COMMUNITY HEALTH NEEDS ASSESSMENT

2022

WELCOME INTRODUCTION FROM FULTON COUNTY MEDICAL CENTER PRESIDENT

We would like to thank you for your continued support of Fulton County Medical Center and your interest in our Community Health Needs Assessment.

Fulton County Medical Center has served this area for more than 70 years and we plan to continue our mission to continuously improve the health of our community for years to come. The health and well-being of our community is at the forefront of all we do.

A valuable tool in providing us with the information we need is the Community Health Needs Assessment. This regional assessment helps us make important decisions regarding programs and services to meet the needs of the community. It also provides insights into the health of our community, as well as brings to the surface any underlying issues.

While we cannot provide every service here in our county, we can form partnerships across the region to collaborate with others. We appreciate the opportunity to serve you and are grateful that you entrust us with the future of your health care and it is our pleasure to share with you this Community Health Needs Assessment.

Sincerely,

Michael Makosky
President and CEO
Fulton County Medical Center

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Questions and/or comments regarding Fulton County Medical Center's Community Health Needs Assessment may be directed to:

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EXECUTIVE SUMMARY

Internal Revenue Code (IRC) Section 501(r) requires health care organizations to assess the health needs of their communities and adopt implementation strategies to address identified needs. Per IRC Section 501(r), a byproduct of the Affordable Care Act, to comply with federal tax-exemption requirements, a tax-exempt hospital facility must:

- Conduct a community health needs assessment (CHNA) every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how it is addressing the needs identified in the CHNA as well as a description of needs that are not being addressed with the reasons why such needs are not being addressed.

The CHNA must consider input from persons including those with special knowledge of or expertise in public health, those who serve or interact with vulnerable populations and those who represent the broad interest of the community served by the hospital facility. The hospital facility must make the CHNA widely available to the public.

This CHNA, which describes both a process and a document, is intended to document Fulton County Medical Center's ("Hospital" or "FCMC") compliance with IRC Section 501(r)(3). Health needs of the community have been identified and prioritized so that the Hospital may adopt an implementation strategy to address specific needs of the community.

This document is a summary of all the available evidence collected during the CHNA conducted during in 2021 and 2022. It will serve as a compliance document, as well as a resource, until the next assessment cycle. Both the process and document serve as the basis for prioritizing the community's health needs and will aid in planning to meet those needs.

Fulton County Medical Center is an acute care hospital located in McConnellsburg, Pennsylvania. For the purposes of this CHNA, the Medical Center's has defined its "community" as Fulton, Bedford, Blair, Franklin, and Huntington Counties, located in central Pennsylvania, which account for the most significant portion the Medical Center's patients. While the Medical Center may serve patients across a broader region, defining its community will allow it to more effectively focus its resources to address identified significant health needs, targeting areas of greatest need and health disparities.

Identified health needs were prioritized with input from members of the Medical Center's management team utilizing a weighting method that weighs 1) the size of the problem, 2) the seriousness of the problem, 3) the impact of the issues on vulnerable populations, 4) how important the issue is to the community and 5) the prevalence of common themes. Significant needs were further reviewed and analyzed regarding how closely the need aligns with the Medical Center's mission, current and key service lines, and/or strategic priorities.

Based on the information gathered through this CHNA and the prioritization process described later in this report, the following priorities were identified. Opportunities for health improvement exist in each area. The Medical Center will work to identify areas where it can most effectively focus its resources to have significant impact and develop an Implementation Strategy for 2022-2024 for the priority areas identified below.

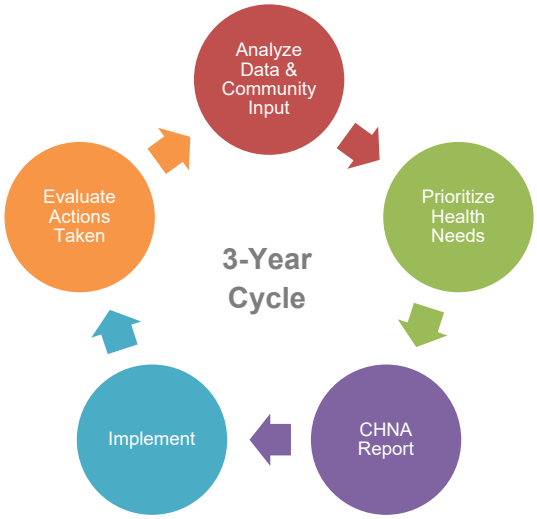
Identified Priority Areas	Correlated Community Health Need
Drug and Alcohol Abuse	Access to drug and alcohol treatment services Access to care (affordability of healthcare services and uninsured and underinsured) Excessive drinking Healthy behaviors and healthy lifestyle choices Alcohol-impaired driving deaths Drug poisoning
Mental Health	Access to mental health services - adults and children Access to care (affordability of healthcare services and uninsured and underinsured) Suicide deaths
Housing	Access to safe and affordable housing Poverty and lack of financial resources
Transportation	Transportation
Senior Housing and Assisted Living	Access to safe and affordable housing Access to senior housing, assisted living, long term care, and continuing care facilities Unintentional injury Transportation
Healthy Behaviors	Access to and use of preventative care treatments Access to COVID-19 testing and vaccines Access to primary care physicians Treatment of and management of chronic diseases and conditions Access to dental health services Obesity Healthy behaviors and healthy lifestyle choices Access to exercise opportunities Mammography screening Physical inactivity Health education Smoking Sexually transmitted infections

Identified Priority Areas	Correlated Community Health Need
Poverty	• Access to mental health services - adults and children • Access to drug and alcohol treatment services • Access to and use of preventative care treatments • Access to safe and affordable housing • Access to care (affordability of healthcare services and uninsured and underinsured) • Poverty and lack of financial resources • Children in poverty • Access to medical specialists • Access to primary care physicians • Treatment of and management of chronic diseases and condition • Access to services for the aging • Access to dental health services • Transportation • Access to senior housing, assisted living, long term care, and continuing care facilities • Access to exercise opportunities • Children in single-parent households

COMMUNITY HEALTH NEEDS ASSESSMENT GOALS

EVALUATION OF PROGRESS SINCE PRIOR CHNA

The CHNA process should be viewed as a 3-year cycle. An important piece of that cycle is revisiting the progress made on priority health topics set forth in the preceding CHNA. By reviewing the actions taken to address a priority health issue and evaluating the impact those actions have made in the CHNA Community, it is possible to better target resources and efforts during the next round of the CHNA cycle.



PRIORITIZED GOALS FROM PRECEDING CHNA

The 2019 CHNA prioritized the following goals for action between 2019 and 2022:

1. Develop programs to help reduce obesity and the related health conditions
2. Increase access to prevention and ongoing management of chronic conditions
3. Improve access and care coordination for behavioral health services
4. Develop a full continuum of aging services to meet the needs of older persons in Fulton County

For each of the prioritized goals, the Medical Center developed objects to addresses the goals. Those objectives are listed on the following table.

Goals	Objectives
Develop programs to help reduce obesity and the related health conditions	→ Improve access and education related to fresh affordable food → Increase opportunities for physical activity and recreation throughout the community and educate on available opportunities
Increase access to prevention and ongoing management of chronic conditions	→ Improve education and access to existing services → Increase preventative services available in community → Expand case management for chronic conditions → Continue to provide community education and screenings related to chronic conditions (i.e. diabetes, coronary heart disease)
Improve access and care coordination for behavioral health services	→ Increase awareness of available behavioral health services (Mental Health and Substance Use Disorder) → Improve treatment, support and care → Improve access for commercial insurance and Medicare individuals → Minimize barriers (including stigma) to accessing available services → Work collaboratively to address youth risk behaviors as identified in the PAYS data

Goals	Objectives
Develop a full continuum of aging services to meet the needs of older persons in Fulton County	→ Continue to explore options for developing senior living services/assisted living on FCMC campus → Continue to integrate hospice into the continuum of aging services → Revamp the senior services collaboration to include Bedford/Huntingdon/Fulton Area Agency on Aging and Franklin/Fulton Mental Health to increase education, awareness, and services available to aging adults in the

A summary of the action steps (and status of each action step) related to each of the Objectives above is located in Appendix A.

COMMUNITY FEEDBACK FROM PRECEDING CHNA & IMPLEMENTATION PLAN

Fulton County Medical Center's preceding CHNA is available to the public via the website https://fcmcpa.org/community-resources. FCMC provided a link on its Community Health webpage under contact us for questions and comments on its prior CHNA. No substantive comments have been received through this site.

HOW THE ASSESSMENT WAS CONDUCTED

Fulton County Medical Center partnered with BKD, LLP ("BKD") to conduct this community health needs assessment. BKD is one of the largest CPA and advisory firms in the United States, with approximately 3,000 partners and employees in 40 offices. BKD serves hospitals and health care systems across the country. The CHNA was conducted during 2021 and 2022.

The CHNA was conducted to support its mission responding to the needs in the community it serves and to comply with Internal Revenue Code Section 501(r) and federal tax-exemption requirements. Identified health needs were prioritized to facilitate the effective allocation of hospital resources to respond to the identified health needs. Based on guidance from the United States Treasury and the Internal Revenue Service, the following steps were conducted as part of the CHNA:

- Community benefit initiatives, which were implemented over the course of the last three years, were evaluated.
- The "community" served by the Medical Center was defined by utilizing inpatient and outpatient data regarding patient origin and is inclusive of medically underserved, low-income, minority populations and people with limited English proficiency. This process is further described in Community Served by the Medical Center.

- Population demographics and socioeconomic characteristics of the community were gathered and assessed utilizing various third parties.
- The health status of the community was assessed by reviewing community health status indicators from multiple sources, including those with specialized knowledge of public health and members of the underserved, low-income and minority population or organizations serving their interests.
- Community input was also obtained through key stakeholder interviews of community leaders. See Appendix B for a listing of key stakeholders that provided input through interviews.
- Identified health needs were then prioritized considering the community's perception of the significance of each identified need as well as the ability for the Medical Center to impact overall health based on alignment with its mission and the services it provides. The Medical Center's leadership participated in identifying and prioritizing significant health needs.
- An inventory of health care facilities and other community resources potentially available to address the significant health needs identified through the CHNA was prepared.

LIMITATIONS AND INFORMATION GAPS

This assessment was designed to provide a comprehensive and broad picture of the health in the overall community served by the Medical Center; however, there may be a few of medical conditions that are not specifically addressed in this report due to various factors, including but not limited to, publicly available information or limited community input.

In addition, certain population groups might not be identifiable or might not be represented in numbers sufficient for independent analysis. Examples include homeless, institutionalized persons, undocumented residents and members of certain ethnic groups who do not speak English. Efforts were made to obtain input from these specific populations through key stakeholder interviews.

As with all data collection efforts, there are limitations related to the CHNA's research methods that should be acknowledged. Years of the most current data available differ by data source. In some instances, 2021 may be the most current year available for data, while 2020 or 2019 may be the most current year for other sources.

GENERAL DESCRIPTION OF FULTON COUNTY MEDICAL CENTER

The Fulton County Medical Center is a Pennsylvania non-profit corporation which owns and operates an 88-bed critical access hospital and skilled nursing care facility. It's nestled between two mountain ranges in the valley of Great Cove. FCMC is located just hours from the metropolitan areas of Baltimore, Maryland, and Washington D.C. and just an hour from the Pennsylvania state

capital in Harrisburg. FCMC has been serving its community for over seventy years. FCMC offers a full suite of health services for people of all ages, that include therapy, rehab, surgery, home health assistance and much more.

The Mission of the Fulton County Medical Center is "To continuously improve the health of our community."

We perform this mission by:

- Providing diagnostic and therapeutic services in our acute care hospital
- Maintaining health and providing a higher quality of life in our community by operating a nursing home and a home care program
- Offering access to care through a multi-specialty clinic
- Working with other local providers and agencies to promote wellness in our community; and
- Providing services regardless of the ability to pay.

DESCRIPTION OF SERVICES PROVIDED BY FULTON COUNTY MEDICAL CENTER

Fulton County Medical Center promotes the importance of maintaining good health and wellness for the welfare of the community. FCMC's team of professional medical staff is available twenty-four hours a day to handle any illness or injury with compassion and state-of-the-art care. Its healthcare facility offers a wide range of basic and specialized clinic and emergency medical services, including the following:

- 24-Hour Emergency Care
- Cardiology
- Community Health and Wellness Center
- Diabetes Education
- Diagnostic Services
- Hospital Services
- Home Health Services
- Infection Control
- Laboratory Services
- Long-Term Care
- Nutrition Services
- Rehabilitation Services - PT/OT/Speech
- Respiratory Care Services
- Social Services
- Wound Care Services

FCMC's campus includes a 21-bed critical access hospital, laboratory, radiology department, and 67 bed nursing home with easy access to our in-house medical services. In addition, FCMC's Community Health and Wellness Center offers exercise and fitness classes for all ages and abilities. It is our mission "To continuously improve the health of our community."

FCMC understands the importance for patients to get the answers they need quickly. FCMC offers a full range of diagnostic laboratory and imaging services including:

- General X-Ray
- Bone Densitometry
- Mammography
- Ultrasound
- Nuclear Medicine
- Magnetic Resonance Imaging
- Computed Tomography

Fulton County Medical Center provides emergency treatment for acute and urgent care needs. Its on-site lab and radiology department ensures a quick diagnosis.

For patients needing more specialized needs, FCMC provides care in its cardiopulmonary center with its cardiologist team of specialists. Services include:

- Electrocardiogram
- Echocardiogram
- Cardiac Stress Testing
- Holter Monitoring, MCOT, and Event Recording
- Cardioversion
- TransEsophageal Echocardiogram
- Ankle Brachial Index
- Cardiac Imaging
- Fulton County Health Center also offers outpatient surgical services for:
- Ear, Nose, and Throat
- Orthopedics
- Podiatry
- Gynecological Services
- Ophthalmology Surgery

FCMC's facility provides on-going rehabilitation and physical therapy services to ensure patients' complete recovery. Services include:

- Occupational Therapy
- Cardiopulmonary Rehabilitation
- Speech Therapy

FCMC provides patients the education they need to heal and prevent future injuries or illnesses. FCMC also offers home health and long-term care services in its nursing home.

COMMUNITY SERVED BY FULTON COUNTY MEDICAL CENTER

The Medical Center is in McConnellsburg, Pennsylvania in Fulton County, located in central Pennsylvania.

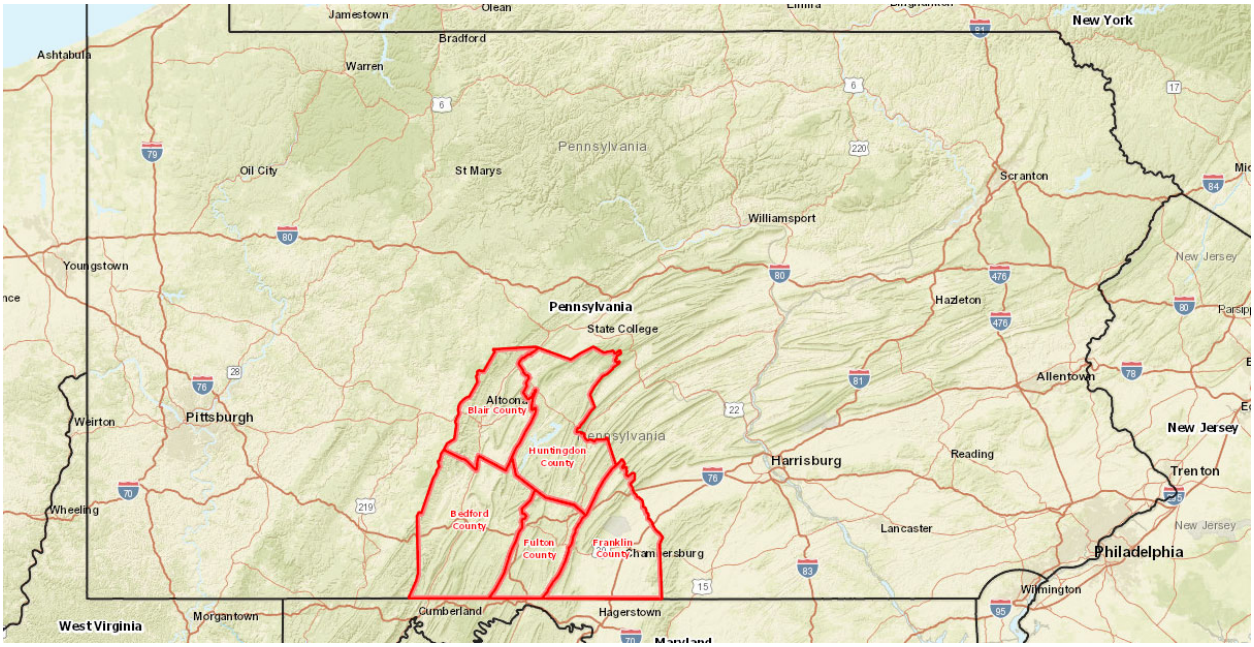
DEFINED COMMUNITY

A community is defined as the geographic area from which a significant number of the patients utilizing the Medical Center's services reside. While the CHNA considers other types of health care providers, the hospital is the single largest provider of acute care services. For this reason, the utilization of hospital services provides the clearest definition of the community. Based on the patient origin of inpatient and outpatient discharges, management has identified the CHNA community to include Fulton, Bedford, Blair, Franklin, and Huntington Counties, hereafter referred to as the "CHNA Community". Based on analysis of patient discharge zip codes, the CHNA community represents the majority of total discharges.

COMMUNITY DETAILS

IDENTIFICATION AND DESCRIPTION OF GEOGRAPHICAL COMMUNITY

The following map geographically illustrates the Medical Center's community. The map below displays its geographic relationship to the community, as well as significant roads and highways.



COMMUNITY POPULATION AND DEMOGRAPHICS

The U.S. Bureau of Census has compiled population and demographic data. The data below shows the total population of the CHNA community. It also provides the breakout of the CHNA community between the male and female population, age distribution, race/ethnicity and the Hispanic population.

Demographic Characteristics

Gender	CHNA Community	Bedford County	Blair County	Franklin County	Fulton County	Huntingdon County	PA	US
Total Population	385,516	48,337	123,157	154,147	14,506	45,369	12,791,530	324,697,795
Total Male Population	191,374	23,972	60,259	75,710	7,322	24,111	6,265,113	159,886,919
Total Female Population	194,142	24,365	62,898	78,437	7,184	21,258	6,526,417	164,810,876
Percent Male	49.64%	49.59%	48.93%	49.12%	50.48%	53.14%	48.98%	49.24%
Percent Female	50.36%	50.41%	51.07%	50.88%	49.52%	46.86%	51.02%	50.76%

Population Age Distribution

Age Group	Percent of CHNA Community	Percent of Bedford County	Percent of Blair County	Percent of Franklin County	Percent of Fulton County	Percent of Huntingdon County	Percent of PA	Percent of US
0 - 4	5.41%	4.83%	5.27%	6.04%	4.80%	4.47%	5.52%	6.09%
5 - 17	15.45%	14.83%	15.13%	16.42%	15.32%	13.76%	15.29%	16.53%
18 - 24	7.92%	7.32%	7.74%	7.80%	7.42%	9.60%	9.19%	9.44%
25 - 34	11.68%	10.11%	12.29%	11.72%	10.66%	11.88%	13.14%	13.87%
35 - 44	11.57%	10.74%	11.46%	11.86%	11.20%	11.87%	11.68%	12.62%
45 - 54	13.45%	14.19%	13.11%	13.39%	14.69%	13.40%	13.23%	12.96%
55 - 64	14.35%	15.74%	14.70%	1.52%	14.95%	14.51%	14.11%	12.86%
65+	20.17%	22.24%	20.30%	19.25%	20.96%	20.50%	17.84%	15.63%
Total	100.00%	100.00%	100.00%	88.00%	100.00%	99.99%	100.00%	100.00%

Total Population by Race Alone

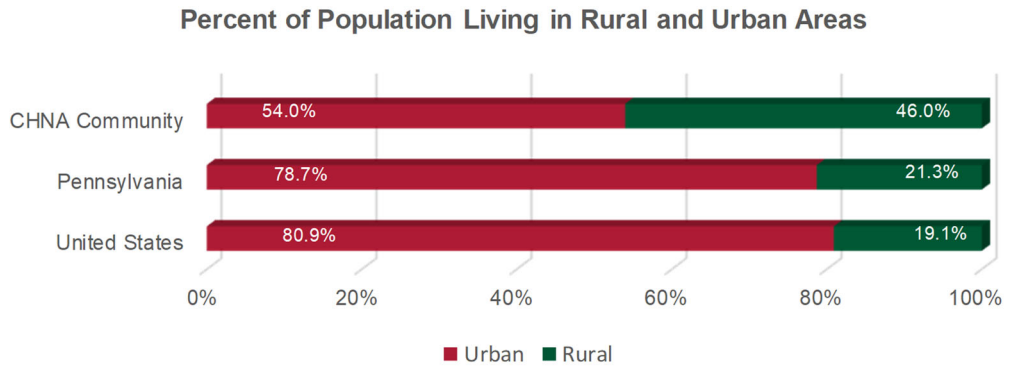
Race	Percent of CHNA Community	Percent of Bedford County	Percent of Blair County	Percent of Franklin County	Percent of Fulton County	Percent of Huntingdon County	Percent of PA	Percent of US
White	94.09%	97.60%	95.46%	92.42%	96.57%	91.51%	80.53%	72.49%
Black	2.83%	0.64%	1.67%	3.75%	1.52%	5.62%	11.18%	12.70%
Asian	0.66%	0.40%	0.61%	0.84%	0.26%	0.59%	3.41%	5.52%
Native American / Alaska Native	0.19%	0.15%	0.13%	0.25%	0.29%	0.17%	0.19%	0.85%
Native Hawaiian / Pacific Islander	0.02%	0.00%	0.05%	0.01%	0.00%	0.02%	0.03%	0.18%
Some Other Race	0.46%	0.21%	0.35%	0.64%	0.25%	0.43%	2.16%	4.94%
Multiple Race	1.75%	1.00%	1.73%	2.09%	1.11%	1.66%	2.50%	3.32%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Total Population by Ethnicity Alone

Ethnicity	Percent of CHNA Community	Percent of Bedford County	Percent of Blair County	Percent of Franklin County	Percent of Fulton County	Percent of Huntingdon County	Percent of PA	Percent of US
Hispanic or Latino	3.09%	1.22%	1.27%	5.64%	1.20%	1.97%	7.31%	18.01%
Non-Hispanic or Latino	96.91%	98.78%	98.73%	94.36%	98.80%	98.03%	92.69%	81.99%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

While the relative age of the community population can impact community health needs, so can the ethnicity and race of a population. The population of the CHNA community by race illustrates different categories of race such as, white, black, Asian, other, and multiple races.

The graphic below shows the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban. Per the graph below, the population of the CHNA Community has a nearly even split living in an urban and rural areas.



SOCIOECONOMIC CHARACTERISTICS OF THE COMMUNITY

The socioeconomic characteristics of a geographic area influence the way residents access health care services and perceive the need for health care services within society. The economic status of an area may be assessed by examining multiple variables within the CHNA community. The following exhibits are a compilation of data that includes median household income, unemployment rates, poverty, uninsured population, and educational attainment for the CHNA community. These standard measures will be used to compare the socioeconomic status of the community to Pennsylvania and the United States.

INCOME AND EMPLOYMENT

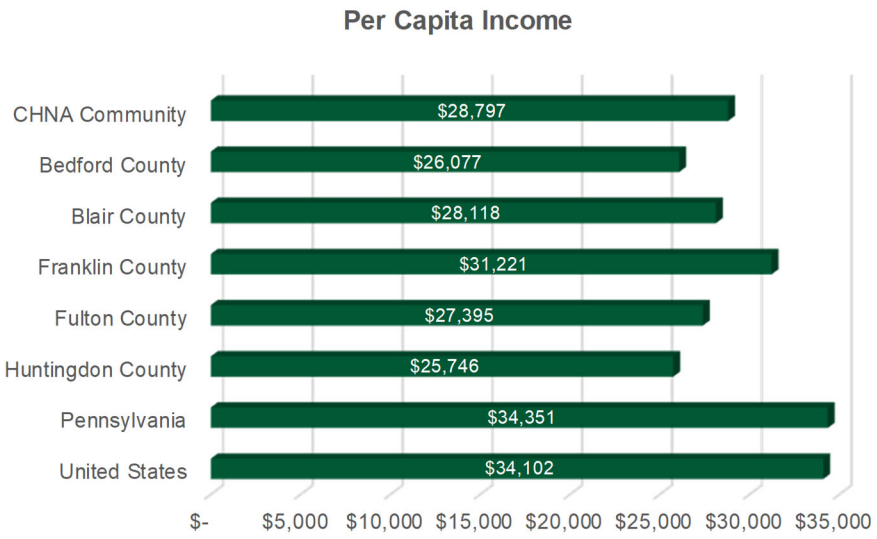
INCOME

The median household income includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one-person, average household income is usually less than average family income. Except for Franklin County, the counties in the CHNA Community have median household incomes below Pennsylvania and the United States.

