COMMUNITY HEALTH IMPROVEMENT PLAN 2025-2029

Geary County, KS

The Geary County CHIP provides a shared framework for collective action to improve health outcomes, reduce barriers, and strengthen quality of life for residents.

Abstract

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Executive Summary

Overview

The Geary County Community Health Improvement Plan (CHIP) 2025–2029 is a community-driven roadmap designed to improve health outcomes, advance equity, and strengthen systems that support the well-being of all residents. Developed through cross-sector collaboration and informed by local data and community input, this CHIP aligns with Kansas Department of Health and Environment (KDHE) guidance and Public Health Accreditation Board (PHAB) standards and is intended for public posting, partner engagement, and accreditation purposes.

The CHIP focuses on addressing social determinants of health (SDOH), increasing access to services, and building sustainable community systems. Implementation will occur through shared leadership among public health, healthcare, education, local government, and community-based partners.

Community Context

Geary County is a diverse community that includes rural residents, military-connected families, veterans, older adults, youth, and low-income households. Community health outcomes are shaped by factors such as transportation access, food security, mental health availability, youth development opportunities, and the ability to navigate complex service systems.

The 2024 Community Health Needs Assessment (CHNA) findings and partner input highlighted key challenges, including:

- Food insecurity rates above desired benchmarks
- Transportation barriers limiting access to healthcare, employment, and food
- Gaps in mental health access and provider capacity
- Limited awareness of and ability to navigate available community resources
- Need for expanded youth development and family engagement opportunities

Priority Areas and Goals

Priority 1: Access to Resources
Goal: Improve awareness, navigation, and equitable access to community resources so residents can find and use health, social, and economic supports.

Strategies include standardizing referral processes, promoting centralized resource platforms, expanding one-to-one navigation support, and reducing administrative barriers across systems.

Priority 2: Youth Character Development

Goal: To empower youth to tap into their full potential across a variety of fields by providing meaningful opportunities for learning, leadership, and personal growth.

Strategies include strengthening the social, emotional, and leadership development skills of young people across our community. To support this mission, the community will host quarterly educational workshops open to all community youth. These events will feature a variety of engaging and practical

topics, including Stop the Bleed, cooking safety, community gardening, and leadership skill building. Each session is designed to empower youth with knowledge, confidence, and hands on experiences that support their overall growth and success.

Priority 3: Transportation Access
Goal: Improve reliable, affordable, and accessible transportation options for all residents, particularly underserved populations.

Strategies include transportation training and navigation support, development of “How to Ride” resources, infrastructure improvements, targeted marketing and outreach, and long-term systems planning to support equitable transportation access.

Priority 4: Obesity, Nutrition, and Physical Activity
Goal: Reduce food insecurity, improve nutrition knowledge, and increase physical activity among residents.

Strategies include expanding nutrition education, increasing Healthy Food Prescriptions, promoting healthy food access points, and hosting regular low-cost physical activity opportunities throughout the community.

Priority 5: Mental Health
Goal: Improve access to mental health services, strengthen provider support, and increase training and awareness to reduce stigma.

Strategies include sustaining the Mental Health Task Force, improving resource awareness and crisis response education, increasing community outreach, and expanding training opportunities for providers and community members.

Implementation and Evaluation

Implementation of the CHIP will be led through community workgroups and coalitions, with shared responsibility among partner organizations. Progress will be monitored annually using defined performance measures for each priority area, including participation data, service utilization, infrastructure milestones, and community feedback.

Annual progress updates will be publicly shared and used to guide continuous improvement and mid-course adjustments.

Community Engagement and Partnerships

Community engagement was foundational to CHIP development and will remain central throughout implementation. Partners from healthcare, education, local government, public safety, social services, and community-based organizations contributed to assessment, priority setting, and action planning.

Ongoing engagement will occur through workgroups, task forces, and coordination meetings to ensure transparency, shared accountability, and responsiveness to emerging needs.

Moving Forward

The Geary County CHIP represents a collective commitment to improving health and quality of life through collaboration, equity, and data-informed action. By working together across sectors and

engaging residents throughout implementation, Geary County is positioned to make meaningful, sustainable improvements that benefit the entire community.

For more information or to get involved, community members and partners are encouraged to contact Live Well Geary County.

Introduction

Community Vision

Geary County is a healthy, connected, and resilient community where all residents—regardless of income, age, ability, or location—have equitable access to services, opportunities, and environments that support physical, mental, and social well-being.

