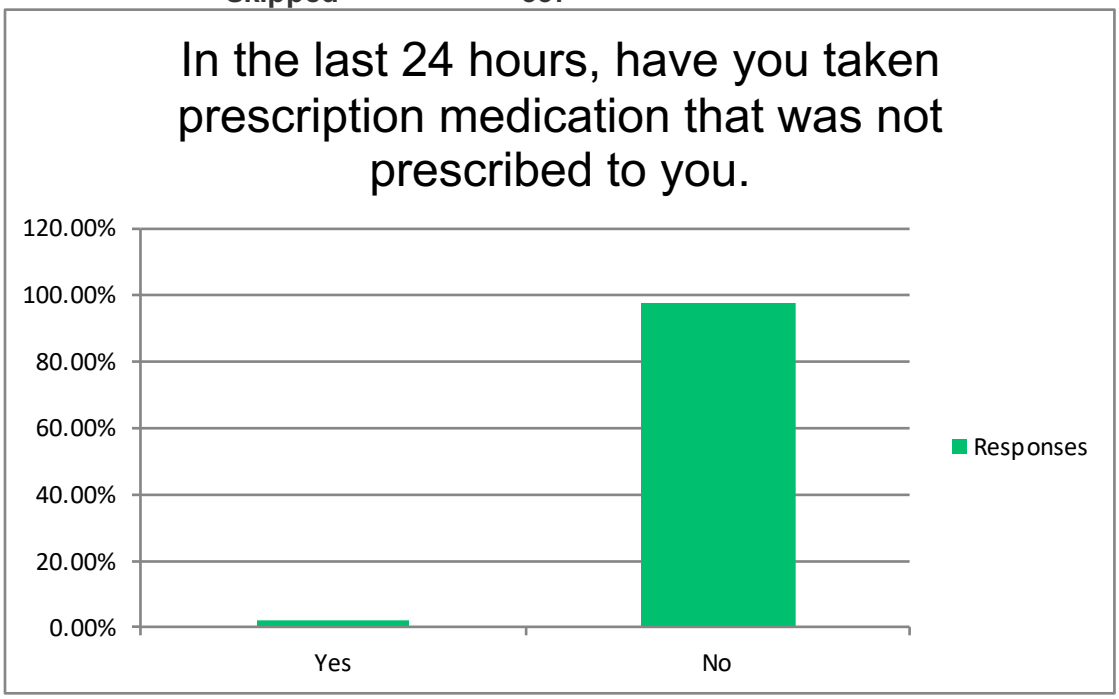
Answer Choices	Responses	
No expuesto	81.82%	27
Restaurante, Negocio, y/u otro	12.12%	4
En casa	0.00%	0
Trabajo	9.09%	3
	Answered	**33**
	Skipped	**2491**



Question 9

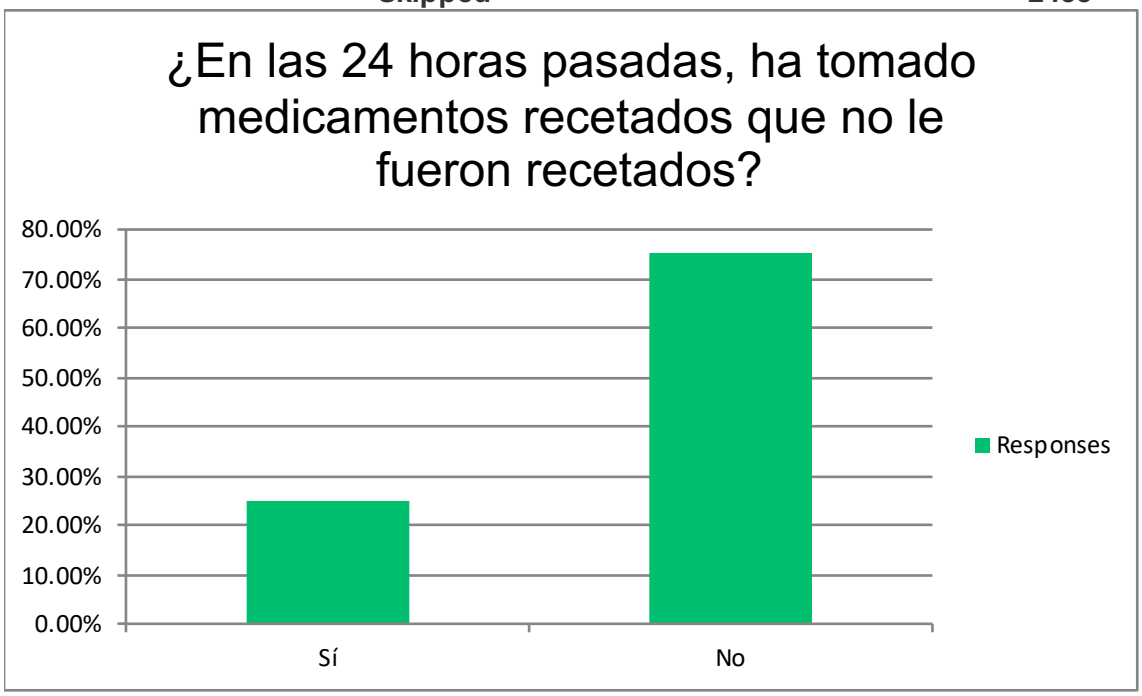
In the last 24 hours, have you taken prescription medication that was not prescribed to you.

Answer Choices	Responses	
Yes	2.19%	48
No	97.81%	2139
	Answered	**2187**
	Skipped	**337**



¿En las 24 horas pasadas, ha tomado medicamentos recetados que no le fueron recetados?

Answer Choices	Responses	
Sí	25.00%	9
No	75.00%	27
Answered		**36**
Skipped		**2488**

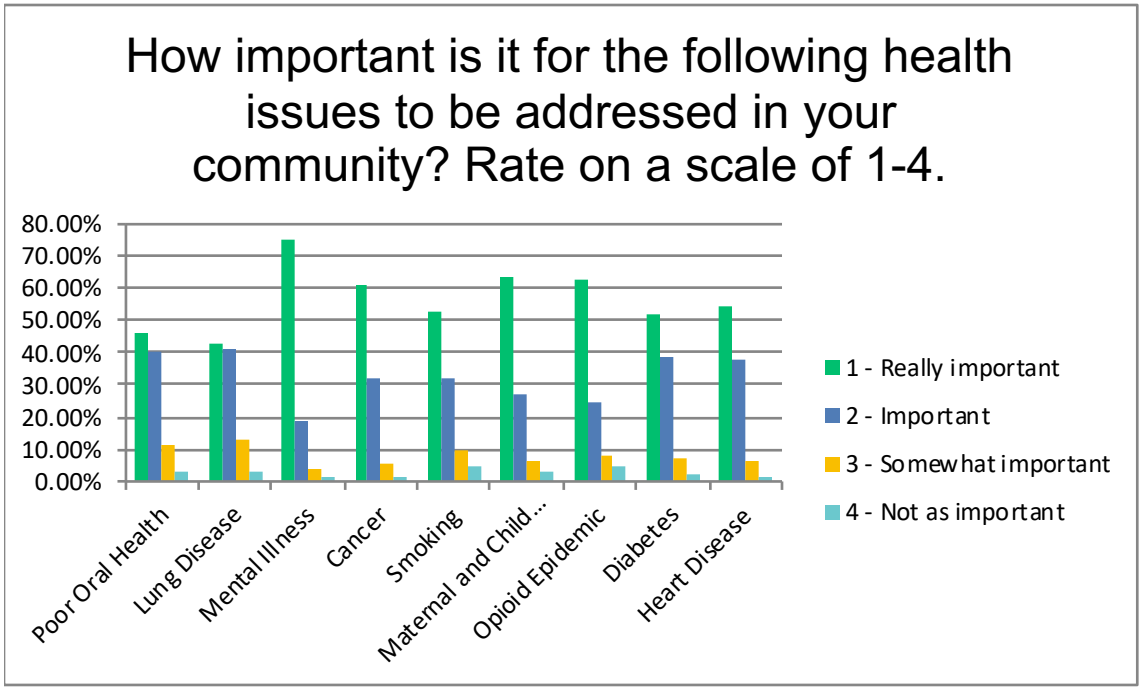


Question 10

How important is it for the following health issues to be addressed in your community? Rate on a scale of 1-4.

