

Cleveland County Community Health Assessment



Fall 2015

Cleveland County Demographics

Population: 255,755

Cleveland County is home to a bustling, diverse, and ever-growing population. It is the third most populous county in Oklahoma, and seated within it are two major metropolitan cities: Norman and Moore. The majority of the population resides within these two cities, with the remainder spread out among the rural areas of the county.

Norman

Population: 110,925

A large portion of Norman's population is made up of college students, particularly those from the University of Oklahoma, which is well known for its sports, arts, and academics. Norman is also home to the National Weather Center, located near the University of Oklahoma campus. The Max Westheimer Municipal Airport, a reliever airport owned by the University of Oklahoma, is located in Norman, too.

Residents of Norman also benefit from the Cleveland Area Rapid Transit (CART). This is a public transportation system that serves over 1 million passengers annually. There are seven routes mapped out within the city that run five days per week. During the week, CART also supplies transportation via Sooner Express to Oklahoma City.

Moore

Population: 55,081

Moore is smaller in population than its sister city Norman, however it has the third largest school system in the state of Oklahoma. There are currently over 21,000 Moore public school students divided among 24 elementary schools, five junior high schools, and three high schools, with an additional five Vista Alternative Academies.

Other Cities in Cleveland County

*Noble Hall Park
Lexington Etowah
Slaughterville*

Population By Races

Race	Population	% of Total
<i>Total Population</i>	<i>255,755</i>	<i>100</i>
<i>White</i>	<i>202,811</i>	<i>79</i>
<i>Hispanic or Latino</i>	<i>17,892</i>	<i>6 (ethnicity NOT race)</i>
<i>Two or More Races</i>	<i>14,258</i>	<i>5</i>
<i>American Indian</i>	<i>11,978</i>	<i>4</i>
<i>Black or African American</i>	<i>10,848</i>	<i>4</i>
<i>Asian</i>	<i>9,698</i>	<i>3</i>
<i>Some Other Race</i>	<i>5,974</i>	<i>2</i>
<i>Three or more races</i>	<i>809</i>	<i>Below 1%</i>
<i>Native Hawaiian Pacific Islander</i>	<i>188</i>	<i>Below 1%</i>

Geography

Cleveland County is centrally located within the state of Oklahoma and is made up of approximately 558 square miles of land and water. A major source of water supply to Norman and surrounding communities is Lake Thunderbird, a large reservoir located east of Norman. The lake's surface is approximately 6,000 acres, with a volume of 105,838 acre feet. Alongside its drinking water supply, Lake Thunderbird State Park also offers an abundance of recreational activities for residents and travelers.

Healthcare Facilities

When it comes to healthcare facilities, Cleveland County has three major hospitals, two health departments, one Indian health clinic, mental health services/counseling, and various medical clinics.

Average Household Income: \$54,989

Employment

163,651 residents who are over the age of 16 are currently employed, with the majority in the civilian workforce.

Civilian workforce: 67%

Armed forces: 1%

Unemployed: 3%

3,447 individuals (12.9%) live below the federal poverty line, including 2,573 (6.4%) who have children under the age of 18.

Other Demographics

Neighboring counties of Cleveland County include Canadian, McClain, Oklahoma, and Pottawatomie.



I. Introduction

During the spring of 2015, the Cleveland County Health Department engaged community partners in an effort to assess the health status of county residents. Using the Mobilizing for Action through Planning and Partnerships (MAPP) model, organizers gathered information for four assessment categories, including Community Health Status, Community Themes and Strengths, Local Public Health System, and Forces of Change. Using these broad assessment categories provides for a comprehensive view of the current health outcomes, as well as the factors, both real and perceived, that influence this community's health.

After reviewing the assessment data in the fall of 2015, ten issues emerged as most prominent and were identified for closer review and discussion. It is among these ten issues that priority areas for improvement will be selected. They include:

- Obesity
- Tobacco
- Child Health
- Substance Abuse
- Mental Health
- Cardiovascular Health
- Sexual Health
- Diabetes
- Cancer
- Access to Care/Poverty

This report will briefly discuss these elements and the factors that resulted in their consideration for targeted health improvement.



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III. The MAPP Process

The following description of MAPP is taken from the NACCHO website, and can be found at: [MAPP Basics - Introduction to the MAPP Process | NACCHO \(http://www.naccho.org/topics/infrastructure/mapp/framework/mappbasics.cfm\)](http://www.naccho.org/topics/infrastructure/mapp/framework/mappbasics.cfm)

Mobilizing for Action through Planning and Partnerships (MAPP) is a strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide strategic planning. Using MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, taking into account their unique circumstances and needs, and forming effective partnerships for strategic action.

The MAPP tool was developed by NACCHO in cooperation with the Public Health Practice Program Office, Centers for Disease Control and Prevention (CDC). A work group composed of local health officials, CDC representatives, community representatives, and academicians developed MAPP between 1997 and 2000. The vision for implementing MAPP is:

“Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action.”



The benefits of using the MAPP process, as identified by NACCHO, include:

- **Create a healthy community and a better quality of life.** The ultimate goal of MAPP is optimal community health—a community where residents are healthy and safe, and have a high quality of life. Here, a “healthy community” goes beyond physical health alone.
- **Increase the visibility of public health within the community.** By implementing a participatory and highly publicized process, increased awareness and knowledge of public health issues and greater appreciation for the local public health system as a whole may be achieved.
- **Anticipate and manage change.** Community strategic planning better prepares local public health systems to anticipate, manage, and respond to changes in the environment.
- **Create a stronger public health infrastructure.** The diverse network of partners within the local public health system is strengthened through the implementation of MAPP. This leads to better coordination of services and resources, a higher appreciation and awareness among partners, and less duplication of services.
- **Engage the community and create community ownership for public health issues.** Through participation in the MAPP process, community residents may gain a better awareness of the area in which they live and their own potential for improving their quality of life. Community-driven processes also lead to collective thinking and a sense of community ownership in initiatives and, ultimately, may produce more innovative, effective, and sustainable solutions to complex problems. Community participation in the MAPP process may augment community involvement in other initiatives and/or have long-lasting effects on creating a stronger community spirit.

IV. Community Themes and Strengths Assessment

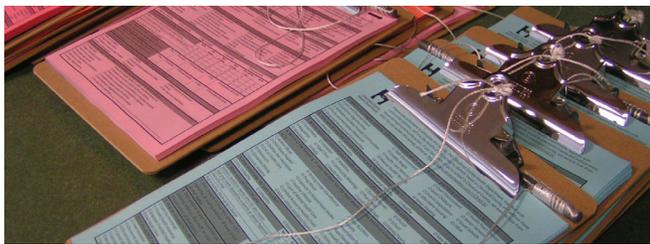
The Community Themes and Strengths Assessment provides insight into the issues that residents perceive as important. This assessment delves into perceived quality of life issues in the community and looks into the assets and resources recognized by community members.

This assessment includes the 2015 Cleveland County Community Health Survey, combined with feedback through a variety of forums throughout the county.

- **2,457 responses**
- **Online through SurveyMonkey**
- **Website and Facebook postings**
- **Email distribution through community partners**
- **Distributed hard copies throughout the community at targeted sites to reach underrepresented populations**
- **English, Spanish, and Vietnamese Versions**

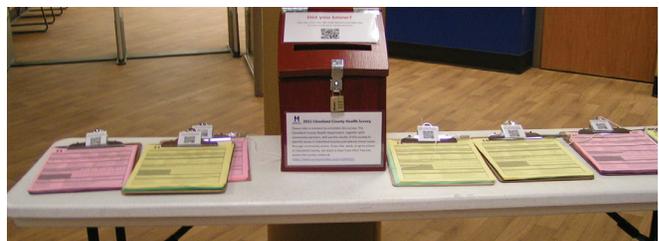
What has the most impact on the health of Cleveland County?

1. Inactive Lifestyle
2. Drug Abuse
3. Cost of Healthcare



80.6% believe Cleveland County is "somewhat healthy" or "healthy."

82.6% classified their own health as "somewhat healthy" or "healthy."



When you imagine a strong, vibrant community, what are the features you think of?

1. Safe Environment
2. Good Schools
3. Clean Environment

V. Community Health Status Assessment

Cleveland County is the 4th healthiest county in a state that is ranked 46th in the U.S.

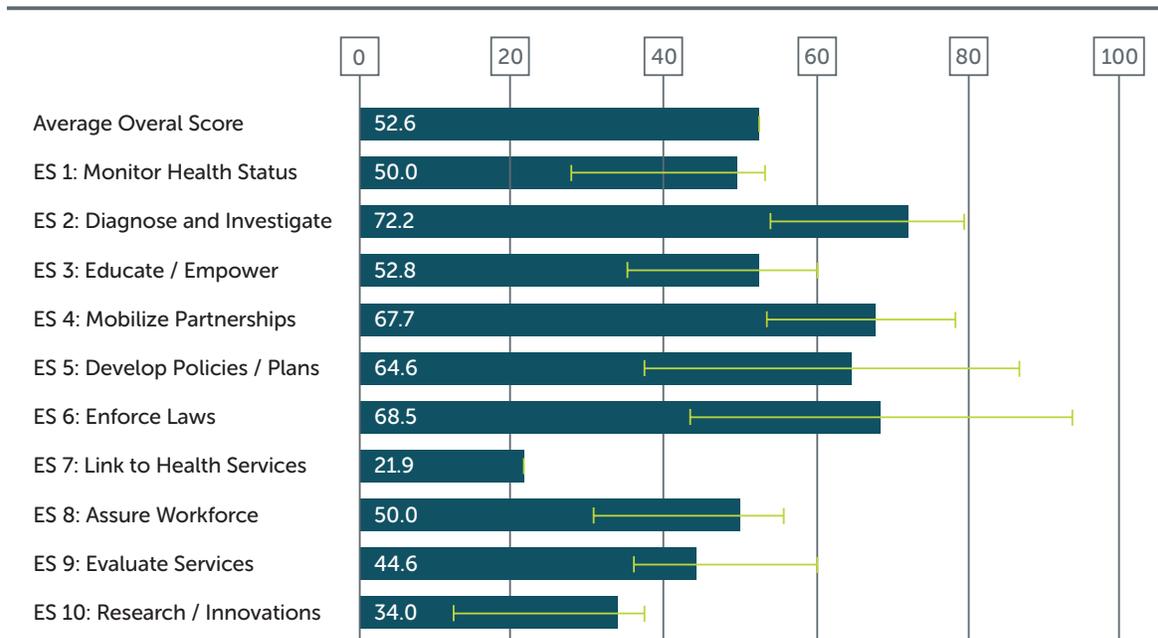
	PREVIOUS	CURRENT	GRADE
MORTALITY			
INFANT (RATE PER 1,000)	6.3	4.9	B
TOTAL (RATE PER 100,000)	882.9	786.4	C
LEADING CAUSES OF DEATH (RATE PER 100,000)			
HEART DISEASE	256.0	192.1	C
MALIGNANT NEOPLASM (CANCER)	175.8	170.0	C
CEREBROVASCULAR DISEASE (STROKE)	62.3	42.1	C
CHRONIC LOWER RESPIRATORY DISEASE	54.0	63.9	F
UNINTENTIONAL INJURY	38.2	43.7	D
DIABETES	23.5	16.9	A
INFLUENZA/PNEUMONIA	19.6	16.4	C
ALZHEIMER'S DISEASE	19.4	20.7	B
NEPHRITIS (KIDNEY DISEASE)	15.9	9.8	B
SUICIDES	9.8	12.8	C
DISEASE RATES			
DIABETES PREVALENCE	9.2%	9.5%	C
CURRENT ASTHMA PREVALENCE	9.6%	10.2%	D
CANCER INCIDENCE (RATE PER 100,000)	535.0	442.2	B
RISK FACTORS & BEHAVIORS			
MINIMAL FRUIT CONSUMPTION	NA	48.5%	F
MINIMAL VEGETABLE CONSUMPTION	NA	24.8%	D
NO PHYSICAL ACTIVITY	25.5%	22.8%	C
CURRENT SMOKING PREVALENCE	22.9%	20.3%	C
OBESITY	28.9%	30.0%	D
IMMUNIZATIONS < 3 YEARS	70.9%	72.0%	C
SENIORS INFLUENZA VACCINATION	62.6%	67.9%	B
SENIORS PNEUMONIA VACCINATION	75.0%	77.0%	A
LIMITED ACTIVITY DAYS	16.2%	17.6%	C
POOR MENTAL HEALTH DAYS	25.0%	23.4%	C
POOR PHYSICAL HEALTH DAYS	20.9%	21.5%	C
GOOD OR BETTER HEALTH RATING	86.3%	87.2%	B
TEEN FERTILITY (RATE PER 1,000)	12.9	12.1	B
FIRST TRIMESTER PRENATAL CARE	70.7%	75.3%	C
LOW BIRTH WEIGHT	7.3%	7.7%	C
ADULT DENTAL VISITS	67.4%	69.1%	C
USUAL SOURCE OF CARE	77.0%	77.1%	C
OCCUPATIONAL FATALITIES (RATE PER 100,000 WORKERS)	2.4	2.2	B
PREVENTABLE HOSPITALIZATIONS (RATE PER 100,000)	1895.7	1486.8	C
SOCIOECONOMIC FACTORS			
NO INSURANCE COVERAGE	16.9%	13.3%	B
POVERTY	11.4%	13.3%	B

VI. Local Public Health System Assessment

The Local Public Health System Assessment focuses on the public health system within the county and includes any entity that contributes to the public's health. This assessment breaks down the system into its individual components as they contribute to the 10 essential services of public health. Those components are then evaluated for their effectiveness within the public health system. The 10 essential services of public health include:

- Monitor Health Status
- Diagnose and Investigate
- Inform, Educate, and Empower
- Mobilize Community Partnerships
- Develop Policies and Plans
- Enforce Laws and Regulations
- Link People to Needed Services/Assure Care
- Assure a Competent Workforce
- Evaluate Health Services
- Research

SUMMARY OF AVERAGE ES PERFORMANCE SCORE



VII. Forces of Change Assessment

The MAPP Steering Committee discussed at length the 'Forces of Change' facing Cleveland County in the coming years. As Cleveland County has been an active and progressive county within the state, it should not be surprising that many strengths and opportunities were recognized. The economic forecast for the county appears steady even though Oklahoma as a whole faces significant economic woes anchored in the energy sector. Expansion and growth within the county continues, and efforts are well underway to enhance individual community's infrastructure in a way that supports healthy living. Additionally, the health system is rebuilding with Norman Regional set to reopen its Moore facility following the 2013 Tornadoes.

Regardless of the many strengths and opportunities that exist, weaknesses and threats cannot be denied. Many communities are lacking in connectivity or public transit. Mental health services are in high demand, often exceeding the supply of facilities and professionals. Further, there is a palpable uncertainty about the future of our healthcare systems, primarily focused around the ACA. There is concern that access to healthcare will decline before it improves. Additionally, a rash of natural disasters over the past few years, including tornadoes and floods, fuels fears of continued upheaval with residents helpless to defend against it.

Ultimately, there is great optimism that Cleveland County's future is bright, and the county has the resources and willpower necessary to take on a robust health improvement plan.

VIII. Priority Elements

A data review including the four assessments revealed 10 priority elements that lend themselves to health improvement. In some cases, clear statistical data elevated the topic, while in other cases, residents themselves increased the priority. Regardless of the source, the following 10 items are considered the priority elements of this assessment, and will be elevated to a MAPP Steering Committee for further discussion. The ultimate goal will be to select 3-4 priority areas that a Community Health Improvement Plan (CHIP) will be built upon.

Obesity

The prevalence of obesity has been increasing gradually across the nation over the last decade. Cleveland County saw a 2% increase in obesity between 2011 and 2012. This brings the estimated total of obese individuals to be 30% of the population. Although more recent statistics are not available, one can assume the trend will continue. Obesity is a complex issue to address. A few of the contributing behavioral factors include:

- **Minimal fruit and vegetable consumption**
- **Physical inactivity**
- **Smoking**

Environmental factors, which are often difficult to pinpoint, are becoming the focus of systemic interventions to combat obesity. This is evidenced by the increased emphasis on connecting sidewalks in neighborhoods to local schools. In contrast, numerous fast food restaurants are competing for Cleveland County resident's patronage, and a lack of walkability exists in parts of the community. The push for obesity reduction seeks to prevent the development of chronic diseases. Obesity is strongly connected to heart disease, some forms of cancer, and diabetes. Since heart disease is the number one killer of Cleveland County residents, the reduction of obesity would mean fewer individuals dying from this disease.

Assets and Resources

Assets and resources include a funded Cleveland County Healthy Living Program that addresses nutrition and physical activity; Cleveland County Obesity Workgroup; Large number of city parks; Joint Use Agreements between city governments and public schools; Farmers markets; Moore Food Resource Center; Regional Food Bank feeding sites and programs; Extensive sidewalks and walking trails within communities; and Cleveland County OSU Extension Center/Educators.

Tobacco

In the state of Oklahoma, tobacco use – which includes the use of cigarettes, cigars, chewing tobacco, and electric cigarettes – is currently slightly above the national average. In Cleveland County, the percentage of those using tobacco (20.3%) is lower than the state average (23.3%) but still above the national average (19.6%). Tobacco prevention and cessation initiatives have been effective at decreasing the number of smokers from 21 of every 100 adults in 2005 to 17 of every 100 adults in 2014 (CDC). However, as e-cigarettes and vaping have become popular, statistics suggest that smoking is decreasing but vaping is increasing, especially among current smokers. Tobacco increases the likelihood of users experiencing poor health-related outcomes such as heart disease, asthma, hypertension, and cancer. These diseases are also a concern among those exposed to secondhand smoke.

Tobacco is the leading preventable cause of death in the United States.

Assets and Resources

Assets and resources include a funded Cleveland County Healthy Living Program that addresses tobacco control and prevention; Tobacco-free city-owned property; Youth Access Ordinances to prevent youth from accessing e-cigarettes; 24/7 Tobacco-free schools throughout the county.

Child Health

As a population, children are the least able to control their environment. Decisions that may have great impacts on their health are often left up to the adults in their lives. Car seat use, safe sleep, secondhand smoke, immunizations, and a healthy diet all fall under the umbrella of child health. While many of these matters can be aided through individual education efforts, there are also concerns that must be addressed through community collaboration.

