Community Health Needs Assessment

Sherman County, KS
January 2013

In partial fulfillment of requirements related to the Patient Protection and Affordable Care Act

Sponsored by:

Goodland Regional Medical Center
Sherman County Health Department

In cooperation with:
Sherman County Community Health Needs Assessment
Executive Summary
January 2013

The Patient Protection and Affordable Care Act (PPACA) created a new IRS Code which imposes additional requirements on tax-exempt hospitals. Specifically, hospitals must complete a Community Health Needs Assessment (CHNA) at least once every three years. The CHNA must include input from persons who represent the broad interest of the community with input from persons having public health knowledge or expertise. They then must make the assessment widely available to the public and adopt a written implementation strategy to address identified community needs.

The Public Health Accreditation Board (PHAB) defines public health accreditation as the development of a set of standards, a process to measure health department performance against those standards, and reward or recognition for those health departments who meet the standards. This accreditation process also requires a periodic Community Public Health Needs Assessment.

In September, 2012, the Goodland Regional Hospital and the Sherman County Health Department co-sponsored the Kansas Rural Health Works (KRHW) Community Health Needs Assessment. The KRHW program is offered through K-State Research and Extension at Kansas State University. A broadly representative group of forty-eight Sherman County leaders met over the course of three meetings to identify priorities and devise action strategies. After consideration of a host of information, local health-related priorities were established.

Steering Committee Consensus on Overall Priorities for Sherman County
Below are the most important issues identified by the Steering Committee following the prioritization process. Specific action plans were developed to address each as Sherman County moves forward to improve the local health-related situation.

Priority #1: General focus on health and wellness and public health issues such as chronic disease prevention (e.g. obesity, diabetes, nutrition, etc.).
Priority #2: Regional communication and collaboration among health care providers
  • Enhance communication and collaboration between health care entities for improved customer service and satisfaction and health outcomes.
  • Improved communication between major providers and the general public for improved information, understanding, and community relations.
Priority #3: Expanded access to mental health assistance, including education emphasis to:
  • Help the general public better understand mental health need and issues (recognize need/reduce stigma).
  • Help providers and public officials to improve recognition and response and treatment of mental health problems.
Priority #4: Physician recruitment and retention.
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Sherman County Community Health Needs Assessment  
September 6-27, 2012

The contents of this file document participation, discussion and information resources developed through the course of the Sherman County Community Health Needs Assessment. These documents and resources were compiled with the assistance of the Office of Local Government located in the Department of Agricultural Economics at Kansas State University. The process used to compile information, establish health-related priorities, and develop action plans employed the Kansas Rural Health Works Community Engagement Process.

The Community Engagement Process provides a way in which community members can evaluate their health care system through the analysis of information reports. The process is community-driven with input from health care providers. It helps the community identify, brainstorm, and solve problems related to local health care. As a result, the process leads to the identification of priority local health-related issues and mobilizes the community to improve the relative situation. A major element of the program was the development of action plans to address priority issues.

The full Community Engagement Process consists of a series of three public meetings over three weeks. The geographic scope of the program typically reflects the extent of the local hospital’s market area identified based on the residential zip codes of inpatients from the previous calendar year.

A broad-based community Steering Committee is formed to analyze the information resources included in this packet to determine relevant issues and propose an action plan to improve local circumstances. The Steering Committee then presents their action plan to the community for review and possible implementation.

What follows are the work products developed by the Steering Committee through the course of the program. The Priorities and Action Plans records participants’ thoughts and concerns about local issues and unmet needs. In the first meeting, participants identify all of their thoughts and ideas. Broader themes are identified and validated by the Steering Committee to begin building consensus about priorities in the second meeting. Finally, the Steering Committee develops action plans in response to the priority issues during the final meeting. The priorities identified and the action plans developed leads this compilation of information resources. The full Meeting Schedule follows this introduction.

Examining the composition of the Meeting Participants reveals that a priority of the program is to solicit input from a broad cross section of the community, not simply members of the local healthcare sector. The meeting participants refine their ideas about the local priorities going forward through the development of a variety of local information resources that follow.

The Community Identification page documents determinants of the geographic scope of the program.
The **Economic Contribution** report illustrates the relative importance of the health care sector to rural community economic viability. The estimates contained therein typically include a complete local census of current health care employment in the market area. Health care will generally be found to be among the top contributors to local economic wellbeing in most rural areas.

The **Data and Information** reports compile a wide variety of published data to show the current situation and trends affecting the local health-related situation. Data reflect conditions related to demographic, economic, social and behavioral, education, traffic, crime, and public health trends. These data represent objective indicators to help validate perceptions of the local situation. Further, these data have continuing utility to various local institutions seeking grants and funding support to work on local problems.

The **Community Survey** presents an effort to solicit input from the broader community. While the initiative is informal and non-representative, it does contribute considerable input from the broader community. The survey typically queries respondent's health-related needs and behaviors. This provides both an indication of local demand for health services and the level of satisfaction with the services received. At the end, an open-ended question queries respondents' views about local health-related issues and concerns.

The health **Asset Inventory** represents a comprehensive listing of local health providers and services. The broad distribution of the directory helps ensure that community members are aware of full extent of locally-available services. Further, it can help to identify any gaps that may exist in the current local inventory of health services and providers.

The **Presentations** display the information considered during the course of the health needs assessment, and describes the processes used to reach consensus and develop action plans.

Finally, the **CHNA Requirements** summarize the Affordable Care Act's requirements for affected hospitals and the requirements for health department accreditation.

All of the information presented here is available for public access at the **Kansas Rural Health Works Website: www.krhw.net**. Local health care institutions are welcome to disseminate these information resources freely provided they are in their full and unaltered form.

Taken as a whole, the Community Engagement Process and these information resources fulfill most requirements for the community health needs assessment requirements for tax-exempt hospitals. The final requirement is that the governing board of the hospital or its designee must then formally declare its own strategic action priorities for the three-year period going forward until a new periodic review of community health-related needs is again required.

Questions about the Rural Health Works program can be directed to John Leatherman, Office of Local Government, Department of Agricultural Economics, K-State Research and Extension. Phone: 785-532-2643/4492; E-mail: jleather@k-state.edu. The Kansas Rural Health Works Website can be found at: www.krhw.net.
Sherman County Rural Health Works  
Community Health Needs Assessment  
September 6th - 27th, 2012

Sponsors:  
Goodland Regional Medical Center  
Sherman County Health Department

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Meeting Schedule

Meeting 1: Local Data Thursday, September 6, 2012  
The Rockhouse, 326 E. 6th Street in Goodland

Agenda

11:30 a.m.  Introduction and Purpose  
11:40 a.m.  Economic Contribution Report  
11:55 a.m.  Preliminary Needs Identification  
  •  Issue Identification Cards  
  •  Discussion  
12:15 p.m.  Secondary Data Reports  
12:35 p.m.  Group Discussion  
12:45 p.m.  Community Survey  
  •  Participant Survey  
  •  Community Outreach  
1:00 p.m.  Gathering Community Input  
1:05 p.m.  Preparation for Prioritization  
1:15 p.m.  Discussion  
1:30 p.m.  Adjourn
Meeting 2: Issue Prioritization Thursday, September 20, 2012
The Rockhouse, 326 E. 6th Street in Goodland

Agenda
11:30 a.m. Introduction and Review
11:40 a.m. Review of Data
11:45 a.m. Service Gap Analysis
11:50 a.m. Survey Results
12:00 p.m. Focus Group Formation and Instruction
12:40 p.m. Group Summaries
1:00 p.m. Prioritization
1:20 p.m. Action Committee Formation
1:25 p.m. Committee Charge
1:30 p.m. Adjourn

Meeting 3: Action Planning Thursday, September 27, 2012
The Rockhouse, 326 E. 6th Street in Goodland

Agenda
11:30 a.m. Introduction and Review
11:40 a.m. Action Planning
  • Objectives and Input
  • Instruction
  • Organization
12:00 p.m. Workgroups Begin
12:30 p.m. Workgroup Reports
1:00 p.m. Organization and Next Steps
1:20 p.m. Summary
1:25 p.m. Program Evaluation
1:30 p.m. Adjourn
Sherman County

Community Health Priorities
Action Plans
Issue Identification
and Participants
Identification of Sherman County Health Needs and Priorities

The purpose of the second meeting of the Kansas Rural Health Works Community Health Needs Assessment is to identify the overall health-related priorities that would be the focus of future efforts to improve the community health environment. Following a review of the community secondary data, health services directory, and community survey results, Steering Committee participants form small groups for the purpose of discussing local health related needs and issues.

To facilitate the discussion, the groups are asked to consider the following questions:

- What is your vision for a healthy community?
- What are the top 3-4 things that need to happen to achieve your vision?
  - What’s right? What could be better?
  - Consider acute needs and chronic conditions
  - Discrete local issues, not global concerns
  - Consider the possible, within local control and resources, something to rally the community
- What can the hospital do to help?
- What can the health department do to help?

Each group comes to a consensus regarding the top two-four health-related issues they recommend as the focus to the overall Steering Committee. After each group reports, an effort is made to identify the top two-four issues across all of the groups. These, then, become the focus for action planning going forward. Below are the most important issues identified by the Steering Committee following the prioritization process. On the pages that follow are the notes taken be Steering Committee members participating in the small group discussions leading to the overall prioritization.

Steering Committee Consensus on Overall Priorities for Sherman County

Priority #1: General focus on health and wellness and public health issues such as chronic disease prevention (e.g. obesity, diabetes, nutrition, etc.).

Priority #2: Regional communication and collaboration among health care providers.
  - Enhance communication and collaboration between health care entities for improved customer service and satisfaction and health outcomes.
  - Improved communication between major providers and the general public for improved information, understanding, and community relations.

Priority #3: Expanded access to mental health assistance, including education emphasis to:
  - Help the general public better understand mental health need and issues (recognize need/reduce stigma).
  - Help providers and public officials to improve recognition and response and treatment of mental health problems.

Priority #4: Physician recruitment and retention
Focus Group 1 Discussion
September 20, 2012

Discussion Questions

What is your vision for a healthy community?
- What's right?
- What could be better
- Consider acute needs and chronic conditions
- Discrete local issues, not global concerns
- Consider the possible, within local control and resources, something to rally the community

What can the hospital do to help?
What can the health department do to help?

Response

Focus:

Prevention – eating, weight.
Dental – uninsured.

What could be better?

Prevention – smoking, weight
- Create walking paths at ball fields, more walkable and bikeable paths.
Lack of dental care for uninsured.
- No Medicaid provider.
- Rawlins County has dental clinic.
- Medicaid provider, CCC students to Goodland.
Access to psychiatric care.
- Try to grow our own.
- How does the hospital recruit?
Good array of services for a small community.
- Share resources within the region.
- Specialists are aging.
- Working together with other agencies.
- Transportation.
Better education about health and healthcare beginning as a child and more for adults.
- Evening hours for classes that are in place.
Better collaboration between GRMC and County Health Department for chronic care.

What can the hospital do to help?

Collaboration.
Home monitoring.
Programs available to general public outside of work hours.
Help with motivation.
Convenient.
Core group of people with interests.
Use NP to educate public for prevention and preventable care help (Shorten wait list for MD).
Grant programs.
Work with grants.

What can the health department do to help?

Well-woman clinic.
Focus Group 2 Discussion
September 20, 2012

Discussion Questions

What is your vision for a healthy community?
- What's right?
- What could be better
- Consider acute needs and chronic conditions
- Discrete local issues, not global concerns
- Consider the possible, within local control and resources, something to rally the community

What can the hospital do to help?
What can the health department do to help?

Response

Focus:
- Wellness Center improvements.
- Extended hours for alternative care.
- Technology for shared services.
- Mental Health – High Plains.
- – Technology services.

What is right?

Access to specialists, Eagle Med, availability to Mental Health.
Largest user of Eagle Med in a 4 state area.
What we do have is good.
Caring people in our facilities.
Access to basic care through providers in Goodland.
Access to specialists through GRMC.
Access to emergency 24/7 through GRMC.
Access to emergency specialists through Eagle-Med transportation services.
We are lucky to have one non-medical vendor provider to provide services for employer
drug/alcohol testing programs.
We are lucky to have “rapid results” drug/alcohol testing available through the one non-medical
vendor provider.
Tele-med.
Some oncology services through KU Med.
The upcoming Kidney Dialysis Center.
Availability and choice in prescription services.
MRI can come to the city of Goodland.
HPMHC for services employer EAP needs.
What could be better?

Accessibility to more doctors and 24/7 walk-in clinic.
More preventative and education/ Health Fairs.
Wellness in the community (GAC-pool in the winter).
Mental Health counselors – Big Need.
Affordability.
Natural/Holistic Medicine.
Specialty services, Eagle Med, Dialysis Center.
Wellness center.
Sharing Technology.

Consider acute needs/chronic conditions:
  Oncology and Dialysis Center.
  Midwest Cancer Alliance – Telemed.
  Share services and technology/co-operate.
  High Plains – use Telemed-type counseling.

TOP NEEDS:
1. Wellness Center Improvement/Preventative & Education.
   a. Health Department Health Fairs ($).
   b. Employer driven.
   c. GAC – improved (health-dietary-pool).
   d. Community partnership in putting in a facility.
2. After hours/Extended hours.
   a. Health Facility.
   b. Nurse Practitioners/Physicians Assistants.
   c. Recruit new doctors.
3. Technology – shared services.
   a. Electronic health records.
   b. Funding.
   a. Use technology to use the counselors already coming to GRMC.
   b. High Plains – ask if they have technology services.

Availability of Bio-Metric testing for Wellness Programs.
Availability of Physical Capacity Profile testing in Goodland.
Availability of drug/alcohol counseling services for EAP needs.
Perhaps health fairs twice a year.
The health fairs need to have more emphasis on employer wellness program needs.
Let employers drive health fair attendance.
Invite employers to use the fair for meeting wellness biometric testing criteria.
Be willing to do a little more like BMI’s if an employer needs it.
If the first major employers (GRMC, Frontier Ag, USD 352, City, and County) did drive attendance by biometric testing/screenings (Frontier Ag will almost require by 7/1/13), this would guarantee a base of activity to make the fair worth the economic investment of medical vendors.
Have the ability to expense the employer for their participating employee.
What can the hospital do to help?

- Added providers.
- Use technology for Mental Health.
- Facility.
- PAs and registered nurses.
- More recruitment for doctors.

What can the health department do to help?

- Lead in Health Fair/wellness.
- Health education.
- Technology, share transportation
- Extended services and hours for weekend.
- I believe the county health department should have someone versed in wellness programs about what is being done in the way of education, promote community events, assist employers through state resources with education, event ideas, etc.
- It would be great to have the ability through a county health department to review an individual’s health care assessment and assist with a plan of action if the individual doesn’t have one.
- At least provide direction through state web-based assistance.

High Plains use technology for additional services?
Focus Group 3 Discussion
September 20, 2012

Discussion Questions

What is your vision for a healthy community?

- What’s right?
- What could be better
- Consider acute needs and chronic conditions
- Discrete local issues, not global concerns
- Consider the possible, within local control and resources, something to rally the community

What can the hospital do to help?

What can the health department do to help?

Response

Focus:
- Mental Health services options.
- Communication and collaboration;
- Culture within hospital:
  - Customer services.
  - Recruitment and retention.
  - Primary care and specialists.

What could be better?

- More providers/female obstetrician.
- Increased specialists/finding replacements for the ones that have left.
- Culture within the hospital – improved customer service, better attitudes, condescending providers.
- Communication – with administration, hospital staff, community, school system, communicate with integrity.
- Keeping obstetricians in community, keeping young families in community.
- Improve customer service and professionalism.
- Attitudes.
- Options for mental health for community/school system.
- Options for elderly (nursing home placement).
- Addressing obesity/nutrition.
- Housing.
- Under-used pediatrician.
- Urgent care clinic.
- Community communication/collaboration/improving customer service.
- Mental health access/urgent care model.
- Wellness/prevention/community programs.
Condensed:
Mental Health – increase options.
Communication with hospital, community, school system.
Culture within hospital – improved customer services/professionalism.
Increased providers/replace specialists that have left the hospital.
Focus Group 4 Discussion
September 20, 2012

Discussion Questions

What is your vision for a healthy community?
- What's right?
- What could be better
- Consider acute needs and chronic conditions
- Discrete local issues, not global concerns
- Consider the possible, within local control and resources, something to rally the community

What can the hospital do to help?
What can the health department do to help?

Response

Focus:
Access to specialists – recruitment and retention.
Billing and customer services:
  Improved customer communication.
Wellness and prevention:
  Obesity, wellness, recreation and exercise.

What is good?

Excellent providers – people in community.
Many opportunities in community.
Good doctors.
Excellent facility and capabilities.
Basics are there.
Good care.

What could be better?

Better scheduling, better billing, prevention.
Less mediation-focused.
Recruitment of doctors, wellness program, surgeon, more specialists.
Scheduling of specialist – recruiting doctors.
Better access to local services and specialists.
  Better doctor-PT communications, more doctors.
  Call with results.
  Prevention group.
  More social media.
Communication – access with doctors and PT.
Billing! Billing! PT advocate from the beginning giving conversations on costs and options.
Collection.
Mental Health concerns.

**Acute & Chronic Needs**

People with no insurance can’t pay – won’t come for care.
  Obesity.
  Exercise that people don’t have to pay.
No insurance.
Obesity, heart disease.

**Discrete Local Issues**

Billing.
Customer service issues.
Wait time – specialist.
People go other places due to wait time, doctor choices, and customer service.

**Rally Programs**

Exercise that doesn’t cost.
Customer services!
Prevention measures.
Access to health care.
Recruitment.
Billing.
Offering Health Fair test more frequently.
Sherman County Community Health Action Plans

The final step in the Rural Health Works Community Health Needs Assessment is to devise action plans to guide future implementation efforts. A primary emphasis of the program is to devise specific, action-oriented plans so the momentum of the community health initiative is not lost following the needs assessment.

To accomplish this, Steering Committee member break into work groups to focus on a specific priority. Their effort is to apply elements of the Logic Model planning process to craft action strategies. Following are the questions workgroup participants considered in drafting action plans. Given time constraints within the formal program setting, the resulting action plans are currently in draft form. It's recognized that crafting a detailed and effective action plan requires time and ongoing commitment. Program participants now have a template and a start in their efforts to create a road map guiding their way forward.

Community Health Planning Process

Getting Started
To start, we need to articulate the change we would like to see take place. To do so, we need to recognize the existing situation we believe can be improved. Consideration of the many data and information resources generated through the program can bolster the case for needed action. We can't accomplish everything at once, so we need a sense of priority about what we should do now rather than later. Finally, we need to articulate the goal or intended outcome we would like to see achieved.

- What's the Situation you'd like to see changed? What are the needs or problems to be addressed?
- What should the Priorities for attention, effort, and investment be? What are the most important things that need to be done to address the situation?
- What are the Intended Outcomes you'd like to see achieved? What will be the situation or condition when the goal has been achieved?

Filling in the Plan
- Now that we've established what we would like to achieve, we need to figure out how to do it. We can create an effective action plan by carefully considering what resources we need to invest into the effort, what activities we need to do to make progress, who we need to reach and involve, identify the milestones we'll need to see in order to know we're making progress, and, finally, the ultimate impact we would like to see achieved.
- What Resources are needed to take action? Who's available to work on the problem? How much time will it take? Is money or other resources needed? Who can we partner with to make progress?
- What Activities need to take place? Do we need to conduct regular meetings? Do we need to have special public meetings or events? Do products or information resources need to be developed? How should the media be involved? How do we foster needed partnerships and alliances?
• Who needs to **Participate** in order to make progress? Who are we trying to reach and influence? Who are the targets of our effort? Who needs to be involved?

• What are the **Short-Term Results** (6-12 months) you'd like to see? What would we like people to learn? What are the changes in awareness, knowledge, attitudes, or skills we'd like to see people exhibit? How will we measure this?

• What are the **Intermediate-Term Results** (1-2-3 years) you'd like to see? What are the behaviors, actions, decisions, or policies we'd like to see in place? How will we measure this?

• What is the desired **Ultimate Impact** (long-term) on the community? What are the social, economic, or other conditions we'd like to see in place in order to effect the kind of change the would be desired? How will we measure this?
Sherman County Community Health Needs Assessment Action Planning
September 27, 2012

Priority #1: General focus on health and wellness and public health issues such as chronic disease prevention, e.g., obesity, diabetes, nutrition, etc.

Action Committee Members
To be Determined

Action Plan

Getting Started

Situation
Address obesity, prevention.
There are opportunities and lack of opportunities.
Affordability and availability.
We have OK – but we need better.
Expand chronic disease management.
More focus on healthy activities for adults and incentives for their participation in an effort to reduce obesity and prevent chronic health issues.
Provide more education on availability of services and programs that promote healthy eating and exercise.
Heart disease, cancer.
Chronic diseases caused by obesity have a negative impact on finances for individual, healthcare institutions, and government.

Priorities
Provide free exercise.
Create more and safer walking parks and paths that include fitness/exercise stations with health signage.
Supporting residents in making healthy choices/exercises.
Exercise is medicine.
Education for the need of healthy eating habits and exercise to improve and prevent chronic health issues.
Healthy lifestyle changes/information.
Community Wellness Committee that functions through worksites and the local senior center.
Central communication center.
Addition/Expansion of GAS.
Access during off hours.
Encourage businesses to have walk/bike to work Fridays with employee incentives (5 with more than 10 employees, 5 with less than 10 employees).
Health providers encouraged to provide written “prescriptions” for physical activity – like walk 30 minutes 3 times a week.
Available community resources.
Nutrition.
EIM program.

Intended Outcomes
Increased activities, decreased chronic disease.
Increased awareness.
Adult directed.
Development of plans and ideas.
By providing and encouraging more education, programs, and activities for adults, we can take a step towards reducing obesity. If adults eat better and exercise more, hopefully this will expose our youth to better and healthier tendencies also.
Increase rates of adult physical activity from 45-55% (moderate activity 30 minutes 5 days a week or vigorous 3 times a week).
Decrease adult obesity from 24-20% (KS Health Matters WCPHI region).
Decrease adult obesity from 50-45% (KS Health Matters).
Increase use of trails/parks by all age groups.
Decrease in chronic disease (statistical information).
Reduce indicators associated with lack of exercise and eating/nutrition. Forth chronic diseases are affected by exercise.

Filling in the Plan

Resources
Money – Grant writing from County Health/City/Extension/Hospital.
Community Fundraising campaign (Sherman County Foundation?) for trails.
Create steering committee.
Should come from a cross section of community, not just health care professionals.
Join with local conditions (CPPE – Community Partners for Prevention and Education).
Meet monthly with sub-committees.
Establish a timeline/goal for completion of phases, but some phases are ongoing.
Some things immediate and some long – existing coalition.
Partner with various employers and the city of Goodland – for incentives like bike locks or coupons for fresh fruit or vegetables.
Signage for trail system.
Survey of park usage.
Project team assembles from multiple businesses that create a collaborative plan for action and will be tasked with implementing the plan for the benefit of all the residents of Goodland.

Activities
Build, educate.
Regular meetings.
Public meetings and events.
Develop information and education – newspaper, radio, and social media.
Employers – show needs and benefit.
Publicity – it helps.
Speakers’ bureau for ongoing information – resource?
We need to be able to show a need and a benefit to gain partnerships.
Ask for grant funds or sponsorships – local, state, national.
Steal other people’s ideas! We have to all give up territory and work together.
Plan for trail system (which first, cost, etc.).
Fundraise.
Revolving signage messaging (hospital, health department, extension) for healthy snacks, flu shot season, tobacco cessation resources, etc.
Positive media messages (may need to write articles for newspaper, radio, etc.).
Coalition to help medical providers/hospital/health department to impact change – give direction plus assistance with community.
Organize moonwalks.
Community-wide education campaign focused on healthy living including the development of key media messages, a directory of healthy living, a speakers’ bureau, and healthy dining guide.
Sponsor health events in town that promote and educate wellness.
Partner with Wal-Mart to launch healthy food workshops.
Participate

Large cross section of participants.
Health professionals.
Local government – parks and recreation.
Employers and local businesses (target 5 large, 5 small to start).
General public represented.
Organizational leaders.
The City of Goodland.
The goal will be to have a healthier-minded community that works to control obesity and its’ related health issues.
Health Department and GRMC.
Extension.
Media.
Walking groups (neighborhood, work, church, etc.).
Stakeholder & power brokers.
Multidisciplinary approach is a must!

Short-Term Results

Visual and perceptive increase in activity.
Formulation of action committee.
Increase in participation.
Install a few fitness stations in existing parks (see it, use it, want more!) and we can continue to build from there.
Helping employers to see the benefits/needs for healthy employees. It has to come from the top down at worksites. Start small – don’t overwhelm that with costs on time.
Trail plan developed.
Grant writing occurs.
Foundation drive begins.
Employer incentive programs for biking/walking to work.
Survey park usage.
Health providers initiate physical activity prescriptions and track BMI at all visits.
Increase number of adults and children who regularly exercise, eat daily nutritious meals, and receive regular screenings for health risk factors.
Intermediate-Term Results (1-3 years)

Decrease percentage of adults with high blood pressure, diabetes and other chronic disease measures.

Progress on infrastructure development.

Employer norm – not the exception to workplace incentives.

Need to continue to meet and work towards goals. Over time, the plan may evolve and we need to be ready to go with it while maintaining the overall goals.

Trail begins construction/development.

Signage for parks installed.

Business program triples.

Health providers track improvement in BMI and follow-up on activity at routine visits.

Survey of park usage shows increase.

Decrease percentage of adults with high blood pressure, high cholesterol, and obesity.

Ultimate Impact

Surveys – higher levels of satisfaction?

Health data improving.

Buy-in from the community – employers and public.

Improved infrastructure.

More fit community measured by increased physical activity, reductions in overweight and obesity rates.

Reduced cost of health insurance due to improved health (business and individual benefit).

More attractive city with improved trail system (business friendlier, family friendlier).

Reduce obesity and associated health conditions.

Partnerships with organizations with similar goals to improve wellness.

Impact the costs related to obesity and inactivity.

Develop a physically fit workforce to position Goodland as a community of choice for new business.
Sherman County Community Health Needs Assessment Action Planning
September 27, 2012

Priority #2: Regional communication and collaboration among health care providers

- Enhance communication and collaboration between health care entities for improved customer service and satisfaction and health outcomes.
- Improved communication between major providers and the general public for improved information, understanding, and community relations.

Action Committee Members
To be Determined

Action Plan

Getting Started

Situation

Figure out who does what.
Transportation service.
Collaboration of resources.
Community better understand the needs of uninsured or under-insured and support/empower community social services organizations (Genesis) or see more efficient ways to provide assistance.
More information about how to better manage their own health care/prevention (literacy/noncompliance).
Reduce the redundancy of services, better focus, clearinghouse agency overlap, immunization.

Priorities

Broaden scope, organization of Genesis organization, possible partnership/merge with Ministerial Alliance.
Form some type of broad-based organization that can be a clearinghouse of local services/resources.

Intended Outcomes

More collaboration to reduce redundancy.
Maybe a paid position (program manager) to relieve responsibility (financially) on the volunteers.
Filling in the Plan

Resources
Church leadership (who).
Funding for a coordinator – possible from churches – look how much each spends on social services and channel to fund this.

Activities
Mainly organizations.

Short-Term Results
Formation of “clearinghouse” – social service organization resources such as a facility that has dealt with a piece of it.
Education needs from each facility’s perspective.

Intermediate-Term Results
Organizations structure – program manager to move away from volunteer-run.
Funding mechanism.
Mission scope.

Ultimate Impact
Take responsibility off each organization.
Perhaps create a culture of community services in exchange for resources – offer a way for people to pay back, take responsibility for their needs, accountability.
Measurable changes – monitor repeat users.
Decrease in demand of social services.
Better utilize our local volunteers – more directed efforts by having a clearinghouse.
Priority #3: Expanded access to mental health assistance, including education emphasis to:
- Help the general public better understand mental health need and issues (recognize need/reduce stigma).
- Help providers and public officials to improve recognition and response and treatment of mental health problems.

Action Committee Members
To be Determined

Action Plan

Getting Started

Situation
Overall improvement to the mental health resources in Sherman County – availability, quality providers, emergency services.
Access issues, resources to be gained.
Expanded access to mental health.
Education to recognize need and stigma along with expanded access.
Online self-evaluation for and at GRMC – Beck’s self-evaluation would be good.
People willing to own up to the need for mental health care!
Communication and community.

Priorities
Public education regarding how mental health affects overall health.
Improved resources, including online self-evaluation program and confidential means of acquiring help.
More experts available locally.
Medical doctors including mental health questions during office visits.
Continuity of care and scarcity of mental health providers. Students at GRMC are self-limiting in terms of continuity when they are only present for a number of weeks at a time.
Education to reduce need and recognize a need for treatment in self OR others that we come into contact with. Education toward reducing the stigma that continues even in modern day.
Cost issues and affordability. Make sliding scale based on income more available in the public arena. Insurance benefits more known to patients.

Emergency services.
Increased availability to quality specialists.
Hospital or county health website – scales, Ad Campaign – local and celebrity.

Intended Outcomes
Decreased stigma, increased awareness, and medical doctors making questions about mental health part of their daily routines (as well as EMTs, nurses, etc.).
Quick access.
Continuum of care.
More satisfied public.
Better quality of life for patients.
Decreased emergency room visits related to mental health crisis.

Filling in the Plan

Resources
Educated mental health personnel, law enforcement, EMTs, ER personnel, family physicians.
Training and educational materials needed.
HPMH offers training.
Federal and state reimbursement issues for Medicaid and Medicare need to be addressed at a Grass Roots level.
Monies to support and entice professionals to come to our community or region. Shared opportunities at a regional level with contacting KU and other universities to recruit. Organized recruitment efforts!
Start earlier with career opportunities at a Grass Roots level too, opportunities to shadow leaders at a community level.
Increase access to mental health specialists.
Telemedicine coordinator, nursing staff, HPMH, community counselors, law enforcement, religious.
Uncertain – depends on the availability of others.
Technology always takes money.
Heartland Telehealth Resource Center, HPMH, others.
Activities

Incorporate into existing public events, such as the health fair, Flatlanders, etc. EMS, police, and dispatch could conduct mental health training and monthly meetings.
Senior centers could host classes.
Assign or ask for a volunteer committee to promote mental health.
Financial planning.
Contact other counties, universities and regional leaders.
Ad campaign to witness to success stories.
Public services announcements, radio, etc.
Mental health association with the Health Fair.
Contact congress/political officials to place pressure on insurance companies to recognize TM as a way to provider services.
Find specialists.
If an action committee is created, quarterly or bi-annual meetings to ensure goals/objectives are met.
Support groups in community.
Advertise in newspaper or radio on options in community.
Open communication.

Participate

Employers, health departments, clinics, HPMHC, governmental officials, churches, schools.
Leadership in religious organizations, law enforcement, schools, private sector representation.
Hospital, city health clinic, High Plains Mental Health Center, universities who have access to teach mental health.
Leaders at Vo-Tech colleges.
Case managers for kids who are taken out of homes – like St. Francis Community Services.
Those involved with patients who are affected by mental health issues.
All age groups.

Short-Term Results

Funding set aside.
Establish recruitment plan for mental health professionals.
Ad campaign designed and implemented including local people willing to tell their stories.
More information on websites and available links to other communities.
Money set aside right away to study this issue.
Public relations communicating the initiatives that are taken.
Public relations on holiday stress, for example – Facebook page for mental health for High Plains and website!
Create more access to specialists.
Advertise to schools/doctors/providers on specialists.
Advertise to community what is available.
Increase outpatient services to decrease number of ER visits.
Increase number of insurance companies who recognize TM as a way to provide services.

Intermediate-Term Results
- Professionals with working relationships with local responders and doctors.
- Reduced stigma within local area.
- Steady funding.
- Plan for prevention in public schools.
- Stable provider access through growing our own.
- Access to quality specialists.
- Make mental health a priority.

Ultimate Impact
- Decreased instance of physical illness due to mental illness.
- Less law enforcement resources utilized (transporting, incarcerating, etc.).
- More satisfied public.
- Better affordability.
- Better quality of life.
- Local ER visit decreased because of access.
- Survey to measure success and usage!
- Consistent use of quality mental health specialists.
- More stable mental health patient population with fewer ER visits, less family/work/interpersonal disputes flowing over into law enforcement.
Sherman County Community Health Needs Assessment Action Planning
September 27, 2012

Priority #4: Physician recruitment and retention

Action Committee Members
Lori Gaydusek
Vicki Baker
Chet Ross
Harlan House
Faye Paxton
Curtis Duncan

Action Plan

Getting Started

Situation
Access (timely and appropriate) to physicians, including quality.
Outpatient is important.
More providers (doctors).
Better communication with all.
Dermatologist.

Priorities
Recruitment for whole family.
Retention.
Mid-levels.
Open Clinics – major providers exchange.
Public access to information.

Intended Outcomes
Shorter wait time – quicker services.
More walk-in available.
Extended hours in the evening.
Draw in outside sources.
Publish/media.
End result of faster care for more people at economical cost.
Quicker – more economical care.
Stronger; weak linkages smaller.
Annual health fair.

Filling in the Plan

Resources
Community support – media, board, public health, outreach clinics, mid-levels.
18 months.
Money - not from the hospital. Seek broader community support.
Media with sealed deal.
Eagle Med.
Money – personnel, finances.
Major provider involved.
IT capacity.

Activities
Keep ears open for interested people. Invite them to network. Network with the same interest people (e.g., scuba diving)
Regular community meeting – quarterly.
Media coverage.
Schedule events – event leaders.
Solicit financial leaders.

Participate
Trying to get family and provider.
Interested people.
All citizens.
Leaders – right person.
Who from outside can help?
Business, education, etc. underserved.

Short-Term Results (6-12 months)
More signed and present – strategically placed.
Media upon signing – going out to meet and meet at all service.
Interstate/Vo-Tech.
Target metrics.
Public relation initiatives.
Sponsors secured.
Plans solidified and finalized.

Intermediate-Term Results (1-3 years)
How many providers present – Measure by satisfaction, increase number of appointments, lab, X-ray, decreased ER visits.
Better services/draw from Interstate.
Provider meetings.
Community by-in for all initiatives.
Annual Health Fair.

Ultimate Impact
Regional focus – improved access for the region.
Retired community – Turn community around.
Financial – bottom line.
Measure – surveys, provider survey.
Improvement/enlargement of departments.
Community surveys – higher satisfaction.
Have dealt with issues.
Businesses more involved.
Kansas Rural Health Works
Action Planning Worksheet

This worksheet is intended to help Rural Health Works program participants build an effective action plan for improving conditions in the community.

Getting Started
To start, we need to articulate the change we would like to see take place. To do so, we need to recognize the existing situation we believe can be improved. Consideration of the many data and information resources generated through the program can bolster the case for needed action. We can’t accomplish everything at once, so we need a sense of priority about what we should do now rather than later. Finally, we need to articulate the goal or intended outcome we would like to see achieved.

What’s the Situation you’d like to see changed? What are the needs or problems to be addressed?
____________________________________________________________________________
____________________________________________________________________________

What should the Priorities for attention, effort, and investment be?
1st: _________________________________________________________________________
2nd: _________________________________________________________________________
3rd: _________________________________________________________________________

What are the Intended Outcomes you’d like to see achieved? What will be the situation or condition when the goal has been achieved?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Filling in the Plan
Now that we’ve established what we would like to achieve, we need to figure out how to do it. We can create an effective action plan by carefully considering what resources we need to invest into the effort, what activities we need to do to make progress, who we need to reach and involve, identify the milestones we’ll need to see in order to know we’re making progress, and, finally, the ultimate impact we would like to see achieved.
What **Resources** are needed to take action? Who’s available to work on the problem? How much time will it take? Is money or other resources needed? Who can we partner with to make progress?

____________________________________________________________________________

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What **Activities** need to take place? Do we need to conduct regular meetings? Do we need to have special public meetings or events? Do products or information resources need to be developed? How should the media be involved? How do we foster needed partnerships and alliances?

____________________________________________________________________________

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Who needs to **Participate** in order to make progress? Who are we trying to reach and influence? Who are the targets of our effort? Who needs to be involved?

____________________________________________________________________________

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____________________________________________________________________________

What are the **Short-Term Results** (6-12 months) you'd like to see? What would we like people to learn? What are the changes in awareness, knowledge, attitudes, or skills we’d like to see people exhibit? How will we measure this?

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

What are the **Intermediate-Term Results** (1-2-3 years) you'd like to see? What are the behaviors, actions, decisions, or policies we’d like to see in place? How will we measure this?

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

What is the desired **Ultimate Impact** (long-term) on the community? What are the social, economic, or other conditions we'd like to see in place in order to effect the kind of change the would be desired? How will we measure this?