	1 - Really important		2 - Important		3 - Somewhat important		4 - Not as important	
Poor Oral Health	45.85%	994	39.99%	867	11.49%	249	2.68%	58
Lung Disease	42.89%	923	41.54%	894	12.59%	271	2.97%	64
Mental Illness	75.25%	1645	18.98%	415	4.16%	91	1.60%	35
Cancer	60.99%	1315	31.77%	685	5.66%	122	1.58%	34
Smoking	52.83%	1139	32.47%	700	9.88%	213	4.82%	104
Maternal and Child Health	63.74%	1378	27.38%	592	6.20%	134	2.68%	58
Opioid Epidemic	62.59%	1362	25.00%	544	8.00%	174	4.41%	96
Diabetes	51.82%	1127	39.08%	850	7.17%	156	1.93%	42
Heart Disease	54.49%	1184	37.97%	825	6.26%	136	1.29%	28

Answered
Skipped



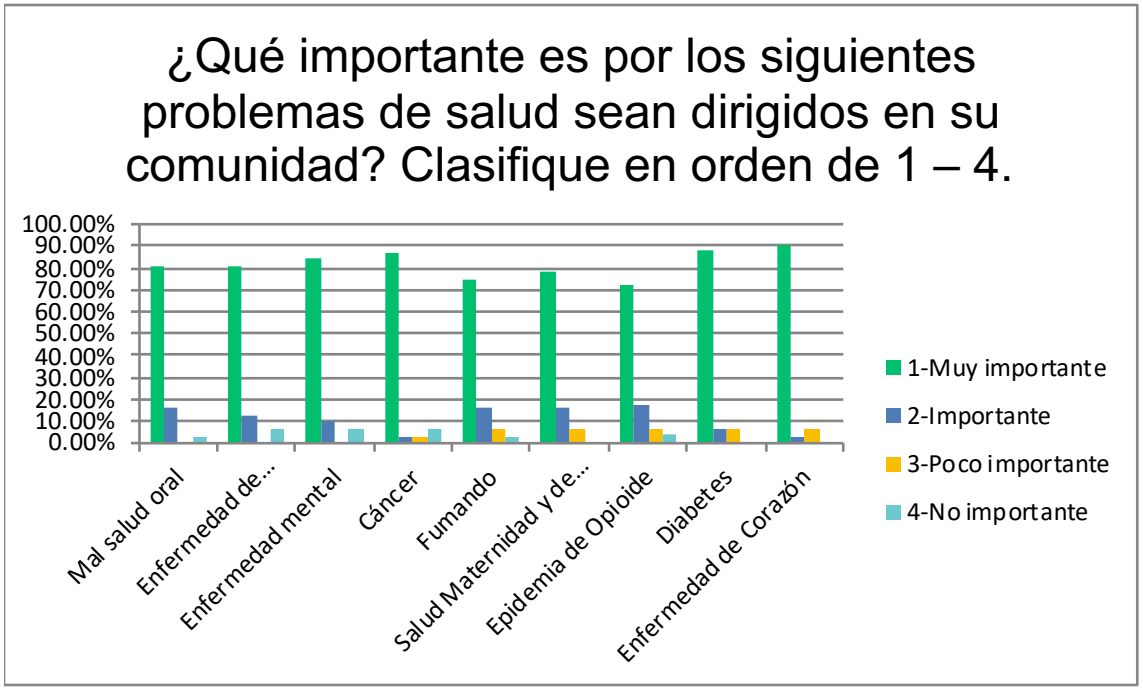
? Rate

Total
2168
2152
2186
2156
2156
2162
2176
2175
2173
2210
314

¿Qué importante es por los siguientes problemas de salud sean dirigidos en su comunidad?

	1-Muy importante		2-Importante		3-Poco importante		4-No importante	
Mal salud oral	80.65%	25	16.13%	5	0.00%	0	3.23%	1
Enfermedad de Pulmones	81.25%	26	12.50%	4	0.00%	0	6.25%	2
Enfermedad mental	83.87%	26	9.68%	3	0.00%	0	6.45%	2
Cáncer	87.10%	27	3.23%	1	3.23%	1	6.45%	2
Fumando	75.00%	24	15.63%	5	6.25%	2	3.13%	1
Salud Maternidad y de Niños	78.13%	25	15.63%	5	6.25%	2	0.00%	0
Epidemia de Opioide	72.41%	21	17.24%	5	6.90%	2	3.45%	1
Diabetes	87.50%	28	6.25%	2	6.25%	2	0.00%	0
Enfermedad de Corazón	90.32%	28	3.23%	1	6.45%	2	0.00%	0

Answered
Skipped

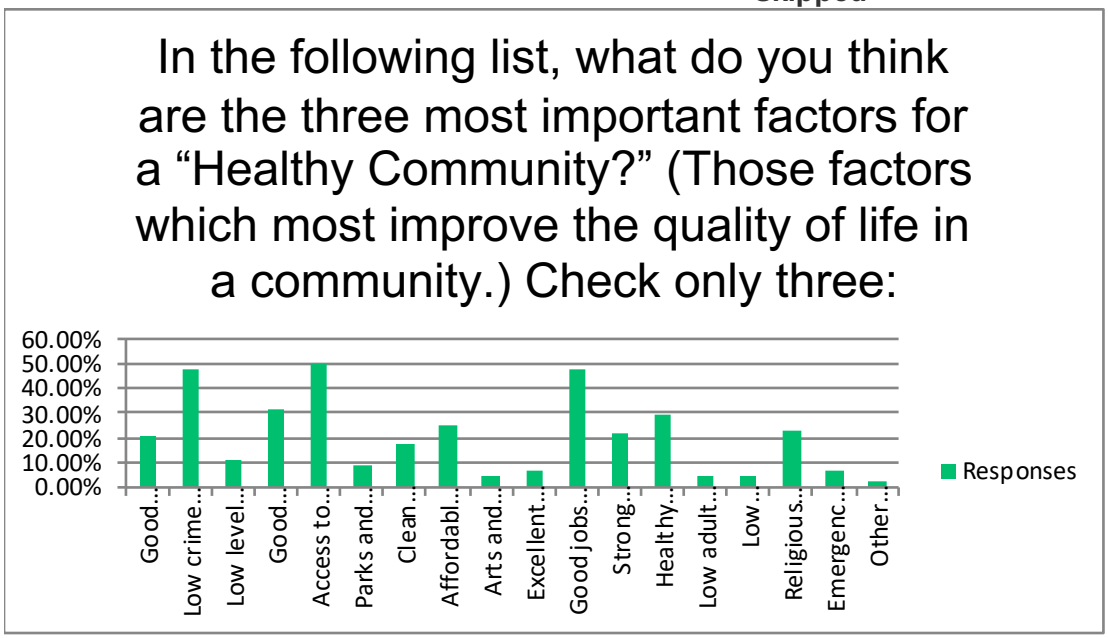


Total
31
32
31
31
32
32
29
32
31
34
2490

Question 11

In the following list, what do you think are the three most important factors for a "Healthy Community?" (Those factors which most improve the quality of life in a community.) Check only three:

Answer Choices	Responses	
Good place to raise children	21.24%	467
Low crime / safe neighborhoods	47.57%	1046
Low level of child abuse	11.46%	252
Good schools	31.65%	696
Access to health care (e.g., family doctor)	49.39%	1086
Parks and recreation	8.64%	190
Clean environment	17.60%	387
Affordable housing	25.24%	555
Arts and cultural events	4.46%	98
Excellent race/ethnic relations	6.32%	139
Good jobs and healthy economy	47.52%	1045
Strong family life	21.74%	478
Healthy behaviors and lifestyles	29.65%	652
Low adult death and disease rates	4.14%	91
Low infant deaths	4.18%	92
Religious or spiritual values	22.87%	503
Emergency preparedness	6.91%	152
Other (please specify)	2.50%	55
	Answered	**2199**
	Skipped	**325**



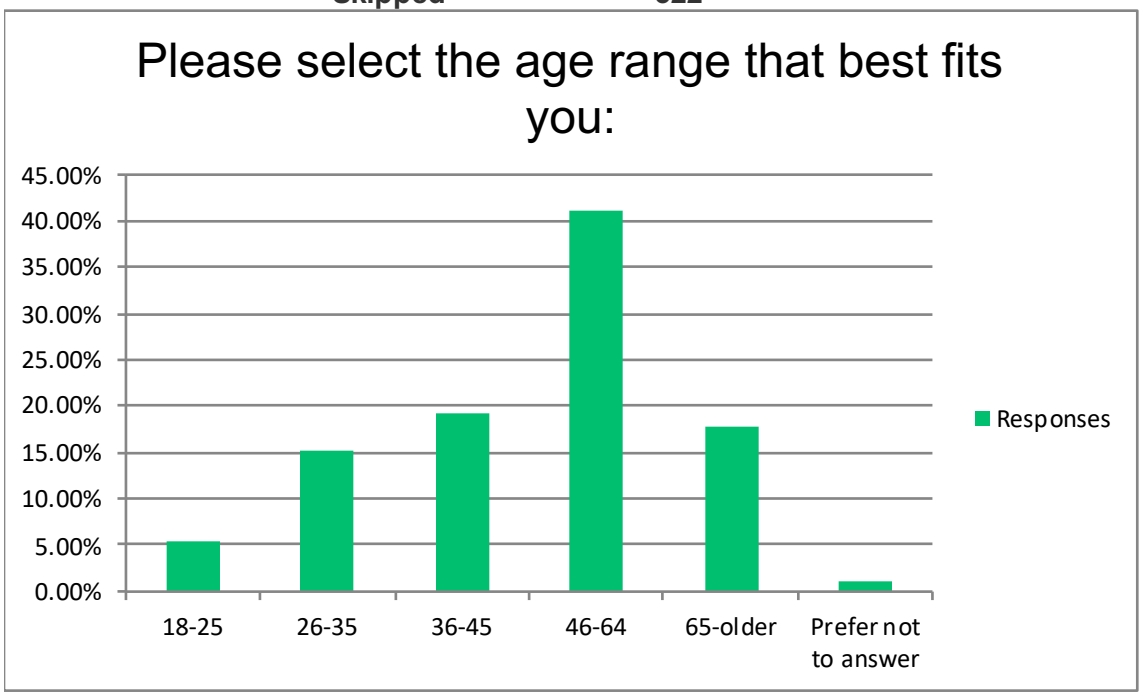
¿En la lista siguiente, que piensa que son los tres factores más importantes por un "Comunidad Sano"? (Los factores que más mejoran la calidad de vida en una comunidad.) Marque solo tres:

Answer Choices	Responses	
Buen sitio a crear niños	36.84%	14
Poco crimen / barrios seguros	26.32%	10
Nivel bajo de abuso infantil	0.00%	0
Buenas escuelas	44.74%	17
Acceso a la atención de salud (médico de familia)	31.58%	12
Parques y recreación	7.89%	3
Ambiente limpia	50.00%	19
Las viviendas económicas	5.26%	2
Eventos de arte y cultura	2.63%	1
Relaciones excelentes de raza y étnicos	0.00%	0
Buen trabajo y economía saludable	15.79%	6
La vida familiar fuerte	18.42%	7
Comportamientos y estilo de vidas saludables	5.26%	2
Índices de mortalidad de adultos y enfermedad bajos	0.00%	0
Muertes infantiles bajos	2.63%	1
Valores religiosos y espiritual	21.05%	8
Preparación para emergencias	18.42%	7
Otro (por favor especifique)	0.00%	0
	Answered	**38**
	Skipped	**2486**