Oklahoma is ranked 43rd in infant mortality

In our state, 6.8 babies per 1,000 do not live to see their first birthday. With various health and societal concerns to address in this outcome, a broad yet strategic response is required. To prevent infant mortality, strategies employed may include increased access to prenatal care, more education on safe sleep, increased parental support, and communication between engaged programs. Child health also includes effort to address adolescent and teen health. Approximately 25 per 100,000 children between 1 and 14 years old died in 2013 in Oklahoma (Kaiser Henry). Through campaigns to promote safety and inform parents and caregivers, unintentional injuries may be prevented or decreased. Community attention to children's health improves the chances of Oklahoma's youth living a healthier tomorrow.

Assets and Resources

Assets and resources include school gardens; CATCH Kids Club after school program at the YMCA; Cleveland County Immunization Coalition; Success by Six Coalition; Local library programs and resources; Reach Out

and Read Program; CCHD Car Seat Program; Partnership with Safe Kids Coalition to provide car seats and bike helmets; Child Passenger Safety Technicians at multiple agencies in the county; Goddard Health Services available to OU students; and Women, Infant and Children (WIC) Nutrition Program.

Substance Abuse

The issue of substance abuse is not to be overlooked in Oklahoma. It is estimated by the Oklahoma Department of Mental Health and Substance Abuse that nearly 140,000 Oklahomans need alcohol addiction treatment, 21,000 need treatment for other drug addictions, and 20,000 teenagers need treatment for alcohol and drug abuse. The epidemic of prescription drug abuse has also greatly affected the state. Unintentional poisoning deaths are the leading cause of injury death in the state, outpacing even motor vehicle crashes.

Opioid painkillers are responsible for 4 of 5 unintentional poisoning deaths in Oklahoma.

This is not isolated to a certain demographic. According to the 2014 Oklahoma Prevention Needs Assessment Survey, approximately 5% of 8th grade children indicated they had used prescription painkillers in the last 30 days. The impacts are seen in deaths, accidents, and addiction. In 2012, 145 hospital admissions were required in Cleveland County to address Substance Abuse Related Disorders, averaging four days per admission. The economic impacts of this disease are great. Missed work, the cost of addiction, and the medical needs of those addicted are costing the state an estimated \$7 billion per year (OMHSAS). The driving forces of addiction are often unclear, and the cure requires an investment from families and communities.

Assets and Resources

Assets and resources include the partnership with OU Southwest Prevention Center to address alcohol and substance abuse prevention; Local law enforcement regularly providing compliance checks with alcohol retailers; Partnership with ODMHSAS to provide the Naloxone program to local law enforcement and first responders; Absentee Shawnee Tribe grant to prevent prescription drug abuse and overdose; Cleveland County Substance Abuse Workgroup; Partnership with Norman Addiction Information and Counseling services; Griffin Memorial Hospital; Large number of non-profits in the area addressing substance abuse prevention and treatment; and Cleveland County Drug Court.

Mental Health

Recently, as the consequences of a mentally unhealthy society have become apparent, mental health has come to the forefront of national conversations. In Cleveland County, the outcomes are on a smaller scale, but nonetheless obvious. Residents disclose experiencing four or more poor mental health days in the past month. Hospital admissions stretch for 12 days to address mental diseases and disorders.

The suicide rate in the county has increased to 12.8 per 100,000.

Mental health services are available in the community, yet 10% of surveyed citizens report they were unable to access these services when needed. The complexities of insurance, levels of care, and eligibility can confuse consumers and prevent them from obtaining the counseling they need. Community providers and consumers alike acknowledge the wait time for services as a substantial barrier. A mental health system that communicates between providers, offers flexible appointments, and offers a simple access point can make all the difference to those seeking services. The links between mental health and self-medication, obesity, and child abuse are being explored, making mental health a central piece of the public health puzzle.

Assets and Resources

Assets and resources include Cleveland County Mental Health Workgroup; Griffin Memorial Hospital; Thunderbird Clubhouse; Large number of non-profits in the area addressing mental health treatment and awareness; Partnership with ODMHSAS; Center for Children and Families who provide parenting classes and programs for children; Crossroads Youth and Family Center.

Cardiovascular Health

When the health of a community is considered, the status of individual cardiovascular health is a top indicator. The interrelatedness of cardiovascular health to other public health issues is undeniable. Obesity, smoking, diabetes, inactivity, and poor diet are all risk factors for this disease.

Cardiovascular disease is the leading cause of death for Cleveland County residents.

While the rate has improved slightly from 256 per 100,000 to 192 per 100,000, there is continued cause for concern. Individual change happens slowly, and community-wide change is even more gradual. Community respondents to the Community Health Survey note they see exposure to secondhand smoke (13.1%), have limited access to healthy foods (14.7%), experience poor nutrition (26.8%), use tobacco (18.7%), and live an inactive lifestyle (33.4%). While experiencing any one of the previous is a risk factor for cardiovascular disease, many individuals regularly experience multiple risks, increasing their chance of cardiovascular disease.

Assets and Resources

Assets and resources include Norman Regional Hospital; Opportunities to be physically active such as parks, community sports, gyms, YMCA; Farmers Markets; Large number of retailers providing fresh fruits and vegetables; Restaurants with heart healthy options; and tobacco-free city ordinances.

Sexual Health

As health topics are addressed and evaluated within a population, it is vital to examine all areas of health. The sexual health of a population can be determined by a variety of data, including birth statistics and rates of sexually transmitted infections, like chlamydia and gonorrhea. Chlamydia, syphilis, and HIV/AIDS have all seen an increase in incidence over time in Cleveland County. Teen fertility and gonorrhea are two indicators that saw a slight decline.

Teen fertility decreased from 12.9 per 1,000 to 12.1 per 1,000. Gonorrhea saw a decline from 100.2 per 100,000 to 86.7 per 100,000.

All five indicators are lower than the state's level of occurrence. It's important to mention that, in years previous, syphilis had a negligible presence in the county, but is now seeing an increase on both the local and state levels. Factors impacting the sexual health of county residents are also typically easily addressed and prevented through education and information over how infections are spread and appropriate methods of protection. Although education over sexual health is vast and research is clear on causes and effective prevention, access to information and the stigma of having such infections may be difficult barriers to overcome as individuals. On a community level, organizations, schools, and workplaces can collaborate with health professionals in order to provide greater availability of sexual health information, prevention, testing, and treatment to decrease the spread of sexually transmitted infections.

Assets and Resources

Assets and resources include Cleveland County Health Department; Non-profits in the area providing pregnancy testing/STD testing/STD treatment; CCHD Health Education partnering with local schools to provide teen pregnancy and STD/HIV prevention programs.

Diabetes

As one of the leading causes of death in the country and county, diabetes is an underestimated disease with multiple factors linked to its cause. Within Cleveland County, approximately 20,000 have been diagnosed with diabetes, which results in 16.9 per 100,000 deaths. While there are two forms of diabetes, also known as diabetes mellitus, it is typically type 2 diabetes that is most often discussed. Type 2 diabetes does not develop overnight, but stems from the presence of long-term risk factors. Some of these risk factors include:

- **Being overweight/obese**
- **Physical inactivity**
- **High blood pressure**
- **Abnormal cholesterol levels**

Age, genetics, and race may also play a part in an individual's risk for developing diabetes. Cleveland County residents listed an inactive lifestyle, limited access to healthy foods, and poor nutrition as having a significant impact on the health of the community. It is evident that, to prevent diabetes as effectively as possible, strategies need to be directed towards the concerns of county residents to impact the prevalence of diabetes in the community.

Assets and Resources

Assets and resources include Norman Regional Hospital's Diabetes Prevention Program; Close proximity to Harold Hamm Diabetes Center in OKC; Large number of retailers providing fresh produce; Opportunities to be physically active such as gyms, YMCA, parks, sidewalks; and CCHD Pre-Diabetes Prevention Program.

Cancer

With various forms and causes of cancer, the list of risk factors for the disease is numerous. Cancer may develop from genetic predispositions, tobacco use, obesity, sun and UV exposure, and other environmental carcinogens. In Oklahoma, the four most prevalent types of cancer among all races are:

- **Breast cancer (115.7 per 100,000)**
- **Lung cancer (69.3 per 100,000)**
- **Prostate cancer (96.8 per 100,000)**
- **Colon cancer (43.2 per 100,000)**

Source: CDC

Lung and colon cancer may be caused by behaviors and environmental influences. Public health efforts to decrease tobacco use and increase the intake of fruits and vegetables aim to encourage preventive behaviors that can help reduce such cancers. Breast and prostate cancers are less behavior-based and largely result from genetics or carcinogenic exposures. With this in mind, public health efforts focus on awareness and health screenings for at-risk populations. Like cardiovascular disease and diabetes, access to healthy foods and a physically active lifestyle are important for cancer prevention among Cleveland County residents. Specific efforts to address community concerns of secondhand smoke and tobacco use will also assist in cancer prevention.

Assets and Resources

Assets and resources include Norman Regional Hospital; Close proximity to Stephenson Cancer Center; Tobacco-free city ordinances; City youth access ordinances; 24/7 tobacco-free schools; Farmers markets; Large number of retailers providing fresh produce.

Access to Healthcare

Without access to appropriate healthcare, health outcomes for individuals suffer and the community as a whole absorbs the cost both financially and socially. When referencing “access to care,” a broad spectrum of subjects is included. The term “access” may include personal barriers such as time off work, finances, child care, and transportation. “Care” encompasses insurance, available doctors, appointments at convenient times, and affordable preventive options. This leaves room for significant disparities among groups of citizens, particularly the working poor and underinsured.

In fact, throughout the United States, lifespans are now more than ever correlated to the level of one’s socioeconomic status. With higher levels of income and education, an individual is more likely to have personal and economic resources that benefit their health.

Such benefits may mean access to better care, being able to afford to take off work for doctor visits, and personal behaviors which prevent diseases. In Cleveland County areas that have a per capita income of \$30,000 and above, less than 10% of the population is uninsured. In contrast, areas with lower per capita income may have upward of 20% of the population uninsured (US Census Bureau, American Community Survey. 2009-13). Creativity within community collaborations is necessary to provide services and resources, but supporting strategic policies and advocacy are crucial to long-term change.

Assets and Resources

Assets and resources include Norman Regional Hospital; CCHD; Variety Care; Affordable Quality Care; Moore Faith Clinic; City transportation (Norman CART); Sooner Ride; Sooner Care; Many providers willing to see Medicaid patients; Large number of Urgent Care Centers; Large number of pharmacies/minute clinics.

IX. Next Steps

Each of the four assessment categories combines to form a comprehensive review of Cleveland County’s health status. However, as raw data, it simply serves as a broad tool to guide the efforts of a dedicated community. With that in mind, this information will be shared with a cross-section of community partners and leaders in an effort to narrow the focus to 4-6 priority areas targeted for improvement. Once the priorities are established, workgroups for each priority area will be established to develop goals, objectives, and strategies, and a community health improvement plan will be developed, initiated, and implemented.

X. Appendix

- A. 2015 Cleveland County Health Survey
- B. 2014 State of the State's Health/Cleveland County Report Card
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- E. County Health Rankings & Roadmaps Cleveland County
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Cleveland County Health Survey 2015 - Results

When you imagine a strong, vibrant community what are the features you think of? (Please select 3)

Sixty-one percent of respondents (n = 1,484) selected 3 features as requested. More than 5% (n = 136) selected fewer than 3 features, and 4.5% (n = 108) selected all features. One percent of respondents (n = 27) also selected the “other” category and provided a specific response. The frequencies and percentages of the features selected are listed in Table 1 in the order they appeared on the survey.

Table 1. Frequency and Percentage of Responses Selected to Represent Features of a Strong, Vibrant Community (n = 2,456).

Community Features:	Frequency	Percentage
Arts and Entertainment	759	30.9
Economic Opportunities	776	31.6
Walkable and Bike-friendly Communities	799	32.5
Parks and Recreation Resources	897	36.5
Drug and Alcohol Free Communities	691	28.1
Safe Environment	1,503	61.2
Livable Wages	915	37.3
Health Care Services	838	34.1
Mental Health Services	426	17.4
Transportation	431	17.6
Clean Environment	1,021	41.6
Good Childcare	563	22.9
Diverse Populations	373	15.2
Affordable Housing	731	29.8
Senior Housing	287	11.7
Health Food Choices	497	20.2
Senior Services	346	14.1
Good Schools	1,224	49.8
Other	27	1.1

Features that were listed in the “other” category include:

- Aquatics center
- Child food programs for the off times
- Children’s programs
- Churches (3); strong religious presence available to the public
- Disc golf courses; inexpensive outdoor activities like disc golf; rebuild disc golf course in Moore
- Dog Park for Moore, OK; more animal awareness, spay & neuter, microchipping; pet friendly
- Environmentally sustainable



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Economic Opportunities	776	31.6
Walkable and Bike-friendly Communities	799	32.5
Parks and Recreation Resources	897	36.5
Drug and Alcohol Free Communities	691	28.1
Safe Environment	1,503	61.2
Livable Wages	915	37.3
Health Care Services	838	34.1
Mental Health Services	426	17.4
Transportation	431	17.6
Clean Environment	1,021	41.6
Good Childcare	563	22.9
Diverse Populations	373	15.2
Affordable Housing	731	29.8
Senior Housing	287	11.7
Health Food Choices	497	20.2
Senior Services	346	14.1
Good Schools	1,224	49.8
Other	27	1.1

Features that were listed in the “other” category include:

- Aquatics center
- Child food programs for the off times
- Children’s programs
- Churches (3); strong religious presence available to the public
- Disc golf courses; inexpensive outdoor activities like disc golf; rebuild disc golf course in Moore
- Dog Park for Moore, OK; more animal awareness, spay & neuter, microchipping; pet friendly
- Environmentally sustainable



- Gardens
- Good libraries (2)
- Good neighborhoods
- Less drugs to strict no drug at all
- Medical freedom to choose what goes into my body
- No homeless
- Police and fire services (JH note: relates to safe environment)
- Recycling
- Senior discounts in more businesses and health including fitness
- Citizens not making unnecessary complaints on residents and wasting the time of law officials
- Good street lighting everywhere (JH note: relates to safe environment)
- Quiet

For those who selected only 3 items per the instructions, some indicated wanting to select other items:

- Child care and good schools
- Senior services
- All are important (4)

How would you rate Cleveland County as a “Healthy Community?”

The majority of respondents (80.6%) believed Cleveland County is “somewhat healthy” or “healthy” (Table 2).

Table 2. Respondents’ Rating of the Health of Cleveland County.

Rating	Frequency	Percentage
Very unhealthy	63	2.6
Unhealthy	148	6.2
Somewhat healthy	968	40.3
Healthy	967	40.3
Very healthy	255	10.6
Missing	55	-



- My gym
- Newsletters
- Online email
- Personal study

Which of the following, in your opinion, has the most impact on the health of Cleveland County? (Please select up to 5)

Almost half of respondents (n = 1,099) selected 5 items they believed had the most impact on the health of Cleveland County. Thirty-five percent (n = 796) selected 4 or fewer items as having the most impact, and 8 respondents selected all items. More than 1% of respondents (n = 34) also selected the “other” category and provided a specific response. Inactive lifestyle, cost of health care, and drug abuse were the three items most commonly selected as impacting the health of Cleveland County. The frequencies and percentages of responses are listed in Table 4 in the order they appeared on the survey.

Table 4. Frequency and Percentage of Responses Selected as Having the Most Impact on the Health of Cleveland County (n = 2,456).

	Frequency	Percentage
Alcohol Abuse	638	26.0
Child Abuse/Neglect	512	20.9
Children not Vaccinated	224	9.1
Cost of Health Care	811	33.0
Depression	333	13.6
Distracted Driving	433	17.6
Domestic Violence	289	11.8
Driving Under the Influence	327	13.3
Drug Abuse	810	33.0
Exposure to Secondhand Smoke	322	13.1
Inactive Lifestyle	819	33.4
Lack of Mental Health Care	372	15.2
Limited Access to Healthy Foods	362	14.7
Motor Vehicle Accidents/Injuries	135	5.5
Poor Nutrition	658	26.8
Poverty	551	22.4
Prescription Drug Abuse	321	13.1
Rape/Sexual Assault	146	5.9
Sexually Transmitted Diseases	188	7.7
Stress	627	25.5
Suicide	105	4.3
Teen Pregnancy	393	16.0
Tobacco Use	458	18.7
Uninsured	424	17.3
Youth Tobacco Use	218	8.9
Youth/Gang Violence	159	6.5
Violent Crime	190	7.7
Other	34	1.4



Two individuals listed “other” impacts that were already represented by the choices above (stress and domestic abuse and help for victims). Some of the impacts below may fit into categories in the table above, also. Other impacts on health provided by respondents include:

- Access to care:
 - Convenience of local hospital for non-acute issues (women’s center for childbirth, outpatient surgeries, full capacity ER). Concerned that NRH will not rebuild the hospital.
 - Limitations of health insurance: “Oklahoma has the worst insurance, Medicaid policy does not allow adults full scope and ohca is a joke”
 - Lack of good diagnosticians in health care for senior adults
 - Mental health and drug abuse services: “better access to those addicted to prescription drugs - doctors need a new approach to treating pain and be held accountable for handing out scripts so freely. Also we need a 24hr physical response team for mental health emergencies along with an officer”
- Education
 - Lack of parental education; isolated uneducated low income parents
 - Lack of family counseling and parent training classes
 - Lack of training; poor education; school education; need proper health education in elementary schools
 - Preconception health (JH note: could be education or access to care)
 - Horrible child care
- Nutrition
 - Access to unhealthy foods for kids: “Schools need to limit children's access to junk food. Students should not be rewarded with junk food. Even the food listed on the so called healthy vendor list are a joke. Pop tarts and chips are on the healthy snack list and are sold at schools as a fund”
 - Access to food for seniors: “The "Cap" that is put on number of meals available to serve Senior Citizens by the Aging Services. The number of Seniors over the daily "cap" get fed Peanut butter and jelly sandwich. Seniors need a balanced meal at least once a day. This is a problem.”
 - Need affordable foods that are GMO free and organic
 - Choosing junk food over proper nutritional foods
- Need public transportation (2)
- Obesity (2)
- Disasters; tornadoes (2); public shelter please
- Responsible moral adults (JH note: lack of?)
- Failure to respect rights of others



- Lack of parenting/nurturing
- Traffic NON enforcement
- Youth crime
- Low wages/standard of living
- Theft
- Too many stores, not enough nature
- Adults not vaccinated
- Boredom. There is next to nothing to do here.
- Dog poop on the grass
- Homeless

Consider that many of these items relate to each other, and improvements in some areas may assist with improvements in other areas.

