MOHAVE COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

2025-2028

Live Well Mohave

CONTENTS

Executive Summary

Mohave County Community Health Improvement Plan (CHIP)

The 2025-2028 Mohave County Community Health Improvement Plan (CHIP) represents a strategic, long-term, community-led effort to address priority issues identified in the Mohave County Community Health Assessment (CHNA).

Organizations, community leaders, and community members collaborated to identify priority issues, develop and implement strategies for action, and establish accountability to ensure measurable health improvement.

Live Well Mohave

Kingman Regional Medical Center (KRMC) and the Mohave County Department of Public Health (MCDPH) support our county's informal health initiative, Live Well Mohave, by overseeing coalition efforts for data collection and health improvement planning.

The purpose of this document is to guide decision-making in Mohave County communities, focusing on developing public health strategies and actions. It is essential for coordinating and directing resources toward community health priorities.

MAPP 2.0 Framework

Mobilizing for Action through Planning and Partnerships is a community-wide strategic planning framework for improving public health systems.

Shared Vision

Healthy people in healthy communities for all Mohave County residents.

Community Meetings

- *Reviewed CHNA findings*
- *Prioritized health needs*
- *Discussed current activities, barriers, and potential actions*

2025-2028 Mohave County CHIP Priorities

Priorities	Bullhead City	Colorado City	Kingman	Lake Havasu City	Topock/Golden Shores	White Hills	Dolan Springs
Access to Healthcare	✓	✓	✓				
Community Engagement & Volunteers							✓
Community Services & Communication							✓
County Wide Medical Coalition				✓			
Internet						✓	
Navigation & Resources			✓		✓		
Nutrition	✓				✓	✓	
Recreation Center & Dedicated Space for Activities		✓					
Stigma Training for Leaders				✓			
Transportation					✓	✓	✓
Youth and Children	✓	✓	✓	✓			

ACKNOWLEDGEMENTS

The success of the Mohave County CHNA/CHIP shows the collaborative spirit of the many organizations, healthcare systems, and community members who participated in assessments, focus groups, thought leadership, plan development, publicity, and so much more. Together, we created evidence-based methods to achieve lasting positive health changes. This collaboration lays the foundation for better health outcomes and community well-being. We thank everyone for their unwavering dedication to our community's health and look forward to continuing this journey toward a healthier Mohave County.

Organizations That Contributed to the Mohave County CHNA/CHIP

Applied Worldwide
Arizona Complete Health
Arizona Youth Partnership
Arizona@Work
BeConnected Veteran Services
Blayre Agency LLC
Bullhead City Police Department
CASA Council Helping Children of Mohave County
Catholic Charities
Cherish Families
Chicanos Por La Causa
City of Bullhead City
City of Kingman
City of Lake Havasu City
Colorado City Unified School District
Community Medical Services
Cornerstone Mission Project
Creek Valley Health Clinic
Culver's (Kingman)
Dolan Springs Community Council
Encompass Health Services
Family Dollar (Dolan Springs)
First Southern Baptist Church of Mohave Valley
First Things First
Healthy Families Program & Parents As Teachers - Child and Family Resources, Inc.
Hickory Recovery Network
Hope & Health Hub
Hospital District Number One of Mohave County
Kingman Area Chamber of Commerce
Make Bullhead Better
Masada Charter School
Meadview Food Bank
Mohave Community College
Mohave County
Mohave County Board of Health
Mohave County Board of Supervisors
Mohave County Library
Mohave County Probation
Mohave County Sheriff's Office
Mohave County Tobacco Use Prevention Program
Mohave Mental Health
Mohave Substance Treatment, Education, & Prevention Partnership
North County Healthcare
Overdose to Action (OD2A)
Pancho Villa (Kingman)
River Cities United Way
River Valley Home Health and Hospice
Rivyve Behavioral Health
Rosebird Farms
Senior Enrichment Center of Bullhead City
Southwest Behavioral & Health Services
St. Mary's Hospital & Regional Medical Center
Terros Health
The Boathouse Restaurant (Meadview)
The Society of St. Vincent de Paul
The Views at Lake Havasu
Town of Colorado City
VEN Centers

Kingman Area Food Bank
Kingman Cares
Kingman Family Walk-In Clinic
Kingman Main Street
Kingman Regional Medical Center
Lake Havasu Area Chamber of Commerce
Lake Havasu Now
LGBTQ Awareness Group of Arizona / Bullhead City Pride Center
Linde/PraxAir
Westcare Arizona
Western Arizona Regional Medical Center
Western Arizona Vocational Education / Career and Technical Education District
White Hills Community Association, Inc.
Xtreme Body Nutrition
Young Scholars Charter School
Yucca Community Food Pantry
Yucca Elementary School

Thank You to the Hosts of the Community Meetings for Their Help and Hospitality

Bullhead City: **Lorrie Duggins, Mohave Area Partnership Promoting Educated Decisions (MAPPED)**
Colorado City / Lake Havasu City: **Lori Howell, Mohave Community College (MCC)**
Kingman: **Nutrition Services, Kingman Regional Medical Center (KRMC)**

Special Thanks to the Following Individuals Who Provided Leadership and Guidance

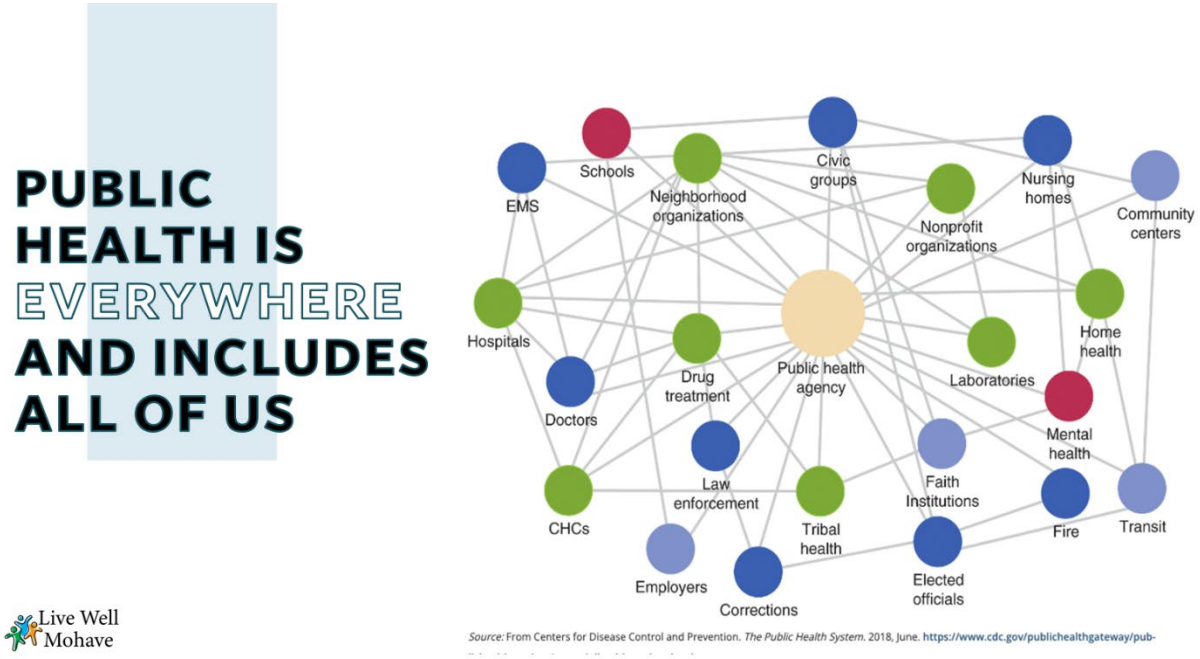
Allen Poston, Kingman Regional Medical Center, Public Relations
Anthony Santarelli, Kingman Regional Medical Center, Office of Research and Sponsored Programs
Barry Moore, Kingman Regional Medical Center, Finance
Candice McDaniel, Kingman Regional Medical Center, Finance
Clint Welty, Mohave County, Department of Public Health
Danielle Lagana, Mohave County, Department of Public Health
Diana Lalitsasivimol, Kingman Regional Medical Center, Office of Research and Sponsored Programs
Jacqueline Neff, Kingman Regional Medical Center, Office of Research and Sponsored Programs
Julya Walters-Koalska, Kingman Regional Medical Center, Public Relations
John Ashurst, Midwestern University, Arizona College of Osteopathic Medicine
Melissa Palmer, Mohave County, Department of Public Health
Sarah Brady, Kingman Regional Medical Center, Population Health
Tyrus Nelson, Kingman Regional Medical Center, Office of Research and Sponsored Programs

INTRODUCTION

What is Live Well Mohave?

Live Well Mohave is an informal community-based initiative that engages the public and community stakeholders in efforts to improve the health and quality of life for the residents of Mohave County, Arizona. The process involves assessing community health, prioritizing health issues, planning improvements, and organizing action on a continuous basis.

The Mohave County Department of Public Health (MCDPH) and Kingman Regional Medical Center (KRMC) have partnered to lead the Live Well Mohave initiative. Other members include representatives from city and county governments, tribal organizations, healthcare providers, mental health providers, businesses, local charitable organizations, faith organizations, law enforcement, courts, schools, colleges and other community-based organizations. Community members actively participate in decision-making, shaping the community health assessment and improvement plan, thereby giving them a significant level of control and ownership over the process and its outcomes.



Shared ownership is vital. This synergy fosters a sense of collective responsibility and empowers individuals to contribute to the well-being of their community, creating a healthier and more resilient Mohave County.

What is a Community Health Improvement Plan (CHIP)?

The purpose of the CHIP is to set priorities, coordinate activities, and target resources to improve the health and wellbeing of our community. It lays out the plans to address identified community health needs based on the results of the Community Health Needs Assessment (CHNA). The CHIP identifies strategies that can improve the quality of life for all Mohave County residents—particularly the most vulnerable—by reducing preventable illness and promoting wellness. The CHIP is intended as a tool for self-directed action groups and their partners to improve community health in simple, sustainable ways.

Community Engagement is a Fundamental Practice of Community Health

The Centers for Disease Control and Prevention (CDC) defines **community engagement** as: "*the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being.*" Community engagement principles (Figure 1) are rooted in the belief that community members actively participate in efforts to enhance health and social conditions. Empowering the community to voice their concerns leads to long-lasting improvements in health and social well-being.

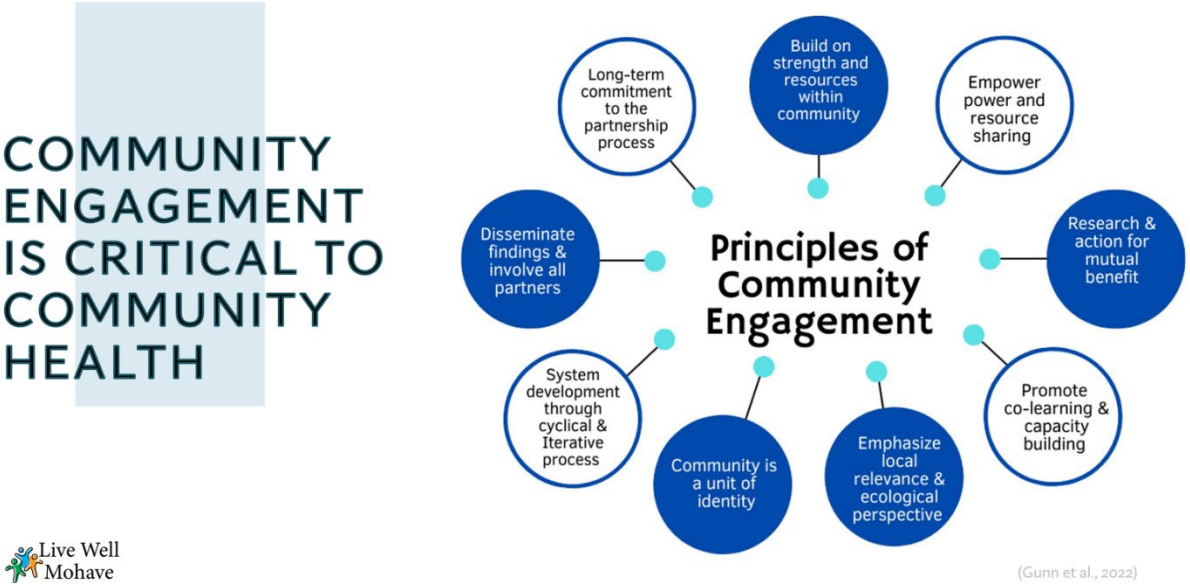


Figure 1. Community engagement principles (Source: Gunn et al., 2022)

The public has valuable knowledge about what will work in their own communities to improve health. Together, public health expertise and community collective intelligence can identify problems accurately and develop elegant and effective solutions. Through initiatives like assessing community health needs, devising health strategies, and fostering health education, we can identify and address the challenges of healthcare access and work towards influencing policy changes.

Reducing Disparities and Promoting Health Equity

Social Determinants of Health

Social determinants of health (SDOH) affect everyone. They include both the positive and negative aspects of the conditions in which people are born, live, learn, work, play, worship, and age. SDOH influence health, functioning, and quality of life. These conditions are shaped by the distribution of money, power, and resources. SDOH can be grouped into five domains (Figure 2): Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context. Healthy People 2030 has set data-driven national objectives to improve health and well-being over the next decade. These objectives and data indicators are included in the CHIP descriptions.

Health Related Social Needs

Health-related social needs (HRSNs) (Figure 2) are individual-level, adverse social conditions that negatively impact a person's health or healthcare. HRSNs include employment, food insecurity, housing instability, early childhood development and education, access to primary care, health literacy, access to healthy foods, crime and violence, environmental conditions, civic participation, discrimination, incarceration, and social cohesion.