Median Household Income		
CHNA Community		N/A
Bedford County	$	50,509
Blair County	$	49,181
Franklin County	$	63,379
Fulton County	$	53,476
Huntingdon County	$	51,678
Pennsylvania	$	61,744
United States	$	62,843

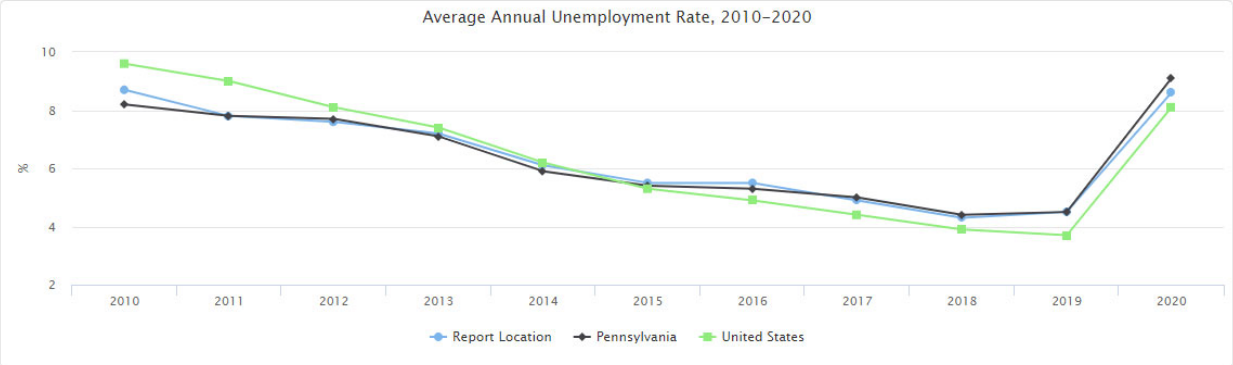
The per capita income for the CHNA Community is $28,797. This includes all reported income from wages and salaries as well as income from self-employment, interest or dividends, public assistance, retirement, and other sources. The per capita income in this report area is the average

(mean) income computed for every man, woman, and child in the specified area. The per capita income for all counties in the CHNA Community are below the per capita income for both Pennsylvania and the United States.



UNEMPLOYMENT RATE

The following graph presents the average annual unemployment rate from 2010 through 2020 for the CHNA Community, as well as the trend for Pennsylvania and the United States. The unemployment rates for the CHNA Community are nearly identical to rates for Pennsylvania (within ±0.5%). These rates were below the rates for the United States from 2010 through 2015 but have exceed the United States rates since 2015. In general, unemployment was decreasing until 2019 and has been increasing since. 2020 showed a sharp increase in unemployment where the CHNA Community's rate remained slightly higher than United States rate.



POVERTY

Poverty is considered a key driver of health status.

Within the CHNA Community 11.74% or 43,918 individuals are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status. All counties within the CHNA Community, except for Blair County, compare favorably to both Pennsylvania and United States percentages of individuals living in households below 100% of FPL. Within the CHNA Community, Blair County has the highest percentage (14.67%) of individuals living in households with income below the FPL.

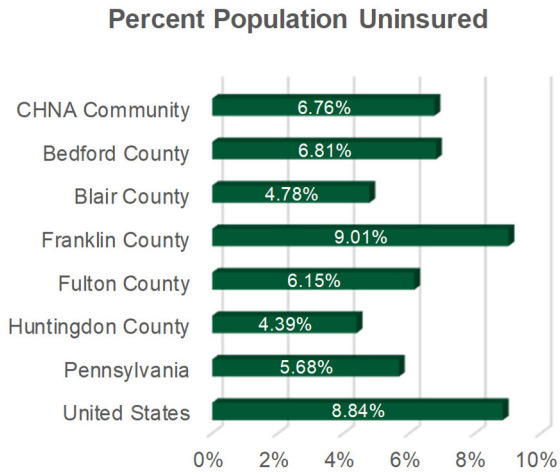
Percent Population Below 100% FPL	
CHNA Community	11.74%
Bedford County	11.90%
Blair County	14.67%
Franklin County	9.25%
Fulton County	11.27%
Huntingdon County	12.35%
Pennsylvania	12.43%
United States	13.42%

In the CHNA Community, 16.94% or 13,374 children aged 0-17 are living in households with income below the FPL. Like the percentages for total poverty, all counties within the CHNA Community, except for Blair County, compare favorably to both Pennsylvania and United States percentages of individuals under age 18 living in households below 100% of FPL. Within the CHNA Community, Blair County has the highest percentage (20.46%) of individuals under age 18 living in households below 100% of FPL.

Percent Population Under Age 18 in Poverty	
CHNA Community	16.94%
Bedford County	14.51%
Blair County	20.46%
Franklin County	14.77%
Fulton County	15.03%
Huntingdon County	18.76%
Pennsylvania	17.56%
United States	18.52%

UNINSURED

The percentage of the total civilian non-institutionalized population without health insurance coverage is represented in this graphic. The rate of uninsured persons in the report area is greater than the state average of 5.68% This indicator is relevant because lack of insurance is a primary barrier to health care access, including regular primary care, specialty care and other health services that contribute to poor health status. Approximately 378,040 persons are uninsured in the CHNA community. The uninsured rate is estimated to be 6.76% for



the CHNA Community compared to 5.68% for Pennsylvania and 8.84% for the United States.

EDUCATION

Nearly 20% of the population of the CHNA Community age twenty-five and older have obtained a bachelor's degree or higher compared to 31% in Pennsylvania and 32% in the United States. This indicator is relevant because educational attainment has been linked to positive health outcomes.

Education levels obtained by community residents may also impact the local economy. Higher levels of education generally lead to higher wages, less unemployment and job stability. These factors indirectly influence community health.

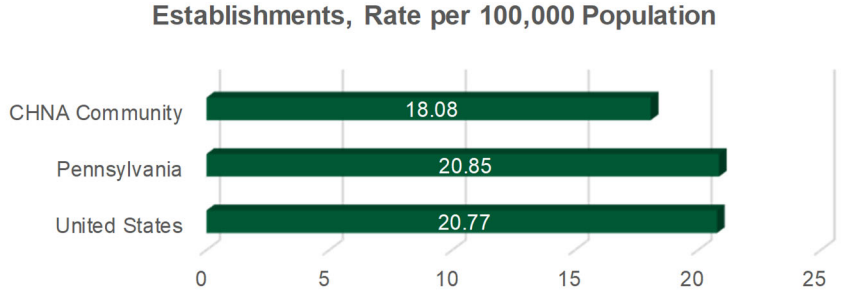
Percent Population Age 25+ with Bachelor's Degree or Higher	
CHNA Community	19.82%
Bedford County	14.82%
Blair County	21.28%
Franklin County	21.62%
Fulton County	13.57%
Huntingdon County	17.42%
Pennsylvania	31.43%
United States	32.15%

PHYSICAL ENVIROMENT OF THE COMMUNITY

A community's health is also affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining and improving community health. This section will touch on a few of the elements that relate to some needs mentioned throughout the report.

GROCERY STORE ACCESS

Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods, fresh fruits and vegetables and fresh and prepared meats, such as fish and poultry. Included are delicatessen-type establishments. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors. The CHNA Community compares unfavorably to Pennsylvania and the United States.

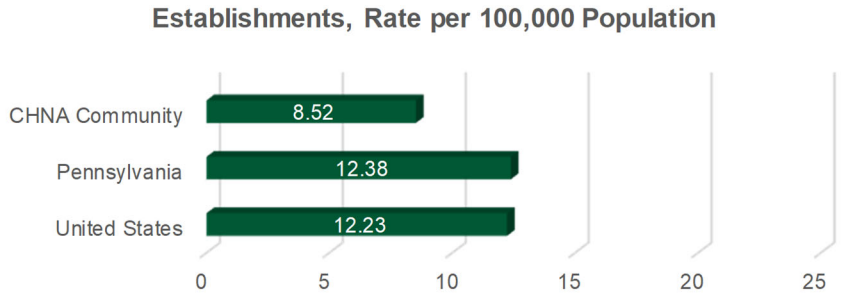


FOOD ACCESS/FOOD DESERTS

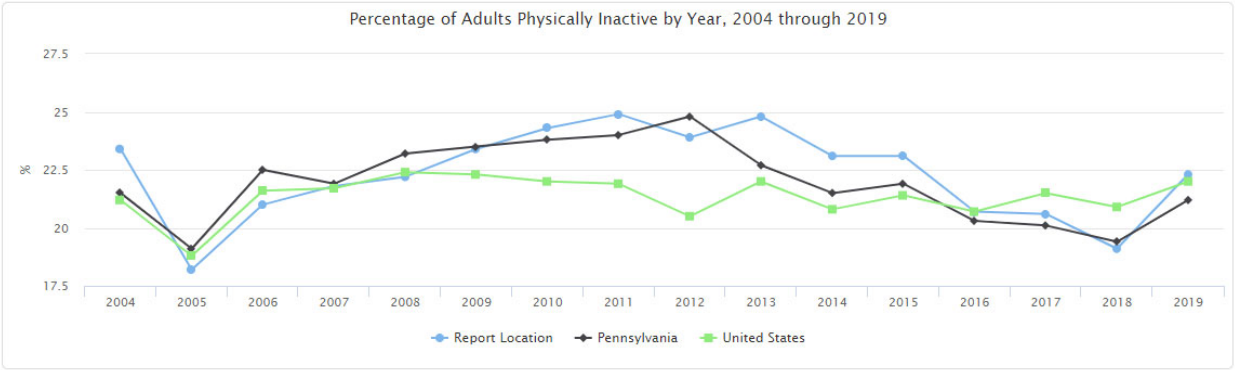
This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract where a substantial number or share of residents has low access to a supermarket or large grocery stores. The information in is relevant because it highlights populations and geographies facing food insecurity. The CHNA Community has a population of 23,422 or 6.05% living in food deserts compared to 6.30% for Pennsylvania and 12.66% for the United States.

RECREATION AND FITNESS FACILITY ACCESS

This indicator reports the number per 100,000-population of recreation and fitness facilities as defined by North American Industry Classification System (NAICS) Code 713940. It is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors. The rate of fitness establishments available to the residents of the CHNA Community compares unfavorably to the rate for Pennsylvania and the United States.



The trend graph below shows the percentage of adults who are physically inactive by year (2004 through 2019) for the CHNA Community and compared to Pennsylvania and the United States. For 2019, the rate for the CHNA Community was 22.3% compared to 21.2% for Pennsylvania and 22.0% for the United States. From 2013 to 2018, the CHNA Community's percentage of adults who were physically inactive decreased, that trend changed in 2018 with the percentage increasing in from 2018 to 2019.



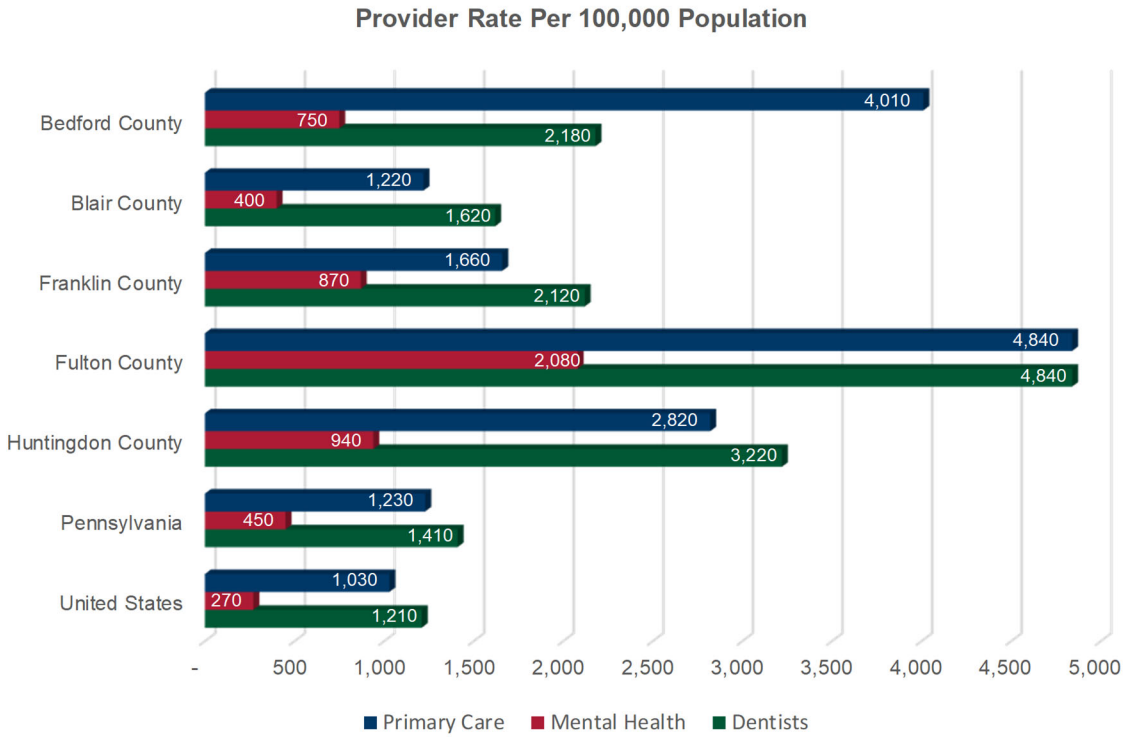
CLINICAL CARE OF THE COMMUNITY

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of uninsured, financial hardship, transportation barriers, cultural competency and coverage limitations affect access.

Rates of morbidity, mortality and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests, and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

ACCESS TO CARE

Doctors classified as "primary care physicians" by the American Medical Association include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs and general pediatrics MDs. Physicians aged 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. The primary care physician ratio for all counties in the CHNA Community compares unfavorably to the ratios for both Pennsylvania and the United States. In addition, the number of mental health providers and dentists practicing in the counties of the CHNA Community compares unfavorably to the ratios for both Pennsylvania and the United States.



HEALTH STATUS OF THE COMMUNITY

This section of the assessment reviews the health status of the CHNA community and its residents. As in the previous section, comparisons are provided with the state of Pennsylvania and the United States. This in-depth assessment of the mortality and morbidity data, health outcomes, health factors and mental health indicators of the county residents that make up the CHNA community will enable the Hospital to identify priority health issues related to the health status of its residents.

Good health can be defined as a state of physical, mental, and social well-being, rather than the absence of disease or infirmity. According to Healthy People 2020, the national health objectives released by the U.S. Department of Health and Human Services, individual health is closely linked to community health. Community health, which includes both the physical and social environment in which individuals live, work and play, is profoundly affected by the collective behaviors, attitudes, and beliefs of everyone who lives in the community. Healthy people are among a community's most essential resources.

Numerous factors have a significant impact on an individual's health status: lifestyle and behavior, human biology, environmental and socioeconomic conditions, as well as access to adequate and appropriate health care and medical services.

Studies by the American Society of Internal Medicine conclude that up to 70% of an individual's health status is directly attributable to personal lifestyle decisions and attitudes. Persons who do not smoke, drink in moderation (if at all), use automobile seat belts (car seats for infants and small children), maintain a nutritious low-fat, high-fiber diet, reduce excess stress in daily living and exercise regularly have a significantly greater potential of avoiding debilitating diseases, infirmities, and premature death.

The interrelationship among lifestyle/behavior, personal health attitude and poor health status is gaining recognition and acceptance by both the general public and health care providers. Some examples of lifestyle/behavior and related health care problems include the following:

Health problems should be examined in terms of morbidity as well as mortality. Morbidity is defined as the incidence of illness or injury, and mortality is defined as the incidence of death. Such information provides useful indicators of health status trends and permits an assessment of the impact of changes in health services on a resident population during an established period. Community attention and health care resources may then be directed to those areas of greatest impact and concern.

LEADING CAUSES OF DEATH

The data below reflects the leading causes of death for the CHNA Community and compares the crude death rates to the state of Pennsylvania and the United States.

Area	CHNA Community	Bedford County	Blair County	Franklin County
Cancer	241.50	248.90	247.90	231.90
Heart Disease	143.90	186.40	150.50	125.20
Lung Disease	53.50	54.70	57.30	48.10
Stroke	54.70	72.90	57.00	45.80
Unintentional Injury	61.40	69.20	70.90	50.30
Motor Vehicle	13.90	16.10	13.60	13.00
Drug Poisoning	24.20	25.30	29.60	18.50
Homicide	2.10	0.00	0.00	2.10
Suicide	16.30	22.80	15.10	14.40

Area	Fulton County	Huntingdon County	Pennsylvania	United States
Cancer	297.60	230.70	220.80	184.00
Heart Disease	181.00	131.20	137.60	112.10
Lung Disease	38.40	65.20	51.00	48.40
Stroke	65.80	56.40	52.60	44.70
Unintentional Injury	89.20	56.40	66.30	50.30
Motor Vehicle	24.70	11.90	9.30	11.60
Drug Poisoning	31.50	25.10	36.50	21.50
Homicide	0.00	0.00	5.80	5.80
Suicide	16.50	19.40	15.30	14.30

Note: Crude Death Rate (Per 100,000 Pop.)

The table above shows leading causes of death within the CHNA Community as compared to the state of Pennsylvania and the United States. The crude death rate is shown per 100,000 residents. The rates in red represent the CHNA Community and corresponding leading causes of death that are higher than the national rates.

HEALTH OUTCOMES AND FACTORS

An analysis of various health outcomes and factors for a community can, if improved, help make the community a healthier place to live, learn, work and play. A better understanding of the factors that affect the health of the community will assist with how to improve the community's habits, culture, and environment. This portion of the community health needs assessment utilizes information from County Health Rankings.

The County Health Rankings model is grounded in the belief that programs and policies implemented at the local, state, and federal levels have an impact on the variety of factors that, in turn, determine the health outcomes for communities across the nation. The model provides a ranking method that ranks all 50 states and the counties within each state, based on the measurement of two types of health outcomes for each county: how long people live (mortality) and how healthy people feel (morbidity). These outcomes are the result of a collection of health factors and are influenced by programs and policies at the local, state, and federal levels.

Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, e.g., 1 or 2, are the "healthiest". Counties are ranked relative to the health of other counties in the same state based on health outcomes and factors, clinical care, economic status, and the physical environment.

A number of different health factors shape a community's health outcomes. The County Health Rankings (www.countyhealthrankings.org) model includes four types of health factors: health behaviors, clinical care, social and economic and the physical environment. The following tables include the 2018 and 2021 indicators reported by County Health Rankings for Bedford, Blair, Franklin, Fulton, and Huntingdon Counties. The health indicators that are unfavorable when compared to the Pennsylvania rates are listed in red.

Health Outcomes	Bedford County: 2018	Bedford County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Mortality: Pennsylvania County Ranking	**50**	**51**	-		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	7,800	8,300	-	7,500	5,400
Morbidity: Pennsylvania County Ranking	**6**	**21**	-		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	14%	19%	-	18%	14%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	3.7	4.5	-	4.0	3.4
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.2	5.2	-	4.7	3.8
Low birth weight – Percent of live births with low birth weight (<2500 grams)	4.0%	6.0%	-	8.0%	6.0%

Health Outcomes	Bedford County: 2018	Bedford County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Health Behaviors: Pennsylvania County Ranking	**19**	**30**			
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	16.0%	24.0%	-	18.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	32.0%	31.0%	+	31.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	8.4	8.4	NC	8.4	8.7
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	26.0%	27.0%	-	22.0%	19.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	42.0%	62.0%	+	84.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	19.0%	20.0%	-	20.0%	15.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	23.0%	20.0%	+	26.0%	11.0%
Sexually transmitted infections – Chlamydia rate per 100K population	155.3	130.0	+	463.4	161.2
Teen birth rate – Per 1,000 female population, ages 15-19	24.0	20.0	+	17.0	12.0
Clinical Care: Pennsylvania County Ranking	**51**	**51**			
Uninsured adults – Percent of population under age 65 without health insurance	8.0%	7.0%	+	7.0%	6.0%
Primary care physicians – Ratio of population to primary care physicians	3,740:1	4,010:1	-	1,230:1	1,030:1
Dentists – Ratio of population to dentists	2,010:1	2,180:1	-	1,410:1	1,210:1
Mental health providers – Ratio of population to mental health providers	830:1	750:1	+	450:1	270:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	63.0	37.4	+	44.6	25.7
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	67.0%	44.0%	-	45.0%	51.0%

Health Outcomes	Bedford County: 2018	Bedford County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Social and Economic Factors: Pennsylvania County Ranking	**23**	**24**			
High school graduation – Percent of ninth grade cohort that graduates in 4 years	92.0%	88.0%	-	91.0%	94.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	48.0%	48.0%	NC	66.0%	73.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	5.9%	4.7%	+	4.4%	2.6%
Children in poverty – Percent of children under age 18 in poverty	17.0%	14.0%	+	17.0%	10.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	4.1	4.2	-	4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent	29.0%	15.0%	+	26.0%	14.0%
Social associations – Number of membership associations per 10,000 population	19.1	18.3	-	12.2	18.2
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	171.0	80.0	+	315.0	63.0
Injury deaths – Number of deaths due to injury per 100,000 population	85.0	99.0	-	89.0	59.0
Physical Environment: Pennsylvania County Ranking	**29**	**26**			
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	10.2	8.7	+	9.0	5.2
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	11.0%	11.0%	NC	15.0%	9.0%
Driving alone to work – Percentage of the workforce that drives alone to work	81.0%	81.0%	NC	76.0%	72.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	35.0%	35.0%	NC	38.0%	16.0%

Health Outcomes	Blair County: 2018	Blair County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Mortality: Pennsylvania County Ranking	**46**	**47**	-		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	7,700	7,200	+	6,600	5,400
Morbidity: Pennsylvania County Ranking	**38**	**28**	+		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	15%	41%	-	19%	14%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	3.8	5.9	-	3.8	3.4
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.1	4.9	-	3.8	3.8
Low birth weight – Percent of live births with low birth weight (<2500 grams)	7.0%	9.0%	-	8.0%	6.0%

Health Outcomes	Blair County: 2018	Blair County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Health Behaviors: Pennsylvania County Ranking	**48**	**51**			
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	17.0%	24.0%	-	18.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	32.0%	32.0%	NC	31.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	7.7	7.7	NC	8.4	8.7
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	25.0%	25.0%	NC	22.0%	19.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	60.0%	75.0%	+	84.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	19.0%	21.0%	-	20.0%	15.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	32.0%	23.0%	+	26.0%	11.0%
Sexually transmitted infections – Chlamydia rate per 100K population	219.9	311.8	-	463.4	161.2
Teen birth rate – Per 1,000 female population, ages 15-19	28.0	23.0	+	17.0	12.0
Clinical Care: Pennsylvania County Ranking	**25**	**47**			
Uninsured adults – Percent of population under age 65 without health insurance	6.0%	6.0%	NC	7.0%	6.0%
Primary care physicians – Ratio of population to primary care physicians	1,160:1	1,220:1	-	1,230:1	1,030:1
Dentists – Ratio of population to dentists	1,780:1	1,620:1	+	1,410:1	1,210:1
Mental health providers – Ratio of population to mental health providers	480:1	400:1	+	450:1	270:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	60.0	51.9	+	44.6	25.7
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	57.0%	41.0%	-	45.0%	51.0%