How would you rate your health?

Most respondents (82.6%) classified their health as “somewhat healthy” or “healthy” (Table 5).

Table 5. Respondents’ Rating of Their Health.

Rating	Frequency	Percentage
Very unhealthy	50	2.1
Unhealthy	129	5.5
Somewhat healthy	803	34.2
Healthy	1,136	48.4
Very healthy	229	9.8
Missing	109	-

When was the last time you....?

More than half of respondents have accessed basic medical or dental care or gotten a flu shot within the past year. A very small percentage have never visited a dentist, dental hygienist, or had a routine medical checkup. Fifteen percent of respondents have never had a flu shot. Frequencies and percentages of respondents’ last access to select preventive services are presented in Table 6.

Table 6. Frequency (Percentage) of Respondents’ Accessing Select Preventive Services.

	Visited a dentist/dental clinic for any reason	Had your teeth cleaned by a dentist or hygienist	Had a flu shot	Had a routine checkup by a doctor
Never	42 (1.8)	68 (2.9)	359 (15.2)	63 (2.7)
Past year	1,416 (59.0)	1,325 (55.9)	1,200 (50.8)	1,591 (67.4)
1-2 years ago	470 (19.6)	449 (18.9)	310 (13.1)	373 (15.8)



3-5 years ago	247 (10.3)	245 (10.3)	167 (7.1)	146 (6.2)
>5 years ago	169 (7.0)	213 (9.0)	158 (6.7)	93 (3.9)
Don't know	55 (2.3)	72 (3.0)	168 (7.1)	96 (4.1)
Missing	57 (-)	84 (-)	94 (-)	94 (-)

Does anyone in your household use e-cigarettes or vaping devices? (Please select all that apply)

Does anyone in your household use chewing tobacco, dip, snuff, or snus? (Please select all that apply)

Nine respondents have at least 3 people in the household who use e-cigarettes or vaping devices, and 453 respondents have at least one person in the household using these devices. One respondent has at least 3 people in the household who use smokeless tobacco, and 197 respondents have at least one person who use smokeless tobacco. Frequencies and percentages of household members who use vaping devices and smokeless tobacco are presented in Table 7.

Table 7. Frequency (Percentage) of Household Members Who Use Vaping Devices or Smokeless Tobacco.

	E-cigarettes or vaping devices	Chewing tobacco, dip, snuff, or snus
No	1,955 (79.6)	2,185 (89.0)
Self	275 (11.2)	82 (3.3)
Spouse/significant other	154 (6.3)	105 (4.3)
Child	22 (0.9)	14 (0.6)
Roommate	83 (3.4)	37 (1.5)



How do you pay for your health care? (Please select all that apply)

Seventy-six percent (n = 1,748) of respondents have a single means and 19.4% (n = 446) have two means of paying for their health care. Twenty-one percent of respondents indicated paying cash/not having health insurance. However, several of these respondents also selected other methods of payment. For example, 27 “cash-only” respondents also selected private insurance; 30 selected employer-provided insurance; 99 use a free clinic; 3 use Tricare; 11 use a tribal clinic; 12 are on Medicare; 45 have SoonerCare; and 7 use the Veteran’s Administration services. One-hundred fifty-eight people either did not know how they paid for healthcare or did not respond to this question. The frequencies and percentages of responses are listed in Table 8 in the order they appeared on the survey.

Table 8. Frequency and Percentage of Methods Used to Pay for Health Care (n = 2,456).

Health Care Payment Options:	Frequency	Percentage
Cash (No Insurance)	517	21.1
Private Health Insurance	480	19.5
Employer Provided Health Insurance	861	35.1
Free Health Clinic	228	9.3
TRICARE	107	4.4
Indian Health Service/Tribal Health	100	4.1
Medicare	208	8.5
SoonerCare	393	16.0
Veterans Administration	29	1.2
Don’t Know	65	2.7
Other	41	1.7

Several individuals listed “other” methods that were already represented by the choices above (such as a specific health insurance, though it is unknown whether it is private or employer-provided insurance). Other methods of payment that were not represented on the list include:

- Private insurance (JH category):
 - Student insurance
 - Supplemental
 - United Healthcare Senior Horizons
 - Medicare Supplement (2)
 - Obamacare/Healthcare.gov (2)
 - TRICARE Reserve Select (military)
- Private or employee, not stated:
 - State retiree coverage
 - Parent/spouse insurance
- BX Marketplace
- Charity
- Church



- Drug company sponsorship
- Federal healthcare
- Government
- Walgreen’s prescription discount program
- Insure Oklahoma (2)
- Medi-Cal
- Medicaid
- Healthcare.gov subsidy
- Social security disability
- Free clinic
- Variety Care

If you do not have health insurance, what are the reasons? (Please select all that apply)

While 974 respondents (39.7%) indicated that they had health insurance, leaving 1,482 potentially without insurance, only 674 respondents selected reasons as to why they did not have health insurance. Of those, 70% (n = 469) provided a single reason and 20% (n = 137) provided two reasons. The primary reason provided for not having insurance was the inability to afford the premiums, followed by a loss of or change in jobs. The frequencies and percentages of responses are listed in Table 9 in the order they appeared on the survey.

Table 9. Frequency and Percentage of Reasons Why Respondents Did Not Have Health Insurance (n = 674).

Reasons to Not Have Insurance:	Frequency	Percentage
Choose not to/do not want it	28	1.1
Do not know how to get it	67	2.7
Cannot afford to pay the premiums	384	15.6
Lost job or changed employers	125	5.1
Became divorced or separated	27	1.1
Spouse or parent died	7	0.3
Became ineligible because of age or left school	66	2.7
Employer doesn’t offer or stopped offering coverage	75	3.1
Cut back to part time or became a temp employee	42	1.7
Benefits from employer or former employer ran out	16	0.7
Insurance company refused coverage	12	0.5
Lost Medicaid or medical assistance eligibility	60	2.4
Other	79	3.2

Several of the “other” reasons could be classified into the listed categories; some of these are presented below, along with other reasons that do not tie in to the above categories.

- Cannot afford it (JH category)
 - ACA is far from affordable and don’t qualify for SoonerCare
 - Cannot afford it
 - Deductible is \$6000
 - High cost and doctors don’t take Obamacare



- Part-time employment
 - Can't work enough at job to qualify because of health issue
- Not eligible
 - Denied because of income
- Denied child support (2); did not respond to child support (JH note: cannot afford?)
- Full-time student (3)
- New employment (JH category-changed employers? This implies that the individual had a job before, rather than going from unemployed to employed)
 - Had to find job, insurance starts in June
 - Haven't started new job yet
 - Husband started new job
 - New employee, not in effect yet
 - Just started new job
 - Waiting on coverage through employment
 - Waiting on open enrollment to add child
- Use Indian Health Service (5)
- I'm a minor
- Immigrant; just arrived in states; just arrived from Mexico
- Just haven't enrolled this year
- Just moved here
- Just qualified
- No SSN (3); do not have card
- Premiums are more expensive than I ever use it
- Applying for disability SSA (2)
- Coverage is becoming more limited
- Our governor refused funds from President Obama
- Self-employed (JH note: cannot afford?)
- Worker's comp



In the past 12 months, which of the following did you visit the most for your medical care?

About half of respondents (n = 1,099) visited a primary care physician for most of their medical care in the past 12 months. Urgent Care was the second most common source of medical care, followed by a free health clinic. The frequencies and percentages of responses are listed in Table 10 in the order they appeared on the survey.

Table 10. Frequency and Percentage of Primary Source of Respondents’ Medical Care (n = 2,456).

Source of Care:	Frequency	Percentage
Urgent Care	418	19.2
Primary Care	1,099	50.5
Pharmacy Clinic	46	2.1
Emergency Room	174	8.0
Free Health Clinic	236	10.9
Chiropractor	59	2.7
Non-traditional Healer	29	1.3
Other	75	3.5
N/A; None; Did Not Get Care	39	1.8
Missing	281	-

Some respondents selected multiple persons/places, such as Urgent Care and ER. Several of the “other” places/persons from which respondents received care include:

- Specialists
 - Cardiologist (2)
 - Ophthalmologist
 - Dentist (5)
 - Psychiatrist
 - Rheumatologist
 - Specialist (8)
 - Ob/Gyn (21)
 - Neurologist (2)
 - Neurosurgeon
 - Oncologist
 - Eye doctor
 - Pain management physician
- Nurse Practitioner
- Church
- Employer provided medical clinic
- Health department (7)
- Physical therapist
- Mental health
- Midwife



- Tinker, Military
- VA (4)
- Variety Care
- Tribal medicine man (JH note: non-traditional healer)
- Tribal clinic (6)
- Self care

In the past 12 months, did any of the following keep you from receiving needed medical care? (Please select all that apply)

Nine hundred thirty-two respondents selected reasons as to why they did not receive needed medical care. Of those, 44.3% (n = 413) provided a single reason and 49.2% (n = 459) provided two or three reasons. About 4.5% of respondents listed an “other” reason, though some of those reasons relate to those already provided in the survey’s list of responses. Almost 1,200 respondents said “no” to all of the reasons listed, which implies that they did not experience one of these reasons for not receiving care. The frequencies and percentages of responses are listed in Table 11 in the order they appeared on the survey.

Table 11. Frequency and Percentage of Reasons Why Respondents Did Not Receive Care (n = 2,456).

Reason:	Frequency	Percentage
Can’t afford copay	510	26.8
Can’t afford to fill prescriptions	455	24.4
No insurance	456	24.5
No provider available	44	5.5
No provider accepted my insurance	95	5.7
Not able to get an appointment in time	230	14.0
Other	42	1.7
Reason not selected	1,161	55.5
Missing	363	-

Several of the “other” reasons respondents presented for not receiving needed medical care include:

- Not able to leave work (6)
- Transportation (2)
- Did not need to go; n/a (10)
- Too busy (3)
- Procrastination
- Lazy; didn’t try
- Need to find a new dentist who is not trying to upsell
- Insurance denial (JH note: meaning the doctor denied the insurance, or the respondent could not get insurance?)
- Medication no longer available
- Provider not open after hours
- Relocation – don’t trust doctors
- Save money
- Didn’t qualify



- Had to look really hard
- Our governor
- Long wait for an appointment
- Pre-existing conditions

In the past 12 months, if needed, were you able to access mental health services?

More than 1,400 respondents (n = 1,442; 58.7%) indicated not needing any of the mental health services listed (crisis care, hospitalization, or counseling/therapy). Ten percent (n = 209) of respondents indicated needing all three types of services and not being able to get them. The frequencies and percentages of responses are listed in Table 12.

Table 12. Frequency and Percentage of Reasons Why Respondents Did Not Receive Care (n = 2,456).

	Mental Health Service		
	Crisis Care	Hospitalization	Counseling/Therapy
Able to Access Service	237 (11.5)	212 (10.4)	273 (13.2)
Not Able to Access Service	108 (5.3)	161 (7.9)	290 (14.0)
Did Not Need Service	1,709 (83.2)	1,670 (81.7)	1,509 (72.8)
Missing	402 (-)	413 (-)	384 (-)

Eighty respondents provided specific reasons as to why they could not access the mental health service. Their responses include:

- Unable to afford the service (24)
 - Did not specify if they had insurance or not
- No insurance (8)
- Providers did not accept insurance/Medicare (6)
 - Not taking new patients
- Insurance restrictions on who can be seen and services covered
 - No practitioners met criteria within insurance coverage area
 - Not covered by insurance (3)
- Difficulty with available times
 - Cannot get time off from work (5)
- Don't know how to get it (2) or if it is offered free
- Unable to locate provider specific to my needs
- Lack of quality providers
 - No beds available
 - Contacted but still on wait list after 5 weeks
 - Not good selection of counselors
 - Lack of facility space
 - Not available/adequate



- Needed help with an adult child
- No one accepts therapy alone
- No one would call me back
 - Very slow response from the state
- Car was stolen
- Hard to find or no one wants to help
- Unknown location
- Want info

Are you the primary caregiver for any of the following?

Twenty-three percent of survey respondents did not provide an answer to these items, although a “not applicable” (N/A) category was available as a response. Of those who answered these items, 40.5% were primary caregivers to at least one biological or adopted child, and about half selected the “N/A” response. Sixty-seven individuals were primary caregivers for more than one type of person listed. The frequencies and percentages of responses are presented in Table 13.

Table 13. Frequency and Percentage of the Primary Caregiver Status of Respondents (n = 2,456).

Primary Caregiver for...	Frequency	Percent
Biological/adopted child	765	40.5
Grandchild	41	2.2
Foster child	25	1.3
Senior adult	97	5.1
Relative under 18	73	3.9
Non-relative under 18	20	1.1
N/A	944	49.9
Missing	566	-

Do you have children under 18 living in your home?

Fifty percent (n = 995) of survey respondents who answered this question (n = 1,973) had children under the age of 18 years living in their home. Responses were missing for 483 individuals.

Please indicate how often you do the following things...

Fewer than 1,200 survey respondents provided answers to these questions. The frequencies and percentages of responses are presented in Table 14.

Table 14. Frequency and Percentage of Responses to Select Injury Prevention Questions.



	Always	Almost Always	Sometimes	Rarely	Never	N/A
Require your child or children wear a helmet when riding a bicycle, ATV, scooter, etc.	393 (33.3)	187 (15.9)	137 (11.6)	66 (5.6)	109 (9.3)	287 (24.3)
Had a car seat inspected by a certified child passenger safety technician	321 (27.1)	65 (5.5)	82 (6.9)	59 (5.0)	319 (26.9)	339 (28.6)
Assure children 12 and under are properly restrained in the car	916 (77.4)	90 (7.6)	11 (0.9)	1 (0.1)	24 (2.0)	141 (11.9)
Assure children under 6 are in a properly installed child passenger restraint system	803 (68.5)	66 (5.6)	9 (0.8)	3 (0.3)	25 (2.1)	266 (22.7)

In the past 12 months, which of the following did you visit the most for medical care for the children in your household?

Two-thirds (n = 727) of those who answered this question indicated taking the children in their household most often to the primary care provider in the past 12 months. Urgent Care was the second most common source of medical care for the children in the household, and the emergency room was a distant third. The frequencies and percentages of responses are listed in Table 15 in the order they appeared on the survey.

Table 15. Frequency and Percentage of Primary Source of Children’s Medical Care (n = 2,456).

Source of Care:	Frequency	Percentage
Urgent Care	194	17.2
Primary Care	727	64.6
Pharmacy Clinic	23	2.0
Emergency Room	75	6.7
Free Health Clinic	57	5.1
Chiropractor	7	0.1
Non-traditional Healer	7	0.1
Other	11	1.0
N/A; None; Did not get care; Do not have children	24	2.1
Missing	1,331	-

The “other” places/persons from which respondents’ children received care include:

- Church
- Employer provided medical clinic
- OU Childrens (JH note: Hospital)
- VA
- Indian clinic (2)
- OB/GYN
- Specialist



Note: There were 995 survey respondents who said they had children under the age of 18 in their household. If you cross-tabulate the medical care for children question with those who indicated having children under 18 in the household, the numbers for Table 15 are different.

In the past 12 months, did any of the following keep you from receiving needed care for the children in your household? (Please select all that apply)

Two hundred forty-five respondents selected reasons as to why they did not receive needed care for children in their household. Of those, 67.4% (n = 165) provided a single reason. Ten respondents listed an “other” reason. The top three reasons for not getting care for children in the household include no insurance, inability to afford the co-pay, and inability to get an appointment in time. The frequencies and percentages of responses are listed in Table 16 in the order they appeared on the survey.

Table 16. Frequency and Percentage of Reasons Why Respondents’ Children Did Not Receive Care (n = 2,456).

Reason:	Frequency	Percentage
Can’t afford copay	76	31.0
Can’t afford to fill prescriptions	44	18.0
No insurance	81	33.1
No medical provider available	11	4.5
No medical provider accepted child’s insurance	9	3.7
No dental provider available	15	6.1
No dental provider accepted child’s insurance	10	4.1
No mental health provider available	10	4.1
No mental health provider accepted child’s insurance	10	4.1
Not able to afford glasses/hearing aids	29	11.8
Not able to get an appointment in time	64	26.1
Other	10	4.1
N/A	238	-
Missing	2,211	-

The “other” reasons respondents presented for not receiving needed care for children in their household include:

- Not able to leave work (2)
- No vehicle; transportation

2014 STATE OF THE STATE'S HEALTH
OKLAHOMA STATE DEPARTMENT OF HEALTH



B. 2014 State of the State's Health/Cleveland County Report Card



CLEVELAND COUNTY

	PREVIOUS	CURRENT	GRADE
MORTALITY			
INFANT (RATE PER 1,000)	6.3	4.9	B
TOTAL (RATE PER 100,000)	882.9	786.4	C
LEADING CAUSES OF DEATH (RATE PER 100,000)			
HEART DISEASE	256.0	192.1	C
MALIGNANT NEOPLASM (CANCER)	175.8	170.0	C
CEREBROVASCULAR DISEASE (STROKE)	62.3	42.1	C
CHRONIC LOWER RESPIRATORY DISEASE	54.0	63.9	F
UNINTENTIONAL INJURY	38.2	43.7	D
DIABETES	23.5	16.9	A
INFLUENZA/PNEUMONIA	19.6	16.4	C
ALZHEIMER'S DISEASE	19.4	20.7	B
NEPHRITIS (KIDNEY DISEASE)	15.9	9.8	B
SUICIDES	9.8	12.8	C
DISEASE RATES			
DIABETES PREVALENCE	9.2%	9.5%	C
CURRENT ASTHMA PREVALENCE	9.6%	10.2%	D
CANCER INCIDENCE (RATE PER 100,000)	535.0	442.2	B
RISK FACTORS & BEHAVIORS			
MINIMAL FRUIT CONSUMPTION	NA	48.5%	F
MINIMAL VEGETABLE CONSUMPTION	NA	24.8%	D
NO PHYSICAL ACTIVITY	25.5%	22.8%	C
CURRENT SMOKING PREVALENCE	22.9%	20.3%	C
OBESITY	28.9%	30.0%	D
IMMUNIZATIONS < 3 YEARS	70.9%	72.0%	C
SENIORS INFLUENZA VACCINATION	62.6%	67.9%	B
SENIORS PNEUMONIA VACCINATION	75.0%	77.0%	A
LIMITED ACTIVITY DAYS	16.2%	17.6%	C
POOR MENTAL HEALTH DAYS	25.0%	23.4%	C
POOR PHYSICAL HEALTH DAYS	20.9%	21.5%	C
GOOD OR BETTER HEALTH RATING	86.3%	87.2%	B
TEEN FERTILITY (RATE PER 1,000)	12.9	12.1	B
FIRST TRIMESTER PRENATAL CARE	70.7%	75.3%	C
LOW BIRTH WEIGHT	7.3%	7.7%	C
ADULT DENTAL VISITS	67.4%	69.1%	C
USUAL SOURCE OF CARE	77.0%	77.1%	C
OCCUPATIONAL FATALITIES (RATE PER 100,000 WORKERS)	2.4	2.2	B
PREVENTABLE HOSPITALIZATIONS (RATE PER 100,000)	1895.7	1486.8	C
SOCIOECONOMIC FACTORS			
NO INSURANCE COVERAGE	16.9%	13.3%	B
POVERTY	11.4%	13.3%	B

Mortality and Leading Causes of Death

- Cleveland County ranked 5th in the state for total mortality (age-adjusted).
- Cleveland County led the state with the lowest (best) rate for infant mortality. The rate was 40% lower than the state rate and 29% lower than the national rate.
- Heart disease, cancer and chronic lower respiratory disease were the leading causes of death in Cleveland County.
- Cleveland County had the 3rd lowest rate of deaths due to unintentional injuries and is ranked 8th in the state for deaths due to both suicide and diabetes.