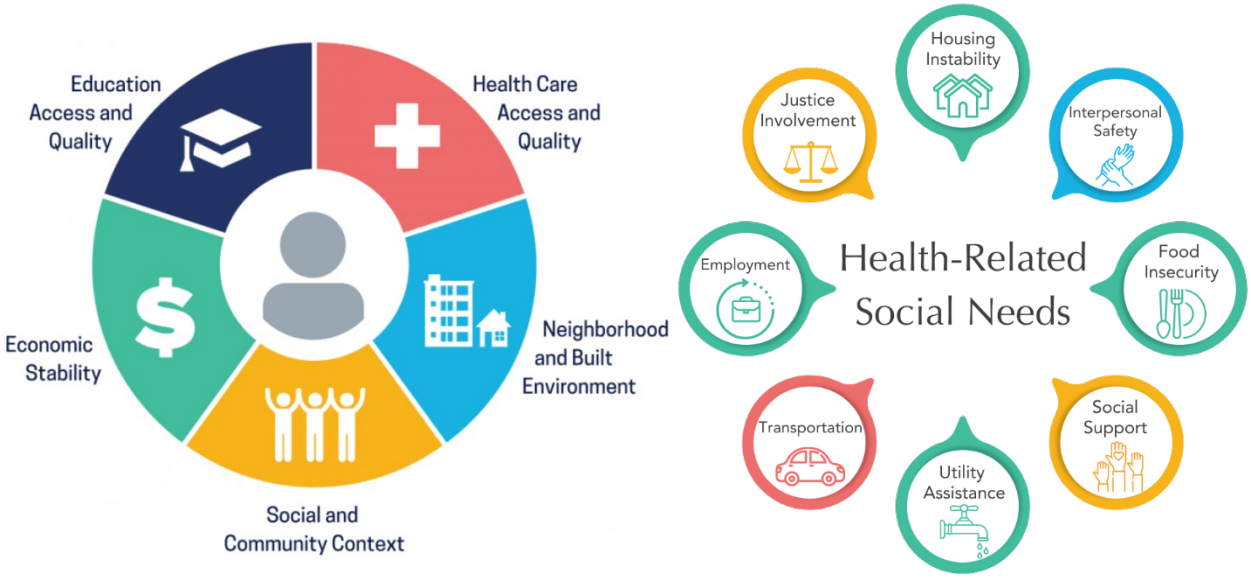


Figure 2. (Left) Social determinants of health. (Source: U.S. Department of Health and Human Services). (Right) Health-related social needs.

During the CHIP discussions, Live Well Mohave participants mentioned many health-related concerns such as affordable housing, access to affordable nutritious foods, reliable transportation to medical appointments, access to social services, and human-wildlife conflicts. After selecting priority focus areas, participants considered interventions to target SDOH that shape health and help everyone lead healthier lives.

About the Plan

Since 2012, KRMC and MCDPH have partnered to do important community health planning work. As the only non-profit hospital in Mohave County, KRMC has taken the initiative to collaborate with MCDPH and other community partners to do its required health needs assessment and community health planning.

Benefits of the Live Well Mohave project and community-driven health planning include:

- Building powerful partnerships and reducing "silo" work on health issues.
- Maximizing resources, minimizing duplication of effort.
- Empowering the community to work together to improve public health.
- Implementing best practices for health programs and strategic planning alongside local hospitals and public health departments.
- Helping KRMC meet Internal Revenue Service (IRS) requirements for non-profit hospitals.
- Helping MCDPH with re-accreditation from the national Public Health Accreditation Board (PHAB).

METHODOLOGY

To ensure a comprehensive approach to community health improvement efforts, Live Well Mohave is guided by the *Mobilizing for Action Through Planning and Partnerships (MAPP)* framework, originally developed by the National Association of County and City Health Officials (NACCHO) in 2001. MAPP 2.0 (2023) builds upon its predecessor and emphasizes achieving health equity. MAPP is a community-driven approach to engaging stakeholders and the public in continuous improvement, with the overarching goal of achieving health equity.

MAPP Cycle

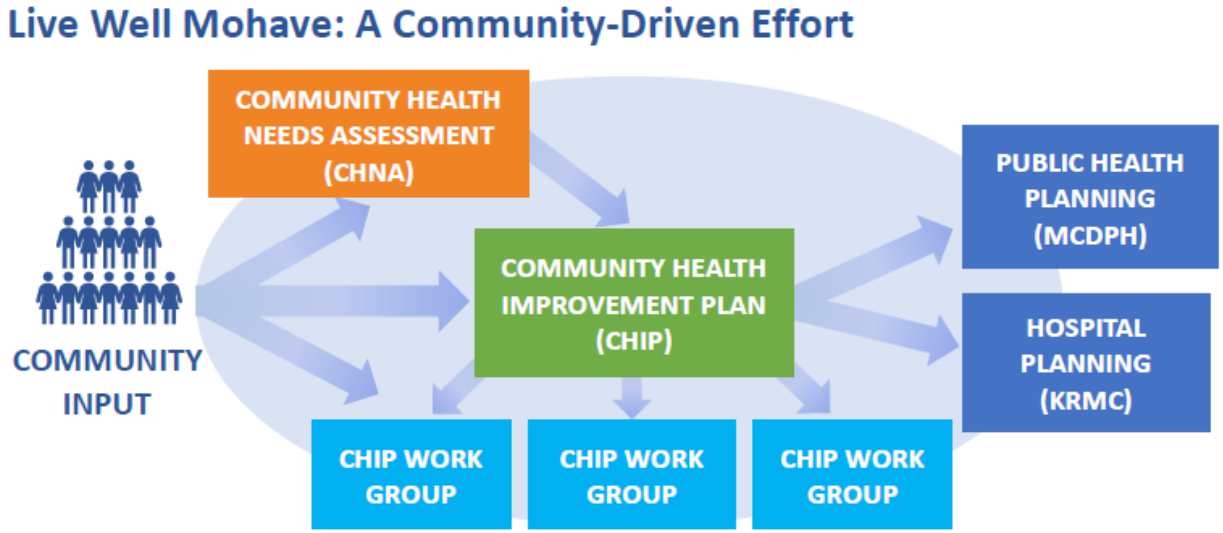
- Phase I unites many partner organizations and people.
- Phase II includes preparation, application, and analysis of community assessments.
- Phase III centers on developing the community health improvement plan (CHIP) by prioritizing issues and applying and evaluation strategies with community partners.

MAPP Practices and Foundational Principles

The MAPP process begins with assessing the community's available resources, skills, expertise, experiences and individual goals. It is critical to build community partnerships to advance health equity – it cannot be done by one organization alone. The MAPP framework encourages a collective examination of who is most affected by inequities, their root causes, the community's strengths, and resources to tackle them. Partnerships built through the CHNA/CHIP cycles lead the development and application of strategies to address health inequity. Finally, strategic partnership with members of the community creates a culture of ownership in their healthcare decisions and empowers them to develop equitable solutions that benefit the community as a whole.

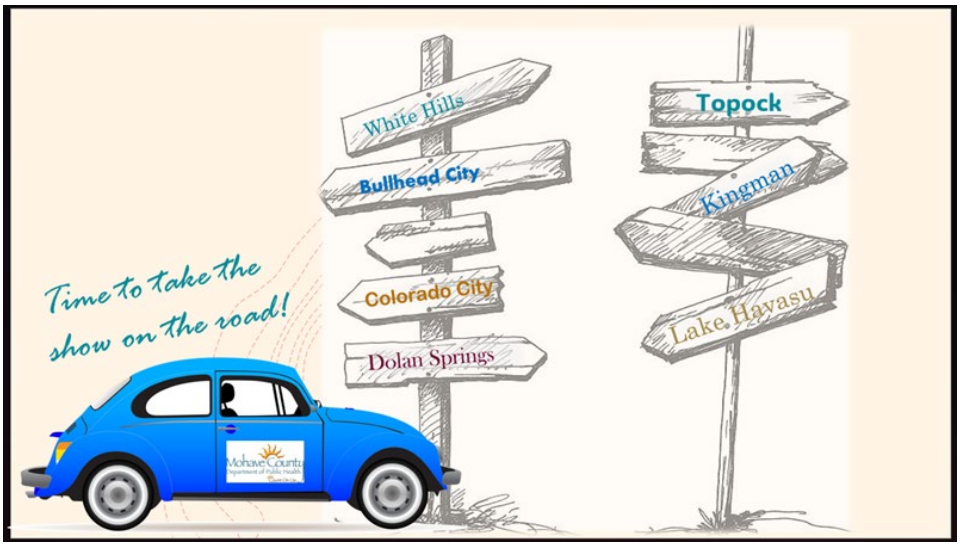
The Live Well Mohave team adopted a simplified version of the MAPP 2.0 model. The intent is *not* to produce traditional academic-style documents or a complex health planning process that depends on experts. Instead, the aim has been to build self-sufficient work groups that can take meaningful action on health priorities in their own communities. The Mohave Substance Treatment Education & Prevention Partnership (MSTEPP) and Mental Health Resource Team (MHRT) exemplify thriving community-led groups that originated from former CHIPs. Empowering community members by fostering a sense of ownership is crucial for sustainable progress. When individuals have a stake in their community's future, they become more invested in its success. By collaborating on an improvement plan that involves everyone, we can drive meaningful change and build a healthier Mohave County.

As work on the 2025-2028 Mohave County Community Health Improvement Plan (CHIP) commenced, the Live Well Mohave team invited a variety of community stakeholders to participate in the community health planning process. This work culminated with in-person community meetings hosted by the Mohave County Public Health Department (MCDPH) and Kingman Regional Medical Center (KRMC); multiple workgroups were formed at these meetings to address the priorities identified from the initial CHIP meetings.

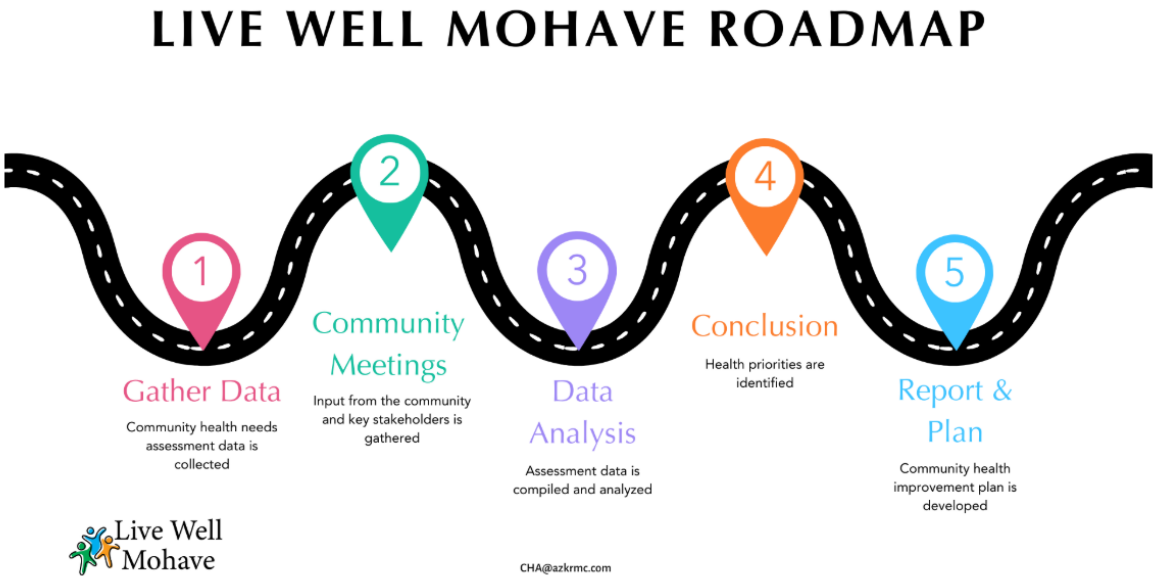


Stakeholders across Mohave County engaged in a community-driven process to identify the most pressing issues facing residents. Led by Live Well Mohave, community members and organizations came together to provide valuable insights on the experiences of health and sickness, as well as realistic ways to affect change. In order to meet the unique needs of communities within Mohave County, separate CHIP processes were carried out in the Bullhead City, Colorado City, Kingman, and Lake Havasu City regions.

Process and Timeline



- January 2024 – Community Health Needs Assessment (CHNA) launched. The Community Survey opened to the public.
- April 2024 – Key Informants interviewed.
- May 2024 – Focus groups shared open dialogue on their health concerns.
- September-November 2024 - Held community meetings, mobilized Community Health Improvement Plan (CHIP) action groups and reviewed progress. Local groups identified health priority topics and chose strategies for implementation.
- November 2024 - Actions to implement CHIP strategies with local self-directed teams.



LIVE WELL MOHAVE COMMUNITY MEETINGS

The Community Health Improvement Plan (CHIP) planning process started with a kickoff on September 11, 2024. The process encompasses a mix of in-person gatherings and online meetings and is set to continue throughout the 2025-2028 cycle. More than 60 community partners attended the hybrid (in-person and virtual) kickoff meeting, where presenters shared the goals of the CHIP and the aim for the CHIP to be a community-driven process. Participants discussed their shared vision for a healthy Mohave County, reviewed findings from the Community Health Needs Assessment (CHNA), and completed activities to prioritize the significant health areas to work on in the CHIP.

In the Live Well Mohave sessions, facilitators actively gathered feedback from attendees to ensure the diverse voices of community members were heard and valued. During the CHIP discussions, community participants addressed the effectiveness of existing strategies to improve health. They identified necessary adjustments and the development of new initiatives that may better serve the community's evolving needs. By taking these steps, Live Well Mohave can more effectively contribute to the health and well-being of the Mohave County community.

