Community Health Needs Assessment

COLE Memorial

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Executive Summary

Charles Cole Memorial Hospital "Cole Memorial" is a 501 (c) 3, charitable, nonprofit healthcare organization located in Coudersport, Potter County, in north-central Pennsylvania. The hospital, designated as a Critical Access Hospital (CAH) in 2007, serves 55,000 residents in its primary and secondary service areas, encompassing Potter, Cameron, McKean, and Tioga Counties in Pennsylvania, and portions of New York's southern tier. Cole Memorial is only 1 of 13 hospitals in Pennsylvania and 1,314 nationwide certified as a CAH.

The mission of Cole Memorial is to provide excellent healthcare services, responding to the changing needs of the communities we serve. We strive to be a care system committed to you. We will partner in the pursuit of your health and wellness and earn your trust by providing an excellent experience every time.

Since its doors opened in 1967, Cole Memorial has been committed to providing quality, personalized healthcare through a comprehensive range of services, using the latest technology and treatments. Our hospital features 24-hour emergency care; 25-bed acute care facility; inpatient geriatric behavioral health; long-term care; surgical services; home health and hospice; comprehensive cancer care services ; rehabilitation; and wound and sleep center service.

The 2016 Community Health Needs Assessment has four objectives:

- Identify a set of priority health needs (public health and health care).
- Provide recommendations on clinical and community strategies that can be undertaken by healthcare providers, public health staff, communities, policy makers, and others to follow-up on the information provided with actions that may improve the health status of the communities we serve.
- Provide access to the CHNA data and assistance to stakeholders who are interested in using it.
- Meet the requirements for the Affordable Care Act (ACA).

The Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA). The organization must conduct a "community health needs assessment" not less frequently than every three years and adopt an implementation strategy to meet the community health needs identified through the assessment.

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c) (3) hospital facility is required to conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment;

- The assessment may be based on current information collected by a public health agency or non-profit organizations and may be conducted together with one or more other organizations, including related organizations;
- The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues;
- The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources);
- Each hospital facility is required to make the assessment widely available, and ideally downloadable from the hospital web site;
- Failure to complete a community health needs assessment in any applicable three-year period results in a penalty on the organization equal to $50,000. For example, if a facility does not complete a community health needs assessment in taxable years one, two or three, it is subject to the penalty in year three. If it then fails to complete a community health needs assessment in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four);
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.

Organizational Structure and Approach

To complete a CHNA, we must:

- Describe the process and methods used to conduct the assessment;
    - Sources of data; and data retrieved;
    - Analytical methods applied;
    - Information gaps impacting ability to assess the needs;
    - Identify with whom Cole Memorial collaborated.
- Describe how Cole Memorial gained input from community representatives;
    - When and how the Cole Memorial consulted with these individuals;
    - Names, titles, and organizations of these individuals; and
    - Any special knowledge or expertise in public health possessed by these individuals.
- Describe process and criteria used in prioritizing health needs;
- Describe existing resources available to meet the community health needs assessment;
- Identify programs and resources the hospital facility plans to commit to meeting each identified need and the anticipated impact of those programs and resources in the health need.

The CHNA steering committee took a comprehensive approach to assess community health needs. We used the 6 step approach (Appendix B) to complete our needs assessment. We performed several data analysis, based on secondary source data; augment this with community health survey data. Since the service area does not comprise some of the entire counties we serve, we asked local residents to note if they perceived the problems, or needs, identified by secondary sources to exist in their portion of the county they live in. The secondary data used in our analysis are presented in the Appendices. Data sources used include:

- www.countyhealthrankings.com- to assess the health needs of the counties we serve to all Pennsylvania counties.
- www.census.gov- to access current population data and the latest economic indicators
- www.healthypeople.gov- to assess characteristics of certain health objectives
- www.phc4.org- to address the problem of escalating health costs, ensuring the quality of health care, and increasing access for all citizens regardless of ability to pay
- www.health.state.pa.us- to capture data that can help understand health statistics

In addition, we conducted 3 surveys; survey within the communities Cole serves for any community resident to complete; key leaders of the region, and our service providers. Respondents replied from August 3, 2015 through August 14, 2015. The terms of gaining input specified each respondent remained anonymous. The hospital did incorporate comments on the 2013 CHNA, although the comments were not written. The feedback was solicited through the survey and interview process.