Disease Rates

- Cleveland County had one of the lowest diabetes prevalence rates in the state.

Risk Factors, Behaviors and Socioeconomic Factors

- Cleveland County had the lowest (best) rate of teen fertility, and the 6th best percentage of mothers obtaining early prenatal care in the state.
- Cleveland County ranked 2nd (best) in the state for obesity prevalence, physically inactive adults, self-health rating, and adult dental visits.
- Cleveland County ranked 1st (best) in the state for occupational fatalities; a rate that was 46% better than the national rate.
- Approximately 1 in 2 adults consumed at least 1 piece of fruit each day (49%) and 1 in 4 consumed at least 1 vegetable per day (25%).
- 1 in 8 people in Cleveland county lived in poverty (13%).
- Approximately 1 in 6 adults reported 3+ days with limited activity in the past month (18%).
- Approximately 1 in 5 adults reported 4+ days of poor physical health (22%) and nearly 1 in 4 reported 4+ days of poor mental health (23%) in the previous month.

Changes from Previous Year

- Total mortality and infant mortality rates declined 11% and 22% respectively from the previous year.
- The percent of adults without health care coverage improved 21%.

Full report is available at <https://www.ok.gov/health/pub/boh/state/index.html>.

U.S. Census Bureau



DP05 ACS DEMOGRAPHIC AND HOUSING ESTIMATES

2009-2013 American Community Survey 5-Year Estimates

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Subject	Cleveland County, Oklahoma			
	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE				
Total population	261,047	*****	261,047	(X)
Male	130,428	+/-45	50.0%	+/-0.1
Female	130,619	+/-45	50.0%	+/-0.1
Under 5 years	16,467	+/-43	6.3%	+/-0.1
5 to 9 years	17,644	+/-546	6.8%	+/-0.2
10 to 14 years	15,996	+/-546	6.1%	+/-0.2
15 to 19 years	19,614	+/-149	7.5%	+/-0.1
20 to 24 years	28,546	+/-145	10.9%	+/-0.1
25 to 34 years	40,061	+/-53	15.3%	+/-0.1
35 to 44 years	32,657	+/-34	12.5%	+/-0.1
45 to 54 years	33,726	+/-44	12.9%	+/-0.1
55 to 59 years	14,877	+/-585	5.7%	+/-0.2
60 to 64 years	13,634	+/-593	5.2%	+/-0.2
65 to 74 years	16,389	+/-159	6.3%	+/-0.1
75 to 84 years	8,420	+/-283	3.2%	+/-0.1
85 years and over	3,016	+/-282	1.2%	+/-0.1
Median age (years)	32.7	+/-0.2	(X)	(X)
18 years and over	201,362	+/-21	77.1%	+/-0.1
21 years and over	184,900	+/-735	70.8%	+/-0.3
62 years and over	35,671	+/-506	13.7%	+/-0.2
65 years and over	27,825	+/-87	10.7%	+/-0.1
18 years and over	201,362	+/-21	201,362	(X)
Male	99,706	+/-39	49.5%	+/-0.1
Female	101,656	+/-34	50.5%	+/-0.1
65 years and over	27,825	+/-87	27,825	(X)
Male	12,249	+/-4	44.0%	+/-0.1
Female	15,576	+/-86	56.0%	+/-0.1
RACE				
Total population	261,047	*****	261,047	(X)

C. U.S. Census Bureau Cleveland County Demographics

Subject	Cleveland County, Oklahoma			
	Estimate	Margin of Error	Percent	Percent Margin of Error
One race	243,989	+/-1,009	93.5%	+/-0.4
Two or more races	17,058	+/-1,009	6.5%	+/-0.4
One race	243,989	+/-1,009	93.5%	+/-0.4
White	207,954	+/-733	79.7%	+/-0.3
Black or African American	11,301	+/-473	4.3%	+/-0.2
American Indian and Alaska Native	10,690	+/-799	4.1%	+/-0.3
Cherokee tribal grouping	1,703	+/-291	0.7%	+/-0.1
Chippewa tribal grouping	13	+/-26	0.0%	+/-0.1
Navajo tribal grouping	190	+/-117	0.1%	+/-0.1
Sioux tribal grouping	17	+/-21	0.0%	+/-0.1
Asian	10,128	+/-353	3.9%	+/-0.1
Asian Indian	882	+/-317	0.3%	+/-0.1
Chinese	1,685	+/-379	0.6%	+/-0.1
Filipino	758	+/-288	0.3%	+/-0.1
Japanese	564	+/-280	0.2%	+/-0.1
Korean	1,634	+/-451	0.6%	+/-0.2
Vietnamese	3,448	+/-516	1.3%	+/-0.2
Other Asian	1,157	+/-325	0.4%	+/-0.1
Native Hawaiian and Other Pacific Islander	217	+/-45	0.1%	+/-0.1
Native Hawaiian	125	+/-80	0.0%	+/-0.1
Guamanian or Chamorro	8	+/-13	0.0%	+/-0.1
Samoan	0	+/-23	0.0%	+/-0.1
Other Pacific Islander	84	+/-97	0.0%	+/-0.1
Some other race	3,699	+/-565	1.4%	+/-0.2
Two or more races	17,058	+/-1,009	6.5%	+/-0.4
White and Black or African American	2,606	+/-407	1.0%	+/-0.2
White and American Indian and Alaska Native	8,981	+/-799	3.4%	+/-0.3
White and Asian	2,122	+/-330	0.8%	+/-0.1
Black or African American and American Indian and Alaska Native	419	+/-120	0.2%	+/-0.1
Race alone or in combination with one or more other races				
Total population	261,047	*****	261,047	(X)
White	224,116	+/-1,159	85.9%	+/-0.4
Black or African American	15,460	+/-417	5.9%	+/-0.2
American Indian and Alaska Native	21,159	+/-309	8.1%	+/-0.1
Asian	12,958	+/-363	5.0%	+/-0.1
Native Hawaiian and Other Pacific Islander	609	+/-190	0.2%	+/-0.1
Some other race	5,341	+/-667	2.0%	+/-0.3
HISPANIC OR LATINO AND RACE				
Total population	261,047	*****	261,047	(X)
Hispanic or Latino (of any race)	19,096	*****	7.3%	*****
Mexican	14,338	+/-698	5.5%	+/-0.3
Puerto Rican	818	+/-312	0.3%	+/-0.1
Cuban	126	+/-87	0.0%	+/-0.1
Other Hispanic or Latino	3,814	+/-671	1.5%	+/-0.3
Not Hispanic or Latino	241,951	*****	92.7%	*****
White alone	195,743	+/-149	75.0%	+/-0.1
Black or African American alone	11,061	+/-403	4.2%	+/-0.2
American Indian and Alaska Native alone	10,347	+/-754	4.0%	+/-0.3
Asian alone	9,874	+/-286	3.8%	+/-0.1
Native Hawaiian and Other Pacific Islander alone	217	+/-45	0.1%	+/-0.1
Some other race alone	176	+/-133	0.1%	+/-0.1
Two or more races	14,533	+/-903	5.6%	+/-0.3
Two races including Some other race	172	+/-78	0.1%	+/-0.1
Two races excluding Some other race, and Three or more races	14,361	+/-883	5.5%	+/-0.3

C. U.S. Census Bureau Cleveland County Demographics

Subject	Cleveland County, Oklahoma			
	Estimate	Margin of Error	Percent	Percent Margin of Error
Total housing units	105,998	+/-262	(X)	(X)

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

The ACS questions on Hispanic origin and race were revised in 2008 to make them consistent with the Census 2010 question wording. Any changes in estimates for 2008 and beyond may be due to demographic changes, as well as factors including questionnaire changes, differences in ACS population controls, and methodological differences in the population estimates, and therefore should be used with caution. For a summary of questionnaire changes see http://www.census.gov/acs/www/methodology/questionnaire_changes/. For more information about changes in the estimates see <http://www.census.gov/population/hispanic/files/acs08researchnote.pdf>.

For more information on understanding race and Hispanic origin data, please see the Census 2010 Brief entitled, Overview of Race and Hispanic Origin: 2010, issued March 2011. (pdf format)

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Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2010 data. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Source: U.S. Census Bureau, 2009-2013 5-Year American Community Survey

Explanation of Symbols:

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2. An '-1' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
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6. An '*****' entry in the margin of error column indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
7. An 'N' entry in the estimate and margin of error columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.
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U.S. Census Bureau



S0901

CHILDREN CHARACTERISTICS

2009-2013 American Community Survey 5-Year Estimates

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Subject	Cleveland County, Oklahoma				
	Total		In married-couple family household		In male householder, no wife present, family household
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
Children under 18 years in households	59,319	+/-135	42,429	+/-1,038	4,798
AGE					
Under 6 years	33.7%	+/-0.7	34.8%	+/-1.1	31.3%
6 to 11 years	35.1%	+/-1.1	36.3%	+/-1.5	36.1%
12 to 17 years	31.2%	+/-1.1	28.9%	+/-1.3	32.6%
RACE AND HISPANIC OR LATINO ORIGIN					
One race	87.8%	+/-1.0	89.5%	+/-1.0	85.2%
White	72.3%	+/-0.7	75.2%	+/-1.3	70.4%
Black or African American	4.7%	+/-0.6	3.8%	+/-0.8	3.2%
American Indian and Alaska Native	5.5%	+/-0.6	4.8%	+/-0.9	8.0%
Asian	3.3%	+/-0.4	3.9%	+/-0.5	1.4%
Native Hawaiian and Other Pacific Islander	0.1%	+/-0.1	0.1%	+/-0.1	0.9%
Some other race	1.9%	+/-0.5	1.7%	+/-0.5	1.3%
Two or more races	12.2%	+/-1.0	10.5%	+/-1.0	14.8%
Hispanic or Latino origin (of any race)	11.4%	+/-0.1	10.3%	+/-0.9	14.6%
White alone, not Hispanic or Latino	65.7%	+/-0.2	68.7%	+/-1.4	63.5%
RELATIONSHIP TO HOUSEHOLDER					
Own child (biological, step or adopted)	90.1%	+/-0.9	92.8%	+/-1.1	86.2%
Grandchild	6.5%	+/-0.8	5.3%	+/-1.0	6.3%
Other relatives	2.2%	+/-0.6	1.4%	+/-0.4	5.1%
Foster child or other unrelated child	1.3%	+/-0.4	0.6%	+/-0.3	2.4%
NATIVITY					
Native	98.5%	+/-0.4	98.3%	+/-0.4	99.4%
Foreign born	1.5%	+/-0.4	1.7%	+/-0.4	0.6%
PRESENCE OF OTHER ADULTS					
Unmarried partner of householder present	5.5%	+/-1.0	(X)	(X)	27.2%

C. U.S. Census Bureau Cleveland County Demographics

Subject	Cleveland County, Oklahoma				
	Total		In married-couple family household		In male householder, no wife present, family household
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
DISABILITY STATUS					
Civilian children under 18 years in households	59,319	+/-135	42,429	+/-1,038	4,798
With any disability	3.8%	+/-0.6	3.1%	+/-0.6	4.3%
SCHOOL ENROLLMENT					
Children 3 to 17 years in households	49,734	+/-489	35,242	+/-1,013	4,154
Enrolled in school	44,371	+/-526	31,355	+/-999	3,680
Public	88.4%	+/-1.4	86.1%	+/-1.8	93.2%
Private	11.6%	+/-1.4	13.9%	+/-1.8	6.8%
Not enrolled in school	5,363	+/-585	3,887	+/-510	474
MEDIAN FAMILY INCOME IN THE PAST 12 MONTHS (IN 2013 INFLATION-ADJUSTED DOLLARS) FOR FAMILIES WITH OWN CHILDREN					
Median income (dollars)	64,067	+/-2,784	79,404	+/-3,101	41,103
Children under 18 years in households	59,319	+/-135	42,429	+/-1,038	4,798
PUBLIC ASSISTANCE IN THE PAST 12 MONTHS					
Children living in households with Supplemental Security Income (SSI), cash public assistance income, or Food Stamp/SNAP benefits	20.0%	+/-1.7	13.9%	+/-1.9	24.3%
POVERTY STATUS IN THE PAST 12 MONTHS					
Children in households for whom poverty status is determined	58,813	+/-247	42,249	+/-1,046	4,703
Income in the past 12 months below poverty level	13.8%	+/-1.5	6.9%	+/-1.3	14.8%
Income in the past 12 months at or above poverty level	86.2%	+/-1.5	93.1%	+/-1.3	85.2%
HOUSING TENURE					
Children under 18 years in occupied housing units	59,319	+/-135	42,429	+/-1,038	4,798
In owner-occupied housing units	68.7%	+/-2.2	79.0%	+/-2.5	50.5%
In renter-occupied housing units	31.3%	+/-2.2	21.0%	+/-2.5	49.5%

C. U.S. Census Bureau Cleveland County Demographics

Subject	Cleveland County, Oklahoma		
	In male householder, no wife present, family household	In female householder, no husband present, family household	
	Margin of Error	Estimate	Margin of Error
Children under 18 years in households	+/-758	11,800	+/-907
AGE			
Under 6 years	+/-5.8	30.7%	+/-3.2
6 to 11 years	+/-5.7	31.1%	+/-3.0
12 to 17 years	+/-5.9	38.1%	+/-3.6
RACE AND HISPANIC OR LATINO ORIGIN			
One race	+/-7.6	82.6%	+/-3.3
White	+/-7.9	62.6%	+/-4.9
Black or African American	+/-2.4	8.6%	+/-2.5
American Indian and Alaska Native	+/-4.7	7.3%	+/-2.1
Asian	+/-1.3	2.1%	+/-1.4
Native Hawaiian and Other Pacific Islander	+/-0.9	0.0%	+/-0.2
Some other race	+/-1.8	2.0%	+/-1.2
Two or more races	+/-7.6	17.4%	+/-3.3
Hispanic or Latino origin (of any race)	+/-6.0	13.4%	+/-3.1
White alone, not Hispanic or Latino	+/-7.5	56.3%	+/-4.8
RELATIONSHIP TO HOUSEHOLDER			
Own child (biological, step or adopted)	+/-5.1	84.2%	+/-3.2
Grandchild	+/-3.3	10.8%	+/-2.6
Other relatives	+/-3.3	3.9%	+/-1.9
Foster child or other unrelated child	+/-2.3	1.1%	+/-1.0
NATIVITY			
Native	+/-0.6	99.0%	+/-0.9
Foreign born	+/-0.6	1.0%	+/-0.9
PRESENCE OF OTHER ADULTS			
Unmarried partner of householder present	+/-7.8	14.9%	+/-3.4
DISABILITY STATUS			
Civilian children under 18 years in households	+/-758	11,800	+/-907
With any disability	+/-2.1	6.0%	+/-1.6
SCHOOL ENROLLMENT			
Children 3 to 17 years in households	+/-686	10,092	+/-818
Enrolled in school	+/-624	9,131	+/-802
Public	+/-3.4	94.3%	+/-1.9
Private	+/-3.4	5.7%	+/-1.9
Not enrolled in school	+/-173	961	+/-187
MEDIAN FAMILY INCOME IN THE PAST 12 MONTHS (IN 2013 INFLATION-ADJUSTED DOLLARS) FOR FAMILIES WITH OWN CHILDREN			
Median income (dollars)	+/-7,950	26,929	+/-2,599
Children under 18 years in households	+/-758	11,800	+/-907
PUBLIC ASSISTANCE IN THE PAST 12 MONTHS			
Children living in households with Supplemental Security Income (SSI), cash public assistance income, or Food Stamp/SNAP benefits	+/-7.6	40.5%	+/-4.5
POVERTY STATUS IN THE PAST 12 MONTHS			
Children in households for whom poverty status is determined	+/-771	11,737	+/-896
Income in the past 12 months below poverty level	+/-5.0	37.4%	+/-5.1

C. U.S. Census Bureau Cleveland County Demographics

Subject	Cleveland County, Oklahoma		
	In male householder, no wife present, family household	In female householder, no husband present, family household	
	Margin of Error	Estimate	Margin of Error
Income in the past 12 months at or above poverty level	+/-5.0	62.6%	+/-5.1
HOUSING TENURE			
Children under 18 years in occupied housing units	+/-758	11,800	+/-907
In owner-occupied housing units	+/-7.8	39.6%	+/-4.8
In renter-occupied housing units	+/-7.8	60.4%	+/-4.8

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Foreign born excludes people born outside the United States to a parent who is a U.S. citizen.

Excludes householders, spouses, and unmarried partners.

The Census Bureau introduced a new set of disability questions in the 2008 ACS questionnaire. Accordingly, comparisons of disability data from 2008 or later with data from prior years are not recommended. For more information on these questions and their evaluation in the 2006 ACS Content Test, see the Evaluation Report Covering Disability.

Public assistance includes receipt of Supplemental Security Income (SSI), cash public assistance income, or Food Stamps.