____________________________________________________________________________

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<th>Meeting 2 – 9/20/2012</th>
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Basis for the Organization of the Sherman County
Community Health Needs Assessment

Share of Inpatient Discharges from Sherman County Zip Code, 2011

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<th>Hospital</th>
<th>Zip</th>
<th>City</th>
<th>State</th>
<th>County</th>
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**Sherman County Shares** 89.50%
Sherman County CHNA Preliminary Issues List
9/6/2012

Themes
Additional primary/specialty service providers
Distance/access to specialty services
Access for the uninsured and underinsured
Chronic health conditions and prevention
Access to mental health assistance
Provider communication/collaboration
Community attitudes and leadership

What are the major health-related concerns in Sherman County?
Cost/affordability (9)
Lower income/uninsured access to health care services (9)
Access/distance to specialty services/diagnostics (9)
Lack of mental health assistance (7)
Elder/geriatric concerns (6)
Lack of providers/primary care (6)
Lifestyle choices leading to chronic conditions (6)
Physician recruitment (5)
Sustainability of our local system (2)
Transportation services to out-of-county health providers (2)
Prevention education (2)
Access (waiting time) (2)
Overuse of prescription medications (2)
Facilities
Awareness of local service availability
Chronic conditions
Quality of care
Local leadership for health care concerns
Female obstetrics provider
Improved quality of providers
Additional surgical services
Increase technology for record keeping and information access
Dental assistance for Medicaid patients
Progressive and active community involvement
Oncology services
Physical and mental disabilities
Community conflicts
Increase recreational opportunities
Obstetrics
Lack of progressive community attitudes
Housing
What needs to be done to improve the local healthcare system?
More providers/physician recruitment (10)
More preventive health/wellness/educational initiatives (5)
Greater networking among local providers (4)
Using technology to offer more services (3)
Progressive thinking and community involvement (3)
Lower cost of accessing services (3)
Services for the underinsured/uninsured (3)
More specialty services (2)
Mental health assistance (2)
Young, motivated providers
Additional surgical services
More professional nursing providers
A better local economy
Stop hospital in-fighting
Planning to deal with substandard reimbursements from the federal government
Deadbeat patient users
Expanded treatment locally, instead of referrals
Better public relations between hospital and community
Improve cooperation among health care institutions
Technology for improved communication between providers
Local willingness to pay for quality local services
Public relations between major providers and the public
Preventive services beyond minimal education
Wellness and fitness opportunities
Education about locally-available education opportunities
Physician recruitment
Improved fiscal management by providers
Improved quality of providers
Tobacco-free hospital
Community involvement and support
Accessing physicians (wait time)
Improved access to primary care
Local government involvement
Local health services are good
Transportation assistance
Elder assistance
Reducing costs of services
Increased recreational opportunities
Increase awareness of locally-available services
Financial stability
Support existing services
What should be the over-arching health care goals of the community?
Universal access to quality/affordable health care (11)
Preventive treatment and care (8)
Maintaining local services (4)
Preventable/chronic illness prevention (4)
Cooperation/collaboration among providers (3)
Physician recruitment (2)
Improved professionalism of health care providers (2)
Expand local specialty access (2)
Community involvement and cooperation (2)
Provide care without tax subsidies
Better general economic conditions
Lower cost and improved access to public health opportunities from GRMC
Access to underserved households
Local growth and progress
Public education about availability of quality local providers
Greater community service focus for more
Tobacco-free hospital
Quality physical therapy assistance
Emergency services
Infant care
Dialysis services
Long-term care and assisted living options
Expanded mental health assistance
Expand recreational opportunities
What are the greatest barriers to achieving health care goals?
Financial resources (12)
Community attitudes/pessimism/apathy (9)
Greater cooperation among local providers (8)
Improved access for uninsured/underinsured (5)
Distance to specialty assistance (4)
Rural remoteness (3)
Prevention (3)
Small population/demographics (2)
Lack of providers/physician recruitment (2)
Competition with surrounding communities for providers (2)
Structure of local hospital health care
Only those who can pay should have access
Greater emphasis on public awareness of health maintenance
Public education
Community support
Lack of cooperation among local leadership
Hospital public involvement
Lack of general recreation opportunities
Access to rehabilitation assistance
Additional quality family practice physicians
Weak local economic base
Waiting times for physician access
Elder assistance
Community perceptions relating to quality of local care
Lack of time
Medicare cuts/reimbursements
Transportation assistance
The Importance of the Health Care Sector to the Economy of Sherman County

Kansas Rural Health Options Project
December 2010

Jill Patry, Research Assistant
Katie Morris, Extension Assistant
John Leatherman, Director

Funding for this report provided by: Health Resources and Services Administration
The Economics of Rural Health Care

The organization and delivery of health care services have undergone rapid evolution in recent years. For many Americans, the cost of services and access to care are important issues. This certainly is true in many rural areas where communities have struggled to maintain affordable, quality health care systems. As economic forces and technical advances continue to change health care, it is more important than ever for rural community leaders and health care providers to work together to ensure affordable, sustainable health care systems.

In an effort to provide useful information resources to rural community and health care leaders, the Kansas Rural Health Options Project (KRHOP) has teamed with the Office of Local Government, a unit of the Department of Agricultural Economics and K-State Research and Extension, to develop this report as a component of the Kansas Rural Health Works program. KRHOP is a partnership of the Office of Local and Rural Health at the Kansas Department of Health and Environment, the Kansas Hospital Association, the Kansas Board of Emergency Medical Services and the Kansas Medical Society. KRHOP is dedicated to assuring quality health care delivery in rural Kansas through the promotion of collaborative systems of care. Kansas Rural Health Works is supported by a federal grant to KRHOP (No. 5 H54 RH 00009-03) from the Health Resources and Services Administration, Office of Rural Health Policy.

The purpose of this report is to provide information resources that may be used to communicate to community leaders and concerned citizens the relative importance of health care to the local economy.

Much of this information draws on the national Rural Health Works program sponsored by the Office of Rural Health Policy, an initiative led by Cooperative Extension Service specialists at Oklahoma State University. Many persons knowledgeable about the Kansas health care system also contributed to this report, including specialists at the Kansas Hospital Association, the Office of Local and Rural Health, and hospital administrators from across the state who cooperated in the development of these resources.

The Office of Local Government welcomes any questions, comments or suggestions about this report or any of their other services. Contact your county Extension office or:

Dr. John Leatherman  Phone: 785-532-2643  
Office of Local Government  10E Umberger Hall  
Department of Agricultural Economics  Fax: 785-532-3093  
K-State Research and Extension  E-mail: jleather@ksu.edu  
Manhattan, KS 66506-3415
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The Economic Contribution of the Health Care Sector  
In Sherman County, Kansas

Introduction

The rapidly changing delivery of health services in rural counties has the potential to greatly impact the availability of health care services in the future. These changes include:

- Insufficient Medicare and Medicaid payments to hospitals and providers may force a reduction in the provision of health care services.
- Although Kansas rural health networks are already fairly strong, creation of provider networks may substantially change the delivery of, and access to, local health care services.
- Use of telemedicine could increase access to primary, consultative and specialty health care services at the county level.
- Development of critical access hospitals could help health care services remain in rural counties. Kansas currently has over 80 critical access hospitals.

As a result, the health care sector can have a large impact on the local economy. All of these changes make it imperative that decision makers in Sherman County become proactive in maintaining high quality local health care services.

Health care facilities such as hospitals and nursing homes provide jobs and income to people in the community. As these employees spend their income in the community, a ripple spreads throughout the economy, creating additional jobs and income in other economic sectors. To help understand this important connection between the health sector and the local economy, this report will:

- Discuss the role of the health sector in rural development.
- Measure the employment, income, and retail sales impact of the health sector on the Sherman County economy.

This report will not make any recommendations.
Health Care Changes and Their Effects on Rural Communities

The changes occurring in the health care sector have had a substantial impact on many rural communities. Many people have found it more difficult to get health care coverage, insurance premiums have increased, and rural health care providers have been reimbursed at rates less than their urban counterparts for doing the same work. Concurrently, changes in urban health systems have had impact on rural health care delivery with the result that some rural communities have lost their ability to make decisions about their local health care.

Rapid increases in health care costs have driven these changes. In 1990, a person spent an average of $2,239 (2008$) on health care expenditures. By 2008, health care expenditures rose to $3,486 per person. Additionally, the average person spent $1,415 (2008$) for insurance premiums and $824 on out-of-pocket expenses such as deductibles and co-payments in 1990. In 2008, those figures rose to $2,573 for insurance premiums and $913 for out-of-pocket expenses. Table 1 shows the trend of increasing health care expenses from 1970 through 2008. Because of the increases in the demand for and cost of health care, the major purchasers of health care services — employers and government (through Medicare, Medicaid and other programs) — must search for ways to slow the rapid growth in health care expenditures.

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<tr>
<td>1970</td>
<td>$913</td>
<td>$350</td>
<td>$563</td>
</tr>
<tr>
<td>1980</td>
<td>$1,307</td>
<td>$708</td>
<td>$598</td>
</tr>
<tr>
<td>1990</td>
<td>$2,239</td>
<td>$1,415</td>
<td>$824</td>
</tr>
<tr>
<td>2000</td>
<td>$2,786</td>
<td>$1,957</td>
<td>$829</td>
</tr>
<tr>
<td>2001</td>
<td>$2,915</td>
<td>$2,081</td>
<td>$834</td>
</tr>
<tr>
<td>2002</td>
<td>$3,114</td>
<td>$2,251</td>
<td>$863</td>
</tr>
<tr>
<td>2003</td>
<td>$3,291</td>
<td>$2,400</td>
<td>$892</td>
</tr>
<tr>
<td>2004</td>
<td>$3,376</td>
<td>$2,476</td>
<td>$900</td>
</tr>
<tr>
<td>2005</td>
<td>$3,460</td>
<td>$2,547</td>
<td>$912</td>
</tr>
<tr>
<td>2006</td>
<td>$3,492</td>
<td>$2,586</td>
<td>$906</td>
</tr>
<tr>
<td>2007</td>
<td>$3,530</td>
<td>$2,603</td>
<td>$926</td>
</tr>
<tr>
<td>2008</td>
<td>$3,486</td>
<td>$2,573</td>
<td>$913</td>
</tr>
</tbody>
</table>

Centers for Medicare & Medicaid Services; data are inflation adjusted to 2008 dollars.
Typically, rural community residents pay little attention to their local health care system until it is needed. Consequently, many rural people have little idea of the overall importance of the health care sector to their community’s economy, such as the number of jobs it currently provides and its potential to provide more jobs. To ensure that health care services remain available locally, rural communities need to understand these economic relationships. First, rural communities need to learn about their own local health care needs and take stock of their local health care system. While the emphasis at the national level is on controlling costs and eliminating duplication and overcapacity in the system (de-licensing unused hospital beds, for example), the issues are very different in rural communities.

One of the issues that underlies differences between health care systems in rural and urban areas is demographics. In rural areas, there are proportionately more elderly, more children living in poverty, higher unemployment and lower incomes. Rural people report poorer health and have more chronic health conditions. Rural people are more likely to be uninsured and have fewer health services available in the town where they live. Finally, people in rural communities are more likely to derive part of their income from the health care industry (either directly or indirectly).

Another issue that underlies the differences between urban and rural health care is the structure of the systems. In general, there are fewer providers and hospitals in rural areas, and they operate on very thin profit margins. In fact, many rural hospitals operate at a loss, with too few patients to cover daily costs. Also, until recently, most rural health care systems had been locally operated and controlled.

Pressures outside of the health care system also come into play in rural communities, creating stresses not applicable to urban systems. Cyclical commodity prices cause a periodic farm financial crisis, undermining the financial viability of family farms and business, such as farm implement manufacturers and dealers. Businesses located in rural areas tend to be small, often do not provide health insurance, and are highly vulnerable to changing economic conditions. Although these stresses can lead to mental and physical health problems, many people do not seek help for their health problems. Some will say they have too little time to seek out health care services, especially if they are working two jobs to make ends meet. For others, the strong sense of pride and self-reliance inherent among rural people may preclude many from seeking care, especially if they cannot afford it.

What is the ultimate impact of these changes and stresses on rural communities? Will it be a net gain or net loss, or will it all balance out in the end?

On the positive side, urban-based specialists may set up periodic office hours in rural clinics, health centers and hospitals; an urgent care center may open; and air medivac helicopters and other emergency medical services may be strategically located in a rural community. These services, while provided by many urban health systems, are convenient for rural residents, and otherwise would not be available to rural communities.
On the negative side, ties with financially strong urban health care providers can be detrimental to rural providers if the rural providers lose decision-making ability. Rural providers may also find themselves aligned with an organization that does not share their mission and values, or the rural provider may be unable to meet the expectations of the larger provider.

Anecdotal evidence suggests that the downsides can be significant and potentially devastating for a rural community. In some instances, urban or other outside interests have purchased rural clinics and hospitals and then closed them because they did not provide sufficient profit. Employers have signed contracts with insurance plans that push patients to the city for their health care, bypassing local, more convenient services. Emergency medical service providers have changed their service areas or closed their doors. When urban health organizations encourage insured rural residents to spend their health care dollars in the city rather than to purchase equivalent services locally, it can have a significant negative economic impact and result in a loss of health dollars within the local community. In addition, out of town trips to obtain health care naturally offer opportunities to spend dollars out of town that may have been spent locally. These out-migrated dollars are missed opportunities and can significantly impact the local economic base.

Rural communities need to overcome inertia and take stock of local health care. Rural providers should be challenged to organize, whether through formal or informal mechanisms, so that they can compete with urban systems. In general, regional strategies will probably work better than local ones. Providers must be willing to take risks and coordinate services.

Well-positioned rural health systems can meet these challenges. Fragmentation is a big problem in health systems, but smaller, independent rural systems have more opportunity to create linkages. The scarce resources available to rural health services have engendered innovation and efficiencies as a matter of survival. Strong local leadership helps sustain these systems. Many rural health organizations are committed to fiscal accountability, expressed as quality health care at low cost. It should not be too difficult to remind rural residents of the long-term commitment these rural providers have made in the communities they serve. In time, rural providers need to offer sustainable health care services that best meet community need.

Success in meeting these challenges can be measured in terms of increased local services, more spending on locally-available health care, local control of health resources, negotiation of good reimbursement rates for providers, and high levels of community satisfaction with local health care.

If rural health providers do not act, they will face the prospect of losing jobs; rural communities could lose health care services; and everybody may lose local control of their health care.
**Health Services and Rural Development**

Though the connections between health care services and rural development are often overlooked, at least three primary areas of commonality exist. A strong health care system can help attract and maintain business and industry growth, attract and retain retirees, and also create jobs in the local area.

**Health Services and Community Industry**

Studies have found that quality of life factors play a dramatic role in business and industry location decisions. Health care services represent some of the most significant quality of life factors for at least three reasons. First, good health and education services are imperative to industrial and business leaders as they select a community for location. Employees and participating management may offer strong resistance if they are asked to move into a community with substandard or inconvenient health services. Secondly, when a business or industry makes a location decision, it wants to ensure that the local labor force will be productive, and a key productivity factor is good health. Thus, investments in health care services can be expected to yield dividends in the form of increased labor productivity. The third factor that business and industry consider in location decisions is cost of health care services. A 1990 site selection survey concluded that corporations looked carefully at health care costs, and sites that provided health care services at a low cost sometimes received priority. In fact, 17 percent of the respondents indicated that their companies used health care costs as a tie-breaking factor between comparable sites (Lyne, 1990).

**Health Services and Retirees**

A strong and convenient health care system is important to retirees, a special group of residents whose spending and purchasing can provide a significant source of income for the local economy. Many rural areas have environments (for example, moderate climate and outdoor activities) that enable them to attract and retain retirees. Retirees represent a substantial amount of spending, including the purchasing power associated with pensions, investments, Social Security, Medicare and other transfer payments. Additionally, middle and upper income retirees often have substantial net worth. Although the data are limited, several studies suggest health services may be a critical variable that influences the location decision of retirees. For example, one study found that four items were the best predictors of retirement locations: safety, recreational facilities, dwelling units, and health care. Another study found that nearly 60 percent of potential retirees said health services were in the “must have” category when considering a retirement community. Only protective services were mentioned more often than health services as a “must have” service.
Health Services and Job Growth

Job creation represents an important goal for most rural economic development programs. National employment in health care services increased 70 percent from 1990 to 2008. In rural areas, employment in health-related services often accounts for 10 to 15 percent of total employment. This reflects the fact that the hospital is often the second largest employer in a rural community (local government including schools typically being the largest employer).

Another important factor is the growth of the health sector. Health services, as a share of gross domestic product (GDP), has increased over time. In 1990, Americans spent $1.1 trillion on health care (2008$), which accounted for 12.3 percent of the GDP. In 2005, health care costs increased to $2.0 trillion, or 15.7 percent of the GDP. If current trends continue, projections indicate that Americans will spend 19.3 percent of GDP on health care by 2019. Capturing a share of this economic growth can only help a rural community.

Understanding Today’s Health Care Impacts and Tomorrow’s Health Care Needs

A strong health care system represents an important part of a community’s vitality and sustainability. Thus, a good understanding of the community’s health care system can help leaders and citizens fully appreciate the role and contributions of the health care system in maintaining community economic viability. In addition, a community should also examine the future health care needs of its residents in order to position itself so that it can respond to those needs. This report is designed to provide the kind of information that a community can use to understand its health care system and some possible indicators of current and future health care needs of its residents. The report begins with an examination of demographic, economic and health indicators and culminates with an illustration of the full economic impact of the health care sector in the county’s economy.
Sherman County Demographic Data

Table 2 presents population trends for Sherman County. In 2010, an estimated 6,007 people live in the county. Between 1990 and 2010, the population decreased 13.3 percent and also decreased 11.0 percent between 2000 and 2010. Population projections indicate that 5,998 people will live in the county by 2015. The state of Kansas population increased 8.5 percent between 1990 and 2000 and an additional 5.5 percent through 2010.

<table>
<thead>
<tr>
<th>Year</th>
<th>Count</th>
<th>Years</th>
<th>County</th>
<th>State</th>
<th>Year</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>6,929</td>
<td>1990-2000</td>
<td>-2.6</td>
<td>8.5</td>
<td>2015</td>
<td>5,998</td>
</tr>
<tr>
<td>2000</td>
<td>6,746</td>
<td>2000-2010</td>
<td>-11.0</td>
<td>5.5</td>
<td>2020</td>
<td>6,001</td>
</tr>
<tr>
<td>2010</td>
<td>6,007</td>
<td>1990-2010</td>
<td>-13.3</td>
<td>14.5</td>
<td>2025</td>
<td>6,010</td>
</tr>
</tbody>
</table>

U.S. Census Bureau; population projections from Woods and Poole Economics, Inc.

Figure 1. Population by Age and Gender

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Population Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero to 9</td>
<td>600</td>
</tr>
<tr>
<td>10-19</td>
<td>500</td>
</tr>
<tr>
<td>20-24</td>
<td>400</td>
</tr>
<tr>
<td>25-34</td>
<td>300</td>
</tr>
<tr>
<td>35-44</td>
<td>200</td>
</tr>
<tr>
<td>45-54</td>
<td>200</td>
</tr>
<tr>
<td>55-59</td>
<td>200</td>
</tr>
<tr>
<td>60-64</td>
<td>200</td>
</tr>
<tr>
<td>65-74</td>
<td>200</td>
</tr>
<tr>
<td>75-84</td>
<td>200</td>
</tr>
<tr>
<td>85 and older</td>
<td>200</td>
</tr>
</tbody>
</table>

U.S. Census Bureau

Figure 1 shows a breakdown of the population by age and by gender. Here, people aged 19 and younger made up the largest portion of the population, with 27.2 percent. People aged 65 and older represented 18.7 percent of the population. Of those 65 and older, 41.5 percent were male and 58.5 percent were female. Age range can indicate the future health care needs of a county’s population. A growing population of older adults has a different set of health care needs than a population with more young people.
Race can also play a role in assessing the health needs of the community. In the case of Hispanic immigrants, lack of English speaking skills may prevent them from using health care services within the county or from using health care services at all. Figure 2 shows the racial and ethnic composition of the county. Whites made up 88.9 percent of the county’s population, while Native Americans represented 0.3 percent, African Americans made up 0.5 percent, Asians were 0.3 percent and Hispanics were 10.0 percent of the population. In Kansas, whites make up 80.5 percent of the population, Native Americans represent one percent, African Americans 6.3 percent, Asians 2.5 percent and Hispanics 9.6 percent.

**Figure 2. Population by Race (2010)**

Woods and Poole Economics, Inc. Native American includes American Indians and Alaska Natives; Asian or Pacific Islander includes Asian Americans, Native Hawaiians, Pacific Islanders; Hispanic population is persons of Hispanic origin regardless of race.

**Economic Indicators**

An important question for health care providers is how people will pay for services. In rural areas, the likelihood of poverty, lack of insurance and chronic health conditions increases. Additionally, rural areas tend to have higher numbers of elderly, for whom supplemental income becomes a proportionally larger source of income. Such supplemental income comes in the form of transfer payments such as Social Security and other retirement benefits, disability, medical payments like Medicare and Medicaid, unemployment insurance, and veterans’ benefits. The elderly, major consumers of health care services, receive much of this income, and a large portion of this assistance is available only to those who make the effort to apply. In order to maximize the income resources available in the county, one strategy is to ensure that every person receives all of the financial assistance from broader levels of government for which they are eligible.
Figure 3. Total Per Capita Personal Income (2008$)

Bureau of Economic Analysis; data are inflation adjusted to 2008 dollars.

Figure 3 shows the change in total per capita personal income, adjusted for inflation from 2005 through 2008. Per capita personal income has increased in Kansas and the United States. In Sherman County, personal income has increased from $31,960 in 2005 to $40,917 in 2008.

Figure 4. Transfer Income as a Percent of Total Income (2008$)

Bureau of Economic Analysis; data are inflation adjusted to 2008.

Figure 4 shows how the relative proportion of transfer income to total income has changed during the same four years. In the U.S., transfer payments have increased as a percentage of total income by 6.6 percent, while transfer payments in Kansas have increased by 2.5 percent. In the county, the proportion of income stemming from transfer payments has decreased from 22.9 percent in 2005 to 19.3 in 2008.
Table 3 shows personal income data by source for Sherman County, Kansas and the nation. Within the county, 44.6 percent of all earnings come from wages and salaries, compared to 69.4 percent in Kansas and 71.6 percent for the entire United States. Retirement and disability make up 35.9 percent of transfer payments in the county, with another 50.4 percent coming from medical payments. In Kansas, 39.0 percent of all transfers come from retirement and disability, while medical payments represent 42.2 percent. For the U.S., medical payments make up the largest portion of transfers at 44.0 percent.

Table 3. 2008 Personal Income Data

<table>
<thead>
<tr>
<th>Source</th>
<th>County Total</th>
<th>County Per Capita</th>
<th>County Percent</th>
<th>State Percent</th>
<th>U.S. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Earnings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wages and Salaries</td>
<td>$77,481,000</td>
<td>$12,886</td>
<td>44.6</td>
<td>69.4</td>
<td>71.6</td>
</tr>
<tr>
<td>Other Labor Income</td>
<td>$19,312,000</td>
<td>$3,212</td>
<td>11.1</td>
<td>17.0</td>
<td>16.3</td>
</tr>
<tr>
<td>Proprietor’s Income</td>
<td>$77,032,000</td>
<td>$12,811</td>
<td>44.3</td>
<td>13.6</td>
<td>12.1</td>
</tr>
<tr>
<td>Total Earnings</td>
<td>$173,825,000</td>
<td>$28,908</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Transfer Payments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement and Disability</td>
<td>$17,091,000</td>
<td>$2,842</td>
<td>35.9</td>
<td>39.0</td>
<td>34.2</td>
</tr>
<tr>
<td>Medical Payments</td>
<td>$23,969,000</td>
<td>$3,986</td>
<td>50.4</td>
<td>42.2</td>
<td>44.0</td>
</tr>
<tr>
<td>Other</td>
<td>$6,542,000</td>
<td>$1,088</td>
<td>13.7</td>
<td>18.7</td>
<td>21.9</td>
</tr>
<tr>
<td>Total Transfer Payments</td>
<td>$47,602,000</td>
<td>$7,917</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Personal Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Earnings by Place of Residence</td>
<td>$163,508,000</td>
<td>$27,192</td>
<td>67.8</td>
<td>68.8</td>
<td>66.6</td>
</tr>
<tr>
<td>Dividends, Interest, and Rent</td>
<td>$29,930,000</td>
<td>$4,978</td>
<td>12.4</td>
<td>17.0</td>
<td>18.0</td>
</tr>
<tr>
<td>Transfer Payments</td>
<td>$47,602,000</td>
<td>$7,917</td>
<td>19.7</td>
<td>14.3</td>
<td>15.3</td>
</tr>
<tr>
<td>Total Personal Income</td>
<td>$241,040,000</td>
<td>$40,086</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Bureau of Economic Analysis
Per capita estimates based on 2009 Woods and Poole Economics, Inc. estimates.
Due to rounding error, numbers may not sum to match total.
Health Indicators and Health Sector Statistics

The following health indicators and statistics provide information from which communities may infer several things about local health care needs. While some items provide an indication of need by type of service, other items suggest the amount and source of resources available to pay for health services. Health care planners can use this information to arrange for necessary services and anticipate the administrative requirements needed to support such services.

<table>
<thead>
<tr>
<th>Table 4. Health Services, Medicare, and Medicaid Funded Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitals (2009)</strong></td>
</tr>
<tr>
<td>Number(^1)</td>
</tr>
<tr>
<td>Number of beds(^1)</td>
</tr>
<tr>
<td>Admissions per bed(^1)</td>
</tr>
<tr>
<td><strong>Adult Care Homes (2009)</strong></td>
</tr>
<tr>
<td>Number of beds(^2)</td>
</tr>
<tr>
<td><strong>Assisted Living Facilities (2009)</strong></td>
</tr>
<tr>
<td>Number of beds(^2)</td>
</tr>
<tr>
<td><strong>Medicare (2007)</strong></td>
</tr>
<tr>
<td><strong>Medicaid Funded Programs</strong></td>
</tr>
<tr>
<td>Temporary Assistance for Families (FY 2009)(^4)</td>
</tr>
</tbody>
</table>

Kansas Hospital Association; Kansas Department on Aging; Kansas Department of Social and Rehabilitative Services; Center for Medicare and Medicaid Services

\(^1\)Rate per 1,000 population.

\(^2\)Number of beds per 1,000 people 65 years and older.

\(^3\)Annual average number of original Medicare eligibles—individuals who are either currently or formerly entitled or enrolled in either part A or part B original Medicare.

\(^4\)Percent of total 2007 estimated population.

Table 4 shows the availability of certain types of health services in Sherman County as well as usage of some health care-related government programs. The county has 25 available hospital beds, with a rate of 3.7 admissions per bed per 1,000 people. Additionally, the county has 60 adult care home beds, or 54.7 beds per 1,000 older adults, and 50 assisted living beds, or 45.6 beds per 1,000 older adults. Medicare users make up 21.5 percent of the county’s total population and 8.9 percent of the county’s population receive food stamp benefits.
Table 5. Maternity and Children’s Health Statistics

<table>
<thead>
<tr>
<th></th>
<th>County Number</th>
<th>County Percent/Rate</th>
<th>State Percent/Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty (2008)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Persons in Poverty¹</td>
<td>825</td>
<td>13.9</td>
<td>11.3</td>
</tr>
<tr>
<td>Children in Poverty²</td>
<td>267</td>
<td>21.5</td>
<td>14.6</td>
</tr>
<tr>
<td>Total Births³ (2008)</td>
<td>86</td>
<td>14.3</td>
<td>14.9</td>
</tr>
<tr>
<td>Births to Mothers without High-School Diploma⁴ (2007)</td>
<td>N/A</td>
<td>17.2</td>
<td>18.2</td>
</tr>
<tr>
<td>Births with Adequate Prenatal Care³ (2008)</td>
<td>62</td>
<td>77.6</td>
<td>77.6</td>
</tr>
<tr>
<td>Low Weight Births⁵ (2007)</td>
<td>N/A</td>
<td>14.9</td>
<td>7.1</td>
</tr>
<tr>
<td>Immunization⁶ (2007)</td>
<td>N/A</td>
<td>67.0</td>
<td>58.0</td>
</tr>
<tr>
<td>Infant Mortality⁷ (2008)</td>
<td>0</td>
<td>7.8</td>
<td>7.4</td>
</tr>
<tr>
<td>Child Deaths⁸ (2008)</td>
<td>0</td>
<td>0.0</td>
<td>1.7</td>
</tr>
<tr>
<td>Child Care Subsidies⁹ (2008)</td>
<td>26</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

U.S. Census Bureau; 2008 Kansas Kids Count Data Book, Kansas Department of Health and Environment

¹Percent of total population.
²Percent of children younger than 18 years in families below poverty level.
³Percent of live births to all mothers who received adequate or better prenatal care.
⁴Rate of live births per thousand females.
⁵Percent of live births in a calendar year.
⁶Percent of total kindergarteners who received all immunizations by age two.
⁷Number of infant deaths younger than one year per thousand live births.
⁸Number of deaths from all causes per 100,000 children ages 1-14.
⁹Average monthly number of children participating in the Kansas Child Care Assistance program.

Table 5 gives information which can indicate the situation for young children and mothers. Within the county, 21.5 percent of children live in poverty, while 14.6 percent of children statewide live in poverty. Births to school age mothers occurred at a rate of 17.2 births per thousand teenage females, while school age mothers gave birth at a rate of 18.2 births per thousand teens statewide. Low weight births occurred in 14.9 percent of all live births in the county, while statewide low weight births occurred in 7.1 percent of all live births.
The Economic Impact of the Health Care Sector
An Overview of the Sherman County Economy, Highlighting Health Care

Table 6 presents employment, income and sales data for Sherman County for 2008. Health care income and sales data were estimated using state average data. Data for all other economic sectors come from various government statistics and published data sources.

The table aggregates the economic sectors into broad categories, and the employment numbers indicate “average” jobs in each sector, including full- and part-time employment. Labor income represents local wages and proprietary income. Total income is the broadest measure of income generated within the local economy, and includes labor income plus dividend, interest, rents, corporate profits, etc.

Table 6. Direct Employment, Income and Sales by Economic Sector and Health Services Relative Shares Compared to the State and U.S., 2008 ($thousands)

<table>
<thead>
<tr>
<th>Sector</th>
<th>Employment</th>
<th>Labor Income</th>
<th>Total Income</th>
<th>Total Sales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>616</td>
<td>$9,639</td>
<td>$87,721</td>
<td>$194,940</td>
</tr>
<tr>
<td>Mining</td>
<td>8</td>
<td>$521</td>
<td>$1,383</td>
<td>$2,685</td>
</tr>
<tr>
<td>Construction</td>
<td>120</td>
<td>$3,366</td>
<td>$3,674</td>
<td>$12,734</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>185</td>
<td>$6,528</td>
<td>$8,166</td>
<td>$76,762</td>
</tr>
<tr>
<td>Transportation, Information, Public Utilities</td>
<td>145</td>
<td>$7,367</td>
<td>$13,690</td>
<td>$21,321</td>
</tr>
<tr>
<td>Trade</td>
<td>732</td>
<td>$23,574</td>
<td>$38,270</td>
<td>$58,928</td>
</tr>
<tr>
<td>Services</td>
<td>1,925</td>
<td>$51,505</td>
<td>$92,939</td>
<td>$160,491</td>
</tr>
<tr>
<td>Health Services(^1)</td>
<td>389</td>
<td>$13,826</td>
<td>$20,337</td>
<td>$31,478</td>
</tr>
<tr>
<td>Health and Personal Care Stores</td>
<td>12</td>
<td>$344</td>
<td>$537</td>
<td>$738</td>
</tr>
<tr>
<td>Veterinary Services</td>
<td>2</td>
<td>$34</td>
<td>$38</td>
<td>$108</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>5</td>
<td>$93</td>
<td>$119</td>
<td>$163</td>
</tr>
<tr>
<td>Doctors and Dentists</td>
<td>27</td>
<td>$891</td>
<td>$1,034</td>
<td>$1,753</td>
</tr>
<tr>
<td>Other Ambulatory Health Care</td>
<td>4</td>
<td>$123</td>
<td>$217</td>
<td>$359</td>
</tr>
<tr>
<td>Hospitals</td>
<td>151</td>
<td>$7,757</td>
<td>$13,637</td>
<td>$21,651</td>
</tr>
<tr>
<td>Nursing/Residential Care Facilities</td>
<td>186</td>
<td>$4,582</td>
<td>$4,754</td>
<td>$6,706</td>
</tr>
<tr>
<td>Government</td>
<td>727</td>
<td>$30,023</td>
<td>$34,397</td>
<td>$37,550</td>
</tr>
<tr>
<td>Total</td>
<td>4,457</td>
<td>$132,524</td>
<td>$280,239</td>
<td>$565,412</td>
</tr>
</tbody>
</table>

Health Services as a Percent of Total

<table>
<thead>
<tr>
<th></th>
<th>County</th>
<th>State</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
<td>8.7</td>
<td>8.7</td>
<td>8.1</td>
</tr>
<tr>
<td>State</td>
<td>10.4</td>
<td>8.1</td>
<td>8.4</td>
</tr>
<tr>
<td>Nation</td>
<td>7.3</td>
<td>6.0</td>
<td>6.4</td>
</tr>
</tbody>
</table>

\(^{1}\)In some Kansas counties, various health services are consolidated within a single entity in the classification system shown here. In such cases, it may not be possible to break apart employment, income or sales information. If you have questions regarding the organization of health care services in your county, contact your local hospital administrator.

Minnesota IMPLAN Group; Due to rounding error, numbers may not sum to match total.

\(^{1}\)In some Kansas counties, various health services are consolidated within a single entity in the classification system shown here. In such cases, it may not be possible to break apart employment, income or sales information. If you have questions regarding the organization of health care services in your county, contact your local hospital administrator.
Health services are separated from the service and retail trade sectors but not double counted in the totals. The numbers for each sector include not only the professionals in the sector (the doctors, dentists, etc.) but also support staff (assistants, clerks, receptionists, etc.) employed by the business. In the health sector, the Health and Personal Care stores category includes pharmacies, while the Doctors and Dentists category includes chiropractors, optometrists, and other health care practitioners. Other Ambulatory Health Care Services includes services such as medical and diagnostic labs and outpatient care centers.

Health Services employs 389 people, 8.7 percent of all job holders in the county. Health Services for the state of Kansas employs 8.7 percent of all job holders, while 8.1 percent of all job holders in the United States work in Health Services. Health Services in the county has a number 5 ranking in terms of employment (Figure 5). Health Services is number 4 among payers of wages to employees (Figure 6) and number 5 in terms of total income (Figure 7). As with most rural areas, the health sector plays an important role in the economy.

**Figure 5. Employment by Sector (2008)**

- Agriculture: 14%
- Mining: 0%
- Construction: 3%
- Manufacturing: 4%
- TIPU: 3%
- Trade: 16%
- Services: 34%
- Government: 16%
- Health Services: 9%
Figure 6. Labor Income by Sector (2008)

Agriculture 7%
Mining 0%
Construction 3%
Manufacturing 5%
TIPU 6%
Trade 18%
Services 28%
Government 23%
Health Services 10%

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Figure 7. Total Income by Sector (2008)

Agriculture 31%
Mining 0%
Construction 1%
Manufacturing 3%
TIPU 5%
Trade 14%
Services 26%
Government 12%
Health Services 7%

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Health Sector Impact and Economic Multipliers

The previous section detailed the direct contributions of the Health Services sector within the Sherman County economy, but the full impact of the sector goes beyond the number of people employed and the wages they receive. The employment and income levels in the health sector have a significant impact on employment and income throughout other industries in the market area. This secondary impact or “ripple effect” comes from local businesses buying and selling to each other and from area workers spending their income for household goods and services; the ripple effect spreads the economic impact of the health sector throughout the community economy.

As dollars are spent locally, they are, in turn, re-spent for other goods and services. Some of these goods are produced locally while others are imports (the portion of the dollar spent on imports leaves the community as leakage). This spending and re-spending occurs over multiple rounds until it is finally exhausted.

Graphically, we can illustrate the round-by-round relationships modeled as shown in Figure 8. The direct effect of spending is shown in the far left-hand side of the figure (the first bar (a)). For simplification, the direct effects of a $1.00 change in the level of spending plus the indirect effects spillover into other sectors and create an additional 66 cents of activity. In this example, the multiplier is 1.66. A variety of multipliers can be calculated using these analysis techniques.

Figure 8. Multipliers and the round-by-round impacts

![Figure 8. Multipliers and the round-by-round impacts](image)
Tables 7 and 8 illustrate the ripple effect in the county. As an example, Table 7 shows that the hospital sector employs 151 people and has an employment multiplier of 1.27. This means that for each job created in the hospital sector, another 0.27 jobs are created in other businesses and industries in the county’s economy. The direct impact of the 151 hospital employees results in an indirect impact of 41 jobs (151 x 0.27 = 41) throughout all businesses and industries in the market area. Thus, the hospital sector employment had a total impact on area employment of 192 jobs (151 x 1.27 = 192).

Table 7. Health Sector Impact on Employment, 2008

<table>
<thead>
<tr>
<th>Health Sectors</th>
<th>Direct Employment</th>
<th>Economic Multiplier</th>
<th>Total Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Personal Care Stores</td>
<td>12</td>
<td>1.14</td>
<td>14</td>
</tr>
<tr>
<td>Veterinary Services</td>
<td>2</td>
<td>1.15</td>
<td>2</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>5</td>
<td>1.09</td>
<td>5</td>
</tr>
<tr>
<td>Doctors and Dentists</td>
<td>27</td>
<td>1.17</td>
<td>32</td>
</tr>
<tr>
<td>Other Ambulatory Health Care</td>
<td>4</td>
<td>1.17</td>
<td>5</td>
</tr>
<tr>
<td>Hospitals</td>
<td>151</td>
<td>1.27</td>
<td>192</td>
</tr>
<tr>
<td>Nursing and Residential Care Facilities</td>
<td>186</td>
<td>1.12</td>
<td>209</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>389</strong></td>
<td><strong>1.12</strong></td>
<td><strong>461</strong></td>
</tr>
</tbody>
</table>

Note: Most data obtained from secondary sources; some data unavailable or extrapolated. Minnesota IMPLAN Group

Similarly, multiplier analysis can estimate the total impact of the estimated $13,637,000 direct income for hospital employees shown in Table 8. The hospital sector had an income multiplier of 1.15, which indicates that for every one dollar of income generated in the hospital sector, another $0.15 is generated in other businesses and industries in the county’s economy. Thus, the hospital sector had an estimated total impact on income throughout all businesses and industries of $15,659,000 ($13,637,000 x 1.15 = $15,659,000).

Table 8. Health Sector Impact on Income and Retail Sales, 2008 ($thousands)

<table>
<thead>
<tr>
<th>Health Sectors</th>
<th>Direct Income</th>
<th>Economic Multiplier</th>
<th>Total Impact</th>
<th>Retail Sales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Personal Care Stores</td>
<td>$537</td>
<td>1.14</td>
<td>$611</td>
<td>$245</td>
</tr>
<tr>
<td>Veterinary Services</td>
<td>$38</td>
<td>1.22</td>
<td>$46</td>
<td>$19</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>$119</td>
<td>1.12</td>
<td>$133</td>
<td>$53</td>
</tr>
<tr>
<td>Doctors and Dentists</td>
<td>$1,034</td>
<td>1.15</td>
<td>$1,185</td>
<td>$476</td>
</tr>
<tr>
<td>Other Ambulatory Health Care</td>
<td>$217</td>
<td>1.18</td>
<td>$256</td>
<td>$103</td>
</tr>
<tr>
<td>Hospitals</td>
<td>$13,637</td>
<td>1.15</td>
<td>$15,659</td>
<td>$6,290</td>
</tr>
<tr>
<td>Nursing/Residential Care Facilities</td>
<td>$4,754</td>
<td>1.14</td>
<td>$5,396</td>
<td>$2,167</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$20,337</strong></td>
<td><strong>$23,285</strong></td>
<td><strong>$9,353</strong></td>
<td></td>
</tr>
</tbody>
</table>

Note: Most data obtained from secondary sources; some data unavailable or extrapolated.
Minnesota IMPLAN Group
In this manner, the total employment and income impacts of all the health services sectors can be estimated. In Table 7, the total employment impact of the health services sector results in an estimated 461 jobs in the local economy. In Table 8, the total income impact of health services results in an estimated $23,285,000 for the economy.