Health Outcomes	Blair County: 2018	Blair County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Social and Economic Factors: Pennsylvania County Ranking	**29**	**32**			
High school graduation – Percent of ninth grade cohort that graduates in 4 years	88.0%	91.0%	+	91.0%	94.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	55.0%	58.0%	+	66.0%	73.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	5.3%	4.5%	+	4.4%	2.6%
Children in poverty – Percent of children under age 18 in poverty	21.0%	22.0%	-	17.0%	10.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	4.5	4.5	NC	4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent	33.0%	23.0%	+	26.0%	14.0%
Social associations – Number of membership associations per 10,000 population	17.8	18.5	+	12.2	18.2
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	232.0	224.0	+	315.0	63.0
Injury deaths – Number of deaths due to injury per 100,000 population	80.0	88.0	-	89.0	59.0
Physical Environment: Pennsylvania County Ranking	**32**	**7**			
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	10.4	8.2	+	9.0	5.2
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	13.0%	14.0%	-	15.0%	9.0%
Driving alone to work – Percentage of the workforce that drives alone to work	83.0%	83.0%	NC	76.0%	72.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	19.0%	21.0%	-	38.0%	16.0%

Health Outcomes	Franklin County: 2018	Franklin County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Mortality: Pennsylvania County Ranking	**11**	**16**	-		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	6,000	7,200	-	6,600	5,400
Morbidity: Pennsylvania County Ranking	**13**	**22**	-		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	12%	41%	-	19%	14%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	3.4	5.9	-	3.8	3.4
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.8	4.9	-	3.8	3.8
Low birth weight – Percent of live births with low birth weight (<2500 grams)	7.0%	9.0%	-	8.0%	6.0%

Health Outcomes	Franklin County: 2018	Franklin County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Health Behaviors: State of Pennsylvania County Ranking	**17**	**19**			
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	15.0%	21.0%	-	18.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	34.0%	33.0%	+	31.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	8.3	8.5	-	8.4	8.7
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	29.0%	25.0%	+	22.0%	19.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	42.0%	69.0%	+	84.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	19.0%	20.0%	-	20.0%	15.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	12.0%	15.0%	-	26.0%	11.0%
Sexually transmitted infections – Chlamydia rate per 100K population	292.4	300.2	-	463.4	161.2
Teen birth rate – Per 1,000 female population, ages 15-19	26.0	21.0	+	17.0	12.0
Clinical Care: Pennsylvania County Ranking	**29**	**53**			
Uninsured adults – Percent of population under age 65 without health insurance	9.0%	9.0%	NC	7.0%	6.0%
Primary care physicians – Ratio of population to primary care physicians	1,510:1	1,660:1	-	1,230:1	1,030:1
Dentists – Ratio of population to dentists	2,260:1	2,120:1	+	1,410:1	1,210:1
Mental health providers – Ratio of population to mental health providers	1,080:1	870:1	+	450:1	270:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	41.0	39.6	+	44.6	25.7
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	65.0%	46.0%	-	45.0%	51.0%

Health Outcomes	Franklin County: 2018	Franklin County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Social and Economic Factors: Pennsylvania County Ranking	**14**	**8**			
High school graduation – Percent of ninth grade cohort that graduates in 4 years	86.0%	88.0%	+	91.0%	94.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	51.0%	53.0%	+	66.0%	73.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	5.2%	3.8%	+	4.4%	2.6%
Children in poverty – Percent of children under age 18 in poverty	14.0%	13.0%	+	17.0%	10.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	3.8	3.6	+	4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent	28.0%	20.0%	+	26.0%	14.0%
Social associations – Number of membership associations per 10,000 population	15.8	15.5	-	12.2	18.2
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	147.0	146.0	+	315.0	63.0
Injury deaths – Number of deaths due to injury per 100,000 population	63.0	68.0	-	89.0	59.0
Physical Environment: Pennsylvania County Ranking	**45**	**29**			
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	11.1	8.9	+	9.0	5.2
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	12.0%	11.0%	+	15.0%	9.0%
Driving alone to work – Percentage of the workforce that drives alone to work	84.0%	82.0%	+	76.0%	72.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	30.0%	32.0%	-	38.0%	16.0%

Health Outcomes	Fulton County: 2018	Fulton County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Mortality: Pennsylvania County Ranking	**67**	**17**	+		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	10,400	7,200	+	6,600	5,400
Morbidity: Pennsylvania County Ranking	**29**	**52**	-		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	14%	41%	-	19%	14%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	3.6	5.9	-	3.8	3.4
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.9	4.9	-	3.8	3.8
Low birth weight – Percent of live births with low birth weight (<2500 grams)	8.0%	9.0%	-	8.0%	6.0%

Health Outcomes	Fulton County: 2018	Fulton County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Health Behaviors: State of Pennsylvania County Ranking	**16**	**29**			
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	16.0%	24.0%	-	18.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	29.0%	27.0%	+	31.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	8.3	8.4	+	8.4	8.7
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	23.0%	25.0%	-	22.0%	19.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	34.0%	55.0%	+	84.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	20.0%	22.0%	-	20.0%	15.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	24.0%	9.0%	+	26.0%	11.0%
Sexually transmitted infections – Chlamydia rate per 100K population	116.2	116.5	-	463.4	161.2
Teen birth rate – Per 1,000 female population, ages 15-19	34.0	27.0	+	17.0	12.0
Clinical Care: State of Pennsylvania County Ranking	**67**	**67**			
Uninsured adults – Percent of population under age 65 without health insurance	8.0%	7.0%	+	7.0%	6.0%
Primary care physicians – Ratio of population to primary care physicians	4,880:1	4,840:1	-	1,230:1	1,030:1
Dentists – Ratio of population to dentists	7,320:1	4,840:1	+	1,410:1	1,210:1
Mental health providers – Ratio of population to mental health providers	2,090:1	2,080:1	+	450:1	270:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	84.0	64.7	+	44.6	25.7
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	59.0%	42.0%	+	45.0%	51.0%

Health Outcomes	Fulton County: 2018	Fulton County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Social and Economic Factors: Pennsylvania County Ranking	**40**	**44**			
High school graduation – Percent of ninth grade cohort that graduates in 4 years	86.0%	88.0%	+	91.0%	94.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	45.0%	44.0%	-	66.0%	73.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	6.4%	4.4%	+	4.4%	2.6%
Children in poverty – Percent of children under age 18 in poverty	17.0%	19.0%	-	17.0%	10.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	3.8	3.8	NC	4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent	28.0%	24.0%	+	26.0%	14.0%
Social associations – Number of membership associations per 10,000 population	19.8	15.8	-	12.2	18.2
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	190.0	216.0	-	315.0	63.0
Injury deaths – Number of deaths due to injury per 100,000 population	104.0	111.0	-	89.0	59.0
Physical Environment: Pennsylvania County Ranking	**9**	**30**			
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	10.1	8.2	+	9.0	5.2
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	12.0%	12.0%	-	15.0%	9.0%
Driving alone to work – Percentage of the workforce that drives alone to work	78.0%	80.0%	-	76.0%	72.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	47.0%	48.0%	-	38.0%	16.0%

Health Outcomes	Huntingdon County: 2018	Huntingdon County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Mortality: Pennsylvania County Ranking	**18**	**35**	-		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	6,300	7,200	-	6,600	5,400
Morbidity: Pennsylvania County Ranking	**54**	**35**	+		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	16%	41%	-	19%	14%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	3.9	5.9	-	3.8	3.4
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.1	4.9	-	3.8	3.8
Low birth weight – Percent of live births with low birth weight (<2500 grams)	8.0%	9.0%	-	8.0%	6.0%

Health Outcomes	Huntingdon County: 2018	Huntingdon County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Health Behaviors: Pennsylvania County Ranking	**45**	**31**			
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	18.0%	23.0%	-	18.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	31.0%	32.0%	-	31.0%	26.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	8.3	8.4	+	8.4	8.7
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	26.0%	26.0%	NC	22.0%	19.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	58.0%	68.0%	+	84.0%	91.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	20.0%	21.0%	-	20.0%	15.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	29.0%	31.0%	-	26.0%	11.0%
Sexually transmitted infections – Chlamydia rate per 100K population	142.1	191.2	-	463.4	161.2
Teen birth rate – Per 1,000 female population, ages 15-19	23.0	18.0	+	17.0	12.0
Clinical Care: Pennsylvania County Ranking	**34**	**38**			
Uninsured adults – Percent of population under age 65 without health insurance	7.0%	7.0%	NC	7.0%	6.0%
Primary care physicians – Ratio of population to primary care physicians	2,400:1	2,820:1	-	1,230:1	1,030:1
Dentists – Ratio of population to dentists	3,040:1	3,220:1	-	1,410:1	1,210:1
Mental health providers – Ratio of population to mental health providers	1,140:1	940:1	+	450:1	270:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	86.0	43.1	+	44.6	25.7
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	67.0%	47.0%	-	45.0%	51.0%

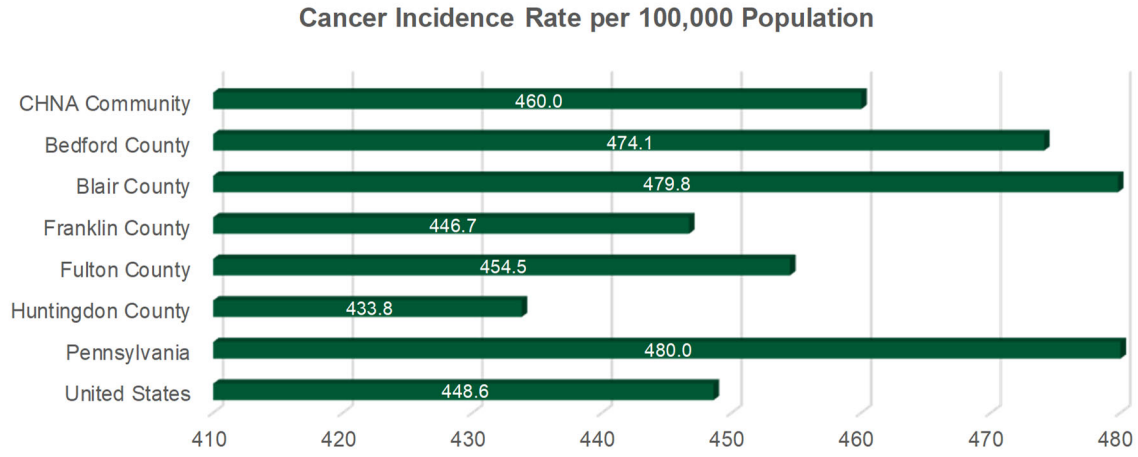
Health Outcomes	Huntingdon County: 2018	Huntingdon County: 2021	Change	Pennsylvania: 2021	Top US Performers: 2021
Social and Economic Factors: Pennsylvania County Ranking	**49**	**56**			
High school graduation – Percent of ninth grade cohort that graduates in 4 years	89.0%	89.0%	NC	91.0%	94.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	43.0%	48.0%	+	66.0%	73.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	7.1%	5.9%	+	4.4%	2.6%
Children in poverty – Percent of children under age 18 in poverty	19.0%	18.0%	+	17.0%	10.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	4.2	4.2	NC	4.8	3.7
Children in single-parent households – Percent of children that live in household headed by single parent	25.0%	21.0%	+	26.0%	14.0%
Social associations – Number of membership associations per 10,000 population	17.3	17.7	+	12.2	18.2
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	176.0	182.0	-	315.0	63.0
Injury deaths – Number of deaths due to injury per 100,000 population	84.0	77.0	+	89.0	59.0
Physical Environment: Pennsylvania County Ranking	**28**	**27**			
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	10.5	9.0	+	9.0	5.2
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	11.0%	11.0%	NC	15.0%	9.0%
Driving alone to work – Percentage of the workforce that drives alone to work	78.0%	78.0%	NC	76.0%	72.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	41.0%	44.0%	-	38.0%	16.0%

Data Source: Countyhealthrankings.org

The following data shows a more detailed view of certain health outcomes and factors. The percentages for the CHNA Community are compared to the state of Pennsylvania and the United States.

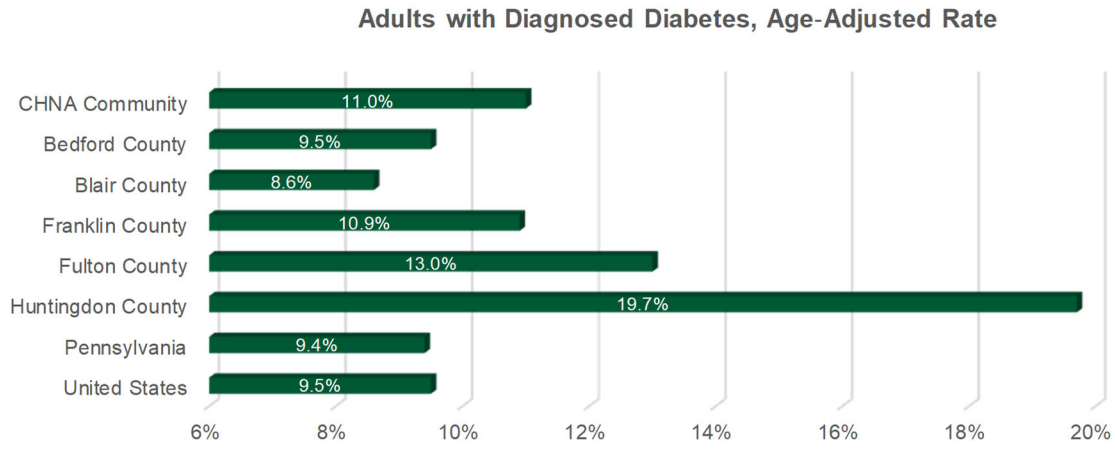
CANCER INCIDENCE

The CHNA Community's cancer incidence rate is 460.0 for every 100,000 of total population. Within the CHNA Community, there were 2,486 new cases of cancer reported. This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancer (all sites) adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older).



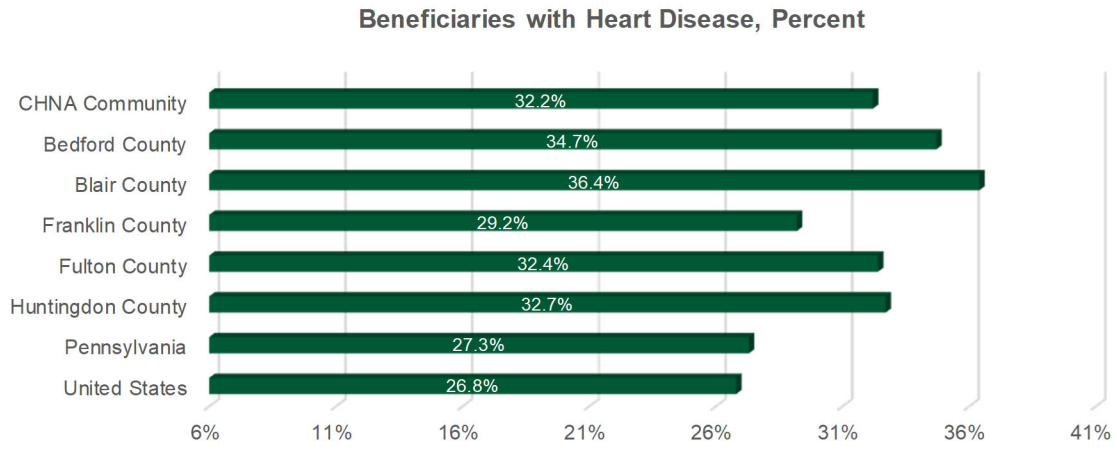
DIABETES (ADULT)

The CHNA Community's percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes is higher than the state rate and national rate. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.



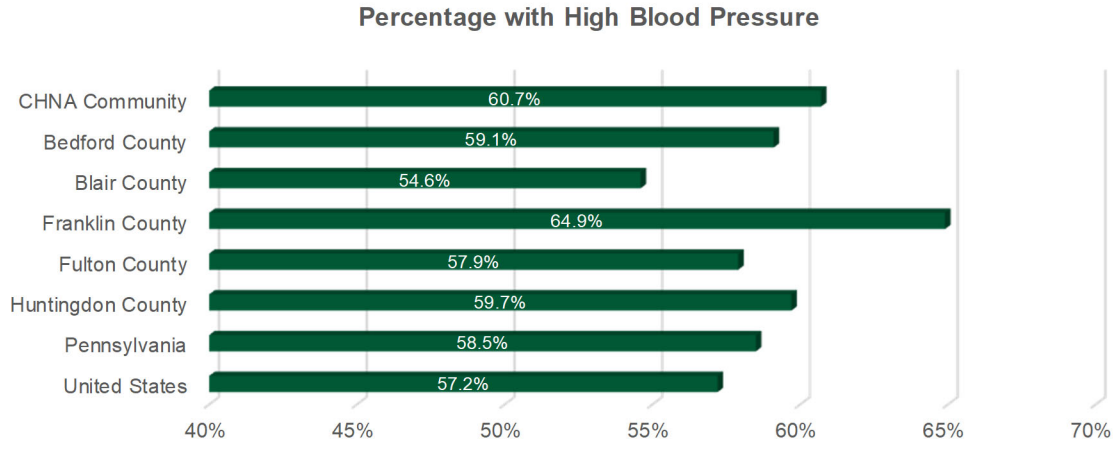
HEART DISEASE (MEDICARE POPULATION)

The CHNA Community's percentage Medicare population with Heart Disease is the higher than the state rate and national rate. This indicator reports the number and percentage of the Medicare fee-for-service population with ischemic heart disease.



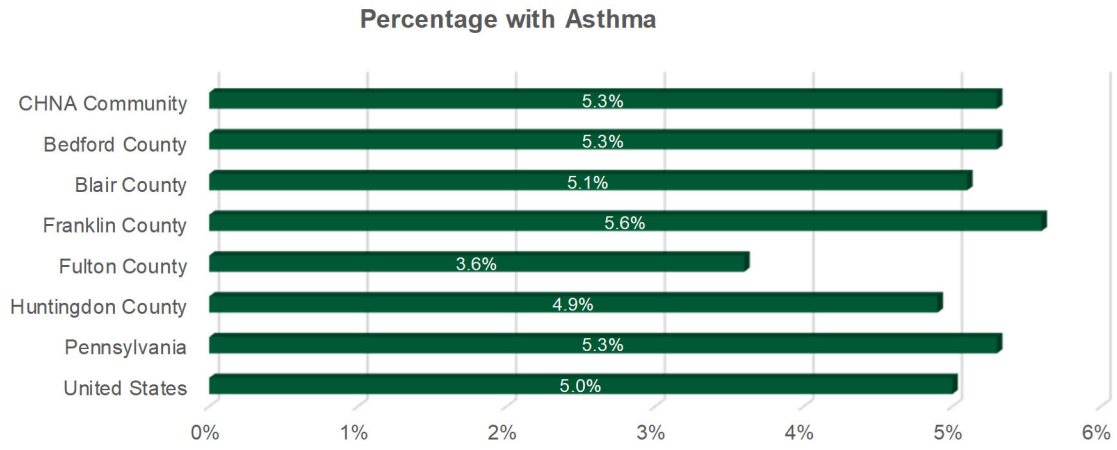
HIGH BLOOD PRESSURE (MEDICARE POPULATION)

The CHNA Community's percentage Medicare population with hypertension (high blood pressure) is higher than the state rate and national rates. This indicator reports the number and percentage of the Medicare fee-for-service population with hypertension (high blood pressure).



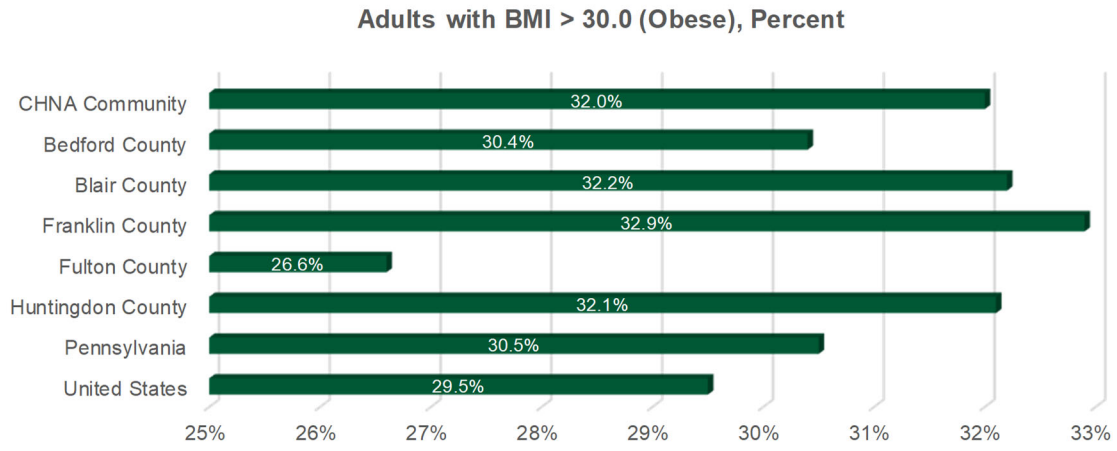
ASTHMA (MEDICARE POPULATION)

The CHNA Community's percentage Medicare population with asthma is equal to the state rate and slightly higher than national rate. This indicator reports the number and percentage of the Medicare fee-for-service population with asthma.



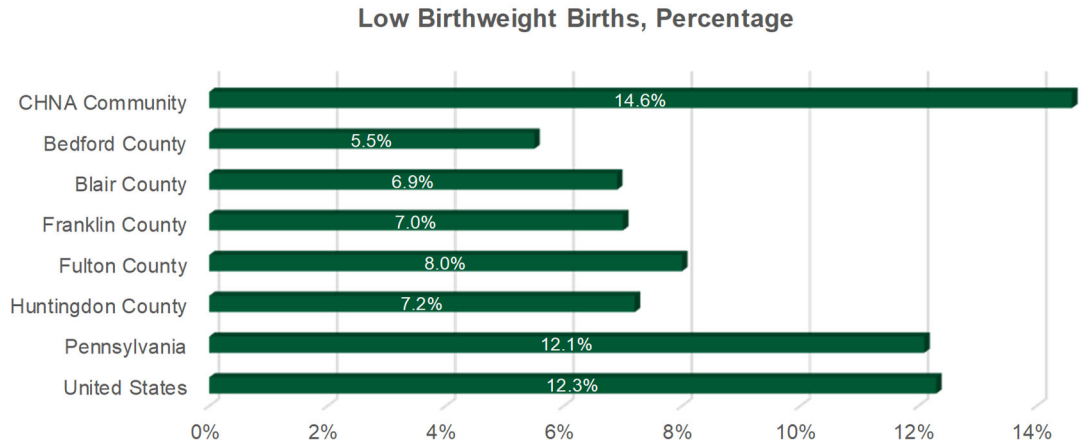
OBESITY

The CHNA Community's percentage of adults aged 20 and older that self-reported that they have a Body Mass Index (BMI) greater than 30.0 (obese) is higher than the state and national rates. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.



LOW BIRTH WEIGHT

The CHNA Community's percentage of total births that are low birth weight (under 2500g) is higher than the state and the national rates. This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.



PRIMARY DATA ASSESSMENT

Obtaining input from key stakeholders (persons with knowledge of or expertise in public health, persons representing vulnerable populations, or community members who represent the broad interest of the community, or) is a technique employed to assess public perceptions of the CHNA Community's health status and unmet needs. Key stakeholder input is intended to ascertain opinions among individuals likely to be knowledgeable about the community and influential over the opinions of others about health concerns in the community.

METHODOLOGY

Interviews with thirty key informants were conducted between October 2021. The interview participants were determined based on their a) specialized knowledge or expertise in public health, b) their affiliation with local government, schools, or c) their involvement with underserved and minority populations and represent a broad aspect of the community.

A representative from Fulton County Family Partnership assisted representatives from Fulton County Medical Center in contacting and scheduling all individuals selected for interviews. Their knowledge of the community, and the personal relationships they held with the potential interviewees added validity to the data collection process. If the respective key informant agreed to interviewed, an interview was scheduled with BKD.