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U.S. Census Bureau



S1401

SCHOOL ENROLLMENT

2009-2013 American Community Survey 5-Year Estimates

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Subject	Cleveland County, Oklahoma					
	Total			Percent of enrolled population		
				In public school		In private school
	Estimate	Margin of Error		Estimate	Margin of Error	Estimate
Population 3 years and over enrolled in school	81,229	+/-1,220		89.9%	+/-0.9	10.1%
Nursery school, preschool	3,674	+/-389		63.5%	+/-5.3	36.5%
Kindergarten to 12th grade	42,916	+/-452		91.1%	+/-1.3	8.9%
Kindergarten	4,168	+/-431		89.1%	+/-3.4	10.9%
Elementary: grade 1 to grade 4	14,091	+/-597		89.8%	+/-1.8	10.2%
Elementary: grade 5 to grade 8	12,688	+/-719		91.1%	+/-2.0	8.9%
High school: grade 9 to grade 12	11,969	+/-418		93.3%	+/-1.6	6.7%
College, undergraduate	28,927	+/-1,090		92.4%	+/-1.2	7.6%
Graduate, professional school	5,712	+/-563		85.0%	+/-3.2	15.0%
Percent of age group enrolled in school --						
3 and 4 years	38.4%	+/-4.8		58.5%	+/-7.1	41.5%
5 to 9 years	96.1%	+/-1.1		88.8%	+/-1.9	11.2%
10 to 14 years	98.4%	+/-0.8		91.0%	+/-1.8	9.0%
15 to 17 years	97.5%	+/-1.1		92.1%	+/-1.9	7.9%
18 and 19 years	83.5%	+/-2.6		98.3%	+/-1.0	1.7%
20 to 24 years	57.8%	+/-2.8		93.7%	+/-1.6	6.3%
25 to 34 years	19.0%	+/-1.2		89.9%	+/-2.7	10.1%
35 years and over	3.3%	+/-0.3		72.1%	+/-4.1	27.9%
Population 18 years and over	201,362	+/-21		(X)	(X)	(X)
Enrolled in college or graduate school	17.1%	+/-0.6		91.2%	+/-1.1	8.8%
Males 18 years and over	99,706	+/-39		(X)	(X)	(X)
Enrolled in college or graduate school	16.8%	+/-0.9		91.0%	+/-1.6	9.0%
Females 18 years and over	101,656	+/-34		(X)	(X)	(X)
Enrolled in college or graduate school	17.5%	+/-0.7		91.4%	+/-1.8	8.6%
Population 18 to 24 years	38,582	+/-23		(X)	(X)	(X)
Enrolled in college or graduate school	59.6%	+/-2.3		95.1%	+/-1.2	4.9%
Males 18 to 24 years	19,697	+/-14		(X)	(X)	(X)
Enrolled in college or graduate school	57.0%	+/-2.9		94.1%	+/-2.0	5.9%
Females 18 to 24 years	18,885	+/-18		(X)	(X)	(X)
Enrolled in college or graduate school	62.2%	+/-3.4		96.0%	+/-1.5	4.0%

C. U.S. Census Bureau Cleveland County Demographics

Subject	Cleveland County, Oklahoma				
	Total		Percent of enrolled population		
			In public school		In private school
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
PERCENT IMPUTED					
School enrollment	3.2%	(X)	(X)	(X)	(X)
Grade enrolled	4.8%	(X)	(X)	(X)	(X)

C. U.S. Census Bureau Cleveland County Demographics

Subject	Cleveland County, Oklahoma
	Percent of enrolled population
	In private school
	Margin of Error
Population 3 years and over enrolled in school	+/-0.9
Nursery school, preschool	+/-5.3
Kindergarten to 12th grade	+/-1.3
Kindergarten	+/-3.4
Elementary: grade 1 to grade 4	+/-1.8
Elementary: grade 5 to grade 8	+/-2.0
High school: grade 9 to grade 12	+/-1.6
College, undergraduate	+/-1.2
Graduate, professional school	+/-3.2
Percent of age group enrolled in school --	
3 and 4 years	+/-7.1
5 to 9 years	+/-1.9
10 to 14 years	+/-1.8
15 to 17 years	+/-1.9
18 and 19 years	+/-1.0
20 to 24 years	+/-1.6
25 to 34 years	+/-2.7
35 years and over	+/-4.1
Population 18 years and over	
Enrolled in college or graduate school	+/-1.1
Males 18 years and over	
Enrolled in college or graduate school	+/-1.6
Females 18 years and over	
Enrolled in college or graduate school	+/-1.8
Population 18 to 24 years	
Enrolled in college or graduate school	+/-1.2
Males 18 to 24 years	
Enrolled in college or graduate school	+/-2.0
Females 18 to 24 years	
Enrolled in college or graduate school	+/-1.5
PERCENT IMPUTED	
School enrollment	(X)
Grade enrolled	(X)

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Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2010 data. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Source: U.S. Census Bureau, 2009-2013 5-Year American Community Survey

C. U.S. Census Bureau Cleveland County Demographics

Explanation of Symbols:

1. An '***' entry in the margin of error column indicates that either no sample observations or too few sample observations were available to compute a standard error and thus the margin of error. A statistical test is not appropriate.
2. An '-' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
3. An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.
4. An '+' following a median estimate means the median falls in the upper interval of an open-ended distribution.
5. An '***' entry in the margin of error column indicates that the median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
6. An '*****' entry in the margin of error column indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
7. An 'N' entry in the estimate and margin of error columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.
8. An '(X)' means that the estimate is not applicable or not available.

U.S. Census Bureau



S1601

LANGUAGE SPOKEN AT HOME

2009-2013 American Community Survey 5-Year Estimates

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Sample size and data quality measures (including coverage rates, allocation rates, and response rates) can be found on the American Community Survey website in the Methodology section.

Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

Subject	Cleveland County, Oklahoma				
	Total		Percent of specified language speakers		
			Speak English "very well"		Speak English less than "very well"
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
Population 5 years and over	244,580	+/-43	96.6%	+/-0.3	3.4%
Speak only English	90.6%	+/-0.5	(X)	(X)	(X)
Speak a language other than English	9.4%	+/-0.5	63.5%	+/-2.7	36.5%
Spanish or Spanish Creole	4.2%	+/-0.3	64.2%	+/-4.2	35.8%
Other Indo-European languages	1.3%	+/-0.3	80.8%	+/-5.5	19.2%
Asian and Pacific Island languages	3.1%	+/-0.2	51.2%	+/-4.6	48.8%
Other languages	0.8%	+/-0.2	80.0%	+/-7.7	20.0%
SPEAK A LANGUAGE OTHER THAN ENGLISH					
Spanish or Spanish Creole	10,256	+/-749	64.2%	+/-4.2	35.8%
5-17 years	1,878	+/-263	83.6%	+/-5.3	16.4%
18-64 years	7,788	+/-553	60.5%	+/-5.0	39.5%
65 years and over	590	+/-112	51.2%	+/-14.4	48.8%
Other Indo-European languages	3,178	+/-665	80.8%	+/-5.5	19.2%
5-17 years	420	+/-169	86.0%	+/-12.7	14.0%
18-64 years	2,382	+/-522	79.2%	+/-5.9	20.8%
65 years and over	376	+/-122	85.4%	+/-11.4	14.6%
Asian and Pacific Island languages	7,645	+/-578	51.2%	+/-4.6	48.8%
5-17 years	1,141	+/-220	74.9%	+/-9.8	25.1%
18-64 years	5,883	+/-482	49.3%	+/-5.7	50.7%
65 years and over	621	+/-44	25.4%	+/-10.7	74.6%
Other languages	1,913	+/-434	80.0%	+/-7.7	20.0%
5-17 years	239	+/-136	79.1%	+/-23.5	20.9%
18-64 years	1,540	+/-329	81.1%	+/-7.3	18.9%
65 years and over	134	+/-77	69.4%	+/-38.7	30.6%
CITIZENS 18 YEARS AND OVER					
All citizens 18 years and over	193,715	+/-811	98.2%	+/-0.2	1.8%
Speak only English	93.5%	+/-0.4	(X)	(X)	(X)
Speak a language other than English	6.5%	+/-0.4	72.4%	+/-2.8	27.6%
Spanish or Spanish Creole	2.8%	+/-0.3	77.1%	+/-4.8	22.9%
Other languages	3.6%	+/-0.3	68.7%	+/-3.9	31.3%

C. U.S. Census Bureau Cleveland County Demographics

Subject	Cleveland County, Oklahoma				
	Total		Percent of specified language speakers		
			Speak English "very well"		Speak English less than "very well"
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
PERCENT IMPUTED					
Language status	3.2%	(X)	(X)	(X)	(X)
Language status (speak a language other than English)	3.8%	(X)	(X)	(X)	(X)
Ability to speak English	4.9%	(X)	(X)	(X)	(X)

C. U.S. Census Bureau Cleveland County Demographics

Subject	Cleveland County, Oklahoma
	Percent of specified language speakers
	Speak English less than "very well"
	Margin of Error
Population 5 years and over	+/-0.3
Speak only English	(X)
Speak a language other than English	+/-2.7
Spanish or Spanish Creole	+/-4.2
Other Indo-European languages	+/-5.5
Asian and Pacific Island languages	+/-4.6
Other languages	+/-7.7
SPEAK A LANGUAGE OTHER THAN ENGLISH	
Spanish or Spanish Creole	+/-4.2
5-17 years	+/-5.3
18-64 years	+/-5.0
65 years and over	+/-14.4
Other Indo-European languages	+/-5.5
5-17 years	+/-12.7
18-64 years	+/-5.9
65 years and over	+/-11.4
Asian and Pacific Island languages	+/-4.6
5-17 years	+/-9.8
18-64 years	+/-5.7
65 years and over	+/-10.7
Other languages	+/-7.7
5-17 years	+/-23.5
18-64 years	+/-7.3
65 years and over	+/-38.7
CITIZENS 18 YEARS AND OVER	
All citizens 18 years and over	+/-0.2
Speak only English	(X)
Speak a language other than English	+/-2.8
Spanish or Spanish Creole	+/-4.8
Other languages	+/-3.9
PERCENT IMPUTED	
Language status	(X)
Language status (speak a language other than English)	(X)
Ability to speak English	(X)

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The value shown here is the 90 percent margin of error. The margin of error can be interpreted roughly as providing a 90 percent probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

Methodological changes to data collection in 2013 may have affected language data for 2013. Users should be aware of these changes when using multi-year data containing data from 2013.

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C. U.S. Census Bureau Cleveland County Demographics

Estimates of urban and rural population, housing units, and characteristics reflect boundaries of urban areas defined based on Census 2010 data. As a result, data for urban and rural areas from the ACS do not necessarily reflect the results of ongoing urbanization.

Source: U.S. Census Bureau, 2009-2013 5-Year American Community Survey

Explanation of Symbols:

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C. U.S. Census Bureau Cleveland County Demographics

U.S. Census Bureau

AMERICAN
FactFinder



S1703

SELECTED CHARACTERISTICS OF PEOPLE AT SPECIFIED LEVELS OF POVERTY IN THE PAST 12

2009-2013 American Community Survey 5-Year Estimates

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Subject	Cleveland County, Oklahoma				
	Total		Less than 50 percent of the poverty level		Less than 100 percent of the poverty level
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
Population for whom poverty status is determined	249,667	+/-711	6.8%	+/-0.7	12.9%
SEX					
Male	123,646	+/-531	6.6%	+/-0.8	12.4%
Female	126,021	+/-446	7.0%	+/-0.7	13.3%
AGE					
Under 18 years	58,901	+/-232	7.4%	+/-1.4	13.9%
Related children under 18 years	58,537	+/-301	6.9%	+/-1.4	13.4%
18 to 64 years	163,853	+/-622	7.3%	+/-0.6	13.6%
65 years and over	26,913	+/-202	1.9%	+/-0.6	6.4%
RACE AND HISPANIC OR LATINO ORIGIN					
One race	234,135	+/-1,054	6.6%	+/-0.6	12.6%
White	199,698	+/-821	6.2%	+/-0.7	11.7%
Black or African American	10,555	+/-509	11.4%	+/-3.2	20.5%
American Indian and Alaska Native	10,267	+/-761	7.3%	+/-2.4	12.3%
Asian	9,827	+/-379	10.2%	+/-3.0	21.4%
Native Hawaiian and Other Pacific Islander	217	+/-45	12.4%	+/-16.6	38.7%
Some other race	3,571	+/-564	6.3%	+/-4.2	17.2%
Two or more races	15,532	+/-1,033	8.9%	+/-2.7	16.3%
Hispanic or Latino origin (of any race)	18,251	+/-233	7.6%	+/-2.4	21.8%
White alone, not Hispanic or Latino	187,996	+/-571	6.1%	+/-0.7	11.0%
LIVING ARRANGEMENT					
In family households	204,336	+/-1,697	4.7%	+/-0.7	9.6%
In married-couple family	155,723	+/-2,802	2.0%	+/-0.5	4.9%
In Female householder, no husband present households	33,577	+/-2,241	14.5%	+/-2.6	28.4%
In other living arrangements	45,331	+/-1,594	16.1%	+/-1.5	27.5%
EDUCATIONAL ATTAINMENT					
Population 25 years and over	159,197	+/-324	3.7%	+/-0.4	8.5%
Less than high school graduate	13,846	+/-816	7.8%	+/-1.8	19.8%
High school graduate (includes equivalency)	41,001	+/-1,225	5.3%	+/-1.0	11.1%

C. U.S. Census Bureau Cleveland County Demographics

Subject	Cleveland County, Oklahoma				
	Total		Less than 50 percent of the poverty level		Less than 100 percent of the poverty level
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
Some college or associate's degree	53,705	+/-1,446	3.5%	+/-0.6	7.8%
Bachelor's degree or higher	50,645	+/-1,528	1.6%	+/-0.4	4.0%
NATIVITY AND CITIZENSHIP STATUS					
Native	234,815	+/-1,122	6.7%	+/-0.7	12.5%
Foreign born	14,852	+/-904	8.2%	+/-2.0	19.1%
Naturalized citizen	6,984	+/-526	2.2%	+/-1.4	10.1%
DISABILITY STATUS					
With any disability	31,188	+/-1,259	6.7%	+/-1.1	18.3%
No disability	217,095	+/-1,296	6.8%	+/-0.7	12.2%
WORK STATUS					
Population 16 to 64 years	169,761	+/-680	7.3%	+/-0.6	13.6%
Worked full-time, year-round	89,018	+/-1,627	0.5%	+/-0.2	2.7%
Worked less than full-time, year-round	45,705	+/-1,724	13.4%	+/-1.3	24.1%
Did not work	35,038	+/-1,372	16.8%	+/-1.8	27.8%

C. U.S. Census Bureau Cleveland County Demographics

Subject	Cleveland County, Oklahoma		
	Less than 100 percent of the poverty level	Less than 125 percent of the poverty level	
	Margin of Error	Estimate	Margin of Error
Population for whom poverty status is determined	+/-0.8	17.2%	+/-0.9
SEX			
Male	+/-0.9	16.2%	+/-1.0
Female	+/-0.9	18.2%	+/-1.0
AGE			
Under 18 years	+/-1.5	19.4%	+/-1.7
Related children under 18 years	+/-1.5	19.0%	+/-1.7
18 to 64 years	+/-0.9	17.6%	+/-1.0
65 years and over	+/-1.1	10.1%	+/-1.3
RACE AND HISPANIC OR LATINO ORIGIN			
One race	+/-0.8	16.8%	+/-0.9
White	+/-0.9	15.9%	+/-1.0
Black or African American	+/-3.9	24.4%	+/-4.5
American Indian and Alaska Native	+/-2.6	17.2%	+/-3.5
Asian	+/-4.4	26.5%	+/-4.8
Native Hawaiian and Other Pacific Islander	+/-41.6	38.7%	+/-41.6
Some other race	+/-7.2	20.6%	+/-7.8
Two or more races	+/-3.2	22.6%	+/-3.2
Hispanic or Latino origin (of any race)	+/-3.8	30.0%	+/-4.1
White alone, not Hispanic or Latino	+/-0.9	14.9%	+/-1.0
LIVING ARRANGEMENT			
In family households	+/-0.9	13.4%	+/-1.0
In married-couple family	+/-0.7	6.9%	+/-0.8
In Female householder, no husband present households	+/-3.5	37.8%	+/-3.6
In other living arrangements	+/-1.9	34.2%	+/-1.9
EDUCATIONAL ATTAINMENT			
Population 25 years and over	+/-0.6	11.8%	+/-0.7
Less than high school graduate	+/-2.6	28.7%	+/-2.8
High school graduate (includes equivalency)	+/-1.4	15.3%	+/-1.6
Some college or associate's degree	+/-0.9	10.5%	+/-1.0
Bachelor's degree or higher	+/-0.7	5.8%	+/-0.7
NATIVITY AND CITIZENSHIP STATUS			
Native	+/-0.9	16.7%	+/-0.9
Foreign born	+/-3.2	24.8%	+/-3.8
Naturalized citizen	+/-3.2	15.0%	+/-3.9
DISABILITY STATUS			
With any disability	+/-1.9	24.9%	+/-2.4
No disability	+/-0.8	16.2%	+/-1.0
WORK STATUS			
Population 16 to 64 years	+/-0.9	17.7%	+/-0.9
Worked full-time, year-round	+/-0.5	4.9%	+/-0.6
Worked less than full-time, year-round	+/-1.5	30.0%	+/-1.7
Did not work	+/-2.3	33.8%	+/-2.2

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C. U.S. Census Bureau Cleveland County Demographics

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U.S. Census Bureau



ORG014 | Local Governments in Individual County-Type Areas: 2012
 2012 Census of Governments

Geography	Population [1]	Total [2]	General purpose governments		
			Total	County	Subcounty governments
			Total		
Cleveland County, Oklahoma	255,755	21	7	1	6

C. U.S. Census Bureau Cleveland County Demographics

Geography	General purpose governments		Special purpose governments		
	Subcounty governments		Total	Special Districts	Independent school districts [3]
	Municipal	Town or township			
Cleveland County, Oklahoma	6	0	14	7	7

— Represents zero

[1] Population as of April 1, 2010.

[2] Governments that cross county boundaries are enumerated in a single county.

[3] Excludes school districts operated by a state, county, municipal, or township government.

[4] New York City includes population of all 5 county areas comprising the City of New York — Bronx County (population 1,385,108), Kings County (population 2,504,700), New York County (population 1,585,873), Queens County (population 2,230,722), and Richmond County (population 468,730).