Question 12

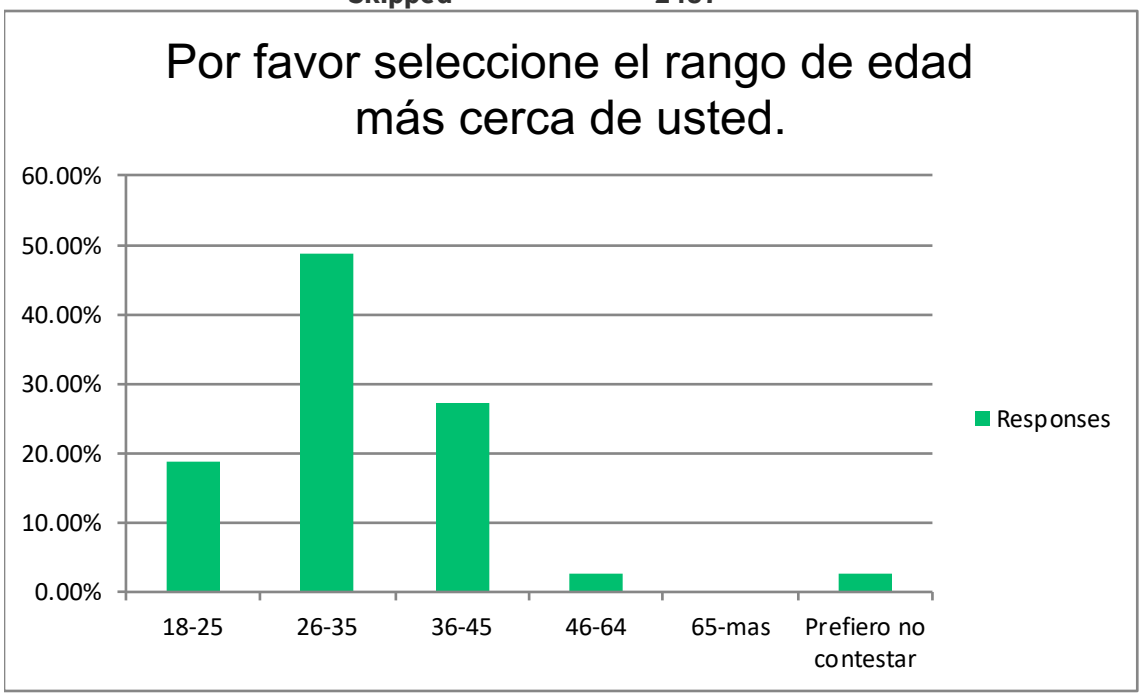
Please select the age range that best fits you:

Answer Choices	Responses	
18-25	5.40%	119
26-35	15.35%	338
36-45	19.35%	426
46-64	41.05%	904
65-older	17.80%	392
Prefer not to answer	1.04%	23
	Answered	**2202**
	Skipped	**322**



Por favor seleccione el rango de edad más cerca de usted.

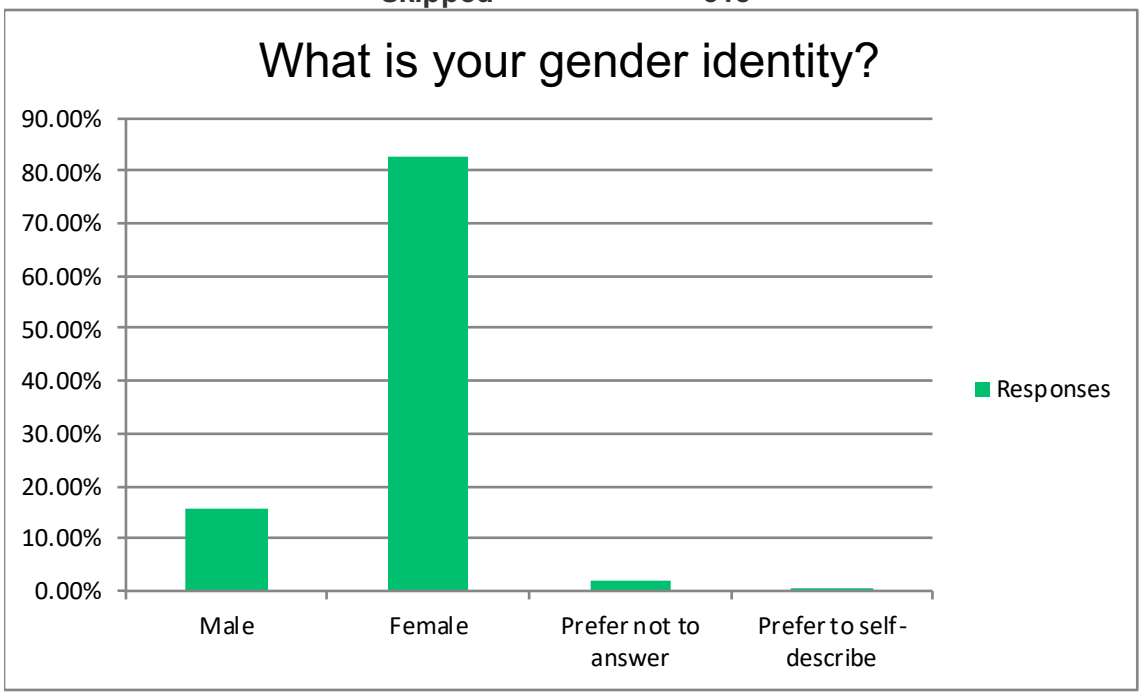
Answer Choices	Responses	
18-25	18.92%	7
26-35	48.65%	18
36-45	27.03%	10
46-64	2.70%	1
65-mas	0.00%	0
Prefiero no contestar	2.70%	1
	Answered	**37**
	Skipped	**2487**



Question 13

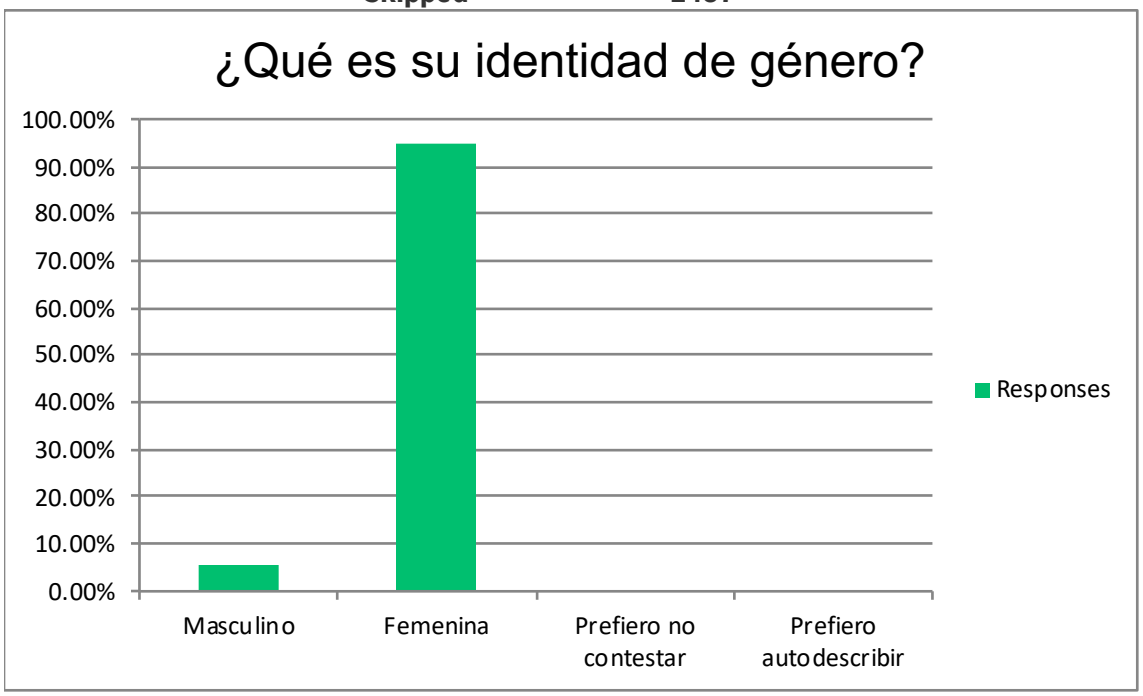
What is your gender identity?

Answer Choices	Responses	
Male	15.46%	341
Female	82.55%	1821
Prefer not to answer	1.77%	39
Prefer to self-describe	0.23%	5
	Answered	**2206**
	Skipped	**318**



¿Qué es su identidad de género?