The last column in Table 8 shows the retail sales that the health sector helps to generate. To estimate this, this study incorporates a retail sales capture ratio (retail sales to total personal income). Sherman County had retail sales of $96,817,790 and $241,040,000 in total personal income. Thus, the estimated retail sales capture ratio equals 40.2 percent. Using this as the retail sales capture ratio for the county, this says that people spent 40.2 percent of their income on retail goods and services within the market. By taking all the household income associated with health sector activities and multiplying by the retail sales capture ratio, we can estimate the impacts of the health sector on area retail sales. Thus, the total retail sales generated by the retail sector equals $9,353,000 ($23,285,000 x 40.2% = $9,353,000). This is a conservative estimate, as this method does not consider the impact of any local purchases made by the health services businesses.
Summary and Conclusions

The Health Services sector of Sherman County, Kansas, plays a large role in the area’s economy. Health Services represents one of the largest employers in the area and also serves as one of the largest contributors to income. Additionally, the health sector has indirect impacts on the local economy, creating additional jobs and income in other sectors. The health sector also contributes substantially to retail sales in the region. All of this demonstrates the importance of the health care sector to the local economy.

While the estimates of economic impact are themselves substantial, they are only a partial accounting of the benefits to the county. Health care industries in rural counties help to preserve the population base, invigorating the communities and school systems. Similarly, many hospitals and nursing care facilities have active community outreach programs that enhance community services and the quality of life for community residents.

A vigorous and sustainable health care system is essential not only for the health and welfare of community residents, but to enhance economic opportunity as well. Health-related sectors are among the fastest growing in economy. Given demographic trends, this growth is likely to continue. The attraction and retention of new business and retirees also depends on access to adequate health care services.

While industry trends related to health care are positive overall, many rural communities have significant challenges. The economics of health care are rapidly changing. As health care costs escalate and government funding becomes tighter, rural markets may become less attractive to many providers. This will lead to the continued restructuring of rural health care services in many areas.

If a community wants to maintain the benefits associated with accessible and affordable health care, it must actively work to meet these challenges. The challenges cannot be met by those directly responsible for health care administration alone. They require a community-wide response involving government, business and civic leaders, and they frequently incorporate outside assistance from professional resources providers, such as the Kansas Hospital Association, the Office of Local and Rural Health, the Kansas Department of Health and Environment, and others.

In meeting current and future challenges, health care and community leaders can engage in an ongoing process of strategic health planning. This is continuous effort to maintain and enhance the community’s health care situation. The strategic health planning process helps local communities identify their health care needs; examine the social, economic, and political realities affecting the local delivery of health care; determine what is wanted and what realistically can be achieved to meet their identified health care needs; and develop and mobilize an action plan based on their analysis and planning.
Strategic health planning involves cooperation among people and organizations to pursue common goals. The process is designed to answer three questions:

1. Where is the community now?
2. Where does the community want to go?
3. How will the community get there?

For the strategic health planning process to be most effective, it must be based in the community and driven by the community. Local residents and their leaders must participate; a current knowledge of the health care industry is not necessary. This process is about local people solving local problems. The local hospital and health care providers should have input into the decision-making and should support and trust the outcomes, but, the community must provide the energy and commitment.
Selected References


Glossary of Terms

**Doctors and Dentists Sector**: includes physicians, dentists, chiropractors, optometrists, other health care professionals, and all support staff employed by these professionals.

**Employment**: annual average number of full and part-time jobs, including self-employed for a given economic sector.

**Employment Economic Multiplier**: indicates the total jobs in the economy closely tied, in this case, to one job in the health sector.

**Employee Compensation**: total payroll (wages, salaries and certain benefits) paid by local employers.

**Government Sector**: includes all federal, state and local government enterprises; federal, state and local electric utilities; state and local government passenger transit; state and local government education and non-education; and federal military and non-military.

**Gross Domestic Product (GDP)**: the total value of output of goods and services produced by labor and capital investment in the United States.

**Health and Personal Care Stores**: pharmacies.

**Income Economic Multiplier**: indicates total income generated in the economy due to one dollar of income, in this case, in the health sector.

**Indirect Business Taxes**: sales, excise fees, licenses and other taxes paid during normal operation. All payments to the government except for income taxes.

**Multipliers**: Its calculation is based on the structure of the local economy. All of the buying and selling relationships between businesses and consumers are charted in an economic transactions table. When a dollar is spent in one area of the economy, all of the economic interconnections are stimulated as the effect “ripples” to other areas of the economy. The effect is caused by businesses buying and selling goods or services to each other and by local labor who use their income to purchase household goods and services. Over successive rounds of spending and re-spending, the effect of the original dollar is multiplied to some new, larger level of activity. Eventually, the economic “leakages” associated with the purchase of imported goods and non-local taxes and investments causes the ripple effect to finally run out. Multipliers are derived through algebraic calculations of the economic transactions table of the local economy.

**Other Ambulatory Health Care Services**: medical and diagnostic labs and other outpatient care services and all of their employees.

**Other Property Income**: corporate income, rental income, interest and corporate transfer payments.
**Proprietor Income**: income from self-employment (farmers and business proprietors, for example).

**Personal Income**: income received by individuals from all sources (employment, Social Security, et cetera).

**Total Income**: employee compensation plus proprietor income plus other property income plus indirect business taxes.

**Total Sales**: total industry production for a given year (industry output).
Demographic, Economic and Health Indicator Data

Introduction

Kansas Rural Health Works (KRHW) is dedicated to helping rural communities build affordable and sustainable local health care systems. The Office of Local Government at K-State Research and Extension is supporting Community Health Needs Assessments. These needs assessments bring a broad-based group of community leaders together to assess local needs, establish priorities, and develop strategic action plans to improve the local health situation. This is an opportunity for the community to rally together to address high-priority local needs and to make the community a better place to live, work, and raise a family. No one can do it for us unless we do it ourselves. The resources presented here support that process. The opportunity is now.

Background Data Summary

Following are a variety of data and statistics about background demographic, economic and health conditions in Sherman County that may have implications related to local health care needs. Most of the data only is available at a county scale and reflects the Sherman County boundaries.

- Between 1990 and 2010, the population decreased 13.3 percent in Sherman County, and is projected to be 5,998 by 2015.

- People aged 35-54 years made up the largest portion of the population, with 24.2 percent. Of those 35-54 years, 49.6 percent were male and 50.4 percent were female.

- In Sherman County, personal income has increased from $31,960 in 2005 to $40,917 in 2008.

- Within the county, 44.6 percent of all earnings come from wages and salaries, while retirement and disability make up 35.9 percent of transfer payments in the county, with another 50.4 percent coming from medical payments.

- Within the county, 21.5 percent of children live in poverty, while 14.6 percent of children statewide live in poverty.
Table 1 presents population trends for Sherman County. In 2010, an estimated 6,007 people live in the county. Between 1990 and 2010, the population decreased 13.3 percent and also decreased 11.0 percent between 2000 and 2010. Population projections indicate that 5,998 people will live in the county by 2015. The state of Kansas population increased 8.5 percent between 1990 and 2000 and an additional 5.5 percent through 2010.

Table 1. Current Population, Population Change and Projections

<table>
<thead>
<tr>
<th>Year</th>
<th>Count</th>
<th>Years</th>
<th>County</th>
<th>State</th>
<th>Year</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>6,929</td>
<td>1990-2000</td>
<td>-2.6</td>
<td>8.5</td>
<td>2015</td>
<td>5,998</td>
</tr>
<tr>
<td>2000</td>
<td>6,746</td>
<td>2000-2010</td>
<td>-11.0</td>
<td>5.5</td>
<td>2020</td>
<td>6,001</td>
</tr>
<tr>
<td>2010</td>
<td>6,007</td>
<td>1990-2010</td>
<td>-13.3</td>
<td>14.5</td>
<td>2025</td>
<td>6,010</td>
</tr>
</tbody>
</table>

U.S. Census Bureau; population projections from Woods & Poole Economics, Inc.

Figure 1 shows a breakdown of the population by age and by gender. Here, people aged 35-54 years made up the largest portion of the population, with 24.2 percent. Of those 35-54 years, 49.6 percent were male and 50.4 percent were female. Age range can indicate the future health care needs of a county’s population. A growing population of older adults has a different set of health care needs than a population with more young people.
Sherman County Rural Health Works

Race can also play a role in assessing the health needs of the community. In the case of Hispanic immigrants, lack of English speaking skills may prevent them from using health care services within the county or from using health care services at all. Figure 2 shows the racial and ethnic composition of the county. Whites made up 88.9 percent of the county’s population, while Native Americans represented 0.3 percent, African Americans made up 0.5 percent, Asians were 0.3 percent and Hispanics were 10.0 percent of the population. In Kansas, whites make up 80.5 percent of the population, Native Americans represent one percent, African Americans 6.3 percent, Asians 2.5 percent and Hispanics 9.6 percent.

Economic Indicators

An important question for health care providers is how people will pay for services. In rural areas, the likelihood of poverty, lack of insurance and chronic health conditions increases. Additionally, rural areas tend to have higher numbers of elderly, for whom supplemental income becomes a proportionally larger source of income. Such supplemental income comes in the form of transfer payments such as Social Security and other retirement benefits, disability, medical payments like Medicare and Medicaid, unemployment insurance, and veterans’ benefits. The elderly, major consumers of health care services, receive much of this income, and a large portion of this assistance is available only to those who make the effort to apply. In order to maximize the income resources available in the county, one strategy is to ensure that every person receives all of the financial assistance from broader levels of government for which they are eligible.
Figure 3 shows the change in total per capita personal income, adjusted for inflation from 2005 through 2008. Per capita personal income has increased in Kansas and the United States. In Sherman County, personal income has increased from $31,960 in 2005 to $40,917 in 2008.

Figure 4. Transfer Income as a Percent of Total Income (2008 $)

Bureau of Economic Analysis; data are inflation adjusted to 2008 dollars.
Figure 4 shows how the relative proportion of transfer income to total income has changed during the same four years. In the U.S., transfer payments have increased as a percentage of total income by 6.6 percent, while transfer payments in Kansas have increased by 2.5 percent. In the county, the proportion of income stemming from transfer payments has decreased from 22.9 percent in 2005 to 19.3 in 2008.

Table 2 shows personal income data by source for Sherman County, Kansas and the nation. Within the county, 44.6 percent of all earnings come from wages and salaries, compared to 69.4 percent in Kansas and 71.6 percent for the entire United States. Retirement and disability make up 35.9 percent of transfer payments in the county, with another 50.4 percent coming from medical payments. In Kansas, 39.0 percent of all transfers come from retirement and disability, while medical payments represent 42.2 percent. For the U.S., medical payments make up the largest portion of transfers at 44.0 percent.

Table 2. 2008 Personal Income Data

<table>
<thead>
<tr>
<th>Source</th>
<th>County Total</th>
<th>County Per Capita</th>
<th>County Percent</th>
<th>State Percent</th>
<th>U.S. Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Earnings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wages and Salaries</td>
<td>$77,481,000</td>
<td>$12,886</td>
<td>44.6</td>
<td>69.4</td>
<td>71.6</td>
</tr>
<tr>
<td>Other Labor Income</td>
<td>$19,312,000</td>
<td>$3,212</td>
<td>11.1</td>
<td>17.0</td>
<td>16.3</td>
</tr>
<tr>
<td>Proprietor’s Income</td>
<td>$77,032,000</td>
<td>$12,811</td>
<td>44.3</td>
<td>13.6</td>
<td>12.1</td>
</tr>
<tr>
<td>Total Earnings</td>
<td>$173,825,000</td>
<td>$28,908</td>
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<td>100.0</td>
<td>100.0</td>
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<tr>
<td><strong>Transfer Payments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement and Disability</td>
<td>$17,091,000</td>
<td>$2,842</td>
<td>35.9</td>
<td>39.0</td>
<td>34.2</td>
</tr>
<tr>
<td>Medical Payments</td>
<td>$23,969,000</td>
<td>$3,986</td>
<td>50.4</td>
<td>42.2</td>
<td>44.0</td>
</tr>
<tr>
<td>Other</td>
<td>$6,542,000</td>
<td>$1,088</td>
<td>13.7</td>
<td>18.7</td>
<td>21.9</td>
</tr>
<tr>
<td>Total Transfer Payments</td>
<td>$47,602,000</td>
<td>$7,917</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Personal Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Earnings by Place of Residence</td>
<td>$163,508,000</td>
<td>$27,192</td>
<td>67.8</td>
<td>68.8</td>
<td>66.6</td>
</tr>
<tr>
<td>Dividends, Interest, and Rent</td>
<td>$29,930,000</td>
<td>$4,978</td>
<td>12.4</td>
<td>17.0</td>
<td>18.0</td>
</tr>
<tr>
<td>Transfer Payments</td>
<td>$47,602,000</td>
<td>$7,917</td>
<td>19.7</td>
<td>14.3</td>
<td>15.3</td>
</tr>
<tr>
<td>Total Personal Income</td>
<td>$241,040,000</td>
<td>$40,086</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Bureau of Economic Analysis

Per capita estimates based on 2009 Woods and Poole Economics, Inc. estimates.

Due to rounding error, numbers may not sum to match total.
Sherman County Rural Health Works

Health Indicators and Health Sector Statistics

The following health indicators and statistics provide information from which communities may infer several things about local health care needs. While some items provide an indication of need by type of service, other items suggest the amount and source of resources available to pay for health services. Health care planners can use this information to arrange for necessary services and anticipate the administrative requirements needed to support such services.

Table 3. Health Services, Medicare, and Medicaid Funded Programs

<table>
<thead>
<tr>
<th></th>
<th>County Number</th>
<th>County Percent/Rate</th>
<th>State Percent/Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals (2009)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>1</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>Number of beds</td>
<td>25</td>
<td>4.3</td>
<td>4.1</td>
</tr>
<tr>
<td>Admissions per bed</td>
<td>21</td>
<td>3.7</td>
<td>0.01</td>
</tr>
<tr>
<td>Adult Care Homes (2009)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>1</td>
<td>0.9</td>
<td>0.8</td>
</tr>
<tr>
<td>Number of beds</td>
<td>60</td>
<td>54.7</td>
<td>56.2</td>
</tr>
<tr>
<td>Assisted Living Facilities (2009)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>1</td>
<td>0.9</td>
<td>0.7</td>
</tr>
<tr>
<td>Number of beds</td>
<td>50</td>
<td>45.6</td>
<td>29.6</td>
</tr>
<tr>
<td>Medicare (2007)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligibles</td>
<td>1,287</td>
<td>21.5</td>
<td>14.8</td>
</tr>
<tr>
<td>Medicaid Funded Programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Stamp Beneficiaries (2009)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>524</td>
<td>8.9</td>
<td>7.4</td>
</tr>
<tr>
<td>Temporary Assistance for Families (FY 2009)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>88</td>
<td>1.5</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Kansas Hospital Association; Kansas Department on Aging; Kansas Department of Social and Rehabilitative Services; Center for Medicare and Medicaid Services

1Rate per 1,000 population.
2Number of beds per 1,000 people 65 years and older.
3Annual average number of original Medicare eligibles—individuals who are either currently or formerly entitled or enrolled in either part A or part B original Medicare.
4Percent of total 2007 estimated population.

Table 3 shows the availability of certain types of health services in Sherman County as well as usage of some health care-related government programs. The county has 25 available hospital beds, with a rate of 3.7 admissions per bed per 1,000 people. Additionally, the county has 60 adult care home beds, or 54.7 beds per 1,000 older adults, and 50 assisted living beds. Medicare users make up 21.5 percent of the county’s total population and 8.9 percent of the county’s population receive food stamp benefits.
Table 4 gives information which can indicate the situation for young children and mothers. Within the county, 21.5 percent of children live in poverty, while 14.6 percent of children statewide live in poverty. Births to mothers without a high-school diploma occurred at a rate of 17.2 births per thousand teenage females, while mothers without a high-school diploma gave birth at a rate of 18.2 births per thousand teens statewide. Low weight births occurred in 14.9 percent of all live births in the county, while statewide low weight births occurred in 7.1 percent of all live births.

This information was prepared by the Office of Local Government, K-State Research and Extension. For questions or other information, call 785-532-2643.
Economic & Demographic Data

Introduction

Kansas Rural Health Works (KRHW) is dedicated to helping rural communities build affordable and sustainable local health care systems. The Office of Local Government at K-State Research and Extension is supporting Community Health Needs Assessments. These needs assessments bring a broad-based group of community leaders together to assess local needs, establish priorities, and develop strategic action plans to improve the local health situation. This is an opportunity for the community to rally together to address high-priority local needs and to make the community a better place to live, work, and raise a family. No one can do it for us unless we do it ourselves. The resources presented here support that process. The opportunity is now.

Economic Data Summary
Following are data and statistics about the economic and demographic characteristics of Sherman County that may have implications related to local health care needs. Some of the data only is available at a county scale and reflects the Sherman County boundaries.

- Continuing a long-term trend, the total population of Sherman County has declined.
- Over 15% of households live on less than $15,000 income per year.
- Whites make up almost 93 percent of the population. Four hundred and twenty-nine persons in Sherman County identify themselves as non-white.
- Transfer income to persons is among the fastest growing sources of income. In 2010, $48 million in transfer income was paid to county residents, about 19.9% of total personal income.
- Within transfer income, government assistance such as Medicare, income maintenance, and veterans pension and disability benefits are growing most strongly.
- The county poverty rate increased according to the most recent available data.

Source: Claritas, Inc. 2012.
Typical of many rural counties in Kansas, county population has been in long-term decline. The trend is expected to continue into the near-term future. The implications of this trend are that there are fewer people to make up local economic markets, fewer people to support local public services, and a thinner local labor market. All of these create greater challenges for businesses, local governments and communities.

![Figure 1. Total Population Projection in the Sherman Health Area](image)

The proportion of the population 65 years and older is among the fastest growing demographic groups even as the overall population declines. The oldest of the old, persons 85 years and older, are increasing to the greatest degree among the elderly, with women commonly outliving men. The implications of these trends are several: without a source of renewal from economic growth, the community will increasingly rely on an elderly, fixed income population base to support local services. Further, the proportion of the population with special health care needs, especially community and home health care assistance, will increase.

<table>
<thead>
<tr>
<th>Table 1. Percent of Aging Population in the Sherman Health Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>65+ Years old</td>
</tr>
<tr>
<td>75+ Years old</td>
</tr>
<tr>
<td>85+ Years old</td>
</tr>
</tbody>
</table>

Claritas, Inc., 2012
Figure 2. Estimated Percent of Aging Population in the Sherman Health Area

Figure 3. Sherman Health Area Population by Sex and Age, 2012
The racial composition of Sherman County is somewhat less homogenous than many rural Kansas counties. Whites make up almost 93 percent of the population. Four hundred and twenty-nine persons in Sherman County identify themselves as non-white. It’s not uncommon for non-whites to have specific health care needs that are very different than the white population. As is the case almost everywhere, the Hispanic and Latino population is increasing.

### Table 2. 2012 Estimated Population by Single Race Classification

<table>
<thead>
<tr>
<th>Population Classification</th>
<th>Population</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Alone</td>
<td>5,523</td>
<td>92.8%</td>
</tr>
<tr>
<td>Black or African American Alone</td>
<td>41</td>
<td>0.7%</td>
</tr>
<tr>
<td>American Indian and Alaska Native Alone</td>
<td>16</td>
<td>0.3%</td>
</tr>
<tr>
<td>Asian Alone</td>
<td>17</td>
<td>0.3%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>7</td>
<td>0.1%</td>
</tr>
<tr>
<td>Some Other Race Alone</td>
<td>236</td>
<td>4.0%</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>112</td>
<td>1.9%</td>
</tr>
<tr>
<td>Total</td>
<td>5,952</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Claritas, Inc., 2012

### Table 3. 2012 Estimated Population Hispanic or Latino by Origin

<table>
<thead>
<tr>
<th>Population Classification</th>
<th>Population</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic or Latino</td>
<td>664</td>
<td>11.2%</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>5,288</td>
<td>88.8%</td>
</tr>
<tr>
<td>Total</td>
<td>5,952</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Claritas, Inc., 2012

### Table 4. Sherman Health Area Hispanic and Latino Population Projection

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2012</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>2,758</td>
<td>2,623</td>
<td>2,612</td>
</tr>
<tr>
<td>Hispanic and Latino Population</td>
<td>571</td>
<td>664</td>
<td>709</td>
</tr>
<tr>
<td>Percentage of Population</td>
<td>20.7%</td>
<td>25.3%</td>
<td>27.1%</td>
</tr>
</tbody>
</table>

Claritas, Inc., 2012
A relatively large proportion of the population 15 years and older is unmarried. About 57 percent of the adult population reported living as a married individual with a spouse present. Conversely, 18 percent reported no longer being married or their spouse was absent. Nine percent are widowed. Many of these individuals probably live in some other cohabitation arrangement. Still, it raises a question about the number of people living alone. Within the context of community health care needs, people living alone face sometimes tremendous challenges should illness arise or injury occur. Most often, there are only informal support structures in place to assist such individuals in times of need.

Table 5. 2012 Estimated Population Age 15+ by Marital Status

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total, Never Married</td>
<td>1,244</td>
<td>25.6%</td>
</tr>
<tr>
<td>Married, Spouse present</td>
<td>2,744</td>
<td>56.5%</td>
</tr>
<tr>
<td>Married, Spouse absent</td>
<td>66</td>
<td>1.4%</td>
</tr>
<tr>
<td>Widowed</td>
<td>427</td>
<td>8.8%</td>
</tr>
<tr>
<td>Divorced</td>
<td>379</td>
<td>7.8%</td>
</tr>
<tr>
<td>Males, Never Married</td>
<td>850</td>
<td>17.5%</td>
</tr>
<tr>
<td>Previously Married</td>
<td>210</td>
<td>4.3%</td>
</tr>
<tr>
<td>Females, Never Married</td>
<td>394</td>
<td>8.1%</td>
</tr>
<tr>
<td>Previously Married</td>
<td>596</td>
<td>12.3%</td>
</tr>
</tbody>
</table>

Claritas, Inc., 2012

Table 6. 2012 Estimated Population Age 25+ by Educational Attainment

<table>
<thead>
<tr>
<th>Education</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 9th grade</td>
<td>135</td>
<td>3.6%</td>
</tr>
<tr>
<td>Some High School, no diploma</td>
<td>198</td>
<td>5.2%</td>
</tr>
<tr>
<td>High School Graduate (or GED)</td>
<td>1,346</td>
<td>35.4%</td>
</tr>
<tr>
<td>Some College, no degree</td>
<td>965</td>
<td>25.4%</td>
</tr>
<tr>
<td>Associate Degree</td>
<td>421</td>
<td>11.1%</td>
</tr>
<tr>
<td>Bachelor's Degree</td>
<td>557</td>
<td>14.7%</td>
</tr>
<tr>
<td>Master's Degree</td>
<td>136</td>
<td>3.6%</td>
</tr>
<tr>
<td>Professional School Degree</td>
<td>18</td>
<td>0.5%</td>
</tr>
<tr>
<td>Doctorate Degree</td>
<td>24</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

Claritas, Inc., 2012
Sherman County Rural Health Works

The income and wealth resources of many Sherman County residents are relatively modest. Almost 30 percent of households report an annual income of less than $25,000, and almost half of that group lives on less than $15,000 per year. As represented by housing values, the wealth resources of many individuals and households also is apparent. About 13.6 percent of the housing stock is valued at less than $40,000. The implications of such income and wealth characteristics in the context of increasing longevity and rising health care costs raises questions as to whether all who need it can afford health insurance and health care services.

Table 7. 2012 Estimated Households by Household Income

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Less than $15,000</td>
<td>377</td>
<td>14.4%</td>
</tr>
<tr>
<td>Income $15,000 - $24,999</td>
<td>402</td>
<td>15.3%</td>
</tr>
<tr>
<td>Income $25,000 - $34,999</td>
<td>396</td>
<td>15.1%</td>
</tr>
<tr>
<td>Income $35,000 - $49,999</td>
<td>512</td>
<td>19.5%</td>
</tr>
<tr>
<td>Income $50,000 - $74,999</td>
<td>489</td>
<td>18.6%</td>
</tr>
<tr>
<td>Income $75,000 - $99,999</td>
<td>240</td>
<td>9.2%</td>
</tr>
<tr>
<td>Income $100,000 - $149,999</td>
<td>166</td>
<td>6.3%</td>
</tr>
<tr>
<td>Income $150,000 - $199,999</td>
<td>16</td>
<td>0.6%</td>
</tr>
<tr>
<td>Income $200,000 - $499,999</td>
<td>23</td>
<td>0.9%</td>
</tr>
<tr>
<td>Income $500,000 or more</td>
<td>2</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Total Estimated Households</strong></td>
<td><strong>2,623</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

| Estimated Average Household Income | $48,071 |
| Estimated Median Household Income  | $38,999 |
| Estimated Per Capita Income        | $21,349 |

Claritas, Inc., 2012
Table 8. 2012 Estimated All Owner-Occupied Housing Values

<table>
<thead>
<tr>
<th>Value Range</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Less than $20,000</td>
<td>122</td>
<td>6.7%</td>
</tr>
<tr>
<td>Value $20,000 - $39,999</td>
<td>126</td>
<td>6.9%</td>
</tr>
<tr>
<td>Value $40,000 - $59,999</td>
<td>189</td>
<td>10.3%</td>
</tr>
<tr>
<td>Value $60,000 - $79,999</td>
<td>274</td>
<td>15.0%</td>
</tr>
<tr>
<td>Value $80,000 - $99,999</td>
<td>330</td>
<td>18.0%</td>
</tr>
<tr>
<td>Value $100,000 - $149,999</td>
<td>438</td>
<td>23.9%</td>
</tr>
<tr>
<td>Value $150,000 - $199,999</td>
<td>158</td>
<td>8.6%</td>
</tr>
<tr>
<td>Value $200,000 - $299,999</td>
<td>127</td>
<td>6.9%</td>
</tr>
<tr>
<td>Value $300,000 - $399,999</td>
<td>31</td>
<td>1.7%</td>
</tr>
<tr>
<td>Value $400,000 - $499,999</td>
<td>24</td>
<td>1.3%</td>
</tr>
<tr>
<td>Value $500,000 - $749,999</td>
<td>5</td>
<td>0.3%</td>
</tr>
<tr>
<td>Value $750,000 - $999,999</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Value $1,000,000 or more</td>
<td>7</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,831</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Claritas, Inc., 2012

Figure 4. Per Capita Income (2005$), 2002-2012

Woods and Poole, Inc., 2012
As with most rural areas, Sherman County is relatively more dependent on transfer income, such as retirement and disability insurance benefits, medical benefits, and income maintenance. That dependence is shrinking over time. These financial resources can be of enormous importance to those who receive them. From an economic perspective, these payments help support the local economy. Every person legitimately entitled to receive them, should have access to this assistance.
### Sherman County Rural Health Works

#### Table 9. Sherman County Personal Income by Major Source

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Earnings (Millions 2005$)</td>
<td>$100.02</td>
<td>$114.10</td>
<td>$100.36</td>
<td>$119.49</td>
<td>$107.41</td>
<td>$148.69</td>
<td>$147.52</td>
<td>$157.32</td>
<td>$178.18</td>
<td>$174.23</td>
<td></td>
</tr>
<tr>
<td>Farm Earnings</td>
<td>$2.81</td>
<td>$18.78</td>
<td>$1.73</td>
<td>$20.99</td>
<td>$6.47</td>
<td>$35.38</td>
<td>$48.01</td>
<td>$47.99</td>
<td>$54.93</td>
<td>$76.12</td>
<td>$69.02</td>
</tr>
<tr>
<td>Agricultural Services, Other</td>
<td>$2.44</td>
<td>$2.63</td>
<td>$1.45</td>
<td>$2.78</td>
<td>$2.71</td>
<td>$1.66</td>
<td>$4.02</td>
<td>$3.56</td>
<td>$3.57</td>
<td>$3.16</td>
<td>$3.34</td>
</tr>
<tr>
<td>Mining</td>
<td>$0.45</td>
<td>$0.46</td>
<td>$0.77</td>
<td>$0.43</td>
<td>$0.51</td>
<td>$0.49</td>
<td>$0.95</td>
<td>$0.74</td>
<td>$0.80</td>
<td>$0.81</td>
<td>$0.79</td>
</tr>
<tr>
<td>Construction</td>
<td>$4.23</td>
<td>$4.22</td>
<td>$4.14</td>
<td>$4.20</td>
<td>$4.09</td>
<td>$3.52</td>
<td>$3.25</td>
<td>$2.62</td>
<td>$2.54</td>
<td>$2.31</td>
<td>$2.84</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>$2.84</td>
<td>$2.24</td>
<td>$2.45</td>
<td>$3.15</td>
<td>$3.77</td>
<td>$4.45</td>
<td>$4.01</td>
<td>$4.02</td>
<td>$4.31</td>
<td>$4.67</td>
<td>$3.83</td>
</tr>
<tr>
<td>Wholesale Trade</td>
<td>$7.86</td>
<td>$7.60</td>
<td>$7.75</td>
<td>$6.95</td>
<td>$7.67</td>
<td>$8.89</td>
<td>$9.71</td>
<td>$10.59</td>
<td>$11.84</td>
<td>$12.58</td>
<td>$13.98</td>
</tr>
<tr>
<td>Retail Trade</td>
<td>$11.49</td>
<td>$11.58</td>
<td>$10.97</td>
<td>$11.03</td>
<td>$11.41</td>
<td>$10.81</td>
<td>$10.66</td>
<td>$10.55</td>
<td>$10.93</td>
<td>$10.96</td>
<td>$10.84</td>
</tr>
<tr>
<td>Finance, Insurance &amp; Real Estate</td>
<td>$8.11</td>
<td>$7.99</td>
<td>$7.66</td>
<td>$7.93</td>
<td>$7.75</td>
<td>$7.83</td>
<td>$6.67</td>
<td>$8.08</td>
<td>$9.12</td>
<td>$10.13</td>
<td>$10.02</td>
</tr>
<tr>
<td>Federal Civilian Government</td>
<td>$4.41</td>
<td>$4.36</td>
<td>$4.58</td>
<td>$4.92</td>
<td>$4.86</td>
<td>$4.82</td>
<td>$4.79</td>
<td>$5.03</td>
<td>$5.40</td>
<td>$5.10</td>
<td>$5.20</td>
</tr>
<tr>
<td>Federal Military Government</td>
<td>$0.68</td>
<td>$0.94</td>
<td>$0.96</td>
<td>$1.11</td>
<td>$1.03</td>
<td>$0.99</td>
<td>$0.99</td>
<td>$1.10</td>
<td>$1.19</td>
<td>$1.19</td>
<td>$0.95</td>
</tr>
<tr>
<td>Personal Income (Millions 2005$)</td>
<td>$161.55</td>
<td>$173.88</td>
<td>$154.94</td>
<td>$177.63</td>
<td>$169.07</td>
<td>$200.91</td>
<td>$215.63</td>
<td>$216.86</td>
<td>$228.66</td>
<td>$252.34</td>
<td>$241.85</td>
</tr>
<tr>
<td>Wages and Salaries</td>
<td>$68.75</td>
<td>$65.30</td>
<td>$67.20</td>
<td>$66.66</td>
<td>$69.30</td>
<td>$71.20</td>
<td>$71.85</td>
<td>$70.61</td>
<td>$72.16</td>
<td>$73.13</td>
<td>$94.83</td>
</tr>
<tr>
<td>Other Labor Income</td>
<td>$16.08</td>
<td>$17.02</td>
<td>$17.46</td>
<td>$17.15</td>
<td>$17.55</td>
<td>$17.48</td>
<td>$18.04</td>
<td>$18.37</td>
<td>$19.14</td>
<td>$19.42</td>
<td>$23.92</td>
</tr>
<tr>
<td>Proprietors Income</td>
<td>$15.18</td>
<td>$31.78</td>
<td>$15.71</td>
<td>$35.68</td>
<td>$20.56</td>
<td>$47.81</td>
<td>$58.81</td>
<td>$58.55</td>
<td>$66.02</td>
<td>$85.63</td>
<td>$55.49</td>
</tr>
<tr>
<td>Dividends, Interest &amp; Rent</td>
<td>$32.08</td>
<td>$29.08</td>
<td>$23.77</td>
<td>$26.92</td>
<td>$29.03</td>
<td>$30.94</td>
<td>$33.21</td>
<td>$32.15</td>
<td>$33.52</td>
<td>$35.72</td>
<td>$33.62</td>
</tr>
<tr>
<td>Transfer Payments To Persons</td>
<td>$39.00</td>
<td>$39.57</td>
<td>$39.97</td>
<td>$40.79</td>
<td>$42.03</td>
<td>$42.72</td>
<td>$43.11</td>
<td>$46.81</td>
<td>$47.59</td>
<td>$47.15</td>
<td>$48.05</td>
</tr>
<tr>
<td>Residence Adjustment</td>
<td>$1.71</td>
<td>$2.04</td>
<td>$2.10</td>
<td>$1.93</td>
<td>$2.36</td>
<td>$2.75</td>
<td>$2.75</td>
<td>$2.40</td>
<td>$2.19</td>
<td>$1.99</td>
<td>$2.57</td>
</tr>
</tbody>
</table>

Note: Historical employment, earnings, and income data 1969-2002, and total population data 1969-2003, are from the U.S. Dept of Commerce (USDoC); employment and earnings data by private non-farm SIC industry for 2001 and 2002 are estimated from private non-farm NAICA industry data.
### Table 10. Personal Current Transfer Receipts for Sherman County

(Thousands of dollars)

<table>
<thead>
<tr>
<th>Description</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal current transfer receipts ($000)</td>
<td>46,960</td>
<td>51,637</td>
<td>53,149</td>
</tr>
<tr>
<td>Current transfer receipts of individuals from governments</td>
<td>45,856</td>
<td>50,481</td>
<td>51,988</td>
</tr>
<tr>
<td>Retirement and disability insurance benefits</td>
<td>17,084</td>
<td>17,895</td>
<td>18,012</td>
</tr>
<tr>
<td>Old-age, survivors, and disability insurance (OASDI) benefits</td>
<td>16,400</td>
<td>17,183</td>
<td>17,285</td>
</tr>
<tr>
<td>Railroad retirement and disability benefits</td>
<td>629</td>
<td>669</td>
<td>682</td>
</tr>
<tr>
<td>Workers’ compensation</td>
<td>(L)</td>
<td>(L)</td>
<td>(L)</td>
</tr>
<tr>
<td>Other government retirement and disability insurance benefits</td>
<td>(L)</td>
<td>(L)</td>
<td>(L)</td>
</tr>
<tr>
<td>Medical benefits</td>
<td>23,294</td>
<td>25,697</td>
<td>26,352</td>
</tr>
<tr>
<td>Medicare benefits</td>
<td>15,344</td>
<td>16,290</td>
<td>17,122</td>
</tr>
<tr>
<td>Public assistance medical care benefits</td>
<td>7,822</td>
<td>9,252</td>
<td>9,055</td>
</tr>
<tr>
<td>Medicaid</td>
<td>7,545</td>
<td>8,988</td>
<td>8,807</td>
</tr>
<tr>
<td>Other medical care benefits</td>
<td>277</td>
<td>264</td>
<td>248</td>
</tr>
<tr>
<td>Military medical insurance benefits</td>
<td>128</td>
<td>155</td>
<td>175</td>
</tr>
<tr>
<td>Income maintenance benefits</td>
<td>3,619</td>
<td>3,840</td>
<td>4,582</td>
</tr>
<tr>
<td>Supplemental security income (SSI) benefits</td>
<td>476</td>
<td>616</td>
<td>610</td>
</tr>
<tr>
<td>Family assistance</td>
<td>263</td>
<td>245</td>
<td>246</td>
</tr>
<tr>
<td>Supplemental Nutrition Assistance Program (SNAP)</td>
<td>544</td>
<td>822</td>
<td>1,030</td>
</tr>
<tr>
<td>Other income maintenance benefits</td>
<td>2,336</td>
<td>2,157</td>
<td>2,696</td>
</tr>
<tr>
<td>Unemployment insurance compensation</td>
<td>256</td>
<td>745</td>
<td>795</td>
</tr>
<tr>
<td>State unemployment insurance compensation</td>
<td>239</td>
<td>707</td>
<td>751</td>
</tr>
<tr>
<td>Unemployment compensation for Fed. civilian employees (UCFE)</td>
<td>(L)</td>
<td>(L)</td>
<td>(L)</td>
</tr>
<tr>
<td>Unemployment compensation for railroad employees</td>
<td>(L)</td>
<td>(L)</td>
<td>(L)</td>
</tr>
<tr>
<td>Unemployment compensation for veterans (UCX)</td>
<td>(L)</td>
<td>(L)</td>
<td>(L)</td>
</tr>
<tr>
<td>Other unemployment compensation</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Veterans benefits</td>
<td>634</td>
<td>710</td>
<td>791</td>
</tr>
<tr>
<td>Veterans pension and disability benefits</td>
<td>581</td>
<td>638</td>
<td>684</td>
</tr>
<tr>
<td>Veterans readjustment benefits</td>
<td>(L)</td>
<td>55</td>
<td>92</td>
</tr>
<tr>
<td>Veterans life insurance benefits</td>
<td>(L)</td>
<td>(L)</td>
<td>(L)</td>
</tr>
<tr>
<td>Other assistance to veterans</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Education and training assistance</td>
<td>943</td>
<td>1,088</td>
<td>1,273</td>
</tr>
<tr>
<td>Other transfer receipts of individuals from governments</td>
<td>(L)</td>
<td>506</td>
<td>183</td>
</tr>
<tr>
<td>Current transfer receipts of nonprofit institutions</td>
<td>620</td>
<td>666</td>
<td>701</td>
</tr>
<tr>
<td>Receipts from the Federal government</td>
<td>233</td>
<td>250</td>
<td>261</td>
</tr>
<tr>
<td>Receipts from state and local governments</td>
<td>141</td>
<td>157</td>
<td>166</td>
</tr>
<tr>
<td>Receipts from businesses</td>
<td>246</td>
<td>259</td>
<td>274</td>
</tr>
<tr>
<td>Current transfer receipts of individuals from businesses</td>
<td>484</td>
<td>490</td>
<td>460</td>
</tr>
</tbody>
</table>

Bureau of Economic Analysis, 2012
Notes for Table 10:
1. Consists largely of temporary disability payments and black lung payments.
2. Consists of medicaid and other medical vendor payments.
3. Consists of payments made under the TriCare Management Program (formerly called CHAMPUS) for the medical care of dependents of active duty military personnel and of retired military personnel and their dependents at nonmilitary medical facilities.
4. Through 1995, consists of emergency assistance and aid to families with dependent children. For 1998 forward, consists of benefits-- generally known as temporary assistance for needy families-- provided under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. For 1996-97, consists of payments under all three of these programs.
5. Consists largely of general assistance, refugee assistance, foster home care and adoption assistance, earned income tax credits, and energy assistance.
6. Consists of trade readjustment allowance payments, Redwood Park benefit payments, public service employment benefit payments, and transitional benefit payments.
7. Consists largely of veterans readjustment benefit payments, educational assistance to spouses and children of disabled or deceased veterans, payments to paraplegics, and payments for autos and conveyances for disabled veterans.
8. Consists of State and local government payments to veterans.
9. Consists largely of federal fellowship payments (National Science Foundation fellowships and traineeships, subsistence payments to State maritime academy cadets, and other federal fellowships), interest subsidy on higher education loans, basic educational opportunity grants, and Job Corps payments.
11. Consists of State and local government educational assistance payments to nonprofit institutions, and other State and local government payments to nonprofit institutions.
12. Consists largely of personal injury payments to individuals other than employees and other business transfer payments.
• All state and local area dollar estimates are in current dollars (not adjusted for inflation).
(L) Less than $50,000, but the estimates for this item are included in the totals.
Table 11. Employment by Major Industry for Sherman County

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Employment</td>
<td>4.19</td>
<td>4.10</td>
<td>4.04</td>
<td>4.01</td>
<td>4.09</td>
<td>4.16</td>
<td>4.12</td>
<td>4.04</td>
<td>4.11</td>
<td>4.08</td>
<td>4.09</td>
</tr>
<tr>
<td>Farm Employment</td>
<td>0.49</td>
<td>0.47</td>
<td>0.46</td>
<td>0.45</td>
<td>0.43</td>
<td>0.43</td>
<td>0.42</td>
<td>0.42</td>
<td>0.41</td>
<td>0.40</td>
<td></td>
</tr>
<tr>
<td>Agricultural Services, Other</td>
<td>0.14</td>
<td>0.13</td>
<td>0.08</td>
<td>0.13</td>
<td>0.13</td>
<td>0.10</td>
<td>0.18</td>
<td>0.18</td>
<td>0.18</td>
<td>0.16</td>
<td>0.17</td>
</tr>
<tr>
<td>Mining</td>
<td>0.02</td>
<td>0.01</td>
<td>0.02</td>
<td>0.02</td>
<td>0.02</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>Construction</td>
<td>0.16</td>
<td>0.16</td>
<td>0.14</td>
<td>0.13</td>
<td>0.14</td>
<td>0.15</td>
<td>0.14</td>
<td>0.13</td>
<td>0.12</td>
<td>0.11</td>
<td>0.11</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>0.07</td>
<td>0.06</td>
<td>0.07</td>
<td>0.11</td>
<td>0.13</td>
<td>0.16</td>
<td>0.14</td>
<td>0.11</td>
<td>0.11</td>
<td>0.11</td>
<td>0.11</td>
</tr>
<tr>
<td>Transport, Comm. &amp; Public Utility</td>
<td>0.20</td>
<td>0.18</td>
<td>0.22</td>
<td>0.18</td>
<td>0.19</td>
<td>0.23</td>
<td>0.23</td>
<td>0.20</td>
<td>0.20</td>
<td>0.19</td>
<td>0.19</td>
</tr>
<tr>
<td>Wholesale Trade</td>
<td>0.20</td>
<td>0.19</td>
<td>0.19</td>
<td>0.18</td>
<td>0.20</td>
<td>0.22</td>
<td>0.22</td>
<td>0.24</td>
<td>0.27</td>
<td>0.29</td>
<td>0.29</td>
</tr>
<tr>
<td>Retail Trade</td>
<td>0.60</td>
<td>0.61</td>
<td>0.59</td>
<td>0.58</td>
<td>0.57</td>
<td>0.57</td>
<td>0.56</td>
<td>0.54</td>
<td>0.56</td>
<td>0.56</td>
<td>0.55</td>
</tr>
<tr>
<td>Finance, Insurance &amp; Real Estate</td>
<td>0.30</td>
<td>0.30</td>
<td>0.29</td>
<td>0.29</td>
<td>0.29</td>
<td>0.32</td>
<td>0.29</td>
<td>0.33</td>
<td>0.37</td>
<td>0.41</td>
<td>0.41</td>
</tr>
<tr>
<td>Services</td>
<td>0.80</td>
<td>0.81</td>
<td>0.82</td>
<td>0.81</td>
<td>0.85</td>
<td>0.82</td>
<td>0.79</td>
<td>0.75</td>
<td>0.75</td>
<td>0.73</td>
<td>0.74</td>
</tr>
<tr>
<td>Federal Civilian Government</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>Federal Military Government</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>State and Local Government</td>
<td>0.72</td>
<td>0.71</td>
<td>0.71</td>
<td>0.68</td>
<td>0.68</td>
<td>0.69</td>
<td>0.69</td>
<td>0.69</td>
<td>0.68</td>
<td>0.65</td>
<td>0.65</td>
</tr>
</tbody>
</table>

Woods and Poole, Inc., 2012

Note: Employment in number of jobs includes proprietors and part-time jobs.
Sherman County Rural Health Works

As with most rural areas, the way people in Sherman County earn a living is changing. While employment in traditional industries such as agriculture, extractive industries and manufacturing has been relatively stable, a lesser proportion of people are earning a living working in service industries. Perhaps consistent with the overall population decline, employment in government also declined. Sherman County has been on par with the state average in terms of the percentage of population living in poverty.