Initial data release: 9/26/2013

Source: U.S. Census Bureau, 2012 Census of Governments: Organization Component Estimates. Data are not subject to sampling error, but for information on nonsampling error and definitions, see <http://www.census.gov/govs/cog2012>. Data users who create their own estimates from these tables should cite the U.S. Census Bureau as the source of the original data only.

C. U.S. Census Bureau Cleveland County Demographics

U.S. Census Bureau

AMERICAN
FactFinder



QT-P10 | Hispanic or Latino by Type: 2010

2010 Census Summary File 1

NOTE: For information on confidentiality protection, nonsampling error, and definitions, see <http://www.census.gov/prod/cen2010/doc/sf1.pdf>.

Geography: Cleveland County, Oklahoma

Subject	Number	Percent
HISPANIC OR LATINO		
Total population	255,755	100.0
Hispanic or Latino (of any race)	17,892	7.0
Not Hispanic or Latino	237,863	93.0
HISPANIC OR LATINO BY TYPE		
Hispanic or Latino (of any race)	17,892	7.0
Mexican	12,766	5.0
Puerto Rican	919	0.4
Cuban	241	0.1
Dominican (Dominican Republic)	51	0.0
Central American (excludes Mexican)	1,082	0.4
Costa Rican	58	0.0
Guatemalan	405	0.2
Honduran	109	0.0
Nicaraguan	44	0.0
Panamanian	143	0.1
Salvadoran	310	0.1
Other Central American	13	0.0
South American	924	0.4
Argentinean	92	0.0
Bolivian	57	0.0
Chilean	46	0.0
Colombian	306	0.1
Ecuadorian	45	0.0
Paraguayan	11	0.0
Peruvian	173	0.1
Uruguayan	5	0.0
Venezuelan	182	0.1
Other South American	7	0.0
Other Hispanic or Latino	1,909	0.7
Spaniard	526	0.2
Spanish	321	0.1
Spanish American	17	0.0
All other Hispanic or Latino	1,045	0.4

X Not applicable.

Source: U.S. Census Bureau, 2010 Census.

Summary File 1, Table PCT 11.

C. U.S. Census Bureau Cleveland County Demographics

U.S. Census Bureau

AMERICAN
FactFinder



QT-P11 | Households and Families: 2010
2010 Census Summary File 1

NOTE: For information on confidentiality protection, nonsampling error, and definitions, see <http://www.census.gov/prod/cen2010/doc/sf1.pdf>.

Geography: Cleveland County, Oklahoma

Subject	Number	Percent
HOUSEHOLD TYPE		
Total households	98,306	100.0
Family households [1]	64,182	65.3
Male householder	46,594	47.4
Female householder	17,588	17.9
Nonfamily households [2]	34,124	34.7
Male householder	16,645	16.9
Living alone	11,685	11.9
Female householder	17,479	17.8
Living alone	13,761	14.0
HOUSEHOLD SIZE		
Total households	98,306	100.0
1-person household	25,446	25.9
2-person household	34,077	34.7
3-person household	16,819	17.1
4-person household	13,448	13.7
5-person household	5,512	5.6
6-person household	1,965	2.0
7-or-more-person household	1,039	1.1
Average household size	2.49	(X)
Average family size	3.02	(X)
FAMILY TYPE AND PRESENCE OF RELATED AND OWN CHILDREN		
Families [3]	64,182	100.0
With related children under 18 years	31,878	49.7
With own children under 18 years	29,281	45.6
Under 6 years only	7,389	11.5
Under 6 and 6 to 17 years	5,967	9.3
6 to 17 years only	15,925	24.8
Husband-wife families	49,069	100.0
With related children under 18 years	22,115	45.1
With own children under 18 years	20,768	42.3
Under 6 years only	5,357	10.9
Under 6 and 6 to 17 years	4,590	9.4
6 to 17 years only	10,821	22.1
Female householder, no husband present families	10,506	100.0
With related children under 18 years	7,008	66.7
With own children under 18 years	6,043	57.5
Under 6 years only	1,393	13.3
Under 6 and 6 to 17 years	1,016	9.7
6 to 17 years only	3,634	34.6

C. U.S. Census Bureau Cleveland County Demographics

X Not applicable.

[1] A household that has at least one member of the household related to the householder by birth, marriage, or adoption is a "Family household." Same-sex couple households are included in the family households category if there is at least one additional person related to the householder by birth or adoption. Same-sex couple households with no relatives of the householder present are tabulated in nonfamily households. Responses of "same-sex spouse" were edited during processing to "unmarried partner."

[2] "Nonfamily households" consist of people living alone and households which do not have any members related to the householder.

[3] "Families" consist of a householder and one or more other people related to the householder by birth, marriage, or adoption. They do not include same-sex married couples even if the marriage was performed in a state issuing marriage certificates for same-sex couples. Same-sex couples are included in the families category if there is at least one additional person related to the householder by birth or adoption. Responses of "same-sex spouse" were edited during processing to "unmarried partner." Same-sex couple households with no relatives of the householder present are tabulated in nonfamily households.

Source: U.S. Census Bureau, 2010 Census.

Summary File 1, Tables P17, P18, P28, P29, P37, P38, and P39.

C. U.S. Census Bureau Cleveland County Demographics

U.S. Census Bureau

AMERICAN
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QT-P3 | Race and Hispanic or Latino Origin: 2010

2010 Census Summary File 1

NOTE: For information on confidentiality protection, nonsampling error, and definitions, see <http://www.census.gov/prod/cen2010/doc/sf1.pdf>.

Geography: Cleveland County, Oklahoma

Subject	Number	Percent
RACE		
Total population	255,755	100.0
One race	241,497	94.4
White	202,811	79.3
Black or African American	10,848	4.2
American Indian and Alaska Native	11,978	4.7
American Indian, specified [1]	10,581	4.1
Alaska Native, specified [1]	46	0.0
Both American Indian and Alaska Native, specified	1	0.0
[1] American Indian or Alaska Native, not specified	1,350	0.5
Asian	9,698	3.8
Native Hawaiian and Other Pacific Islander	188	0.1
Some Other Race	5,974	2.3
Two or More Races	14,258	5.6
Two races with Some Other Race	1,281	0.5
Two races without Some Other Race	12,168	4.8
Three or more races with Some Other Race	123	0.0
Three or more races without Some Other Race	686	0.3
HISPANIC OR LATINO		
Total population	255,755	100.0
Hispanic or Latino (of any race)	17,892	7.0
Mexican	12,766	5.0
Puerto Rican	919	0.4
Cuban	241	0.1
Other Hispanic or Latino [2]	3,966	1.6
Not Hispanic or Latino	237,863	93.0
RACE AND HISPANIC OR LATINO		
Total population	255,755	100.0
One race	241,497	94.4
Hispanic or Latino	15,950	6.2
Not Hispanic or Latino	225,547	88.2
Two or More Races	14,258	5.6
Hispanic or Latino	1,942	0.8
Not Hispanic or Latino	12,316	4.8

X Not applicable.

[1] "American Indian, specified" includes people who provided a specific American Indian tribe, such as Navajo or Blackfeet. "Alaska Native, specified" includes people who provided a specific Alaska Native group, such as Inupiat or Yup'ik.

[2] This category is comprised of people whose origins are from the Dominican Republic, Spain, and Spanish-speaking Central or South American countries. It also includes general origin responses such as "Latino" or "Hispanic."

Source: U.S. Census Bureau, 2010 Census.

Summary File 1, Tables P5, P8, PCT4, PCT5, PCT8, and PCT11.

C. U.S. Census Bureau Cleveland County Demographics

U.S. Census Bureau

AMERICAN
FactFinder



PEPANNRES

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013

2013 Population Estimates

Geography	April 1, 2010		Population Estimate (as of July 1)		
	Census	Estimates Base	2010	2011	2012
Cleveland County, Oklahoma	255,755	255,758	256,918	261,499	265,675

C. U.S. Census Bureau Cleveland County Demographics

Geography	Population Estimate (as of July 1)
	2013
Cleveland County, Oklahoma	269,340

Note: The estimates are based on the 2010 Census and reflect changes to the April 1, 2010 population due to the Count Question Resolution program and geographic program revisions. See Geographic Terms and Definitions at <http://www.census.gov/popest/about/geo/terms.html> for a list of the states that are included in each region and division. All geographic boundaries for the 2013 population estimates series except statistical area delineations are as of January 1, 2013. The Office of Management and Budget's statistical area delineations for metropolitan, micropolitan, and combined statistical areas, as well as metropolitan divisions, are those issued by that agency in February 2013 <http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b13-01.pdf>. For population estimates methodology statements, see <http://www.census.gov/popest/methodology/index.html>.

Suggested Citation:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013

Source: U.S. Census Bureau, Population Division

Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

2014 KIDS COUNT PROFILE

OKLAHOMA

OVERALL RANK

39



THE ANNIE E. CASEY FOUNDATION

ECONOMIC WELL-BEING

DOMAIN RANK

30

Children in poverty

2012

24%

222,000 CHILDREN

WORSENERD

2005 23%

Children whose parents lack secure employment

2012

30%

281,000 CHILDREN

WORSENERD

2008 29%

Children living in households with a high housing cost burden

2012

29%

274,000 CHILDREN

UNCHANGED

2005 29%

Teens not in school and not working

2012

10%

21,000 TEENS

WORSENERD

2008 8%

EDUCATION

DOMAIN RANK

41

Children not attending preschool

2010-12

58%

59,000 CHILDREN

IMPROVED

2005-07 62%

Fourth graders not proficient in reading

2013

70%

N.A.

IMPROVED

2005 75%

Eighth graders not proficient in math

2013

75%

N.A.

IMPROVED

2005 79%

High school students not graduating on time

2011/12

21%

N.A.

IMPROVED

2005/06 22%

N.A. NOT AVAILABLE

HEALTH

DOMAIN RANK

41

Low-birthweight babies

2012

8.0%

4,200 BABIES

UNCHANGED

2005 8.0%

Children without health insurance

2012

10%

94,000 CHILDREN

IMPROVED

2008 13%

Child and teen deaths per 100,000

2010

36

352 DEATHS

IMPROVED

2005 45

Teens who abuse alcohol or drugs

2011-12

6%

19,000 TEENS

IMPROVED

2005-06 8%

FAMILY AND COMMUNITY

DOMAIN RANK

38

Children in single-parent families

2012

35%

311,000 CHILDREN

WORSENERD

2005 32%

Children in families where the household head lacks a high school diploma

2012

13%

125,000 CHILDREN

IMPROVED

2005 14%

Children living in high-poverty areas

2008-12

12%

114,000 CHILDREN

WORSENERD

2000 5%

Teen births per 1,000

2012

47

5,844 BIRTHS

IMPROVED

2005 54

2014 KIDS COUNT PROFILE

UNITED STATES



THE ANNIE E. CASEY FOUNDATION

ECONOMIC WELL-BEING

Children in poverty

2012

23%

16,397,000 CHILDREN

WORSENERD

2005 **19%**

Children whose parents lack secure employment

2012

31%

23,101,000 CHILDREN

WORSENERD

2008 **27%**

Children living in households with a high housing cost burden

2012

38%

27,761,000 CHILDREN

WORSENERD

2005 **37%**

Teens not in school and not working

2012

8%

1,404,000 TEENS

UNCHANGED

2008 **8%**

EDUCATION

Children not attending preschool

2010-12

54%

4,307,000 CHILDREN

IMPROVED

2005-07 **56%**

Fourth graders not proficient in reading

2013

66%

N.A.

IMPROVED

2005 **70%**

Eighth graders not proficient in math

2013

66%

N.A.

IMPROVED

2005 **72%**

High school students not graduating on time

2011/12

19%

N.A.

IMPROVED

2005/06 **27%**

N.A. NOT AVAILABLE

HEALTH

Low-birthweight babies

2012

8.0%

315,709 BABIES

IMPROVED

2005 **8.2%**

Children without health insurance

2012

7%

5,264,000 CHILDREN

IMPROVED

2008 **10%**

Child and teen deaths per 100,000

2010

26

20,482 DEATHS

IMPROVED

2005 **32**

Teens who abuse alcohol or drugs

2011-12

6%

1,618,000 TEENS

IMPROVED

2005-06 **8%**

FAMILY AND COMMUNITY

Children in single-parent families

2012

35%

24,725,000 CHILDREN

WORSENERD

2005 **32%**

Children in families where the household head lacks a high school diploma

2012

15%

10,887,000 CHILDREN

IMPROVED

2005 **16%**

Children living in high-poverty areas

2008-12

13%

9,362,000 CHILDREN

WORSENERD

2000 **9%**

Teen births per 1,000

2012

29

305,388 BIRTHS

IMPROVED

2005 **40**

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

Cleveland (CE)

	Cleveland County	Error Margin	Top U.S. Performers*	Oklahoma	Rank (of 77)
Health Outcomes					3
Length of Life					1
Premature death	6,412	6,077-6,748	5,317	9,291	
Quality of Life					6
Poor or fair health	14%	13-16%	10%	19%	
Poor physical health days	3.7	3.3-4.0	2.5	4.3	
Poor mental health days	3.9	3.5-4.3	2.4	4.2	
Low birthweight	7.3%	6.9-7.6%	6.0%	8.3%	
Health Factors					1
Health Behaviors					4
Adult smoking	21%	19-23%	14%	24%	
Adult obesity	29%	27-32%	25%	32%	
Food environment index	7.8		8.7	7.1	
Physical inactivity	25%	22-27%	21%	31%	
Access to exercise opportunities	80%		85%	64%	
Excessive drinking	16%	14-18%	10%	13%	
Alcohol-impaired driving deaths	33%		14%	34%	
Sexually transmitted infections	250		123	385	
Teen births	23	22-25	20	55	
Clinical Care					7
Uninsured	18%	16-19%	11%	22%	
Primary care physicians	1,979:1		1,051:1	1,597:1	
Dentists	2,506:1		1,392:1	1,838:1	
Mental health providers	430:1		521:1	426:1	
Preventable hospital stays	70	66-73	46	77	
Diabetic screening	81%	77-84%	90%	78%	
Mammography screening	59%	56-63%	71%	55%	
Social & Economic Factors					6
High school graduation	81%			78%	
Some college	70%	67-72%	70%	58%	
Unemployment	4.4%		4.4%	5.2%	
Children in poverty	14%	11-18%	13%	24%	
Inadequate social support	16%	15-18%	14%	20%	
Children in single-parent households	27%	25-29%	20%	33%	
Violent crime	350		64	479	
Injury deaths	55	51-59	49	83	
Physical Environment					54
Air pollution - particulate matter	10.2		9.5	10.3	
Drinking water violations	13%		0%	18%	
Severe housing problems	14%	13-15%	9%	14%	
Driving alone to work	84%	83-85%	71%	82%	
Long commute - driving alone	30%	28-31%	15%	24%	

* 90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data

2014

Program Partner Organizations

American Public Health Association

www.apha.org

Association of State and Territorial Health Officials

www.astho.org

Centers for Disease Control and Prevention

www.cdc.gov

National Association of County and City Health Officials

www.naccho.org

National Association of Local Boards of Health

www.nalboh.org

National Network of Public Health Institutes

www.nnphi.org

Public Health Foundation

www.phf.org

The findings and conclusions stemming from the use of NPHPS tools are those of the end users. They are not provided or endorsed by the Centers for Disease Control and Prevention, nor do they represent CDC's views or policies.



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Acknowledgements

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

Background

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

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

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

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

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

Introduction

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

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

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

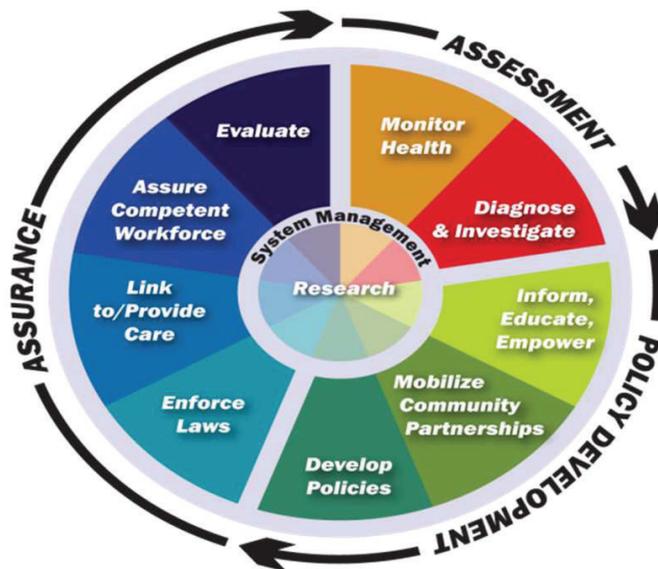


Figure 1. The ten Essential Public Health Services and how they relate to the three Core Functions of Public Health.

Purpose

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

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

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

About the Report

Calculating the Scores

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

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

Table 1. Summary of Assessment Response Options

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

Understanding Data Limitations

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

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

Presentation of results

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

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

Results

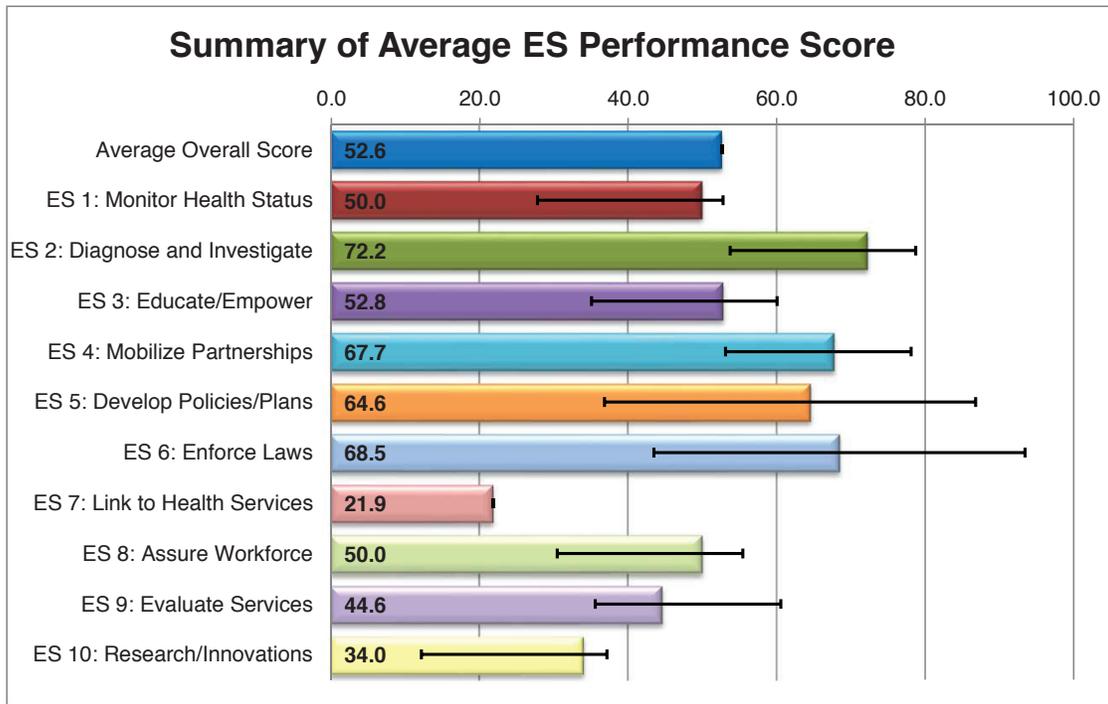
Now that your assessment is completed, one of the most exciting, yet challenging opportunities is to begin to review and analyze the findings. As you recall from your assessment, the data you created now establishes the foundation upon which you may set priorities for performance improvement and identify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

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

Figure 2 displays the average score for each Essential Service, along with an overall average assessment score across all ten Essential Services. Take a look at the overall performance scores for each Essential Service. Examination of these scores can immediately give a sense of the local public health system's greatest strengths and weaknesses. Note the black bars that identify the range of reported performance score responses within each Essential Service.