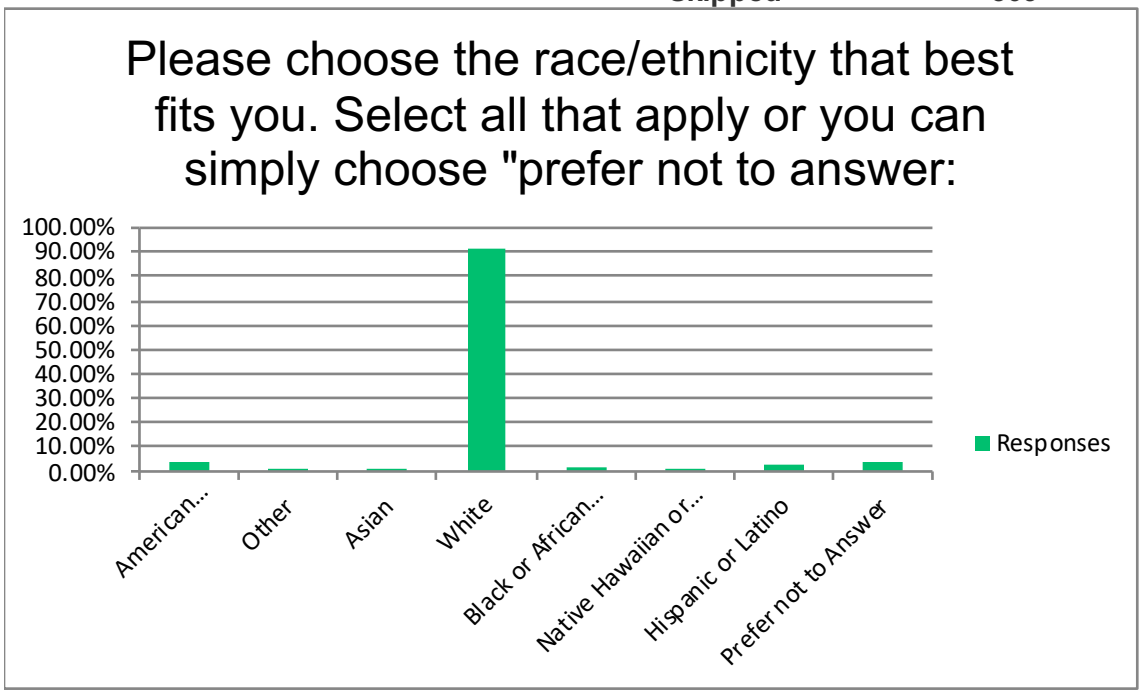
Answer Choices	Responses	
Masculino	5.41%	2
Femenina	94.59%	35
Prefiero no contestar	0.00%	0
Prefiero autodescribir	0.00%	0
	Answered	**37**
	Skipped	**2487**



Question 14

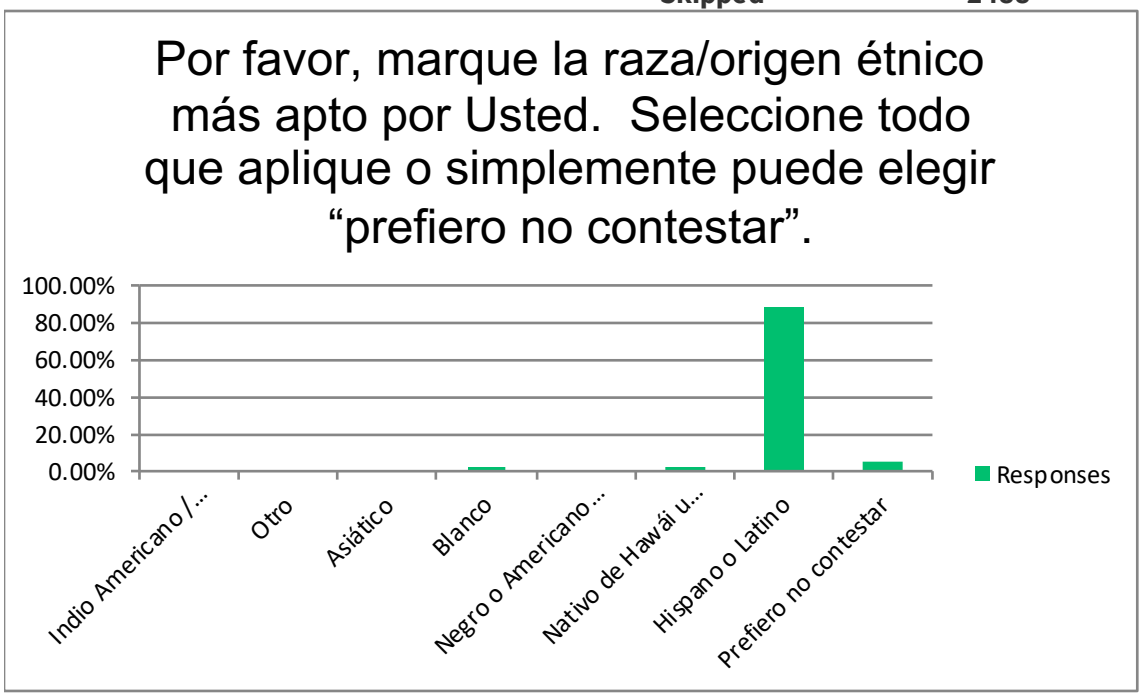
Please choose the race/ethnicity that best fits you. Select all that apply or you can simply choose "prefer not to answer:

Answer Choices	Responses	
American Indian/Alaska Native	3.97%	88
Other	0.77%	17
Asian	0.18%	4
White	91.06%	2017
Black or African American	1.22%	27
Native Hawaiian or other Pacific Islander	0.09%	2
Hispanic or Latino	2.30%	51
Prefer not to Answer	3.48%	77
	Answered	**2215**
	Skipped	**309**



Por favor, marque la raza/origen étnico más apto por Usted. Seleccione todo que aplique o simplemente puede elegir "prefiero no contestar".

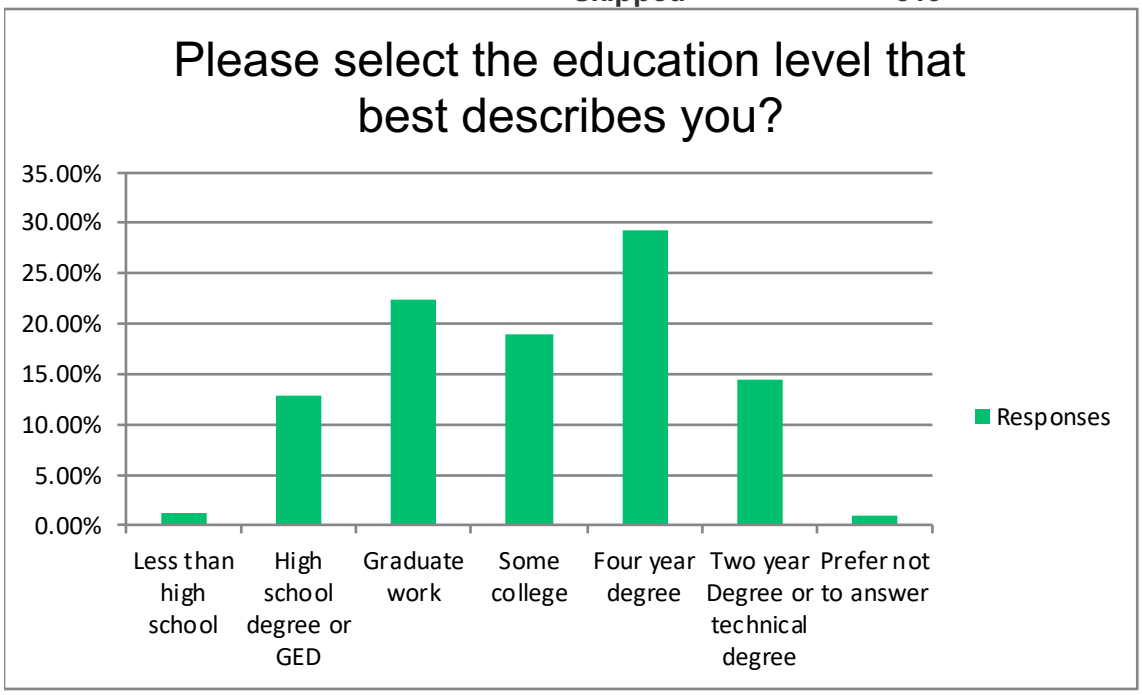
Answer Choices	Responses	
Indio Americano / Nativo de Alaska	0.00%	0
Otro	0.00%	0
Asiático	0.00%	0
Blanco	2.78%	1
Negro o Americano Africano	0.00%	0
Nativo de Hawái u otro Isla Pacifico	2.78%	1
Hispano o Latino	88.89%	32
Prefiero no contestar	5.56%	2
	Answered	**36**
	Skipped	**2488**



Question 15

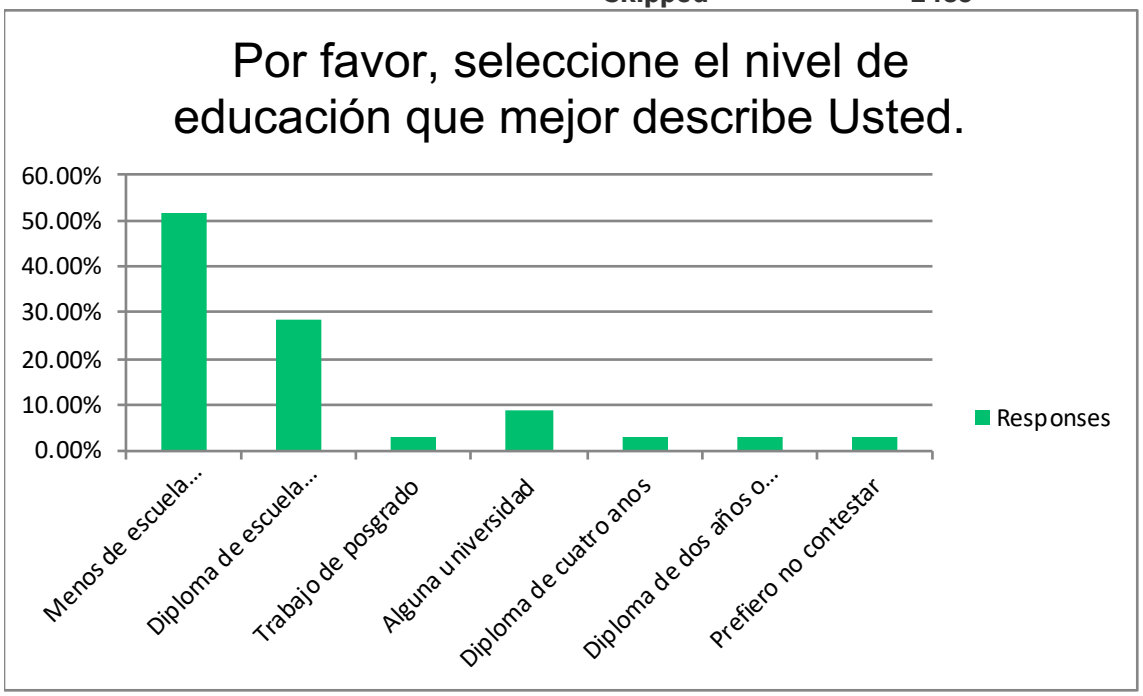
Please select the education level that best describes you?