Community Health Assessment & Data Summary

County Profile

Geary County is a diverse community that includes rural residents, military-connected families, veterans, older adults, and low-income households. Social determinants of health—including transportation access, food security, mental health availability, youth development opportunities, and resource navigation—significantly influence health outcomes in the county. Geary County is a diverse community with demographic characteristics and geographic conditions that shape health outcomes and access to essential resources. Understanding the county's population composition and patterns of food access supports effective Community Health Improvement Planning (CHIP) and helps guide equitable implementation strategies.

Geary County's racial and ethnic makeup reflects greater diversity than many Kansas counties. Approximately 69.8% of residents identify as White alone, while 17.4% identify as Black or African American alone. An additional 6.6% identify as Two or More Races, and 3.5% identify as Asian alone. Ethnically, 18.6% of the population identifies as Hispanic or Latino (of any race). It is important to note that Hispanic/Latino is an ethnicity rather than a racial category, and individuals identifying as Hispanic/Latino may be represented across all racial groups.

Age distribution also informs health services and prevention planning. Approximately 23.1% of Geary County's population is under age 18, while 12.2% is age 65 or older. Based on these figures, the working-age population (ages 18–64) represents approximately 64.7% of county residents. This age profile suggests a need to balance strategies that support children and families, while also maintaining appropriate services and supports for older adults.

Food access is not uniform across the county and varies meaningfully by geography and household circumstances. In general, food retail options and services are most concentrated in the Junction City area, where residents are more likely to have shorter travel distances to grocery stores and greater availability of food outlets. In contrast, residents living outside the city core—including rural areas and communities further from major retail centers—may face longer travel distances to full-service grocery stores. Even in areas where grocery stores are present, barriers such as limited transportation, lack of vehicle access, and financial constraints can reduce practical access to healthy and affordable food.

Food deserts and food access designations are commonly assessed using the USDA Food Access Research Atlas, which identifies low-access conditions at the census-tract level using indicators such as distance to supermarkets and low-income status, with different thresholds applied to urban and rural areas. These measures help communities identify areas where access may be constrained and where

targeted strategies may have the greatest impact. Geary County has several food desert areas, urban areas where 1/3 of residents live more than 1 mile away from a grocery store and rural areas where 1/3 of residents live more than 10 miles from a grocery store.

Equitable CHIP approaches should incorporate strategies that address both structural and household-level barriers to nutrition and food security. Evidence-informed options include mobile food distribution and pop-up markets, transportation supports such as delivery partnerships or ride access, and expanded outreach and enrollment support for SNAP and WIC benefits. Cross-sector coordination—including partnerships with schools, healthcare organizations, nonprofits, and community anchor institutions—can strengthen the reach and sustainability of these strategies. Attention to culturally responsive outreach, language access when needed, and trust-building efforts will further support equitable participation and improved outcomes across diverse population groups.

Population health and well-being is something we create as a society, not something an individual can attain in a clinic or be responsible for alone. Health is more than being free from disease and pain; health is the ability to thrive. Well-being covers both quality of life and the ability of people and communities to contribute to the world. Population health involves optimal physical, mental, spiritual, and social well-being. Geary County is faring worse than the average county in Kansas for Population Health and Well-being, and about the same as the average county in the nation.

Key Health Indicators and Data Highlights

- Food Insecurity: In 2025, food insecurity in Geary County was estimated at 17.4%, compared with a desired benchmark of below 17%.
- Physical Activity: Community partners identified a need to increase the percentage of adults meeting the recommended guideline of 150 minutes/week.
- Transportation: Lack of reliable transportation impacts access to healthcare, food, employment, and essential services—particularly for older adults, rural residents, and people with disabilities.
- Mental Health: Provider capacity, access barriers, and stigma limit timely care—especially for rural residents and veterans.
- Youth Development: Partners identified a need to strengthen youth resilience, leadership, responsibility, and social-emotional skills.

Assessment Methods

Data and priorities were informed by:

- Topic-specific community workgroups and partner meetings
- Task force and coalition input
- Local program utilization and partner-reported needs
- County/state indicator sources and publicly available datasets

Community Engagement & Partnerships

Community Engagement Approach

Community engagement was central to the development of this CHIP. Geary County utilized a collaborative, cross-sector approach to ensure priorities reflect lived experience, provider expertise, and community needs.