All interviews utilized a standard format. Interview participant's opinions were collected without judging the truthfulness or accuracy of their remarks. Interviewees provided comments on the following issues:

- Health and quality of life for residents of the community
- Barriers to improving health and quality of life for residents of the community
- Opinions regarding the important health issues that affect the residents of the CHNA Community and the types of services that are important for addressing these issues
- Delineation of the most important health care issues or services discussed and actions necessary for addressing those issues

Interview data was collected and analyzed. Themes in the data were identified and representative quotes have been drawn from the data to illustrate the themes. Interview participants were assured that personal identifiers such as name or organizational affiliations would not be connected in any way to the information presented in this report. Therefore, quotes included in the report may have been altered slightly to preserve confidentiality. This technique does not provide a quantitative analysis of the leaders' opinions but reveals some of the factors affecting the views and sentiments about overall health and quality of life within the community.

KEY INFORMANT PROFILES

Key informants from the community worked for the following types of organizations and agencies:

- Local, county, and state government
- Public health agencies
- Medical providers

Input from these health care and non-health care professionals was obtained utilizing a standard 15 question interview format.

KEY INFORMANT INTERVIEW QUESTIONS

Input from these health care and non-health care professionals was obtained utilizing a standard 15-question interview format. The questions included were as follows:

1. Please provide a summary of your work and the work of your organization.
2. In general, how would you rate health and quality of life in the community?
3. In your opinion, in the past three years has health and quality of life in the community served by Fulton County Medical Center improved/declined/stayed the same?
4. Please provide what factors influenced your answer in the previous question and describe why you feel it has improved, declined, or stayed the same?
5. What barriers, if any, exist to improving health and quality of life of patients served by Fulton County Medical Center??
6. In your opinion, what needs to be done to address the barriers identified in the previous question?

7. In your opinion, what are the most critical health and quality of life issues in the community?
8. What needs to be done to address these issues?
9. Do you think access to Health Services has improved over the last 3 years? Why or why not
10. Are there any specialists (physicians) which are needed in the community? If so, what specialties are needed?
11. Are there people or groups of people in community whose health or quality of life may not be as good as others? Who are these persons or groups?
12. What is best mechanism for distributing health and wellness information to the community, in your opinion? Why?
13. How could the services provided by Fulton County Medical Center be improved to better meet the needs of its patients and patient's families?
14. In your opinion, what are the most critical health needs in the community served by Fulton County Medical Center?
15. What needs to be done to address the critical health needs issues identified in the previous question?

RESULTS FROM COMMUNITY INPUT

Analysis of key informant interview responses to the questions listed above resulted in the following identified community health needs for the CHNA Community served by Fulton County Medical Center:

- Access to care
- Shortage of healthcare workers
- Access to and use of preventative care treatments
- Treatment of and management of chronic diseases and conditions
- Access to primary care physicians
- Access to medical specialists
- Healthy behaviors and healthy lifestyle choices
- Access to mental health services - adults and children
- Access to COVID-19 testing and vaccines
- Access to drug and alcohol treatment services
- Health education
- Obesity
- Access to exercise opportunities
- Access to services for the aging
- Poverty and lack of financial resources

- Transportation
- Access to dental health services
- Access to senior facilities
- Access to safe and affordable housing
- Physical inactivity
- Suicide deaths

HEALTH ISSUES OF VULNERABLE POPULATIONS

According to Dignity Health's Community Need Index (see *Appendix D*), the counties within the Medical Center's CHNA Community has CNI scores ranging from 2.8 (Franklin and Huntingdon Counties) to 2.4 (Bedford County). Blair and Fulton Counties fell within the rage with CNI scores of 2.7 and 2.6, respectively. The CNI score is an average of five different barrier scores that measure socioeconomic indicators of each community (income, cultural, education, insurance, and housing). The scores range from 1 (lowest) to 5 (highest). The zip codes that have the highest need in the Medical Center's CHNA Community are detailed on the following table:

Zip Code	CNI Score	Population	City	County
16601	3.4	31,877	Altoona	Blair
17201	3.6	26,051	Chambersburg	Franklin
17268	3.4	30,942	Waynesboro	Franklin
16652	3.4	18,103	Huntingdon	Huntingdon
17066	3.6	5,156	Mount Union	Huntingdon

Based on information obtained through key informant interviews, the following populations are vulnerable or underserved in the community and the identified needs are listed:

- Uninsured and under-insured population
  - Transportation
  - High cost of health care prevents needs from being met
  - Healthy lifestyle and health nutrition education
- Elderly
  - Transportation
  - Cost of prescriptions and medical care
  - Lack of health knowledge regarding how to access services
  - Shortage of physicians (limit on patients who are on Medicare)
- Low income
  - High cost of health care prevents needs from being met
  - Healthy lifestyle and health nutrition education
  - Access to services

PRIORITIZATION OF IDENTIFIED HEALTH NEEDS

Priority setting is a required step in the community benefit planning process. The IRS regulations indicate that the CHNA must provide a prioritized description of the community health needs identified through the CHNA and include a description of the process and criteria used in prioritizing the health needs.

Using findings obtained through the collection of primary and secondary data, the Hospital completed an analysis of these inputs (see Appendices) to identify community health needs. The following data was analyzed to identify health needs for the community:

LEADING CAUSES OF DEATH

Leading causes of death for the community and the death rates for the leading causes of death for the county within the Hospital's CHNA Community were compared to U.S. adjusted death rates.

Causes of death in which the county rate compared unfavorably to the U.S. adjusted death rate resulted in a health need for the Hospital's CHNA Community.

HEALTH OUTCOMES AND FACTORS

An analysis of the County Health Rankings health outcomes and factors data was prepared for the county within Fulton County Medical Center's CHNA Community. County rates and measurements for health behaviors, clinical care, social and economic factors, and the physical environment were compared to state benchmarks.

County rankings in which the county rate compared unfavorably (by greater than 30% of the national benchmark) resulted in an identified health need.

PRIMARY DATA

Health needs identified through key informant surveys were included as health needs. Needs for vulnerable populations were separately reported on the analysis in order to facilitate the prioritization process.

HEALTH NEEDS OF VULNERABLE POPULATIONS

Health needs of vulnerable populations were included for ranking purposes.

PRIORITIZATION METHODOLOGY

To facilitate prioritization of identified health needs, a ranking process was used. Health needs were ranked based on the following factors (each factor received a score):

1. **How many people are affected by the issue or size of the issue?** For this factor, ratings were based on the percentage of the community who are impacted by the identified need. The following scale was utilized: >25% of the community= 5; >15% and <25%=4; >10% and <15%=3; >5% and <10%=2 and <5%=1.
2. **What are the consequences of not addressing this problem?** Identified health needs which have a high death rate or have a high impact on chronic diseases received a higher rating.
3. **The impact of the problem on vulnerable populations.** Needs identified which pertained to vulnerable populations were rated for this factor.
4. **How important the problem is to the community?** Needs identified through community interviews and/or focus groups were rated for this factor.
5. **Prevalence of common themes.** The rating for this factor was determined by how many sources of data (leading causes of death, health outcomes and factors and primary data) identified the need.

Each need was ranked based on the prioritization metrics. As a result, the following summary list of needs was identified:

Identified Health Needs	How Many People Are Affected by the Issue? (1 Low - 5 High)	What Are the Consequences of Not Addressing This Problem? (1 Low - 5 High)	What is the Impact on Vulnerable Populations? (1 Low - 5 High)	How Important is it to the Community? (1 Low - 5 High)
Access to care	5	4	5	4.36
Shortage of healthcare workers	5	4	3	4.57
Access to and use of preventative care treatments	5	3	3	4.46
Treatment of & mgmt of chronic diseases & conditions	4	5	3	4.14
Access to primary care physicians	5	3	3	4.18
Access to medical specialists	5	3	3	4.21
Healthy behaviors and healthy lifestyle choices	3	4	5	3.93
Access to mental health services - adults and children	5	3	3	4.82
Access to COVID-19 testing and vaccines	5	4	3	4.24
Access to drug and alcohol treatment services	5	3	3	4.75
Health education	3	3	5	3.72
Obesity	3	5	3	3.93
Access to exercise opportunities	5	3	3	3.83
Access to services for the aging	3	3	5	4.11
Stroke	4	3	3	3.52
Poverty and lack of financial resources	2	4	5	4.21
Transportation	3	3	4	4.04
Access to dental health services	5	2	3	4.10
Access to senior facilities	3	2	5	4.00
Access to safe and affordable housing	5	2	3	4.43
Mammography screening	2	3	2	3.82
Physical inactivity	2	3	3	3.76
Children in poverty	2	2	5	4.21
Adult smoking	2	3	2	3.34
Drug poisoning	3	3	2	3.56
Suicide deaths	2	4	2	4.11
Children in single-parent households	2	2	5	3.72
Preventable hospital stays	2	2	2	3.75
Excessive drinking	3	2	2	3.97
Sexually transmitted infections	2	3	3	3.31

Identified Health Needs	Prevalence of Common Themes (1 Low - 2 High)	Alignment with Mission (1 Low - 5 High)	Alignment with Programs & Strategic Priorities (1 Low - 5 High)	Total Score
Access to care	2	4.40	4.20	28.96
Shortage of healthcare workers	2	4.35	4.00	26.92
Access to and use of preventative care treatments	2	4.65	4.58	26.69
Treatment of & mgmt of chronic diseases & conditions	2	4.32	4.15	26.61
Access to primary care physicians	2	4.40	4.40	25.98
Access to medical specialists	2	4.40	4.30	25.91
Healthy behaviors and healthy lifestyle choices	2	3.95	4.00	25.88
Access to mental health services - adults and children	2	4.00	4.05	25.87
Access to COVID-19 testing and vaccines	1	4.15	4.10	25.49
Access to drug and alcohol treatment services	2	3.65	3.65	25.05
Health education	2	4.10	3.95	24.77
Obesity	2	3.85	3.80	24.58
Access to exercise opportunities	1	4.00	3.90	23.73
Access to services for the aging	1	3.80	3.70	23.61
Stroke	2	4.05	3.65	23.22
Poverty and lack of financial resources	2	2.70	2.75	22.66
Transportation	2	3.15	3.32	22.51
Access to dental health services	2	3.20	2.85	22.15
Access to senior facilities	1	3.55	3.55	22.10
Access to safe and affordable housing	1	2.85	2.60	20.88
Mammography screening	1	4.50	4.40	20.72
Physical inactivity	1	3.65	3.85	20.26
Children in poverty	1	2.65	2.74	19.60
Adult smoking	2	3.55	3.55	19.44
Drug poisoning	1	3.40	3.20	19.16
Suicide deaths	1	3.00	2.95	19.06
Children in single-parent households	1	2.75	2.50	18.97
Preventable hospital stays	1	4.15	3.95	18.85
Excessive drinking	1	3.10	2.95	18.02
Sexually transmitted infections	1	2.85	2.80	17.96

MANAGEMENT'S PRIORITIZATION PROCESS

For the health needs prioritization process, the Hospital engaged the leadership team to review the most significant health needs identified in the current process, using the following criteria:

- Current area of Hospital focus
- Established relationships with community partners to address the health need
- Organizational capacity and existing infrastructure to address the health need

This data was reviewed to identify health issues of uninsured persons, low-income persons and minority groups, and the community. As a result of the analysis described above, seven "Priority Areas" have been identified by FCMC based on the needs identified in the community health needs assessment:

- Drug and Alcohol Abuse
- Mental Health
- Housing
- Healthy Behaviors
- Transportation
- Poverty
- Senior Housing and Assisted Living

The Hospital's next steps include developing an implementation strategy to address these priority areas.

COMMUNITY RESOURCES

The availability of health care resources is a critical component to the health of a county's residents and a measure of the soundness of the area's health care delivery system. An adequate number of health care facilities and health care providers are vital for sustaining a community's health status. Fewer health care facilities and health care providers can impact the timely delivery of services. A limited supply of health resources, especially providers, results in the limited capacity of the health care delivery system to absorb charity and indigent care as there are fewer providers upon which to distribute the burden of indigent care.

HOSPITALS

The Fulton County Medical Center is an 88-bed critical access hospital and skilled nursing care facility located within the CHNA Community. Residents of the community can take advantage of services provided by other hospitals within the CHNA Community, as well as services offered by other facilities and providers.

The following table summarizes hospitals, licensed and regulated by the Pennsylvania Department of Health, available to the residents of the CHNA Community. The facilities listed are located within the CHNA Community served by the Medical Center.

HOSPITALS – BEDFORD COUNTY

Facility Name	Type of Facility	City, State Zip
UPMC Bedford	Hospital	Everett, PA 15537

HOSPITALS – BLAIR COUNTY

Facility Name	Type of Facility	City, State Zip
Conemaugh Nason Medical Center	Hospital	Roaring Spring, PA 16673
Encompass Health Rehab Hospital of Altoona	Hospital	Altoona, PA 16602
Penn Highlands Tyrone	Hospital	Tyrone, PA 16686
UPMC Altoona	Hospital	Altoona, PA 16601

HOSPITALS – FRANKLIN COUNTY

Facility Name	Type of Facility	City, State Zip
The Chambersburg Hospital	Hospital	Chambersburg, PA 17201
Waynesboro Hospital	Hospital	Waynesboro, PA 17268

HOSPITALS – FULTON COUNTY

Facility Name	Type of Facility	City, State Zip
The Fulton County Medical Center	Hospital	McConnellsburg, PA 17233

HOSPITALS – HUNTINGDON COUNTY

Facility Name	Type of Facility	City, State Zip
Penn Highlands Huntingdon	Hospital	Huntingdon, PA 16652

OTHER HEALTH CARE FACILITIES

Short-term acute care hospital services are not the only health services available to members of the Hospital's CHNA Community. The table below provides a listing of other healthcare resources within the Hospital's CHNA Community.

OTHER HEALTHCARE FACILITIES – BEDFORD COUNTY

Facility Name	Type of Facility	City, State Zip
US Renal Care Bedford Dialysis	End Stage Renal Disease	Everett, PA 15537
Hyndman Area Health Center	Federally Qualified Health Center	Everett, PA 15537
Hyndman Area Health Center	Federally Qualified Health Center	Hyndman, PA 15545
EZ Chair Social Services	Home Care Agencies/Registries	Bedford, PA 15522
First Choice in Home Care	Home Care Agencies/Registries	Bedford, PA 15522
Helpmates, Inc.	Home Care Agencies/Registries	Bedford, PA 15522
Home Instead Senior Care	Home Care Agencies/Registries	Saxton, PA 16678
Pennknoll Village	Nursing Care Facility	Everett, PA 15537
Promedica Skilled Nursing and Rehabilitation	Nursing Care Facility	Bedford. PA 15522
New Paris Rural Health Clinic	Rural Health Clinics	New Paris, PA 15554

OTHER HEALTHCARE FACILITIES – BLAIR COUNTY

Facility Name	Type of Facility	City, State Zip
Advanced Center for Surgery	Ambulatory Surgical Center	Altoona, PA 16602
Allegheny Regional Endoscopy	Ambulatory Surgical Center	Altoona, PA 16602
Allegheny Surgery Center	Ambulatory Surgical Center	Altoona, PA 16602
Center for the Surgical Arts	Ambulatory Surgical Center	Altoona, PA 16602
East Freedom Surgical Associates	Ambulatory Surgical Center	Duncansville, PA 16635
Laurel Laser & Surgery Center - Altoona	Ambulatory Surgical Center	Duncansville, PA 16635
UPMC Altoona Surgery Center	Ambulatory Surgical Center	Altoona, PA 16601
Fresenius Medical Care Altoona	End Stage Renal Disease	Altoona, PA 16602
Roaring Spring Dialysis	End Stage Renal Disease	Roaring Spring, PA 16673
Tyrone Dialysis	End Stage Renal Disease	Tyrone, PA 16686
US Renal Care Altoona Dialysis Center	End Stage Renal Disease	Altoona, PA 16601
Altoona Behavioral Health	Federally Qualified Health Center	Altoona, PA 16601
Altoona Community Health Center	Federally Qualified Health Center	Altoona, PA 16601
Aging in Place Services	Home Care Agencies/Registries	Martinsburg, PA 16662
Alsm at Home	Home Care Agencies/Registries	Altoona, PA 16601
Arcadia Home Care & Staffing	Home Care Agencies/Registries	Altoona, PA 16602
Community Resources for Independence	Home Care Agencies/Registries	Altoona, PA 16601
Cove Home Care	Home Care Agencies/Registries	Roaring Spring, PA 16673
From the Heart at Penn State	Home Care Agencies/Registries	Hollidaysburg, PA 16648
Griswold Home Care	Home Care Agencies/Registries	Duncansville, PA 16635
Helpmates	Home Care Agencies/Registries	Duncansville, PA 16635
Home Helpers	Home Care Agencies/Registries	Hollidaysburg, PA 16648
Home Instead Senior Care	Home Care Agencies/Registries	Duncansville, PA 16635
Home Nursing Agency	Home Care Agencies/Registries	Altoona, PA 16601
Homewood at Martinsburg PA	Home Care Agencies/Registries	Martinsburg, PA 16662
Integrity Home Care LLC	Home Care Agencies/Registries	Altoona, PA 16602

Facility Name	Type of Facility	City, State Zip
Interim HC Personal Care & Support Services	Home Care Agencies/Registries	Duncansville, PA 16635
Medstaffers	Home Care Agencies/Registries	Altoona, PA 16601
Our Lady of the Alleghenies Residence	Home Care Agencies/Registries	Hollidaysburg, PA 16648
Presbyterian Village at Hollidaysburg	Home Care Agencies/Registries	Hollidaysburg, PA 16648
Advantage Home Health Services	Home Health	Altoona, PA 16601
Nason Hospital Home Health Agency	Home Health	Roaring Spring, PA 16673
Omni Home Care	Home Health	Tyrone, PA 16686
UPMC Home Healthcare of Central Pennsylvania	Home Health	Altoona, PA 16601
Village in Place Services	Home Health	Martinsburg, PA 16662
Aseracare Hospice	Hospice	Altoona, PA 16602
Family Hospice	Hospice	Altoona, PA 16601
Grane Hospice Care	Hospice	Altoona, PA 16602
Kindred Hospice	Hospice	Altoona, PA 16601
Village in Place Hospice	Hospice	Martinsburg, PA 16662
Altoona Center for Nursing Care	Nursing Care Facility	Altoona PA 16601
Epworth Healthcare and Rehabilitation Center	Nursing Care Facility	Tyrone PA 16686
Garvey Manor	Nursing Care Facility	Hollidaysburg PA 16648
Guardian Healthcare Altoona	Nursing Care Facility	Altoona PA 16602
Hollidaysburg Veterans' Home	Nursing Care Facility	Hollidaysburg PA 16648
Homewood at Martinsburg	Nursing Care Facility	Martinsburg PA 16662
Lutheran Home at Hollidaysburg	Nursing Care Facility	Hollidaysburg PA 16648
Maybrook Hills Rehab and Healthcare Center	Nursing Care Facility	Altoona PA 16602
Morrisons Cove Home	Nursing Care Facility	Martinsburg PA 16662
Presbyterian Homes	Nursing Care Facility	Hollidaysburg PA 16648
Benchmark Therapies	Physical/Speech Therapist	Duncansville, PA 16635
Crossroads Physical Therapy And Rehab	Physical/Speech Therapist	Duncansville, PA 16635
Genesis Rehabilitation Services	Physical/Speech Therapist	Duncansville, PA 16635
Novacare Rehabilitation	Physical/Speech Therapist	Altoona, PA 16602
Procare PT	Physical/Speech Therapist	Altoona, PA 16602
Conemaugh Nason Physician Group	Rural Health Clinics	Claysburg, PA 16625
Penn Highlands Tyrone Rural Health Clinic	Rural Health Clinics	Tyrone, PA 16686

OTHER HEALTHCARE FACILITIES – FRANKLIN COUNTY

Facility Name	Type of Facility	City, State Zip
Ludwick Laser and Surgery Center	Ambulatory Surgical Center	Chambersburg, PA 17201
Wellspan Chambersburg Endoscopy Center	Ambulatory Surgical Center	Chambersburg, PA 17201
Wellspan Dr. Roy A. Himelfarb Surgery Center	Ambulatory Surgical Center	Chambersburg, PA 17201
Dialysis Care Center Chambersburg	End Stage Renal Disease	Chambersburg, PA 17201
Fresenius Medical Care Waynesboro	End Stage Renal Disease	Waynesboro, PA 17268
Fresenius Medical Care Chambersburg	End Stage Renal Disease	Chambersburg, PA 17201

Facility Name	Type of Facility	City, State Zip
US Renal Care Chambersburg Dialysis	End Stage Renal Disease	Chambersburg, PA 17201
Franklin County Heart Center	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Behavioral Health	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Chiropractic Services	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Crisis Intervention	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Dental Center	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Dental Center - Path Valley	Federally Qualified Health Center	Dry Run, PA 17220
Keystone Dental Mont Alto	Federally Qualified Health Center	Waynesboro, PA 17268
Keystone Family Planning	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Foot And Ankle Center Chambersburg	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Foot And Ankle Center Waynesboro	Federally Qualified Health Center	Waynesboro, PA 17268
Keystone Health Center	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Health Center - Path Valley	Federally Qualified Health Center	Dry Run, PA 17220
Keystone Infectious Disease	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Internal Medicine	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Pediatric Dental	Federally Qualified Health Center	Aqua, PA 17201
Keystone Pediatric Therapies	Federally Qualified Health Center	Scotland, PA 17254
Keystone Pediatrics	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Pediatrics - Waynesboro	Federally Qualified Health Center	Waynesboro, PA 17268
Keystone School Health Center	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Urgent Medical Care	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Women's Care	Federally Qualified Health Center	Chambersburg, PA 17201
Keystone Women's Care	Federally Qualified Health Center	Chambersburg, PA 17201
Aveanna Healthcare	Home Care Agencies/Registries	Chambersburg, PA 17201
Baboo Home Care Agency	Home Care Agencies/Registries	Waynesboro, PA 17268
Blue Mountain Home Health Care	Home Care Agencies/Registries	Chambersburg, PA 17201
Golden Hearts Home Health	Home Care Agencies/Registries	Shippensburg, PA 17257
Hearthstone In-Home Care Services	Home Care Agencies/Registries	Waynesboro, PA 17268
Helping Hands In Home Care	Home Care Agencies/Registries	Chambersburg, PA 17202
Heritage In Home Care Services	Home Care Agencies/Registries	Greencastle, PA 17225
In Good Hands Home Care	Home Care Agencies/Registries	Chambersburg, PA 17202
Menno Haven at Home	Home Care Agencies/Registries	Chambersburg, PA 17201
Myers Home Healthcare	Home Care Agencies/Registries	Chambersburg, PA 17201
Penncares	Home Care Agencies/Registries	Chambersburg, PA 17201
Quincy Village	Home Care Agencies/Registries	Quincy, PA 17247
Spiritrust Lutheran Home Care & Hospice	Home Care Agencies/Registries	Chambersburg, PA 17201
Stay Home Senior Services	Home Care Agencies/Registries	Greencastle, PA 17225
Visiting Angels	Home Care Agencies/Registries	Waynesboro, PA 17268
Aveanna Healthcare	Home Health	Chambersburg, PA 17201
Community Home Health Care	Home Health	Chambersburg, PA 17201

Facility Name	Type of Facility	City, State Zip
Spiritrust Lutheran Home Care & Hospice	Home Health	Chambersburg, PA 17201
Franklin Hospice	Hospice	Chambersburg, PA 17201
Spiritrust Lutheran Home Care & Hospice	Hospice	Chambersburg, PA 17201
Brookview Health Care Center	Nursing Care Facility	Chambersburg PA 17201
Chambers Pointe Health Care Center	Nursing Care Facility	Chambersburg PA 17201
Laurel Lakes Rehabilitation and Wellness Center	Nursing Care Facility	Chambersburg PA 17202
Menno Haven Rehabilitation Center	Nursing Care Facility	Chambersburg PA 17201
Promedica Skilled Nursing and Rehabilitation	Nursing Care Facility	Chambersburg PA 17201
Quincy Retirement Community	Nursing Care Facility	Waynesboro PA 17268
The Shook Home	Nursing Care Facility	Chambersburg PA 17201
South Mountain Restoration Center	Nursing Care Facility	South Mountain PA 17261
Spiritrust Lutheran the Village at Luther Ridge	Nursing Care Facility	Chambersburg PA 17202
Genesis Rehabilitation Services	Physical/Speech Therapist	Chambersburg, PA 17202

OTHER HEALTHCARE FACILITIES – FULTON COUNTY

Facility Name	Type of Facility	City, State Zip
Dialysis Care Center Fulton County	End Stage Renal Disease	McConnellsburg, PA 17233
Community Resources for Independence	Home Care Agencies/Registries	McConnellsburg, PA 17233
Team Home Health	Home Health	McConnellsburg, PA 17233
Fulton County Medical Center	Nursing Care Facility	McConnellsburg, PA 17233

OTHER HEALTHCARE FACILITIES – HUNTINGDON COUNTY

Facility Name	Type of Facility	City, State Zip
Fresenius Kidney Care of Huntingdon	End Stage Renal Disease	Huntingdon, PA 16652
US Renal Care Huntingdon Dialysis	End Stage Renal Disease	Huntingdon, PA 16652
Broad Top Area Medical Center	Federally Qualified Health Center	Huntingdon, PA 16652
Broad Top Area Medical Center	Federally Qualified Health Center	Broad Top, PA 16621
Broad Top Area Medical Center	Federally Qualified Health Center	Huntingdon, PA 16652
Broad Top Area Medical Center	Federally Qualified Health Center	Huntingdon, PA 16652
Broad Top Area Medical Center	Federally Qualified Health Center	Mount Union, PA 17066
Broad Top Area Medical Center	Federally Qualified Health Center	Cassville, PA 16623
Huntingdon Family Care Center	Federally Qualified Health Center	Huntingdon, PA 16652
Primary Care Center	Federally Qualified Health Center	Huntingdon, PA 16652
Arcadia Home Care & Staffing	Home Care Agencies/Registries	Huntingdon, PA 16652
Helpmates	Home Care Agencies/Registries	Huntingdon, PA 16652
Huntingdon County Pride	Home Care Agencies/Registries	Huntingdon, PA 16652
Westminster Woods at Huntingdon	Home Care Agencies/Registries	Huntingdon, PA 16652
Embassy of Huntingdon Park	Nursing Care Facility	Huntingdon PA 16652
Embassy of Woodland Park	Nursing Care Facility	Orbisonia PA 17243

Facility Name	Type of Facility	City, State Zip
Westminster Woods at Huntingdon	Nursing Care Facility	Huntingdon PA 16652
Southern Huntingdon County Medical Center	Rural Health Clinics	Orbisonia, PA 17243
UPMC Huntingdon Healthcare	Rural Health Clinics	Huntingdon, PA 16652
UPMC Huntingdon Healthcare	Rural Health Clinics	Alexandria, PA 16611

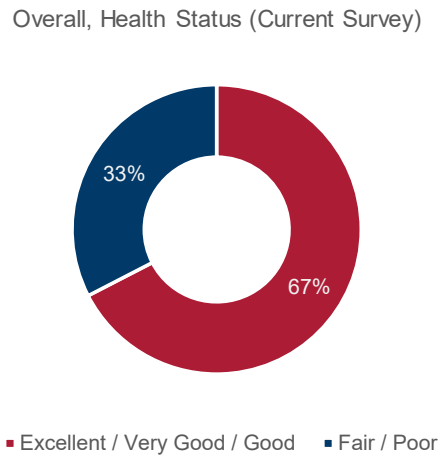
In addition to the facilities listed above, the CHNA Community includes numerous other healthcare facilities (e.g. physician offices, pharmacies, etc.).