Figure 6. Unemployment Rate for Sherman County and Kansas, 2002-2011

Figure 7. Percent of People in Poverty in Sherman County and Kansas, 2001-2010

This information was prepared by the Office of Local Government, K-State Research and Extension. For questions or other information, call 785-532-2643.
Health and Behavioral Data

Introduction

Kansas Rural Health Works (KRHW) is dedicated to helping rural communities build affordable and sustainable local health care systems. The Office of Local Government at K-State Research and Extension is supporting Community Health Needs Assessments. These needs assessments bring a broad-based group of community leaders together to assess local needs, establish priorities, and develop strategic action plans to improve the local health situation. This is an opportunity for the community to rally together to address high-priority local needs and to make the community a better place to live, work, and raise a family. No one can do it for us unless we do it ourselves. The resources presented here support that process. The opportunity is now.

Health and Behavioral Data Summary

Following are a variety of data and statistics about health and behavioral characteristics in Sherman County that may have implications for local health care needs. The data is reported by county.

- Over time, occupancy has decreased while the total number of beds has remained constant.
- The trends related to children receiving necessary immunizations appear positive. On average, about 25 percent of fetuses had not had adequate prenatal care.
- The rates of youth tobacco use and binge drinking are have decreased by about 6-8 percent over the past five years.
- About 19 percent of newborns received less than adequate prenatal care.
- Recent trends in hospital usage suggest a fairly steady level of demand at the Sherman Medical Hospital.

Source: Claritas, Inc. 2012
The number of nursing home beds combines all licensed nursing home beds in Sherman County. Over time, occupancy has decreased while the total number of beds remained constant. This may reflect the broader trend of persons' preference for community-based care outside of a nursing home.

Table 1. Average Sherman County Occupancy of Nursing Home Beds

<table>
<thead>
<tr>
<th>Average Number of Nursing Beds</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Nursing Occupancy Rate</td>
<td>97.8%</td>
<td>93.0%</td>
<td>91.8%</td>
<td>96.6%</td>
<td>95.4%</td>
<td>94.0%</td>
<td>95.8%</td>
<td>95.3%</td>
<td>89.4%</td>
<td>81.0%</td>
</tr>
</tbody>
</table>

Kansas Department on Aging, semi-annual reports
Kansas Hospital Association STAT Report, 2009

Average Bed Occupancy Rate in Nursing Facilities
Considering available indicators of children’s welfare, a relatively large population base can lead to small percentage changes that must be interpreted cautiously. While available data are limited, the trends related to children receiving necessary immunizations appear positive. On average, about 25 percent of fetuses had not had adequate prenatal care. The rates of youth tobacco use and binge drinking are have decreased by about 6-8 percent over the past five years.

Table 2. Indicators of Children's Welfare

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations</td>
<td>Sherman</td>
<td>43.5%</td>
<td>52.1%</td>
<td>67.0%</td>
<td>76.0%</td>
<td>80.0%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>KS</td>
<td>57.9%</td>
<td>51.1%</td>
<td>58.0%</td>
<td>63.0%</td>
<td>70.0%</td>
<td>-</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Sherman</td>
<td>71.2%</td>
<td>66.2%</td>
<td>74.7%</td>
<td>77.5%</td>
<td>72.6%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>KS</td>
<td>79.1%</td>
<td>78.4%</td>
<td>77.4%</td>
<td>77.5%</td>
<td>79.0%</td>
<td>-</td>
</tr>
<tr>
<td>Low Birth Weight Babies</td>
<td>Sherman</td>
<td>6.6%</td>
<td>16.5%</td>
<td>14.9%</td>
<td>9.3%</td>
<td>4.8%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>KS</td>
<td>7.2%</td>
<td>7.2%</td>
<td>7.1%</td>
<td>7.2%</td>
<td>7.3%</td>
<td>-</td>
</tr>
<tr>
<td>Teen Violent Deaths (per 100,000 15-19 year-olds)</td>
<td>Sherman</td>
<td>183.8</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>KS</td>
<td>46.0</td>
<td>40.5</td>
<td>47.1</td>
<td>38.5</td>
<td>36.4</td>
<td>-</td>
</tr>
<tr>
<td>Youth Tobacco Use</td>
<td>Sherman</td>
<td>-</td>
<td>14.7%</td>
<td>17.6%</td>
<td>8.2%</td>
<td>12.5%</td>
<td>9.4%</td>
</tr>
<tr>
<td></td>
<td>KS</td>
<td>15.6%</td>
<td>14.9%</td>
<td>13.5%</td>
<td>13.0%</td>
<td>12.6%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Youth Binge Drinking</td>
<td>Sherman</td>
<td>-</td>
<td>-</td>
<td>15.7%</td>
<td>15.8%</td>
<td>7.7%</td>
<td>13.2%</td>
</tr>
<tr>
<td></td>
<td>KS</td>
<td>16.5%</td>
<td>16.7%</td>
<td>15.6%</td>
<td>15.2%</td>
<td>14.7%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Asthma (per 1,000)</td>
<td>Sherman</td>
<td>-</td>
<td>0.0</td>
<td>0.8</td>
<td>2.4</td>
<td>1.6</td>
<td>0.7</td>
</tr>
<tr>
<td></td>
<td>KS</td>
<td>1.6</td>
<td>1.7</td>
<td>1.9</td>
<td>1.5</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Mental Health (per 1,000)</td>
<td>Sherman</td>
<td>-</td>
<td>0.8</td>
<td>0.8</td>
<td>0.0</td>
<td>3.2</td>
<td>0.7</td>
</tr>
<tr>
<td></td>
<td>KS</td>
<td>3.0</td>
<td>2.9</td>
<td>2.7</td>
<td>3.4</td>
<td>3.3</td>
<td>-</td>
</tr>
</tbody>
</table>

Kansas KIDSCOUNT, 2011

Table 3 contains information about persons served by state and federally-funded services. Across the service categories reported, most appear to have improved slightly. Still, when taken together, the numbers suggest a fairly high proportion of the local population experiencing economic distress. In particular, the need for food and energy assistance has increased recently.
Table 3. Persons Served by Selected Public Assistance Programs in Sherman County

<table>
<thead>
<tr>
<th>Major Services</th>
<th>Persons Served</th>
<th>FY 2009</th>
<th>FY 2010</th>
<th>FY 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Assistance for Families</td>
<td>Avg. monthly persons</td>
<td>88</td>
<td>113</td>
<td>101</td>
</tr>
<tr>
<td>TANF Employment Services</td>
<td>Avg. monthly adults</td>
<td>32</td>
<td>40</td>
<td>35</td>
</tr>
<tr>
<td>Child Care Assistance</td>
<td>Avg. monthly children</td>
<td>40</td>
<td>45</td>
<td>34</td>
</tr>
<tr>
<td>Food Assistance</td>
<td>Avg. monthly persons</td>
<td>524</td>
<td>629</td>
<td>649</td>
</tr>
<tr>
<td>Energy Assistance</td>
<td>Annual persons</td>
<td>376</td>
<td>351</td>
<td>424</td>
</tr>
<tr>
<td>General Assistance</td>
<td>Avg. monthly persons</td>
<td>11</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Vocational Rehabilitation Services</td>
<td>Avg. monthly persons</td>
<td>83</td>
<td>66</td>
<td>71</td>
</tr>
<tr>
<td>Family Preservation</td>
<td>Annual persons</td>
<td>5</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Reintegration/Foster Care</td>
<td>Avg. monthly children</td>
<td>5</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Adoption Support</td>
<td>Avg. monthly children</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

| Home and Community Based Services     |                |         |         |         |
| Physical Disability                   | Annual consumers | 12     | 10      | 9       |
| Traumatic Brain Injury                | Annual consumers | 0      | 0       | 0       |
| Developmental Disability              | Annual consumers | 47     | 1       | 44      |
| Autism                                | Annual consumers | 0      | 0       | 0       |

| Managed Behavioral Health Services    |                |         |         |         |
| Substance Abuse (PIHP)                | Annual consumers | 9      | 15      | 15      |
| Mental Health (PAHP)                  | Annual consumers | 139    | 137     | 155     |

| Institutional Services                |                |         |         |         |
| Intermediate Care Facility (ICF-MR)   | Average daily census | 0      | 0       | 0       |
| State Hospital - Developmental Disability | Average daily census | 0      | 0       | 0       |
| State Hospital - Mental Health        | Average daily census | 0      | 0       | 0       |
| Nursing Facility - Mental Health      | Average daily census | 0      | 0       | 0       |

Kansas Department of Social and Rehabilitation Services, 2010

In considering the selected vital statistics in Table 4, among those that stand out are that about 19 percent of newborns received less than adequate prenatal care. Even a single teenage pregnancy sets a young person on a difficult life path. And, over one-half of all marriages end in dissolution.

In the recent past, usage of Sherman Medical Hospital appears to have remained relatively stable (Table 5). This is evident in the number of inpatient and outpatient visits and procedures. Medicare appear to be an important component of the patient base.
Table 4. Selected Vital Statistics for Sherman County, 2010

<table>
<thead>
<tr>
<th>Live Births by Age-Group of Mother</th>
<th>Total</th>
<th>10-14</th>
<th>15-19</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45 &amp; Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>83</td>
<td>0</td>
<td>14</td>
<td>30</td>
<td>17</td>
<td>14</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adequacy of Prenatal Care by Number and Percentage</td>
<td>Adequate Plus</td>
<td>Adequate</td>
<td>Intermediate</td>
<td>Inadequate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>28</td>
<td>33.7%</td>
<td>39</td>
<td>47.0%</td>
<td>10</td>
<td>12.0%</td>
<td>6</td>
<td>7.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>36</td>
<td>0</td>
<td>10</td>
<td>15</td>
<td>5</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Teenage Pregnancies</td>
<td>Live Births</td>
<td>Stillbirths</td>
<td>Abortions</td>
<td>Total Pregnancies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0-4</td>
<td>0</td>
<td>5-14</td>
<td>15-24</td>
<td>25-34</td>
<td>35-44</td>
<td>45-54</td>
<td>55-64</td>
<td>65-84</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Deaths by Age Group</td>
<td>0-14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Marriages by Number and Rate per 1,000 Population</td>
<td>2006</td>
<td>2007</td>
<td>2008</td>
<td>2009</td>
<td>2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>39</td>
<td>6.5</td>
<td>50</td>
<td>8.4</td>
<td>37</td>
<td>6.2</td>
<td>47</td>
<td>8</td>
<td>44</td>
</tr>
<tr>
<td>Marriages Dissolutions by Number and Rate per 1,000 Population</td>
<td>2006</td>
<td>2007</td>
<td>2008</td>
<td>2009</td>
<td>2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>4.3</td>
<td>29</td>
<td>4.9</td>
<td>20</td>
<td>3.3</td>
<td>30</td>
<td>5.1</td>
<td>42</td>
</tr>
</tbody>
</table>

Kansas Department of Health and Environment, 2010
Table 5. Hospital Data for Goodland and Sherman County

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Practicing Physicians (county)</td>
<td>25</td>
<td>18</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Persons per Physician (county)</td>
<td>221</td>
<td>327</td>
<td>366</td>
<td>389</td>
</tr>
<tr>
<td><strong>Sherman Medical Hospital</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed Acute Beds</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Licensed Swing Beds</td>
<td>22</td>
<td>22</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Staffed Beds-Hospital</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Staffed Beds-Nursing Home Unit</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Admissions-Hospital</td>
<td>620</td>
<td>537</td>
<td>416</td>
<td>403</td>
</tr>
<tr>
<td>Admissions-Nursing Home Unit</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Admissions-Swing Beds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Days - Hospital</td>
<td>1,545</td>
<td>1,346</td>
<td>2,003</td>
<td>1,431</td>
</tr>
<tr>
<td>Inpatient Days - Nursing Home Unit</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Inpatient Days - Swing-beds</td>
<td>1,347</td>
<td>1,226</td>
<td>1,085</td>
<td>656</td>
</tr>
<tr>
<td>Emergency Room Visits</td>
<td>2,313</td>
<td>2,544</td>
<td>2,532</td>
<td>2,925</td>
</tr>
<tr>
<td>Outpatient Visits</td>
<td>39,482</td>
<td>39,584</td>
<td>43,085</td>
<td>46,939</td>
</tr>
<tr>
<td>Inpatient Surgical Operations</td>
<td>42</td>
<td>39</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>Outpatient Surgical Operations</td>
<td>426</td>
<td>557</td>
<td>493</td>
<td>502</td>
</tr>
<tr>
<td>Medicare Inpatient Discharges</td>
<td>488</td>
<td>318</td>
<td>313</td>
<td>275</td>
</tr>
<tr>
<td>Medicare Inpatient Days</td>
<td>2,218</td>
<td>2,159</td>
<td>1,333</td>
<td>1,150</td>
</tr>
<tr>
<td>Medicaid Inpatient Discharges</td>
<td>71</td>
<td>46</td>
<td>18</td>
<td>24</td>
</tr>
<tr>
<td>Medicaid Inpatient Days</td>
<td>180</td>
<td>67</td>
<td>35</td>
<td>42</td>
</tr>
</tbody>
</table>

Kansas Statistical Abstract, 2010

This information was prepared by the Office of Local Government, K-State Research and Extension. For questions or other information, call 785-532-2643.
Education Data

Introduction

Kansas Rural Health Works (KRHW) is dedicated to helping rural communities build affordable and sustainable local health care systems. The Office of Local Government at K-State Research and Extension is supporting Community Health Needs Assessments. These needs assessments bring a broad-based group of community leaders together to assess local needs, establish priorities, and develop strategic action plans to improve the local health situation. This is an opportunity for the community to rally together to address high-priority local needs and to make the community a better place to live, work, and raise a family. No one can do it for us unless we do it ourselves. The resources presented here support that process. The opportunity is now.

Education Data Summary

Following are a variety of data and statistics about the K-12 school system in Sherman County that may have implications related to local health care needs. The data in this case reflects information reported by the school districts located in Sherman County.

- Total student enrollment in Sherman County K-12 school districts has seen an overall decline since 2000 but has rebounded in recent years.

- As the student population has declined, the student-to-teacher ratio also has declined.

- The trend in the student dropout rate has generally been increasing in Sherman County over the past decade, but is due, in part, to the declining student population.

- The trend in student-on-student violence has been decreasing over time. Incidents of student-on-faculty violence is generally small.

Source: Claritas, Inc. 2012.
Total student enrollment in Sherman County K-12 school districts has steadily declined since 2000. Enrollment was 1,020 in the 2011-2012 school year, down from 1,174 in 2000-2001. Recently it has been increasing.

As the student population has declined, the student-to-teacher ratio also has been declining slowly. This generally means that as the school-age population has declined, the district has retained staffing. The ratio of about 14 students per teacher permits fairly close attention for each of the students.
Kansas Department of Education, 2012

The trend in the student dropout rate has generally been increasing in Sherman County over the past decade. This may be due, in part, to the declining enrollment.
Violence in the school is extremely disruptive to learning. The trend in student-on-student violence has been decreasing over time. Student-on-faculty violence has shown no consistent trend.

Figure 4. Incidents of Student-on-Student Violence

Kansas Department of Education, 2012

Figure 5. Incidents of Student-on-Faculty Violence

Kansas Department of Education, 2012

Prepared by the Office of Local Government, K-State Research and Extension. For questions or other information, call 785-532-2643.
Crime Data

Introduction

Kansas Rural Health Works (KRHW) is dedicated to helping rural communities build affordable and sustainable local health care systems. The Office of Local Government at K-State Research and Extension is supporting Community Health Needs Assessments. These needs assessments bring a broad-based group of community leaders together to assess local needs, establish priorities, and develop strategic action plans to improve the local health situation. This is an opportunity for the community to rally together to address high-priority local needs and to make the community a better place to live, work, and raise a family. No one can do it for us unless we do it ourselves. The resources presented here support that process. The opportunity is now.

Crime Data Summary

Following are a variety of data and statistics about criminal activity in Sherman County that may have implications related to local health care needs. Most of the data only is available at a county scale and reflects the Sherman County boundaries.

- The incidence of crime in Sherman County has been decreased significantly and is considerably below the state average between 2008 and 2011.

- Both property crime and violent crime decreased in 2011 from 2008.

- The number of adult and juvenile arrests has dropped markedly in the past three years.

- The number of full-time law enforcement officials per 1,000 persons in Sherman County has consistently been slightly above the state rate.

Source: Claritas, Inc. 2012
The incidence of crime in Sherman County has been decreased significantly and is considerably below the state average between 2008 and 2011. It should be noted that county-level crime statistics are often partial or may be missing in a given year.

Table 1. Crime Statistics for Sherman County and Kansas

<table>
<thead>
<tr>
<th>Year</th>
<th>Crime Index Offenses</th>
<th>Number</th>
<th>Rate per 1,000</th>
<th>Violent Crime</th>
<th>Number</th>
<th>Rate per 1,000</th>
<th>Property Crime</th>
<th>Number</th>
<th>Rate per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>Sherman</td>
<td>157</td>
<td>26.7</td>
<td>18</td>
<td>3.1</td>
<td>139</td>
<td>23.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kansas</td>
<td>93,996</td>
<td>37.5</td>
<td>10,032</td>
<td>4.0</td>
<td>83,964</td>
<td>33.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>Sherman</td>
<td>125</td>
<td>21.3</td>
<td>12</td>
<td>2.0</td>
<td>113</td>
<td>19.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kansas</td>
<td>98,757</td>
<td>35.6</td>
<td>11,099</td>
<td>4</td>
<td>87,658</td>
<td>31.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>Sherman</td>
<td>50</td>
<td>8.6</td>
<td>6</td>
<td>1.0</td>
<td>44</td>
<td>7.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kansas</td>
<td>98,354</td>
<td>34.9</td>
<td>10,428</td>
<td>3.7</td>
<td>87,926</td>
<td>31.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>Sherman</td>
<td>25</td>
<td>4.1</td>
<td>2</td>
<td>0.3</td>
<td>23</td>
<td>3.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kansas</td>
<td>96,596</td>
<td>32.8</td>
<td>10,091</td>
<td>3.4</td>
<td>86,505</td>
<td>29.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Index crimes include violent crimes (murder, rape, robbery, and aggravated assault/battery) plus property crime (burglary, theft, and motor vehicle theft).
Sherman County Rural Health Works

Figure 1. Crime Index Offenses for Sherman County and Kansas

Index crimes include violent crimes (murder, rape, robbery, and aggravated assault/battery) plus property crime (burglary, theft, and motor vehicle theft).

*2007 arrests missing 3 months data for Goodland Police Department
*2009 arrests missing 2 months data for Goodland Police Department
*2010 arrests missing data for Goodland Police Department
*2011 arrests missing data for Goodland Police Department

Kansas Bureau of Investigation, 2012

Figure 2. Crime Index Arrests* for Sherman County and Kansas

Kansas Bureau of Investigation, 2012
The number of full-time law enforcement officials per 1,000 persons in Sherman County has consistently been slightly above the state rate.

This information was prepared by the Office of Local Government, K-State Research and Extension. For questions or other information, call 785-532-2643.
Traffic Data

Introduction

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Traffic Data Summary

Following are a variety of data and statistics about traffic accidents in Sherman County. The data is reported by county.

- The rate of traffic accidents in Sherman County is lower than the rate of the state as a whole.

- In 2008, there were 114 total vehicle crashes in Sherman County. The declining trend is positive, but must be considered in the context of declining population.

- In 2008, the most recent year for which data were available, there were 27 accidents involving injury and no fatalities.

Sherman County Primary Health Market Area

Source: Claritas, Inc. 2012.
Sherman County Rural Health Works

The rate of traffic accidents in Sherman County is lower than the rate of the state as a whole. In 2007, there were 114 total vehicle crashes in Sherman County. The declining trend is positive, but must be considered in the context of declining population. In 2008, the most recent year for which data were available, there were 37 accidents involving injury and no fatalities.

Table 1. 2008 Traffic Accident Facts for Sherman County and Kansas

<table>
<thead>
<tr>
<th>Accidents</th>
<th>Sherman</th>
<th>Kansas</th>
<th>Rate per 1,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sherman</td>
</tr>
<tr>
<td>Total</td>
<td>114</td>
<td>65,858</td>
<td>18.9</td>
</tr>
<tr>
<td>Fatal Accidents</td>
<td>0</td>
<td>348</td>
<td>0.0</td>
</tr>
<tr>
<td>Injury Accidents</td>
<td>27</td>
<td>14,866</td>
<td>4.5</td>
</tr>
<tr>
<td>Property Damage Only</td>
<td>87</td>
<td>50,644</td>
<td>14.5</td>
</tr>
<tr>
<td>Deer Involved</td>
<td>19</td>
<td>9,371</td>
<td>3.2</td>
</tr>
<tr>
<td>Speed Related</td>
<td>5</td>
<td>7,917</td>
<td>0.8</td>
</tr>
<tr>
<td>Alcohol Related</td>
<td>9</td>
<td>3,366</td>
<td>1.5</td>
</tr>
</tbody>
</table>

People

<table>
<thead>
<tr>
<th></th>
<th>Sherman</th>
<th>Kansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths</td>
<td>0</td>
<td>385</td>
</tr>
<tr>
<td>Injuries</td>
<td>41</td>
<td>21,058</td>
</tr>
<tr>
<td>% Restraint Use</td>
<td>82.3%</td>
<td>80.9%</td>
</tr>
</tbody>
</table>

Kansas Traffic Accident Facts, 2012

Figure 1. Total Accidents in Sherman County, 2000-2008

Kansas Department of Transportation, 2012
Figure 2. Injury Accidents in Sherman County, 2000-2008

Figure 3. Fatal Accidents in Sherman County, 2000-2008

Kansas Department of Transportation, 2012
Sherman County Rural Health Works

Figure 4. Property Damage Only Accidents in Sherman County, 2000-2008

Kansas Department of Transportation, 2012

Figure 5. Other Crashes in Sherman County, 2000-2008

Kansas Department of Transportation, 2012

This information was prepared by the Office of Local Government, K-State Research and Extension. For questions or other information, call 785-532-2643.
Kansas Health Matters Data Compilation

Introduction

Kansas Rural Health Works (KRHW) is dedicated to helping rural communities build affordable and sustainable local health care systems. The Office of Local Government at K-State Research and Extension is supporting Community Health Needs Assessments. These needs assessments bring a broad-based group of community leaders together to assess local needs, establish priorities, and develop strategic action plans to improve the local health situation. This is an opportunity for the community to rally together to address high-priority local needs and to make the community a better place to live, work, and raise a family. No one can do it for us unless we do it ourselves. The resources presented here support that process. The opportunity is now.

Kansas Health Matters

The ‘Kansas Health Matters’ Web site is intended to help hospitals, health departments, community members and policy makers learn about the health of the community and how to improve it. It provides local health data, resources, promising best practices, news articles and information about community events related to important community health issues. The site specifically aims at supporting the development of community health assessments and community health improvement plans by hospitals and local health departments, but its content also is relevant for anyone interested in how assess and improve the health of communities.

The Kansas Health Matters Website can be found at: www.kansashealthmatters.org

Data Summary

A host of county-level data have been posted to the Health Matters Website, including:

- Access to Health Services
- Children’s Health
- Immunizations and Infectious Disease
- Maternal, Fetal and Infant Health
- Mortality Data
- Prevention and Safety
- Substance Abuse
- Wellness and Lifestyle
- Economic Conditions
- Poverty
- Education
- Environment
- Public Safety

It should be noted, however, that some places with too few events of a given type may display no results, or may show multi-county regional values.
Sherman County Rural Health Works

Access to Health Services

Average Monthly WIC Participation

Value: 31.4 average cases per 1,000 population
Measurement Period: 2010
Location: County: Sherman
Comparison: KS state value
Categories: Health / Access to Health Services

What is this Indicator?
This indicator shows the average monthly number of women and children participating in WIC per 1,000 population.

Why this is important: WIC is a nutrition program that provides nutrition and health education, healthy food and other services to Kansas families who qualify. WIC stands for Women, Infants and Children. WIC’s goal is to help keep pregnant and breastfeeding women, new moms, and kids under age 5 healthy.

National Studies have documented WIC benefits:
- WIC reduces fetal deaths and infant mortality.
- WIC reduces low birth weight rates and increases the duration of pregnancy.
- WIC improves the growth of nutritionally at-risk infants and children.
- WIC decreases the incidence of iron deficiency anemia in children.
- WIC improves the dietary intake of pregnant and postpartum women and improves weight gain in pregnant women.
- Pregnant women participating in WIC receive prenatal care earlier.
- Children enrolled in WIC are more likely to have a regular source of medical care and have more up to date immunizations.
Sherman County Rural Health Works

- WIC helps get children ready to start school: children who receive WIC benefits demonstrate improved intellectual development. WIC significantly improves children’s diets.

WIC also offers immunization screening and referral, breastfeeding support, and nutrition and health classes on a variety of topics including meal planning, maintaining a healthy weight, picky eaters, caring for a new baby, shopping on a budget and more.

An average of 17,747 women, 18,863 infants and 36,629 children received services each month. Total Average: 76,239.

The percent of eligible women, infants and children (up to age 5), served by WIC is estimated to be 72.23%.

Unduplicated number of WIC participants served in Calendar Year 2008 is 128,407 WIC services are provided at 109 County Health Department clinic sites.

Technical Note: The county and regional values are compared to Kansas State value / US value.
Source: Kansas Department of Health and Environment
URL of Source:  http://www.kdheks.gov/
URL of Data:  http://www.kdheks.gov/nws-wic/

Ratio of Population to Primary Care Physicians

Value: 1,916 population per physician
Measurement Period: 2010
Location: County : Sherman
Comparison: KS State Value
Categories: Health / Access to Health Services
Sherman County Rural Health Works

What is this Indicator?
This indicator shows the ratio of population to one primary care physician FTE.

Why this is important: Primary care is the backbone of preventive health care, and a strong primary care workforce is essential to health of our country. Primary care physicians play a key role in providing and coordinating high-quality health care. Adequate access to primary care can improve care coordination and reduce the frequency of avoidable hospitalizations. The Association of American Medical Colleges estimated that the nation would have a shortage of approximately 21,000 primary care physicians in 2015. Without action, experts project a continued primary care shortfall due to the needs of an aging population, and a decline in the number of medical students choosing primary care.

Technical Note: The county and regional values are compared to Kansas State value / US value.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://www.kdheks.gov/

Staffed Hospital Bed Ratio

Value: 4.3 beds per 1,000 population
Measurement Period: 2009
Location: County : Sherman
Comparison: KS State Value
Categories: Health / Access to Health Service

What is this Indicator?
This indicator shows the ratio of the number of staffed hospital beds to 1,000 population.

Why this is important: Staffed Hospital Bed Ratio Staffed Hospital Bed Ratio Staffed Hospital Bed Ratio is the average complement of beds fully staffed during the year, or
those beds that are set-up, staffed, and equipped, and in all respects, ready for use by patients remaining in the hospital overnight.

The exploding demand for healthcare in the U.S. is nothing new. But the growing critical shortage of staffed hospital beds, fueled primarily by the historic growth of an aging population that requires increasing hospitalization, that looms as a possible crisis. In Kansas, 13.2 percent of the population in 2010 was 65 years or older.

Technical Note: The county and regional values are compared to Kansas State value / US value.
Source: Kansas Hospital Association
URL of Source: http://www.kha-net.org/
URL of Data: http://www.kha-net.org/communications/annualstatreport/de...
Percent of WIC Mothers Breastfeeding Exclusively

Value: 10 percent  
Measurement Period: 2010  
Location: County : Sherman  
Comparison: KS State Value  
Categories: Health / Children’s Health; Health / Access to Health Services

What is this Indicator?
This indicator shows the percentage of babies on WIC whose mothers reported breastfeeding exclusively at age 6 months.

Why this is important: Babies who are breastfed are generally healthier and achieve optimal growth and development compared to those who are fed formula milk.

If the vast majority of babies were exclusively fed breast milk in their first six months of life - meaning only breast milk and no other liquids or solids, not even water - it is estimated that the lives of at least 1.2 million children would be saved every year. If children continue to be breastfed up to two years and beyond, the health and development of millions of children would be greatly improved.

Infants who are not breastfed are at an increased risk of illness that can compromise their growth and raise the risk of death or disability. Breastfed babies receive protection from illnesses through the mother's milk.

Baseline: 43.5 percent of infants born in 2006 were breastfed at 6 months as reported in 2007-09. Target: 60.6 percent

Technical Note: The county and regional values are compared to Kansas State value / US value.
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**Exercise, Nutrition & Weight**

**Percentage of Adults Participating in Recommended Level of Physical Activity**

**Value:** 45.3 percent  
**Measurement Period:** 2009  
**Location:** Public Health Preparedness Region: West Central Public Health Initiative  
**Comparison:** KS State Value  
**Categories:** Health / Exercise, Nutrition, & Weight

![Graph showing percentage of adults participating in recommended level of physical activity](image)

*County data was unavailable; Regional value was reported*

**What is this Indicator?**

This indicator shows the percentage of adults 18 years and older who engage in moderate physical activity for at least 30 minutes on five days per week, or vigorous physical activity for at least 20 minutes three or more days per week.

**Why this is important:** Active adults reduce their risk of many serious health conditions including obesity, heart disease, diabetes, colon cancer, and high blood pressure. In addition, physical activity reduces the symptoms of anxiety and depression, improves mood and feelings of well-being, and promotes healthy sleep patterns. More than 60 percent of adults in the United States do not engage in the recommended amount of activity, and about 25 percent of adults are not active at all. The American College of Sports Medicine (ACSM) recommends that active adults perform physical activity three to five times each week for 20 to 60 minutes at a time to improve cardiovascular fitness and body composition. In addition to reducing the risk of multiple chronic diseases, physical activity helps maintain healthy bones, muscles, joints, and helps to control weight, develop lean muscle, and reduce body fat. **The Healthy People 2020 national health target is to increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination to 47.9%.”**
Sherman County Rural Health Works

Technical Note:  The County / Region value is compared to the Kansas state value. Confidence intervals were not taken into account while making this comparison. Source: Kansas Department of Health and Environment URL of Source:  http://www kdheks gov/ URL of Data:  http://www kdheks gov/bfrss/Expansion/index.html

**Percentage of Adults Who are Obese**

**Value:** 23.8 percent  
**Measurement Period:** 2009  
**Location:** Public Health Preparedness Region: West Central Public Health Initiative  
**Comparison:** KS State Value  
**Categories:** Health / Exercise, Nutrition, & Weight

![Percentage of Adults Who are Obese](chart.png)

*County data was unavailable; Regional value was reported*

**What is this Indicator?**
This indicator shows the percentage of adults (ages 18 and older) who are obese based on the Body Mass Index (BMI). The BMI is calculated by taking a person's weight and dividing it by their height squared in metric units. (BMI = Weight (Kg)/[Height (cm) ^ 2] ) A BMI >=30 is considered obese.

**Why this is important:** The obesity is an indicator of the overall health and lifestyle of a community. Obesity increases the risk of many diseases and health conditions including heart disease, Type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and osteoarthritis. Losing weight and maintaining a healthy weight help to prevent and control these diseases. Obesity leads to significant economic costs due to increased healthcare spending and lost earnings. The Healthy People 2020 national health target is to reduce the proportion of adults (ages 20 and up) who are obese to 30.6%.
Technical Note: The County / Region value is compared to the Kansas state value. Confidence intervals were not taken into account while making this comparison.

Source: Kansas Department of Health and Environment

URL of Source: http://www.kdheks.gov/

Sherman County Rural Health Works

Heart Disease and Stroke

Congestive Heart Failure Hospital Admission Rate

**Value:** 304.45 per 100,000 population  
**Measurement Period:** 2007-2009  
**Location:** County: Sherman  
**Comparison:** KS State Value  
**Categories:** Health / Heart Disease & Stroke; Health / Access to Health Services; Health / Wellness & Lifestyle

**What is this Indicator?**
This indicator shows the number of admissions for congestive heart failure per 100,000 population in an area.

**Why this is important:** Prevention of congestive heart failure admissions is an important role for all health care providers. Providers can help individuals stay healthy by preventing disease, and they can prevent complications of existing disease by helping patients live with their illnesses.

While these indicators use hospital inpatient data, their focus is on outpatient health care. Prevention Quality Indicators (PQIs) assess the quality of the health care system as a whole, and especially the quality of ambulatory care, in preventing medical complications. As a result, these measures are likely to be of the greatest value when calculated at the population level and when used by public health groups, State data organizations, and other organizations concerned with the health of populations. Serving as a screening tool, these indicators can provide initial information about potential problems in the community that may require further, more in-depth analysis.

**Technical Note:** The county and regional values are compared to Kansas State value / US value.

Source: Kansas Department of Health and Environment  
Heart Disease Hospital Admission Rate

**Value:** 198.94 per 100,000 population  
**Measurement Period:** 2007-2009  
**Location:** County: Sherman  
**Comparison:** KS State Value  
**Categories:** Health / Heart Disease & Stroke; Health / Access to Health Services; Health / Wellness & Lifestyle

What is this Indicator?
This indicator shows the number of admissions for heart disease (ICD9 diagnoses 402, 410-414 or 429) per 100,000 population in an area.

Why this is important: Heart disease has consistently been a public health concern and is the leading cause of death in the United States. For coronary heart disease alone, the estimated direct and indirect costs for the overall U.S. population are approximately $165.4 billion for 2009. According to the national hospital discharge survey, hospitalizations for heart disease accounted for 4.2 million hospitalizations in 2006. Approximately 62% of these short-stay hospitalizations occurred among people ages 65 years and older. There is also evidence that heart disease hospitalization rates vary among racial and ethnic groups.