In addition to the kickoff, four Live Well Mohave meetings were held:

- Bullhead City – pop. 43,302*
- Colorado City – pop. 2,734*
- Kingman – pop. 35,334*
- Lake Havasu City – pop. 59,257*

Other meetings not held, but may be scheduled in the future:

- White Hills – pop. 265*
- Dolan Springs – pop. 1,397 (with Meadview – pop. 1,629 and Chloride pop. 287)*
- Golden Shores– pop. 1,927 (with Topock pop. 2)*

**U.S. Census Bureau, Population estimates July 1, 2023*

Community Meeting Schedule

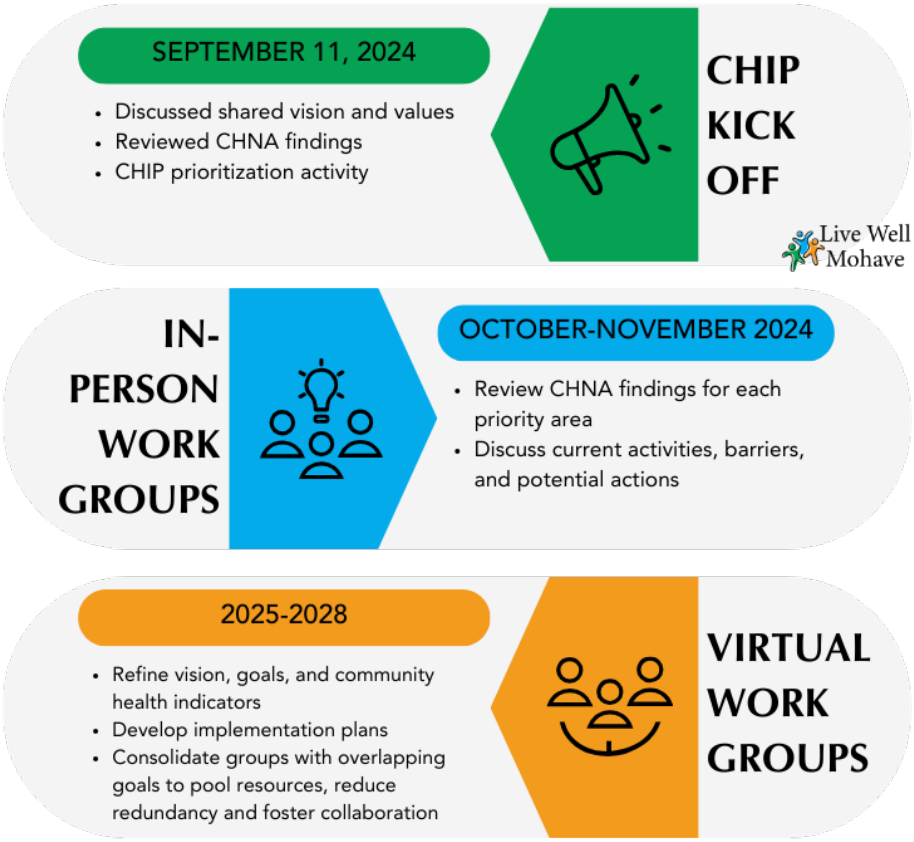
- CHIP Kickoff – September 11, 2024
- Kingman CHIP Work Group – October 15, 2024
- Lake Havasu City CHIP Work Group – November 01, 2024
- Bullhead City CHIP Work Group – November 07, 2024
- Colorado City CHIP Work Group – November 22, 2024

Agenda
The Live Well Mohave community meetings were distinct in nature, featuring various organizations and individuals who contributed ideas aimed at addressing health challenges.

A typical meeting agenda was:

A. Welcome and Introductions
B. Overview of the Live Well Mohave Initiative
C. Review of community data from the CHNA
D. CHIP In! Brainstorm Strategic Framework
E. Closing Remarks

Initial meetings for each community identified priorities that are unique to each community. Additional work groups were then scheduled to meet regularly to create strategies and objectives to address and monitor their progress toward their community health goals.



Health "Visioning"

To set a strong foundation for community health improvement, it is important to develop the community vision. Visioning guides the community through a collaborative creative process that leads to unique goals and a shared concept for a healthy future.

During the Live Well Mohave meetings and community events, Mohave County community members were invited to participate and provide input on three important health "visioning" questions:

1) *What does a healthy Mohave County mean to you?*
2) *What are the important characteristics of a healthy community for all who live, work, and play here?*
3) *What can we do together to improve community health?*

Participants had the opportunity to express their ideas creatively by either writing them on a vision board or recording their responses electronically to generate a word cloud, instead of just being confined to a traditional facilitated discussion. A summary of responses to these health visioning questions can be found in Appendix 2.

VISION FOR COMMUNITY HEALTH IMPROVEMENT

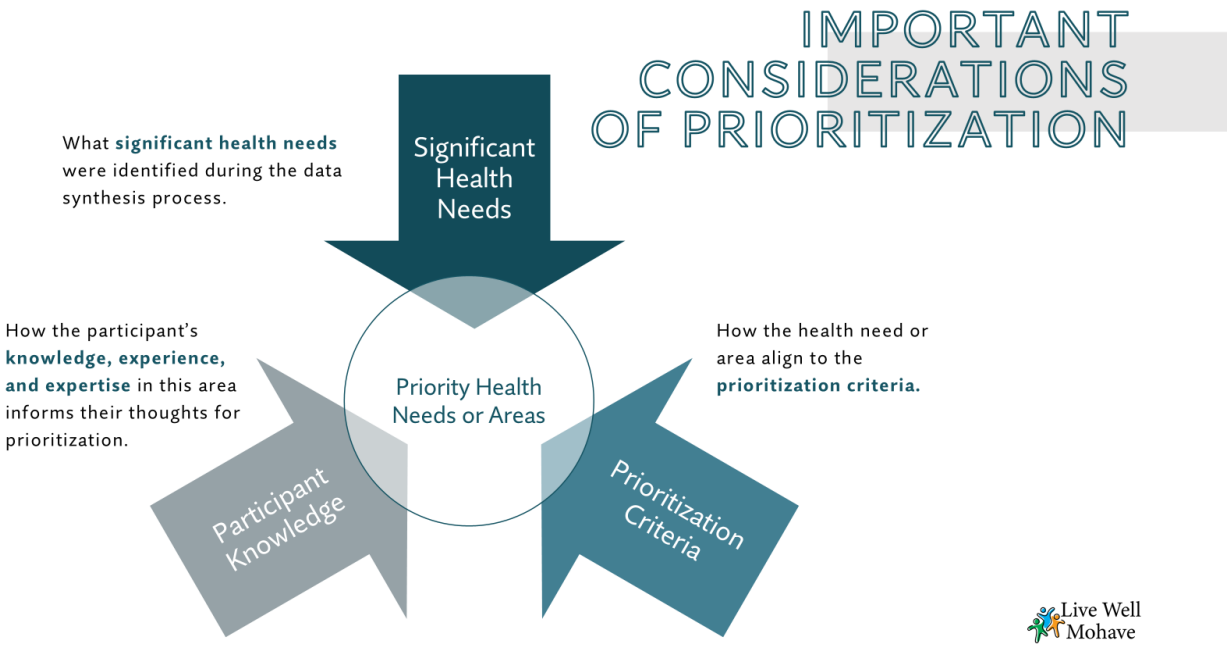
HEALTHY PEOPLE IN HEALTHY COMMUNITIES FOR ALL MOHAVE COUNTY RESIDENTS

OVERVIEW OF HEALTH PRIORITIES

Community stakeholders worked together to distinguish the most pressing community health priorities based on the data collected during the Community Health Needs Assessment (CHNA). After discussing their shared vision and values for a healthy Mohave County, the kickoff participants reviewed the key findings from the CHNA. Participants were then given time to access an online link and rank each of the top nine health areas identified through the CHNA. A summary of responses to these questions can be found in Appendix 3.

Participants were asked to consider the following:

- Significant health needs identified in the CHNA.
- How the health need or area aligned with the prioritization criteria.
- The participant's knowledge, experience, and expertise.



The following were the prioritization criteria and prompts to guide participants:

A. **Magnitude of the Issue** - *How many people in the community are or will be impacted? How does the identified need impact health, quality of life, and the conditions in which we live, work, and play? Has the need worsened over time? Are there differences in how the issue is experienced between different communities?*
B. **Ability to Impact** - *Can actionable and measurable goals be defined to address the health need? Are those goals achievable in a reasonable time frame? Does the Live Well Mohave initiative and its partners have the expertise or resources to address the identified health need? Are organizations already addressing the health issue?*

Key reflections for participants also included how these issues related to health disparities between rural and urban areas, social determinants of health, and how addressing the prioritized needs will impact health equity in measurable ways.

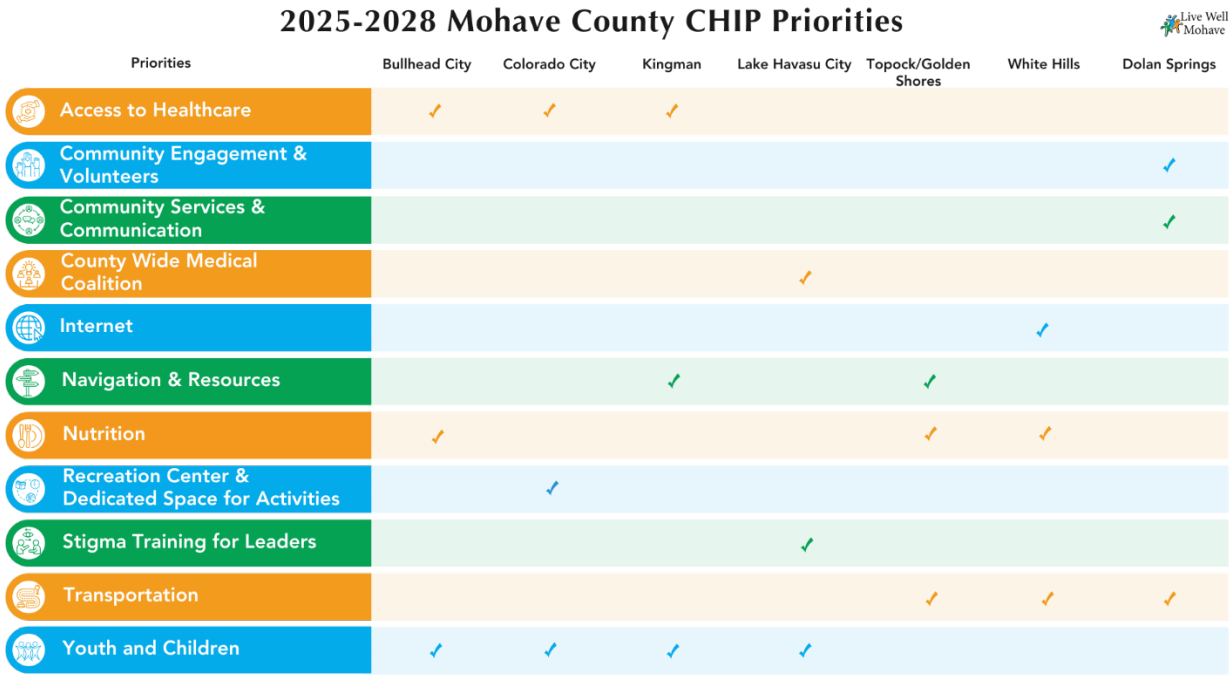


Figure 3. Mohave County CHIP Priorities

Community stakeholders were reengaged through follow-up CHIP groups to make sure selected priority needs aligned with community sentiment. Needs differed based on the community's capacity and resources to act on the issue, existing interventions, or concern over community cohorts that are not doing well. The final list of the top three prioritized health areas for Bullhead City, Colorado City, Kingman, Lake Havasu City, Topock/Golden Shores, White Hills, and Dolan Springs is shown above (Figure 3). Participants included community partners, providers, and subject matter experts knowledgeable about community assets and resources. During the work group sessions, participants received worksheets to guide the development of objectives, intervention strategies, process measures and outcome measures.

Participants were motivated to select goals that adhere to the SMARTIE framework, which stands for Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable. This approach encourages individuals to set clear and precise objectives that can be quantitatively assessed, ensuring trackable progress, and attainable success. The inclusion of time-bound elements helps in setting deadlines, which can increase urgency and focus. Additionally, incorporating inclusivity and equity ensures the goals are considerate of diverse needs and perspectives, fostering a supportive and fair environment for everyone involved.

Topics Discussed:

- Changes they would like to see in their local communities.
- Common barriers blocking improvement.
- Existing programs, activities, and resources addressing the need.
- Previous actions taken to address the priority area.
- Potential actions the group or their respective organizations could commit to.
- Other individuals or organizations that should be invited to the workgroup.

Reflection Questions:

- What am I bringing to the group?
- What **could** we do together?
- What **should** we do together?
- Imagine that Mohave County is recognized nationally for successfully addressing the priority health issues. What would that look like?

Priority Work Groups and Task Forces Formed:

- Kingman: Education, Access to Healthcare, Navigation Services
- Lake Havasu City: County-Wide Medical Coalition, Stigma Training for Leaders, Early Childhood Education & Youth Activities
- Bullhead City: Access to Care, Pediatric Care, Nutrition
- Colorado City: Recreation Center & Dedicated Space for Activities, Access to Specialty Care, Funding in Schools & the Community for Behavioral Health Care and Support Groups

Implementation Strategies and Progress Tracking:

Strategies for addressing identified health priorities are outlined for each city. Priority area work groups will meet regularly to implement activities and track progress. Residents can also join county-wide CHIP work groups (Appendix 4). The CHIP implementation plans will be regularly reviewed and revised to reflect evolving community needs, assets and activities. When health needs overlap health, it can help to integrate them into a single group.