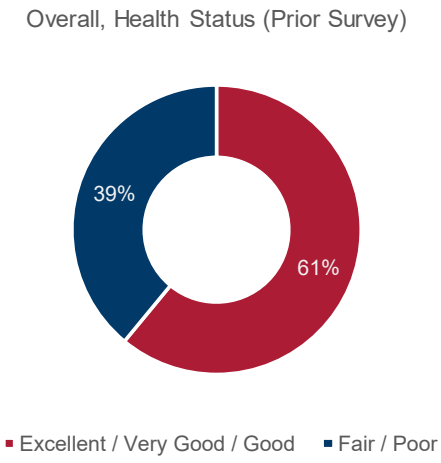
COMMUNITY SURVEY

A community survey was conducted from September 2021 to November 2021 as part of the current community health needs assessment process. The questions in the survey were designed to gather information to assist Fulton County Medical Center in developing a plan to improve health and quality of life in the CHNA Community. Three hundred and sixty individuals completed the survey. The current survey results are compared to results from the survey conducted as part of the prior CHNA.

OVERALL COMMUNITY HEALTH STATUS

Survey participates were asked to rate the overall health status of the community. Survey respondents indicated the overall health status of the community improved from the prior community health needs assessment. The percentage of respondents in the current survey indicating the overall health status of the community as “Fair / Poor” decreased to 33% from 39% in the prior survey.

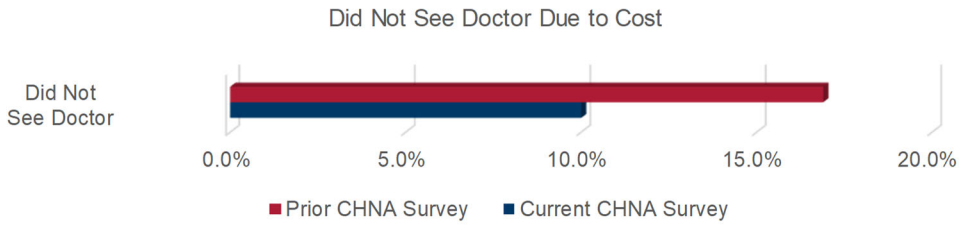


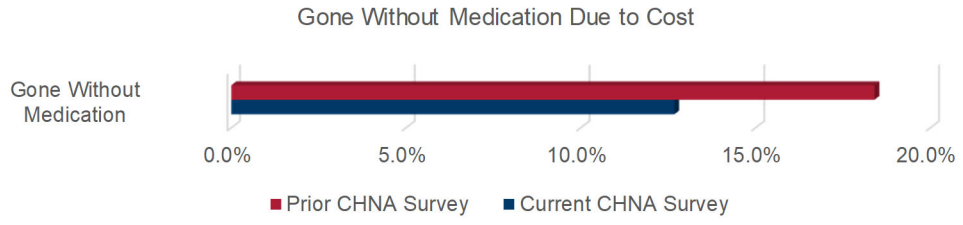


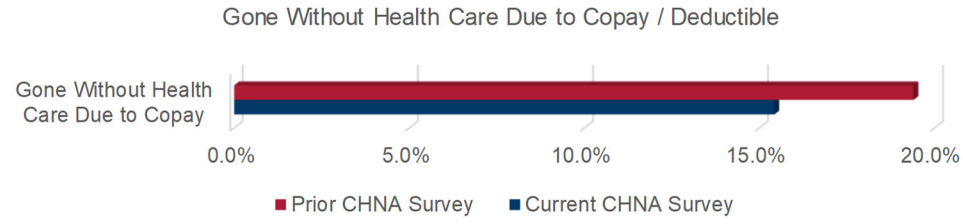
ACCESS ISSUES

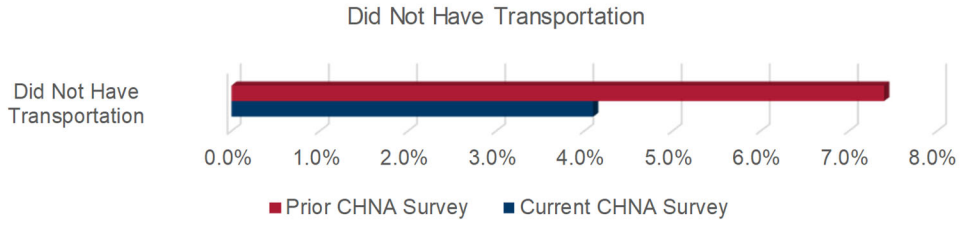
A portion of community survey respondents experienced difficulty accessing needed health care because of cost health care, medication or copays/deductibles. Others indicated they had gone without health care because they lacked transportation. In the current survey. There were

10.0% of the community survey respondents who needed to see a doctor but did not because of cost; 12.7% have gone without medication because of cost; 15.4% have gone without health care due to the cost of copays or deductibles while; and 4.1% have gone without healthcare because they had no way to get there. These percentages have improved since the prior survey.



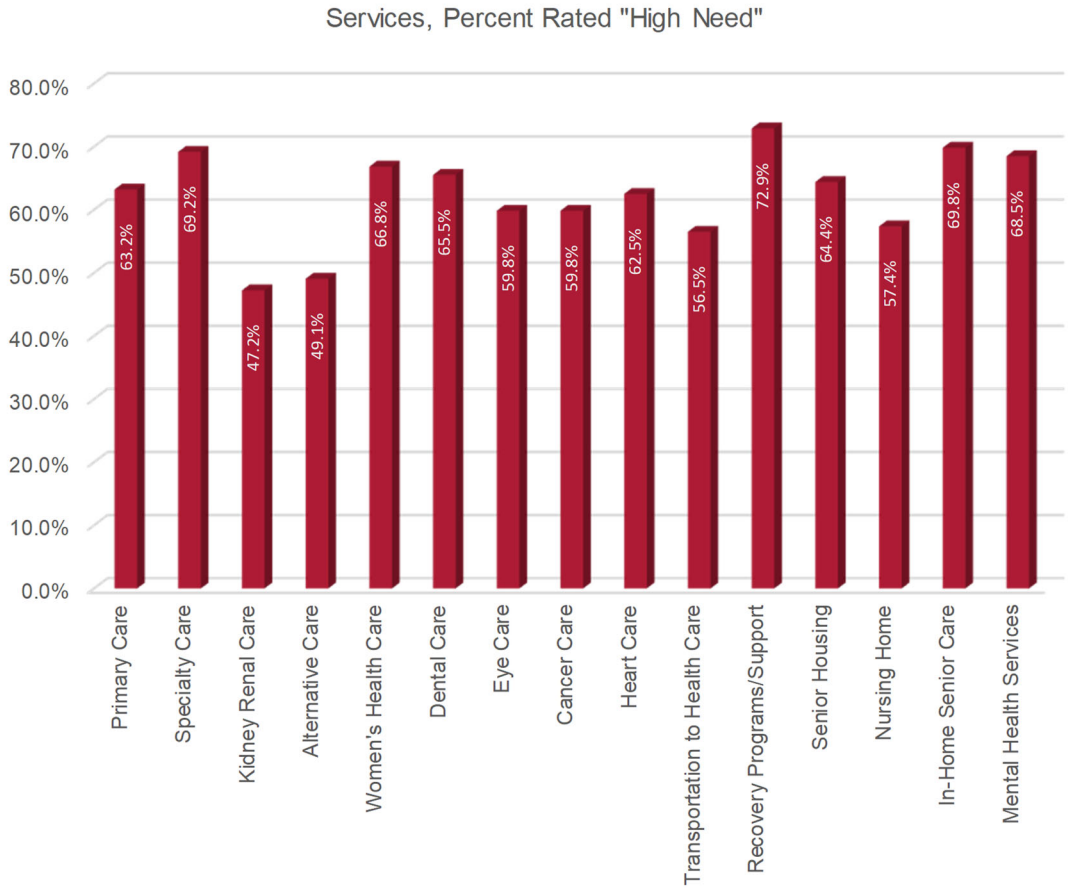






SERVICES

Survey respondents were asked to rate the level of need ("High Need" to "No Need") in the community for various services. The following represents the percentage of respondents that indicated a service has a "High Need" in the community.



APPENDICES

APPENDIX A – 2019 IMPLEMENTATION STRATEGY ACTION STEPS AND STATUS

2019 IMPLEMENTATION STRATEGY ACTION STEPS AND STATUS

Goal 1: Develop programs to help reduce obesity and the related health conditions

Objective	Action Step	Current Status
Improve access and education related to fresh affordable food	1. Continue to offer nutrition education and screenings in the community	Food Drops, community has stepped up to help those in need
	2. Meet with Food Basket to determine how to best provide support to ensure residents have access to affordable healthy food	Other than food drops in the community, this is on hold due to COVID
	3. Meet with Giant to see if they will do healthy food shopping days, cooking classes, etc.	On hold – COVID
	4. Continue to offer and promote monthly cooking classes @ the Wellness Center in collaboration with referrals from PCPs	On hold
	5. Collaborate with Cura Hospitality to offer nutrition education for the community	In process
	6. Continue to offer resources and referral to patients on available food pantries and nutrition education programs	Prescription Pad has been distributed and providers are using it.
Increase opportunities for physical activity and recreation throughout the community and educate on available opportunities	1. Continue to assess community needs and interest and expand offerings at the Wellness Center to meet these needs	Wellness Center has closed due to Covid testing, but has put some of their classes on Zoom.
	2. Partner with the Chamber to create a community calendar of upcoming opportunities	Chamber is not currently meeting, but will send blurbs out in their weekly email
	3. Partner with Chamber to develop brochure that lists all available opportunities for physical activity and recreation in the community that FCMC and Partners can help promote	On hold

Goal 2: Improve access and care coordination for behavioral health services

Objective	Action Step	Current Status
Increase awareness of available behavioral health services (Mental Health and Substance Use Disorder)	1. Collaborate to develop a county-wide marketing plan to increase knowledge within the community on access to behavioral health services which might include reintroduction of Flip Your Card (brochure)	Resources are listed and updated on FCFP Facebook page and website. Resource list is available
	2. Increasing provider participation to support objective and provide data (Fulton County Provider meeting - 1 time)	
	3. Implement county-wide marketing plan	FC Partnership updated Directory and Resource list – Directory went out in the fall and Resource list is updated on the Partnership website

Goal 2: (Continued)

Objective	Action Step	Current Status
Improve treatment, support and care coordination	1. Convene Care Coordination Summit for Providers	On hold
	2. Actively support Individuals in Recovery through workforce initiative that includes collaboration with local employers	Workforce group met on a regular basis and developed resource cards to be given to employers to educate them on MH issues. Also a short video was made and given to the Chamber to present to local employers. Currently have one Certified Recovery Specialist hired, Care Coordinator has been hired at the FCMC, Leadership Academy for Fulton County was held in August/September, Working on Employment and Training with Penn State Mont Alto/DDAP CRS in Franklin and Fulton Counties, Collecting of various surveys for employers as part of an educational agenda HRSA grant is funding the SBIRT program for FCMC. This partnership includes FFDA, True North, FCFP and FCMC
	3. Develop workforce initiative for individuals in recovery (establish who needs to come to table, then determine what are protocols/procedure/criteria, then can recruit employers/employees	Currently on hold
	4. Continue to integrate behavioral health care into primary care and collaborate with True North to provide those services both on site as well as standalone services, continue to identify gaps in continuum	
	5. Support Care Coordination	
Improve access for commercial insurance and Medicare individuals	1. Collaborate with individuals to gather information from providers to assist with understanding barriers.	CoPays tend to be the ongoing issue
Minimize barriers (including stigma) to accessing available services	1. Create a stigma reduction campaign related to OUD/SUD treatment	There are 5 billboards around the county about addiction. Recovery month proclamation on September 8th with several community awareness events being planned including media attention. Project: SAAFE, FCFP, True North, Gaudenzia and FCMC are partnering with FFDA to educate the community as well as offer support to the recovery community
	2. Support the nationwide annual Walk the Walk to sustain and increase awareness across all counties served	FCFP supported the MHA Annual Walk the Walk via virtual sessions on stress and burnout.
	3. Work with local providers and review existing data to identify barriers consumers are experiencing related to compliance with treatment and then work with providers to determine true barrier and collaborative approach to address those barriers	
	4. Form/Implement Community Cross Collaborative Group	
	5. Olmstead plan - (Jim Gilbert county rep) to update, projects that are occurring. Dozens of surveys in Fulton County on quality of life	

Goal 2: (Continued)

Objective	Action Step	Current Status
Work collaboratively to address youth risk behaviors as identified in the PAYS data	1. Will follow the PAYS Workplan	See Partner minutes from June, 2020, September, 2020. – Action plan is developed and being implemented.

Goal 3: Develop a full continuum of aging services to meet the needs of older persons in Fulton County

Objective	Action Step	Current Status
Continue to explore options for developing senior living services/assisted living on FCMC campus	1. Explore the requirements for applying for CMS' NOFA - for community navigation of services for seniors	On hold
	2. Investigate and visit best practice senior living/ assisted living facilities connected to hospital campuses.	On hold
Continue to integrate hospice into the continuum of aging services	1. Continue to work with Spirit Trust Lutheran, Grace Hospice and heartland , offering hospice services to the aging population	FCMC offers available information to patients needing palliative or hospice care
Revamp the senior services collaboration to include Bedford/Huntingdon/ Fulton Area Agency on Aging and Franklin/Fulton Mental Health to increase education, awareness, and services available to aging adults in the community	1. Re-engage the members of the senior workgroup	Looking at FCOAAT to collaborate with for CHNA Goals & Action Steps. January, 2021: FCOAAT Update: Purpose of the FCOAAT is to tie Mental Health Services to the Aging population Challenge is how can we share this information to both groups Comprised of an advocacy team of professionals working to bridge the two areas There are various roles and functions Group started in Franklin County and then expanded to Fulton If there is a potentially unsafe living environment, how can we connect them to services Crisis services as well as prevention Team includes Linda Lafferty, FCMC, HBFAAA, TrueNorth, Mobile Psychiatric nurse This group meets the second Thursday of each month at 10:00 AM

Goal 4: Improve access and care coordination for behavioral health services

Objective	Action Step	Current Status
Improve education and access to existing services	1. Establish contact with MCOs for physical health, UPMC for you Amerihealth, Gateway, United Health Care, Aetna	On hold
	2. Ensure resource document is up to date and handout to all patients identified with a condition	Resource document is updated and will be handed out
	3. Collaborate with local EMS to ensure they have educational materials on managing chronic conditions as well as available services in the community	Prescription pad was developed, given to providers and they are giving it to patients
	4. Market the new dialysis program provided by Dialysis Care Center at FCMC	Dialysis is full with 16 patients seen in January, 2021. Dr. Tijani, internal medicine has joined the FCMC and will work with medically complex patients
	5. Continue 6 week Living Well	On hold
Increase preventative services available in community	1. Increase awareness of preventative screenings by developing a handout of recommended screenings	Still researching methods of doing this
	2. Develop No Shave November Event for Prostate Health	On Hold, but working with Dr. Orange to provide events/information on men's health
	3. Track and assure every visit that patient has received all preventative screenings according to standard care protocols	FCMC held Vouchers, Vittles and Vitamin D event as a drive through – gave out 500 vouchers for screenings. Flu shots have begun.
Expand case management for chronic conditions	1. Recruit staff to work with patients after discharge through transition of care	Linda is still working on this
	2. Continue to offer care coordination and case management services to patients with chronic conditions	
	3. Collaborate with Mental Health Managed Care to help support their nurse navigator who is supporting consumers	On hold
	4. Working with cardiology and transitions of care nurse on decreasing hospital re-admission is for patients which CHF April - In progress - should be in place by June 1, 2020	
	5. Collaborate with cancer treatment providers to established oncology services at FCMC campus	February: 8 patients seen – 9 scheduled
	6. Continue to offer navigation support for women's health (broaden focus to all cancer screenings)	Numbers for Mammograms since January, 2020: January: 122, February: 90, March: 63, April: 4, May: 63. June: 95, July: 113, August: 113, September: 104, October: 146

Goal 4: (Continued)

Objective	Action Step	Current Status
Continue to provide community education and screenings related to chronic conditions (i.e. diabetes, coronary heart disease)	1. Continue to implement standard care protocol and manage patients with chronic disease	(Tri-state)
	2. Ensure all adult patients are screened for pre-hypertension and pre-diabetes and that those identified at a high risk level receive follow up and care coordination	(Tri-state) August – all patients are pre-screened
	3. Provide ongoing education at community diabetes forums offered by Diabetes Educator	Welcome Christine Glancey, Diabetes Educator at FCMC
	4. Resume monthly diabetes education programs for Tri-State patients	Still on Hold
	5. Evaluate current education programs and screenings to determine value, need and ability to expand in other areas (Southern Huntingdon and Mercersburg)	Still on Hold
	6. Continue to provide health screenings, education and referrals and collaborate with PCP to determine tracking mechanism and follow up	

APPENDIX B – ANALYSIS OF DATA

ANALYSIS OF HEALTH STATUS-LEADING CAUSES OF DEATH: BEDFORD COUNTY

Area	United States	(A) 10% of United States Crude Rate	Bedford County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	184.00	18.40	248.90	64.90	Health Need
Heart Disease	112.10	11.21	186.40	74.30	Health Need
Lung Disease	48.40	4.84	54.70	6.30	Health Need
Stroke	44.70	4.47	72.90	28.20	Health Need
Unintentional Injury	50.30	5.03	69.20	18.90	Health Need
Motor Vehicle	11.60	1.16	16.10	4.50	Health Need
Drug Poisoning	21.50	2.15	25.30	3.80	Health Need
Homicide	5.80	0.58	0.00	-5.80	
Suicide	14.30	1.43	22.80	8.50	Health Need

Note: Crude Death Rate (Per 100,000 Pop.)

ANALYSIS OF HEALTH STATUS-LEADING CAUSES OF DEATH: BLAIR COUNTY

Area	United States	(A) 10% of United States Crude Rate	Blair County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	184.00	18.40	247.90	63.90	Health Need
Heart Disease	112.10	11.21	150.50	38.40	Health Need
Lung Disease	48.40	4.84	57.30	8.90	Health Need
Stroke	44.70	4.47	57.00	12.30	Health Need
Unintentional Injury	50.30	5.03	70.90	20.60	Health Need
Motor Vehicle	11.60	1.16	13.60	2.00	Health Need
Drug Poisoning	21.50	2.15	29.60	8.10	Health Need
Homicide	5.80	0.58	0.00	-5.80	
Suicide	14.30	1.43	15.10	0.80	

Note: Crude Death Rate (Per 100,000 Pop.)

ANALYSIS OF HEALTH STATUS-LEADING CAUSES OF DEATH: FRANKLIN COUNTY

Area	United States	(A) 10% of United States Crude Rate	Franklin County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	184.00	18.40	231.90	47.90	Health Need
Heart Disease	112.10	11.21	125.20	13.10	Health Need
Lung Disease	48.40	4.84	48.10	-0.30	
Stroke	44.70	4.47	45.80	1.10	
Unintentional Injury	50.30	5.03	50.30	0.00	
Motor Vehicle	11.60	1.16	13.00	1.40	Health Need
Drug Poisoning	21.50	2.15	18.50	-3.00	
Homicide	5.80	0.58	2.10	-3.70	
Suicide	14.30	1.43	14.40	0.10	

Note: Crude Death Rate (Per 100,000 Pop.)

ANALYSIS OF HEALTH STATUS-LEADING CAUSES OF DEATH: FULTON COUNTY

Area	United States	(A) 10% of United States Crude Rate	Fulton County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	184.00	18.40	297.60	113.60	Health Need
Heart Disease	112.10	11.21	181.00	68.90	Health Need
Lung Disease	48.40	4.84	38.40	-10.00	
Stroke	44.70	4.47	65.80	21.10	Health Need
Unintentional Injury	50.30	5.03	89.20	38.90	Health Need
Motor Vehicle	11.60	1.16	24.70	13.10	Health Need
Drug Poisoning	21.50	2.15	31.50	10.00	Health Need
Homicide	5.80	0.58	0.00	-5.80	
Suicide	14.30	1.43	16.50	2.20	Health Need

Note: Crude Death Rate (Per 100,000 Pop.)

ANALYSIS OF HEALTH STATUS-LEADING CAUSES OF DEATH: HUNTINGDON COUNTY

Area	United States	(A) 10% of United States Crude Rate	Huntingdon County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	184.00	18.40	230.70	46.70	Health Need
Heart Disease	112.10	11.21	131.20	19.10	Health Need
Lung Disease	48.40	4.84	65.20	16.80	Health Need
Stroke	44.70	4.47	56.40	11.70	Health Need
Unintentional Injury	50.30	5.03	56.40	6.10	Health Need
Motor Vehicle	11.60	1.16	11.90	0.30	
Drug Poisoning	21.50	2.15	25.10	3.60	Health Need
Homicide	5.80	0.58	0.00	-5.80	
Suicide	14.30	1.43	19.40	5.10	Health Need

Note: Crude Death Rate (Per 100,000 Pop.)