Engagement strategies included:

- Regular meetings of topic-specific workgroups
- Cross-sector task forces (including the Mental Health Task Force)
- Input from healthcare providers, schools, local government, service agencies, and community-based organizations
- Ongoing dialogue with partners serving priority populations

Key Partnerships

Implementation relies on partnerships across sectors, including:

- Geary County Health Department
- City of Junction City
- Stormont Vail Health / Stormont Vail Health Flint Hills Campus (SVHFC)
- Konza Prairie Community Health Center
- Pawnee Mental Health
- Live Well Geary County
- USD 475 — Geary County Schools
- Fort Riley and veteran-serving organizations
- Geary County Sheriff's Department
- Emergency services, courts, and community-based organizations

Ongoing Partner Engagement

Partners will remain engaged through:

- Workgroups and quarterly coordination meetings
- Shared leadership of action plan activities
- Data sharing and performance monitoring
- Public reporting of progress and outcomes

Community Health Needs Assessment

A Community Health Needs Assessment (CHNA) is a key tool used to understand and improve the health of a community. It provides an overview of community health status by identifying priority needs, existing strengths, and opportunities for action. A CHNA includes comprehensive information on health risks, outcomes, and contributing factors, gathered through the systematic collection and analysis of data as well as input from community leaders and residents. The process for collecting and reviewing this information is guided by a multidisciplinary Steering Committee.

The 2024 Geary County CHNA Steering Committee included leaders from Stormont Vail Health, Live Well Geary County coalition, USD 475, Konza Prairie Community Health Center, and Pawnee Mental Health. This group collaborated to identify health disparities that impact Geary County residents and to assess community resources that can help address these challenges. The goal of this work is to strengthen community health outcomes and advance health equity. The CHNA reflects the perspectives of individuals across the community and provides a foundation for informed decision-making and meaningful change.

The CHNA included:

- 601 Perception Survey responses providing feedback on access to care, preventive care, social determinants of health, income, and demographics
- Eight Roundtables with under-represented voices that included 65 residents providing feedback on community strengths, quality of care, concerns, underlying reasons for poor health, and suggested improvements
- Data analysis, including review of recently released County Health Rankings
- Town Hall event including 75 stakeholders representing over 40 organizations to review all of the Survey and Roundtable results and County Health Ranking data. The event concluded with a prioritization exercise.

Findings from the CHNA directly inform the development of the Community Health Improvement Plan (CHIP). Together, the CHNA and CHIP support a coordinated approach to improving community health by prioritizing strategies, informing residents, guiding policy and systems change, promoting equity, and identifying resources needed to improve health outcomes in Geary County.

The CHNA Steering Team meets regularly to review new and updated data sources, ensuring planning efforts remain responsive to emerging needs and changing conditions. The CHNA will continue to be conducted and released on a three-year cycle to maintain current data for prioritizing and evaluating CHIP strategies. Based on the assessment, the Steering Committee identified five priority areas for action. Additional CHNA information is available through Stormont Vail Health's Community Health Planning webpage.

Summary of Common Themes

By engaging with a wide range of community voices and leveraging the strengths of various organizations, the CHNA Steering Committee was able to develop a comprehensive and inclusive survey assessment of Geary County's health needs. Common themes from participant input included:

Top major/moderate concerns combined	# of responses
1 Adult Obesity	155
2 Up-to-date information on available community services	146
3 Mental Health	144
4 Safe, Affordable, Accessible Housing	140
5 Financial Assistance (Medical)	135
6 Treatment of Chronic Conditions	125
7 Youth development/ character building programs	122
8 Food Assistance	119
9 Disaster response (including shelter)	119
10 Financial Assistance (housing/ utility)	114

Using results from the prioritization process, five issues consistently emerged as top community priorities for the Geary County Community Health Improvement Plan (CHIP). The CHIP Steering Committee consolidated these priorities into five focus areas:

1. Access to Resources
2. Youth Character Development
3. Transportation
4. Obesity (Health & Wellness)
5. Mental Health

Community Health Improvement Plan (CHIP)

Workgroups for each CHIP priority area were formed with strong community representation, bringing together community organizations, public partners, and other key stakeholders who share a commitment to improving health in Geary County. This CHIP is designed to strengthen community capacity by reducing barriers to working together, improving communication across partners, and supporting coordinated action. By building on the work already happening in the community, Geary County partners aim to expand sustainability and create long-term impact through shared CHIP strategies.

The CHIP Steering Committee led and supported these workgroups in developing goals for each priority area to ensure the CHIP reflects what matters most to the people who live and work in Geary County. Workgroups drafted objectives grounded in local strengths, needs, and current efforts, and these objectives were refined through ongoing collaboration with partnering organizations. Outcome targets were then established by reviewing available local and regional trends over time to set realistic and measurable expectations for progress during the CHIP timeframe.