Information about the CHNA/CHIP will be shared on:
Our Story | Mohave County Community Health Needs Assessment
Community Health Improvement Initiative | KRMC | Kingman Regional Medical Center

Limitations

- The CHIP kickoff and work groups were conducted in English, which limited participation from community members or partners not fluent in the language.
- Some meetings were conducted virtually, which may have inhibited participants with limited broadband access or devices from joining or fully participating in meetings.
- No specified funding exists to support objectives or activities identified in the CHIP. While there is aspiration to solicit future funding—or assess resources for redistribution—to support priorities, unfortunately no guarantee of funding exists. In addition, participating organizations are involved in implementing the CHIP on a voluntary basis. Typically, partners are engaged because they see the work as aligned with their mission or priorities. However, the funding uncertainty may limit the ability for some community partners to participate in the process and the types of activities that can be implemented as part of the CHIP.

2025-2028

Mohave County Community Health Improvement Plan

Priority Health Areas: Bullhead City

Live Well Mohave

PRIORITY AREA: PEDIATRIC CARE

Why is Pediatric Care Important to Health?

Pediatric care is crucial to health because it enables early detection and intervention of potential health issues in children. Enhancing a region's pediatric care infrastructure promotes physical, cognitive, and emotional development among youth. Pediatric care lays the foundation for a healthy adult life by providing preventative measures, monitoring growth, and addressing concerns related to nutrition and developmental milestones.

Goal: Increase the amount of pediatric care specialists by 2028.	
Objective A: Increase medical specialists for pediatrics as well as childcare.	**Objective B:** Create a medical provider consortium.
Strategy 1: Identify and assess needs for pediatric subspecialities and childcare in Bullhead City. Increase access to special education services.	**Strategy 1:** Reduce duplication of services.
Strategy 2: Educate elected officials on the impact the lack of childcare has on our economy.	**Strategy 2:** Collect and share data between medical providers for collaboration.
Actions: • Increase participation in the Child Care Taskforce. • Share First Things First Child Care Provider survey which assesses challenges faced by childcare centers. Preliminary data shows need to increase childcare center staffing and reduce high turnover rates. • Promote MCC education programs, particularly those related to early childhood education and teaching certificates. • Follow development of MCC 4-year degrees in human services, psychology, and education. • *Members elected to merge this CHIP with Lake Havasu City Early Childhood Education and Youth Activities CHIP and County Wide Medical Coalition CHIP*	

Strategic Partners: Applied Behavior Analysis (ABA) therapists, Bullhead City School District#15, Bullhead City childcare center directors, Child Care Taskforce, First Things First, Kingman Regional Medical Center (KRMC), Mohave Community College (MCC) Education Department, Mohave County Department of Public Health (MCDPH)

PRIORITY AREA: ACCESS TO CARE

Why is Access to Care Important to Health?

Access to care is crucial for overall health because it allows individuals to receive preventive care, early diagnosis and treatment of illnesses. Lack of access can lead to poorer health outcomes, increased healthcare costs, and disparities based on socioeconomic factors.

Goal: Increase access to care by 2028.	
Objective A: By 2028, develop a community education program on insurance coverage and care.	**Objective B:** By 2028, create positions and a program for trusted community health navigators to ensure our community members don't fall through the cracks.
Strategy 1: Provide community-wide education from insurance companies on the enrollment process, timeline, and benefits.	**Strategy 1:** Partner with the Mohave County Community Services department and onboard local resources to their ATLAS referral platform, bringing all resources in one place.
Strategy 2: Provide educational workshops where residents can ask questions from experts and then take the time to help them go over their plans during the workshop.	**Strategy 2:** Train community health navigators to use the ATLAS referral platform.
Actions: • Educate community partners, navigators at hospitals, and key care points within Bullhead City on community-based resources and the ATLAS hub. • *Members elected to merge this CHIP with Lake Havasu City County Wide Medical Coalition CHIP*	
Strategic Partners: Arizona College of Nursing, First Things First, Hickory Recovery Network, Kingman Regional Medical Center (KRMC), Make Bullhead Better, Mohave County Department of Public Health (MCDPH), Mohave County Community Services, North Country HealthCare, WestCare Arizona, Young Scholars Public School	

PRIORITY AREA: NUTRITION

Why is Nutrition Important to Health?

Balanced nutrition is important as it provides energy for the body to perform daily activities. Poor nutrition can hinder growth and development, while excessive calorie consumption can lead to obesity. Access to adequate nutrition is limited by an individual's food environment, including distance to grocery stores or supermarkets and healthy restaurants, and food cost. Increasing food and nutrition literacy empowers individuals to make informed food choices. The more knowledgeable someone is about nutrition the better equipped they are to select foods that support their overall health and well-being.

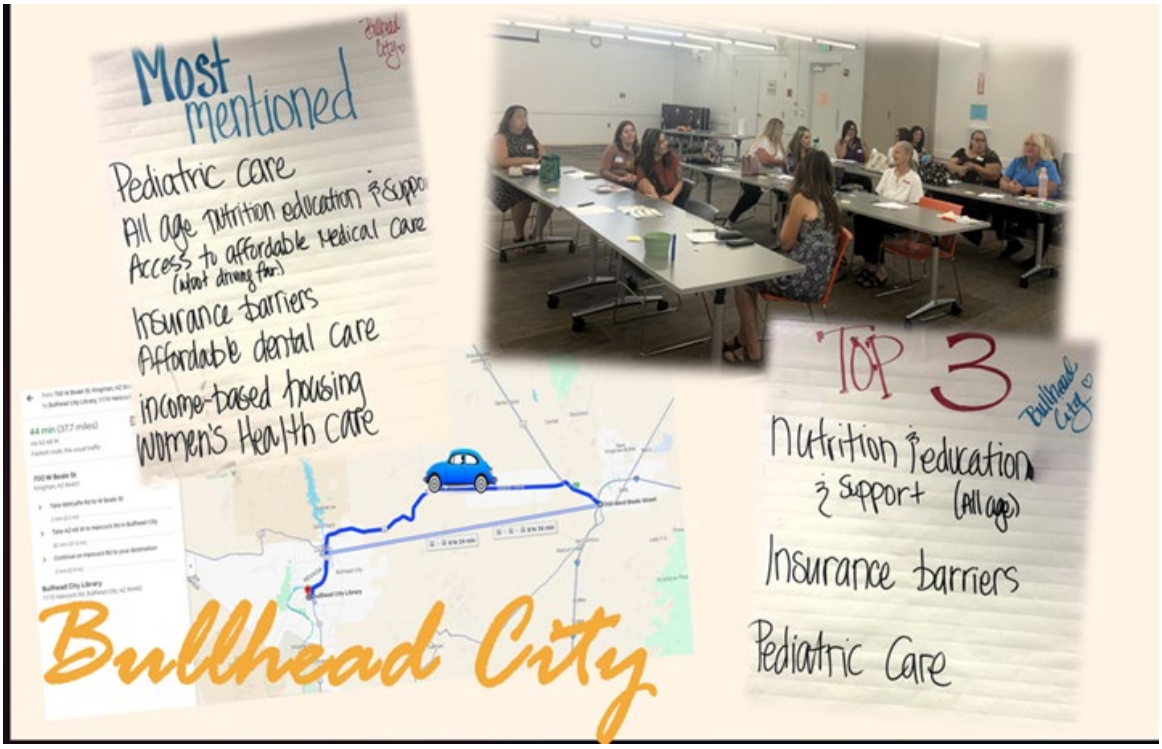
<table>
<tr><td colspan="2">Goal:
Develop a community nutrition program by 2028.</td></tr>
<tr><td>Objective A:
Create a Nutrition Educator program for businesses.</td><td>Objective B:
Develop an educational program for the public that addresses nutrition literacy.</td></tr>
<tr><td colspan="2">Strategy:
Work with MCDPH Nutrition and Health Promotion Division to create programs.</td></tr>
<tr><td colspan="2">Actions:
Create a program in which participants can "train the trainer" on healthy recipes. Participants can then go back to their place of business and teach their clients quick and easy healthy recipes, in addition to the benefits of these choices in the long run.
Develop curriculum. Educational topics will include food bank recipes, demos at farmer's markets, how to buy in bulk and save, canning/freezing/food storage, tips on how to keep produce, healthy food campaigns, possibly lunch and learns or pre-recorded videos, understanding food addiction and addiction effects the brain, and the importance of nutrition on recovery.</td></tr>
<tr><td colspan="2">Strategic Partners:
Arizona Youth Partnership, Bullhead City Police Department, Kingman Regional Medical Center (KRMC), Mohave County Department of Public Health (MCDPH) Nutrition and Health Promotion Division, Smart Recovery/PFLAG</td></tr>
</table>

Performance Measures

The following table describes a set of suggested performance measures that may be used to determine progress of CHIPs in future CHNA/CHIP cycles. The objectives are from the U.S. Department of Health and Human Services (DHHS) Office of Disease Prevention and Health Promotion (ODPHP) **Healthy People 2030,** with targets for the decade. Core objectives have valid, reliable, nationally representative data. National targets are set by ODPHP. Data sources are available in Appendix 5. When we work together to achieve them, we can improve health and well-being not only in Mohave County, but also nationwide.

Alignment to Healthy People 2030 Objectives	Data Indicators	Most Recent National Data	National Target
Increase the proportion of people with health insurance — AHS-01	Percent of persons under 65 years who had medical insurance	91.1% (2023)	94.4% ↑ Increase desired
Increase the proportion of people with a usual primary care provider — AHS-07	Percent of persons who had a usual primary care provider	76.0% (2017)	84% ↑ Increase desired
Increase the proportion of adults who get recommended evidence-based preventive healthcare — AHS-08	Percent of adults aged 35 years and over who received all the recommended high-priority appropriate clinical preventive services	5.3% (2020)	11.5% ↑ Increase desired
Increase the proportion of children and adolescents with communication disorders who have seen a specialist in the past year — HOSCD-05	Percent of children and adolescents aged 3 to 17 years with communication disorders of voice, speech, or language who saw a health care specialist for evaluation or treatment in the past 12 months	59.7% (2012)	64.4% ↑ Increase desired
Increase the proportion of children with mental health problems who get treatment — MHMD-03	Percent of children aged 4 to 17 years with mental health problems who received treatment	70.7% (2019)	79.3% ↑ Increase desired
Increase the proportion of children who receive a developmental screening — MICH-17	Percent of children aged 9 through 35 months who were screened for autism spectrum disorder (ASD) and other developmental delays in the past 12 months	34.8% (2020-21)	35.8% ↑ Increase desired
Increase the proportion of children and adolescents with special healthcare needs who have a system of care — MICH-20	Percent of children and adolescents under 18 years with special healthcare needs who received care in a family-centered, comprehensive, and coordinated system.	13.7% (2020-21)	19.5% ↑ Increase desired
Reduce household food insecurity and hunger — NWS-01	Percent of households that were food insecure	13.5% (2023)	6% ↓ Decrease desired
Reduce the proportion of adults with obesity — NWS-03	Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30	41.8% (2017-20)	36% ↓ Decrease desired

Reduce the proportion of children and adolescents with obesity — NWS-04	Percent of children and adolescents aged 2 to 19 years who had obesity	19.7% (2017-20)	15.5% ↓ Decrease desired
Increase fruit consumption by people aged 2 years and over — NWS-06	Cup equivalents of fruits per 1,000 calories was the mean daily intake by persons aged 2 years and over	0.49 (2017-20)	0.56 ↑ Increase desired
Increase vegetable consumption by people aged 2 years and older — NWS-07	Cup equivalents of total vegetables per 1,000 calories was the mean daily intake by persons aged 2 years and over	0.73 (2017-20)	0.84 ↑ Increase desired



2025-2028

Mohave County Community Health Improvement Plan

Priority Health Areas: Colorado City

Live Well Mohave

PRIORITY AREA: FUNDING IN SCHOOLS & COMMUNITY FOR BEHAVIORAL HEALTH

Why is Funding for Behavioral Health Care and Support Groups Important to Health?

Funding for behavioral health care and support groups in schools is critical to student health because it provides early intervention and accessible mental health support where students spend most of their time. Adequate support allows for potential issues to be identified and addressed before they escalate and helps to improve academic performance and social well-being. Community support groups are also vital to overall health because they provide a safe space for individuals to share experiences with others facing similar challenges.

Goal: Funding in schools & the community for behavioral health care and support groups by 2028	
Objective A: Prioritize funding for behavioral health care.	**Objective B:** Have roundtable discussions with service providers to identify issues and create solutions for schools, parents, and those in need of services.
Strategy 1: Employ behavioral health counselors and nurses at Cottonwood Elementary School and Masada Charter Schools.	**Strategy 1:** Invite professional services providers including speech therapists, OT and PT in the valley to the round table discussions.
Actions: • Establish logistics for roundtable discussions. • Offer Youth Mental Health First Aid (YMHFA) training. • Identify needs for creating a resource guide. • Form Alcoholics Anonymous (AA) group. • Mental Health First Aid (MHFA) training for first responders.	
Strategic Partners:	

Cherish Families, Colorado City Unified School District #14, Cottonwood Elementary School, First Things First, Healthy Families Program & Parents As Teachers Child and Family Resources, Inc., Hickory Recovery Network, Kingman Regional Medical Center (KRMC), Masada Charter Schools, Mohave Community College, Mohave County, Preschools

PRIORITY AREA: ACCESS TO SPECIALTY CARE

Why is Access to Specialty Care Important to Health?

Access to specialty care is crucial for overall health because it allows patients to receive highly focused and expert treatment for complex medical conditions. This is especially crucial for managing chronic diseases or conditions requiring specific interventions.

Goal: Access to specialty care by 2028.
Objective: Identify gaps in care specific to Colorado City.
Strategy 1: Assess specialty care needs and compile a list of issues specific to Colorado City.
Strategy 2: Identify stakeholders with expertise in local community issues who should be at the table.
Actions: • Establish a brainstorming thread over email. • *Members discussed merging this CHIP with Lake Havasu City County Wide Medical Coalition CHIP.*
Strategic Partners: Arizona Complete Health, Creek Valley Health Clinic, Kingman Regional Medical Center (KRMC), Mohave County Department of Public Health (MCDPH)

PRIORITY AREA: RECREATION CENTER

Why is a Recreation Center Important for Health?