Technical Note: The county and regional values are compared to Kansas State value / US value.  
Source: Kansas Department of Health and Environment  
URL of Data: [http://kic.kdhe.state.ks.us/kic/](http://kic.kdhe.state.ks.us/kic/)
Immunizations & Infectious Diseases

**Bacterial Pneumonia Hospital Admission Rate**

*Value:* 583.18 per 100,000 population  
*Location:* County: Sherman  
*Comparison:* KS State Value  
*Categories:* Health / Immunizations & Infectious Diseases; Health / Other Conditions; Health / Access to Health Services

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**What is this Indicator?**  
This indicator shows the number of admissions for bacterial pneumonia per 100,000 population in an area.

**Why this is important:** Prevention of bacterial pneumonia is an important role for all health care providers. Providers can help individuals stay healthy by preventing disease, and they can prevent complications of existing disease by helping patients live with their illnesses.

While these indicators use hospital inpatient data, their focus is on outpatient health care. Prevention Quality Indicators (PQIs) assess the quality of the health care system as a whole, and especially the quality of ambulatory care, in preventing medical complications. As a result, these measures are likely to be of the greatest value when calculated at the population level and when used by public health groups, State data organizations, and other organizations concerned with the health of populations. Serving as a screening tool, these indicators can provide initial information about potential problems in the community that may require further, more in-depth analysis.

**Technical Note:** The county and regional values are compared to Kansas State value / US value.  
*Source:* Kansas Department of Health and Environment  
Percent of Infants Fully Immunized at 24 Months

Value: 85.1 percent  
Measurement Period: 2010-2011  
Location: County : Sherman  
Comparison: KS State Value  
Categories: Health / Immunizations & Infectious Diseases; Health / Children’s Health; Health / Maternal, Fetal & Infant Health

What is this Indicator?  
This indicator shows the percent of infants who were immunized with the 4 DTaP, 3 Polio, 1 MMR, 3 Haemophilus influenzae type b,, and 3 Hepatitis B vaccines (the 4:3:1:3:3 series) by 24 months of age.

Why this is important: Vaccine coverage is of great public health importance. By having greater vaccine coverage, there is an increase in herd immunity, which leads to lower disease incidence and an ability to limit the size of disease outbreaks. In 2006, a widespread outbreak of mumps occurred in Kansas and across the United States. Prior to the outbreak, the incidence of mumps was at a historical low, and even with the outbreak, the mumps disease rates were still lower than pre-vaccination era. Due to high vaccination coverage, tens or hundreds of thousands of cases were possibly prevented. However, due to unvaccinated and under-vaccinated individuals, the United States has seen a rise in diseases that were previously present at low levels, specifically measles and pertussis.

Technical Note: The county value is compared to the Kansas State value.  
Source: Kansas Department of Health and Environment  
URL of Source: http://www.kdheks.gov/
Percentage of Adults Ages 18 Years and Older Who Received A Flu Shot During the Past 12 Months

Value: 38.4 percent  
Measurement Period: 2009  
Location: Public Health Preparedness Region: West Central Public Health Initiative  
Comparison: KS State Value  
Categories: Health / Immunizations & Infectious Diseases

What is this Indicator?
This indicator shows the percentage of adults 18 years and older who received the influenza vaccination (flu shot or flu spray) in the past year.

Why this is important: Influenza is a contagious disease caused by the influenza virus. It can lead to pneumonia and can be dangerous for people with heart or breathing conditions. Infection with influenza can cause high fever, diarrhea and seizures in children. It is estimated that 226,000 people are hospitalized each year due to influenza and 36,000 die - mostly the elderly. The seasonal influenza vaccine can prevent serious illness and death. The Centers for Disease Control and Prevention (CDC) recommends annual vaccinations to prevent the spread of influenza.

Technical Note: The County / Region value is compared to the Kansas state value. Confidence intervals were not taken into account while making this comparison.
Source: Kansas Department of Health and Environment  
URL of Source: http://www.kdheks.gov/  
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Sexually Transmitted Disease Rate

Value: 2.3 cases/10,000 population  
Measurement Period: 2010  
Location: County : Sherman  
Comparison: KS State Value  
Categories: Health / Immunizations & Infectious Diseases

What is this Indicator?  
This indicator shows the crude incidence rate per 1,000 population due to sexually transmitted diseases.

Why this is important: The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 19 million new STD infections each year—almost half of them among young people ages 15 to 24. The cost of STDs to the U.S. health care system is estimated to be as much as $15.9 billion annually. Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the United States.

Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile.

In 2008, 13,500 cases of primary and secondary syphilis were reported in the United States, a 17.7 percent increase from 2007. The rate of primary & secondary syphilis in the United States was 18.4% higher in 2008 than in 2007.

Chlamydia, the most frequently reported bacterial sexually transmitted disease in the United States, is caused by the bacterium, Chlamydia trachomatis. Under-reporting of chlamydia is substantial because most people with chlamydia are not aware of their infections and do not seek testing.
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Healthy People 2020 has set 18 objectives to reduce STD rates in the United States.

Technical Note: The county and regional values are compared to Kansas State value / US value.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://www.kdheks.gov/std/std_reports.html
Infant Mortality Rate

Value: 7.05 deaths/ 1,000 live births
Measurement Period: 2006-10
Location: Public Health Preparedness Region: West Central Public Health Initiative
Comparison: KS State Value
Categories: Health / Maternal, Fetal & Infant Health; Health / Mortality Data

What is this Indicator?
This indicator shows the rate of infant deaths (prior to one year of age) per 1,000 live births.

Why this is important: One of the basic indicators of the health of a community or state is infant mortality, the death of an infant before one year of age. The calculated infant mortality rate (IMR), while not a true measure of population health, serves as one proxy indicator of population health since it reflects the apparent association between the causes of infant mortality and other factors that are likely to influence the health status of the whole population such as economic development, general living conditions, social wellbeing where basic needs are met, rates of illness such as diabetes and hypertension, and quality of the environment.

The number of infant deaths to Kansas residents dropped from 290 in 2009 to 253 in 2010. The number of Kansas resident births in 2010 was 40,439. This resulted in an infant mortality rate of 6.28 per 1,000 live births compared to 7.01 in 2009. Although the one year decline was not statistically significant at the 95% confidence level, the number of infant deaths is the lowest in Kansas since recordkeeping began in 1912. The infant mortality rate is the lowest recorded. Over the last 22 years Kansas has experienced a statistically significant declining trend in the annual infant mortality rate (with a lot of ups and downs in between).
The 2010 infant mortality rate represents a 28.4 percent decrease from the 1989 IMR of 8.77. That change is statistically significant at the 95% confidence level.

The Healthy People 2020 target is 6.0 infant deaths per 1,000 live births. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy.

Technical Note: The county and regional values are compared to Kansas State value.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://kic.kdhe.state.ks.us/kic/index.html

**Number of Births per 1,000 Population**

**Value:** 13 births/1,000 population  
**Measurement Period:** 2008-2010  
**Location:** County: Sherman  
**Comparison:** KS State Value  
**Categories:** Health / Maternal, Fetal & Infant Health

*What is this Indicator?*  
This indicator shows the number of births per 1,000 population.

*Why this is important:* The birth rate is an important measure of population health. The birth rate is usually the dominant factor in determining the rate of population growth; however, it depends on both the level of fertility and the age structure of the population.

Technical Note: The county and regional values are compared to the Kansas State value.  
Source: Kansas Department of Health and Environment
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Percent of all Births Occurring to Teens (15-19 years)

Value: 13.4 percent
Measurement Period: 2008-2010
Location: County: Sherman
Comparison: KS State Value
Categories: Health / Maternal, Fetal & Infant Health; Health / Teen & Adolescent Health

What is this Indicator?
This indicator shows the percentage of births in which mothers were 15-19 years of age.

Why this is important: For many women, a family planning clinic is the entry point into the health care system and one they consider their usual source of care. Each year, publicly funded family planning services prevent 1.94 million unintended pregnancies, including 400,000 teen pregnancies. These services are cost-effective, saving nearly $4 in Medicaid expenditures for pregnancy-related care for every $1 spent.

In Kansas, 4,265 births occurred to women 10-19 years of age, representing 10.3 percent of the births in 2009.

Births resulting from unintended pregnancies can have negative consequences including birth defects and low birth weight. Children from unintended pregnancies are more likely to experience poor mental and physical health during childhood, and have lower educational attainment and more behavioral issues in their teen years.

The negative consequences associated with unintended pregnancies are greater for teen parents and their children. Eighty-two percent of pregnancies to mothers ages 15 to 19 are unintended. One in five unintended pregnancies each year is among teens. Teen mothers are less likely to graduate from high school or attain a GED by the time they
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reach age 30; earn an average of approximately $3,500 less per year, when compared with those who delay childbearing until their 20s; and receive nearly twice as much Federal aid for nearly twice as long.

Unintended pregnancies are associated with many negative health and economic consequences. Unintended pregnancies include pregnancies that are reported by women as being mistimed or unwanted. Almost half of all pregnancies in the United States are unintended. The public costs of births resulting from unintended pregnancies were $11 billion in 2006. (This figure includes costs for prenatal care, labor and delivery, post-partum care, and 1 year of infant care).

Technical Note: Births with unknown values are excluded from the denominator for this calculation. The county and regional values are compared to the Kansas state value. Confidence intervals were not taken into account while making this comparison.

Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://kic.kdhe.state.ks.us/kic/index.html

Percent of Births Occurring to Unmarried Women

Value: 38.5 percent
Measurement Period: 2008-2010
Location: County : Sherman
Comparison: KS State Value
Categories: Health / Maternal, Fetal & Infant Health; Health / Family Planning

What is this Indicator?
This indicator shows the percentage of all births to mothers who reported not being married.

Why this is important: Non-marital births reflect the number of children born to unmarried women and includes both planned and unplanned pregnancies as well as
women who were living with a partner at the time of birth. In previous decades, the term was often used to describe births to teen mothers; however, in recent decades, the average age of unmarried women having children has increased and less than one quarter of non-marital births were to teenaged women. Despite the older age of unmarried mothers, health concerns remain for the children of unmarried women. Studies have found that infants born to non-married women are at greater risk of being born preterm, having a low birth weight, dying in infancy and living in poverty than babies born to married women. In 2007, nearly 4 in 10 births in the U.S. were to unmarried women, according to CDC.

Technical Note: Births with unknown values are excluded from the denominator for this calculation. The county and regional values are compared to the Kansas state value. Confidence intervals were not taken into account while making the comparison with the state.

Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://kic.kdhe.state.ks.us/kic/index.html

Percent of Births where Mother Smoked During Pregnancy

**Value:** 23.9 percent  
**Measurement Period:** 2008-2010  
**Location:** County: Sherman  
**Comparison:** KS State Value  
**Categories:** Health / Maternal, Fetal & Infant Health; Health / Other Chronic Diseases

What is this Indicator?
This indicator shows the percentage of births in which the mothers reported smoked during their pregnancy.

Why this is important: Smoking is a major public health problem. Smokers face an increased risk of lung cancer, stroke, cardiovascular diseases, and multiple other
disorders. Smoking during pregnancy adversely affects the health of both the mother and her baby. Maternal smoking can result in miscarriages, premature delivery, and sudden infant death syndrome. Smoking during pregnancy nearly doubles a woman's risk of having a low birth weight baby, and low birth weight is a key predictor for infant mortality. In addition, smoking also increases the risk of preterm delivery. Low birth weight and premature babies face an increased risk of serious health problems during the infant period, as well as chronic lifelong disabilities such as cerebral palsy, mental retardation, and learning problems.

Technical Note: Births with unknown values are excluded from the denominator for this calculation. The county and regional values is compared to the Kansas State value. Confidence intervals were not taken into account while making this comparison.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://kic.kdhe.state.ks.us/kic/index.html

Percent of Births Where Prenatal Care began in First Trimester

Value: 82.3 percent
Measurement Period: 2008-2010
Location: County : Sherman
Comparison: KS State Value
Categories: Health / Maternal, Fetal & Infant Health

What is this Indicator?
This indicator shows the percentage of births in which mothers received prenatal care in the first trimester.

Why this is important: Babies born to mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care. Early prenatal care (i.e., care in the first trimester of a pregnancy) allows women and their health care providers to identify and,
when possible, treat or correct health problems and health-compromising behaviors that can be particularly damaging during the initial stages of fetal development. Increasing the number of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth.

**Technical Note:** Births with unknown values are excluded from the denominator for this calculation. The county and regional values are compared to the Kansas state value. Confidence intervals were not taken into account while making the comparison with the state.

**Source:** Kansas Department of Health and Environment

**URL of Source:** [http://www.kdheks.gov/](http://www.kdheks.gov/)

**URL of Data:** [http://kic.kdhe.state.ks.us/kic/index.html](http://kic.kdhe.state.ks.us/kic/index.html)

### Percent of Births with Inadequate Birth Spacing

**Value:** 15.9 percent

**Measurement Period:** 2008-2010

**Location:** County: Sherman

**Comparison:** KS State Value

**Categories:** Health / Maternal, Fetal & Infant Health; Health / Children's Health

![Percent of Births with Inadequate Birth Spacing](chart.png)

**What is this Indicator?**

This indicator shows the percentage of live births in which a sibling was born less than 18 months prior.

**Why this is important:** Birth Spacing refers to the time interval from one child's birth date until the next child's birth date. There are many factors to consider in determining what is an optimal time interval between pregnancies. However, researchers agree that 2 ½ years to 3 years between births is usually best for the well being of the mother and her children. When births are spaced 21/2 years to 3 years apart there is less risk of infant and child death. There is also lower risk of the baby being underweight. Short
intervals between births can also be bad for mother’s health. There is a greater risk of bleeding in pregnancy, premature rupture of the bag of waters and increased risk of maternal death. A time interval of six months or more after finishing breastfeeding is also recommended before becoming pregnant again for the mother to be able to rebuild her nutritional stores.

Technical Note: Births with unknown values are excluded from the denominator for this calculation. The county and regional values are compared to the Kansas State value. Confidence intervals were not taken into account while making this comparison.

Source: Kansas Department of Health and Environment
URL of Data: [http://kic.kdhe.state.ks.us/kic/index.html](http://kic.kdhe.state.ks.us/kic/index.html)

**Percent of Births with Low Birth Weight**

**Value:** 9.1 percent  
**Measurement Period:** 2008-2010  
**Location:** County: Sherman  
**Comparison:** KS State Value  
**Categories:** Health / Maternal, Fetal & Infant Health

What is this Indicator?  
This indicator shows the percentage of all births in which the newborn weight is less than 2,500 grams (5 pounds, 8 ounces).

Why this is important: Babies born with a low birth weight are more likely than babies of normal weight to require specialized medical care, and often must stay in the intensive care unit. Low birth weight is often associated with prematurity birth. While there have been many medical advances enabling premature infants to survive, there is still risk of infant death or long-term disability. The most important things an expectant mother can do to prevent prematurity and low birth weight are to take prenatal vitamins, stop smoking, stop drinking alcohol and using drugs, and most importantly, get prenatal care.
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Technical Note: Births with unknown values are excluded from the denominator for this calculation. The county and regional values are compared to the Kansas State value. Confidence intervals were not taken into account while making this comparison.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://kic.kdhe.state.ks.us/kic/index.html
Sherman County Rural Health Works

Mortality Data

Age-adjusted Alzheimer's Disease Mortality Rate per 100,000 Population

Value: 36.4 deaths/100,000 population  
Measurement Period: 2008-2010  
Location: County : Sherman  
Comparison: KS State Value  
Categories: Health / Mortality Data; Health / Older Adults & Aging

What is this Indicator?
This indicator shows the total age-adjusted death rate per 100,000 population due to Alzheimer's disease.

Why this is important: Dementia is the loss of cognitive functioning--thinking, remembering, and reasoning--to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Nationally, Alzheimer's disease is the 6th leading cause of death among adults aged 18 years and older. In Kansas, 963 people died from Alzheimer's, the 6th leading cause of death in the state. The age-adjusted mortality rate was 28.4 deaths per 100,000 population. Estimates vary, but experts suggest that up to 5.1 million Americans aged 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

Dementia affects an individual's health, quality of life, and ability to live independently.

People living with dementia are at greater risk for general disability and experience frequent injury from falls. Older adults with dementia are 3 times more likely to have
preventable hospitalizations. As their dementia worsens, people need more health services and, oftentimes, long-term care. Many individuals requiring long-term care experience major personal and financial challenges that affect their families, their caregivers, and society.

Technical Note: The County / Region values are compared to the Kansas State value.
Source: Kansas Department of Health and Environment
URL of Source: http://www kdheks gov
URL of Data: http://kic kdhe state ks us/kic/index html

Age-adjusted Atherosclerosis Mortality Rate per 100,000 population

Value: 0 deaths/100,000 population
Location: County : Sherman
Comparison: KS State Value
Categories: Health / Mortality Data; Health / Other Chronic Diseases

What is this Indicator?
This indicator shows the total age-adjusted death rate per 100,000 population due to atherosclerosis.

Why this is important: Hardening of the arteries, also called atherosclerosis, is a common disorder. It occurs when fat, cholesterol, and other substances build up in the walls of arteries and form hard structures called plaques. In 2009, atherosclerosis accounted for 321 deaths and was the 11th leading cause of death in the Kansas.

Hardening of the arteries is a process that often occurs with aging. However, high blood cholesterol levels can make this process happen at a younger age. For most people, high cholesterol levels are the result of an unhealthy lifestyle -- most commonly, eating a diet that is high in fat. Other lifestyle factors are heavy alcohol use, lack of exercise, and being overweight.
Other risk factors for hardening of the arteries are:
- Diabetes
- Family history of hardening of the arteries
- High blood pressure
- Smoking

Technical Note: The County / Region values are compared to the Kansas State value.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://kic.kdhe.state.ks.us/kic/index.html

**Age-adjusted Cancer Mortality Rate per 100,000 Population**

**Value:** 141.4 deaths/100,000 population  
**Measurement Period:** 2008-2010  
**Location:** County: Sherman  
**Comparison:** KS State Value  
**Categories:** Health / Mortality Data

![Age-adjusted Cancer Mortality Rate per 100,000 Population](chart.jpg)

**What is this Indicator?**  
This indicator shows the total age-adjusted death rate per 100,000 population due to all cancers.

**Why this is important:** Cancer has been the second leading cause of death in the United States. In Kansas 5,304 persons died of cancer in 2009. With an age-adjusted mortality rate of 173.3 deaths per 100,000 population, Cancer temporarily bumped heart disease from the number one cause of death in Kansas.

Technical Note: The County / Region values are compared to the Kansas State value.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
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URL of Data:  http://kic.kdhe.state.ks.us/kic/index.html

Age-adjusted Cerebrovascular Disease Mortality Rate per 100,000 Population

Value: 39.02 deaths/100,000 population
Measurement Period: 2008-2010
Location: County : Sherman
Comparison: KS State Value
Categories: Health / Mortality Data

What is this Indicator?
This indicator shows the total age-adjusted death rate per 100,000 population due to cerebrovascular disease.

Why this is important: Stroke is the third leading cause of death among Americans, accounting for nearly 1 out of every 17 deaths. It is also the leading cause of serious long-term disability. Risk factors for stroke include inactivity, obesity, high blood pressure, cigarette smoking, high cholesterol, and diabetes

Technical Note: The County / Region values are compared to the Kansas State value.
Source: Kansas Department of Health and Environment
URL of Source:  http://www.kdheks.gov/
URL of Data:  http://kic.kdhe.state.ks.us/kic/index.html

Age-adjusted Chronic Lower Respiratory Disease Mortality Rate per 100,000 Population

Value: 47.6 deaths/100,000 population
Measurement Period: 2008-2010
What is this Indicator?
This indicator shows the total age-adjusted death rate per 100,000 population due to chronic lower respiratory disease.

Why this is important: Chronic Lower Respiratory Disease (CLRD) is the fourth leading cause of death in the United States but the third leading cause of death in Kansas. It is projected to be third nationwide by 2020.

Approximately 124,000 people die each year in the United States from CLRD. This estimate is considered low, however, because CLRD is often cited as a contributory, not underlying, cause of death on the death certificate. In Kansas in CLRD accounted for 1,577 deaths in 2009, producing an age-adjusted mortality rate of 50.9 deaths per 100,000 population.

CLRD comprises three major diseases: chronic bronchitis, emphysema, and asthma. Approximately $42.7 billion is spent annually on direct and indirect health care costs due to CLRD.

Tobacco smoking is the most important risk factor for chronic bronchitis and emphysema, accounting for about 80% of cases. Cigarette smokers are 10 times more likely to die from these diseases than nonsmokers. The remaining 20% of cases are attributable to environmental exposures and genetic factors. Asthma appears to have a strong genetic basis, with 30% to 50% of all cases due to an inherited predisposition.

A direct association between secondhand smoke and lower respiratory disease has been documented by the Environmental Protection Agency. Smoking cessation in the single most effective way to reduce the risk of CLRD and its progression.
Lower respiratory disease deaths increased in the United States by 163% between 1965 and 1998. This trend reflects smoking patterns initiated 30 to 50 years ago.

Technical Note: The County / Region values are compared to the Kansas State value. 
Source: Kansas Department of Health and Environment 
URL of Data: [http://kic.kdhe.state.ks.us/kic/index.html](http://kic.kdhe.state.ks.us/kic/index.html)

**Age-adjusted Diabetes Mortality Rate per 100,000 Population**

**Value:** 33.91 deaths/100,000 population  
**Measurement Period:** 2008-2010  
**Location:** County : Sherman  
**Comparison:** KS State Value  
**Categories:** Health / Mortality Data

What is this Indicator?  
This indicator shows the total age-adjusted death rate per 100,000 population due to Diabetes.

**Why this is important:** In 2007, diabetes was the seventh leading cause of death in the United States. In 2010, an estimated 25.8 million people or 8.3% of the population had diabetes. Diabetes disproportionately affects minority populations and the elderly and its incidence is likely to increase as minority populations grow and the U.S. population becomes older.

Diabetes can have a harmful effect on most of the organ systems in the human body; it is a frequent cause of end-stage renal disease, non-traumatic lower-extremity amputation, and a leading cause of blindness among working age adults. Persons with diabetes are also at increased risk for ischemic heart disease, neuropathy, and stroke. In economic terms, the direct medical expenditure attributable to diabetes in 2007 was estimated to be $116 billion.
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Technical Note: The County / Region values are compared to the Kansas State value.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://kic.kdhe.state.ks.us/kic/index.html

Age-adjusted Heart Disease Mortality Rate per 100,000 Population

Value: 167.45 deaths/100,000 population
Measurement Period: 2008-2010
Location: County : Sherman
Comparison: KS State Value
Categories: Health / Mortality Data

What is this Indicator?
This indicator shows the total age-adjusted death rate per 100,000 population due to heart disease.

Why this is important: Heart disease is the number one cause of death in the U.S. and Hawaii. Physical inactivity, overweight, and obesity are considered cardiovascular risk determinants. Regular physical activity and a diet low in unhealthy fats and high in fruits and vegetables may help reduce the risk for cardiovascular disease. In 2009, the U.S. spent an estimated $68.9 billion on costs associated with stroke, including health care, medicine, and lost productivity.

Technical Note: The County / Region values are compared to the Kansas State value.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://kic.kdhe.state.ks.us/kic/index.html

Age-adjusted Homicide Mortality Rate per 100,000 Population
Value: 0 deaths/100,000 population
Measurement Period: 2008-10
Location: County : Sherman
Comparison: KS State Value
Categories: Health / Mortality Data

What is this Indicator?
This indicator shows the total age-adjusted death rate per 100,000 population due to homicide.

Why this is important: A violent crime is a crime in which the offender uses or threatens to use violent force upon the victim. Violent crimes include homicide, assault, rape, and robbery. Violence negatively impacts communities by reducing productivity, decreasing property values, and disrupting social services. Homicides in Kansas totaled 127 in 2009. The age-adjusted mortality rate was 4.6 deaths per 100,000 population. The 2007 National age-adjusted mortality rate was 6.11 per 100,000 population. The national target is 5.5 homicides per 100,000 population.

Technical Note: The County / Region values are compared to the Kansas State value.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://kic.kdhe.state.ks.us/kic/index.html

Age-adjusted Mortality Rate per 100,000 Population

Value: 809.75 deaths/100,000 population
Measurement Period: 2008-2010
Location: County : Sherman
Comparison: KS State Value
Categories: Health / Mortality Data
What is this Indicator?
This indicator shows the total age-adjusted death rate per 100,000 population due to all causes.

Why this is important: Mortality or death rates are often used as measures of health status for a population. Many factors affect the risk of death, including age, race, gender, occupation, education, and income. By far the strongest of these factors affecting the risk of death is age. Populations often differ in age composition. A "young" population has a higher proportion of persons in the younger age groups, while an "old" population has a higher proportion in the older age groups. Therefore, it is often important to control for differences among the age distributions of populations when making comparisons among death rates to assess the relative risk of death. Age-adjusted mortality rates are valuable when comparing two different geographic areas, causes or time periods.

Technical Note: The County / Region values are compared to the Kansas State value.
Source: Kansas Department of Health and Environment
URL of Data: [http://kic.kdhe.state.ks.us/kic/index.html](http://kic.kdhe.state.ks.us/kic/index.html)

**Age-adjusted Nephritis, Nephrotic Syndrome, Nephrosis Mortality Rate per 100,000 Population**

**Value:** 27.33 deaths/100,000 population
**Measurement Period:** 2008-2010
**Location:** County: Sherman
**Comparison:** KS State Value
**Categories:** Health / Mortality Data
What is this Indicator?
This indicator shows the total age-adjusted death rate per 100,000 population due to nephritis, nephrotic syndrome, nephrosis.

Why this is important: Chronic kidney disease (CKD) -- called kidney disease here for short -- is a condition in which the small blood vessels in the kidneys are damaged, making the kidneys unable to do their job. Waste then builds up in the blood, harming the body. Nephritis, nephrotic syndrome, and nephrosis are diseases associated with the kidney and as a group represented the 9th leading cause of death in Kansas, claiming 556 lives in 2009.

Kidney disease is most often caused by diabetes or high blood pressure. Diabetes and high blood pressure damage the blood vessels in the kidneys, so the kidneys are not able to filter the blood as well as they used to. Usually this damage happens slowly, over many years. As more and more blood vessels are damaged, the kidneys eventually stop working.

Other risk factors for kidney disease are cardiovascular (heart) disease and a family history of kidney failure.

Chronic nephritis is a chronic inflammation of the tissues of the kidney. It is caused by a wide variety of etiological factors. The disease is frequently associated with a slow, progressive loss of kidney function. It is usually discovered accidentally, either by routine urinalysis (tests done to check kidney function) or during a routine physical checkup when anemia, hypertension, or laboratory findings (elevated serum creatinine and blood urea nitrogen) are discovered. Its course is long and the prognosis (expectancy of cure) is poor.

CKD and end-stage renal disease (ESRD) are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. CKD and ESRD are very costly to treat. Nearly 25 percent of the Medicare budget is used to treat people with CKD and ESRD.
Age-adjusted Suicide Mortality Rate per 100,000 Population

Value: 0 deaths/100,000 population
Measurement Period: 2007-09
Location: County : Sherman
Comparison: KS State Value
Categories: Health / Mortality Data

What is this Indicator?
This indicator shows the total age-adjusted death rate per 100,000 population due to suicide.

Why this is important: Suicide results in the tragic loss of human life as well as agonizing grief, fear, and confusion in families and communities. Its impact is not limited to an individual person or family, but extends across generations and throughout communities. The breadth of the problem and the complexity of its risk factors make suicide prevention well suited to a community-based public health approach that engages multiple systems and reaches all citizens. Depression and suicide are significant public health issues. Depression is one of the most common mental disorders experienced by elders, but fortunately is treatable by a variety of means.
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Age-adjusted Traffic Injury Mortality Rate per 100,000 Population

Value: 33.96 deaths/100,000 population  
Measurement Period: 2007-09  
Location: County: Sherman  
Comparison: KS State Value  
Categories: Health / Mortality Data

What is this Indicator?  
This indicator shows the death rate per 100,000 population due to on- or off-road accidents involving a motor vehicle. Deaths resulting from boating accidents and airline crashes are not included in this measure.

Why this is important: Motor vehicle-related injuries kill more children and young adults than any other single cause in the United States. More than 41,000 people in the United States die in motor vehicle crashes each year, and crash injuries result in about 500,000 hospitalizations and four million emergency department visits annually. Increased use of safety belts and reductions in driving while impaired are two of the most effective means to reduce the risk of death and serious injury of occupants in motor vehicle crashes.

Technical Note: The County / Region values are compared to the Kansas State value.  
Source: Kansas Department of Health and Environment  
URL of Data: [http://kic.kdhe.state.ks.us/kic/index.html](http://kic.kdhe.state.ks.us/kic/index.html)

Age-adjusted Unintentional Injuries Mortality Rate per 100,000 Population

Value: 40 deaths/100,000 population  
Measurement Period: 2008-2010
What is this Indicator?
This indicator shows the total age-adjusted death rate per 100,000 population due to unintentional injuries.

Why this is important: Injuries are one of the leading causes of death for Americans of all ages, regardless of gender, race, or economic status. For ages 15 to 24 years, injury deaths exceed deaths from all other causes combined and account for nearly four out of five deaths in this age group. Intentional injuries are those resulting from purposeful human action directed at oneself or others. Major risk factors for intentional injuries from interpersonal or self-inflicted violence include firearms, alcohol abuse, mental illness, and poverty. Unintentional injuries refer to those that are unplanned and include motor-vehicle accidents, falls, fires and burns, and drownings.

In Kansas, unintentional injuries accounted for 1,301 deaths making it the fourth leading cause of death. The age-adjusted mortality rate was 43.8 deaths per 100,000 population. In the US, one death out of every 17 results from injury. In 2006, unintentional injuries were the fifth leading cause of death overall in the U.S, and increased 1.4% from 2005 to 2006. In 2006, 121,599 people died from unintentional injuries.

Technical Note: The County / Region values are compared to the Kansas State value.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
URL of Data: http://kic.kdhe.state.ks.us/kic/index.html
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Prevention & Safety

Injury Hospital Admission Rate

Value: 524.12 Per 100,000 population
Location: County: Sherman
Comparison: KS State Value
Categories: Health/Prevention & Safety

What is this Indicator?
This indicator shows the number of hospital admissions for unintentional and intentional injury (secondary ICD 9CM diagnoses of E800-E928 excluding E870-E879) per 100,000 population in an area.

Why this is important: Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department. Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to: Premature death, disability, poor mental health, high medical costs and lost productivity. The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities. Injuries are not tracked systematically unless they result in hospitalization or death. Hospital admission data only represent the most serious injuries.

Technical Note: The county and regional values are compared to Kansas State value.
Source: Kansas Department of Health and Environment
URL of Data: [http://kic.kdhe.state.ks.us/kic/index.html](http://kic.kdhe.state.ks.us/kic/index.html)
Chronic Obstructive Pulmonary Disease (COPD) Hospital Admission Rate

**Value:** 312.63 Per 100,000 population  
**Measurement Period:** 2007-2009  
**Location:** County: Sherman  
**Comparison:** KS State Value  
**Categories:** Health/Respiratory Diseases

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**What is this Indicator?**  
This indicator shows the number of admissions for chronic obstructive pulmonary disease per 100,000 population in an area.

**Why this is important:** Chronic obstructive pulmonary disease is a leading cause of death in Kansas. Preventing hospital admissions is an important role for all health care providers. Providers can help individuals stay healthy by preventing disease, and they can prevent complications of existing disease by helping patients live with their illnesses. While these indicators use hospital inpatient data, their focus is on outpatient health care. Prevention Quality Indicators (PQIs) assess the quality of the health care system as a whole, and especially the quality of ambulatory care, in preventing medical complications. As a result, these measures are likely to be of the greatest value when calculated at the population level and when used by public health groups. Serving as a screening tool, these indicators can provide initial information about potential problems in the community that may require further, more in-depth analysis.

**Technical Note:** The county and regional values are compared to Kansas State value.  
**Source:** Kansas Department of Health and Environment  
**URL of Source:** [http://www.kdheks.gov/](http://www.kdheks.gov/)  
**URL of Data:** [http://kic.kdhe.state.ks.us/kic/index.html](http://kic.kdhe.state.ks.us/kic/index.html)
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Substance Abuse

Percentage of Adults Who are Binge Drinkers

Value: 7.5 percent  
**Measurement Period:** 2009  
**Location:** Public Health Preparedness Region: West Central Public Health Initiative  
**Comparison:** KS State Value  
**Categories:** Health/Substance Abuse

*County data was unavailable; Regional value was reported*

**What is this Indicator?**
This indicator shows the percentage of adults 18 years and older who reported binge drinking at least once during the 30 days prior to the survey. Male binge drinking is defined as five or more drinks on one occasion, and female binge drinking is four or more drinks on one occasion.

**Why this is important:** Binge drinking is an indicator of excessive alcohol use in the United States. Binge drinking can be dangerous and may result in vomiting, loss of sensory perception, and blackouts. The prevalence of binge drinking among men is twice that of women. In addition, it was found that binge drinkers are 14 times more likely to report alcohol-impaired driving than non-binge drinkers. Alcohol abuse is associated with a variety of negative health and safety outcomes including alcohol-related traffic accidents and other injuries, employment problems, legal difficulties, financial loss, family disputes and other interpersonal problems. **The Healthy People 2020 national health target is to reduce the proportion of adults aged 18 years and older engaging in binge drinking during the past 30 days to 24.3%.**

Technical Note: The County / Region value is compared to the Kansas state value. Confidence intervals were not taken into account while making this comparison.  
Source: Kansas Department of Health and Environment  
URL of Data: [http://kic.kdhe.state.ks.us/kic/index.html](http://kic.kdhe.state.ks.us/kic/index.html)
Percentage of Adults Who Currently Smoke Cigarettes

Value: 18.6 percent  
Measurement Period: 2009  
Location: Public Health Preparedness Region: West Central Public Health Initiative  
Comparison: KS State Value  
Categories: Health/Substance Abuse

What is this Indicator?
This indicator shows the percentage of adults 18 years and older who currently smoke cigarettes.

Why this is important: Tobacco use is one of the most preventable causes of illness and death in America today. Tobacco use causes premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. Approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. Areas with a high smoking prevalence will also have greater exposure to secondhand smoke for non-smokers, which can cause or exacerbate a wide range of adverse health effects, including cancer, heart disease, respiratory infections, and asthma. The Healthy People 2020 national health target is to reduce the proportion of adults aged 18 years and older who smoke cigarettes to 12%.

Technical Note: The County / Region value is compared to the Kansas state value. Confidence intervals were not taken into account while making this comparison.

Source: Kansas Department of Health and Environment  
Percentage of Adults Who are Obese

Value: 23.8 percent
Measurement Period: 2009
Location: Public Health Preparedness Region: West Central Public Health Initiative
Comparison: KS State Value
Categories: Health/Exercise, Nutrition, & Weight

What is this Indicator?
This indicator shows the percentage of adults (ages 18 and older) who are obese based on the Body Mass Index (BMI). The BMI is calculated by taking a person's weight and dividing it by their height squared in metric units. (BMI = Weight (Kg)/[Height (cm) ^ 2] ) A BMI >=30 is considered obese.

Why this is important: The obesity is an indicator of the overall health and lifestyle of a community. Obesity increases the risk of many diseases and health conditions including heart disease, Type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and osteoarthritis. Losing weight and maintaining a healthy weight help to prevent and control these diseases. Obesity leads to significant economic costs due to increased healthcare spending and lost earnings. The Healthy People 2020 national health target is to reduce the proportion of adults (ages 20 and up) who are obese to 30.6%.

Technical Note: The County / Region value is compared to the Kansas state value. Confidence intervals were not taken into account while making this comparison.
Source: Kansas Department of Health and Environment
URL of Source: http://www.kdheks.gov/
Percentage of Adults with Fair or Poor Self-Perceived Health Status

Value: 16.9 percent  
Measurement Period: 2009  
Location: Public Health Preparedness Region: West Central Public Health Initiative  
Comparison: KS State Value  
Categories: Health/Wellness & Lifestyle

What is this Indicator?  
This indicator shows the percentage of adults 18 years and older answering poor or fair to the question: "how is your general health?"

Why this is important: People's subjective assessment of their health status is important because when people feel healthy they are more likely to feel happy and to participate in their community socially and economically. Areas with unhealthy populations lose productivity due to lost work time. Healthy residents are essential for creating a vibrant and successful community.

Technical Note: The County / Region value is compared to the Kansas state value. Confidence intervals were not taken into account while making this comparison.

Source: Kansas Department of Health and Environment  
Sherman County Rural Health Works

Economic Climate

Uninsured Adult Population Rate

Value: 19.2 Percent
Measurement Period: 2009
Location: County: Sherman
Comparison: KS State Value
Categories: Economy/Poverty

What is this Indicator?
This indicator shows the estimated percent of persons ages 18-64 who are uninsured.

Why this is important: Access to health services encompasses four components: coverage, services, timeliness, and workforce.

Health insurance coverage helps patients get into the health care system. Uninsured people are:

Less likely to receive medical care
More likely to die early
More likely to have poor health status

Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills. Current policy efforts focus on the provision of insurance coverage as the principal means of ensuring access to health care among the general population. Other factors, described below, may be equally important to removing barriers to access and utilization of services.

Access to health care services in the United States is regarded as unreliable; many people do not receive the appropriate and timely care they need. The U.S. health care system, which is already strained, will face an influx of patients in 2014, when 32 million Americans will have health insurance for the first time. All of these issues, and others,
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make the measurement and development of new strategies and models essential.

In 2009-2010, the percentage of Kansans without health insurance rose to 13%, the highest rate of the decade, 2000-2010. This percentage climbed from 11.3% in 2005-2006 and 12.7% in 2008-2009. Approximately 357,500 Kansas residents - children and adults - lacked insurance in 2009-2010, also the highest number in the decade and an increase of about 10,000 people from 347,400 during 2008-2009. The percentage of Kansans (13) who were uninsured in 2009-2010 compared favorably with the United States percentage of 16.5%.

Healthy People 2020 has set a target of 100% coverage for medical insurance Increase the proportion of persons with health insurance. The national baseline for comparison was 83.2 percent of persons had medical insurance in 2008.