To strengthen alignment and accountability, the Steering Committee also considered national benchmarks such as Healthy People 2030 and its focus on the Social Determinants of Health—including economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Healthy People 2030 emphasizes the importance of creating conditions where everyone can thrive, including the goal to “Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.” In

line with this vision, the Geary County CHIP recognizes that factors often outside of health care—play a powerful role in improving health and reducing disparities. Because Healthy People 2030 is built around a 10-year target and the Geary County CHIP covers a 4-year timeframe, timelines and expected improvements were adjusted to match the local planning period.

Once priority areas, goals, and objectives were finalized, partner organizations and workgroups collaborated with the Steering Committee to identify interventions and activities to support meaningful progress. The strategies included in this CHIP address both upstream and midstream factors that influence health outcomes by focusing on systems-level improvements, policy opportunities, and community conditions that make healthier choices more accessible. The CHIP also includes approaches that respond to immediate social needs while strengthening the broader environments where residents live, learn, work, and access care. Interventions will continue to evolve throughout implementation to reflect changing community conditions and new opportunities. Throughout the CHIP's development, the Steering Committee prioritized community voice, data-informed decision-making, alignment with evidence-based practices, and the capacity of local partners to carry out strategies that support lasting improvements in health and well-being.

Priority Area 1: Access to Resources

Lead Partners

Dorothy Bramlage Public Library, Konza Prairie Community Health Center, Stormont Vail Health, United Way

Vision

All Geary County residents have equitable access to the health, social, and economic resources they need to thrive.

Goal 1

Improve awareness, navigation, and equitable access to community resources so residents can find, understand, and use health, social, and economic supports.

Priority Populations

- Low-income households
- Veterans and military-connected families
- Older adults
- Individuals with disabilities
- Rural residents

Objective 1.1 — Improve Resource Awareness

By December 2027, increase awareness of available community resources by 30% among residents interacting with partner organizations.

Strategies

- Standardize referral and resource-sharing processes across partners
- Promote use of KNOW JC and other centralized resource platforms
- Develop plain-language, culturally responsive resource materials

Measures

- Resource referrals made (tracked)
- KNOW JC usage metrics (if available)
- Resident awareness surveys (short partner-site survey)

Objective 1.2 — Strengthen Navigation Support

By December 2027, expand one-to-one navigation support across partner sites.

Strategies

- Train frontline staff in resource navigation
- Offer scheduled navigation hours at community locations
- Integrate navigation support with transportation and mental health efforts

Measures

- Navigation encounters
- Successful connections to services
- Client satisfaction feedback

Objective 1.3 — Reduce System Barriers

By December 2029, reduce administrative and access barriers through coordinated systems improvements.

Strategies

- Identify common eligibility and paperwork barriers
- Advocate for simplified processes where possible
- Align intake and referral practices across agencies

Measures

- Documented barrier reductions
- Partner-reported improvements

Action Plan			
Priority 1: Access to Resources (2025–2029)			
Action	**Lead Partners (examples)**	**Timeline**	**Performance Measures**
Standardize referral workflows and resource sharing	DBPL + partner network	2025–2026	# partners using workflow; referrals tracked
Promote KNOW JC and verify listings	DBPL + partners	Ongoing	Listing verification; usage metrics
Train frontline staff in navigation support	Partner organizations	2026–2027	# staff trained; navigation encounters

Offer scheduled navigation hours	Partners (rotating sites)	2026–2029	# sessions; successful connections

Logic Model & Timeline

Inputs: Partners, resource platforms (KNOW JC), staff time, training materials

Activities: Standardize referrals, navigation hours, staff training, public resource materials

Outputs:

- Staff trained
- Navigation encounters
- Referral tracking
- Updated resource listings

Short-Term Outcomes: Increased awareness; improved successful connections to services

Long-Term Outcomes: Reduced inequities; improved access to care and supports

Timeline:
2025–2026 standardization + materials; 2026–2027 training + navigation scale-up; 2028–2029 barrier reduction and sustainability.

Priority Area 2: Youth Character Development

Lead Partners

Stormont Vail Health, USD 475, I.C.A.R.E., Konza Prairie Community Health Center, 4-H Extension, youth-serving nonprofits, Fort Riley, Junction City Main Street, and The Harmony Center

Vision

Geary County youth are supported through inclusive opportunities that build resilience, leadership, responsibility, and lifelong success.

Goal 2

Strengthen the social, emotional, and leadership development of Geary County youth.

Objective 2.1 — Increase Youth Participation

By December 2029, increase participation in youth development and mentoring programs by 40%.