Answer Choices	Responses	
Less than high school	1.22%	27
High school degree or GED	12.74%	281
Graduate work	22.45%	495
Some college	19.00%	419
Four year degree	29.25%	645
Two year Degree or technical degree	14.33%	316
Prefer not to answer	1.00%	22
	Answered	**2205**
	Skipped	**319**



Por favor, seleccione el nivel de educación que mejor describe Usted.

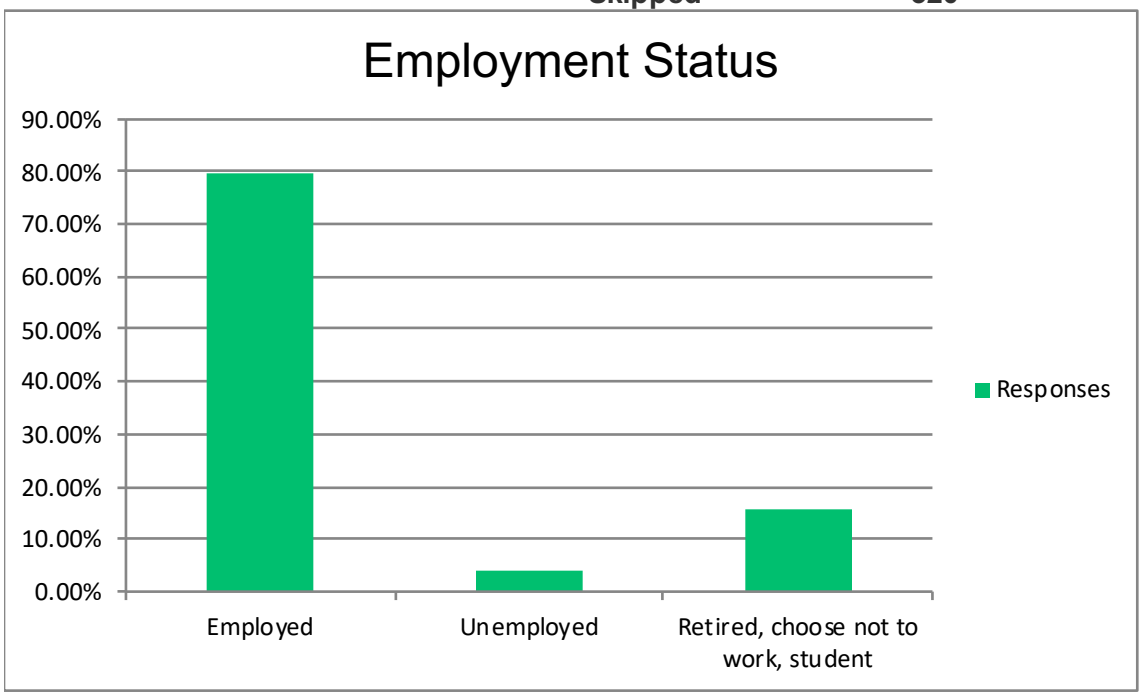
Answer Choices	Responses	
Menos de escuela secundaria	51.43%	18
Diploma de escuela secundaria o GED	28.57%	10
Trabajo de posgrado	2.86%	1
Alguna universidad	8.57%	3
Diploma de cuatro anos	2.86%	1
Diploma de dos años o diploma técnica	2.86%	1
Prefiero no contestar	2.86%	1
	Answered	**35**
	Skipped	**2489**



Question 16

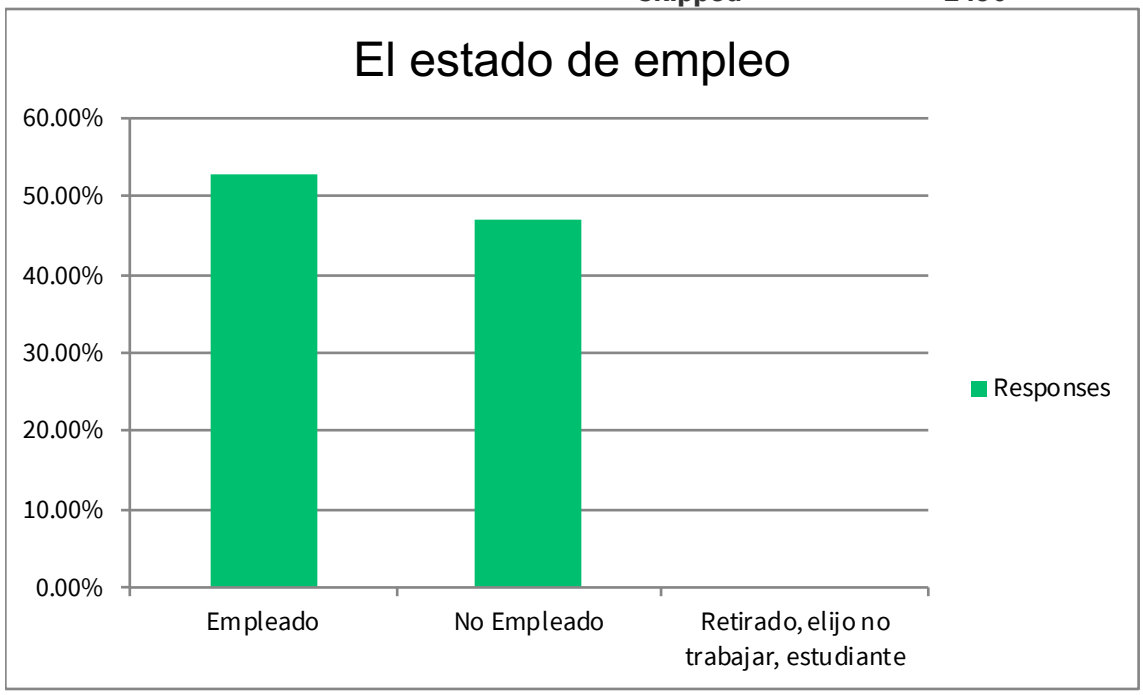
Employment Status

Answer Choices	Responses	
Employed	79.95%	1762
Unemployed	4.13%	91
Retired, choose not to work, student	15.93%	351
	Answered	**2204**
	Skipped	**320**



El estado de empleo

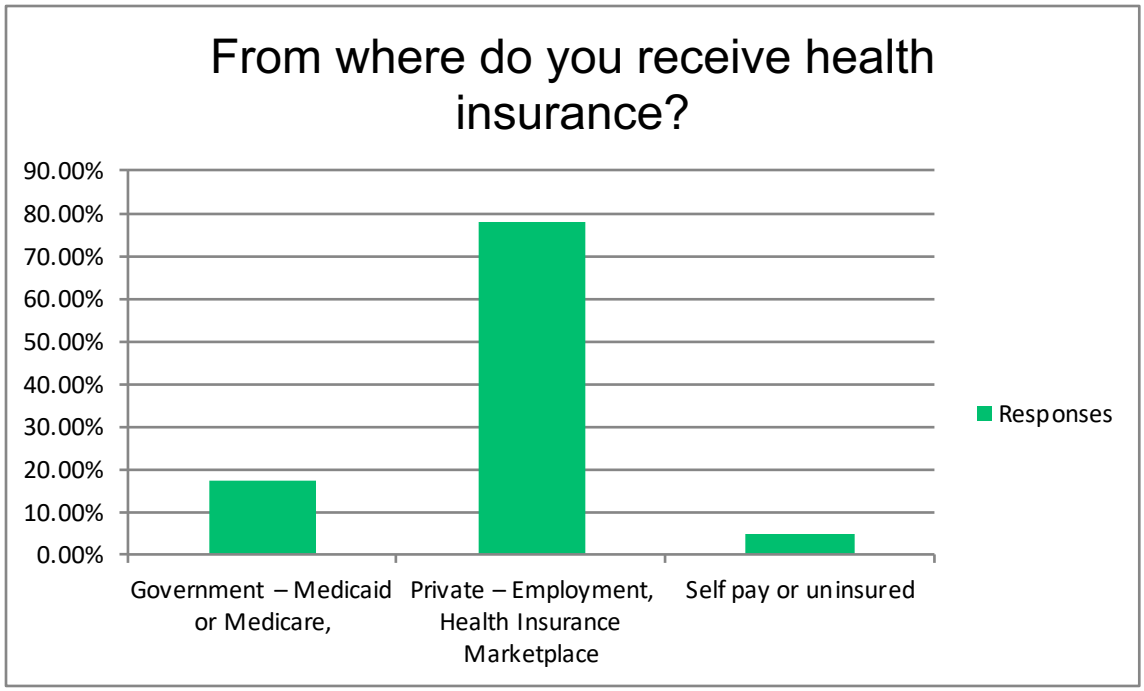
Answer Choices	Responses	
Empleado	52.94%	18
No Empleado	47.06%	16
Retirado, elijo no trabajar, estudiante	0.00%	0
	Answered	**34**
	Skipped	**2490**