ANALYSIS OF HEALTH OUTCOMES: BEDFORD COUNTY

Health Outcomes	Top US Performers: 2021	(A) 30% of National Benchmark	Bedford County: 2021	(B) County Rate Less National Benchmark 2021	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	24.0%	8.0%	Health Need
Adult obesity	26.0%	7.8%	31.0%	5.0%	
Food environment index	8.7	2.6	8.4	(0.3)	
Physical inactivity	19.0%	5.7%	27.0%	8.0%	Health Need
Access to exercise opportunities	91.0%	27.3%	62.0%	-29.0%	
Excessive drinking	15.0%	4.5%	20.0%	5.0%	Health Need
Alcohol-impaired driving deaths	11.0%	3.3%	20.0%	9.0%	Health Need
Sexually transmitted infections	161.2	48.4	130.0	(31.2)	
Teen birth rate	12.0%	3.6%	20.0%	8.0%	Health Need
Uninsured adults	6.0%	1.8%	7.0%	1.0%	
Primary care physicians	1,030	309	4,010	2,980	Health Need
Dentists	1,210	363	2,180	970	Health Need
Mental health providers	270	81	750	480	Health Need
Preventable hospital stays	2,565.0	769.5	3,735.0	1,170.0	Health Need
Mammography screening	51.0%	15.3%	44.0%	-7.0%	
Children in poverty	10.0%	3.0%	14.0%	4.0%	Health Need
Children in single-parent households	14.0%	4.2%	15.0%	1.0%	

ANALYSIS OF HEALTH OUTCOMES: BLAIR COUNTY

Health Outcomes	Top US Performers: 2021	(A) 30% of National Benchmark	Blair County: 2021	(B) County Rate Less National Benchmark 2021	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	24.0%	8.0%	Health Need
Adult obesity	26.0%	7.8%	32.0%	6.0%	
Food environment index	8.7	2.6	7.7	(1.0)	
Physical inactivity	19.0%	5.7%	25.0%	6.0%	Health Need
Access to exercise opportunities	91.0%	27.3%	75.0%	-16.0%	
Excessive drinking	15.0%	4.5%	21.0%	6.0%	Health Need
Alcohol-impaired driving deaths	11.0%	3.3%	23.0%	12.0%	Health Need
Sexually transmitted infections	161.2	48.4	311.8	150.6	Health Need
Teen birth rate	12.0%	3.6%	23.0%	11.0%	Health Need
Uninsured adults	6.0%	1.8%	6.0%	0.0%	
Primary care physicians	1,030	309	1,220	190	
Dentists	1,210	363	1,620	410	Health Need
Mental health providers	270	81	400	130	Health Need
Preventable hospital stays	2,565.0	769.5	5,192.0	2,627.0	Health Need
Mammography screening	51.0%	15.3%	41.0%	-10.0%	
Children in poverty	10.0%	3.0%	22.0%	12.0%	Health Need
Children in single-parent households	14.0%	4.2%	23.0%	9.0%	Health Need

ANALYSIS OF HEALTH OUTCOMES: FRANKLIN COUNTY

Health Outcomes	Top US Performers: 2021	(A) 30% of National Benchmark	Franklin County: 2021	(B) County Rate Less National Benchmark 2021	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	21.0%	5.0%	Health Need
Adult obesity	26.0%	7.8%	33.0%	7.0%	
Food environment index	8.7	2.6	8.5	(0.2)	
Physical inactivity	19.0%	5.7%	25.0%	6.0%	Health Need
Access to exercise opportunities	91.0%	27.3%	69.0%	-22.0%	
Excessive drinking	15.0%	4.5%	20.0%	5.0%	Health Need
Alcohol-impaired driving deaths	11.0%	3.3%	15.0%	4.0%	Health Need
Sexually transmitted infections	161.2	48.4	300.2	139.0	Health Need
Teen birth rate	12.0%	3.6%	21.0%	9.0%	Health Need
Uninsured adults	6.0%	1.8%	9.0%	3.0%	Health Need
Primary care physicians	1,030	309	1,660	630	Health Need
Dentists	1,210	363	2,120	910	Health Need
Mental health providers	270	81	870	600	Health Need
Preventable hospital stays	2,565.0	769.5	3,962.0	1,397.0	Health Need
Mammography screening	51.0%	15.3%	46.0%	-5.0%	
Children in poverty	10.0%	3.0%	13.0%	3.0%	
Children in single-parent households	14.0%	4.2%	20.0%	6.0%	Health Need

ANALYSIS OF HEALTH OUTCOMES: FULTON COUNTY

Health Outcomes	Top US Performers: 2021	(A) 30% of National Benchmark	Fulton County: 2021	(B) County Rate Less National Benchmark 2021	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	24.0%	8.0%	Health Need
Adult obesity	26.0%	7.8%	27.0%	1.0%	
Food environment index	8.7	2.6	8.4	(0.3)	
Physical inactivity	19.0%	5.7%	25.0%	6.0%	Health Need
Access to exercise opportunities	91.0%	27.3%	55.0%	-36.0%	
Excessive drinking	15.0%	4.5%	22.0%	7.0%	Health Need
Alcohol-impaired driving deaths	11.0%	3.3%	9.0%	-2.0%	
Sexually transmitted infections	161.2	48.4	116.5	(44.7)	
Teen birth rate	12.0%	3.6%	27.0%	15.0%	Health Need
Uninsured adults	6.0%	1.8%	7.0%	1.0%	
Primary care physicians	1,030	309	4,840	3,810	Health Need
Dentists	1,210	363	4,840	3,630	Health Need
Mental health providers	270	81	2,080	1,810	Health Need
Preventable hospital stays	2,565.0	769.5	6,471.0	3,906.0	Health Need
Mammography screening	51.0%	15.3%	42.0%	-9.0%	
Children in poverty	10.0%	3.0%	19.0%	9.0%	Health Need
Children in single-parent households	14.0%	4.2%	24.0%	10.0%	Health Need

ANALYSIS OF HEALTH OUTCOMES: HUNTINGDON COUNTY

Health Outcomes	Top US Performers: 2021	(A) 30% of National Benchmark	Huntingdon County: 2021	(B) County Rate Less National Benchmark 2021	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	23.0%	7.0%	Health Need
Adult obesity	26.0%	7.8%	32.0%	6.0%	
Food environment index	8.7	2.6	8.4	(0.3)	
Physical inactivity	19.0%	5.7%	26.0%	7.0%	Health Need
Access to exercise opportunities	91.0%	27.3%	68.0%	-23.0%	
Excessive drinking	15.0%	4.5%	21.0%	6.0%	Health Need
Alcohol-impaired driving deaths	11.0%	3.3%	31.0%	20.0%	Health Need
Sexually transmitted infections	161.2	48.4	191.2	30.0	
Teen birth rate	12.0%	3.6%	18.0%	6.0%	Health Need
Uninsured adults	6.0%	1.8%	7.0%	1.0%	
Primary care physicians	1,030	309	2,820	1,790	Health Need
Dentists	1,210	363	3,220	2,010	Health Need
Mental health providers	270	81	940	670	Health Need
Preventable hospital stays	2,565.0	769.5	4,309.0	1,744.0	Health Need
Mammography screening	51.0%	15.3%	47.0%	-4.0%	
Children in poverty	10.0%	3.0%	18.0%	8.0%	Health Need
Children in single-parent households	14.0%	4.2%	21.0%	7.0%	Health Need

ANALYSIS OF PRIMARY DATA – KEY INFORMANT INTERVIEWS

Identified Needs
Access to care
Shortage of healthcare workers
Access to and use of preventative care treatments
Treatment of & mgmt of chronic diseases & conditions
Access to primary care physicians
Access to medical specialists
Healthy behaviors and healthy lifestyle choices
Access to mental health services - adults and children
Access to COVID-19 testing and vaccines
Access to drug and alcohol treatment services
Health education
Obesity
Access to exercise opportunities
Access to services for the aging
Poverty and lack of financial resources
Transportation
Access to dental health services
Access to senior facilities
Access to safe and affordable housing
Physical inactivity
Suicide deaths

ISSUES OF UNINSURED PERSONS, LOW-INCOME PERSONS AND MINORITY/VULNERABLE POPULATIONS

Population	Issues
Uninsured and under-insured population	○ Transportation ○ High cost of health care prevents needs from being met ○ Healthy lifestyle and health nutrition education ○ Services for children
Elderly	○ Transportation ○ Cost of prescriptions and medical care ○ Lack of health knowledge regarding how to access services ○ Shortage of physicians (limit on patients who are on Medicare)
Low Income	○ High cost of health care prevents needs from being met ○ Healthy lifestyle and health nutrition education ○ Access to services

APPENDIX C – ACKNOWLEDGEMENT OF KEY INFORMANTS

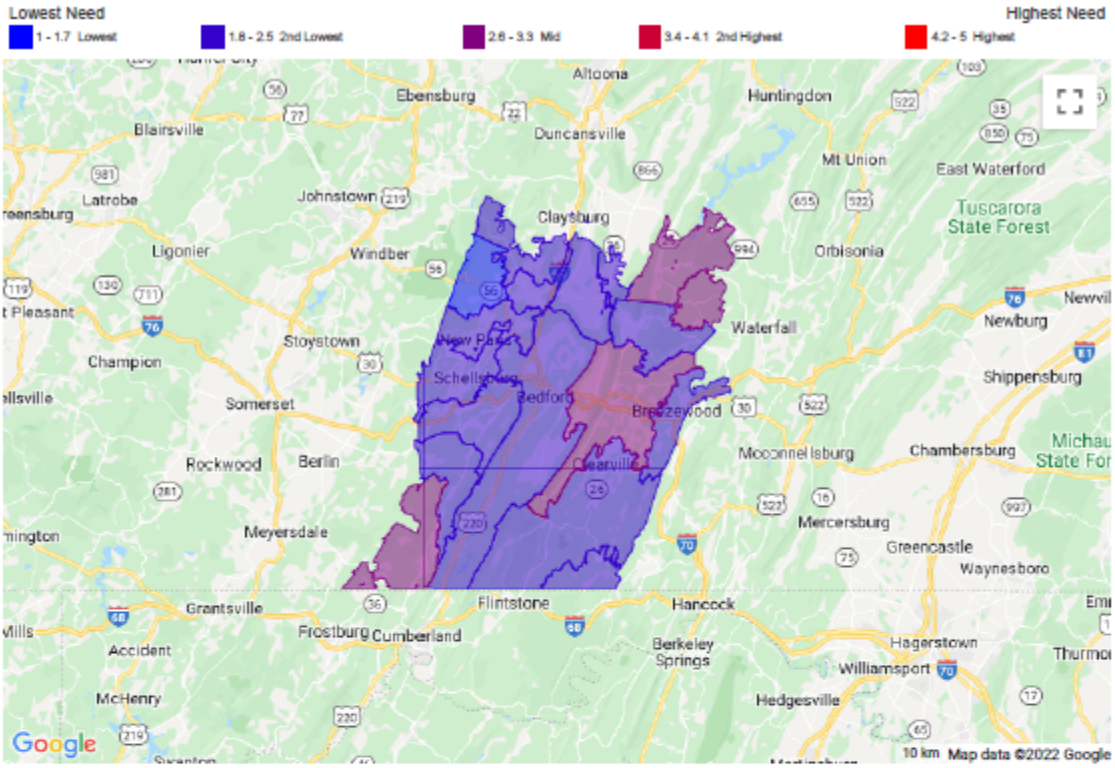
KEY INFORMANTS

Thank you to the following individuals who participated in our key informant interview process:

Name	Organization
Bailey, Joseph	Fulton County Family Partnership
Barton, Brian	Fulton County Emergency Management Agency
Brode, Connie	Huntingdon-Bedford-Fulton Area on Aging
DeShong, Shelia	Tri-State Community Health Center
Dovey, Julie	Fulton County Family Partnership
Eagler, James	Franklin County PA
Flood, Danelle	Pennsylvania County Assistance Office (Fulton County)
Glenn, Crystal	Tri-State Community Health Center
Goshorn, Tasha	Fulton County Medical Center
Hershey, Misty	Fulton County Medical Center
Holland, Deb	Huntingdon-Bedford-Fulton Area on Aging
Jones, Tiffany	Center for Community Action
Keefer, Kate	Fulton County Medical Center
Lafferty, Linda	Fulton County Medical Center
Lynce, Joyce	Employment and Training Inc.
Melius, Wendy	Center for Community Action
Makosky, Michael	Fulton County Medical Center
Paruch, Dixie	Fulton County Family Partnership
Scott-Bollman, Dr. Maria.	Forbes Road School District
Seven Members	Fulton County Silver Sneakers
Slee, Kim	Fulton County Medical Center
Twill, Dr. Tara	Southern Futon School District
Unger, Christy	Franklin County PA
Walter, Susan	Tri-State Community Health Center

APPENDIX D – DIGNITY HEALTH COMMUNITY NEED INDEX (CNI) REPORT

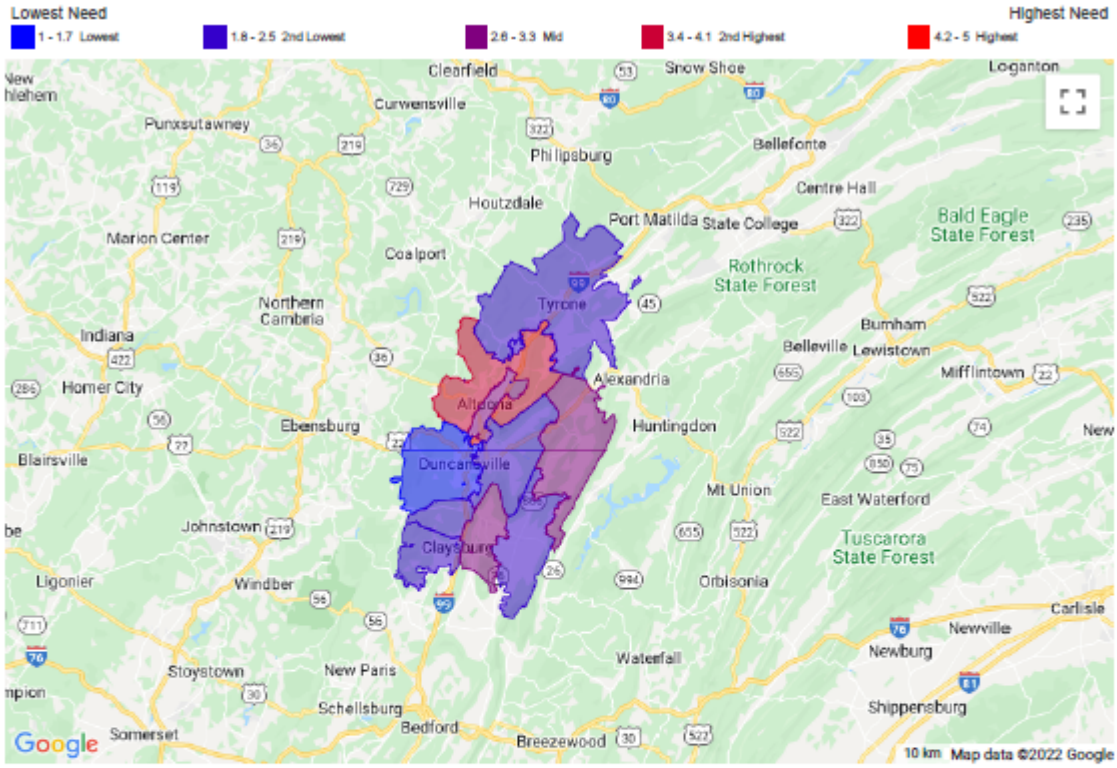
DIGNITY HEALTH CNI SCORE DETAIL – BEDFORD COUNTY



Mean(zipcode): 2.3 / Mean(person): 2.4 CNI Score Median: 2.4 CNI Score Mode: 2.4

Zip Code	CNI Score	Population	City	County	State
15521	1.4	1744	Alum Bank	Bedford	Pennsylvania
15522	2.4	11580	Bedford	Bedford	Pennsylvania
15533	2.4	1245	Breezewood	Bedford	Pennsylvania
15534	2.4	785	Buffalo Mills	Bedford	Pennsylvania
15535	2.2	1980	Clearville	Bedford	Pennsylvania
15537	2.8	7676	Everett	Bedford	Pennsylvania
15539	2	391	Fishertown	Bedford	Pennsylvania
15545	2.6	2825	Hyndman	Bedford	Pennsylvania
15550	2.2	1601	Manns Choice	Bedford	Pennsylvania
15554	2.2	2413	New Paris	Bedford	Pennsylvania
15559	2.4	1907	Schellsburg	Bedford	Pennsylvania
16650	2.4	2117	Hopewell	Bedford	Pennsylvania
16655	1.8	1708	Imler	Bedford	Pennsylvania
16659	2.4	488	Loysburg	Bedford	Pennsylvania
16664	1.8	1917	New Enterprise	Bedford	Pennsylvania
16667	2.4	1302	Osterburg	Bedford	Pennsylvania
16670	1.8	107	Queen	Bedford	Pennsylvania
16678	2.8	2515	Saxton	Bedford	Pennsylvania
16679	3	1012	Six Mile Run	Bedford	Pennsylvania
16695	2.2	910	Woodbury	Bedford	Pennsylvania
17211	2.4	480	Artemas	Bedford	Pennsylvania

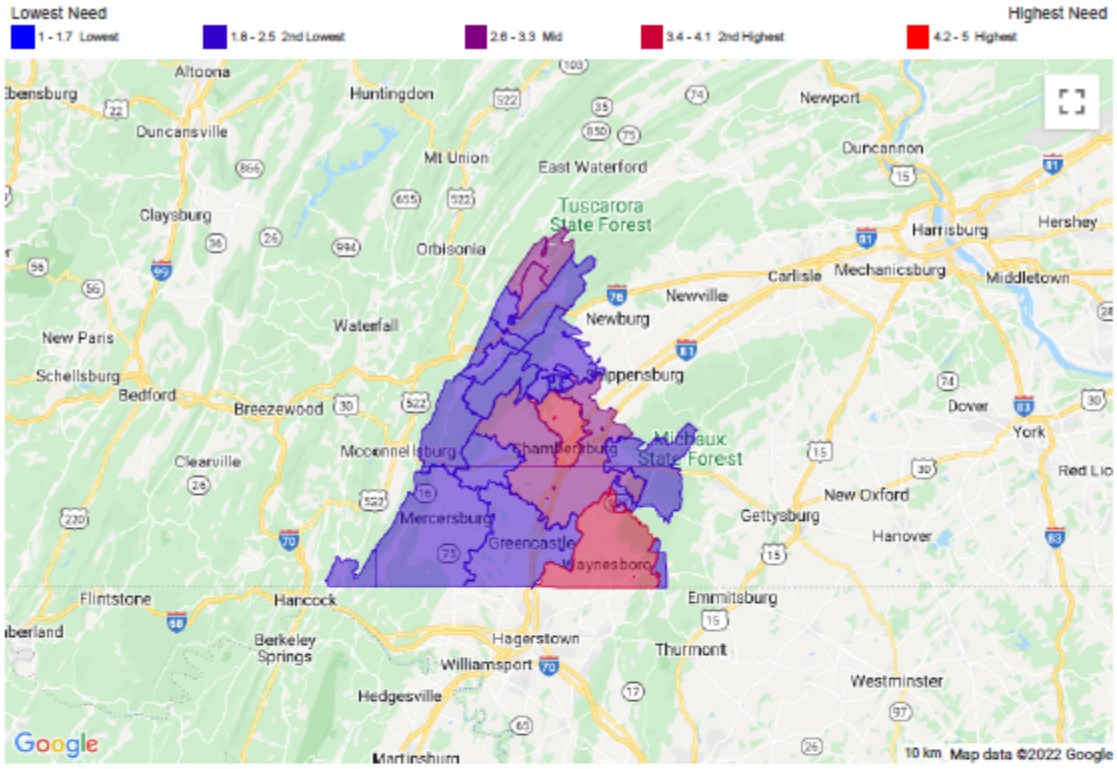
DIGNITY HEALTH CNI SCORE DETAIL – BLAIR COUNTY



Mean(zipcode): 2.4 / Mean(person): 2.7 CNI Score Median: 2.4 CNI Score Mode: 2.2

Zip Code	CNI Score	Population	City	County	State
16601	3.4	31877	Altoona	Blair	Pennsylvania
16602	3.2	27415	Altoona	Blair	Pennsylvania
16617	2.2	2746	Bellwood	Blair	Pennsylvania
16625	2.2	3564	Claysburg	Blair	Pennsylvania
16635	1.6	11431	Duncansville	Blair	Pennsylvania
16637	2.2	2771	East Freedom	Blair	Pennsylvania
16648	1.8	14982	Hollidaysburg	Blair	Pennsylvania
16662	2.4	5785	Martinsburg	Blair	Pennsylvania
16673	2.8	5637	Roaring Spring	Blair	Pennsylvania
16686	2.4	13223	Tyrone	Blair	Pennsylvania
16693	2.6	4076	Williamsburg	Blair	Pennsylvania

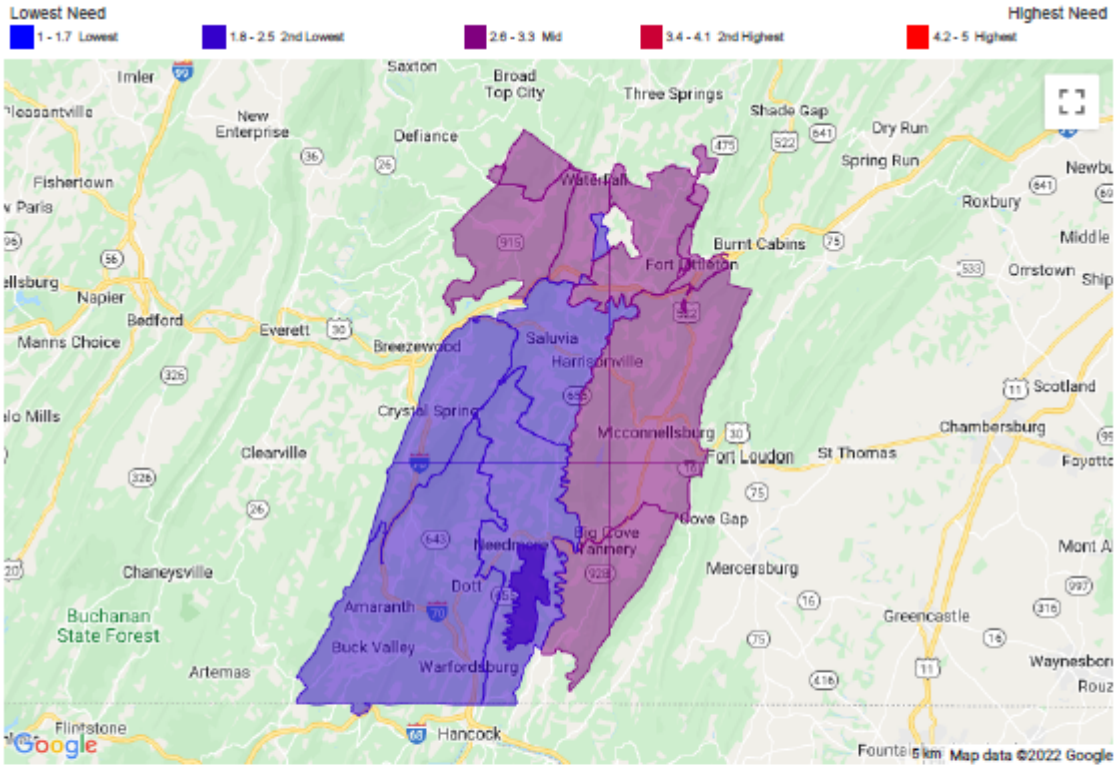
DIGNITY HEALTH CNI SCORE DETAIL – FRANKLIN COUNTY



Mean(zipcode): 2.5 / Mean(person): 2.8 CNI Score Median: 2.4 CNI Score Mode: 2.2

Zip Code	CNI Score	Population	City	County	State
17201	3.6	26051	Chambersburg	Franklin	Pennsylvania
17202	2.6	31895	Chambersburg	Franklin	Pennsylvania
17214	2.2	1129	Blue Ridge Summit	Franklin	Pennsylvania
17217	2.6	116	Concord	Franklin	Pennsylvania
17219	2.8	519	Doylesburg	Franklin	Pennsylvania
17220	2.8	536	Dry Run	Franklin	Pennsylvania
17221	2	552	Fannettsburg	Franklin	Pennsylvania
17222	2.2	12307	Fayetteville	Franklin	Pennsylvania
17224	2.4	1841	Fort Loudon	Franklin	Pennsylvania
17225	2	20122	Greencastle	Franklin	Pennsylvania
17232	2	51	Lurgan	Franklin	Pennsylvania
17236	2.4	9037	Mercersburg	Franklin	Pennsylvania
17237	2.6	1516	Mont Alto	Franklin	Pennsylvania
17244	2.2	2860	Orrstown	Franklin	Pennsylvania
17246	2.4	128	Pleasant Hall	Franklin	Pennsylvania
17252	2.2	3644	Saint Thomas	Franklin	Pennsylvania
17262	2.2	1656	Spring Run	Franklin	Pennsylvania
17265	2.2	321	Upperstrasburg	Franklin	Pennsylvania
17268	3.4	30942	Waynesboro	Franklin	Pennsylvania
17271	2.4	437	Willow Hill	Franklin	Pennsylvania