Overall Scores for Each Essential Public Health Service

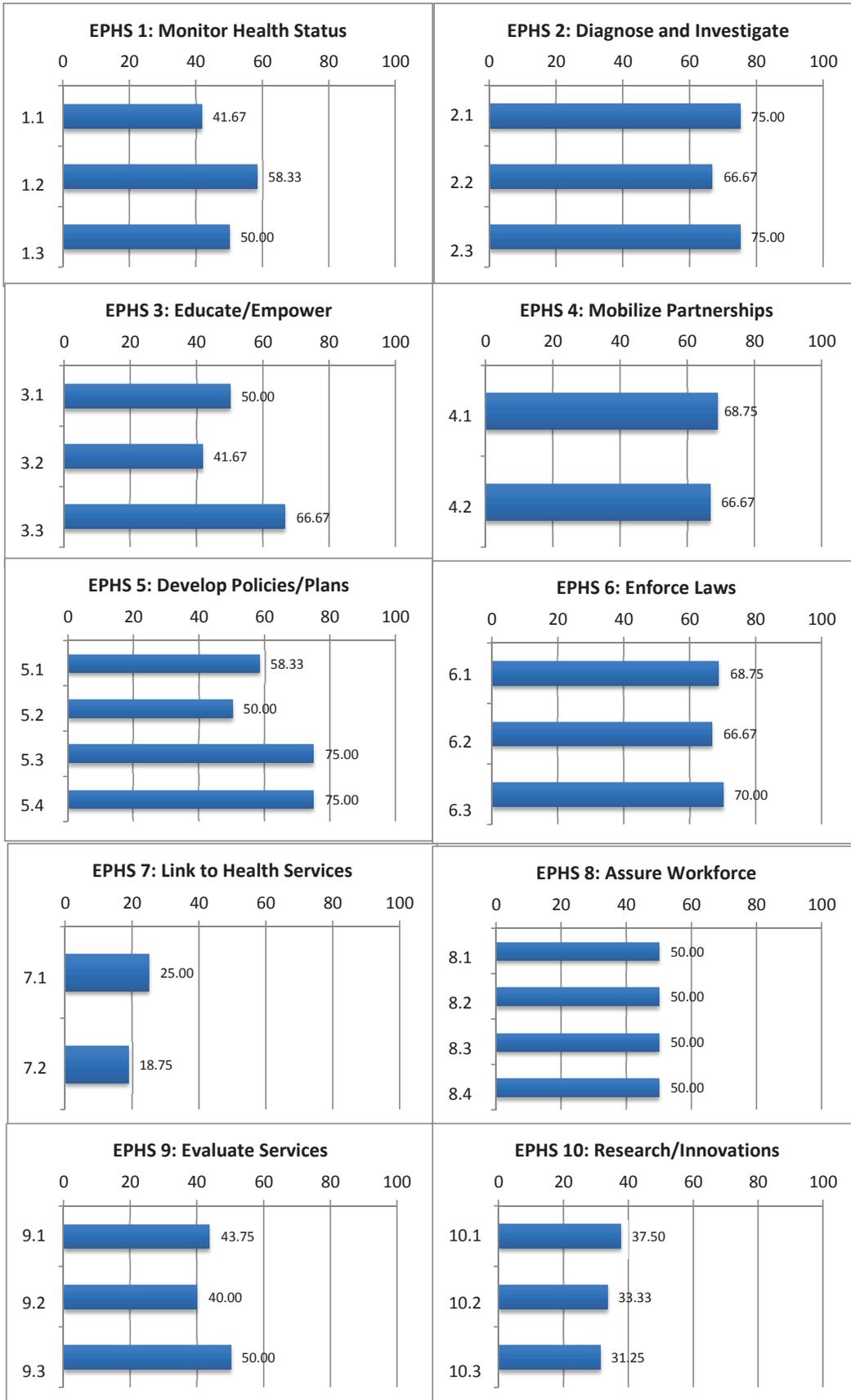
Figure 2. Summary of Average Essential Public Health Service Performance Scores



Performance Scores by Essential Public Health Service for Each Model Standard

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

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



F. 2015 Cleveland County Local Public Health System Assessment

In Table 2 below, each score (performance, priority, and contribution scores) at the Essential Service level is a calculated average of the respective Model Standard scores within that Essential Service. Note – The priority rating and agency contribution scores will be blank if the Priority of Model Standards Questionnaire and the Agency Contribution Questionnaire are not completed.

Table 2. Overall Performance, Priority, and Contribution Scores by Essential Public Health Service and Corresponding Model Standard

Model Standards by Essential Services	Performance Scores	Priority Rating	Agency Contribution Scores
ES 1: Monitor Health Status	50.0		
1.1 Community Health Assessment	41.7		
1.2 Current Technology	58.3		
1.3 Registries	50.0		
ES 2: Diagnose and Investigate	72.2		
2.1 Identification/Surveillance	75.0		
2.2 Emergency Response	66.7		
2.3 Laboratories	75.0		
ES 3: Educate/Empower	52.8		
3.1 Health Education/Promotion	50.0		
3.2 Health Communication	41.7		
3.3 Risk Communication	66.7		
ES 4: Mobilize Partnerships	67.7		
4.1 Constituency Development	68.8		
4.2 Community Partnerships	66.7		
ES 5: Develop Policies/Plans	64.6		
5.1 Governmental Presence	58.3		
5.2 Policy Development	50.0		
5.3 CHIP/Strategic Planning	75.0		
5.4 Emergency Plan	75.0		
ES 6: Enforce Laws	68.5		
6.1 Review Laws	68.8		
6.2 Improve Laws	66.7		
6.3 Enforce Laws	70.0		
ES 7: Link to Health Services	21.9		
7.1 Personal Health Service Needs	25.0		
7.2 Assure Linkage	18.8		
ES 8: Assure Workforce	50.0		
8.1 Workforce Assessment	50.0		
8.2 Workforce Standards	50.0		
8.3 Continuing Education	50.0		
8.4 Leadership Development	50.0		
ES 9: Evaluate Services	44.6		
9.1 Evaluation of Population Health	43.8		
9.2 Evaluation of Personal Health	40.0		
9.3 Evaluation of LPHS	50.0		
ES 10: Research/Innovations	34.0		
10.1 Foster Innovation	37.5		
10.2 Academic Linkages	33.3		
10.3 Research Capacity	31.3		
Average Overall Score	52.6	NA	NA
Median Score	51.4	NA	NA

Performance Relative to Optimal Activity

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

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

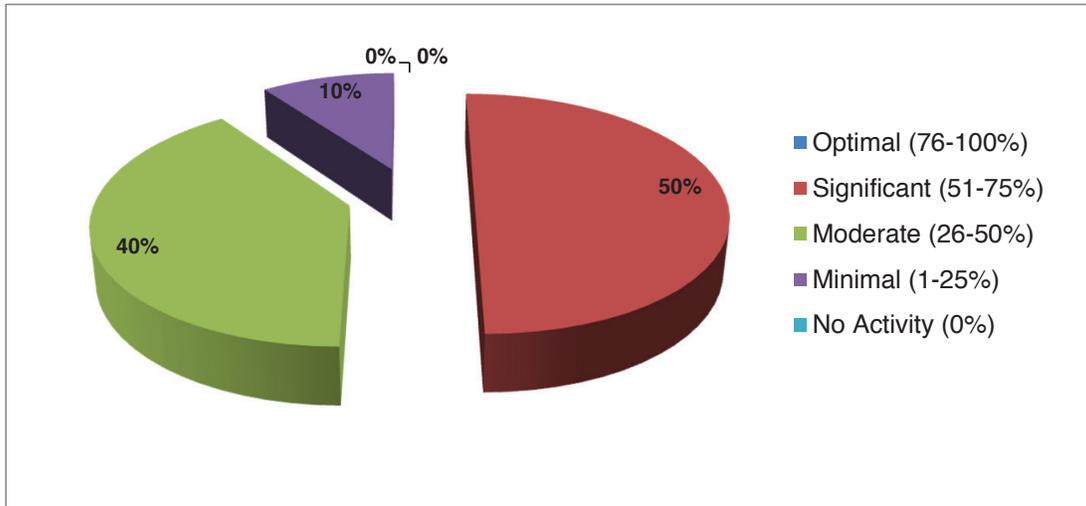
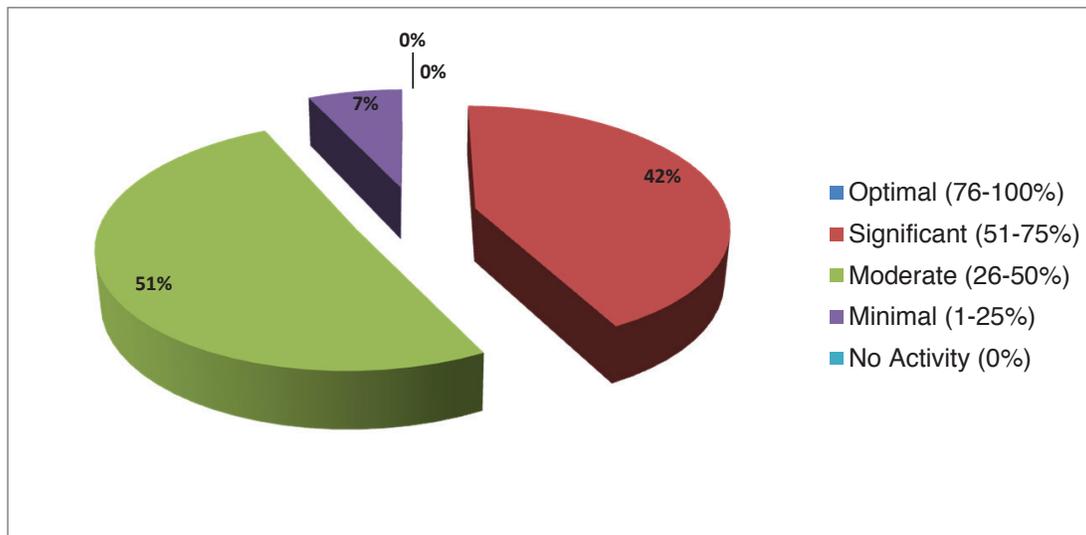


Figure 5. Percentage of the system's Model Standard scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 3, summarizing the composite measures for all 30 Model Standards.



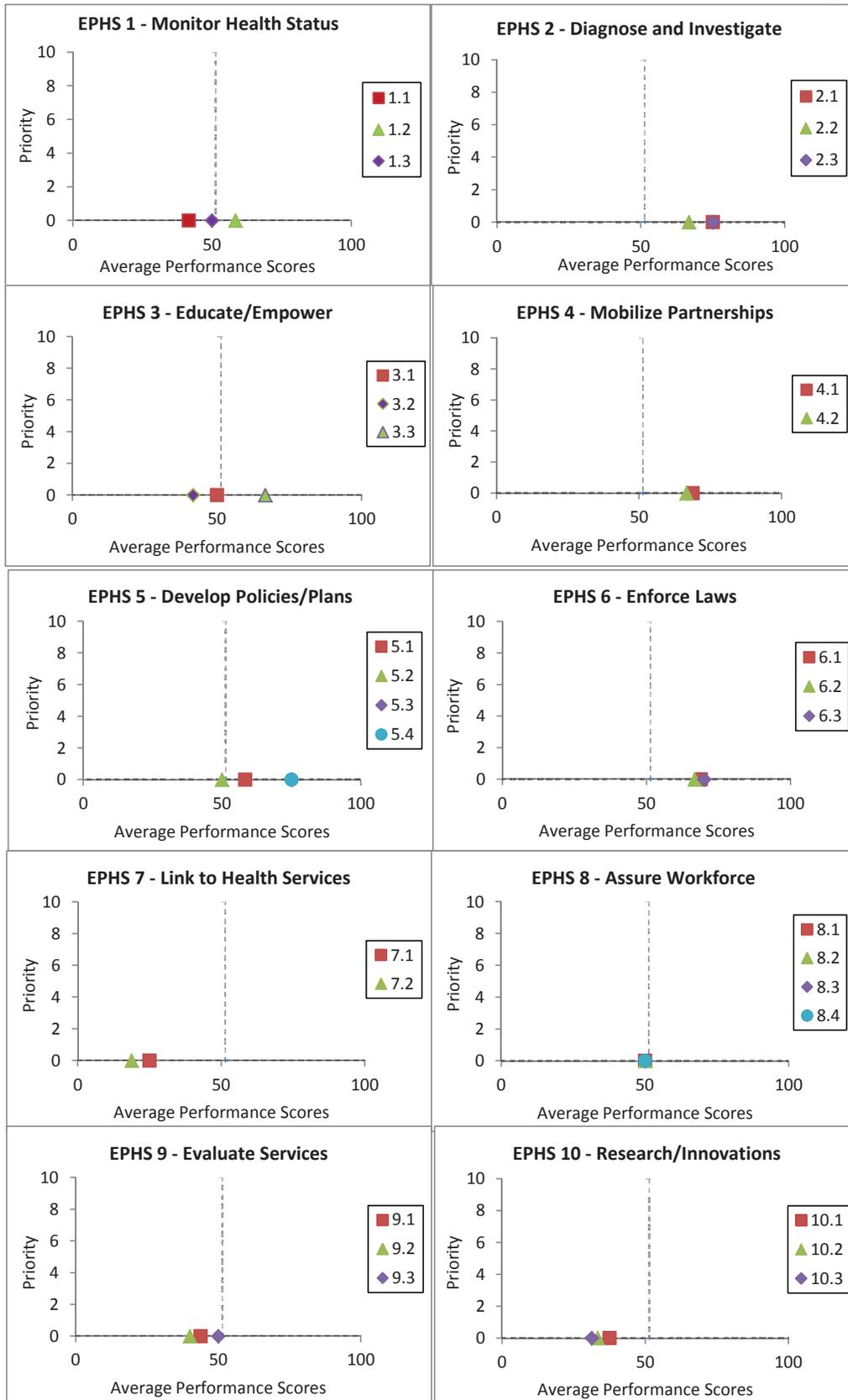
Priority of Model Standards Questionnaire Section (Optional Survey)

If you completed the Priority Survey at the time of your assessment, your results are displayed in this section for each Essential Service and each Model Standard, arrayed by the priority rating assigned to each. The four quadrants, which are based on how the performance of each Essential Service and/or Model Standard compares with the priority rating, should provide guidance in considering areas for attention and next steps for improvement.

Quadrant A	(High Priority and Low Performance) – These activities may need increased attention.
Quadrant B	(High Priority and High Performance) – These activities are being done well, and it is important to maintain efforts.
Quadrant C	(Low Priority and High Performance) – These activities are being done well, consideration may be given to reducing effort in these areas.
Quadrant D	(Low Priority and Low Performance) – These activities could be improved, but are of low priority. They may need little or no attention at this time.

Note - For additional guidance, see Figure 4: Identifying Priorities - Basic Framework in the *Local Implementation Guide*.

Figure 7. Summary of Essential Public Health Service Model Standard Scores and Priority Ratings



Note – Figure 7 will be blank if the Priority of Model Standards Questionnaire is not completed.