Technical Note: The County / Region value is compared to the Kansas state value.
Source: U.S. Census Bureau
URL of Source: http://www.census.gov/
URL of Data: http://www.census.gov/did/www/sahie/

Unemployed Workers in Civilian Labor Force

Value: 3.1 Percent
Measurement Period: 2012, May
Location: County : Sherman
Comparison: U.S. Counties
Categories: Economy/Employment

What is this Indicator?
This indicator describes the civilians, 16 years of age and over, who are unemployed as a percent of the U.S. civilian labor force.
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**Why this is important:** The unemployment rate is a key indicator of the local economy. Unemployment occurs when local businesses are not able to supply enough and/or appropriate jobs for local employees and/or when the labor force is not able to supply appropriate skills to employers. A high rate of unemployment has personal and societal effects. During periods of unemployment, individuals are likely to feel severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate places strain on financial support systems, as unemployed persons qualify for unemployment benefits and food stamp programs.

Technical Note: The distribution is based on non-seasonally adjusted data from 3,141 U.S. counties and county equivalents.
Source: U.S. Bureau of Labor Statistics
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Government Assistance Programs

Household with Public Assistance

Value: 3.2 Percent
Measurement Period: 2006-2010
Location: County: Sherman
Comparison: U.S. Counties
Categories: Economy/Government Assistance Programs

What is this Indicator?
This indicator shows the percentage of households receiving cash public assistance income.

Why this is important: Public assistance income includes general assistance and Temporary Assistance to Needy Families (TANF). It does not include Supplemental Security Income (SSI) or noncash benefits such as Food Stamps. Areas with more households on public assistance programs have higher poverty rates.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/
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Home Ownership

Foreclosure Rate

Value: 5.6 Percent  
Measurement Period: 2008  
Location: County: Sherman  
Comparison: U.S. Counties  
Categories: Economy/Home Ownership

What is this Indicator?  
This indicator shows the percentage of mortgages that ended in foreclosure.

Why this is important: Foreclosure rate is a measure of economic stability. A foreclosure is the repossession of a home and/or property by a lender in the event that the borrower defaults on a loan or is unable to meet the agreement of the mortgage. Unfortunately, foreclosures have become commonplace in many American cities and towns. Following a period of rising housing prices in the U.S., prices began to decline steeply and the years 2006 and 2007 saw unprecedented numbers of foreclosures among homeowners, the majority of whom had subprime mortgages. The ensuing "subprime mortgage crisis" was the first major indicator of the U.S. financial crisis.

Individuals and families who lose their homes to foreclosure are often left homeless or in precarious financial situations. Studies show that both the stress and forced relocation following home foreclosure have negative impacts on the health and well-being of individuals and families.

Technical Note: The distribution is based on data from 3,137 U.S. counties.  
Source: U.S. Department of Housing and Urban Development  
URL of Source: [http://www.huduser.org/portal/](http://www.huduser.org/portal/)  
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Homeowner Vacancy Rate

Value: 4.5 Percent  
Measurement Period: 2006-2010  
Location: County: Sherman  
Comparison: U.S. Counties  
Categories: Economy/Homeownership

What is this Indicator?
This indicator shows the percentage of vacant home property.

Why this is important: The homeowner vacancy rate is the proportion of property that is vacant "for sale." It is computed by dividing the number of vacant units "for sale only" by the sum of the owner-occupied units, vacant units that are "for sale only," and vacant units that have been sold but not yet occupied. Vacancy status is often used as a basic indicator of the housing market. It is used to identify turnover and assess the demand for housing. It provides information on the stability and quality of housing for a particular geographic region.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey  
URL of Source:  [http://www.census.gov/acs/www/](http://www.census.gov/acs/www/)  
URL of Data:  [http://factfinder2.census.gov/](http://factfinder2.census.gov/)

Homeownership

Value: 58.1 Percent  
Measurement Period: 2006-2010
Sherman County Rural Health Works

Location: County : Sherman
Comparison: U.S. Counties
Categories: Economy/Homeownership

What is this Indicator?
This indicator shows the percentage of housing units that are occupied by homeowners.

Why this is important: Homeownership has many benefits for both individuals and communities. Homeowners are more likely to improve their homes and to be involved in civic affairs, both of which benefit the individual and the community as a whole. In addition, homeownership provides tax benefits.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/
Renters Spending 30% or More of Household Income on Rent

Value: 38.1 Percent  
Measurement Period: 2006-2010  
Location: County: Sherman  
Comparison: U.S. Counties  
Categories: Economy/Housing Affordability & Supply

What is this Indicator?  
This indicator shows the percentage of renters who are paying 30% or more of their household income in rent.

Why this is important:  
Spending a high percentage of household income on rent can create financial hardship, especially for lower-income renters. With a limited income, paying a high rent may not leave enough money for other expenses, such as food, transportation and medical. Moreover, high rent reduces the proportion of income a household can allocate to savings each month.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/
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Income

Median Household Income

Value: 41,570 Dollars  
Measurement Period: 2006-2010  
Location: County: Sherman  
Comparison: U.S. Counties  
Categories: Economy/Income

What is this Indicator?
This indicator shows the median household income. Household income is defined as the sum of money received over a calendar year by all household members 15 years and older.

Why this is important: Median household income reflects the relative affluence and prosperity of an area. Areas with higher median household incomes are likely to have more educated residents and lower unemployment rates. Higher employment rates lead to better access to healthcare and better health outcomes, since many families get their health insurance through their employer. Areas with higher median household incomes also have higher home values and their residents enjoy more disposable income.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey  
URL of Source: http://www.census.gov/acs/www/  
URL of Data: http://factfinder2.census.gov/

Per Capita Income
**Sherman County Rural Health Works**

**Value:** 22,651 Dollars  
**Measurement Period:** 2006-2010  
**Location:** County: Sherman  
**Comparison:** U.S. Counties  
**Categories:** Economy/Income

**What is this Indicator?**
This indicator shows the per capita income.

**Why this is important:** Per capita income, or income per person, is the total income of the region divided by the population. It is an aggregate measure of all sources of income and therefore is not a measure of income distribution or wealth. Areas with higher per capita incomes are considered to be more prosperous; however, median income is a more accepted measure of the economic well-being of a region because median income is not skewed by extremely high or low outliers.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.  
**Source:** American Community Survey  
**URL of Source:** [http://www.census.gov/acs/www/](http://www.census.gov/acs/www/)  
**URL of Data:** [http://factfinder2.census.gov/](http://factfinder2.census.gov/)
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Poverty

Children Living Below Poverty Level

Value: 26.6 Percent  
Measurement Period: 2006-2010  
Location: County: Sherman  
Comparison: U.S. Counties  
Categories: Economy/Poverty

What is this Indicator?
This indicator shows the percentage of people under the age of 18 who are living below the federal poverty level.

Why this is important: Family income has been shown to affect a child's well-being in numerous studies. Compared to their peers, children in poverty are more likely to have physical health problems like low birth weight or lead poisoning, and are also more likely to have behavioral and emotional problems. Children in poverty also tend to exhibit cognitive difficulties, as shown in achievement test scores, and are less likely to complete basic education.

Technical Note: The distribution is based on data from 3,142 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/

Families Living Below Poverty Level

Value: 12.4 Percent
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Measurement Period: 2006-2010  
Location: County: Sherman  
Comparison: U.S. Counties  
Categories: Economy/Poverty

What is this Indicator?  
This indicator shows the percentage of families living below the federal poverty level.

Why this is important: Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: [http://www.census.gov/acs/www/](http://www.census.gov/acs/www/)  
URL of Data: [http://factfinder2.census.gov/](http://factfinder2.census.gov/)

Low-Income Persons who are SNAP Participants

Value: 20.2 Percent  
Measurement Period: 2007  
Location: County: Sherman  
Comparison: U.S. Counties  
Categories: Economy/Poverty
What is this Indicator?
This indicator shows the percentage of low-income persons who participate in the Supplemental Nutrition Assistance Program (SNAP). Low-income persons are defined as people living in a household with an income at or below 200 percent of the federal poverty level.

Why this is important: SNAP, previously called the Food Stamp Program, is a federal-assistance program that provides low-income families with electronic benefit transfers (EBTs) that can be used to purchase food. The purpose of the program is to assist low-income households in obtaining adequate and nutritious diets.

The number of Americans receiving SNAP benefits reached 39.68 million in February 2010, the highest number since the Food Stamp Program began in 1939. As of June 2009, the average monthly benefit was $133.12 per person and as of November 2009, one in eight Americans and one in four children were using SNAP benefits.

Technical Note: The distribution is based on data from 3,141 U.S. counties and county equivalents.
Source: U.S. Department of Agriculture - Food Environment Atlas

People 65+ Living Below Poverty Level

Value: 12.7 Percent
Measurement Period: 2006-2010
Location: County : Sherman
Comparison: U.S. Counties
Categories: Economy/Poverty
What is this Indicator?
This indicator shows the percentage of people aged 65 and over living below the federal poverty level.

Why this is important: Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. Seniors who live in poverty are an especially vulnerable group due to increased physical limitations, medical needs, and social isolation. Seniors often live on a fixed income from pensions or other retirement plans and social security. If this income is insufficient in the face of increasing prescription costs and other costs of living, most seniors have no way to supplement their income. Retirement plans may be vulnerable to fluctuations in the stock market as well; the increasing reliance of retirees on stock market based retirement plans may explain why more seniors nationwide are now slipping into poverty.

Technical Note: The distribution is based on data from 3,142 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/

People Living 200% Above Poverty Level

Value: 62.7 Percent
Measurement Period: 2006-2010
Location: County : Sherman
Comparison: U.S. Counties
Categories: Economy/Poverty
**Sherman County Rural Health Works**

**People Living 200% Above Poverty Level**

![Graph showing percentage of people living above 200% poverty level over time.]

**What is this Indicator?**
This indicator shows the percentage of residents living 200% above the federal poverty level in the community.

**Why this is important:** Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: [http://www.census.gov/acs/www/](http://www.census.gov/acs/www/)
URL of Data: [http://factfinder2.census.gov/](http://factfinder2.census.gov/)

**People Living Below Poverty Level**

**Value:** 17.9 Percent  
**Measurement Period:** 2006-2010  
**Location:** County: Sherman  
**Comparison:** U.S. Counties  
**Categories:** Economy/Poverty
What is this Indicator?
This indicator shows the percentage of people living below the federal poverty level.

Why this is important: Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/

Poverty Status by School Enrollment

Value: 27.5 Percent
Measurement Period: 2006-2010
Location: County : Sherman
Comparison: KS State Value
Categories: Economy/Poverty
**Sherman County Rural Health Works**

**Poverty Status by School Enrollment**

![Graph showing poverty status by school enrollment](image)

**What is this Indicator?**
This indicator shows the percentage of school-aged children, aged 5 to 19, who are living below the federal poverty level and enrolled in school.

**Why this is important:** Family income has been shown to affect a child's well-being in numerous studies. Compared to their peers, children in poverty are more likely to have physical health problems like low birth weight or lead poisoning, and are also more likely to have behavioral and emotional problems. Children in poverty also tend to exhibit cognitive difficulties, as shown in achievement test scores, and are less likely to complete basic education.

Technical Note: The distribution is based on data from 105 Kansas counties.
Source: American Community Survey
URL of Source: [http://www.census.gov/acs/www/](http://www.census.gov/acs/www/)
URL of Data: [http://factfinder2.census.gov/](http://factfinder2.census.gov/)

**Students Eligible for the Free Lunch Program**

**Value:** 34.3 Percent
**Measurement Period:** 2009
**Location:** County: Sherman
**Comparison:** U.S. Counties
**Categories:** Economy/Poverty
**What is this Indicator?**

This indicator shows the percentage of students eligible to participate in the Free Lunch Program under the National School Lunch Program.

**Why this is important:** The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. The Free Lunch Program (FLP) under the NSLP has been providing nutritionally balanced lunches to children at no cost since 1946. Families who meet the income eligibility requirements or who receive Supplemental Nutritional Assistance Program (SNAP) benefits can apply through their children’s school to receive free meals. The FLP ensures that students who may otherwise not have access to a nutritious meal are fed during the school day. This helps students remain focused and productive in school. Moreover, the lunches help students meet their basic nutritional requirements when their families may not be able to consistently provide a balanced and varied diet.

Technical Note: The distribution is based on data from 3,122 U.S. counties.
Source: U.S. Department of Agriculture - Food Environment Atlas

**Uninsured Adult Population Rate**

**Value:** 19.2 Percent  
**Measurement Period:** 2009  
**Location:** County: Sherman  
**Comparison:** KS State Value  
**Categories:** Economy/Poverty
What is this Indicator?
This indicator shows the estimated percent of persons ages 18-64 who are uninsured.

Why this is important: Access to health services encompasses four components: coverage, services, timeliness, and workforce.

Health insurance coverage helps patients get into the health care system. Uninsured people are:

Less likely to receive medical care
More likely to die early
More likely to have poor health status

Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills. Current policy efforts focus on the provision of insurance coverage as the principal means of ensuring access to health care among the general population. Other factors, described below, may be equally important to removing barriers to access and utilization of services.

Access to health care services in the United States is regarded as unreliable; many people do not receive the appropriate and timely care they need. The U.S. health care system, which is already strained, will face an influx of patients in 2014, when 32 million Americans will have health insurance for the first time. All of these issues, and others, make the measurement and development of new strategies and models essential.

In 2009-2010, the percentage of Kansans without health insurance rose to 13%, the highest rate of the decade, 2000-2010. This percentage climbed from 11.3% in 2005-2006 and 12.7% in 2008-2009. Approximately 357,500 Kansas residents - children and adults - lacked insurance in 2009-2010, also the highest number in the decade and an increase of about 10,000 people from 347,400 during 2008-2009. The percentage of Kansans (13) who were uninsured in 2009-2010 compared favorably with the United States percentage of 16.5%.
Sherman County Rural Health Works

Healthy People 2020 has set a target of 100% coverage for medical insurance. Increase the proportion of persons with health insurance. The national baseline for comparison was 83.2 percent of persons had medical insurance in 2008.

Technical Note: The county and regional values are compared to the Kansas State value.
Source: U.S. Census Bureau
URL of Source: [http://www.census.gov/](http://www.census.gov/)

Young Children Living Below Poverty Level

Value: 17.4 Percent
Measurement Period: 2006-2010
Location: County: Sherman
Comparison: U.S. Counties
Categories: Economy/Poverty

What is this Indicator?
This indicator shows the percentage of people under the age of 5 who are living below the federal poverty level.

Why this is important: Family income has been shown to affect a child's well-being in numerous studies. Compared to their peers, children in poverty are more likely to have physical health problems like low birth weight or lead poisoning, and are also more likely to have behavioral and emotional problems. Children in poverty also tend to exhibit cognitive difficulties, as shown in achievement test scores, and are less likely to complete basic education.

Technical Note: The distribution is based on data from 3,140 U.S. counties and county equivalents.
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Source: American Community Survey
URL of Source:  http://www.census.gov/acs/www/
URL of Data:  http://factfinder2.census.gov/
High School Graduation

Value: 80 Percent
Measurement Period: 2010
Location: County : Sherman
Comparison: KS State Value
Categories: Education/Educational Attainment in Adult Population

What is this Indicator?
This indicator shows the percentage of students who graduate high school within four years of their first enrollment in 9th grade.

Why this is important: Individuals who do not finish high school are more likely than people who finish high school to lack the basic skills required to function in an increasingly complicated job market and society. Adults with limited education levels are more likely to be unemployed, on government assistance, or involved in crime.

The Healthy People 2020 national health target is to increase the proportion of students who graduate high school within four years of their first enrollment in 9th grade to 82.4%.

Technical Note: The distribution is based on data from 105 Kansas counties.
Source: The Annie E. Casey Foundation
URL of Source: http://datacenter.kidscount.org/
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People 25+ with a High School Degree or Higher

Value: 90.1 Percent
Measurement Period: 2006-2010
Location: County : Sherman
Comparison: U.S. Counties
Categories: Education/Educational Attainment in Adult Population

What is this Indicator?
This indicator shows the percentage of people over age 25 who have completed a high school degree or the equivalent.

Why this is important: Graduating high school is an important personal achievement and is essential for an individual's social and economic advancement. Graduation rates are also an important indicator of the performance of the educational system.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/
Sherman County Rural Health Works

Higher Education

People 25+ with a Bachelor's Degree or Higher

Value: 19.1 Percent
Measurement Period: 2006-2010
Location: County : Sherman
Comparison: U.S. Counties
Categories: Education/Higher Education

What is this Indicator?
This indicator shows the percentage of people 25 years and older who have earned a bachelor's degree or higher.

Why this is important: For many, having a bachelor's degree is the key to a better life. The college experience develops cognitive skills, and allows learning about a wide range of subjects, people, cultures, and communities. Having a degree also opens up career opportunities in a variety of fields, and is often the prerequisite to a higher-paying job. It is estimated that college graduates earn about $1 million more per lifetime than their non-graduate peers.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/
Sherman County Rural Health Works

School Environment

Student-to-Teacher Ratio

Value: 11.7 students/teacher
Measurement Period: 2009-2010
Location: County: Sherman
Comparison: U.S. Counties
Categories: Education/School Environment

What is this Indicator?
This indicator shows the average number of public school students per teacher in the county. It does not measure class size.

Why this is important: The student-teacher ratio gives a rough idea of the amount of individualized attention from teachers that is available to each student. Although it is not the same as class size, the student-teacher ratio is often a reasonable alternative on which to base estimates of class size. According to the National Center for Education Statistics, larger schools tend to have higher student-teacher ratios.

Technical Note: The distribution is based on data from 3,143 U.S. counties.
Source: National Center for Education Statistics
URL of Source: http://nces.ed.gov/
URL of Data: http://nces.ed.gov/ccd/bat/
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Built Environment

Farmers Market Density

Value: .17 markets/1,000 population
Measurement Period: 2011
Location: County : Sherman
Comparison: U.S. Value
Categories: Environment/Build Environment

What is this Indicator?
This indicator shows the number of farmers markets per 1,000 population. A farmers market is a retail outlet in which vendors sell agricultural products directly to customers.

Why this is important: Farmers markets provide a way for community members to buy fresh and affordable agricultural products while supporting local farmers. Farmers markets often emphasize good nutrition and support consumers to cook healthier meals and maintain good eating habits. A diet comprised of nutritious foods, in combination with an active lifestyle, can reduce the incidence of heart disease, cancer and diabetes and is essential to maintain a healthy body weight and prevent obesity.

Technical Note: The regional value is compared to the median value of 3,141 U.S. counties. Market data is from 2009 and the population estimates are from 2008.
Source: U.S. Department of Agriculture - Food Environment Atlas

Fast Food Restaurant Density

Value: 1.19 restaurants/1,000 population
Sherman County Rural Health Works

**Measurement Period:** 2009  
**Location:** County : Sherman  
**Comparison:** U.S. Counties  
**Categories:** Environment/Build Environment

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**What is this Indicator?**

This indicator shows the number of fast food restaurants per 1,000 population. These include limited-service establishments where people pay before eating.

**Why this is important:** Fast food is often high in fat and calories and lacking in recommended nutrients. Frequent consumption of these foods and an insufficient consumption of fresh fruits and vegetables increase the risk of overweight and obesity. Individuals who are overweight or obese are at increased risk for serious health conditions, including coronary heart disease, type-2 diabetes, multiple cancers, hypertension, stroke, premature death and other chronic conditions. Fast food outlets are more common in low-income neighborhoods and studies suggest that they strongly contribute to the high incidence of obesity and obesity-related health problems in these communities.

**Technical Note:** The distribution is based on data from 3,141 U.S. counties.

**Source:** U.S. Department of Agriculture - Food Environment Atlas  
**URL of Data:** [http://www.ers.usda.gov/foodatlas/downloadData.htm](http://www.ers.usda.gov/foodatlas/downloadData.htm)

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**Grocery Store Density**

**Value:** 0 stores/1,000 population  
**Measurement Period:** 2009  
**Location:** County : Sherman  
**Comparison:** U.S. Counties  
**Categories:** Environment/Build Environment
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**What is this Indicator?**
This indicator shows the number of supermarkets and grocery stores per 1,000 population. Convenience stores and large general merchandise stores such as supercenters and warehouse club stores are not included in this count.

**Why this is important:** There are strong correlations between the density of grocery stores in a neighborhood and the nutrition and diet of its residents. The availability and affordability of healthy and varied food options in the community increase the likelihood that residents will have a balanced and nutritious diet. A diet comprised of nutritious foods, in combination with an active lifestyle, can reduce the incidence of heart disease, cancer and diabetes and is essential to maintain a healthy body weight and prevent obesity. Low-income and under-served communities often have limited access to stores that sell healthy food, especially high-quality fruits and vegetables. Moreover, rural communities often have a high number of convenience stores, where healthy and fresh foods are less available than in larger, retail food markets.

Technical Note: The distribution is based on data from 3,141 U.S. counties.
Source: U.S. Department of Agriculture - Food Environment Atlas

**Households without a Car and >1 Mile from a Grocery Store**

*Value:* 3.5 Percent  
*Measurement Period:* 2006  
*Location:* County: Sherman  
*Comparison:* U.S. Counties  
*Categories:* Environment/Build Environment
What is this Indicator?
This indicator shows the percentage of housing units that are more than one mile from a supermarket or large grocery store and do not have a car.

Why this is important: The accessibility, availability and affordability of healthy and varied food options in the community increase the likelihood that residents will have a balanced and nutritious diet. A diet comprised of nutritious foods, in combination with an active lifestyle, can reduce the incidence of heart disease, cancer and diabetes and is essential to maintain a healthy body weight and prevent obesity. Low-income and underserved areas often have limited numbers of stores that sell healthy foods. People living farther away from grocery stores and who do not have personal transportation to access the grocery stores are less likely to access healthy food options on a regular basis and thus more likely to consume foods which are readily available at convenience stores and fast food outlets.

Technical Note: The distribution is based on data from 3,109 U.S. counties. Store data are from 2006 and household data are from 2000.
Source: U.S. Department of Agriculture - Food Environment Atlas

Liquor Store Density

Value: 16.6 stores/100,000 population
Measurement Period: 2010
Location: County: Sherman
Comparison: U.S. Counties
Categories: Environment/Build Environment
What is this Indicator?
This indicator shows the number of liquor stores per 100,000 population. A liquor store is defined as a business that primarily sells packaged alcoholic beverages, such as beer, wine, and spirits.

Why this is important: Studies have shown that neighborhoods with a high density of alcohol outlets are associated with higher rates of violence, regardless of other community characteristics such as poverty and age of residents. High alcohol outlet density has been shown to be related to increased rates of drinking and driving, motor vehicle-related pedestrian injuries, and child abuse and neglect. In addition, liquor stores frequently sell food and other goods that are unhealthy and expensive. Setting rules that mandate minimum distances between alcohol outlets, limiting the number of new licenses in areas that already have a high number of outlets, and closing down outlets that repeatedly violate liquor laws can all help control and reduce liquor store density.

Technical Note: The distribution is based on data from 2,378 U.S. counties and county equivalents. Population estimates are from the U.S. Census Bureau.
Source: U.S. Census - County Business Patterns
URL of Data: [http://factfinder2.census.gov/main.html](http://factfinder2.census.gov/main.html)

Low-Income and >1 Mile from a Grocery Store

Value: 30.1 Percent
Measurement Period: 2006
Location: County: Sherman
Comparison: U.S. Counties
Categories: Environment/Build Environment
What is this Indicator?
This indicator shows the percentage of the total population in a county that is low income and living more than one mile from a supermarket or large grocery store.

Why this is important: The accessibility, availability and affordability of healthy and varied food options in the community increase the likelihood that residents will have a balanced and nutritious diet. A diet comprised of nutritious foods, in combination with an active lifestyle, can reduce the incidence of heart disease, cancer and diabetes and is essential to maintain a healthy body weight and prevent obesity. Low-income and underserved areas often have limited numbers of stores that sell healthy foods. People living farther away from grocery stores are less likely to access healthy food options on a regular basis and thus more likely to consume foods which are readily available at convenience stores and fast food outlets.

Technical Note: The distribution is based on data from 3,109 U.S. counties. Store data are from 2006 and household data are from 2000.
Source: U.S. Department of Agriculture - Food Environment Atlas

Recreation and Fitness Facilities

Value: 0.17 facilities/1,000 population
Measurement Period: 2009
Location: County: Sherman
Comparison: U.S. Value
Categories: Environment/Build Environment
What is this Indicator?
This indicator shows the number of fitness and recreation centers per 1,000 population.

Why this is important: People engaging in an active lifestyle have a reduced risk of many serious health conditions including obesity, heart disease, diabetes, and high blood pressure. In addition, physical activity improves mood and promotes healthy sleep patterns. The American College of Sports Medicine (ACSM) recommends that active adults perform physical activity three to five times each week for 20 to 60 minutes at a time to improve cardiovascular fitness and body composition. People are more likely to engage in physical activity if their community has facilities which support recreational activities, sports and fitness.

Technical Note: The regional value is compared to the median value of 3,141 U.S. counties.
Source: U.S. Department of Agriculture - Food Environment Atlas

SNAP Certified Stores-need to change chart

Value: 0.5 stores/1,000 facilities
Measurement Period: 2010
Location: County: Sherman
Comparison: U.S. Counties
Categories: Environment/Build Environment
What is this Indicator?
This indicator shows the number of stores certified to accept Supplemental Nutrition Assistance Program benefits per 1,000 population. SNAP stores include: supermarkets; grocery stores and convenience stores; super stores and supercenters; warehouse club stores; specialized food stores (retail bakeries, meat and seafood markets, and produce markets); and meal service providers that serve eligible persons.

Why this is important: SNAP, previously called the Food Stamp Program, is a federal-assistance program that provides low-income families with electronic benefit transfers (EBTs) that can be used to purchase food. The purpose of the program is to assist low-income households in obtaining adequate and nutritious diets.

The number of Americans receiving SNAP benefits reached 39.68 million in February 2010, the highest number since the Food Stamp Program began in 1939. As of June 2009, the average monthly benefit was $133.12 per person and as of November 2009, one in eight Americans and one in four children were using SNAP benefits.

Technical Note: The distribution is based on data from 3,137 U.S. counties.
Source: U.S. Department of Agriculture - Food Environment Atlas
Sherman County Rural Health Works

Toxic Chemicals

Increased Lead Risk in Housing Rate

**Value:** 37.91 Percent  
**Measurement Period:** 2000  
**Location:** County: Sherman  
**Comparison:** KS State Value  
**Categories:** Environment/Toxic Chemicals

![Bar chart showing Increased Lead Risk in Housing Rate for Sherman County and Kansas in 2000.](chart.png)

**What is this Indicator?**  
This indicator shows the percentage of housing units, built before 1950 and at an elevated risk for lead exposure.

**Why this is important:** Lead poisoning is a preventable pediatric health problem affecting Kansas' children. Lead is a toxic metal that produces many adverse health effects. It is persistent and cumulative. Childhood lead poisoning occurs in all population groups and income brackets. There is no safe level of lead. Early identification and treatment of lead poisoning reduces the risk that children will suffer permanent damage. A blood lead test is the only way to tell if a child has an elevated blood level. Lead-based paint can be found in most homes built before 1950 and many homes built before 1978. Lead can also be found on walls, woodwork, floors, windowsills, eating and playing surfaces or in the dirt outside the home. In addition, renovation or maintenance projects that disturb lead-based paint can create a lead dust hazard that can be inhaled or can settle on toys, walls, floors, tables, carpets or fingers. Parents whose hobby or occupation involves working with or around lead can unknowingly bring lead dust home. Individuals should avoid "take-home" exposures by utilizing personal protection and hygiene after leaving the workplace. Wash your hands after working in the yard. Wash children's hands and faces after playing outside. Wash all fruits and vegetables before consuming them. Remove shoes before entering your home, and clean dust and tracked-in soil. Lead poisoning can be difficult to recognize and can damage a child's central nervous.
Sherman County Rural Health Works

system, brain, kidneys, and reproductive system. When lead is present in the blood it travels through every organ in the body. Lead interferes with the development of the brain. When lead enters the blood stream it collects in soft tissues of the body and it also settles in the bones and teeth, where it is stored for many years.

Technical Note: The regional value is compared to the Kansas State value.
Source: U.S. Census Bureau
URL of Source:  http://www.census.gov/
URL of Data:   http://keap.kdhe.state.ks.us/epht/portal/ContentArea.aspx
Sherman County Rural Health Works

Elections & Voting

Voter Turnout

Value: 74.2 Percent  
Measurement Period: 2008  
Location: County: Sherman  
Comparison: KS Counties  
Categories: Government & Politics/Elections & Voting

What is this Indicator?
This indicator shows the percentage of registered voters who voted in the previous presidential general election.

Why this is important: Voting is one of the most fundamental rights of a democratic society. Exercising this right allows a nation to choose elected officials and hold them accountable. Voting ensures that all citizens have the opportunity to voice their opinions on issues such as the use of tax dollars, civil rights and foreign policy. By voting, individuals shape their communities and influence the next generation of society. A high level of turnout indicates that citizens are involved in and interested in who represents them in the political system.

Technical Note: The distribution is based on data from 105 Kansas counties.
Source: Kansas Secretary of State
URL of Source: http://www.kssos.org/
URL of Data: http://www.kssos.org/elections/elections_statistics.html

Sherman County Rural Health Works

Crime & Crime Prevention

Rate of Violent Crime per 1,000 population

Value: 2 crimes/1,000 population
Measurement Period: 2009
Location: County : Sherman
Comparison: KS state value
Categories: Public Safety/Crime & Crime Prevention

What is this Indicator?
This indicator shows the rate of violent crimes like assault and robbery per 1,000 population.

Why this is important: Social support and good social relations make an important contribution to health. Social cohesion - defined as the quality of social relationships and the existence of trust, mutual obligations and respect in communities or in the wider society - helps to protect people and their health. Inequality is corrosive of good social relations. Societies with high levels of income inequality tend to have less social cohesion and more violent crime.

Technical Note: The county and regional values are compared to Kansas State value / US value. Under reporting of crime by some public safety jurisdictions may result in lower rates.
Source: Kansas Bureau of Investigation
URL of Source: http://www.accesskansas.org/kbi/
URL of Data: http://www.accesskansas.org/kbi/stats/stats_crime.shtml
Ratio of Children to Adults

Value: 28.9 children per 100 adults
Measurement Period: 2009
Location: County: Sherman
Comparison: KS State Value
Categories: Social Environment/Demographics

What is this Indicator?
This indicator shows the ratio of adolescent dependent persons (under 15 years of age) per 100 persons aged 15-64.

Why this is important: The age structure of a population is important in planning for the future of a community, particularly for schools, community centers, health care, and child care. A population with more youth will have greater education and child care needs, while an older population may have greater health care needs. Older people are also far more likely to vote, making them an important political force.

Technical Note: The county and regional values are compared to Kansas State value.
Source: U.S. Census Bureau
URL of Source: http://www.census.gov/
URL of Data: http://2010.census.gov/2010census/data/

Ratio of Elderly Persons and Children to Adults

Value: 58.5 elderly & children per 100 adults
Measurement Period: 2009
What is this Indicator?
This indicator shows the ratio of all dependent persons (ages 0-14 and 65 and over) per 100 persons aged 15-64.

Why this is important: The age structure of a population is important in planning for the future of a community, particularly for schools, community centers, health care, and child care. A population with more youth will have greater education and child care needs, while an older population may have greater health care needs. Older people are also far more likely to vote, making them an important political force.

Technical Note: The county and regional values are compared to Kansas State value / US value.
Source: U.S. Census Bureau
URL of Source: http://www.census.gov/
URL of Data: http://2010.census.gov/2010census/data/

Ratio of Elderly Persons to Adults

Value: 29.7 elderly per 100 adults
Measurement Period: 2009
Location: County : Sherman
Comparison: KS State Value
Categories: Social Environment/Demographics
What is this Indicator?
This indicator shows the ratio of elderly dependent persons (65 and over) per 100 persons aged 15-64.

Why this is important: The age structure of a population is important in planning for the future of a community, particularly for schools, community centers, health care, and child care. A population with more youth will have greater education and child care needs, while an older population may have greater health care needs. Older people are also far more likely to vote, making them an important political force.

Technical Note: The county and regional values are compared to Kansas State value / US value.
Source: U.S. Census Bureau
URL of Source: http://www.census.gov/
URL of Data: http://2010.census.gov/2010census/data/
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Neighborhood/Community Attachment

People 65+ Living Alone

Value: 29.8 Percent
Measurement Period: 2006-2010
Location: County : Sherman
Comparison: US Counties
Categories: Social Environment/Neighborhood/Community Attachment

What is this Indicator?
This indicator shows the percentage of people 65 and over who live alone.

Why this is important: People over age 65 who live alone may be at risk for social isolation, limited access to support, or inadequate assistance in emergency situations. Older adults who do not live alone are most likely to live with a spouse, but they may also live with a child or other relative, a non-relative, or in group quarters. The Commonwealth Fund Commission on the Elderly Living Alone indicated that one third of older Americans live alone, and that one quarter of those living alone live in poverty and report poor health. Rates of living alone are typically higher in urban areas and among women. Older people living alone may lack social support, and are at high risk for institutionalization or losing their independent life style. Living alone should not be equated with being lonely or isolated, but many older people who live alone are vulnerable due to social isolation, poverty, disabilities, lack of access to care, or inadequate housing.

Technical Note: The distribution is based on data from 3,142 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/
Sherman County Rural Health Works

Commute to Work

Mean Travel Time to Work

Value: 9.8 Minutes
Measurement Period: 2006-2010
Location: County: Sherman
Comparison: US Counties
Categories: Transportation/Commute to Work

What is this Indicator?
This indicator shows the average daily travel time to work in minutes for workers 16 years of age and older.

Why this is important: Lengthy commutes cut into workers' free time and can contribute to health problems such as headaches, anxiety, and increased blood pressure. Longer commutes require workers to consume more fuel which is both expensive for workers and damaging to the environment.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/

Workers who Drive Alone to Work

Value: 73.5 Percent
Measurement Period: 2006-2010
What is this Indicator?
This indicator shows the percentage of workers 16 years of age and older who get to work by driving alone in a car, truck, or van.

Why this is important: Driving alone to work consumes more fuel and resources than other modes of transportation, such as carpooling, public transportation, biking and walking. Driving alone also increases traffic congestion, especially in areas of greater population density.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: [http://www.census.gov/acs/www/](http://www.census.gov/acs/www/)
URL of Data: [http://factfinder2.census.gov/](http://factfinder2.census.gov/)

Workers who Walk to Work

Value: 6.9 Percent
Measurement Period: 2006-2010
Location: County : Sherman
Comparison: US Counties
Categories: Transportation/Commute to Work
What is this Indicator?
This indicator shows the percentage of workers 16 years of age and older who get to work by walking.

Why this is important: Walking to work is a great way to incorporate exercise into a daily routine. In addition to the health benefits, walking helps people get in touch with their communities, reduces commute costs and helps protect the environment by reducing air pollution from car trips. Furthermore, studies have shown that walking to work improves employees overall attitude and morale and reduces stress in the workplace.

The Healthy People 2020 national health target is to increase the proportion of workers who walk to work to 3.1%.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/
Sherman County Rural Health Works

Personal Vehicle Travel

Households without a Vehicle

Value: 7 Percent
Measurement Period: 2006-2010
Location: County: Sherman
Comparison: US Counties
Categories: Transportation/Commute to Work

What is this Indicator?
This indicator shows the percentage of households that do not have a vehicle.

Why this is important: Vehicle ownership is directly related to the ability to travel. In general, people living in a household without a car make fewer than half the number of journeys compared to those with a car. This limits their access to essential local services such as supermarkets, post offices, doctors' offices, and hospitals. Most households with above-average incomes have a car while only half of low-income households do.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: [http://www.census.gov/acs/www/](http://www.census.gov/acs/www/)
URL of Data: [http://factfinder2.census.gov/](http://factfinder2.census.gov/)
Sherman County Rural Health Works

Public Transportation

Workers Commuting by Public Transportation

Value: 0.5 Percent
Measurement Period: 2006-2010
Location: County : Sherman
Comparison: US Counties
Categories: Transportation/Public Transportation

What is this Indicator?
This indicator shows the percentage of workers aged 16 years and over who commute to work by public transportation.

Why this is important: Public transportation offers mobility to U.S. residents, particularly people without cars. Transit can help bridge the spatial divide between people and jobs, services, and training opportunities. Public transportation is also beneficial because it reduces fuel consumption, minimizes air pollution, and relieves traffic congestion.

The Healthy People 2020 national health target is to increase the proportion of workers who take public transportation to work to 5.5%.