A recreation center is important to health because it provides accessible space for physical activity, which can significantly improve overall well-being. Adequate physical activity can reduce the risk of chronic diseases, enhance cardiovascular health, boost mental well-being, and encourage healthy habits across different age groups.

Goal: Recreation center & dedicated space for activities by 2028.	
Objective A: Create space for a variety of activities.	**Objective B:** Make them accessible to everyone for little-to-no cost.
Strategy 1: Ensure that future plans for the rec center's construction continue to stay aligned with community needs.	**Strategy 1:** Create a communications campaign to reach the public utilizing the center's website, Facebook pages, and local area bulletin boards.

Strategy 2: Continue to network, share resources, and work with Colorado City and surrounding cities to participate in raising awareness about the future recreational center.
Actions: • Create an outdoor space with weight equipment at CWP trails • Secure grants, community donations, and other funding opportunities to help make this center and the provided activities low-to-no cost • A rec center is already underway. Interested citizens have joined as volunteers to assist. • Invite more community members to the CHIP group.
Strategic Partners: Colorado City Parks and Recreation, Kingman Regional Medical Center (KRMC), Mohave County, Town of Colorado City

Performance Measures

The following table describes a set of suggested performance measures that may be used to determine progress of CHIPs in future CHNA/CHIP cycles. The objectives are from the U.S. Department of Health and Human Services (DHHS) Office of Disease Prevention and Health Promotion (ODPHP) **Healthy People 2030** with targets for the decade. Core objectives have valid, reliable, nationally representative data. National targets are set by ODPHP. Data sources are available in Appendix 5. When we work together to achieve them, we can improve health and well-being not only in Mohave County, but also nationwide.

Alignment to Healthy People 2030 Objectives	Data Indicators	Most Recent National Data	National Target
Reduce the proportion of people who can't get medical care when they need it — AHS-04	Percent of persons unable to obtain or delayed in obtaining necessary medical care due to cost	6.8% (2023)	5.9% ↓ Decrease desired
Increase the proportion of adults who get recommended evidence-based preventive health care — AHS-08	Percent of adults aged 35 years and over received all the recommended high priority appropriate clinical preventive services	5.3% (2020)	11.5% ↑ Increase desired
Increase the proportion of children with mental health problems who get treatment — MHMD-03	Percent of children aged 4 to 17 years with mental health problems received treatment	70.7% (2019)	79.3% ↑ Increase desired
Increase the proportion of children who receive a developmental screening — MICH-17	Percent of children aged 9 through 35 months were screened for autism spectrum disorder (ASD) and other developmental delays in the past 12 months	34.8% (2020-21)	35.8% ↑ Increase desired
Increase the proportion of children and adolescents with	Percent of children and adolescents under 18 years with	13.7% (2020-21)	19.5%

special health care needs who have a system of care — MICH-20	special health care needs received care in a family-centered, comprehensive, and coordinated system		↑ Increase desired
Increase the proportion of older adults with physical or cognitive health problems who get physical activity — OA-01	Percent of adults aged 65 years and over with reduced physical or cognitive function engaged in light, moderate, or vigorous leisure-time physical activities	41.3% (2018)	51.0% ↑ Increase desired
Reduce the proportion of adults who do no physical activity in their free time — PA-01	Percent of adults aged 18 years and over engaged in no leisure-time physical activity	26.3% (2022)	21.8% ↓ Decrease desired
Increase the proportion of adults who do enough aerobic and muscle-strengthening activity — PA-05	Percent of adults aged 18 years and over met the guidelines for aerobic physical activity and muscle-strengthening activity during their leisure time	25.3% (2022)	29.7% ↑ Increase desired
Increase the proportion of adolescents who do enough aerobic and muscle-strengthening activity — PA-08	Percent of students in grades 9 through 12 were physically active for at least 60 minutes on all 7 days of the past week and participated in muscle-strengthening activity on 3 or more days of the past week	16.0% (2021)	24.1% ↑ Increase desired
Increase the proportion of children and adolescents who play sports — PA-12	Percent of children and adolescents aged 6 to 17 years participated in a sports team or took sports lessons after school or on weekends in the past 12 months	50.7% (2020-21)	63.3% ↑ Increase desired

2025-2028

Mohave County Community Health Improvement Plan

Priority Health Areas: Kingman

Live Well Mohave

PRIORITY AREA: EDUCATION

Why is Education Important to Health?

Education is important to health because it empowers individuals to make informed decisions about their wellbeing by providing knowledge about healthy lifestyles, disease prevention, and access to healthcare. This ultimately leads to better health outcomes and increased life expectancy. The more educated someone is, the better equipped they are to navigate their own health needs and advocate for themselves.

<table>
<tr><td colspan="2">Goal:
Accessing quality education is equitable for all community members.</td></tr>
<tr><td>Objective A: Birth-12 years old
The youth education system and those in it are well supported with access to childcare and early childhood education with qualified professionals.</td><td>Objective B: Teens and Adults
Explore financially sustainable, aligned career paths and opportunities within Mohave County that will increase the number of skilled workers in the labor market.</td></tr>
<tr><td>Strategy 1:
Life skills education to teach students practical skills that help them navigate their lives.</td><td>Strategy 1:
Career exploration and assessment tools to help workers consider and plan career options, preparation, and transitions more effectively.</td></tr>
<tr><td>Strategy 2:
Increase childcare slots at early learning centers.</td><td>Strategy 2:
Create programs that provide on-the-job trainings for positions available locally, possibly following vocational technical models.</td></tr>
<tr><td colspan="2">Actions:
• By 2028, expand daycare in Mohave County through public and private partnerships.
• By 2028, create a KRMC clinical academy.
○ Focus: Nursing extern program.
• By 2028, create and implement vocational education models.</td></tr>
</table>

Strategic Partners: CAMA, Kingman Airport and Industrial Park, Kingman Regional Medical Center (KRMC), Child Care Taskforce, Local First Arizona, Mohave Community College (MCC), Mohave County Department of Public Health (MCDPH), Western Arizona Vocational Education / Career and Technical Education District (WAVE/CTED)

PRIORITY AREA: ACCESS TO HEALTHCARE

Why is Access to Healthcare Important to Health?

Access to healthcare is crucial for overall health because it allows individuals to receive preventive care, early diagnosis and treatment of illnesses, and manage chronic conditions. This ultimately improves their quality of life by addressing health concerns as they arise, rather than letting them worsen due to delayed treatment. A lack of access can lead to poorer health outcomes, increased healthcare costs, and disparities based on socioeconomic factors.

Goal: Improve access to primary and specialty care providers and services.	
Objective A: KRMC to work toward physicians reserving appointment slots for emergency cases (clients seen in the emergency room who need to book a specialty appointment within 48 hours).	**Objective B:** Partner with outside agencies to provide health education which will assist in reducing the burden on the limited KRMC staff.
Strategy 1: Create buy in and demonstrate need with senior leadership to secure champions for change.	**Strategy 1:** Foster partnerships with staff, other healthcare providers, and community organizations to refer individuals and facilitate sharing of information.
Strategy 2: Create implementation plan for all-staff roll out. Create performance monitoring and improvement plan for working out barriers and calling out successes.	**Strategy 2:** Targeted outreach and awareness campaign to promote health education within the community, utilizing various communication channels such as social media, flyers, and word of mouth.
Actions: • Feasibility assessment to anticipate pain points; gather baseline data on wait times, patient attrition, and lost revenue. Explore options such as clinic waitlists and telehealth. • Conduct a buy-in meeting with stakeholders. • Draft policies and procedures. • Draft /update staff and patient education ○ *Where should I seek care? How do I schedule an appointment? How do I access my medical record? In-person care options, virtual care options, health and wellness resources, etc.*	

Strategic Partners: Kingman Regional Medical Center (KRMC), All Mohave County partners

PRIORITY AREA: NAVIGATION SERVICES

Why are Navigation Services Important to Health?

Navigation services through patient navigators, community health workers, or care coordinators are important to health. Navigation guides patients through the complex healthcare system and helps them access necessary services. Enhancing community navigation will help patients understand their diagnoses and treatment options, navigate administrative processes, and overcome barriers to care.

Goal: Launch a community resource network to help reduce disparities in care, increase patient satisfaction, and improve health outcomes	
Objective A: People Create and onboard navigator positions to proactively guide patients through the healthcare continuum to facilitate timely access to care, while fostering self-management through education and social support.	**Objective B: Resources** Train navigator – advocators to utilize ATLAS referral platform created by Mohave County Community Services to assist patients in obtaining appointments and navigating the continuum of care needed for patients.
Strategy 1: Research funding sources for navigators and determine reimbursement requirements.	**Strategy 1:** Enhance collaboration and communication between KRMC & community partners to promote local resources.
Actions: • Research grants & conduct financial assessment. Contact insurers re: reimbursement. • Host quarterly meetings between navigators & community partners. • Advertise online repositories of resources. • Connect to Arizona resource hotline 2-1-1 Arizona. • Determine a mechanism to update resource sheets as needed.	
Strategic Partners: Kingman Regional Medical Center (KRMC) Emergency Department, Mohave County Department of Public Health (MCDPH), Mohave County Community Services, Kingman Police Department, Kingman Fire Department, Schools	

Performance Measures

The following table describes a set of suggested performance measures that may be used to determine progress of CHIPs in future CHNA/CHIP cycles. The objectives are from the U.S. Department of Health and Human Services (DHHS) Office of Disease Prevention and Health Promotion (ODPHP) **Healthy People 2030** with targets for the decade. Core objectives have valid, reliable, nationally representative data. National targets are set

by ODPHP. Data sources are available in Appendix 5. When we work together to achieve them, we can improve health and well-being not only in Mohave County, but also nationwide.

Alignment to Healthy People 2030 Objectives	Data Indicators	Most Recent National Data	National Target
Reduce the proportion of adolescents and young adults who aren't in school or working — AH-09	Percent of teens and young adults ages 16-19 who are neither working nor in school	10.6% (2023)	11.2% ↓ Decrease desired
Reduce the proportion of people who can't get medical care when they need it — AHS-04	Percent of persons were unable to obtain or delayed in obtaining necessary medical care due to cost	6.8% (2023)	5.9% ↓ Decrease desired
Reduce the proportion of people who can't get prescription medicines when they need them — AHS-06	Percent of persons were unable to obtain or delayed in obtaining necessary prescription medicines due to cost	5.8% (2023)	6.3% ↓ Decrease desired
Increase the proportion of people with a usual primary care provider — AHS-07	Percent of persons had a usual primary care provider	76.0% (2017)	84.0% ↑ Increase desired
Increase the proportion of adults who get recommended evidence-based preventive health care — AHS-08	Percent of adults aged 35 years and over received all the recommended high priority appropriate clinical preventive services.	5.3% (2020)	11.5% ↑ Increase desired
Increase employment in working-age people — SDOH-02	Percent of population 16 years and over in labor force	71.5% (2023)	75.0% ↑ Increase desired

2025-2028

Mohave County Community Health Improvement Plan

Priority Health Areas: Lake Havasu City

Live Well Mohave

PRIORITY AREA: EARLY CHILDHOOD EDUCATION & YOUTH ACTIVITIES

Why Are Early Childhood Education and Youth Activities Important to Health?

Early childhood education is important to health because it helps children develop healthy habits and skills that can prevent chronic disease and promote lifelong well-being. Youth activities, like sports and physical play, are important to health because they promote physical fitness and can positively impact mental well-being. Investing in childhood education and youth activities lays the foundation for a healthy lifestyle later in life.

Goal: Expand early childhood education & youth activities by 2028	
Objective A: Childcare Build connections that will lead to increased partnership and community engagement.	**Objective B: Youth Activities** Connect local organizations to gather current resources and youth activities information and expand on future opportunities.
Strategy 1: Provide greater support and access to childcare options.	**Strategy 1:** Create a contact list of current and potential connections to include education, wellness, nutrition, mentorship.
Strategy 2: Work with other community organizations to address childcare issues and needs in the region.	**Strategy 2:** Create family engagement calendars that provide free education to youth during school breaks.
Actions: • *Members elected to split this CHIP in two groups.* • *The childcare group will join forces with the recently established Child Care Task Force.* ○ Child Care Task Force meets every three weeks and is looking for more community partners to come together. • *The youth activities group will be led by First Things First.*	
Strategic Partners:	

First Things First, Kingman Regional Medical Center (KRMC), Lake Havasu Area Chamber of Commerce, Mohave County Department of Public Health (MCDPH) Mohave Mental Health Clinic, Inc.

PRIORITY AREA: STIGMA TRAINING FOR LEADERS

Why is Stigma Training for Leaders Important for Health?

Training leaders to understand and address stigma is vital for health as it enables them to cultivate an environment that enhances patient-provider communication. When people feel less judged about their health conditions, they are more inclined to seek assistance and treatment, which promotes early intervention and better management.

Goal: Establish stigma training for leaders program by 2028.	
Objective A: Assess community needs and build a strong workgroup to help develop the program.	**Objective B:** Implementation of stigma training for medical professionals and leaders.
Strategy 1: Invite community members and professionals missing from this group so resources and contacts can be pooled.	**Strategy 1:** Compile list of available education opportunities, who provides it, and create education resource guide.
Strategy 2: Disseminate community survey to learn where gaps and needs are.	**Strategy 2:** Promote educational resource guide within the community.
Actions: • CHIP members will invite other organizations to meaningfully contribute. • Once the workgroup is established, create poll and share with the community. • Stigma and Mental Health First Aid (MHFA) training for first responders.	
Strategic Partners: Applied Worldwide, Clinical social workers, Community Medical Services, Hope & Health Hub, Kingman Regional Medical Center (KRMC), Mohave Community College (MCC), Mohave County Department of Public Health (MCDPH), Mohave Substance Treatment Education & Prevention Partnership (MSTEPP)	

PRIORITY AREA: COUNTY-WIDE MEDICAL COALITION

Why is a County-Wide Medical Coalition Important for Health?