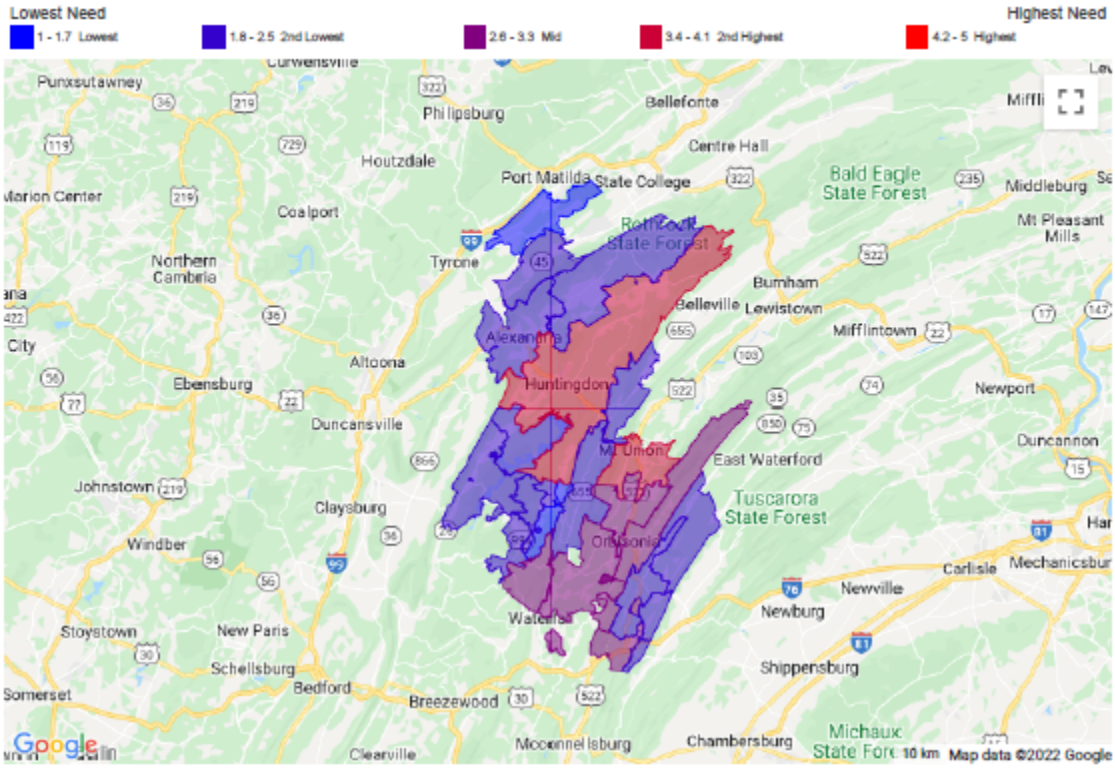
DIGNITY HEALTH CNI SCORE DETAIL – FULTON COUNTY



Mean(zipcode): 2.5 / Mean(person): 2.6 CNI Score Median: 2.6 CNI Score Mode: 2.8

Zip Code	CNI Score	Population	City	County	State
15536	2.4	428	Crystal Spring	Fulton	Pennsylvania
16689	2.8	413	Waterfall	Fulton	Pennsylvania
16691	2.8	296	Wells Tannery	Fulton	Pennsylvania
17212	2.6	682	Big Cove Tannery	Fulton	Pennsylvania
17223	2.8	311	Fort Littleton	Fulton	Pennsylvania
17228	2	1137	Harrisonville	Fulton	Pennsylvania
17229	2.6	1061	Hustontown	Fulton	Pennsylvania
17233	3	5024	Mc Connellsburg	Fulton	Pennsylvania
17238	2.4	1820	Needmore	Fulton	Pennsylvania
17267	2	2812	Warfordsburg	Fulton	Pennsylvania

DIGNITY HEALTH CNI SCORE DETAIL – HUNTINGDON COUNTY



Mean(zipcode): 2.3 / Mean(person): 2.8 CNI Score Median: 2.2 CNI Score Mode: 1.8,2,2.2

Zip Code	CNI Score	Population	City	County	State
16611	2	2446	Alexandria	Huntingdon	Pennsylvania
16621	2	576	Broad Top	Huntingdon	Pennsylvania
16622	1.8	147	Calvin	Huntingdon	Pennsylvania
16623	1.4	567	Cassville	Huntingdon	Pennsylvania
16647	2	843	Hesston	Huntingdon	Pennsylvania
16652	3.4	18103	Huntingdon	Huntingdon	Pennsylvania
16657	1.8	1343	James Creek	Huntingdon	Pennsylvania
16669	2.2	2012	Petersburg	Huntingdon	Pennsylvania
16674	3	730	Robertsdale	Huntingdon	Pennsylvania
16683	1.8	344	Spruce Creek	Huntingdon	Pennsylvania
16685	1.8	320	Todd	Huntingdon	Pennsylvania
16877	1.2	1645	Warriors Mark	Huntingdon	Pennsylvania
17052	2.2	1548	Mapleton Depot	Huntingdon	Pennsylvania
17060	2	1306	Mill Creek	Huntingdon	Pennsylvania
17066	3.6	5156	Mount Union	Huntingdon	Pennsylvania
17213	2.4	592	Blairs Mills	Huntingdon	Pennsylvania
17215	2.6	549	Burnt Cabins	Huntingdon	Pennsylvania
17239	2.2	282	Neelyton	Huntingdon	Pennsylvania
17243	3	1493	Orbisonia	Huntingdon	Pennsylvania
17255	2.2	851	Shade Gap	Huntingdon	Pennsylvania
17260	2.6	1210	Shirleysburg	Huntingdon	Pennsylvania
17264	2.6	2598	Three Springs	Huntingdon	Pennsylvania

APPENDIX E – COMMUNITY SURVEY QUESTIONS

Fulton County Medical Center and its community partner Fulton County Family Partnership is gathering information as part of a plan to improve health and quality of life in the community it serves. Community input is essential to this process. This survey is being used to engage community members. Some of the following survey questions are open-ended. In these instances, we are trying to gather your thoughts and opinions. There are no right or wrong answers. The themes that emerge from these questions will be summarized and made available to the public; however, your identity will be kept strictly confidential. It will take approximately fifteen minutes to complete the questionnaire. Your participation in this study is completely voluntary. There are no foreseeable risks associated with this project. However, if you feel uncomfortable answering any questions, you can withdraw from the survey at any point. It is very important for us to learn your opinions. If you have questions at any time about the survey or the procedures, you may contact Aaron Hershberger at (513) 562-5560 or by email at ahershberger@bkd.com. Thank you very much for your time and support.

How would you rate your (personal) overall health?

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor

Overall, how would you rate the health status of your community?

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor

In general, how satisfied are you with your quality of life?

1. Very satisfied
2. Satisfied
3. Neither satisfied nor dissatisfied
4. Dissatisfied
5. Very dissatisfied

What would improve the quality of life within your community? Please check all that apply.

1. Educational opportunities
2. Employment opportunities
3. Housing
4. After school programs
5. Community safety
6. Partnerships with local police department
7. Health care access
8. Connections to resources/community agencies
9. Dental care access
10. Access to local parks and community classes
11. Public transportation
12. Trails and paths
13. Substance abuse support
14. Recreational opportunities
15. Mental health services
16. Community activities
17. Restaurants
18. Fitness centers/classes
19. Meeting space
20. Entertainment opportunities (such as bowling alley, movie theater)
21. Access to affordable healthy foods
22. Other _____

Do you have one person you consider your personal care doctor or primary care provider?

1. Yes
2. No

Have you had a visit with your personal care doctor or primary care provider within the past year?

1. Yes
2. No

Have you had a dental visit within the past year?

1. Yes
2. No

Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his/her mind is troubled. Within the last 30 days, how often have you felt any kind of stress?

1. All of the time
2. Most of the time
3. Some of the time
4. A little of the time
5. None of the time

Looking at the following items think about what causes stress in your daily life. Stress could be caused from not having the following, or being able to find them, or not having the preferred quality. Please check all that apply.

1. Health care services
2. Finances
3. Food
4. Relationships
5. Transportation
6. Fear of domestic violence
7. Housing
8. Community violence
9. Education
10. Childcare
11. Employment
12. Care for aging parent/relative
13. Senior care/living options
14. Care for disabled relative
15. Other _____

Was there a time in the past 12 months when you experienced any of the following?

	Yes	No	Don't Know
Ate less food than you felt you should because there wasn't enough money for food?	❑	❑	❑
Used a food pantry/soup kitchen, or received a food donation?	❑	❑	❑
Ran out of food and did not have enough money to purchase more?	❑	❑	❑
Been unable to purchase healthy foods due to cost?	❑	❑	❑
Had your utility company shut off your service for not paying your bills?	❑	❑	❑
Needed to see a doctor, but could not because of cost?	❑	❑	❑
Gone without health care because you did not have a way to get there?	❑	❑	❑
Gone without medications due to cost?	❑	❑	❑
Gone without health care because of the cost of your copay or deductible?	❑	❑	❑
Been unable to pay your rent or mortgage?	❑	❑	❑
Slept outside, in a shelter, or in a place not meant for sleeping?	❑	❑	❑

Was there a time in the past 12 months when you experienced any of the following?

	Yes	No	Don't Know
Moved in with a family member or friend because you did not have anywhere else to stay?	❑	❑	❑
Spent a few nights with family members or friends because you did not have anywhere else to stay?	❑	❑	❑
Gone without needed childcare items (such as diapers, formula, car seat, crib, etc.)?	❑	❑	❑
Been unable to make home repairs due to cost?	❑	❑	❑

As a child (during the first 18 years of life) did you experience any of the following?

	Yes	No	Don't Know
Did you or anyone in your family ever experience physical or emotional abuse?	❑	❑	❑
Did you ever feel alone, isolated, or have no one to talk to?	❑	❑	❑
Did you experience the separation, divorce, or breakup of a family?	❑	❑	❑

Are you personally, or is anyone in your family currently experiencing any of the following? Please check all that apply.

1. Illegal drug use/addiction
2. Asthma/COPD related issues
3. Prescription drug use/addiction
4. Cancer
5. Alcohol addiction
6. Diabetes
7. Mental illness (i.e. depression, anxiety)
8. Influenza or Pneumonia
9. COVID-19
10. Long COVID
11. Intellectual or developmental disabilities
12. Heart Disease/Heart Problems
13. Loneliness/isolation
14. Obesity/Overweight
15. Incarceration (i.e. jail)
16. Childhood Obesity
17. Caring for an individual with a disability
18. High Cholesterol
19. Physical abuse
20. Hypertension/High Blood Pressure
21. Mental/emotional abuse
22. Lyme Disease
23. Hunger/not having enough food
24. Dental Problems
25. Homelessness
26. Allergies
27. Thoughts of suicide or attempted suicide
28. Other _____

How safe from crime do you consider the following?

	Extremely Unsafe	Unsafe	Safe	Extremely Safe	Don't Know
Your neighborhood	❑	❑	❑	❑	❑
Your workplace	❑	❑	❑	❑	❑
Your local school(s)	❑	❑	❑	❑	❑
Your home	❑	❑	❑	❑	❑

How much of a problem are the following related to housing in your community?

	Not a Problem	Somewhat of a Problem	Big Problem
Landlords not maintaining properties resulting in poor living conditions	❑	❑	❑
Run down or abandoned properties	❑	❑	❑
Individuals moving in with a relative because of cost of housing	❑	❑	❑
Several families living in one house	❑	❑	❑
People “couch surfing”, spending a few nights at several people’s homes but do not have their own home	❑	❑	❑

Please rate your level of confidence in the following emergency services:

	Not at all Confident	Somewhat Confident	Extremely Confident
An ambulance would respond quickly to my home if I needed it	❑	❑	❑
The fire department would respond quickly to my home if I needed it	❑	❑	❑
The police department would respond quickly to my home if I needed it	❑	❑	❑

Please rate your level of agreement with the following statements:

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Underage drinking is a problem in our community	❑	❑	❑	❑	❑
A minor would be caught by the police if they were drinking or using drugs	❑	❑	❑	❑	❑
Parents in our community do not tolerate underage drinking	❑	❑	❑	❑	❑
It is easy for minors in our community to get alcohol	❑	❑	❑	❑	❑
It is easy for minors in our community to get drugs	❑	❑	❑	❑	❑
Youth crime/delinquency is a problem in our community	❑	❑	❑	❑	❑

Please rate your level of agreement with the following statements:

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
I have taken someone else's prescription pain medication	❑	❑	❑	❑	❑
I have given someone else medication that was prescribed to me	❑	❑	❑	❑	❑
Prescription drug abuse is a problem in our community	❑	❑	❑	❑	❑
Prescription drug abuse is a problem in my family	❑	❑	❑	❑	❑
Alcohol abuse is a problem in our community	❑	❑	❑	❑	❑
Illegal drug abuse is a problem in our community	❑	❑	❑	❑	❑
NARCAN should be available for use in homes	❑	❑	❑	❑	❑

NARCAN (naloxone) is a prescription medication used for the treatment of an opioid emergency such as an overdose or possible overdose. Have you or do you know anyone who has done the following?

	Yes	No	Don't Know
I have had it given to me to stop an overdose	❑	❑	❑
I know someone who has had it given to them to stop an overdose	❑	❑	❑
I have personally given it to stop someone from overdosing	❑	❑	❑
I know someone who has given it to stop someone from overdosing	❑	❑	❑

Do you currently use e-cigarettes or vaping pens?

1. Every day
2. Some days
3. Not at all

Do you currently use chewing tobacco, snuff, or snus? (Note: snus [Swedish for snuff] is a moist smokeless tobacco, usually sold in small pouches that are placed under the lip against the gum)

1. Every day
2. Some days
3. Not at all

Do you currently smoke cigarettes?

1. Yes
2. No

Please enter the number of cigarettes smoked per day:

Do you and or your family have health insurance coverage?

1. Yes. I and/or my family has health insurance
2. No. Neither I nor my family has health insurance

Which of the following describes your health insurance coverage? Please check all that apply.

1. I have health insurance
2. My family has health insurance

Do you have a high deductible insurance plan?

1. Yes
2. No

Please specify the amount of your deductible.

Do you have a high copay?

1. Yes
2. No

Please specify the amount of your copay.

Who is the coverage provided through? Please check all that apply.

1. Employer
2. Spouse's Employer
3. Other Household Member's Employer
4. COBRA
5. Self-Paid, Private Insurance Plan
6. Medicare
7. Medicaid/Access
8. Veteran's Administration
9. Champus / TriCare
10. CHIP
11. Other _____

Did you purchase your health insurance through the marketplace (i.e. healthcare.gov)?

1. Yes
2. No
3. Don't know

Why do you not have health insurance?

In the community, how much of a need do you think there is for the following?

	High Need	Low Need	No Need	Don't know
Primary Care	❑	❑	❑	❑
Specialty Care	❑	❑	❑	❑
Kidney/Renal Care	❑	❑	❑	❑
Alternative Care (e.g. chiropractor, holistic treatment, acupuncture)	❑	❑	❑	❑
Women's Health Care	❑	❑	❑	❑
Dental Care	❑	❑	❑	❑
Eye Care	❑	❑	❑	❑
Cancer Care	❑	❑	❑	❑
Heart Care	❑	❑	❑	❑
Medical Marijuana	❑	❑	❑	❑
Access to affordable healthy foods	❑	❑	❑	❑
Access to healthy foods in school	❑	❑	❑	❑
Access to healthy foods in stores	❑	❑	❑	❑
Transportation to health care	❑	❑	❑	❑
Transportation to work	❑	❑	❑	❑
Transportation to grocery stores	❑	❑	❑	❑
Reliable, scheduled transportation	❑	❑	❑	❑
Affordable transportation	❑	❑	❑	❑

In the community, how much of a need do you think there is for the following?

	High Need	Low Need	No Need	Don't know
Transportation to community activities	❑	❑	❑	❑
Prevention programs	❑	❑	❑	❑
Reduction of illegal drug use	❑	❑	❑	❑
Reduction of prescription drug use	❑	❑	❑	❑
Reduction of alcohol use	❑	❑	❑	❑
Access to treatment	❑	❑	❑	❑
Recovery programs and support	❑	❑	❑	❑
Affordable housing	❑	❑	❑	❑
Available Housing	❑	❑	❑	❑
Loans and other financial assistance for housing	❑	❑	❑	❑
Senior housing / retirement community	❑	❑	❑	❑
Nursing home	❑	❑	❑	❑
In-home senior care	❑	❑	❑	❑
Infant/toddler childcare	❑	❑	❑	❑
Preschool/early childhood education	❑	❑	❑	❑
Before/after school programs for school aged children	❑	❑	❑	❑
Child development support services (speech therapy, physical therapy, occupational therapy)	❑	❑	❑	❑
Access to mental health services	❑	❑	❑	❑
Access to intellectual disability/developmental disability services	❑	❑	❑	❑
Access to autism services	❑	❑	❑	❑

In the community, if the following were available how likely would you be to use them?

	Very Likely	Somewhat Likely	Not Likely	Don't know
Primary Care	❑	❑	❑	❑
Specialty Care	❑	❑	❑	❑
Kidney/Renal Care	❑	❑	❑	❑
Alternative Care (e.g. chiropractor, holistic treatment, acupuncture)	❑	❑	❑	❑
Women's Health Care	❑	❑	❑	❑
Dental Care	❑	❑	❑	❑
Eye Care	❑	❑	❑	❑
Cancer Care	❑	❑	❑	❑
Heart Care	❑	❑	❑	❑
Medical Marijuana	❑	❑	❑	❑
Access to affordable healthy foods	❑	❑	❑	❑
Access to healthy foods in school	❑	❑	❑	❑
Access to healthy foods in stores	❑	❑	❑	❑
Transportation to health care	❑	❑	❑	❑
Transportation to work	❑	❑	❑	❑
Transportation to grocery stores	❑	❑	❑	❑
Reliable, scheduled transportation	❑	❑	❑	❑
Affordable transportation	❑	❑	❑	❑
Transportation to community activities	❑	❑	❑	❑
Prevention programs	❑	❑	❑	❑
Reduction of illegal drug use	❑	❑	❑	❑
Reduction of prescription drug use	❑	❑	❑	❑
Reduction of alcohol use	❑	❑	❑	❑

In the community, if the following were available how likely would you be to use them?

	Very Likely	Somewhat Likely	Not Likely	Don't know
Access to treatment	❑	❑	❑	❑
Recovery programs and support	❑	❑	❑	❑
Affordable housing	❑	❑	❑	❑
Available Housing	❑	❑	❑	❑
Loans and other financial assistance for housing	❑	❑	❑	❑
Senior housing / retirement community	❑	❑	❑	❑
Nursing home	❑	❑	❑	❑
In-home senior care	❑	❑	❑	❑
Infant/toddler childcare	❑	❑	❑	❑
Preschool/early childhood education	❑	❑	❑	❑
Before/after school programs for school aged children	❑	❑	❑	❑
Child development support services (speech therapy, physical therapy, occupational therapy)	❑	❑	❑	❑
Access to mental health services	❑	❑	❑	❑
Access to intellectual disability/developmental disability services	❑	❑	❑	❑
Access to autism services	❑	❑	❑	❑

Have you ever been told by a doctor that you have diabetes?

1. Yes
2. No

Please answer the following regarding your diabetes (please check all that apply)

1. Physician diagnosed you with diabetes but only during pregnancy.
2. Physician diagnosed you with pre-diabetes or borderline diabetes.
3. Neither of the options above apply to me.

How are you managing your symptoms? Please check all that apply.

1. Medication
2. Exercise
3. Diet
4. Health Care Provider
5. Endocrinologist
6. Diabetes Educator
7. I am not managing my symptoms
8. Other

Have you ever been told by a doctor that you have high blood pressure?

1. Yes
2. No

Please answer the following regarding your high blood pressure (please check all that apply)

1. Physician diagnosed you with high blood pressure but only during pregnancy.
2. Physician diagnosed you with pre-hypertensive.
3. Neither of the options above apply to me.

How are you managing your symptoms? Please check all that apply.

1. Medication
2. Exercise
3. Diet
4. Health Care Provider
5. I am not managing my symptoms
6. Other _____

What do you feel are the top three health problems in the county you live in? (For Example: Cancer, Diabetes, Obesity, Etc.) Your response does not need to be limited to the topics previously listed.

What do you feel are the top three social or environmental problems in the county you live in? (For Example: High Rates of Drug Use, Poor Weather Conditions, Lack of Jobs, Etc.) Your response does not need to be limited to the topics previously listed.

What additional resources would you like to see in your community?

Are you the primary caregiver of a grandchild(ren) (i.e. child lives with you, you provide 50% or more financial support, you are the primary decision maker)?

1. Yes
2. No

Please specify the number of grandchildren to whom you are the primary caregiver.

Are you the primary caregiver of a parent or other relative (i.e. individual lives with you and/or you are responsible for the daily care of this individual)?

1. Yes
2. No

If you are you the primary caregiver of a parent or other relative, please specify your relationship to the individual you care for.

A Power of Attorney is a legal document you use to allow another person to act for you. Please check all that apply.

1. I personally have a Power of Attorney in place
2. I am the Power of Attorney for another individual

Have you ever served on active duty in the U.S. Armed Forces?

1. Yes, on active duty in the past, but not now
2. Yes, now on active duty
3. No, never on active duty except for initial/basic training
4. No, never served in the U.S. Armed Forces

Do you have access to the internet at home?

1. Yes
2. No

What type of internet do you have at home? Please check all that apply.

1. Dial - Up
2. DSL
3. Cable
4. Wireless/Cellular
5. Satellite

If you do not have home internet, please provide the reason why. Please check all that apply.

1. Too expensive
2. No internet option available at my home
3. Internet available at my home is not reliable
4. I am not interested in having internet in my home
5. Other

Do you have cell phone reception at your home?

1. Yes
2. No

Is your cell phone reception at your home reliable and consistent?

1. Yes
2. No

How do you like to receive information on upcoming community events? Please check all that apply.

1. Email
2. Regular Postal Mail
3. Phone
4. Text
5. Newspaper
6. Social Media (Facebook, Twitter, Instagram, Etc.)
7. Other _____

To your knowledge, do you have or have you had COVID-19?

1. Yes
2. No
3. Don't Know

Describe the level of care you received, or are receiving for COVID-19.

1. Did not seek medical care
2. Received medical care but was not hospitalized
3. Was hospitalized

Have you received a COVID-19 vaccine?

1. Yes
2. No
3. Not sure

What makes it difficult for you to get a COVID-19 vaccine? *(Select all that apply.)