Technical Note: The distribution is based on data from 3,143 U.S. counties and county equivalents.
Source: American Community Survey
URL of Source: http://www.census.gov/acs/www/
URL of Data: http://factfinder2.census.gov/
Sherman County Community Survey Results

Survey Highlights

- 178 total responses
- Important to remember – non-representative
- 94% see a doctor; 93% use local provider
- 89% were satisfied/somewhat satisfied
- 81% used a hospital in the past 2 years; GRMC captured 88%
- 94% had prior GRMC experience; 91% were satisfied/somewhat satisfied
- Specialty care
  - Orthopedist – 23
  - OB/GYN – 21
  - Ear/Nose/Throat – 20
  - Urologist – 15
  - Cardiologist – 12
  - Neurologist – 12
  - Dermatologist – 12
  - Allergist - 9
- 88% used Goodland Family Health Center; 90% were satisfied/somewhat satisfied
- 68% used County Health; 97% satisfied
- Comments suggest some unmet needs and challenges
  - access to primary care physicians/long wait times
  - lack of services/ specialty assistance
  - customer service issues
  - local cost/billing issues
### 1. Home Zip Code

<table>
<thead>
<tr>
<th>Number</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>67732</td>
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</tr>
<tr>
<td>67733</td>
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</tr>
<tr>
<td>67735</td>
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</tr>
<tr>
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<tr>
<td>80807</td>
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</tr>
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### 2. Family Doctor

<table>
<thead>
<tr>
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<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>94.4%</td>
</tr>
<tr>
<td>No</td>
<td>5.6%</td>
</tr>
<tr>
<td>Don't Know</td>
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</tr>
<tr>
<td>Sum</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

### 3. Medical Provider for Routine Health Care

<table>
<thead>
<tr>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>Community Health Center</td>
</tr>
<tr>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>Health Department</td>
</tr>
<tr>
<td>Specialist</td>
</tr>
<tr>
<td>Emergency Room/Hospital</td>
</tr>
<tr>
<td>None, don't see anyone</td>
</tr>
<tr>
<td>Other:</td>
</tr>
<tr>
<td>Complimentary Provider</td>
</tr>
<tr>
<td>Chiropractor</td>
</tr>
<tr>
<td>Alternative Medicine</td>
</tr>
</tbody>
</table>

### 4. Family Doctor in Service Area

<table>
<thead>
<tr>
<th>Number</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>93.2%</td>
</tr>
<tr>
<td>No</td>
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</tr>
<tr>
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<tr>
<td>Sum</td>
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</tbody>
</table>
5. Satisfaction with Quality of Care

<table>
<thead>
<tr>
<th>Number</th>
<th>Percent</th>
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<tbody>
<tr>
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<tr>
<td>Somewhat Satisfied</td>
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<tr>
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<tr>
<td>Dissatisfied</td>
<td>5</td>
</tr>
<tr>
<td>Sum</td>
<td>159</td>
</tr>
</tbody>
</table>

6. Why were you satisfied/unsatisfied?
Satisfied Responses:
1. Providers were thorough.
2. Good, knowledgeable doctor and good verbal explanation to me
3. They helped us know what was going on, get rehabilitation, and medicine
4. The concern was addressed
5. Professional and did a good job
6. Physician was excellent but if that individual left, I would drive an hour for better healthcare.
7. Care, concern, diagnosis
8. All issues were addressed – was about to access the doctor timely
9. Took time to take care of me
10. Problems were/are addressed promptly, referred as necessary
11. We have a very thorough diagnostician
12. They are dedicated to their profession.
13. I don’t have any major health problems and my doctor is very helpful.
14. Needs were met in a caring manner
15. The doctor was very thorough with my four-year-old.
16. Problem resolved, knowledgeable friendly care
17. Nurse practitioners were great.
18. Familiarity with provider. Good customer service
19. Drs. are always thorough and take time.
20. Competent, timely, caring, but poor human relations by doctor
21. Accurately diagnosed conditions
22. Everything went well
23. Competent service
24. Very knowledgeable, friendly and helpful
25. Good care
26. Doctor is very knowledgeable and caring.
27. Great personable service – love small town of feeling known by doctor, not just a number
28. I received the care I needed.
29. They are knowledgeable but would be more knowledgeable.
30. Treated symptoms and aware of discomfort I was having
31. Dr. took good care of my family
32. My needs have been met.
33. He listens to my concerns and doesn’t just push pills.
34. Doctor was very thorough.
35. Very knowledgeable and I was able to relay opinion.
36. Good, caring care
37. Medical emergency – Would have died without service provided.
38. Because I know and trust the doctor.
39. Received prompt service at the office – caring doctor
40. Excellent care and thorough diagnosis and care
41. Taken care of professionally
42. The service was quite satisfactory and done in a timely manner.
43. Extremely pleasant personality with great results
44. Services always offered quickly
45. Most health issues resolved or improved
46. Because he is familiar with the problem and knows how to treat it.
47. Doctor does blood follow-up and refers when necessary.
48. Complete and thorough
49. We had time to ask questions and overall felt comfortable with the doctor.
50. Easy to get appointment. Very good care from nurse practitioner
51. Good doctor took time with me to explain what he was doing.
52. They have always been very helpful and friendly.
53. Professional, gave informative diagnosis
54. Timely, good service
55. Exams have been thorough.
56. Good service, questions answered, friendly
57. Friendly staff, nurses, doctor were satisfactory.
58. Satisfied if I actually get my own doctor when I need him. I will schedule with the PA when that is all I need to see and I do that quite often.
59. Got in soon after I called for an appointment. Appointment was on-time and I received the appropriate amount of time at the appointment.
60. My condition was diagnosed and satisfactorily treated.
61. Very personable
62. Rural health care can’t beat it!
63. Correct and fast diagnosis
64. Primary physician we are very pleased with
65. Good doctors and nurses – very knowledgeable
66. I was satisfied because I see the same doctor every time. I trust him and my problems were taken care of.
67. The reason I went was taken care of or else referred to a specialist.
68. Friendly and helpful
69. Excellent patient care! Always available to answer questions
70. Trust their expertise
71. Qualified personnel
72. Efficient, informative care
73. The people who assisted me were professional and efficient. Attitudes could be worked on.
74. Feel that issue was taken care of professionally
75. He is everything we expect in a doctor.
76. Care was excellent! People were caring!
77. I felt my health care needs were met.

Dissatisfied Responses:
1. Addressed symptoms but not the issue
2. Response time is slow – but feel we have some quality providers; they are just too busy!
3. Difficult to get an appointment. Rushed
4. Staff smelled like smoke. Physician was too busy to care about our needs.
5. Misdiagnosed. We were told by the provider that took care of the problem, “It was the worst sonogram they had ever seen.”
6. Not comprehensive care/needs
7. Provider chose not to test my urine. Specialist later the following week ran test and discovered I had a UTI
8. I think the primary care doctor has too many patients. The other two doctors are rude so no one wants to see them.
9. He was grouchy.
10. Western medicine does not cover all the bases being insurance and pharmacy driven.
11. Waiting time for appointments is long.
12. Having to wait to get into the doctor – scheduling
13. Cost too much without insurance
14. Order tests but don’t call to let you know the results
15. Tests ordered and would not answer questions as to why
16. You always see the P.A. This town needs some new, young doctors for families.
17. They would rather just prescribe an antibiotic that covers everything instead of taking the time to find the right action.
18. Waited over one hour from scheduled appointment time
19. Hard to get in.
20. Never seems to be able to get you in for 2-3 weeks
21. Didn’t find out my results.
22. Doctor is so busy it’s hard to get into. He doesn’t always follow up timely – I finally went to another doctor over fainting and found out I needed a Pacemaker – fainting quit.
23. In ER, I feel like we shop out via flight to Denver. We need to be able to handle more here and not fly so quickly.
24. Not enough staff at windows, unfriendly staff
25. Doctor was not professional – Child was told they had cancer over the phone; no conversation! We were referred to Hays – treated very unprofessionally and so took matters into our own hands and went to Denver – received the best professional care there!
26. It is very hard to get into Dr. so you have to settle with a less than favorable doctor.
27. Took over one week to get appointment. Did not resolve or refer to resolve issue
28. Some of the staff seem disinterested and have made mistakes. They don’t listen.
29. Doctor was too busy to focus on our needs.
30. Takes too long to get an appointment – don’t feel like they genuinely care.
31. The doctors did not follow-up.
32. After visit, you do not get results unless you call.
33. Difficult to get appointment with doctor of choice, sometimes several days wait.
34. Doctor was rude and offered no explanation.
35. Conditions were not treated properly, more than one occasion.
36. More dissatisfied with the wait than the quality of care
37. I didn’t get an answer to the problem.
38. Feel like you’re just a number and they don’t really take the time or feel they care about you.
39. Hard to get an appointment scheduled
40. Sometimes it seems like they do too much with the computer instead of talking to the patient.
41. Had to wait too long for schedule appointment.
42. Front office people are rude. Long wait in waiting room

Neutral Responses:
1. Job was done. Too expensive
2. When they have an opening, the doctors are great but if you’re not scheduled, it takes weeks to a month to get in.
3. Doctor care is good but timeliness of appointments and walk-in clinic need a lot of improvement.
4. Small town hospitality is good. Only complaint is that the wait can be too long
5. Good care but always experience a lack of customer service
6. Wait for doctor is long but good care overall
7. Like walk-in clinic – however long wait times

7. Used Services of a Hospital in Past 24 Months

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>No</td>
<td>33</td>
<td>18.6%</td>
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### 8. Hospitals Services Received

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Location</th>
<th>Number</th>
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<tbody>
<tr>
<td>Goodland Regional Medical Center</td>
<td>Goodland</td>
<td>127</td>
</tr>
<tr>
<td>Citizens Medical Center</td>
<td>Colby</td>
<td>10</td>
</tr>
<tr>
<td>Family Center for Healthcare</td>
<td>Colby</td>
<td>1</td>
</tr>
<tr>
<td>Hays Medical Center</td>
<td>Hays</td>
<td>8</td>
</tr>
<tr>
<td>Sheridan County Health Complex</td>
<td>Hoxie</td>
<td>1</td>
</tr>
<tr>
<td>Manhattan Surgical Center</td>
<td>Manhattan</td>
<td>1</td>
</tr>
<tr>
<td>Cheyenne County Hospital</td>
<td>St. Francis</td>
<td>2</td>
</tr>
<tr>
<td>Mayo Clinic Hospital</td>
<td>Phoenix, AZ</td>
<td>1</td>
</tr>
<tr>
<td>Anschutz MS Center</td>
<td>Aurora, CO</td>
<td>1</td>
</tr>
<tr>
<td>Aurora Central Hospital</td>
<td>Aurora, CO</td>
<td>1</td>
</tr>
<tr>
<td>Burlington Hospital</td>
<td>Burlington, CO</td>
<td>1</td>
</tr>
<tr>
<td>Kit Carson County Memorial Hospital</td>
<td>Burlington, CO</td>
<td>2</td>
</tr>
<tr>
<td>Presbyterian/St. Lukes Medical Center</td>
<td>Denver, CO</td>
<td>7</td>
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<tr>
<td>Porter Hospital</td>
<td>Denver, CO</td>
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</tr>
<tr>
<td>Children's Hospital</td>
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<tr>
<td>St. Anthony's Hospital</td>
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<tr>
<td>University of Colorado Hospital</td>
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<tr>
<td>National Jewish Hospital</td>
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<tr>
<td>Rocky Mountain Health</td>
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<tr>
<td>Swedish Hospital</td>
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<tr>
<td>Longmont Surgical Center/Hospital</td>
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<tr>
<td>North Suburban Medical Center</td>
<td>Thornton, CO</td>
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<tr>
<td>Mary Lanning Memorial Hospital</td>
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<tr>
<td>Brodestone Memorial Hospital</td>
<td>Superior, NE</td>
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### 9. Used Services of Goodland Regional Medical Center

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number</th>
<th>Percent</th>
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<tbody>
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<tr>
<td>No</td>
<td>10</td>
<td>5.8%</td>
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<td>Don't Know</td>
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### 10. Most Recent Service Obtained at GRMC

<table>
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<tbody>
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<td>Inpatient</td>
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<tr>
<td>Outpatient</td>
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<tr>
<td>Emergency</td>
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## 11. Satisfaction with Last GRMC Experience

<table>
<thead>
<tr>
<th>Satisfied</th>
<th>Number</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Somewhat Satisfied</td>
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<tr>
<td>Somewhat Dissatisfied</td>
<td>9</td>
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<tr>
<td>Dissatisfied</td>
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<td>3.1%</td>
</tr>
<tr>
<td>Sum</td>
<td>162</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**12. Why were you satisfied/dissatisfied?**

Satisfied Responses:

1. I felt the staff did a wonderful job and Dr.
2. Hospital met our needs.
3. Professional and informative
4. Service variety and good customer service.
5. Good service
6. Problems were taken care of.
7. NP was very helpful and quick. Also answered all questions.
8. Great service, informed about what was going on.
9. Everything went well.
10. Received care
11. Good, through exam
12. X-ray was quick
13. Competent Dr. and staff
14. Professionals were caring.
15. Quick and friendly.
16. The results were given in a timely matter
17. Happy that I could have the service done locally.
18. Every test came out negative.
19. Very professional and compassionate.
20. Very caring people with concern and compassion.
21. Was well taken care of- diagnosed and treated same day, good results.
22. Well taken care of.
23. Got in, got out- routine services
24. Competent staff
25. Excellent physical therapy department
26. Outpatient doctor top notch and personable
27. Staff was thorough and professional
28. Quality care and good Dr. and patient communication
29. Met requirement for blood work; physical therapy helped injury
30. They were prompt and did a good job.
31. Good services- knowledgeable
32. Service was satisfactory and done in a timely matter.
33. Professionally taken care of.
34. Appointment-ok treatment-ok
35. Radiology department very good at performing procedures.
36. I got in and out quick and had my blood work done.
37. Received professional care
38. Received prompt, excellent care
39. Pleasant staff
40. Trust their expertise
41. I was satisfied because they got us in that day!
42. They were friendly and helped me though the C-section.
43. I was satisfied because I knew my child was being taken care of properly.
44. Got right in.
45. They tried their hardest and cared.
46. Taken care of within an hour.
47. The care given met my expectations.
48. Ease of speed and service results.
49. Good lab service.
50. Friendly staff.
51. Had good service and care.
52. My needs were taken care of
53. Most everything went smoothly.
54. Easy blood drawn.
55. It was a thorough visit.
56. Timely service and good quality.
57. Went well
58. The staff listen and sincerely try to relieve the problem.
59. The radiology techs were efficient and friendly.
60. Great care, good results.
61. Doctor’s and nurses were very helpful.
62. Caring people well organized and responsive.
63. Fast, efficient, pleasant
64. Good service
65. Problems addressed and responses timely
66. Was seen on time and med issues addressed
67. The P.A. I went to was amazing.
68. They knew his problems and how to treat them.
69. Health issue resolved
70. Staff was professional
71. Service was good
72. The good care given
73. Prompt results
74. Waiting time was short; Dr was thorough.
75. It was physical therapy- basic but good
76. Blood test- relatively painless
77. Quick response- good pt to provider
78. Very friendly and informative
79. They treated me well and took good care of me.
80. Everyone was very nice and caring.
81. Feeling of compassion from care givers.
82. Caring staff; efficient
83. Nurses and doctors very in time with us.
84. Prompt care/ diagnosis
85. They really check me out.
86. Experienced staff.

Dissatisfied Responses:
1. Had to be shipped to Denver and it could have been done here.
2. Sometimes have to wait a long time for lab- long lines of people waiting to have blood drawn.
3. My only real complaint is that the cause of the problem was not identified during hospitalization.
4. Cost was too high.
5. Issue misdiagnose at great expense.
6. Untimely
7. The cost was double the cost of other local hospitals
8. As an inpatient, RN depended on nurse assistant and patient only saw RN once or twice a shift.
9. Lab tech had difficulty obtaining blood sample from my baby.
10. A lot of waiting
11. Had to go to GD because the providers were too busy. The providers at the ED were rude.
12. Rude physician/ physician not knowledgeable/ staff smelled like smoke
13. Customer service was TERRIBLE. The culture NEEDS to change.
14. The billing for the same service elsewhere was 2-3x more.
15. Seems most emergencies are immediately flow out causing extra expense.
16. I would rather drive to Hays and get in within 2 weeks than wait a month to see a doctor here if I need a specialist. Too many patients for too few doctors. Most x-rays have to be rerun at specialist’s offices and I hate to have to pay twice.
17. Report did not get to specialist doctor who ordered test.
18. No answers were given.
19. Poorly organized- had to go out of town to get “real” treatment.
20. Too many forms to fill out prior to receiving emergency care.
21. Quality of care and attitudes made me somewhat dissatisfied.
22. It took almost an hour for the doctor on call to show up. It if was a life threatening thing my husband would or could have died.
23. LONG wait time to see specialist (2 hours)
24. Slow service
25. Fly to quickly... was discharged on arrival at Denver with $25,000 flight.
26. Not on time
27. Billing department is the biggest downfall.
28. Family doctor would not see my daughter for a bead in her nose. Made me go to the ER because they did no have tweezers to remove it.

Neutral Responses:
1. Great customer service although the cost was too high
2. EMS crew took a long time, staff was good.
3. Good care with a lack of customer service.
4. I’m satisfied with (one doctor) but NOT (other doctors) who diagnosed with cancer but didn’t have it.
5. The hospital is not bad but the billing has a lot to be desired.
6. Was only there one day and night- it was an ok stay- nothing to rave about.
13. Past 24 mo, Type of Medical Specialists Services and Where

<table>
<thead>
<tr>
<th>Type Specialist</th>
<th>City</th>
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13. Past 24 mo, Type of Medical Specialists Services and Where

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14. Used Services of the Goodland Family Health Center

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<td>Sum</td>
<td>177</td>
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15. If yes, what type of service was obtained?
1. Family doctor for Pre-Op/ Common Cold.
2. Health care for heart/urology follow-up.
3. P.A. routine checkups/ specialty clinic/ physical therapy.
4. Walk in clinic (6)
5. Annual female exam
6. Office visits (what else is available?)
7. General medicine
8. At Pioneer Health I got allergy shots and routine check-ups.
9. Doctors visit sometimes feels like some reports are not read thoroughly finding this out as I went to another Dr.
10. Ear infection
11. Family Practice
12. Chronic care, urgent care
13. Physicals/ general office visits
14. OC
15. Regular doctor care
16. Regular appts- flu, diabetes
17. Doctor calls, blood work, colonoscopies
18. Treatment for colds, etc
19. Heartburn, common cold, woman’s exam
20. Routine check-ups (18)
21. Colonoscopy
22. Blood work
23. Colds- physical exam
24. Many times with good results
25. Well child and general health issues
26. Doctor appointment, lab work, x-rays
27. Morning walk-in clinic, family clinic
28. Respiratory and general health checks
29. Walk in clinic, scheduled appointments
30. Physicals for kids, coughs and colds
31. Pre and post natal care
32. Sciatica
33. Colonoscopy
34. Various medical exams by P.A.
35. Wellness checkups, flu shots, treatments for cols, etc
36. Normal- routine visits
37. Medical checkups and refill prescriptions
38. Specialists
39. Doctor
40. Treatment for illness
41. Our family physician
42. OB and well child checks
43. Well child checks, obstetric care
44. Family practice
45. Check-ups, pediatrics, diabetes treatments
46. Follow up after ER visit
47. Doctor appointment (10)
48. Bad headache
49. Doctor for infection
50. Pre-op
51. Pediatrics
52. Treatment for sinus
53. PT, doctor, lab, x-ray
54. Routine well-baby visits, men’s annual, sick visits
55. Family practice and OB care
56. Exam (yearly), diabetes
57. Office visit and walk in clinic
58. Hearing problem
59. Office visits, routine complaints
60. Primary care and specialty care
61. Physical (12)
62. Pediatrician
63. Family health care, well child, immunizations, OB care
64. Office visit, restless leg syndrome
65. Skin-warts
66. Sinus infection
67. Clinical, emergency, radiology, lab
68. Walk-in, specialty referrals
69. Seeing physician for pre-op
70. General office visits (12)
71. Office visits (8)
72. Wellness checkup
73. Examine by physician
74. General and well-baby check-ups
75. OB care and routine medical care
### 16. Satisfaction with GFHC Experience

<table>
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<tr>
<td>Sum</td>
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### 17. Why were you satisfied/dissatisfied?

Satisfied Responses:
1. The doctor and their staff cared about their patients
2. The doctor was excellent
3. The doctor was good with children
4. It was thorough, informative, and efficient
5. The doctor did what I wanted and what I needed
6. Everything was done in a timely matter
7. Taken care of
8. Availability of doctors and waiting time
9. Prompt appointments, good exam, followed up on care
10. They were great / knee pain - depression
11. Very caring, although prescriptive options only
12. Familiarity with providers, great customer service
13. Nurse always willing to take calls and answer questions. Very helpful
14. Treated with kindness and apathy/ Do get put on hold when frequently calling for appointment
15. They always handle my needs
16. Friendly
17. Good care at GFHC
18. Received good care
19. Were able to get me in and get me out quickly
20. Everyone helped me
21. Had no problems
22. I like it because we don’t have to wait to see a doctor
23. Good doctor/ PA
24. On time
25. Prompt, good service
26. Good result
27. Short wait, efficient congenial workers and professionals
28. Appointment was scheduled quickly
29. Timely and friendly, good quality
30. It was a thorough visit
31. Friendly and good service
32. Problems taken away
33. Friendly staff
34. Ease and speed of service and results
35. Diagnosed and treated
36. Labs, Rx refilled
37. Needs were met
38. Courteous and professional
39. Diagnosed and treated promptly, got in to be seen quickly
40. Made sure to get to proper care
41. Good service
42. Good care
43. Competent staff
44. Physician and his staff were top notch beyond that not much to write home about
45. Office staff could be more courtesy/professional
46. All good; end up going to doctor in Hays once to get additional assessment of pediatric issue
47. Concerns were addressed
48. Knowledgeable staff
49. Only one we have
50. Service satisfactory and done in a timely manner
51. Courteous and professionally taken care of
52. Friendly, quick and on time
53. Extremely pleased with care given
54. Fast
55. Trust expertise
56. Great care
57. Because I trust our family doctor. He is very knowledgeable

Dissatisfied Responses:
1. Some staff attitudes, minor delays
2. Very unfriendly, feel like they need more training
3. It is really hard to get in, I don’t like talking to the receptionist
4. Cost too much
5. Lack of care and consideration for the patient and their families
6. Billing department refused to split the bill in half due to divorce agreement (copy was provided, along with ex-spouses billing info)
7. They would rather just prescribe an antibiotic that covers everything instead of taking the time to find the right action.
8. Long wait- almost an hour from appointment/Nurse practitioner was calling patience on follow-up care while I waited in exam room. I could hear everything she discussed with her patients.
9. Received care needed/ required
10. Helpful in some areas and some aspects
11. I don’t like the sliding glass window. Secretary’s seem to ignore that you are there
12. If it weren’t for some other company entering the billing it would of be a no complaint visit.
13. Difficult to get an appointment- long wait time. Delay in test results
14. Not always able to get appointment the same day
15. Scheduling, front desk
16. Billing was an issue... they told me one price and charged me that a time of service then sent me another bill for more
17. Was seen 3 times for the same thing and never had a diagnosis that said what I had
18. Long time to see a doctor
19. They are slow at getting people in and seen
20. Seems like the people behind the window are not as attentive as they should be
21. Every time I use the walk-in clinic, I am there for 2-3 hours. Even when I have an appointment, it is usually ½ an hour later before seeing the doctor.
22. Nurse seems more interested in laptop than listening to concerns and has made mistakes which fortunately could be corrected
23. Registration staff was rude, doctor didn’t want to fix the problem and was referred to as a specialist that didn’t do anything different
24. They weren’t in any hurry to help you
25. Took forever to get an appointment
26. Very difficult to get into doctor of personal choice. Told to try a walk-in clinic- usually a long wait to be seen.
27. Our primary doctor’s schedule is always full weeks in advance and need letter schedule to cut down on waiting time for appointments- cant get in
28. Doctor was rude and offered no explanation
29. Conditions were not treated properly
30. When you have to wait an hour to see a doctor for your appointment
31. Provider chose not to test my urine. Specialist later the following week ran test discovered I had a UTI
32. Long wait
33. Not very friendly or professional
34. Long wait to be seen
35. Rude doctor/rude staff/staff smelled like smoke
36. Overworked providers who handle too many patients
37. Charges high for just an office visit
38. Easy stuff they do their thing but serious stuff they rush and feel like they don’t understand you

Neutral Responses:
1. Good quality, friendly care but wait too long to see the providers
2. Service/ visit was good- waiting time to get the appointment (3 weeks) was not acceptable
3. Most of the time access is easy, however, sometimes we can’t get through on the phone
18. Used Services to the Sherman County Health Department

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<tr>
<td>Sum</td>
<td>176</td>
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19. If yes, what type of service was obtained?

1. Years ago - child immunization, recently flu shots
2. Infant/toddler shots, annual paps
3. Blood work
4. Shots (35)
5. Immunizations (27)
6. Vaccinations (9)
7. Emergency dog bite
8. TB test (7)
9. Family planning
10. Toe trim
11. Inoculation for H1N1 flu
12. When children were babies that’s where we got immunizations
13. TB tests and vaccines
14. Birth control, tetanus
15. Health check-BP
16. Check blood pressure
17. Several years ago - got flu shot
18. Blood pressure check
19. Shots & blood pressure check
20. Pedicure
21. School assessment for son
22. Breast pump rental
23. Shots, toenail care
24. WIC
25. Flu shot, TDAP shot
26. Getting shots for trip to Africa
27. Check hearing
28. WIC
29. Blood pressure check, got grandchildren immunizations
30. Had blood pressure checked
31. Check blood pressure flu shot, tetanus shot
32. Pneumonia shot was okay but shingles wasn’t covered under my health plan so went to Colby
33. Paps
34. Flu shots, tetanus shot
35. Immunization, family planning
36. WIC and immunizations
37. Routine checkups
38. Papsmear and depo shot
39. Vaccination and blood pressure monitoring
40. Gynecology/family planning
41. WIC (several years ago), Immunizations
42. Wellness check-Kindergarten

### 20. Satisfaction with Health Department Experience

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<tr>
<td><strong>Sum</strong></td>
<td>116</td>
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### 21. Why were you satisfied/dissatisfied?

Satisfied Responses:
1. Very prompt, professional and courteous
2. Got what we needed
3. Familiarity, great customer service
4. Services were rendered in a timely fashion
5. Able to get in in a timely manner
6. Good service
7. Free flu shot as a county employee
8. Good service, friendly, explain everything well
9. Quick response, friendly
10. Did what we needed
11. Friendly
12. Efficient
13. Ladies are very nice and don't judge you
14. They administer well and easy access
15. Friendly and patient
16. On time appointment
17. They did their job
18. Short waiting time
19. So nice-friendly
20. It was handy to go there and cost effective- $2 at that time
21. They were knowledgeable and efficient
22. Children treated very well, especially child with needle anxiety
23. They're pretty fast at getting you in
24. Fast
25. Prompt and pleasant
26. Fast service
27. Shots they had were given and information given where to get others
28. Staff is considerate and efficient
29. Friendly and accommodating
30. Quick and painless
31. Friendly and good service
32. Caring and quick
33. Friendly staff
34. Very short wait/quick and polite staff
35. Quick and good service
36. Fast service-knowledgeable advice
37. Services were good
38. Service was OK
39. Got waited on and over in a few minutes, no waiting
40. If you call ahead you don’t have to wait- great staff
41. They were very helpful and caring
42. Staff was informed
43. A waiting, friendly staff
44. Took care of business-offered what I needed
45. Needs were met and at a discount
46. They were very helpful
47. They were very qualified
48. Treated well
49. Good service-took interest in my concerns
50. In-out fast
51. Kind and efficient
52. Pleasant staff, prompt affordable service
53. The time in waiting room was significantly less than GFHC/you actually feel like your time is important to them as they get you in and out
54. Caring staff
55. Quality work and knowledgeable and caring staff members
56. Shots technically delivered
57. Got what was needed
58. Went the extra mile to remind you of options and services
59. Good services provided
60. Cheerful care
61. Friendly; caring
62. Helpful and affordable
63. I was satisfied with the people
64. They take their time and do a thorough job

Dissatisfied Responses:
1. Slow
2. Cost help
3. Did not have a sliding payment schedule
4. Pneumonia shot was okay, but shingles wasn’t covered under my health plan so went to Colby
5. They make you uncomfortable

Neutral Responses:
1. Positive: availability Negative: cost
2. Satisfied: availability Not satisfied: too costly

22. Concerns about health care in Sherman County.
1. There are not enough doctors. We need more physicians.
2. There is a low availability of doctors for routine exams, colds, etc.
3. Some people are not able to get help unless they are established with a physician.
4. The doctor’s office is slow and if you don’t have insurance or a medical reason for insurance, they really don’t work with you on payments. Trying to get insurance in always impossible when you’re pregnant with no job, even though your husband works at the prison.
5. I really like the walk-in clinic.
6. Clinic wait times can be quite long, especially at the walk-in clinic.
7. Patient turnover needs improvement.
8. Waiting for a doctor’s call for an entire day and getting a call very shortly before the pharmacy closes is not good practice.
9. I would like to see continued services here so we don’t have to go to bigger cities for services.
10. I think the facility itself needs to be updated consistently. The hospital must remain a large part of our community.
11. There is a lack of coverage by a dermatologist. This is a high skin cancer section of the country with many farmers, outdoor workers, and outdoor recreation.
12. I am pleased with the specialists that come in; this is a worthwhile service. It seems that the services such as cat scans, bone density scans, etc. are easily used.
13. Some of the staff needs to develop better listening skills and not assume that they know the problem and not belittle the patient’s health concerns. Other staff does an excellent job.
14. Many elderly are going home because they do not quality for in-home assistance. Medication management at home will increase compliance.
15. I have no issues with the services, though the specialists are sometimes hard to get.
16. Services will be always available and competently staffed.
17. We need more qualified doctors and staff – less managers
18. We need more family doctors and obstetricians.
19. Birthing classes need to be revised because they weren’t as informative as they could have been.
20. There needs to be better communication between doctors, nurses, and lab. The wrong tests were given, resulting in more blood to be drawn from newborn and an over 30 minutes wait
21. Post-natal care for the mother was never explained by the nurse. It was just assumed. After having a baby, you don’t really think about all these questions until later.
22. When leaving the hospital, we were never informed of the next steps, as far as setting up the next doctor’s appointment for the newborn or circumcision date.
23. There needs to be better food options. I didn’t know there was even an option of food until the third day in the hospital. There needs to also be healthier and higher quality foods for breastfeeding moms.
24. There needs to be better billing between the hospital and the health department. If we had not checked into immunizations at the health department after having our first shots at the hospital, we would have over-paid by $700 because they did not use the state program for families without health insurance for immunizations.
25. The invoices and statements were always very confusing.
26. There are no family doctors who are interested in caring for our entire health needs. We are examined and sent out of town.
27. The doctor doesn’t seem to care how you feel or even ask what your thoughts are or seem to care at all for that matter.
28. Waiting time to get an appointment is long.
29. It is difficult to get in and see the doctors. At other times, I have used the walk-in clinic and still had to wait two hours or longer to be seen. We do not currently have an endocrinologist coming to Goodland.
30. It takes weeks to get appointments and the doctors are seeing far too many patients in the short amount of time they are here. I like the doctors connected with Hays more than those from Denver because I do not like to drive in Denver. We are lucky to have what we have here at home. We have to be thankful for that.
31. I feel that it seems to be more of a “First-Aid Station” It seems to me that everything is “farmed out” to other hospitals or specialists causing more expense than is needed to the patient!
32. Compared to outside facilities, I feel the knowledge case could have been better, the technology was lacking and behind, and the billing was never correct, resulting in more expense to the patient.
33. We have a real need to continue to attract new, young doctors. We are very fortunate to have access to the specialists that come to the Goodland hospital.
34. You have to wait extended amounts of time for an appointment. I understand there are emergencies, but please tell me I can come back in 30 minutes or I can reschedule.
35. We want to keep health care services in Sherman County so we don’t have to drive to Hays or Denver.
36. We need more women doctors.
37. We need a pediatrician who actually likes kids.
38. Current physician is excellent, however I am not satisfied with the front desk help and the very long wait period to be seen at the Goodland Family Health Center. The center needs more high quality family/OBGYN physicians.
39. There are a number of people close to retiring at the hospital.
40. What is the future of the EMS?
41. We need blister packs for medication.
42. We need quicker access to specialists.
43. The Eagle Med flights are very expensive if you have no insurance or low insurance and likelihood of sending people via plane.
44. We need more public awareness campaigns on the local radio stations.
45. “Top of the mind awareness” is essential for GRMC- year round.
46. There should be more consistent customer service at hospital and GFHC.
47. I would like to see more resources available in the county.
48. The hospital and the clinic are too closely connected.
49. The providers are overworked.
50. The providers are un-personable.
51. There are many financial concerns.
52. The billing practices are unprofessional. It takes a long time to receive the bill and sometimes it is not even right.
53. The providers do not listen- they think they are right and won’t listen to you.
54. There is an inconvenience to care.
55. You have to drive 30 minutes to get great service.
56. There is a lack of family doctors/ physicians.
57. It is difficult to get appointments.
58. We need better quality/ more providers that do not smoke.
59. Old providers are not motivated to take care of patients.
60. We need a surgeon on staff.
61. People are going out of town for health care.
62. Many people do not have the ability to afford care.
63. We need more primary care physicians.
64. We will lose some of the specialists that come here due to the reductions of Medicare and Medicaid.
65. We have a concern with the drug usage with youth and adults.
66. We need to focus on the poverty in children and their needs.
67. The cost of everything is expensive.
68. We need to have an access to care for the uninsured or underinsured.
69. I know people that have had misdiagnosis.
70. There are long waits in the clinic.
71. Too many people go to the ER instead of the clinic.
72. We have a lack of communication for services available and education.
73. Providers refuse to see the physical therapists.
74. There needs to be more info about alternative/ non-traditional health care options.
75. We need a dermatologist.
76. There is a need for geriatrics and more OB.
77. I hope our service grows and continues.
78. The population decline causes lower economics and a lack of ability to attract good health care providers.
79. The communication between staff and patients are limited.
80. Physicians are rarely available.
81. The current business model is unsustainable.
82. We need low cost health care for college students and uninsured community members.
83. I think the hospital needs to close and Emergy-Care needs to be opened.
84. We do not have any qualified doctors or surgeons.
85. I want another hometown doctor to come in and not get burnt out.
86. I love our health care.
87. They are very comforting in time of need.
88. We have a low SES rate.
89. It is cheaper to drive 30-45 minutes then to go to a local hospital.
90. We need lower cost of well-baby checks.
91. We need a more aggressive approach on specialty doctors and recruitment.
92. We need to expand our specialty care.
93. They lack quality of care and prices are way too high for the area.
94. People are being flown out for minor things that could be taken care of here.
95. ERMC needs to mend its relationship with Colorado.
96. Our hospitals moral is low.
97. A friendlier receptionist would be nice.
98. We need a bigger lab.
99. More Medicaid/Unicare specialists need to be here.
100. There needs to be a nail clipping day for the elderly.
101. I think we need a digital mammography machine.
102. There should be better cooperation between GRMC and SCHD.
103. The employees and administration are too highly paid for what they do.
Sherman County Community Health Needs Assessment Survey

You are invited to participate in a survey intended to help identify health-related needs in Sherman County. This survey is being sponsored by the Goodland Regional Medical Center and the Sherman County Health Department with assistance from the Department of Agricultural Economics at Kansas State University. This survey invitation is open to any county resident 18 years of age or older.

There will be no information obtained with this survey that will identify you. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. At the end of the survey we invite your comments regarding your perceptions about local health-related issues or this survey initiative; however, do not include any identifying information.

Participation in this survey is voluntary. You may choose to refuse to answer any or all of the questions on this survey. If you have any questions, please feel free to contact Dr. John Leatherman, (785) 532-4492; jleather@k-state.edu.

1. First, what is your home zip code? _______________

2. Do you use a family doctor (physician, nurse practitioner, physician's assistant) for most of your routine health care?
   - [ ] Yes (Skip to Q4)
   - [ ] No
   - [ ] Don't Know

3. If no, then what kind of medical provider do you use for routine health care?
   - [ ] Community Health Center
   - [ ] Rural Health Clinic
   - [ ] Health Department
   - [ ] Specialist
   - [ ] Emergency Room/Hospital
   - [ ] None, don't see anyone
   - [ ] Other (specify): ____________________________

4. Have you or someone else in your household been to a family doctor (physician, nurse practitioner, physician's assistant) in the Goodland service area?
   - [ ] Yes
   - [ ] No (Skip to Q7)
   - [ ] Don't Know (Skip to Q7)

5. If yes, how would you describe your satisfaction with the quality of care provided by that doctor? Were you…
   - [ ] Satisfied
   - [ ] Somewhat Satisfied
   - [ ] Somewhat Dissatisfied
   - [ ] Dissatisfied

6. Why were you satisfied/dissatisfied?
   ______________________________________________________________________

7. Have you or someone in your household used the services of a hospital in the past 24 months?
   - [ ] Yes
   - [ ] No (Skip to Q9)
   - [ ] Don't Know (Skip to Q9)

8. At which hospital(s) were services received?
   - [ ] Goodland Regional Medical Center (Skip to Q10)
   - [ ] Other (please specify Hospital(s) and City)

   Hospital       City
   ____________________________________________  ____________________________
   ____________________________________________  ____________________________
   ____________________________________________  ____________________________

9. Have you or any members of your household ever used the services of the Goodland Regional Medical Center?
   - [ ] Yes
   - [ ] No (skip to Q13)
   - [ ] Don’t Know (skip to Q13)

10. Recalling the most recent visit to the Goodland Regional Medical Center, what type of service was obtained? (check all that apply)
    - [ ] Inpatient
    - [ ] Outpatient
    - [ ] Emergency
    - [ ] Other (please specify)
11. How would you describe your satisfaction with your last Goodland Regional Medical Center experience? Were you….  
☐ Satisfied  ☐ Somewhat Satisfied  ☐ Somewhat Dissatisfied  ☐ Dissatisfied

12. Why were you satisfied/dissatisfied?
________________________________________________________________________

13. In the past 24 months, what type of medical specialist services have you or someone in your household used and where was that service provided?  
Type of Specialist         City
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________

14. Have you or any members of your household ever used the services of the Goodland Family Health Center?  
☐ Yes  ☐ No (skip to Q18)  ☐ Don’t Know (skip to Q18)

15. If yes, what type of service was obtained? (please specify)  
________________________________________________________________________

16. How would you describe your satisfaction with your Goodland Family Health Center experience? Were you….  
☐ Satisfied  ☐ Somewhat Satisfied  ☐ Somewhat Dissatisfied  ☐ Dissatisfied

17. Why were you satisfied/dissatisfied?
________________________________________________________________________

18. Have you or any members of your household ever used the services of the Sherman County Health Department?  
☐ Yes  ☐ No (skip to Q26)  ☐ Don’t Know (skip to Q26)

19. If yes, what type of service was obtained? (please specify)  
________________________________________________________________________

20. How would you describe your satisfaction with your county health department experience? Were you….  
☐ Satisfied  ☐ Somewhat Satisfied  ☐ Somewhat Dissatisfied  ☐ Dissatisfied

21. Why were you satisfied/dissatisfied?
________________________________________________________________________

22. Please indicate any general concerns you have about health care in Sherman County:  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Thank you for your assistance.

Please drop your completed survey off at the Goodland Regional Medical Center, 220 West 2nd, Goodland, or the Sherman County Health Department, 1623 Broadway in Goodland between 9:00 a.m. 5:00 p.m., no later than Monday, September 10.
May 2012

K-State Research and Extension
Department of Agricultural Economics
Office of Local Government

Health Services Directory
Sherman County
Sherman County Area Health Services Directory

This directory contains contact information for service providers supporting the local health care system. The directory includes telephone and Internet contact information for many health-related information centers in Kansas and throughout the U.S.

There are two purposes motivating the compilation of this information. The first is to ensure that local residents are aware of the scope of providers and services available in their communities, capturing the greatest share of health care spending in the local health care market. The second is to identify gaps that may exist in the local health care inventory of health-related services and providers can help fill.

The importance of community economic activity, capturing the greatest share of health care spending is an important source of community economic activity. This could become the focus of future community efforts to fill the gaps in needed services.

This publication is formatted for printing as a 5.5” x 8.5” booklet. Set your printer to print 2 pages per sheet. In Acrobat, go to Print/Properties/Finishing and select 2 Pages per Sheet.