A county-wide medical coalition is important because it brings together various healthcare providers and organizations within the Mohave County area to collaborate, share resources, and coordinate efforts to improve community health.

Goal: Create a County-Wide Medical Coalition by 2028		
Objective A: Network	**Objective B: Education**	**Objective C: Representation**

<table>
<tr><td>Collaboration between healthcare providers (including pharmacies) to promote data-driven decision making and strategic use of community resources.</td><td>Cohesive health-related education for the public.</td><td>Ensure consideration of diverse perspectives and fair representation from different community groups to better address needs.</td></tr>
<tr><td>Strategy 1:
Establish a quarterly resource virtual meeting where all hospitals can come to the table and have a voice.</td><td>Strategy 1:
Assess and address common health literacy needs across Mohave County to lessen the burden on health systems.</td><td rowspan="2">Strategy:
Include a broad range of stakeholders like hospitals, clinics, public health agencies, EMS providers, community-based organizations, and patient advocates.</td></tr>
<tr><td>Strategy 2:
Develop agreements to share health-related knowledge. Suggestions: disease distribution and patterns between regional care providers, identified problems in access to care, and insurance barriers all over Mohave County.</td><td>Strategy 2:
Develop educational materials. Requested topics include deciphering diagnoses, prescription medication, medical appointment transportation, and understanding the differences between telehealth, urgent care, and the emergency room.</td></tr>
<tr><td colspan="3">Actions:
Develop health educational materials based on available guidance (e.g. CDC, ADHS).
PR campaign to share education and resources.
Establish data-sharing agreements between regional care providers.
Formalize network with member roles and responsibilities.
Sustainability plan to develop and maintain the coalition’s capabilities over time.
Federal grant funding
CHIP members will invite other organizations to meaningfully contribute.</td></tr>
<tr><td colspan="3">Strategic Partners:
Arizona Complete Health, Kingman Regional Medical Center (KRMC), Mohave County Board of Supervisors, Mohave County Department of Public Health (MCDPH), Mohave Substance Treatment, Education, & Prevention Partnership (MSTEPP), Western Arizona Regional Medical Center (WARMC)</td></tr>
</table>

Performance Measures

The following table describes a set of suggested performance measures that may be used to determine progress of CHIPs in future CHNA/CHIP cycles. The objectives are from the U.S. Department of Health and Human Services (DHHS) Office of Disease Prevention and Health Promotion (ODPHP) **Healthy People 2030** with targets for the decade. Core objectives have valid, reliable, nationally representative data. National targets are set by ODPHP. Data sources are available in Appendix 5. When we work together to achieve them, we can improve health and well-being not only in Mohave County, but also nationwide.

Alignment to Health People 2030 Objectives	Data Indicators	Most Recent National Data	National Target
Increase the proportion of adults whose health care provider checked their understanding — HC/HIT-01	Percent of adults aged 18 years and over reported that a health care provider asked them to describe how they will follow instructions	26.3% (2021)	32.2% ↑ Increase desired
Decrease the proportion of adults who report poor communication with their health care provider — HC/HIT-02	Percent of adults aged 18 years and over reported poor provider communication	8.9% (2021)	8% ↓ Decrease desired
Increase the proportion of adults whose health care providers involved them in decisions as much as they wanted — HC/HIT-03	Percent of adults aged 18 years and over reported that their health care providers always involved them in decisions about their health care as much as they wanted	52.2% (2022)	62.7% ↑ Increase desired
Increase the proportion of adolescents who do enough aerobic and muscle-strengthening activity — PA-08	Percent of students in grades 9 through 12 were physically active for at least 60 minutes on all 7 days of the past week and participated in muscle-strengthening activity on 3 or more days of the past week	16.0% (2021)	24.1% ↑ Increase desired
Increase the proportion of children and adolescents who play sports — PA-12	Percent of children and adolescents aged 6 to 17 years participated in a sports team or took sports lessons after school or on weekends in the past 12 months	50.7% (2020-21)	63.3% ↑ Increase desired

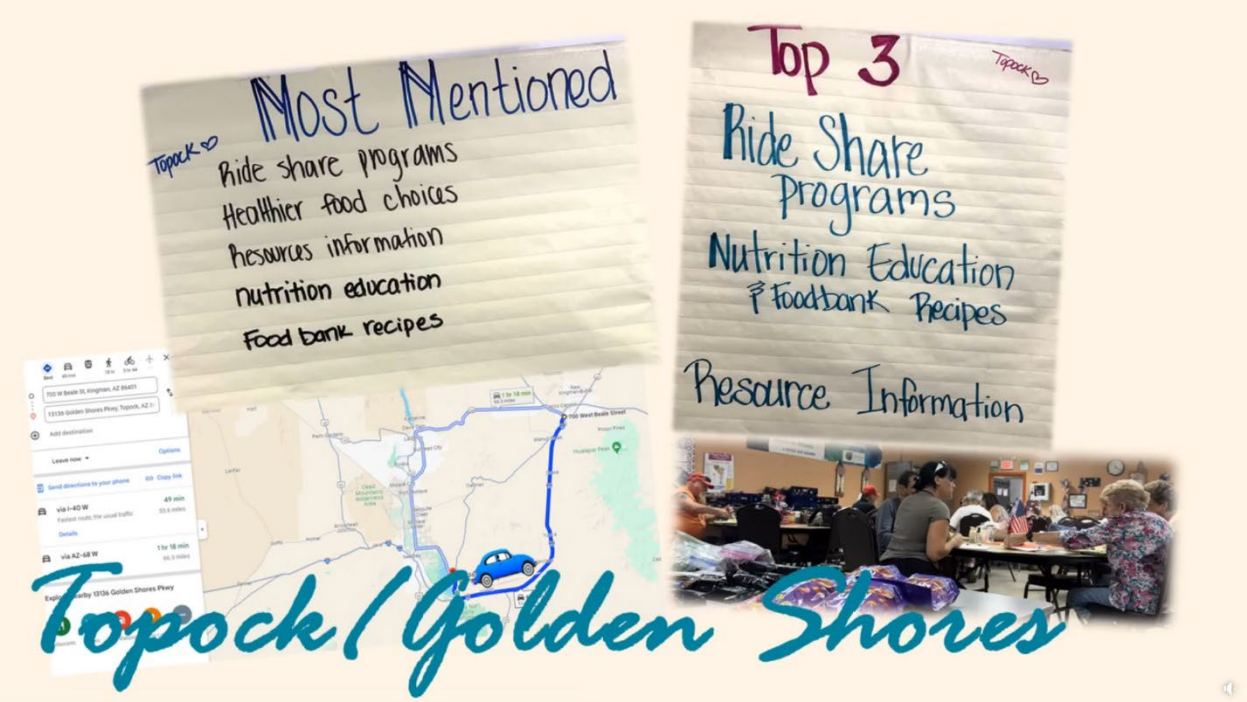
Future Plans

Where We Are Now:

Residents have zero interest in follow-up CHIP groups. It is highly unlikely that a CHIP group will come to fruition.

What We Are Working On:

- Getting the MC Street Team out there to share about available resources.
- Nutrition education and demonstrations.



2025-2028

Mohave County Community Health Improvement Plan

Priority Health Areas: White Hills

Live Well Mohave

Where We Are Now:

So far only one citizen has expressed interest in participating in a CHIP group. MCDPH will continue attempts to get something scheduled.

What We Are Working On:

- Internet connectivity is being evaluated and options explored.
- Transportation to/from appointments seems to be the largest issue for persons unable to drive themselves due to aging barriers.

2025-2028

Mohave County Community Health Improvement Plan

Priority Health Areas: Dolan Springs

Live Well Mohave

Transportation

Community Engagement & Volunteers

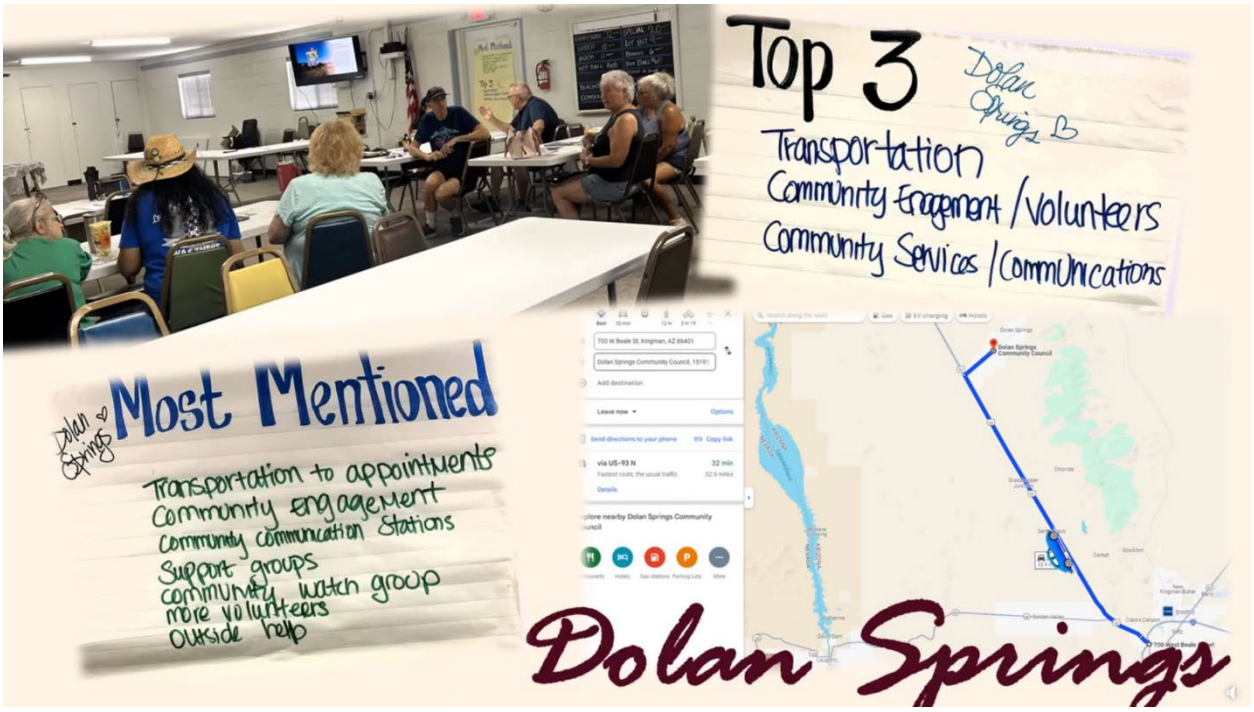
Community Services & Communication

Where We Are Now:

Talks about scheduling follow-up CHIP groups have not yielded results. MCDPH will continue attempts to get something scheduled.

What We Are Working On:

- The MC Street Team includes Mt. Tipton in its monthly circuit of Health Resource Fairs, held at different venues across the county. Public Health programs attending the event share available resources and recruit for more volunteers and solutions to citizens' concerns.



CONCLUSIONS

With the completion of the 2025-2028 CHIP, **it is time to take action.** This initiative has been instrumental in identifying the pressing health needs within our community and developing strategic plans to address them effectively. Health concerns encompass a wide range of issues, including accessing high-quality healthcare, ensuring proper nutrition, facilitating transportation, and addressing the needs of youth and children. With the identification of overarching goals, outcomes, strategies, and activities, community partners can see what actions need to be taken to improve the health of Mohave County residents and how to get involved. This document will serve as a roadmap for use by community partners working to improve health in the goals identified in this CHIP.

The 2025-2028 Mohave County CHIP is intended to be an adaptive plan that changes as new complexities emerge within our local public health system. It is crucial to periodically revisit and reaffirm our overarching vision – *healthy people in healthy communities for all Mohave County residents*. Future action by CHIP work groups will be self-directed and supported as appropriate by MCDPH and KRMC. Residents can also join established county-wide CHIP work groups like the Mohave Substance Treatment, Education, & Prevention Partnership (MSTEPP) and the Mental Health Resource Team (MHRT) (Appendix 4).

While participating in the development of the CHIP, partners demonstrated enthusiasm for ensuring that the CHIP Committee utilizes the plan to improve the health of Mohave County and the KRMC service region. This enthusiasm relates not only to the important priorities outlined in the CHIP but also to the spirit of partnership that is required to work together across organizations to improve the health of residents in Mohave County. Health improvement cannot be achieved alone. Through collaboration with healthcare professionals, policymakers, and community leaders, we strive to implement sustainable solutions that will foster a healthier future for all.