Question 17

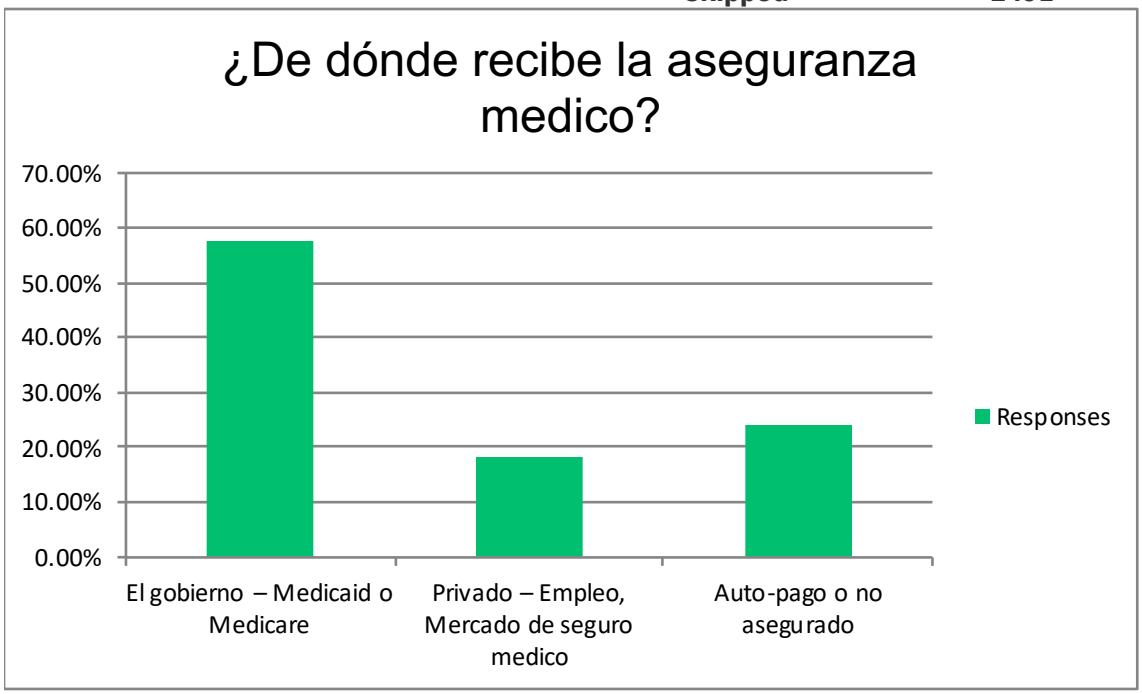
From where do you receive health insurance?

Answer Choices	Responses	
Government – Medicaid or Medicare,	17.55%	386
Private – Employment, Health Insurance Marketplace	77.58%	1706
Self pay or uninsured	4.87%	107
	Answered	**2199**
	Skipped	**325**



¿De dónde recibe la aseguranza medico?

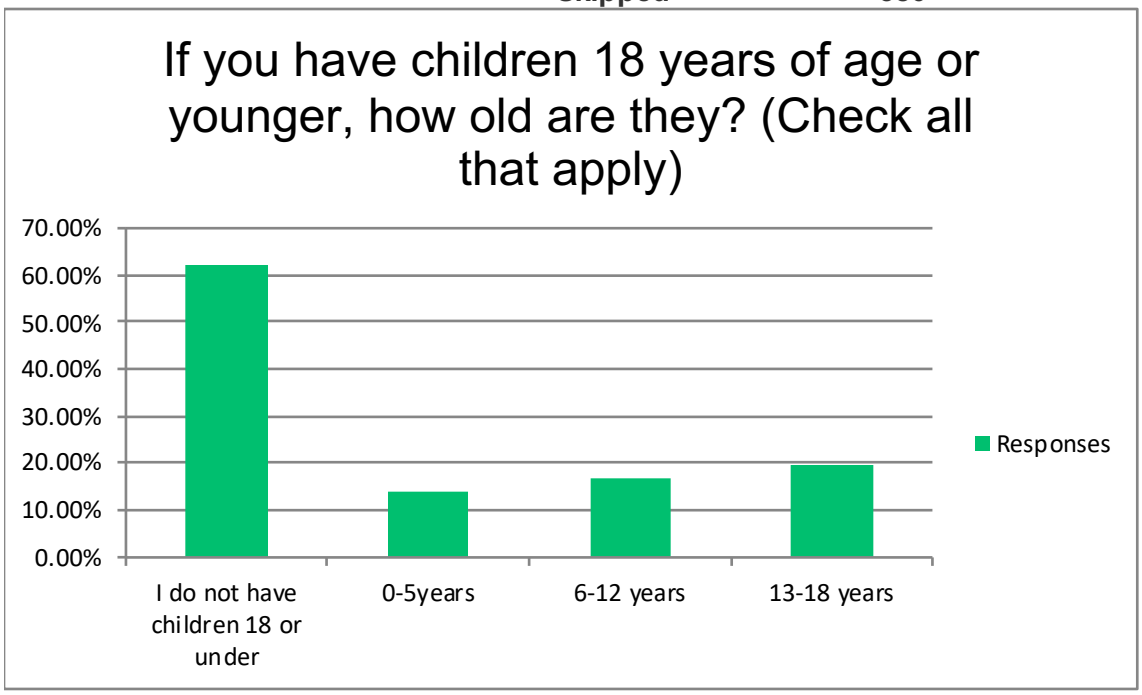
Answer Choices	Responses	
El gobierno – Medicaid o Medicare	57.58%	19
Privado – Empleo, Mercado de seguro medico	18.18%	6
Auto-pago o no asegurado	24.24%	8
	Answered	**33**
	Skipped	**2491**



Question 18

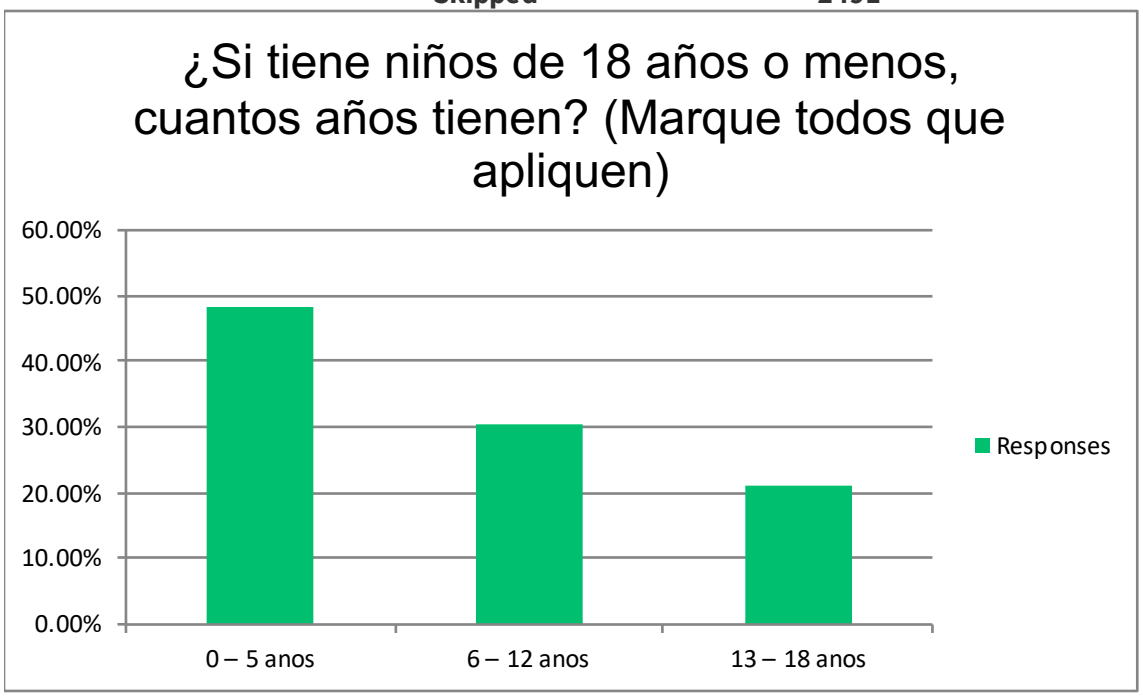
If you have children 18 years of age or younger, how old are they? (Check all that apply)

Answer Choices	Responses	
I do not have children 18 or under	61.94%	1328
0-5years	13.90%	298
6-12 years	16.79%	360
13-18 years	19.87%	426
	Answered	**2144**
	Skipped	**380**



¿Si tiene niños de 18 años o menos, cuantos años tienen? (Marque todos que apliquen)