Funding for this work was provided by the Kansas Health Foundation Professor in Community Health Endowment administered by K-State Research and Extension at Kansas State University.
To provide updated information or to add new health and medical services to this directory, please contact:

Office of Local Government
K-State Research and Extension
10E Umberger
Manhattan, KS 66506
Phone: (785)-532-2643
Fax: (785)-532-3093
John Leatherman: Jleather@K-state.edu
www.ksu-olg.info
www.krhw.net

Emergency Numbers

Sherman County Sheriff 785-899-4835
Goodland 785-899-4570 785-899-4545

Police
Fire

Non-Emergency Numbers

Sherman County Sheriff 785-899-4835

Police 911
Fire 911
Ambulance 911

Police/Sheriff 911

DRIFT
Other Emergency Numbers

Domestic Violence Shelter
1-800-799-7233
www.ndvh.org

Domestic Violence Hotline
1-800-794-4624
Kansas Child/Adult Abuse and Neglect Hotline
1-800-922-5330
www.srskansas.org/hotlines.html

Domestic Violence Hotline
1-888-END-ABUSE
www.kcsdv.org

Emergency Management (Topeka)
785-274-1409 or 785-274-1409
www.ksdot.org

Poison Control Center
1-800-222-1222
www.aapcc.org

Suicide Prevention Hotline
1-800-799-7233
www.ndvh.org

Toxic Chemical and Oil Spills
1-800-424-8802
www.epa.gov/region2/contract.htm

Kansas Arson/Crime Hotline
1-800-KS-CRIME
www.accesskansas.org/kbi

Kansas Bureau of Investigation (Topeka)
785-276-8181
www.fbi.gov/congress/congress01/caruso100301.htm

Kansas Arson/Crime Hotline
1-800-424-8802
www.epa.gov/region2/contract.htm

Federal Bureau of Investigation
1-800-KS-CRIME
www.accesskansas.org/kbi

Kansas Arson/Crime Hotline
1-800-424-8802
www.epa.gov/region2/contract.htm

Toxic Chemical and Oil Spills
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Kansas Bureau of Investigation (Topeka)
785-276-8181
www.fbi.gov/congress/congress01/caruso100301.htm

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www.accesskansas.org/kbi

Kansas Arson/Crime Hotline
1-800-KS-CRIME
www/accesskansas.org/kbi
Goodland Regional Medical Center

220 W 2nd (Goodland)
785-890-3625

Goodland Regional Medical Center Services

Provided Include:

- Inpatient Acute and Skilled Care
- Outpatient Services
- Specialty Clinic

Health Services

Emergency

800-432-0333 (Emergency)
785-890-3625

Sherman County Health Department

324 W 2nd (Goodland)
785-890-3625

High Plains Mental Health Center

85-890-4888
1622 Broadway Avenue (Goodland)

Mental Health

Health Department

Telemedicine - Call 911

Ambulance - See Specialist Listing

Specialty Clinic - See Specialist Listing

Goodland Regional Medical Center

785-890-3625
220 W 2nd (Goodland)

Hospital

Call 911
Medical Professionals

Physicians

Goodland Family Health Center
106 Willow Rd (Goodland)
785-890-6075
Travis Daise, MD
Moe Shafei, MD
David Younger, MD
Lisa M Unruh, MD - Pediatrician
Jackie Jorgensen, ARNP
Kathy Wiley, ARNP

Pioneer Health Clinic, LLC
910 Main Street (Goodland)
785-890-7950

Audiology
Colorado Hearing Center
785-890-6030
Sherri Beck, MA, CCC-A
Nicole Pygott, MA, CCC-A

KCDHI Relay Service (Topeka)
1-800-432-0698

Northwest Kansas Hearing Services, Inc
175 S Range (Colby)
1-800-500-0206

Precision Hearing Aid Center
1002 Main Avenue (Goodland)
785-899-3166

Chiropractors

Clifton E. Porterfield, DC
2233 Caldwell (Goodland)
785-899-2500

Gleason Chiropractic
1015 Main (Goodland)
785-899-2225
Sid Unruh, DC

Poling Chiropractic
785-728-7282
1109 Main (Goodland)

Sherman County Health Department
1622 Broadway (Goodland)
785-899-3316
Dental
Goodland Dental Arts
504 Main Avenue (Goodland)
785-899-6222
Terry Imel, DDS
Megan Pearce, DDS
James Baker, DDS
1009 Main Avenue (Goodland)
785-890-2562
Dental-Orthodontics
Dr. Waterhouse, DDS
1014 Main Avenue (Goodland)
785-899-3025
Home Health Services
Assured Occupation Solutions
1005 Main Street (Goodland)
785-890-5738
Goodland Home Health
655 E 22nd (Goodland)
785-890-7658
Sue McCracken
Massage Therapy
Paige Campbell
785-899-5788
220 W 2nd, Room 144 (Goodland)
Healthful Solutions
Hospice Services Inc
866-365-3788 (St. Francis)
785-468-7444
160 E 2nd (Colby)
L & C Home Health
Hospice
1008 Aspen Road
Rescare Homecare
785-890-2562
1009 Main Avenue (Goodland)
James Baker, DDS
Megan Pearce, DDS
Terri Imel, DDS
785-899-6222
504 Main Avenue (Goodland)
Goodland Dental Arts
DRAFT
Optometrists
Newman Vision Care
919 Main (Goodland)
785-890-3937
Ryan Newman, OD

Vision Source
1002 Broadway (Goodland)
785-899-3654
Daniell McAtee, OD

Pharmacy
Medical Arts Pharmacy
2160 Commerce Rd (Goodland)
785-899-2266

Wal-Mart Pharmacy
202 Willow (Goodland)
785-890-5111

Reflexology
Sole Satisfaction
604 Center (Goodland)
785-821-4721
Linda Enfield

Specialists
Goodland Regional Medical Center Outpatient Clinic
220 W 2nd (Goodland)
785-890-6030

Allergy
Cardiology
Ears, nose and throat
Endocrinology
Gastroenterology
Gynecology
OB/GYN
Oncology/hematology
Orthopedics
Pediatrics
Psychiatry
Podiatry
Pulmonology
Rheumatology
Speech therapy
Substance abuse
Urology

Veterinary Services
Prairieland Animal Clinic
204 N Caldwell (Goodland)
785-899-6166
General Health Services
Sherman County Health Department
1622 Broadway Ave (Goodland)
785-899-4888

Assisted Living
Wheat Ridge Acres Retirement Community
707 Wheat Ridge Cr (Goodland)
785-899-0100

Diabetes
Arriva Medical
1-800-375-5137
Diabetes Care Club
1-888-395-6009

Disability Services
American Disability Group
1-877-790-8899

Domestic/Family Violence
Child/Adult Abuse Hotline
1-800-722-3330
Kansas Crisis Hotline
785-539-7935
(Manhattan)

Domestic/Family Violence
Kansas Department on Aging
1-800-432-3530

Kansas Department on Aging
www.WomenShelters.org
General Information – Women’s Shelters
Business Line: 620-793-1966
Hotline: 620-792-1985
(Great Bend)

Family Crisis Center
www.Shrmancounty.org/services/child-protective-services/child-abuse
Hotline: 1-800-722-3330

Other Health Care Services
Sherman County Health Department
1622 Broadway Ave (Goodland)
785-899-4888

Other Health Care Services
DRAFT
Lactation Consultant
Kay Younger
106 Willow Rd (Goodland)
785-890-6075
Medical Equipment and Supplies / Disability Services
American Medical Sales and Repair
1-866-637-6803
202 Willow Rd (Goodland)
Medical Arts Pharmacy
800-733-8661
785-462-8661
1255 S County Club Drive (Colby)
Elaine Ptacek
505G N Franklin (Colby)
785-890-6075
1013 Main Ave (Goodland)
Lincare, Inc
785-699-5991
723 Main Street (Goodland)
Goodland Regional Medical Center
785-890-6030
220 W 2nd (Goodland)
High Plains Mental Health Center
785-890-3021
824 Main Ave (Goodland)
VFW Post 1133
785-890-5111
202 Willow Rd (Goodland)
Medical Arts Pharmacy
800-736-9418
505G N Franklin (Colby)
LINK Inc
785-899-6848
1610 Main (Goodland)
Rural Counseling Services Inc.
800-432-0333 (Emergency)
785-899-5991
723 Main Street (Goodland)
Golden West Skills Center
785-625-5678
2703 Hall (Hays)
Developmental Services of NW Kansas
785-733-8661
785-462-8661
1255 S County Club Drive (Colby)
Alpha Healthcare
785-899-2322
108 Aspen Rd (Goodland)
Golden West Skills Center
785-625-5678
2703 Hall (Hays)
Developmental Services of NW Kansas
785-733-8661
785-462-8661
1255 S County Club Drive (Colby)
American Medical Sales and Repair
1-866-637-6803
106 Willow Rd (Goodland)
Kay Younger
Lactation Consultant
785-890-6075
106 Willow Rd (Goodland)
Kay Younger
Lactation Consultant
Nursing Care
Sherman County Good Samaritan Center
208 W 2nd (Goodland)
785-890-7517

Nutrition
Harvest America
109 W 11th (Goodland)
785-899-3878

Sarah Linton, RD, LD
220 W 2nd (Goodland)
785-890-3625

Senior Adult Center
208 W 15th (Goodland)
785-890-5082

Sherman County Health Department
1622 Broadway (Goodland)
785-890-4888

Preventive Health/Wellness
Regional Prevention Center
505 Franklin (Colby)
785-460-8177

Physical, Occupational, Cardiac, Speech Rehabilitation Therapy
Sherman County Good Samaritan Center
785-890-3625
220 W 2nd (Goodland)

Senior Services
Elder Care, Inc.
PO Box 1364 (Great Bend)
620-792-5942

Northwest Kansas Area Agency on Aging
601 W 9th (Great Bend)
785-890-7517

Regional Rehabilitation
Sherman County Good Samaritan Center
208 W 2nd (Goodland)
785-890-3625

Stroke Support Group GRMC
220 W 2nd (Goodland)
785-890-3625

Local Government, Community,
and Social Services

Adult Protection

Alcohol and Drug Abuse Services

www.srskansas.org/services/adult
1-800-486-3690

Alcohol and Drug Treatment

1-800-922-5330

Alcohol Detoxification 24-Hour Helpline

Adult Protective Services (APS)

www.srskansas.org/services/aps
1-800-922-5330

Elder Abuse Hotline

www.srskansas.org/services/elderabuse
1-800-842-0078

Adult Protection Reporting Center

Rehabilitation Services West Region
Kansas Department of Social and
Human Services

www.kdahr.gov/services/adult
1-800-922-5330

Alcohol and Drug Abuse Services

1-800-586-3690

Alcohol Detoxification 24-Hour Helpline

1-877-403-3387

www.ACenterForRecovery.com

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Child Protection

Kansas Department of Social and
Rehabilitation Services
Protection Reporting Center – i.e.
Rehabilitation Services West Region

1-800-922-5330
Available 24 hours/7 days per week – including
holidays

Children and Youth

Children’s Alliance

Child Protective Services

Child/Adult Abuse and Neglect Hotline

Children and Youth

Center for Recovery

1-877-403-6236
G&G Addiction Treatment Center
1-866-439-1807
Road Less Traveled
1-866-486-1812
Seabrook House
1-800-579-0377
The Treatment Center
1-888-433-9869
Regional Prevention Center

785-899-3848
109 W 11th (Goodland)
Regional Prevention Center

785-235-6437
627 SW Topeka Boulevard (Topeka)
Children’s Alliance

800-922-5330

800-922-5330
Child/Adult Abuse and Neglect Hotline

785-890-3665
330 W 17th, Suite 102 (Goodland)
Big Brothers Big Sisters of Sherman County

www.kids.org
785-890-3665
627 SW Topeka Boulevard (Topeka)
Children’s Alliance

800-922-5330

800-922-5330
Child/Adult Abuse and Neglect Hotline

785-699-3848
104 W Highway 24 (Goodland)
Department of Social and Rehabilitation
Services

www.kids.org
785-699-3678
109 W 11th (Goodland)
Regional Prevention Center

www.kids.org
785-699-3678
109 W 11th (Goodland)
Regional Prevention Center

www.kids.org
785-699-3678
109 W 11th (Goodland)
Regional Prevention Center

www.kids.org
785-699-3678
109 W 11th (Goodland)
Regional Prevention Center

www.kids.org
785-699-3678
109 W 11th (Goodland)
Regional Prevention Center

Children and Youth

Children’s Alliance

Child Protective Services

Child/Adult Abuse and Neglect Hotline

Children and Youth
Counseling
Adoption Centre of Kansas, Inc.
1831 Woodrow Ave (Wichita)
800-804-3632

Boulder Abortion Clinic
800-535-1287

Catholic Charities
877-625-2644

High Plains Mental Health Center
723 Main Street (Goodland)
785-899-5991
800-432-0333

Regional Prevention Center
109 W 11th (Goodland)
785-899-3848

Harvest America
109 W 11th (Goodland)
785-899-3878

Weight Watchers
902 W Highway 24 (Goodland)
785-890-3285

Crime Prevention
Goodland Area Crime Stoppers
204 W 11th (Goodland)
785-899-5665

Kansas Highway Patrol
912 E. Hwy 24 (Goodland)
785-899-5655

Police Administration
204 W 11th (Goodland)
785-899-6697

Sherman County Sheriff
813 Broadway (Goodland)
785-899-4860

Regional Prevention Center
109 W 11th (Goodland)
785-899-3848

Domestic/Family Violence
Child/Adult Abuse Hotline
1-800-922-5330

Harvest America
109 W 11th (Goodland)
785-899-3878

Weight Watchers
902 W Highway 24 (Goodland)
785-890-3285

Crime Prevention
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785-899-5655

Police Administration
204 W 11th (Goodland)
785-899-6697

Sherman County Sheriff
813 Broadway (Goodland)
785-899-4860

Regional Prevention Center
109 W 11th (Goodland)
785-899-3848
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Adoption is a Choice
1-877-524-5614
Adoption Network
1-888-281-8054
Adoption Spacebook
1-866-881-4376
Graceful Adoptions
1-888-896-7787
Kansas Children's Service League
1-877-75-30-5275
Kansas Crisis Hotline
Manhattan
785-539-7935
Northwest Kansas Family Shelters
800-794-4624
403 E 23rd St (Hays)
American Red Cross
785-899-2011
212 E 17th (Goodland)
Rape
1-888-896-7787
Domestic Violence and Rape Hotline
1-888-74-1499
Graceful Adoptions
1-888-896-7787
Kansas Children's Service League
1-877-75-30-5275
Kansas Crisis Hotline
Manhattan
785-539-7935
Northwest Kansas Family Shelters
800-794-4624
403 E 23rd St (Hays)
American Red Cross
785-899-2011
212 E 17th (Goodland)
Rape
State and National Information, Services, Support

Adult Protection Services
1-800-922-5330  www.srskansas.org/SD/ees/adult.htm

Domestic Violence and Sexual Assault (DVACK)
1-800-874-1499  www.dvack.org

Elder Abuse Hotline
1-800-842-0078  www.elderabusecenter.org

Elder and Nursing Home Abuse Legal
www.resource4nursinghomeabuse.com/index.html

Kansas Coalition Against Sexual and Domestic Violence
1-888-END-ABUSE (363-2287)
www.kcsdv.org/ksresources.html

Kansas Department on Aging

Adult Care Complaint Program
Kansai Department on Aging
1-800-842-0078

Consumer Protection
1-888-777-3630  www.ksda.org/consumer/protection/

Domestic Violence and Sexual Assault (DVACK)
1-800-787-3224 (TTY)  www.dvack.org

Domestic Violence Hotline
www.womancaselaw.kckanss.gov/web/sexualassault.htm

Domestic Violence and Sexual Assault
1-800-222-1222  poisoncenter.org

Domestic Violence Hotline
1-800-701-3630  www.srskansas.org/SD/ees/adult.htm
Social and Rehabilitation Services (SRS)
1-888-369-4777 (HAYS)
www.srskansas.org
Suicide Prevention Helpline
785-841-2345

Alcohol and Drug Treatment Programs
AAA
1-800-993-3869
Abandon A Addiction
AAA
1-800-405-4810
A 1 A Detox Treatment
1-800-757-0771

Able Detox-Rehab Treatment
1-800-577-2481 (NATIONAL)
Abandon A Addiction
1-800-405-4810
A 1 A Detox Treatment
1-800-757-0771

Al-Anon Family Group
1-888-4AL-ANON (425-2666)
www.al-anon.alateen.org
Alcohol and Drug Abuse Hotline
1-800-ALCOHOL
Alcohol and Drug Abuse Services
1-800-586-3690
www.srskansas.org/services/alc-drug_assess.htm
Alcohol and Drug Addiction Treatment Programs
1-800-510-9435
Alcohol and Drug Helpline
1-800-821-4357
Alcoholism/Drug Addiction Treatment Center
1-800-510-9435

Mothers Against Drunk Driving
1-800-GET-MADD (438-6233)
www.madd.org
National Council on Alcoholism and Drug Dependence, Inc.
1-800-NCA-CALL (622-2255) www.ncadd.org

Recovery Connection
www.recoveryconnection.org

Regional Prevention Centers of Kansas
www.smokyhillfoundation.com/pcp-local.html

Child/Adult Abuse and Neglect Hotline
1-800-922-5330

Children and Youth
Child/Adult Abuse National Hotline
1-800-4-A-CHILD (422-4453)
www.childabuse.com

 Adoption
1-800-862-3678
www.adopt.org

Boys and Girls Town National Hotline
1-800-448-3000
www.girlsandboystown.org

Child Abuse Hotline
1-800-922-5330

Child Abuse National Hotline
1-800-422-4453 (TDD)
www.childhelpusa.org/home

Child Abuse National Hotline
1-800-222-4453

Child/Adult Abuse and Neglect Hotline
1-800-222-5330

Child/Adult Abuse National Hotline
1-800-222-4453

Child Abuse National Hotline
1-800-222-4453

Regional Prevention Centers of Kansas
1-800-757-2180
www.smokyhillfoundation.com/pcp-local.html

National Council on Alcoholism and Drug Dependence, Inc.
1-800-NCA-CALL (622-2255)

Better Business Bureau
316-263-3146
www.wichita.bbb.org
Community Action
Peace Corps
1-800-424-8580
www.peacecorps.gov
Public Affairs Hotline (Kansas Corporation Commission)
1-800-662-0027
www.kcc.state.ks.us
Counseling Care Counseling
Family counseling services for Kansas and Missouri
1-888-999-2196
Carl Feril Counseling
608 N Exchange (St. John) 620-549-6411
Castlewood Treatment Center for Eating Disorders
1-888-822-8938 www.castlewoodtc.com
Catholic Charities
1-888-468-6909
www.catholiccharitiessalina.org
Center for Counseling
5815 W Broadway (Great Bend) 1-800-875-2544
Central Kansas Mental Health Center
1-800-744-8281
Peace Corps
1-800-424-8580
Peace Corps
Community Action
43
Kansas Rural Health Works
Community Health Needs Assessment

Sherman County

John Leatherman
Professor, Department of Agricultural Economics
Director, Office of Local Government
K-State Research and Extension

Agenda

• CHNA overview
• Economic contribution of local health care
• Preliminary list of community concerns
• Health service area
• Local data reports
• Community health services directory
• Community health care survey
• Proposed schedule of meetings
• Focus group questions
• Next meeting
Local Health Needs Assessment

- Patient Protection and Affordable Care Act
- 501(c)3 (charitable) hospital every 3 years
  - Community Health Needs Assessment
  - Implementation strategy
  - Demonstrable effort for progress
- Public Health Accreditation every 5 years
  - Community Public Health Needs Assessment
  - Public health action planning
  - Strategic plan

KRHW CHNA Objectives

- KRHW Community Engagement Process since 2005
  - Help foster healthy communities
  - Help foster sustainable rural community health care system
  - Identify priority health care needs
  - Mobilize/organize the community
  - Develop specific action strategies with measurable goals
Community-driven Process

• Community-based, not driven by hospital, health care provider, or outside agency
• Local people solving local problems
• Community provides energy and commitment, with input from health care providers
• Public represented by you - community leaders who care enough to participate
• I make no recommendations

Steering Committee Meetings

• 3 two-hour working meetings over 3 weeks
• Examine information resources
  – Economic contribution of health care; health services directory; community health care survey; data and information reports
• Identify priority health-related needs
  – Revisit information; small group discussion; group prioritization; form action teams
• Develop action strategies for priority needs
  – Leadership, measurable goals
Keys to Success

• Our process has a beginning and an end
• Your participation is critical
• Your preparation allows effective participation
• Every community has needs and the capacity to improve its relative situation
• Your ongoing commitment and initiative will determine whether that’s true here
• We’ll provide discussion forum and tools
• The rest is up to you

The Importance of the Health Care Sector to the Economy of Sherman County

Kansas Rural Health Options Project

December 2010

Jill Boley, Research Assistant
Kate Banta, Enterprise Assistant
John Leachman, Director

In cooperation with:

K-State Research and Extension

Funding for this project provided by Health Resources and Services Administration
Importance of Health Care Sector

• Health services and rural development
  – Major U.S. Growth Sector
    • Health services employment up 70% from 1990-08
    • 10%-15% employment in many rural counties
  – Business location concern
    • Quality of life; productive workforce; ‘tie-breaker’ location factor
  – Retiree location factor
    • 60% called quality health care “must have”

Health Services in Sherman Co.

Figure 5. Employment by Sector (2008)
## Total Health Care Impact

<table>
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<th>Health Sectors</th>
<th>Direct Employment</th>
<th>Economic Multiplier</th>
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<td>Home Health Care Services</td>
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## Health Care Impact ($000)

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Health Care Impact ($000)

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Summary and Conclusions

- Trends and indicators show health care’s economic importance
- Health services among the fastest growing sectors – demographic trends suggest growth will continue
- Attracting/retaining businesses & retirees depends on adequate health care services
- Sustainable health care system essential for local health and economic opportunity
Summary and Conclusions

- Economics of health care rapidly changing
- Maintaining a sustainable local health care system is a community-wide challenge
- Strategic health care planning must be ongoing and inclusive

Initial Community Perceptions

- What are major health-related concerns?
- What needs to be done to improve local health care?
- What should be the over-arching health care goals in the county?
- What are the greatest barriers to achieving those goals?
GRMC Health Care Market

89.5% of Inpatient Discharges in 2011

Data Fact Sheets
Data Fact Sheets

• Seeking issues/needs in secondary data, i.e. that which is missing, a challenge, or could be improved
• Looking at the negative doesn’t mean there isn’t much that is good
• Data are indicators that require interpretation
• You decide what’s important

Data Fact Sheets

• Seeking issues/needs in secondary data
• Economic & demographic data
  – Declining total population ~ 13% since 1990
  – Aging population ~ 18.5% 65+ and growing
  – 43% of population without spouse
  – 14% of HH live on <$15,000, 30% <$25,000
  – Transfer income > importance (> $48m, 20%)
  – 17% live in poverty (21.5% of children)
Data Fact Sheets

• Health & behavioral data
  – LTC capacity: community-based alternatives?
  – Youth tobacco use ~10%, ~ KS & improving
  – Youth binge drinking ~10%, < KS & improving
  – Child immunizations ~ 75-80%, < KS & improving
  – 28% newborns < than adequate prenatal care (small numbers)
  – Government family/food assistance increasing
  – Hospital short-term trends stable

• Crime data
  – Crime ½ state rates (incomplete data)
  – Trends stable

• Education data
  – Long-term enrollment decline but rebounding
  – Dropout rate up/violence down (low numbers)

• Traffic data
  – 18% of crashes w. injury/death, no seatbelt
  – Positive overall trends
Data Fact Sheets

• Health Matters (random impressions)
  – Missing data/small numbers due to sampling
  – Obesity, diabetes, hypertension ~ same as KS
  – Teen, unmarried births rising, > KS
  – 24% of pregnant women smoke, > KS
  – Uninsured pop. ~ 2% higher than KS
  – Injuries are high vs. KS
  – Indications of economic distress
  – Families and children in poverty “severe”
  – High lead risk with older housing

Overall Conclusions from Data

• Population trends and income levels are creating challenges
• Accessing state/federal assistance is essential
• Community-based services for those elderly, alone
• Room for improvement in preventable problems – neonatal care, tobacco/alcohol use, immunization
Reactions, discussion?
You look. You decide.
Community Directory

- Comprehensive listing of health and related providers and services
- If they know it’s available locally, they can choose to buy it at home
- Extended description of hospital, county health department, others as justified
- You ensure completeness and accuracy
- Consider the “gaps” that may exist
- Updatable, reproducible

Community Health Care Survey

- Community health services
  - Residents’ health usage of doctors, hospital, clinics, and Health Department
  - Any general concerns
- Non-random, non-representative
- “Lots” of input - You + 5
- 5 minutes – answer on the spot
- Deadline is Monday. Drop off at Goodland Health Center or County Health, 9-5
Public Meeting Schedule

• September 6 – Overview, economic impact report, community concerns, data reports, draft health services directory, survey
• September 20 – Review data & information; group discussion; issue prioritization; team formation
• September 27 – Action planning
• After? That’s up to you

Next Meeting

• Introduction and Review
• Review of Data
• Service Gap Analysis
• Survey Results
• Focus group formation and charge
• Group Summaries
• Prioritization
• Next meeting date
Next Meeting

• Homework: review the information, consider the questions
• Focus Group questions
  – What is your vision for a healthy community?
  – What can the hospital do to help?
  – What can the health department do to help?
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Kansas Rural Health Works
Community Health Needs Assessment

Sherman County

John Leatherman
Professor, Department of Agricultural Economics
Director, Office of Local Government
K-State Research and Extension

Agenda

• CHNA overview and review
• Preliminary list of community concerns
• Local data reports
• Community health services gap analysis
• Community health care survey results
• Small group discussion
• Group prioritization
• Next meeting
Local Health Needs Assessment

- Patient Protection and Affordable Care Act creates hospital requirements
- Public Health Department Accreditation
- Both require Community Health Needs Assessment

KRHW CHNA Objectives

- KRHW CHNA
  - Help foster healthy communities and a sustainable rural community health care system
  - Identify priority health care needs
  - Mobilize/organize the community
  - Develop specific action strategies with measurable goals
Community-driven Process

- Community-based, not driven by hospital, health care provider, or outside agency
- Local people solving local problems
- Community provides energy and commitment, with input from health care providers
- Public represented by you
- I make no recommendations
Summary and Conclusions

- Trends and indicators show health care’s economic importance
- Health services among the fastest growing sectors – demographic trends suggest growth will continue
- Sustainable health care system essential for local health and economic opportunity
- Maintaining a sustainable local health care system is a community-wide challenge

Initial Community Perceptions

- What are major health-related concerns?
- What needs to be done to improve local health care?
- What should be the over-arching health care goals in the county?
- What are the greatest barriers to achieving those goals?
Collective Themes

- Additional primary/specialty service providers
- Distance/access to specialty services
- Access for uninsured/underinsured
- Chronic health conditions/prevention
- Access to mental health assistance
- Provider communication/collaboration
- Community attitudes/leadership
- Your conclusions?

Data Fact Sheets

- Seeking issues/needs in secondary data, i.e. that which is missing, a challenge, or could be improved
- Looking at the negative doesn’t mean there isn’t much that is good
- Data are indicators that require interpretation
- You decide what’s important
Overall Conclusions from Data

- Population trends and income levels are creating challenges
- Accessing state/federal assistance is essential
- Community-based services for elderly, alone
- Mental health
- Room for improvement in preventable problems – neonatal care, tobacco/alcohol use, immunization

Your Analysis

- What did you see that you liked?
- What do you see that was troubling?
- What do you think could be improved?
- What do you think is in your collective capacity to make better?
Community Directory

- Comprehensive listing of health and related providers and services
- If they know it’s available locally, they can choose to buy it at home
- You ensure completeness and accuracy
- Consider the “gaps” that may exist
- What was missing that you would like to see?
Community Health Care Survey

- 178 total responses
- Important to remember – non-representative
- 94% see a doctor; 93% use local provider
- 89% were satisfied/somewhat satisfied
- 81% used a hospital in the past 2 years; GRMC captured 88%
- 94% had prior GRMC experience; 91% were satisfied/somewhat satisfied

Community Health Care Survey

- Specialty care
  - Orthopedist – 23
  - OB/GYN – 21
  - Ear/Nose/Throat – 20
  - Urologist – 15
  - Cardiologist – 12
  - Neurologist – 12
  - Dermatologist – 12
  - Allergist - 9
Community Health Care Survey

- 88% used Goodland Family Health Center; 90% were satisfied/somewhat satisfied
- 68% used County Health; 97% satisfied
- Comments suggest some unmet needs and challenges – access to primary care physicians/long wait times; lack of services/specialty assistance; customer service issues; local cost/billing issues
- Your observations?

Small Group Discussion

- Discussion leader and note taker
- Everyone contributes
- Time is critical – 10 minutes/question
- Consider the question
  - Everyone 30 seconds to respond
  - Seek commonalities/themes/combine concerns
  - Identify 1-2 group responses
  - Report to the group
Discussion Questions

- What is your vision for a healthy community?
- What are the top 3-4 things that need to happen to achieve your vision?
  - What’s right? What could be better?
  - Consider acute needs and chronic conditions
  - Discrete local issues, not global concerns
  - Consider the possible, within local control and resources, something to rally the community
- What can the hospital do to help?
- What can the health department do to help?

Issue Prioritization

- Group reports
- What are the discrete local health concerns?
- What are the chronic health issues of local concern?
- What are the top three issues that should be the focus of local priority over the next 3-5 years?
- Which priority will you focus on?
- Homework
Next Meeting

• Introduction and Review
• Review of priorities
• Work groups
• Work group reports
• Action group formation and leadership
• Action group meetings
• One-year follow up meeting
• Summary and evaluation

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Kansas Rural Health Works
Community Health Needs Assessment

Sherman County

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Agenda

• CHNA overview and review
• Priority community health issues
• Work group formation and instructions
• Action plan development
• Group review
• Next steps
• Evaluation
Local Health Needs Assessment

- Patient Protection and Affordable Care Act creates hospital requirements
- Public Health Department Accreditation
- Both require Community Health Needs Assessment

KRHW CHNA Objectives

- KRHW CHNA
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Initial Perceptions: Themes

- Additional primary/specialty service providers
- Distance/access to specialty services
- Access for uninsured/underinsured
- Chronic health conditions/prevention
- Access to mental health assistance
- Provider communication/collaboration
- Community attitudes/leadership
- Your conclusions?

Data Fact Sheets
Overall Conclusions from Data

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Community Health Care Survey

• 178 total responses
• Important to remember – non-representative
• Use and satisfaction with local providers
• Comments suggest some unmet needs and challenges – access to primary care physicians/long wait times; lack of services/specialty assistance; customer service issues; local cost/billing issues
Small Group Discussion

- What is your vision for a healthy community?
- What are the top 3-4 things that need to happen to achieve your vision?
- What can the hospital do to help?
- What can the health department do to help?

Issue Prioritization #1

- Health and wellness/prevention
- Chronic disease management
  - Obesity and related health concerns
  - Nutrition education
Issue Prioritization #2

• Health provider collaboration and communication
  – Between each other to improve collaborative efforts for improved customer service, greater satisfaction and best health care outcomes
  – With the community to enhance community relations, improve understanding, and inform about plans and events

Issue Prioritization #3

• Expanded access to mental health assistance
  – Including education to the general public to better recognize need and reduce stigma
  – Including providers and public officials to improve recognition and response/treatment of mental health problems
Issue Prioritization #4

• New: Physician Recruitment
  – Current opportunities
  – Need to mobilize

Action Planning

• This ain’t easy
• This is only the start
• Once you begin, you’ll see more is needed
• If this is important and if you are committed, you’ll know how!
• The rest is up to you. It always has been.
Action Plan: Situation

• What is the existing situation you would like to see changed?
• What is the specific need/problem that you would like to see changed?
• Example: Enhance communication across providers and with the community
  – Providers in “silos” to patient detriment
  – Hospital board is insular

Action Plan: Priorities

• What are the top three things that need to happen to change the existing situation?
• Example:
  – Major providers meet periodically to exchange information and seek collaborative initiatives
  – Create a common public access point for information
  – Create an annual event to bring community and providers together
Action Plan: Intended Outcomes

• What will be the situation when you have achieved the goal?
• Example:
  – Patients experience continuum of care; providers are stronger with fewer leakages
  – Single Web-based portal for all provider info
  – Annual county health fair to learn about personal health, provider services, healthy choices, meet providers personally

Action Plan: Resources

• What resources are needed: who must be involved, how much time, money, what partnerships
• Example:
  – Major provider cooperation
  – Significant organizational and public relations capacity
  – IT capacity
  – Financial sponsorships
Action Plan: Activities

- What meetings, events, public involvement, information resources, media, partnerships are needed?
- Examples:
  - Quarterly provider meetings – private sharing
  - Event leadership and planning committee
  - Solicit financial sponsorship
  - Media collaboration
  - State/regional provider involvement
  - Schedule of events

Action Plan: Participation

- Who needs to be involved?
- Examples:
  - **Leadership** – who is the right person?
  - Who within this group will start?
  - Who outside this group should be involved?
  - Business, education, religious, social, public, customers and the underserved
Action Plan: Short-term

- What has to happen in 6-12 months?
- What are the evaluation target metrics (awareness, knowledge, attitudes)?
- Examples:
  - Providers buy in, establish a regular meeting schedule, identify meeting coordinator
  - Public relations to announce initiatives
  - Work committees recruited and organized
  - Sponsors secured
  - Plans and designs solidified/finalized

Action Plan: Intermediate-term

- What has to happen in 1-3 years?
- What are the evaluation target metrics (behaviors, decisions, actions, policies)?
- Examples:
  - Providers meeting regularly
  - Web-based portal up and updated regularly
  - Annual health fair with broad community participation
  - Expanded community “buy-in” for initiatives
Action Plan: Ultimate Impact

• What has to happen in the long-term?
• What are the evaluation target metrics (how will the situation be different)?
• Examples:
  – Community surveys show high local usage and satisfaction with local providers
  – Data health indicators are improving
  – Annual health fair growth, business outreach and participation, multiple community events
  – Community undertakes new health initiatives

Next Meeting

• Yes, there is a next meeting (sorry)
• Overall leadership and monitoring
• Work group leadership and meeting schedule
• Communicating with the community
• One-year follow up meeting open to the community
• Summary and evaluation
Welcome to Kansas Rural Health Works, a resource dedicated to helping rural communities build affordable and sustainable local health care systems.

The organization and delivery of health care services have undergone rapid evolution in recent years. For many Americans, the cost of services and access to care are important issues. This is especially true in many rural areas where communities have struggled to maintain affordable, quality health care systems. As economic factors and technical advances continue to change health care, it is more important than ever for rural community leaders and health care providers to work together to ensure affordable, sustainable health care systems.

In an effort to provide useful information resources to rural community and health care leaders, the Kansas Rural Health Works Project (KRHW) has teamed with the Office of Local Government, a unit of the Department of Agricultural Economics and K-State Research and Extension.

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Community Health Needs Assessment

Hospital Requirements

The Patient Protection and Affordable Care Act (PPACA) created a new IRS Code Section 501(r) which imposes additional requirements on tax-exempt hospitals. Specifically:

- All 501(c)3 Hospitals
- Governmental hospitals that have an IRS Determinate (c)3 Letter
- If you have ever applied for and received a letter (for the hospital entity) you have to comply.

Hospitals must Complete Community Needs Assessment

- At least once every three years; first one must be completed by end of tax year beginning after March 23, 2012.
- Include input from persons who represent the broad interest of the community.
- Include input from persons having public health knowledge or expertise.
- Make assessment widely available to the public
- Adopt a written implementation strategy to address identified community needs.*
- Failure to comply results in excise tax penalty of $50,000 per year.

Patient Protection and Affordable Care Act (Health Care Reform Law March, 2010)

* Notice 2011-52 – must be approved by authorized governing body (board of directors)

Community Health Needs Assessment Written Report Treasury and the IRS intend to require a hospital organization to document a Community Health Needs Assessment for a hospital facility in a written report that includes the following information:

1. A description of the community served by the hospital facility and how it was determined.
2. A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. The report should also describe information gaps that impact the hospital organization’s ability to assess the health needs of the community served by the hospital facility. If a hospital organization collaborates with other organizations in conducting a CHNA, the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist it in conducting a CHNA, the report should also disclose the identity and qualifications of such third parties.
3. A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility, including a description of when and how the organization consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.) If the hospital organization takes into account input from an organization, the written report should identify
the organization and provide the name and title of at least one individual in such organization with whom the hospital organization consulted.

4. A prioritized description of all of the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs.

5. A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

CHNA Written Report needs to be:

- Widely available to the public
- On hospital website
- Given to anyone who asks

Implementation Strategy

Treasury and the IRS intend to require a hospital organization to specifically address each of the community health needs identified through a CHNA for a hospital facility in an implementation strategy, rather than in the written report documenting the hospital facility’s CHNA.

An implementation strategy is a written plan that addresses each of the community health needs identified through a CHNA.

An implementation strategy will address a health need identified through a CHNA for a particular hospital facility if the written plan either:

1. describes how the hospital facility plans to meet the health need; or
2. identifies the health need as one the hospital facility does not intend to meet and explains why the hospital facility does not intend to meet the health need.

An Implementation Strategy needs to be:

- Approved by Board of Directors
- Attached to 990, and the 990 has to be widely available to the public

This summary was obtained from the Kansas Health Matters Website (http://www.kansashealthmatters.org/), and can be found here: (https://www.mycbt.org/wst/kansashealthmatters/hospitals/default.aspx)
Community Health Needs Assessment

Health Department Accreditation

The Public Health Accreditation Board (PHAB) defines public health accreditation as the development of a set of standards, a process to measure health department performance against those standards, and reward or recognition for those health departments who meet the standards.

The PHAB standards were developed through the framework of the 10 Essential Public Health Services:

1. Monitor the health of the community
2. Diagnose and investigate health problems
3. Inform, educate, and empower people
4. Mobilize community partnerships
5. Develop policies
6. Enforce laws and regulations
7. Link to/provide health services
8. Assure a competent workforce
9. Evaluate quality
10. Research for new insights

Accreditation is a mechanism for demonstrating a local health department’s capacity for providing the essential services as well as its ability to do so through a culture of continuous quality improvement. The [PHAB Standards and Measures Version 1.0](https://www.phaboard.org) were released in May 2011.

Local health departments may seek accreditation as an individual agency or as a region, using the multi-jurisdictional approach. Accreditation status lasts for 5 years; at the end of the 5 year cycle, the department must seek reaccreditation.

Health departments must complete three prerequisites prior to applying for accreditation within the past 5 years

1. A community health assessment
2. A community health improvement plan
3. An agency strategic plan

The seven steps of the accreditation process are

1. Pre-application
2. [Accreditation Readiness Checklist](https://www.phaboard.org)
3. [Online Orientation](https://www.phaboard.org)
4. Statement of Intent
5. Application
6. Documentation Selection and Submission
7. Site Visit
8. Accreditation Decision
9. Reports
10. Reaccreditation

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