To review the Community Health Needs Assessment and Community Health Improvement Plan and stay up to date on the CHIP implementation activities visit: https://www.mohave.gov or http://www.azkrmc.com

Our Story | Mohave County Community Health Needs Assessment
Community Health Improvement Initiative | KRMC | Kingman Regional Medical Center

APPENDICES

Appendix 1 Acronyms and Abbreviations

ABBREVIATION	DEFINITION
AA	Alcoholics Anonymous
ABA	Applied Behavior Analysis
ACS	American Community Survey, U.S. Census Bureau
ADHS	Arizona Department of Health Services
AHRQ	Agency for Healthcare Research and Quality
BJA	Bureau of Justice Assistance
BRFSS	Behavior Risk Factor Surveillance System, CDC
CADCA	Community Anti-Drug Coalitions of America
CDC	Centers for Disease Control and Prevention
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
DHHS	U.S. Department of Health and Human Services
DOJ	U.S. Department of Justice
HINTS	Health Information National Trends Survey
HRSA	Health Resources and Services Administration
HRSN	Health Related Social Need
IRS	Internal Revenue Service
KRMC	Kingman Regional Medical Center
LOSS	Loved Ones Stolen by Suicide
MAGNET	Mohave Area General Narcotics Enforcement Team
MAPP	Mobilizing for Action Through Planning and Partnerships
MAPPED	Mohave Area Partnership Promoting Educated Decisions
MCC	Mohave Community College
MCDPH	Mohave County Department of Public Health
MCHB	Maternal and Child Health Bureau
MEPS	Medical Expenditure Panel Survey, AHRQ
MHFA	Mental Health First Aid
MHRT	Mental Health Resource Team
MSTEPP	Mohave Substance Treatment Education and Prevention Partnership
MYC~SUP	MSTEPP Youth Coalition, Stepping Up for our Peers
NACCHO	National Association of County and City Health Officials
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCHS	National Center for Health Statistics, CDC
NCI	National Cancer Institute
NHANES	National Health and Nutrition Examination Survey, CDC/NCHS
NHIS	National Health Interview Survey, CDC/NCHS
NSCH	National Survey of Children's Health, HRSA/MCHB
OD2A	Overdose to Action
ODMAP	Overdose Mapping Application Program

ODPHP	Office of Disease Prevention and Health Promotion
OUD	Opioid Use Disorder
PDMP	Prescription Drug Monitoring Program
PHAB	Public Health Accreditation Board
SDOH	Social Determinants of Health
SMARTIE	Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable
SUD	Substance Use Disorder
WARMC	Western Arizona Regional Medical Center
WAVE/CTED	Western Arizona Vocational Education / Career and Technical Education District
YMHFA	Youth Mental Health First Aid
YRBSS	Youth Risk Behavior Surveillance System, CDC/NCCDPHP

Appendix 2 Health Visioning

To set a strong foundation for community health improvement, an important step is to develop the community vision. Visioning guides the community through a collaborative creative process that leads to unique goals and a shared community vision for a healthy future.

During the Live Well Mohave meetings and community events, Mohave County community members were invited to participate and provide input on three important health "visioning" questions:

1. *What does a healthy Mohave County mean to you?*
2. *What are the important characteristics of a healthy community for all who live, work, and play here?*
3. *What can we do together to improve community health?*

Participants had the opportunity to express their ideas creatively by either writing them on a vision board or generating a visually engaging word cloud, instead of just being confined to a traditional facilitated discussion. Moderators invited responses to these three questions via Mentimeter Poll. The following is a list of responses to all three questions.

Responses below are verbatim as written by participants.

Question #1: What does a healthy Mohave County mean to you? (n = 38)

Thriving	Access to all types of healthcare	Accessible healthcare
Affordable quality care	All ages care	Broad based care
Community	Community activity	Drugs down treatment up
Easy access to a PCP	Equitable quality service	Equitable resources
Equity for all residents	Exceptional healthcare	Holistic
Improving life for all	Inclusive	Inclusivity
Longevity	Low health issues	Mental health awareness
More providers	Outreach action	Reducing health care csost
Reduction in smoking	Resilience	Resource access
Resource utilization	Security	Stability
Strength	Support for one another	Supportive
Thriving community	Vitality	

Questions #2: What are the important characteristics of a healthy community for all who live, work, and play here? (n = 35)

Access to care	Resources	Access
Accessible	Support	Access to resources
Accessibility	Accessibility and inclusive	Accessibility to services
Active	Basic needs resources	Better quality life
Clean vibrant	Equity	Health education
Learning and changing	Local resources	Nonjudgmental
Open-minded	Opportunities	Safety
Safety and resources	Safety and stability	Support of community
Transportation	Unity	Vast resources
Well resourced		

Question #3: What can we do together to improve community health? (n = 32)

Collaborate	Educate	Educate the community
Advocate	Be available	Collaborate better
Collaboration	Communicate resources	Continued collaboration
Coordinate and collaborate	Create ride share program	Education of resources
Engage with the community	Funding	Get creative
Health van for rural area	Interagency cooperation	No wrong door
Outreach	Partnership and community	Partnership-connect
Partnerships	Sense of community	Share resources
Support	Work together	

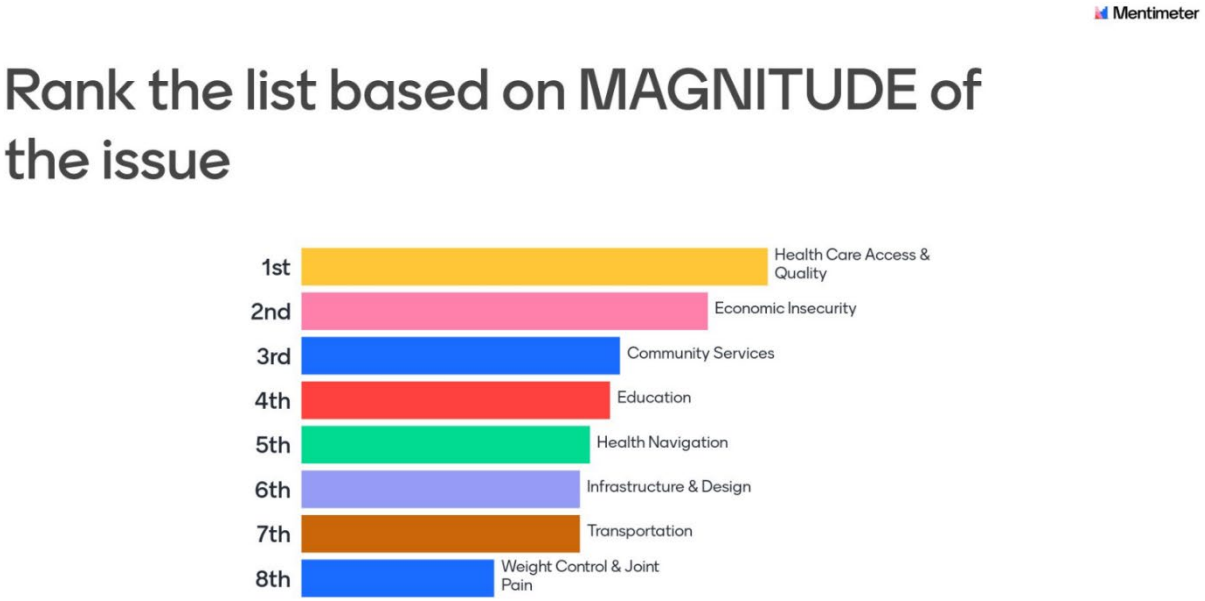
Appendix 3 Prioritization

As part of continuously improving the community, community stakeholders engaged in a shared process to distinguish the most pressing community health needs and assets based on the data collected during the Community Health Needs Assessment (CHNA). After discussing their shared vision and values for a healthy Mohave County, the kickoff participants reviewed the key findings from the CHNA. Moderators invited responses to rank each of the top nine health areas identified through the CHNA via Mentimeter Poll. The following is a list of responses.

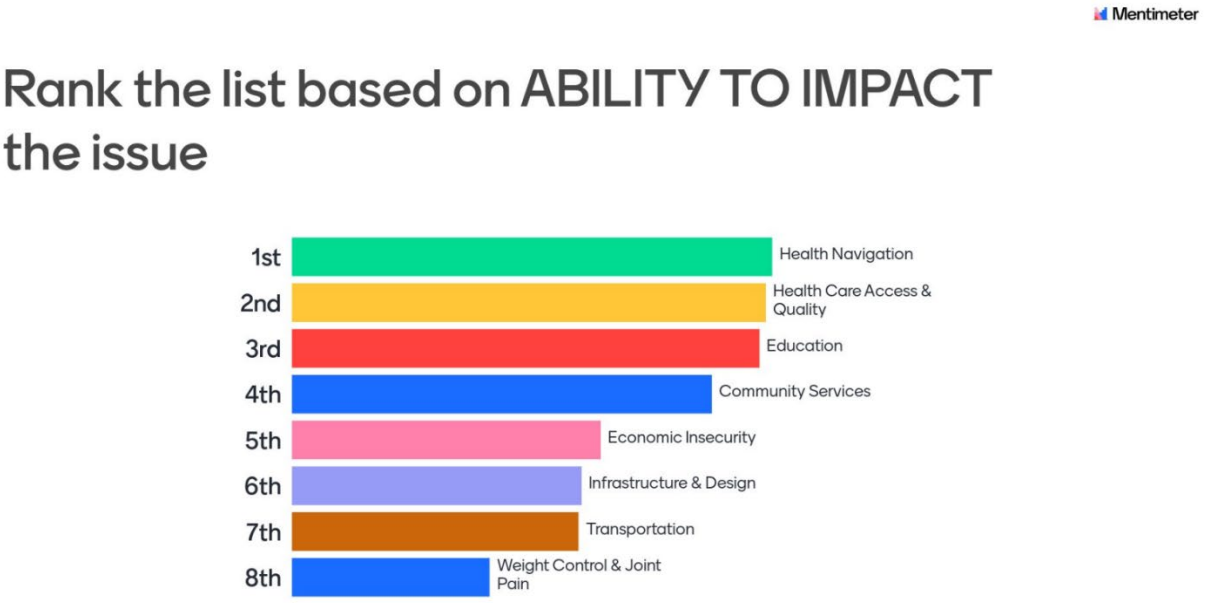
Participants were asked to consider the following prioritization criteria and prompts:

1. **Magnitude of the Issue**
    a. *How many people in the community are or will be impacted?*
    b. *How does the identified need impact health, quality of life, and the conditions in which we live, work, and play?*
    c. *Has the need worsened over time?*
    d. *Are there differences in how the issue is experienced between different communities?*
2. **Ability to Impact**
    a. *Can actionable and measurable goals be defined to address the health need?*
    b. *Are those goals achievable in a reasonable time frame?*
    c. *Does the Live Well Mohave initiative and its partners have the expertise or resources to address the identified health need?*
    d. *Are organizations already addressing the health issue?*

Question #1: Rank the list based on MAGNITUDE of the issue (n = 38)



Question #2: Rank the list based on ABILITY TO IMPACT the issue (n = 27)



Appendix 4 County-wide CHIP Work Groups

There are two CHIP work groups that cover all of Mohave County: Mohave Substance Treatment Education & Prevention Partnership (MSTEPP) and Mental Health Resource Team (MHRT). The following information was provided by each of the groups.

Mohave Substance Treatment Education & Prevention Partnership (MSTEPP)

MSTEPP was established in 2007 to unite citizens throughout Mohave County in finding solutions to the substance use disorders epidemic pervasive throughout our communities. MSTEPP's mission is to work with organizations and individuals throughout Mohave County who endeavor to decrease substance use disorders in our communities and improve treatment options and outcomes for our citizens.

MSTEPP is a community coalition focused on addressing substance use disorders and on the statewide strategies that were created to combat the opioid epidemic.

1) Enhance assessment and referral to treatment.
2) Promote responsible prescribing and dispensing policies and practices.
3) Enhance prescription drug practice and policies in law enforcement.
4) Increase public awareness and patient education about prescription drug misuse.
5) Provide substance use prevention education in public schools and throughout our communities.

MSTEPP Success Stories

1. MSTEPP has become the networking hub for addressing substance use in Mohave County with membership that includes treatment facilities, peer support, behavioral health, courts and law enforcement. Membership has grown to over 100 individuals and organizations.
2. Achieved 100% participation in the Prescription Drug Monitoring Program (PDMP).
3. Mohave County needs to keep the pressure on opioid prevention efforts because Mohave County ranks #1 in opioid overdose deaths in Arizona. (Source: ADHS Dashboard, Jan 2025)
4. Achieved county-wide drug drop boxes in all law enforcement agencies in the county and have destroyed thousands of pounds of unused or expired medications.
5. Kingman Police Department was the first law enforcement agency to train and equip officers with Naloxone.
6. Entered an Inter-Governmental Agreement with Arizona Youth Partnership to serve as the Kingman Naloxone distribution center.
7. Kingman was the first rural community in Arizona to implement a harm reduction program.
8. Kingman was the first community in Arizona to pilot the Overdose Mapping Application Program (ODMAP). It has now expanded to 54 communities with over 8,400 entries.
9. Developed the Mohave County Overdose Fatality Review Team.
10. Developed an early intervention program in partnership with the Kingman Justice Court to address first time or low-level offenders in the Quality of Life Court. There are 37 graduates with zero recidivism and 8 of the graduates are working as Peer Support Specialists in the area
11. Placed a caseworker in the Mohave County Jail to help identify Substance Use Disorder (SUD) and Opioid Use Disorder (OUD) inmates for referral for treatment.

12. Assists in planning and facilitating the Annual Walk Away from Drugs event in October. This event has been the largest and longest lasting drug prevention event in Arizona over the past 18 years
13. Received national recognition from organizations such as Community Anti-Drug Coalitions of America (CADCA), U.S. Department of Justice (DOJ), Bureau of Justice Assistance (BJA), highlighting the success of our coalitions and programs that have been implemented.
14. Provides information/prevention education throughout the county through facilitating resource fairs and prevention curriculum in schools.
15. The Mohave Area General Narcotics Enforcement Team (MAGNET) Task Force was the first in the state to implement the Leave it Behind program.
16. MSTEPP is now in charge of the Mohave County Street Team, which brings free healthcare resources and education to rural areas once a month.

MSTEPP efforts have also resulted in the formation of the following subgroup:

- **MYC~SUP**

  High School students are invited to join in MSTEPP's mission in making positive changes in our community! The MSTEPP Youth Coalition, Stepping Up for our Peers is a youth led, adult guided club that will promote healthy habits, peer mentoring, and advocacy for change regarding substance use and mental health in our community. High schoolers will have the opportunity to learn about coalition work, gain leadership and advocacy skills, organize and participate in community events and focus groups. A Parent/Guardian Participation Permission Form is available on the MSTEPP website.

If you would like more information on how you can help MSTEPP promote a healthy, drug free community, check out their website https://mstepp.org/

Mental Health Resources Team (MHRT)

The MHRT (Mental Health Resource Team) is a coalition of local stakeholders to address community need for mental health resources. Formed in 2013, MHRT has grown steadily from about 15 members to over 130 county-wide agency representatives and community members in 2025.