Strategies

- Expand evidence-based youth development programs (e.g., Boys & Girls Club, 4-H, JAG, YMCA)
- Implement character education initiatives in schools
- Launch a Youth Advisory Council to elevate youth voice in county planning
- Support after-school and summer enrichment opportunities

Measures

- Enrollment increases in youth development programs
- Positive youth behavior indicators (attendance, engagement, self-reported skills)
- Youth Advisory Council participation and policy recommendations

Objective 2.2 — Strengthen Family and Caregiver Engagement

By December 2029, improve parent and caregiver engagement in youth development efforts.

Strategies

- Offer workshops on positive parenting and adolescent development
- Promote family-friendly community events
- Develop culturally inclusive family support resources

Measures

- Number of families completing workshops
- Caregiver-reported confidence and skills
- Growth in family engagement at school and community events

Action Plan			
Priority 2: Youth Character Development (2025–2029)			
Action	**Lead Partners (examples)**	**Timeline**	**Performance Measures**
Expand mentoring and youth development programs	USD 475, 4-H, nonprofits, SVH	2026–2029	Program enrollment; attendance
Implement character education initiatives	Schools + youth partners	2026–2029	Adoption status; participation
Launch Youth Advisory Council	County + schools	2026	Council formed; recommendations issued
Deliver parenting/caregiver workshops	SVHFC, KPCHC, partners	Annual	# families completing; confidence gains

Logic Model & Timeline

Inputs: Schools, youth organizations, mentors, families, facilities

Activities:

- Mentoring and enrichment programs
- Character education initiatives
- Youth Advisory Council development
- Parenting and caregiver workshops
- Quarterly youth workshops (e.g., Stop the Bleed, cooking safety, community gardening, leadership skill-building)

Outputs:

- Enrollment growth in youth programs
- Workshops delivered
- Youth council actions and recommendations

Short-Term Outcomes: Improved youth skills; stronger caregiver engagement

Long-Term Outcomes: Increased resilience, leadership, and positive life outcomes

Timeline

2025 program expansion; 2026 Youth Advisory Council launch; 2027–2029 scaling and evaluation.

Priority Area 3: Transportation Access

Lead Partners

Flint Hills Area Transportation Agency, Stormont Vail Health, Konza Prairie Community Health Center, Flint Hills Metropolitan Planning Organization (MPO), City of Junction City, Geary County, and Live Well Geary County

Vision

All Geary County residents have reliable, affordable, and accessible transportation to reach healthcare, food, employment, and essential services—supporting better health outcomes and stronger community connections.

Priority Populations

- Low-income residents
- Older adults
- Rural residents
- Individuals with disabilities or limited mobility
- Veterans

Goal 3.1 — Improve Access

Increase reliable, affordable, and timely transportation options for all residents, particularly underserved populations.

Objective 3.1.1 — Training and Navigation Support

By December 31, 2026, conduct transportation trainings with key partners and increase both referrals generated from trainings and one-to-one trainings for residents needing individualized support.

Strategies

- Create a county-specific “Transportation 101” training package (slides, quick reference materials, and referral workflow)
- Deliver trainings at partner sites with a brief competency check
- Offer rotating “Transportation Help Hours” at partner locations
- Implement simple referral forms (paper and digital) and track outcomes

Measures

- Trainings completed and attendees trained
- One-to-one trainings completed
- Referrals generated and percentage successfully connected
- Common barriers identified

Objective 3.1.2 — Resources and Enrollment Support

By December 31, 2026, develop and distribute “How to Ride” resources and provide paperwork/enrollment assistance.

Strategies

- Produce plain-language, large-print “How to Ride” guides
- Distribute resources through clinics, meal programs, partner organizations, and online
- Provide application/enrollment help and a document checklist for partner staff

Measures

- Guides distributed or downloads tracked
- Paperwork assistance encounters
- Riders successfully enrolled
- Resident satisfaction and confidence feedback

Goal 3.2 — Promote Health Equity

Reduce transportation barriers to healthcare, grocery stores, employment, and social services.

Objective 3.2.1 — Increase Healthcare Transportation Accessibility

Achieve key infrastructure and service milestones that improve transportation access.

Strategies

- Complete the K-18 connector (by March 2026) and align outreach for immediate use
- Conduct a bus stop accessibility assessment (ADA compliance, safety, proximity) and upgrade prioritized stops (by end of 2026)
- Complete one transportation pullout project (in 2026)
- Develop standardized ride contract templates and establish organizational ride contracts (by end of 2027)

Measures

- Connector completed (yes/no)
- Bus stop upgrades completed
- Pullouts completed
- Ride contracts signed and active
- Partner-reported reductions in missed appointments or access barriers (if available)

Objective 3.2.2 — Increase Awareness through Marketing

By December 31, 2026, increase transportation awareness through measurable marketing and outreach efforts.