Figure 8. Summary of Essential Public Health Service Performance Scores and Contribution Ratio

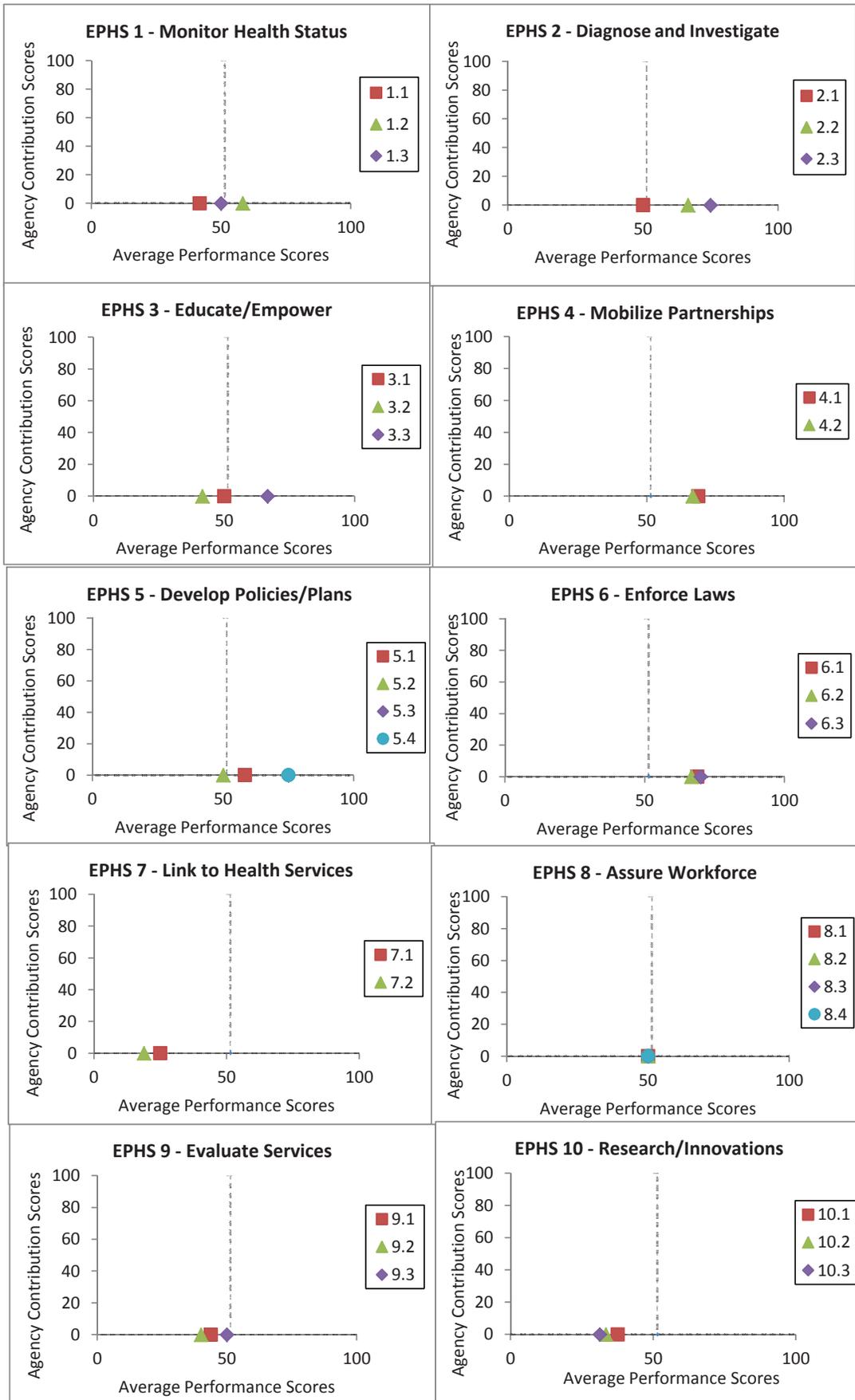
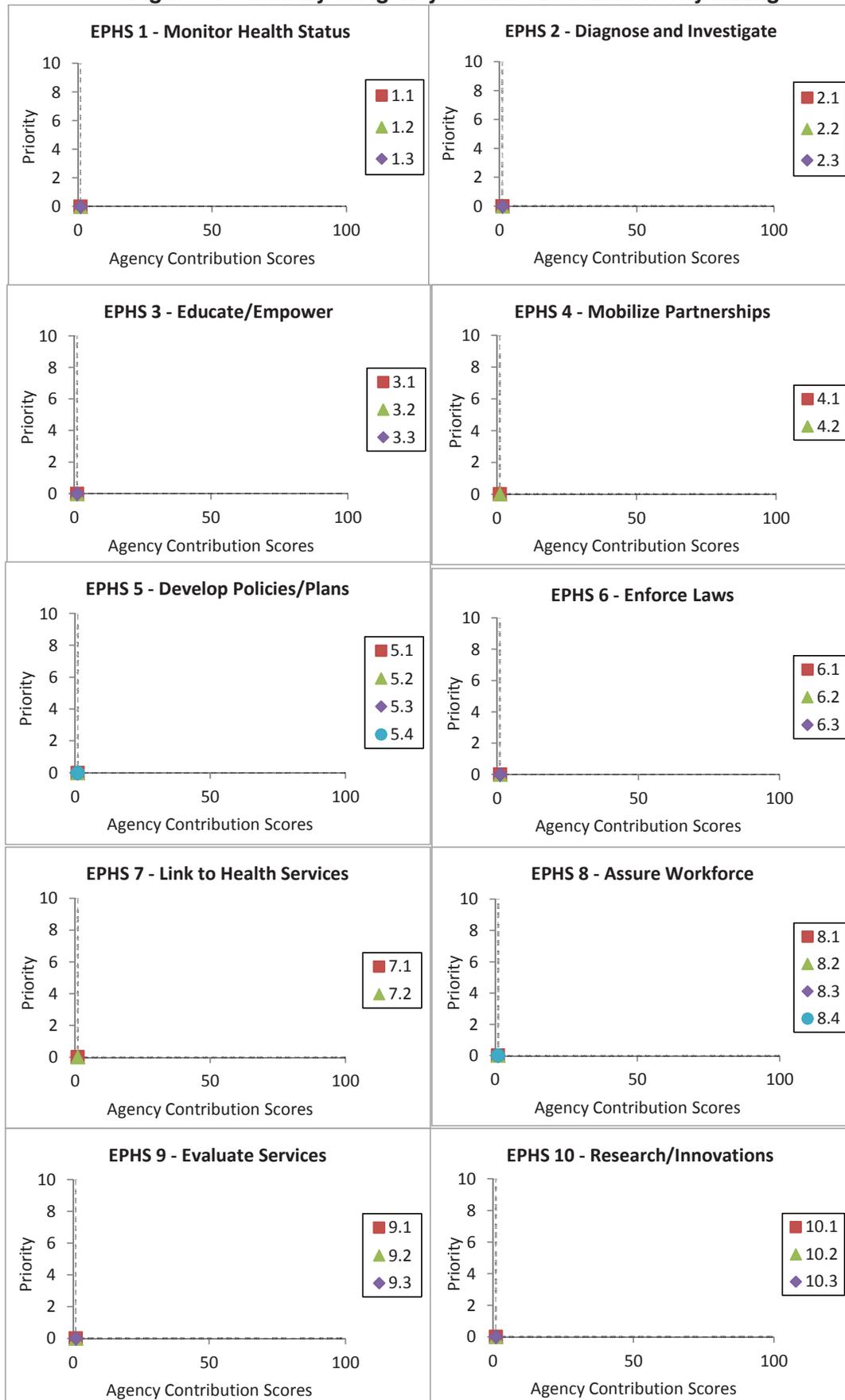


Figure 9. Summary of Agency Contribution and Priority Rating



Analysis and Discussion Questions

Having a standard way in which to analyze the data in this report is important. This process does not have to be difficult; however, drawing some initial conclusions from your data will prove invaluable as you move forward with your improvement efforts. It is crucial that participants fully discuss the performance assessment results. The bar graphs, charts, and summary information in the Results section of this report should be helpful in identifying high and low performing areas. Please refer to Appendix H of the Local Assessment Implementation Guide. This referenced set of discussion questions will help guide you as you analyze the data found in the previous sections of this report.

Using the results in this report will help you to generate priorities for improvement, as well as possible improvement projects. Your data analysis should be an interactive process, enabling everyone to participate. Do not be overwhelmed by the potential of many possibilities for QI projects – the point is not that you have to address them all now. Consider this step as identifying possible opportunities to enhance your system performance. Keep in mind both your quantitative data (Appendix A) and the qualitative data that you collected during the assessment (Appendix B).

Next Steps

Congratulations on your participation in the local assessment process. A primary goal of the NPHPS is that data is used proactively to monitor, assess, and improve the quality of essential public health services. This report is an initial step to identifying immediate actions and activities to improve local initiatives. The results in this report may also be used to identify longer-term priorities for improvement, as well as possible improvement projects.

As noted in the Introduction of this report, NPHPS data may be used to inform a variety of organization and/or systems planning and improvement processes. Plan to use both quantitative data (Appendix A) and qualitative data (Appendix B) from the assessment to identify improvement opportunities. While there may be many potential quality improvement projects, do not be overwhelmed – the point is not that you have to address them all now. Rather, consider this step as a way to identify possible opportunities to enhance your system performance and plan to use the guidance provided in this section, along with the resources offered in Appendix C, to develop specific goals for improvement within your public health system and move from assessment and analysis toward action.

Note: Communities implementing Mobilizing for Action through Planning and Partnerships (MAPP) may refer to the MAPP guidance for considering NPHPS data along with other assessment data in the Identifying Strategic Issues phase of MAPP.

Action Planning

In any systems improvement and planning process, it is important to involve all public health system partners in determining ways to improve the quality of essential public health services provided by the system. Participation in the improvement and planning activities included in your action plan is the responsibility of all partners within the public health system.

Consider the following points as you build an Action Plan to address the priorities you have identified

- Each public health partner should be considered when approaching quality improvement for your system
- The success of your improvement activities are dependent upon the active participation and contribution of each and every member of the system
- An integral part of performance improvement is working consistently to have long-term effects
- A multi-disciplinary approach that employs measurement and analysis is key to accomplishing and sustaining improvements

You may find that using the simple acronym, 'FOCUS' is a way to help you to move from assessment and analysis to action.

F Find an opportunity for improvement using your results.

O Organize a team of public health system partners to work on the improvement. Someone in the group should be identified as the team leader. Team members should represent the appropriate organizations that can make an impact.

C Consider the current process, where simple improvements can be made and who should make the improvements.

U Understand the problem further if necessary, how and why it is occurring, and the factors that contribute to it. Once you have identified priorities, finding solutions entails delving into possible reasons, or "root causes," of the weakness or problem. Only when participants determine why performance problems (or successes!) have occurred will they be able to identify workable solutions that improve future performance. Most performance issues may be traced to well-defined system causes, such as policies, leadership, funding, incentives, information, personnel or coordination. Many QI tools are applicable. You may consider using a variety of basic QI tools such as brainstorming, 5-whys, prioritization, or cause and effect diagrams to better understand the problem (refer to Appendix C for resources).

S Select the improvement strategies to be made. Consider using a table or chart to summarize your Action Plan. Many resources are available to assist you in putting your plan on paper, but in general you'll want to include the priority selected, the goal, the improvement activities to be conducted, who will carry them out, and the timeline for completing the improvement activities. When complete, your Action Plan should contain documentation on the indicators to be used, baseline performance levels and targets to be achieved, responsibilities for carrying out improvement activities and the collection and analysis of data to monitor progress. (Additional resources may be found in Appendix C.)

Monitoring and Evaluation: Keys to Success

Monitoring your action plan is a highly proactive and continuous process that is far more than simply taking an occasional "snap-shot" that produces additional data. Evaluation, in contrast to monitoring, provides ongoing structured information that focuses on why results are or are not being met, what unintended consequences may be, or on issues of efficiency, effectiveness, and/or sustainability.

After your Action Plan is implemented, monitoring and evaluation continues to determine whether quality improvement occurred and whether the activities were effective. If the Essential Service performance does not improve within the expected time, additional evaluation must be conducted (an additional QI cycle) to determine why and how you can update your Action Plan to be more effective. The Action Plan can be adjusted as you continue to monitor and evaluate your efforts.

APPENDIX A: Individual Questions and Responses

Performance Scores

ESSENTIAL SERVICE 1: Monitor Health Status to Identify Community Health Problems		
1.1	Model Standard: Population-Based Community Health Assessment (CHA) <i>At what level does the local public health system:</i>	
1.1.1	Conduct regular community health assessments?	50
1.1.2	Continuously update the community health assessment with current information?	25
1.1.3	Promote the use of the community health assessment among community members and partners?	50
1.2	Model Standard: Current Technology to Manage and Communicate Population Health Data <i>At what level does the local public health system:</i>	
1.2.1	Use the best available technology and methods to display data on the public's health?	50
1.2.2	Analyze health data, including geographic information, to see where health problems exist?	50
1.2.3	Use computer software to create charts, graphs, and maps to display complex public health data (trends over time, sub-population analyses, etc.)?	75
1.3	Model Standard: Maintenance of Population Health Registries <i>At what level does the local public health system:</i>	
1.3.1	Collect data on specific health concerns to provide the data to population health registries in a timely manner, consistent with current standards?	50
1.3.2	Use information from population health registries in community health assessments or other analyses?	50

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

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2.2.1	Maintain written instructions on how to handle communicable disease outbreaks and toxic exposure incidents, including details about case finding, contact tracing, and source identification and containment?	75
2.2.2	Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?	75
2.2.3	Designate a jurisdictional Emergency Response Coordinator?	75
2.2.4	Prepare to rapidly respond to public health emergencies according to emergency operations coordination guidelines?	75
2.2.5	Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or and nuclear public health emergencies?	50
2.2.6	Evaluate incidents for effectiveness and opportunities for improvement?	50
2.3	Model Standard: Laboratory Support for Investigation of Health Threats <i>At what level does the local public health system:</i>	
2.3.1	Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?	75
2.3.2	Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?	75
2.3.3	Use only licensed or credentialed laboratories?	75
2.3.4	Maintain a written list of rules related to laboratories, for handling samples (collecting, labeling, storing, transporting, and delivering), for determining who is in charge of the samples at what point, and for reporting the results?	75

ESSENTIAL SERVICE 3: Inform, Educate, and Empower People about Health Issues		
3.1	Model Standard: Health Education and Promotion <i>At what level does the local public health system:</i>	
3.1.1	Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?	50
3.1.2	Coordinate health promotion and health education activities to reach individual, interpersonal, community, and societal levels?	50
3.1.3	Engage the community throughout the process of setting priorities, developing plans and implementing health education and health promotion activities?	50
3.2	Model Standard: Health Communication <i>At what level does the local public health system:</i>	
3.2.1	Develop health communication plans for relating to media and the public and for sharing information among LPHS organizations?	25
3.2.2	Use relationships with different media providers (e.g. print, radio, television, and the internet) to share health information, matching the message with the target audience?	50

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3.2.3	Identify and train spokespersons on public health issues?	50
3.3	Model Standard: Risk Communication <i>At what level does the local public health system:</i>	
3.3.1	Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?	75
3.3.2	Make sure resources are available for a rapid emergency communication response?	75
3.3.3	Provide risk communication training for employees and volunteers?	50

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

4.1	Model Standard: Constituency Development <i>At what level does the local public health system:</i>	
4.1.1	Maintain a complete and current directory of community organizations?	75
4.1.2	Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?	75
4.1.3	Encourage constituents to participate in activities to improve community health?	50
4.1.4	Create forums for communication of public health issues?	75
4.2	Model Standard: Community Partnerships <i>At what level does the local public health system:</i>	
4.2.1	Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	75
4.2.2	Establish a broad-based community health improvement committee?	75
4.2.3	Assess how well community partnerships and strategic alliances are working to improve community health?	50

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

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

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

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

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

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

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

7.1	Model Standard: Identification of Personal Health Service Needs of Populations <i>At what level does the local public health system:</i>	
7.1.1	Identify groups of people in the community who have trouble accessing or connecting to personal health services?	25
7.1.2	Identify all personal health service needs and unmet needs throughout the community?	25
7.1.3	Defines partner roles and responsibilities to respond to the unmet needs of the community?	25
7.1.4	Understand the reasons that people do not get the care they need?	25
7.2	Model Standard: Assuring the Linkage of People to Personal Health Services <i>At what level does the local public health system:</i>	
7.2.1	Connect (or link) people to organizations that can provide the personal health services they may need?	25
7.2.2	Help people access personal health services, in a way that takes into account the unique needs of different populations?	0
7.2.3	Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?	25
7.2.4	Coordinate the delivery of personal health and social services so that everyone has access to the care they need?	25

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

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

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8.4.4	Provide opportunities for the development of leaders representative of the diversity within the community?	50
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ESSENTIAL SERVICE 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

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

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

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

APPENDIX C: Additional Resources

General

Association of State and Territorial Health Officers (ASTHO)

<http://www.astho.org/>

CDC/Office of State, Tribal, Local, and Territorial Support (OSTLTS)

<http://www.cdc.gov/ostlts/programs/index.html>

Guide to Clinical Preventive Services

<http://www.ahrq.gov/clinic/pocketgd.htm>

Guide to Community Preventive Services

www.thecommunityguide.org

National Association of City and County Health Officers (NACCHO)

<http://www.naccho.org/topics/infrastructure/>

National Association of Local Boards of Health (NALBOH)

<http://www.nalboh.org>

Being an Effective Local Board of Health Member: Your Role in the Local Public Health System

<http://www.nalboh.org/pdffiles/LBOH%20Guide%20-%20Booklet%20Format%202008.pdf>

Public Health 101 Curriculum for governing entities

http://www.nalboh.org/pdffiles/Bd%20Gov%20pdfs/NALBOH_Public_Health101Curriculum.pdf

Accreditation

ASTHO's Accreditation and Performance Improvement resources

<http://astho.org/Programs/Accreditation-and-Performance/>

NACCHO Accreditation Preparation and Quality Improvement

<http://www.naccho.org/topics/infrastructure/accreditation/index.cfm>

Public Health Accreditation Board

www.phaboard.org

Health Assessment and Planning (CHIP/ SHIP)

Healthy People 2010 Toolkit:

Communicating Health Goals and Objectives

<http://www.healthypeople.gov/2010/state/toolkit/12Marketing2002.pdf>

Setting Health Priorities and Establishing Health Objectives

<http://www.healthypeople.gov/2010/state/toolkit/09Priorities2002.pdf>

Healthy People 2020:

www.healthypeople.gov

MAP-IT: A Guide To Using Healthy People 2020 in Your Community

<http://www.healthypeople.gov/2020/implementing/default.aspx>

Mobilizing for Action through Planning and Partnership:

<http://www.naccho.org/topics/infrastructure/mapp/>

MAPP Clearinghouse

<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/>

MAPP Framework

<http://www.naccho.org/topics/infrastructure/mapp/framework/index.cfm>

National Public Health Performance Standards Program

<http://www.cdc.gov/nphpsp/index.html>

Performance Management /Quality Improvement

American Society for Quality; Evaluation and Decision Making Tools: Multi-voting

<http://asq.org/learn-about-quality/decision-making-tools/overview/overview.html>

Improving Health in the Community: A Role for Performance Monitoring

<http://www.nap.edu/catalog/5298.html>

National Network of Public Health Institutes Public Health Performance Improvement Toolkit

<http://nnphi.org/tools/public-health-performance-improvement-toolkit-2>

Public Health Foundation – Performance Management and Quality Improvement

<http://www.phf.org/focusareas/Pages/default.aspx>

Turning Point

<http://www.turningpointprogram.org/toolkit/content/silostosystems.htm>

US Department of Health and Human Services Public Health System, Finance, and Quality Program

<http://www.hhs.gov/ash/initiatives/quality/finance/forum.html>

Evaluation

CDC Framework for Program Evaluation in Public Health

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>

Guide to Developing an Outcome Logic Model and Measurement Plan (United Way)

http://www.yourunitedway.org/media/Guide_for_Logic_Models_and_Measurements.pdf

National Resource for Evidence Based Programs and Practices

www.nrepp.samhsa.gov

W.K. Kellogg Foundation Evaluation Handbook

<http://www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx>

W.K. Kellogg Foundation Logic Model Development Guide

<http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx>



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