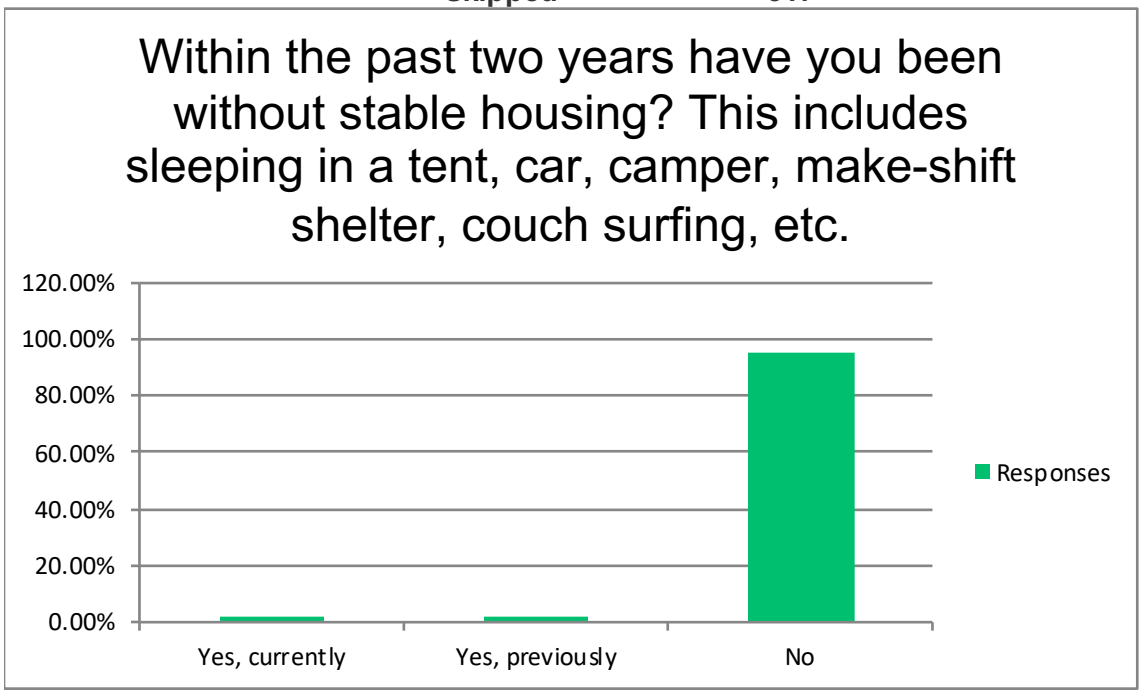
Answer Choices	Responses	
0 – 5 anos	48.48%	16
6 – 12 anos	30.30%	10
13 – 18 anos	21.21%	7
Answered		**33**
Skipped		**2491**



Question 19

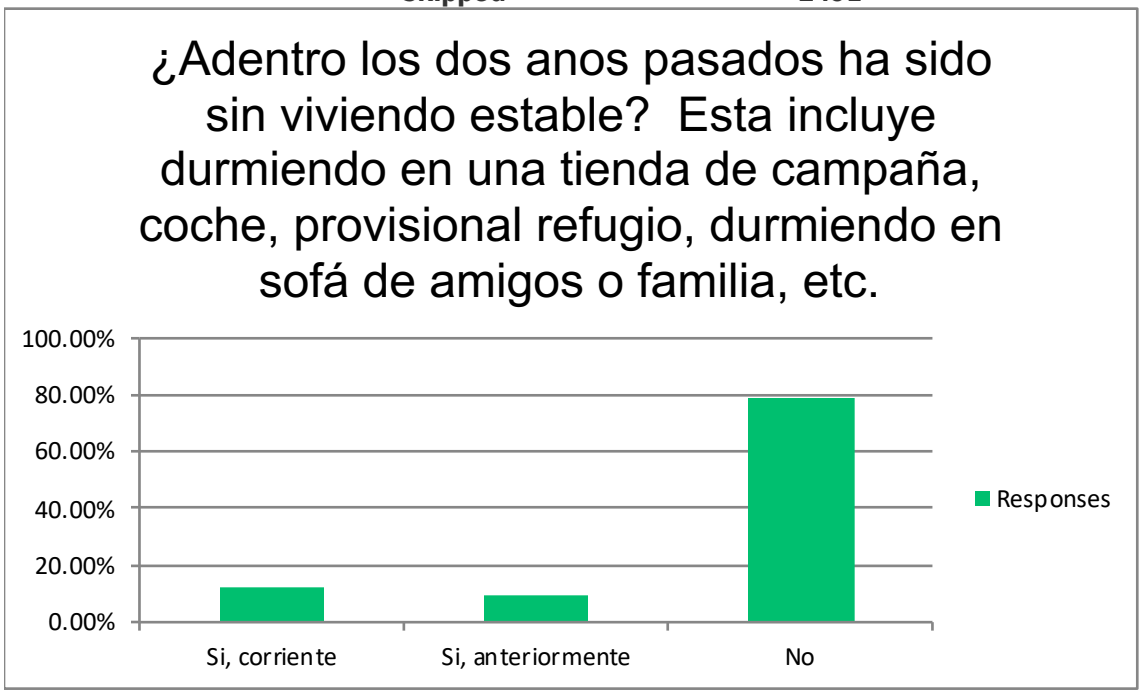
Within the past two years have you been without stable housing? This includes sleeping in a tent, car, camper, make-shift shelter, couch surfing, etc.

Answer Choices	Responses	
Yes, currently	2.08%	46
Yes, previously	2.08%	46
No	95.83%	2115
	Answered	**2207**
	Skipped	**317**



¿Adentro los dos anos pasados ha sido sin viviendo estable? Esta incluye durmiendo en una tienda de campaña, coche, provisional refugio, durmiendo en sofá de amigos o familia, etc.

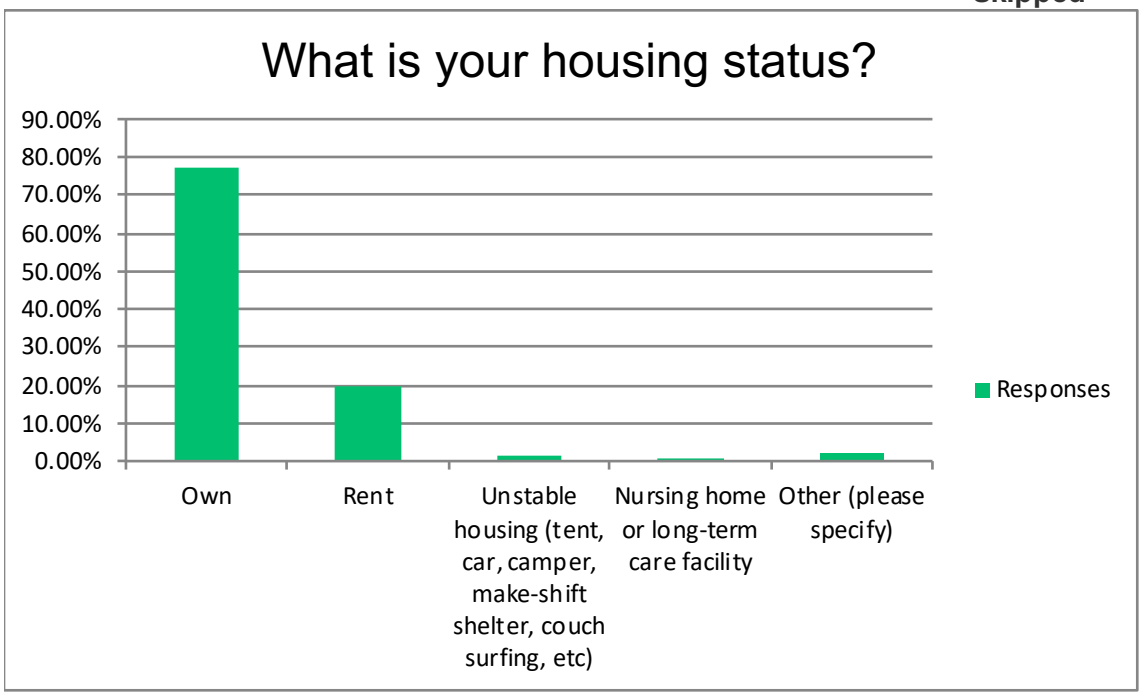
Answer Choices	Responses	
Si, corriente	12.12%	4
Si, anteriormente	9.09%	3
No	78.79%	26
Answered		**33**
Skipped		**2491**



Question 20

What is your housing status?

Answer Choices	Respo
Own	77.06%
Rent	19.85%
Unstable housing (tent, car, camper, make-shift shelter, couch surfing, etc	1.22%
Nursing home or long-term care facility	0.05%
Other (please specify)	1.81%
	Answered
	Skipped



onses
1700
438
27
1
40
2206
318

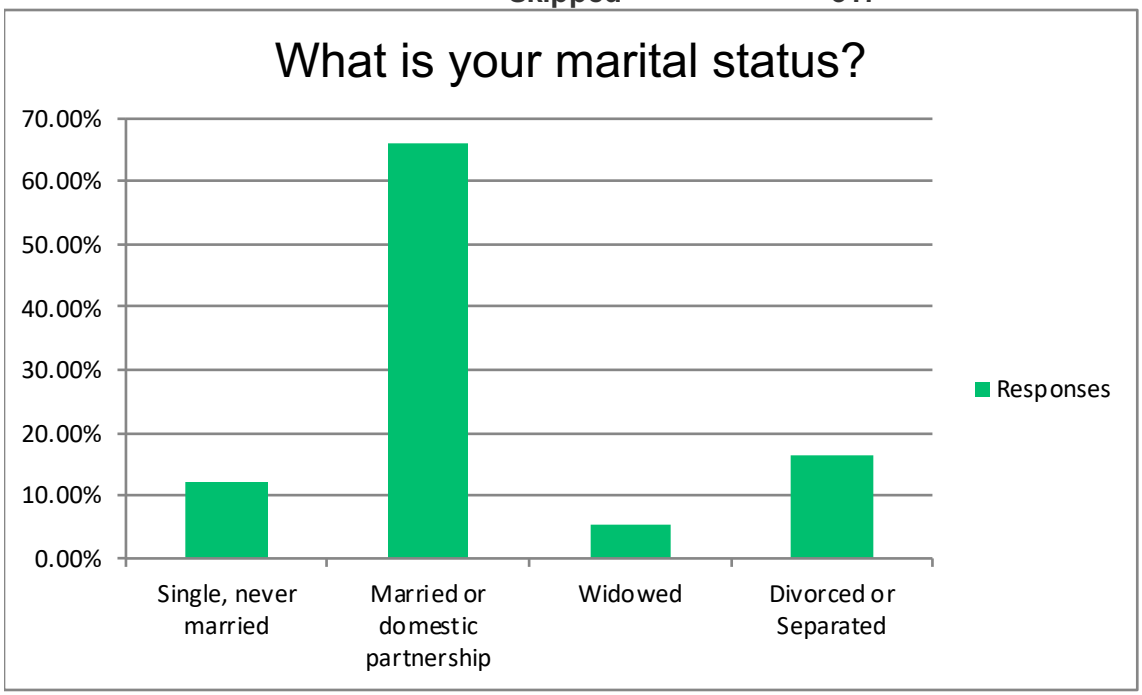
¿Cuál es su estado de vivienda?