Strategies

- Maintain a monthly content calendar and consistent accessible posting
- Conduct outreach at public events with live trip-planning assistance
- Ensure transportation resources are correctly listed in KNOW JC and train partner staff
- Promote SVHFC specialty services to reduce out-of-town appointments where appropriate

Measures

- Posts per month, engagement, and follower growth
- Events attended and residents reached
- KNOW JC listings verified and updated

Goal 3.3 — Sustain and Integrate Systems

Build sustainable partnerships and policies to support long-term, community-centered transportation planning.

Objective 3.3.1 — Map Priority Projects

By April 2026, identify and map priority transportation projects and update quarterly.

Objective 3.3.2 — Implement City Project Checklist

By June–December 2026, adopt a checklist to ensure roadway projects include ADA and bike/pedestrian elements.

Objective 3.3.3 — Convene Quarterly Transportation Group

Beginning in 2026, convene quarterly meetings to coordinate progress, barriers, outreach, and funding.

Action Plan			
Priority 3: Transportation Access (2025–2027)			
Action	**Lead Partners (examples)**	**Timeline**	**Performance Measures**
Deliver Transportation 101 trainings	Flint Hills ATA Bus + partners	2025–2026	# trainings; referrals generated
Offer Transportation Help Hours	Partner sites	2025–2026	# encounters; successful connections
Develop and distribute How-to-Ride guides	FHATA + partners	2025–2026	# guides distributed/downloads
Complete K-18 connector and outreach	FHATA, MPO + partners	By Mar 2026	Connector operational; outreach outputs
Bus stop upgrades + one pullout	City + FHATA	2026	# stops improved; pullout completed
Establish ride contracts	Service organizations + FHATA	By the end of 2027	# contracts active

Logic Model & Timeline

Inputs: Transportation agencies, public health, city and county partners, MPO, community-based organizations, and funding sources

Activities: Trainings, navigation support, How-to-Ride guides, infrastructure improvements, marketing and outreach

Outputs: Trainings delivered, guides distributed, stops improved, contracts signed

Short-Term Outcomes: Increased utilization; fewer access barriers

Long-Term Outcomes: Improved access to healthcare, food, employment, and reduced social isolation

Timeline
2025 trainings/guides; 2026 connector + stop improvements; 2027 ride contracts and systems integration.

Priority Area 4: Obesity, Nutrition, and Physical Activity

Lead Partners

Konza Prairie Community Health Center, Stormont Vail Health, Live Well Geary County, Geary County K-State Extension, Fort Riley Public Health, and Geary County Health Department

Vision

Partners across Geary County will work together to increase access to healthy food, expand opportunities for physical activity, and support a healthier community for everyone.

Goal 4.1 — Improve Food and Nutrition Security

Decrease food insecurity and increase nutrition security and nutrition knowledge in Geary County.

Objective 4.1.1 — Reduce Food Insecurity

By December 2029, reduce the Geary County food insecurity rate to below 17%.

Strategies

- Research the feasibility of a weekend backpack program for school-age children facing food insecurity
- Promote healthy choices where the community accesses food (food pantries, blessing boxes, food drives)
- Strengthen outreach and support for food assistance resources as appropriate

Measures

- County food insecurity rate
- Participation in local food access supports and programs

Objective 4.1.2 — Expand Healthy Food Prescriptions and Nutrition Education

By December 2029, increase Healthy Food Prescriptions to 100 annually, with a redemption rate of at least 65%, and provide quarterly low-cost nutrition education opportunities.

Strategies

- Expand Healthy Food Prescription programming through healthcare and community partners
- Increase low-cost nutrition education classes to at least quarterly
- Partner with local organizations to promote nutrition knowledge and healthy food access

Measures

- Healthy Food Prescriptions issued annually
- Prescription redemption rate
- Attendance and participation in nutrition education classes
- Participant feedback and knowledge gains (when feasible)

Goal 4.2 — Increase Physical Activity

Increase physical activity among Geary County adults so that at least 25% meet the guideline of 150 minutes of activity per week.

Objective 4.2.1 — Expand Community Physical Activity Opportunities

By December 2029, increase the number of low-cost physical activity opportunities available and promoted throughout the community, including hosting at least one quarterly activity event.