MHRT meets monthly on the third Thursday of the month. Co-chairs from the community facilitate the group. Coalition members continue to focus on a variety of initiatives to meet mental health resource needs throughout Mohave County. Some past accomplishments include developing a community resource guide, offering Mental Health First Aid (MHFA) training to community stakeholders, providing education and community outreach to reduce mental health stigma, and aligning activities to reduce duplication of effort among pertinent organizations providing types of mental health services.

MHRT efforts have also resulted in the formation of the following subgroups:

- **Loved Ones Stolen by Suicide (L.O.S.S.)**

  Two MHRT members created LOSS, a peer run weekly grief support group for individuals and families who have experienced a loss to suicide. The group meets weekly to provide a supportive environment where survivors of suicide can share experiences, emotions, questions, and coping mechanisms. The group gives survivors the opportunity to create connections within the community where they can move through the different stages of grief together.

- **"Futures Without Fear" — Mohave County Human Trafficking/Domestic Violence Coalition**

  Several county-wide public and agency members created the Domestic Violence/Human Trafficking Coalition 'Futures without Fear.' The mission of the coalition is to "Create a community environment of safety against human trafficking and domestic violence with collaborative services for survivors." Its vision is to: "Engage, educate and empower communities to change social conditions that enable domestic violence, sexual violence assault, and human trafficking by raising community awareness, educating citizens, coordinating comprehensive victim's services and empowering survivors."

If you would like more information on how you can help MHRT improve the mental health and wellbeing of Mohave County residents, please follow them on https://www.facebook.com/p/Mohave-County-Mental-Health-Resource-Team-MHRT-100083385938119/

Appendix 5 Healthy People 2030 Objectives and Data Sources

The U.S. Department of Health and Human Services (DHHS) Office of Disease Prevention and Health Promotion (ODPHP) Healthy People initiative sets national goals and measurable objectives every decade to steer evidence-based policies, programs, and actions aimed at improving health and well-being. **Healthy People 2030** represents the fifth and current phase of the Healthy People initiative, building upon four decades of experience. It emphasizes health equity, the social determinants of health, and health literacy, with a new emphasis on overall well-being.

The following suggested performance measures may be used to determine progress of CHIPs in future CHNA/CHIP cycles. Core objectives have valid, reliable, nationally representative data. Data sources are listed below. Objectives have been collapsed across CHIPs. When we work together to achieve them, we can improve health and well-being not only in Mohave County, but also nationwide.



Alignment to Health People 2030 Objectives	Data Indicators	Data Source
Reduce the proportion of adolescents and young adults who aren't in school or working — AH-09	Percent of teens and young adults ages 16-19 who are neither working nor in school.	*U.S. Census Bureau, American Community Survey (ACS), 1-, 5-year estimates*
Increase the proportion of people with health insurance — AHS-01	Percent of persons under 65 years had medical insurance	*U.S. Department of Health and Human Services (DHHS) Office of Disease Prevention and Health Promotion (ODPHP), Centers for Disease Control and Prevention / National Center for Health Statistics (CDC/NCHS) National Health Interview Survey (NHIS)*
Reduce the proportion of people who can't get medical care when they need it — AHS-04	Percent of persons were unable to obtain or delayed in obtaining necessary medical care due to cost.	*DHHS ODPHP, CDC/NCHS NHIS*
Reduce the proportion of people who can't get prescription medicines when they need them — AHS-06	Percent of persons were unable to obtain or delayed in obtaining necessary prescription medicines due to cost	*DHHS ODPHP, CDC/NCHS NHIS*
Increase the proportion of people with a usual primary care provider — AHS-07	Percent of persons had a usual primary care provider.	*DHHS ODPHP, Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS)*

Increase the proportion of adults who get recommended evidence-based preventive health care — AHS-08	Percent of adults aged 35 years and over received all of the recommended high priority appropriate clinical preventive services.	*DHHS ODPHP, AHRQ MEPS*
Increase the proportion of adults whose health care provider checked their understanding — HC/HIT-01	Percent of adults aged 18 years and over reported that a health care provider asked them to describe how they will follow instructions	*DHHS ODPHP, AHRQ MEPS*
Decrease the proportion of adults who report poor communication with their health care provider — HC/HIT-02	Percent of adults aged 18 years and over reported poor provider communication	*DHHS ODPHP, AHRQ MEPS*
Increase the proportion of adults whose health care providers involved them in decisions as much as they wanted — HC/HIT-03	Percent of adults aged 18 years and over reported that their health care providers always involved them in decisions about their health care as much as they wanted	*DHHS ODPHP, National Institutes of Health / National Cancer Institute (NIH/NCI) Health Information National Trends Survey (HINTS)*
Increase the proportion of children and adolescents with communication disorders who have seen a specialist in the past year — HOSCD-05	Percent of children and adolescents aged 3 to 17 years with communication disorders of voice, speech, or language saw a health care specialist for evaluation or treatment in the past 12 months	*DHHS ODPHP, CDC/NCHS NHIS*
Increase the proportion of children with mental health problems who get treatment — MHMD-03	Percent of children aged 4 to 17 years with mental health problems received treatment	*DHHS ODPHP, CDC/NCHS NHIS*
Increase the proportion of children who receive a developmental screening — MICH-17	Percent of children aged 9 through 35 months were screened for autism spectrum disorder (ASD) and other developmental delays in the past 12 months	*DHHS ODPHP, Health Resources and Services Administration/ Maternal and Child Health Bureau (HRSA/MCHB) National Survey of Children's Health (NSCH)*
Increase the proportion of children and adolescents with special health care needs who have a system of care — MICH-20	Percent of children and adolescents under 18 years with special health care needs received care in a family-centered, comprehensive, and coordinated system.	*DHHS ODPHP, HRSA/MCHB NSCH*

Reduce household food insecurity and hunger — NWS-01	Percent of households were food insecure	*DHHS ODPHP, U.S. Census Bureau and U.S. Department of Agriculture / Economic Research Service (USDA/ERS) Current Population Survey Food Security Supplement (CPS-FSS)*
Reduce the proportion of adults with obesity — NWS-03	Percentage of the adult population (age 18 and older) that reports a body mass index (BMI) greater than or equal to 30	*DHHS ODPHP, CDC Behavior Risk Factor Surveillance System (BRFSS)*
Reduce the proportion of children and adolescents with obesity — NWS-04	Percent of children and adolescents aged 2 to 19 years had obesity	*DHHS ODPHP, CDC/NCHS National Health and Nutrition Examination Survey (NHANES)*
Increase fruit consumption by people aged 2 years and over — NWS-06	Cup equivalents of fruits per 1,000 calories was the mean daily intake by persons aged 2 years and over	*DHHS ODPHP, CDC/NCHS NHANES*
Increase vegetable consumption by people aged 2 years and older — NWS-07	Cup equivalents of total vegetables per 1,000 calories was the mean daily intake by persons aged 2 years and over	*DHHS ODPHP, CDC/NCHS NHANES*
Increase the proportion of older adults with physical or cognitive health problems who get physical activity — OA-01	Percent of adults aged 65 years and over with reduced physical or cognitive function engaged in light, moderate, or vigorous leisure-time physical activities	*DHHS ODPHP, CDC/NCHS NHIS*
Reduce the proportion of adults who do no physical activity in their free time — PA-01	Percent of adults aged 18 years and over engaged in no leisure-time physical activity	*DHHS ODPHP, CDC/NCHS NHIS*
Increase the proportion of adults who do enough aerobic and muscle-strengthening activity — PA-05	Percent of adults aged 18 years and over met the guidelines for aerobic physical activity and muscle-strengthening activity during their leisure time	*DHHS ODPHP, CDC/NCHS NHIS*
Increase the proportion of adolescents who do enough aerobic and muscle-strengthening activity — PA-08	Percent of students in grades 9 through 12 were physically active for at least 60 minutes on all 7 days of the past week and participated in muscle-strengthening activity on 3 or more days of the past week	*DHHS ODPHP, Centers for Disease Control and Prevention/ National Center for Chronic Disease Prevention and Health Promotion (CDC/NCCDPHP) Youth Risk Behavior Surveillance System (YRBSS)*
Increase the proportion of children and adolescents who play sports — PA-12	Percent of children and adolescents aged 6 to 17 years participated in a sports	*DHHS ODPHP, HRSA/MCHB NSCH*

	team or took sports lessons after school or on weekends in the past 12 months	
Increase employment in working-age people — SDOH-02	Percent of population 16 years and over in labor force.	*Census, ACS, 1-, 5-year estimates*

REFERENCES

Arizona Department of Health Services. (2024). *Opioids Prevention. Dashboards - Opioid Overdose Deaths*. Retrieved from https://www.azdhs.gov/opioid/dashboards/index.php

Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry. (2024). *Principles of Community Engagement*. Retrieved from https://www.atsdr.cdc.gov/community-engagement/php/executive-summary/index.html

Gunn CM, Sprague Martinez LS, Battaglia TA, Lobb R, Chassler D, Hakim D, Drainoni ML. (2022). *Integrating community engagement with implementation science to advance the measurement of translational science*. J Clin Transl Sci. 6(1):e107.

National Association of County and City Health Officials. (2023). *A Guide to Aligning Healthy People 2030 and MAPP 2.0*. Retrieved from https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

National Association of County and City Health Officials. (2023). *MAPP Related Toolkit*. Retrieved from https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

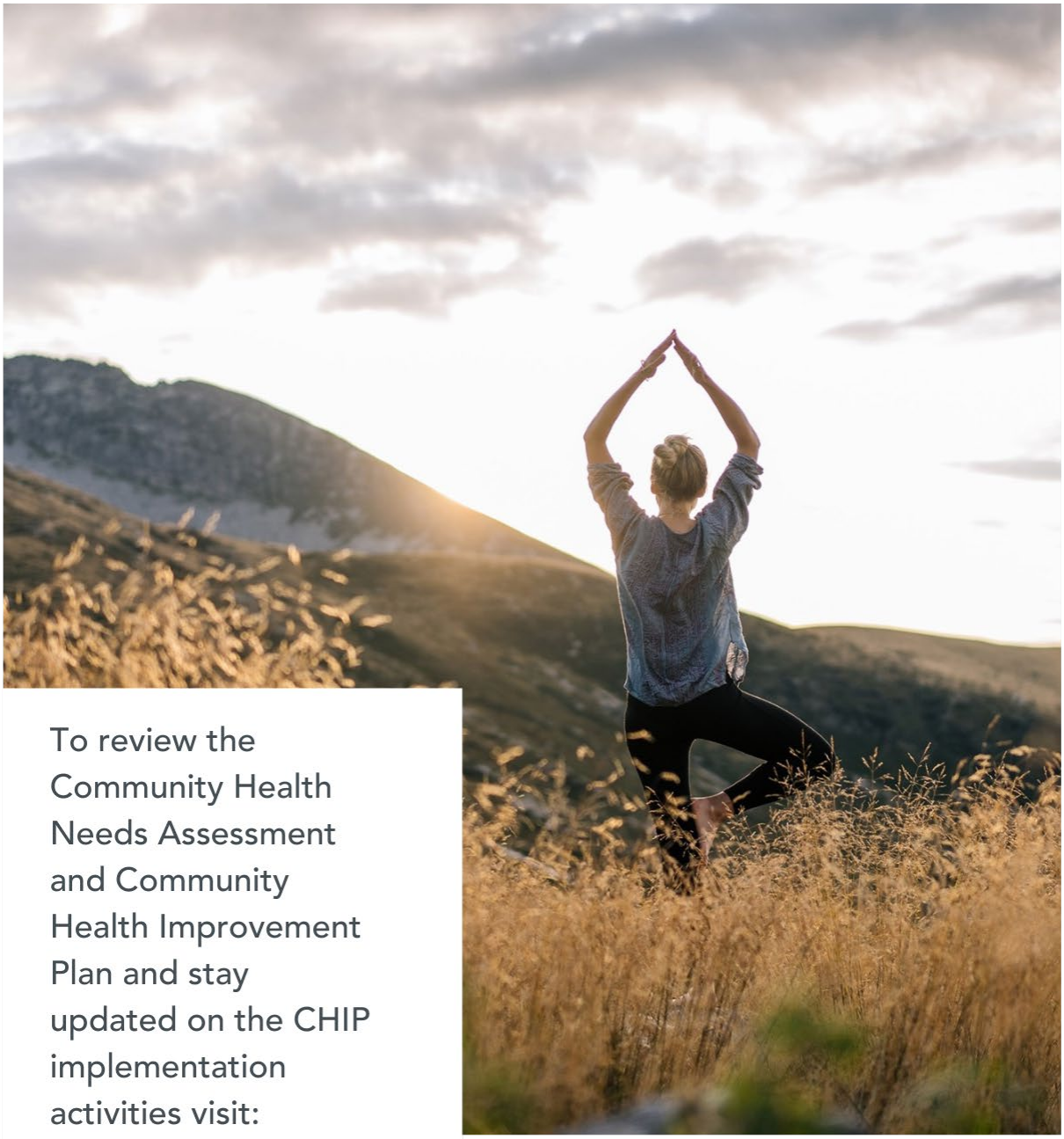
U.S. Census Bureau, U.S. Department of Commerce. (2023). ACS Demographic and Housing Estimates. *American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP05. Retrieved from* https://data.census.gov/

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (2021). *Healthy People 2030*. Retrieved from https://odphp.health.gov/healthypeople

Live Well Mohave

Mohave County Department of Public Health
Count On Us.

KRMC KINGMAN REGIONAL MEDICAL CENTER



To review the Community Health Needs Assessment and Community Health Improvement Plan and stay updated on the CHIP implementation activities visit:

https://www.mohave.gov

http://www.azkrmc.com