Answer Choices	Responses	
Dueño	27.03%	10
Alquila	72.97%	27
Vivienda inestable (tienda de campaña, coche, camper, provisional refugio, durmiendo en sofá de amigos o familia, etc.)	0.00%	0
Hogar de ancianos o facilidad de cuidado a largo plaza	0.00%	0
Otro (por favor especifique)	0.00%	0
	Answered	**37**
	Skipped	**2487**

Question 21

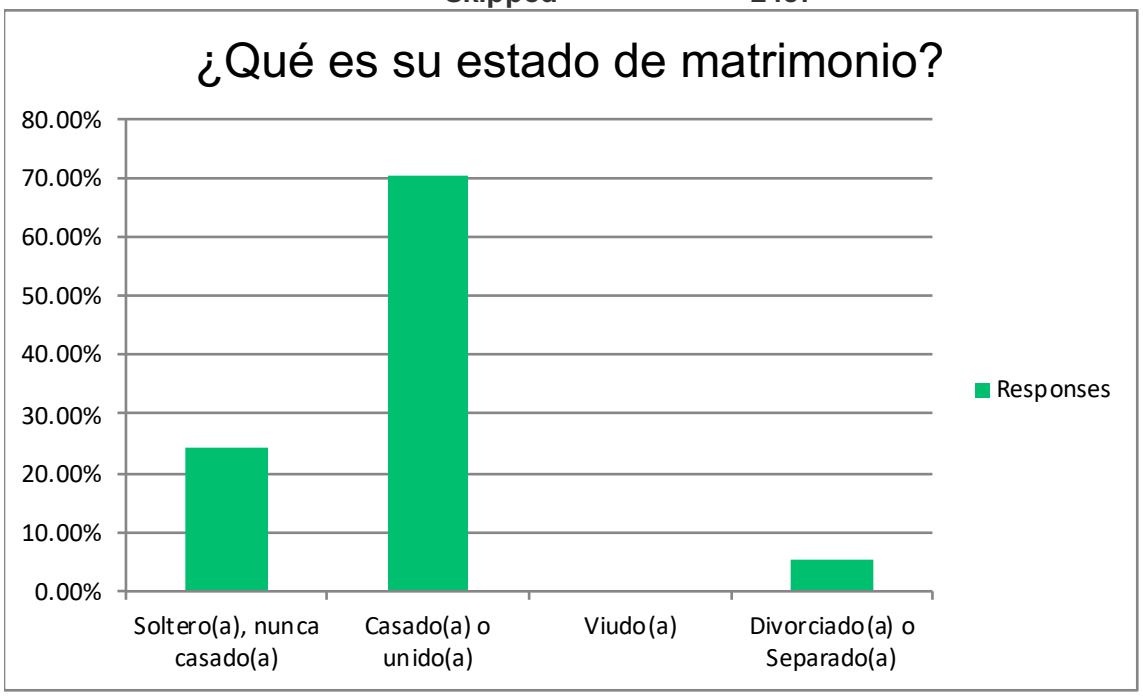
What is your marital status?

Answer Choices	Responses	
Single, never married	12.01%	265
Married or domestic partnership	66.20%	1461
Widowed	5.57%	123
Divorced or Separated	16.22%	358
	Answered	**2207**
	Skipped	**317**



¿Qué es su estado de matrimonio?

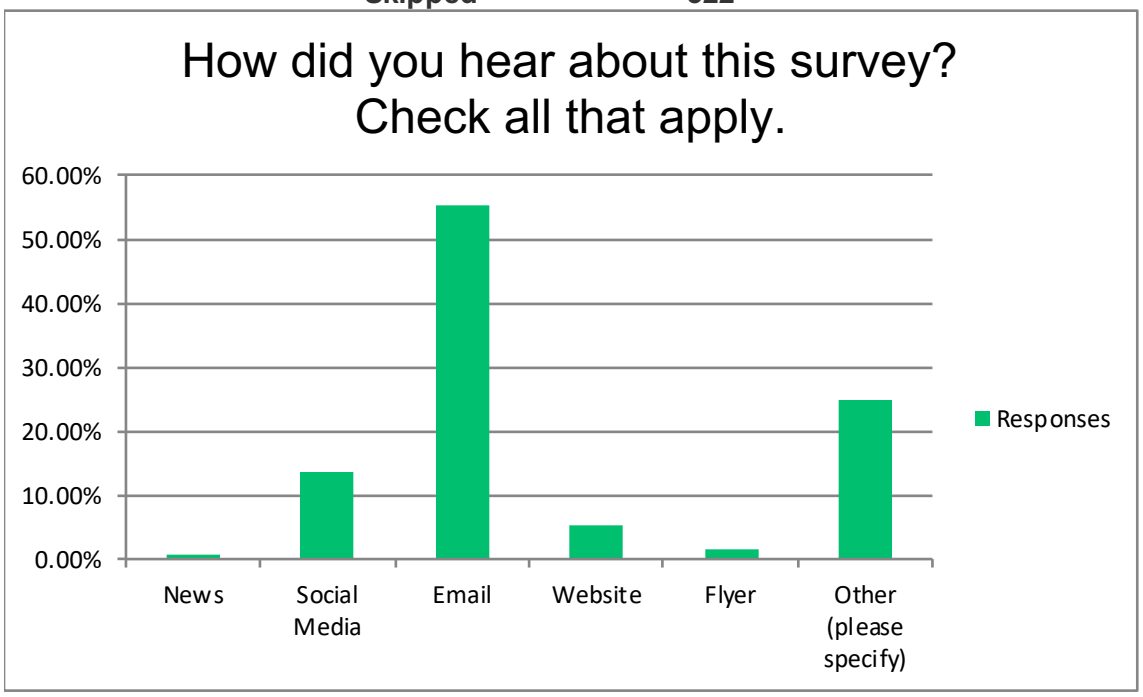
Answer Choices	Responses	
Soltero(a), nunca casado(a)	24.32%	9
Casado(a) o unido(a)	70.27%	26
Viudo(a)	0.00%	0
Divorciado(a) o Separado(a)	5.41%	2
	Answered	**37**
	Skipped	**2487**



Question 22

How did you hear about this survey? Check all that apply.

Answer Choices	Responses	
News	0.64%	14
Social Media	13.71%	302
Email	55.40%	1220
Website	5.18%	114
Flyer	1.68%	37
Other (please specify)	24.98%	550
	Answered	**2202**
	Skipped	**322**



Local Input Findings

A total of 2,525 individuals responded to the survey. Of these 2,478 (98%) were in English and 44 (2%) were in Spanish. Respondents were asked to indicate the county where they receive the majority of their health care. Jasper County, MO (38%); Greene County, MO (26%); and Newton County, MO (16%) accounted for 81% of the total responses, which coincides with the location of the largest hospitals in the OHC Region.

Respondents, 83% were female; 58% were 46 years of age or older; 91% identified themselves as white, 4% as Hispanic or Latino; 39% reported having children under the age of 18; 66% were married or in a domestic partnership; and, overall, the group was highly educated with 51% having a bachelor's degree or higher compared to 15% with a high school diploma or less. Only 5% of those taking the survey reported themselves as unemployed and self-pay/uninsured, respectively. Home ownership was reported by 76% of those surveyed, and 4% reported living without stable housing either currently or at some point within the past two years.

The large majority (88%) of respondents rated their own health as either healthy or very healthy, with 1% rating themselves as very unhealthy. The primary barrier preventing use of health services was cost (43%), with lack of insurance coverage (21%) and lack of providers (10%) also cited.

Mental illness (75%), maternal and child health (64%), and opioid abuse (63%) were the top three health issues to be addressed in their communities, as indicated by the rating "really important." The three most important factors for a "Healthy Community" selected were access to health care (49%), low crime/safe neighborhoods (47%), and good jobs and healthy economy (47%). Other influential factors included good schools (32%) and healthy behaviors and lifestyles (29%).

The majority of those surveyed (77%) denied any exposure to secondhand smoke. When exposure was reported, 15% of the time it was attributed to exposure from restaurants and businesses. Secondhand smoke exposure at home was reported by 9% of those surveyed.

Dissemination Plan

This report was designed to be a resource for and embraced by the public. Therefore, multiple efforts will be made to disseminate these reports to a variety of audiences.

Websites

An interactive web-based version of each Community's report will be available at the Ozarks Health Commission website.

http://www.ozarkshealthcommission.org

PDFs of each report will also be available for corresponding Communities on partner healthcare systems' websites.

http://www.coxhealth.com

http://www.freemanhealth.com

http://www.mercy.net

Printed Copies

Printed copies will be available by request through hospital and public health partners or at ozarkshealthcommission.org.

Process to Share Information with the Community

A news release will be sent out by key partners including hospitals and public health entities to encourage media coverage, with links to the report and key messages for the public. Social media modalities will also be utilized:

https://www.facebook.com/coxhealth/

https://twitter.com/coxhealth

https://www.facebook.com/freemanhealthsystem/

https://twitter.com/FreemanCares4U

https://www.facebook.com/JasperCountyHealthDept/

https://www.facebook.com/joplinhealthdepartment/

https://www.facebook.com/MercyHospitalSpringfield/

https://twitter.com/MercySGF

https://www.facebook.com/MercyHospitalJoplin/

https://twitter.com/MercyJoplin

https://www.facebook.com/SGCHD/

https://twitter.com/SGCHD

https://www.facebook.com/taneycountyhealthdepartment/

https://twitter.com/TaneyCoHealth