Strategies

- Increase participation of physical activity organizations at Family Fit N Fun Day (from 1 to 3 partners)
- Promote use of the 7th Street Bike Boulevard and host one annual community event
- Collaborate with healthcare organizations to develop a community walking group and other accessible programs

Measures

- Event count and participation totals
- Awareness and usage of active transportation and recreation resources
- Engagement in walking groups or partner-led activity programs

Planned Quarterly Physical Activity Events (Examples)

- **May:** LWGC Bike Boulevard Event
- **June:** Family Fit N Fun Day
- **August/September:** Farmers Market Wellness Event
- **Ongoing:** JCMS / 12th Street Community Center activity opportunities

Action Plan
Priority 4: Obesity, Nutrition, and Physical Activity (2025–2027)

Action	Lead Partners (examples)	Timeline	Performance Measures
Pilot/assess weekend backpack feasibility	Schools + food partners	2025–2026	Feasibility decision; pilot status
Quarterly low-cost nutrition education	Health & Wellness Workgroup	Quarterly	Attendance; participant feedback
Healthy Food Prescriptions expansion	LWGC + partners	Annual	# issued; redemption rate
Quarterly physical activity events	Health & Wellness Workgroup	Quarterly	Participation; partner involvement
Annual Bike Boulevard promotion event	LWGC + partners	Annual	Event held; attendance
Launch community walking group (WWAD)	Healthcare + partners	2026–2027	# groups formed; participation

Logic Model & Timeline

Inputs: Health & Wellness Workgroup, food partners, educators, healthcare organizations, community venues

Activities: Nutrition education, food access initiatives, Healthy Food Prescriptions, quarterly activity events

Outputs: Classes held, prescriptions redeemed, events hosted

Short-Term Outcomes: Increased nutrition knowledge and physical activity participation

Long-Term Outcomes: Reduced food insecurity and improved healthy weight outcomes

Timeline
2025 education + planning; 2026 quarterly events + pilots; 2027 evaluation + sustainability.

Priority Area 5: Mental Health

Lead Partners

Konza Prairie Community Health Center, Stormont Vail Health, Pawnee Mental Health, Geary County Sheriff's Department, Junction City Police Department, Live Well Geary County, and BCBSKS Pathways to a Healthy Kansas

Vision

Mental health needs in Geary County will be addressed through increased provider support, improved access to services, and community-wide training and awareness for both individuals seeking care and those providing services.

Priority Populations

- Low-income residents
- Older adults
- Rural residents
- Individuals with disabilities or limited mobility
- Veterans

Goal 5.1 — Increase Provider Support

Increase support for mental health providers to reduce burnout and improve retention.

Objective 5.1.1 — Establish and Sustain the Mental Health Task Force

By December 31, 2026, maintain the Mental Health Task Force meeting structure, invite additional stakeholders, and establish defined roles.

Strategies

- Hold regular meetings (e.g., 3rd Wednesdays) with a defined facilitator and minutes keeper
- Recruit additional stakeholders, including faith leaders, public library representatives, and private practices

Measures

- Meetings scheduled and held
- Attendance and sector representation
- Task force roles established

Goal 5.2 — Increase Mental Health Access for All

Reduce barriers to care and increase awareness of mental health supports.

Objective 5.2.1 — Collect and Distribute Mental Health Resources

By December 31, 2026, increase knowledge of local mental health resources and distribute information widely throughout the community.

Strategies

- Submit agency/provider descriptions for public posting and community resource directories
- Create and distribute a mental health access brochure
- Inform agencies about PMH Mobile Crisis services and distribute handouts
- Build relationships with community supports (YMCA, public library, etc.)

Measures

- Resource information submitted and updated
- Brochure distribution counts
- Partner awareness of Mobile Crisis and access pathways

Objective 5.2.2 — Community Events Outreach Subcommittee

By December 31, 2026, form a subcommittee to coordinate mental health outreach and education at community events.

Goal 5.3 — Training and Awareness

Reduce stigma by increasing mental health training and awareness for providers, stakeholders, and community members.

Objective 5.3.1 — Identify Training Needs and Implement Trainings

By December 31, 2026, identify community training needs and increase participation in evidence-based mental health training opportunities.