1. I can't go on my own (I have a physical limitation)
2. It's too far away
3. I don't know where to go to get vaccinated
4. I'm not eligible to get a COVID-19 vaccine
5. I have a medical reason that makes me ineligible to get vaccinated (e.g., I have had a severe allergy to vaccines in the past)
6. I don't have transportation
7. The hours of operation are inconvenient
8. The waiting time is too long
9. It is difficult to find or make an appointment
10. I am too busy to get vaccinated
11. It was difficult to arrange for childcare
12. I don't have time off work
13. I do not want the vaccine
14. Other
15. Not sure

Has the COVID-19 (coronavirus) pandemic made any of the these more difficult for you? (Check all that apply)

1. Housing (paying rent, facing eviction, foreclosure, maintenance, Etc.)
2. Job Security (unemployed, got fired or laid off, less work to do than before, less income, Etc.)
3. Transportation (getting to places you need to go, riding public transit, driving a car, Etc.)
4. Access to food (affording groceries, getting SNAP benefits, feeding family or loved ones, Etc.)
5. Utilities (facing electric, gas, or water shut-offs or difficulty paying for them)
6. Paying bills (medical or other)
7. Affording other basic needs (not mentioned above)
8. Other
9. None of these items have been more difficult for me as a result of the COVID-19 pandemic

Since the start of the COVID-19 (coronavirus) pandemic, have you tried to get a COVID-19 test near you?

1. Yes
2. No

Was it easy or difficult was it to get tested?

1. Easy
2. Difficult

Was it easy or difficult was it to get a result?

1. Easy
2. Difficult

How many times a week are you exercising?

1. Once a week
2. Twice a week
3. 3-4 times a week
4. 5-7 times a week
5. Never
6. Other _____

Is this more or less than before the COVID-19 (coronavirus) pandemic?

1. More than before
2. Less than before
3. Same as before

Since the start of the COVID-19 (coronavirus) pandemic, do you feel that your mental health is better, worse, or stayed the same?

1. Better
2. Worse
3. Same

How often do you feel isolated from others?

1. Always
2. Sometimes
3. Never

What is the zip code where you currently live?

What county do you currently live in?

1. Bedford
2. Blair
3. Franklin
4. Fulton
5. Huntingdon
6. Other _____

Which one or more of the following would you say is your race? Please check all that apply.

1. Caucasian/White
2. Black or African American
3. Asian
4. Native Hawaiian or Other Pacific Islander
5. American Indian or Alaska Native
6. Don't Know
7. Other _____

Are you Hispanic or Latino?

1. Yes
2. No
3. Don't Know

What is the highest level of school you completed?

1. Some School, No High School Diploma or GED
2. High School Graduate (or GED)
3. Some College, No Degree
4. Associate Degree (2-Year Degree)
5. Bachelor's Degree (4-Year Degree)
6. Master's Degree
7. Doctorate Degree
8. Certificated Program (Cosmetology, HVAC, Welder, Etc.)

What is your total annual household income?

1. Less than $15,000
2. $15,000 to less than $25,000
3. $25,000 to less than $50,000
4. $50,000 to less than $100,000
5. $100,000 to less than $150,000
6. $150,000 or more

How many people are currently living in your home?

How many of those living in your home are children under the age of 18?

Which of the following best describes your gender?

1. Male
2. Female
3. Other
4. Prefer not to answer

What is your age?

What is your marital status?

1. Single, Never Married
2. Married
3. Divorced
4. Widowed
5. Separated
6. Member of an unmarried couple

What is your employment status?

1. Employed full-time
2. Employed part-time
3. Self-employed
4. Out of work for less than one year
5. Out of work for more than one year
6. Homemaker
7. Student
8. Retired
9. Unable to work
10. Other _____

Please check any of the following statements that describe your current work situation:

1. Working part time, but would like full time employment
2. Working in a job that does not require or utilize my education, experience, or training
3. Currently seeking employment
4. None of the above

If you are currently employed how many minutes do you travel for work one way?

1. Less than 15 minutes
2. 15 to 29 minutes
3. 30 to 44 minutes
4. 45 to 59 minutes
5. 1 to 2 hours
6. More than 2 hours
7. Work from home
8. NA

APPENDIX F – SOURCES

Data Indicator	Source
Total Population	US Census Bureau, American Community Survey, 2015-19.
Total Population Change, 2000 - 2010	US Census Bureau, Decennial Census, 2000 - 2010.
Total Population Change, 2010-2020	US Census Bureau, Decennial Census, 2020.
Urban and Rural Population	US Census Bureau, Decennial Census, 2010.
Group Quarters Population	US Census Bureau, Decennial Census, 2020.
Female Population	US Census Bureau, American Community Survey, 2015-19.
Families with Children	US Census Bureau, American Community Survey, 2015-19.
Median Age	US Census Bureau, American Community Survey, 2015-19.
Male Population	US Census Bureau, American Community Survey, 2015-19.
Population Under Age 18	US Census Bureau, American Community Survey, 2015-19.
Population Age 0-4	US Census Bureau, American Community Survey, 2015-19.
Population Age 5-17	US Census Bureau, American Community Survey, 2015-19.
Population Age 18-64	US Census Bureau, American Community Survey, 2015-19.
Population Age 18-24	US Census Bureau, American Community Survey, 2015-19.
Population Age 25-34	US Census Bureau, American Community Survey, 2015-19.
Population Age 35-44	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Population Age 45-54	US Census Bureau, American Community Survey, 2015-19.
Population Age 55-64	US Census Bureau, American Community Survey, 2015-19.
Population Age 65+	US Census Bureau, American Community Survey, 2015-19.
Population with Any Disability	US Census Bureau, American Community Survey, 2015-19.
Population in Limited English Households	US Census Bureau, American Community Survey, 2015-19.
Population with Limited English Proficiency	US Census Bureau, American Community Survey, 2015-19.
Population Geographic Mobility	US Census Bureau, American Community Survey, 2015-19.
Foreign-Born Population	US Census Bureau, American Community Survey, 2015-19.
Hispanic Population	US Census Bureau, American Community Survey, 2015-19.
Non-Hispanic White Population	US Census Bureau, American Community Survey, 2015-19.
Black or African American Population	US Census Bureau, American Community Survey, 2015-19.
Citizenship Status	US Census Bureau, American Community Survey, 2015-19.
Veteran Population	US Census Bureau, American Community Survey, 2015-19.
Migration Patterns - Total Population	University of Wisconsin Net Migration Patterns for US Counties, 2000 to 2010.
Migration Patterns - Young Adult	University of Wisconsin Net Migration Patterns for US Counties, 2000 to 2010.
Commuter Travel Patterns - Driving Alone to Work	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Commuter Travel Patterns - Long Commute	US Census Bureau, American Community Survey, 2015-19.
Commuter Travel Patterns - Overview	US Census Bureau, American Community Survey, 2015-19.
Commuter Travel Patterns - Overview 2	US Census Bureau, American Community Survey, 2015-19.
Commuter Travel Patterns - Public Transportation	US Census Bureau, American Community Survey, 2015-19.
Commuter Travel Patterns - Walking or Biking	US Census Bureau, American Community Survey, 2015-19.
Employment - Business Creation	US Census Bureau, Statistics of U.S. Businesses, 2018-2019.
Employment - Employment Change	US Census Bureau, Business Dynamics Statistics, 2018-2019.
Employment - Job Sectors, Largest	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Employment - Jobs and Earnings by Sector	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Employment - Jobs Sectors, Highest Earnings	US Department of Commerce, US Bureau of Economic Analysis.
Employment - Labor Force Participation Rate	US Census Bureau, American Community Survey, 2015-19.
Gross Domestic Product (GDP)	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Employment - Unemployment Rate	US Department of Labor, Bureau of Labor Statistics, 2021 - December.
Income - Earned Income Tax Credit	IRS - Statistics of Income, 2018.
Income - Families Earning Over $75,000	US Census Bureau, American Community Survey, 2015-19.
Income - Income and AMI	US Census Bureau, American Community Survey, 2015-2019.

Data Indicator	Source
Income - Inequality (Atkinson Index)	US Census Bureau, American Community Survey, University of Missouri, Center for Applied Research and Engagement Systems, 2007-11.
Income - Inequality (GINI Index)	US Census Bureau, American Community Survey, 2015-19.
Income - Median Family Income	US Census Bureau, American Community Survey, 2015-19.
Income - Median Household Income	US Census Bureau, American Community Survey, 2015-19.
Income - Net Income of Farming Operations	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Income - Per Capita Income	US Census Bureau, American Community Survey, 2015-19.
Income - Proprietor Employment and Income	US Department of Commerce, US Bureau of Economic Analysis, 2016.
Income - Public Assistance Income	US Census Bureau, American Community Survey, 2015-19.
Income - Transfer Payments	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Poverty - Children Below 100% FPL	US Census Bureau, American Community Survey, 2015-19.
Poverty - Children Below 200% FPL	US Census Bureau, American Community Survey, 2015-19.
Poverty - Children Eligible for Free/Reduced Price Lunch	National Center for Education Statistics, NCES - Common Core of Data, 2019-20.
Poverty - Population Below 100% FPL	US Census Bureau, American Community Survey, 2015-19.
Poverty - Population Below 100% FPL (Annual)	US Census Bureau, Small Area Income and Poverty Estimates, 2020.
Poverty - Population Below 185% FPL	US Census Bureau, American Community Survey, 2015-19.
Poverty - Population Below 200% FPL	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Poverty - Population Below 50% FPL	US Census Bureau, American Community Survey, 2015-19.
Access - Head Start	US Department of Health & Human Services, HRSA - Administration for Children and Families, 2019.
Access - Preschool Enrollment (Age 3-4)	US Census Bureau, American Community Survey, 2015-19.
Access - Public Schools	National Center for Education Statistics, NCES - Common Core of Data, 2019-2020.
Attainment - Associate's Level Degree or Higher	US Census Bureau, American Community Survey, 2015-19.
Attainment - Bachelor's Degree or Higher	US Census Bureau, American Community Survey, 2015-19.
Attainment - High School Graduation Rate	US Department of Education, EDFacts, 2018-19.
Attainment - No High School Diploma	US Census Bureau, American Community Survey, 2015-19.
Attainment - Overview	US Census Bureau, American Community Survey, 2015-19.
Attainment - Some Post-secondary Education	US Census Bureau, American Community Survey, 2014-18.
Chronic Absence Rate	U.S. Department of Education, US Department of Education - Civil Rights Data Collection, 2017-18.
Proficiency - Student Math Proficiency (4th Grade)	US Department of Education, EDFacts, 2018-19.
Proficiency - Student Reading Proficiency (4th Grade)	US Department of Education, EDFacts, 2018-19.
Family Households - Overview	US Census Bureau, American Community Survey, 2015-19.
Households - Overview	US Census Bureau, American Community Survey, 2015-19.
Affordable Housing	US Census Bureau, American Community Survey, 2015-2019.

Data Indicator	Source
Affordable Housing - Low Income Tax Credits	US Department of Housing and Urban Development, 2019.
Affordable Housing - Assisted Housing Units	US Department of Housing and Urban Development, US Census Bureau, American Community Survey, 2019.
Evictions	Eviction Lab, 2016.
Household Structure - Older Adults Living Alone	US Census Bureau, American Community Survey, 2015-19.
Household Structure - Single-Parent Households	US Census Bureau, American Community Survey, 2015-2019.
Housing Costs - Cost Burden (30%)	US Census Bureau, American Community Survey, 2015-19.
Housing Costs - Cost Burden, Severe (50%)	US Census Bureau, American Community Survey, 2015-19.
Housing Costs - Owner Costs	US Census Bureau, American Community Survey, 2015-19.
Housing Costs - Owner Costs by Mortgage Status	US Census Bureau, American Community Survey, 2015-19.
Housing Costs - Renter Costs	US Census Bureau, American Community Survey, 2015-19.
Housing Quality - Overcrowding	US Census Bureau, American Community Survey, 2015-19.
Housing Quality - Substandard Housing	US Census Bureau, American Community Survey, 2015-19.
Housing Quality - Substandard Housing, Severe	US Census Bureau, American Community Survey, 2011-2015.
Housing Stock - Age	US Census Bureau, American Community Survey, 2015-19.
Housing Stock - Housing Unit Value	US Census Bureau, American Community Survey, 2015-19.
Housing Stock - Modern Housing	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Housing Stock - Mortgage Lending	Federal Financial Institutions Examination Council, Home Mortgage Disclosure Act, 2014.
Housing Stock - Net Change	US Census Bureau, Decennial Census, US Census Bureau, American Community Survey, 2015-19.
Housing Stock - Residential Construction	US Department of Housing and Urban Development, 2014.
Housing Units - Overview	US Census Bureau, Census Population Estimates.
Housing Units - Single-Unit Housing	US Census Bureau, American Community Survey, 2015-19.
Tenure - Mortgage Status	US Census Bureau, American Community Survey, 2015-19.
Tenure - Owner-Occupied Housing	US Census Bureau, American Community Survey, 2015-19.
Tenure - Renter-Occupied Housing	US Census Bureau, American Community Survey, 2015-19.
Vacancy (ACS)	US Census Bureau, American Community Survey, 2015-19.
Vacancy (HUD)	US Department of Housing and Urban Development, 2020-Q4.
Area Deprivation Index	University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas, 2021.
Food Insecurity Rate	Feeding America, 2017.
Homeless Children & Youth	US Department of Education, EDFacts, 2019-2020.
Households with No Motor Vehicle	US Census Bureau, American Community Survey, 2015-19.
Incarceration Rate	Opportunity Insights, 2018.
Insurance - Insured Population and Provider Type	US Census Bureau, American Community Survey, 2015-2019.

Data Indicator	Source
Insurance - Medicare Enrollment Demographics	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Insurance - Population Receiving Medicaid	US Census Bureau, American Community Survey, 2015-19.
Insurance - Uninsured Adults	US Census Bureau, Small Area Health Insurance Estimates, 2019.
Insurance - Uninsured Children	US Census Bureau, Small Area Health Insurance Estimates, 2019.
Insurance - Uninsured Population (ACS)	US Census Bureau, American Community Survey, 2015-19.
Insurance - Uninsured Population (SAHIE)	US Census Bureau, Small Area Health Insurance Estimates, 2019.
Opportunity Index	Opportunity Nation.
Racial Diversity (Theil Index)	US Census Bureau, Decennial Census, University of Missouri, Center for Applied Research and Engagement Systems, 2020.
Racial Segregation (Interaction Index)	US Census Bureau, Decennial Census, University of Missouri, Center for Applied Research and Engagement Systems, 2010.
SNAP Benefits - Households Receiving SNAP (ACS)	US Census Bureau, American Community Survey, 2015-19.
SNAP Benefits - Population Receiving SNAP (SAIPE)	US Census Bureau, Small Area Income and Poverty Estimates, 2019.
Social Capital Index	Pennsylvania State University, College of Agricultural Sciences, Northeast Regional Center for Rural Development, 2014.
Social Vulnerability Index	Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2018.
Student Loan Debt	Debt in America, The Urban Institute, 2021.
Teen Births	Centers for Disease Control and Prevention, National Vital Statistics System, 2013-2019.
Teen Births (ACS)	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Violent Crime - Assault	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016.
Violent Crime - Rape	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016.
Violent Crime - Robbery	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016.
Violent Crime - Total	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014; 2016.
Property Crime - Total	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014&2016.
Voter Participation Rate	Townhall.com Election Results, 2016.
Young People Not in School and Not Working	US Census Bureau, American Community Survey, 2015-2019.
Air & Water Quality - Drinking Water Safety	US Environmental Protection Agency, 2018-19.
Air & Water Quality - Ozone	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2015.
Air & Water Quality - Particulate Matter 2.5	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2016.
Air & Water Quality - Respiratory Hazard Index	EPA - National Air Toxics Assessment, 2014.
Air & Water Quality - RSEI Score	US Environmental Protection Agency, 2019.
Built Environment - Banking Institutions	US Census Bureau, County Business Patterns, 2019.
Built Environment - Broadband Access	National Broadband Map, Dec 2020.
Built Environment - Households with No Computer	US Census Bureau, American Community Survey, 2015-19.
Built Environment - Households with No or Slow Internet	US Census Bureau, American Community Survey, 2015-19.

Data Indicator	Source
Built Environment - Liquor Stores	US Census Bureau, County Business Patterns, 2019.
Built Environment - Recreation and Fitness Facility Access	US Census Bureau, County Business Patterns, 2019.
Built Environment - Social Associations	US Census Bureau, County Business Patterns, 2019.
Built Environment - Tobacco Product Compliance Check Violations	US Department of Health & Human Services, US Food and Drug Administration Compliance Check Inspections of Tobacco Product Retailers, 2018-2020.
Climate & Health - Climate-Related Mortality Impacts	Climate Impact Lab.
Climate & Health - Dominant Land Cover	Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2016.
Climate & Health - Drought Severity	US Drought Monitor, 2017-2019.
Climate & Health - Flood Vulnerability	Federal Emergency Management Agency, National Flood Hazard Layer.
Climate & Health - High Heat Index Days (Relative)	Center for Disease Control and Prevention, CDC National Environmental Public Health Tracking, 2017-2019.
Climate & Health - High Heat Index Days (Absolute)	National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS) , 2014.
Climate & Health - National Risk Index	Federal Emergency Management Agency, National Risk Index, 2020.
Climate & Health - Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2016.
Community Design - Park Access (CDC)	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2015.
Community Design - Park Access (ESRI)	US Census Bureau, Decennial Census, ESRI Map Gallery, 2013.
Food Environment - Fast Food Restaurants	US Census Bureau, County Business Patterns, 2019.
Food Environment - Food Desert Census Tracts	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.

Data Indicator	Source
Food Environment - Grocery Stores	US Census Bureau, County Business Patterns, 2019.
Food Environment - Leading Agricultural Products (1)	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Food Environment - Leading Agricultural Products (2)	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Food Environment - Low Food Access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Food Environment - Low Income & Low Food Access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Food Environment - Modified Retail Food Environment Index	Centers for Disease Control and Prevention, CDC - Division of Nutrition, Physical Activity, and Obesity, 2011.
Food Environment - SNAP-Authorized Food Stores	US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator, 2021.
Orchards	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2012.
Threatened and Endangered Species	US Fish and Wildlife Service, Environmental Conservation Online System, 2019.
Cancer Screening - Mammogram (Medicare)	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Cancer Screening - Mammogram (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Cancer Screening - Pap Smear Test	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Cancer Screening - Sigmoidoscopy or Colonoscopy	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Dental Care Utilization	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Diabetes Management - Hemoglobin A1c Test	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2019.
Prevention - High Blood Pressure Management	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2018.

Data Indicator	Source
Hospitalizations - Preventable Conditions	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2020.
Hospitalizations - Emergency Room Visits	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Hospitalizations - Inpatient Stays	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Hospitalizations - Heart Disease	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2016-2018.
Hospitalizations - Stroke	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2016-2018.
Late or No Prenatal Care	Centers for Disease Control and Prevention, National Vital Statistics System, Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research, 2019.
Opioid Drug Claims	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Prevention - Annual Wellness Exam (Medicare)	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Prevention - Seasonal Influenza Vaccine	Centers for Disease Control and Prevention, CDC - FluVaxView, 2019-20.
Prevention - Cholesterol Screening	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Prevention - Recent Primary Care Visit (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Prevention - Recent Primary Care Visit (Medicare)	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2019.
Prevention - Core Preventative Services for Men	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Prevention - Core Preventative Services for Women	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Readmissions - All Cause (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Readmissions - Chronic Obstructive Pulmonary Disease	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2015-2018.

Data Indicator	Source
Readmissions - Heart Attack	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2015-2018.
Readmissions - Heart Failure	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2015-2018.
Readmissions - Pneumonia	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2015-2018.
Timely and Effective Care - Heart Attack	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-19.
Timely and Effective Care - Elective Delivery	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-19.
Timely and Effective Care - Stroke	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2015-16.
Alcohol - Heavy Alcohol Consumption	University of Wisconsin Population Health Institute, County Health Rankings, 2018.
Alcohol - Binge Drinking	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Alcohol - Expenditures	Nielsen, Nielsen SiteReports, 2014.
Breastfeeding - Ever	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Breastfeeding (Any)	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Breastfeeding (Exclusive)	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Fruit/Vegetable Expenditures	Nielsen, Nielsen SiteReports, 2014.
Physical Inactivity	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Soda Expenditures	Nielsen, Nielsen SiteReports, 2014.
STI - Chlamydia Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018.

Data Indicator	Source
STI - Gonorrhea Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018.
STI - HIV Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018.
STI - HIV Prevalence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2018.
Tobacco Expenditures	Nielsen, Nielsen SiteReports, 2014.
Tobacco Usage - Current Smokers	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Insufficient Sleep	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Walking or Biking to Work	US Census Bureau, American Community Survey, 2015-19.
Alcohol Use Disorder (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Cancer Incidence - All Sites	State Cancer Profiles, 2014-18.
Cancer Incidence - Breast	State Cancer Profiles, 2014-18.
Cancer Incidence - Cervical	State Cancer Profiles, 2014-18.
Cancer Incidence - Colon and Rectum	State Cancer Profiles, 2014-18.
Cancer Incidence - Lung	State Cancer Profiles, 2014-18.
Cancer Incidence - Prostate	State Cancer Profiles, 2014-18.
Chronic Conditions - Alzheimer's Disease (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - Asthma (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.

Data Indicator	Source
Chronic Conditions - Asthma Prevalence (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - Cancer (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions – Chronic Obstructive Pulmonary Disease (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - Chronic Obstructive Pulmonary Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - Depression (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - Diabetes (Adult)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Chronic Conditions - Newly Diagnosed Diabetes (Adults)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2018.
Chronic Conditions - Diabetes (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - Heart Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - Kidney Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - Heart Disease (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - High Blood Pressure (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - High Blood Pressure (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - High Cholesterol (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - High Cholesterol (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Chronic Conditions - Multiple Chronic Conditions (Medicare Population)	Centers for Medicare and Medicaid Services, 2018.

Data Indicator	Source
Chronic Conditions - Kidney Disease (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Deaths of Despair (Suicide + Drug/Alcohol Poisoning)	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Low Birth Weight (CDC)	University of Wisconsin Population Health Institute, County Health Rankings, 2013-2019.
Mortality - Infant Mortality (CDC)	University of Wisconsin Population Health Institute, County Health Rankings, 2013-2019.
Mortality - Cancer	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Coronary Heart Disease	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Poisoning	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Heart Disease	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Homicide	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Life Expectancy	Institute for Health Metrics and Evaluation, 2017.
Mortality - Life Expectancy (Census Tract)	Centers for Disease Control and Prevention and the National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project, 2010-15.
Mortality - Lung Disease	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Motor Vehicle Crash	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Motor Vehicle Crash, Alcohol-Involved	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2015-2019.
Mortality - Motor Vehicle Crash, Pedestrian	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2015-2019.
Mortality - Opioid Overdose	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.

Data Indicator	Source
Mortality - Premature Death	University of Wisconsin Population Health Institute, County Health Rankings, 2017-2019.
Mortality - Stroke	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Suicide	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Unintentional Injury (Accident)	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Obesity	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Mortality - Influenza & Pneumonia	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Mortality - Firearm	Centers for Disease Control and Prevention, National Vital Statistics System, 2016-2020.
Teeth Loss	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Poor or Fair Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Poor Mental Health - Days	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Poor Mental Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Poor Physical Health - Days	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Poor Physical Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Poor Mental Health - Mental Health and Substance Use Conditions	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Stroke (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Stroke (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.

Data Indicator	Source
Substance Use Disorder (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018.
Access to Care - Addiction/Substance Abuse Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), May, 2021.
Access to Care - Buprenorphine Providers	US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Feb. 2022.
Access to Care - Dental Health	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2015.
Access to Care - Dental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2021.
Access to Care - Mental Health	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2020.
Access to Care - Mental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), May, 2021.
Access to Care - Nurse Practitioners	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2021.
Access to Care - Primary Care	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2017.
Access to Care - Primary Care Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), May, 2021.
Federally Qualified Health Centers	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, September 2020.
Hospitals with Cardiac Rehabilitation Units	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, 2019.
Health Professional Shortage Areas - All	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021.
Health Professional Shortage Areas - Dental Care	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021.
Population Living in a Health Professional Shortage Area	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021.
COVID-19 - Confirmed Cases	Johns Hopkins University, 2022.

Data Indicator	Source
COVID-19 - Mortality	Johns Hopkins University, 2022.
COVID-19 Fully Vaccinated Adults	Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2022.
Social Distancing - Mobility Reports (Google)	Google Mobility Reports, Feb 01, 2022.
Discharges by Zip Code	Fulton County Medical Center
County Health Rankings	County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute. https://www.countyhealthrankings.org/explore-health-rankings
Sparkmap Data Analysis	https://sparkmap.org/report/
Dignity Health Community Need Index	http://cni.dignityhealth.org/