Strategies

- Use task force meetings to identify gaps and available trainings
- Promote Mental Health First Aid (MHFA), QPR, and other training opportunities

Measures

- Trainings hosted or completed
- Participant knowledge and confidence gains (brief surveys when feasible)

Action Plan			
Priority 5: Mental Health (2025–2027)			
Action	**Lead Partners (examples)**	**Timeline**	**Performance Measures**
Maintain Mental Health Task Force structure	FHMHTF members	Ongoing	Meetings held; attendance
Build and distribute resource materials	Task Force	2025–2026	Brochures distributed; website updates
Expand training participation (MHFA/QPR)	PMH, KPCHC, partners	2026	# trained; confidence measures
Form outreach/events subcommittee	Task Force	By end of 2026	Subcommittee formed; events attended

Logic Model & Timeline

Inputs: Providers, task force members, training resources, outreach venues

Activities: Task force coordination, resource distribution, training, outreach, and stigma reduction efforts

Outputs: Meetings held, materials distributed, trainings completed

Short-Term Outcomes: Increased awareness; reduced stigma; improved coordination

Long-Term Outcomes: Improved mental health access and provider retention

Timeline
2025–2026 strengthen task force + materials; 2026 training expansion; 2027 sustain and evaluate.

Implementation, Evaluation, and Accreditation Alignment

Implementation Structure

Implementation will be led through community workgroups and coalitions, coordinated through public health and key partners. Each priority area has identified lead partners responsible for implementation and reporting.

Geary County has been a Blue Cross Blue Shield of Kansas *Pathways to a Healthy Kansas* grant community through three phases of the program. This initiative allows local partners to seek implementation grants to improve health factors and outcomes aligned with the social determinants of health SDOH. Additional Pathways funding may be pursued to support implementation of CHIP strategies.

Evaluation Plan

Progress will be monitored annually using the performance measures outlined in each priority area. Evaluation will include program utilization data, milestone tracking, brief surveys where feasible, and partner/resident feedback. Annual progress summaries will be made publicly available.

Accreditation Alignment (PHAB)

This CHIP supports PHAB expectations by:

- Using data and assessment findings to prioritize needs (Domain 1)
- Documenting ongoing community engagement and partnerships (Domain 4)
- Establishing measurable goals, objectives, and action plans (Domain 5)

Appendix A: Partner Organizations (Initial)

Healthcare & Clinical Services

- Konza Prairie Community Health Center
- Pawnee Mental Health
- Stormont Vail Health / Stormont Vail Health Flint Hills Campus

Public Health & Wellness Partners

- Blue Cross Blue Shield of Kansas – Pathways to a Healthy Kansas
- Fort Riley Public Health
- Geary County Health Department
- Live Well Geary County

Education & Youth-Serving Organizations

- USD 475 — Geary County Schools
- Youth-serving organizations and community volunteers

Government, Planning & Public Service Agencies

- City of Junction City
- Flint Hills Metropolitan Planning Organization
- Geary County
- Geary County Court Services
- Geary County K-State Extension
- Kansas Department for Children and Families

Transportation & Access Services

- Flint Hills Area Transportation Agency

Community & Support Organizations

- Dorothy Bramlage Public Library
- Faith-based and community-based organizations
- Fort Riley and veteran-serving organizations
- I.C.A.R.E.
- Junction City Main Street

Public Safety & Emergency Response

- Emergency Medical Services (EMS)

- Junction City Police Department
- Junction City Sheriff's Department

Appendix B: Data Sources

- Feeding America—Map the Meal Gap (Food Insecurity)
- County Health Rankings & Roadmaps
- Kansas Department of Health and Environment (KDHE)
- Local partner program utilization and service data
- Community partner input and workgroup discussions
- USDA Food Access Research Atlas (low-income/low-access indicators and census tract food access mapping)
- U.S. Census Bureau QuickFacts: Geary County, Kansas (race/ethnicity, age, and socioeconomic indicators)
- Healthy People 2030
- Social Determinants of Health (SDOH)

Appendix C: Priority Populations

- Low-income households
- Older adults
- Veterans and military-connected families
- Individuals with disabilities or limited mobility
- Rural residents
- Youth and families

Appendix D: Plan Maintenance and Updates

This CHIP will be reviewed annually by community partners to assess progress, incorporate updated data, and adjust strategies as needed. Updates and progress summaries will be made publicly available to ensure transparency and accountability.

Closing Acknowledgements

Live Well Geary County extends sincere appreciation to the community partners, organizations, agencies, and residents who contributed to the development of this Community Health Improvement Plan. Their time, insight, and dedication were essential in identifying priorities and shaping strategies to improve the health and well-being of all Geary County residents. Continued collaboration will be critical as we work together to implement this plan and advance health equity across the community.

Community Health Improvement plan prepared by

Live Well Geary County

Thank you for your support of community Health!