The administration of an internet-based and paper survey was promoted through advertisements in local newspapers, blogs, and television and was distributed to local civic and health organizations with a request for participation. Preliminary conclusions of the three survey results were presented to the CHNA steering committee, which were asked to validate prior assessments and to establish priority among

various identified health needs. Members of the Community Health Needs Assessment steering committee include 40 professionals and over 25 community organizations such as:

- Cole Memorial
- Dickinson Center, Inc.
- Office of Aging
- Drug and Alcohol Services
- DCNR
- WIC
- Local Area School Districts
- Potter County Link
- Multi-Care Center
- Lakeview Nursing Home
- McKean and Potter County District Office
- Emergency Services
- IU9
- A Way Out
- Lock Haven PA Program

After a couple of months analyzing the preceding data and information we received from the surveys and secondary data, we put the information in front of our Board of Directors and Community Benefit Advisors during our Annual Meeting on October 5, 2015. They were asked to agree and disagree with our current summary conclusions. They also were at liberty to augment potential conclusions with additional statements.

With the prior steps identifying potential community needs, the steering committee participated in the Hanlon method activity. This is well respected prioritization method utilized by the public health community. The Hanlon Method uses a logical process to focus on the highest-priority problems. Using the baseline data collected on the community health needs assessment survey, helped the steering committee assign a score to each health problem on the basis of three (3) primary factors: *size of the problem* (scale 1 to 10), *seriousness of the problem* (scale 1 to 10), and *effectiveness of interventions* (scale of 1 to 100). See below for example:

Hypothetical Health Problem: Adult Diabetes			
Size of Problem	Seriousness of Problem	Effectiveness of Intervention	Score
0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	8 (raw)
Weight Factor: 1 2 x 1= 2	Weight Factor: 2 4 x 2= 8	Weight Factor: 3 2 x 1= 2	12 (weighted)
		Total Potential Score:	20

After all health problems had been ranked by their composite score, the group eliminated any health need from the list that could not be addressed due to economic, social, legal or other reasons. The health needs than ultimately appeared from this prioritization process were the health problems that the focus groups will be addressing through meaningful interventions and available resources.

In order to address the needs identified in the Community Health Needs Assessment (CHNA), CHNA Steering Committee formed three focus teams to create and implement strategies and programs to address these identified health needs.

Cole Memorial Board of Directors met on May 26, 2016 to review and adopt the written plan with results and recommendations that the CHNA steering committee suggested.

We have established leadership accountability and an organizational structure for ongoing planning, budgeting, implementation and evaluation of community health needs assessment, which are integrated into our 2017 strategic plan under improve population and community health. (See Figure 1 below)

FY17 Priorities and Focus Areas

1. Improve Population and Community Health: Continue to define and pursue our vision for improving the health of defined populations and communities principally through our primary care network with a focus on those who are vulnerable.

III. Strategic Focus Area: Through specific short and long term strategies and actions in coordination with our "aligned partners" improve the overall health and wellness of our region over time	**Sponsor is Kari Kurtz**	**Clinical Council**
4	A. Refer to the Strategic Plan for Advancing Community Health using HP2020 as a guide.	
4	B. Refer to the 2016 approved Community Health Needs Assessment Plan, actions and targets. Components of this plan will include focus on Mental Health Substance Abuse Obesity Oral Health	
4	C. We will use the Northern Tier Community Collaborative as a strategic vehicle to improve health and support vulnerable populations	
4	D. We will promote Health Literacy as our primary patient engagement strategy in FY17	

IV. Strategic Focus Area: Align employers in the region with our organization through programs designed to assist them with managing the health of their employees	**Sponsor is Kari Kurtz**	**Jamie**
12	Introduce and deploy a multi-year **Workplace Wellness Plan** to improve the health of employees throughout the region including Cole Memorial using PBGH assistance and programs.	

Methodology

Understanding the health needs of the community allows Cole Memorial to design and implement effective strategies that improve the health status of the populations we serve. A comprehensive data driven assessment process can identify priority health needs and issues related to prevention, diagnosis and treatment through quantitative and qualitative data.

This assessment is intended to provide an overview of the health and well-being status of residents in the communities we serve. There are areas where our counties compare favorably with the state and/or the national benchmark and there are health indicators where it does not. In some cases, the data tends to raise more questions than answered.

To complete this work, we focused on 28 zip codes in Cameron, McKean, Potter and Tioga counties. The 28 zip-codes were first identified in our 2009 Community Health Needs Assessment. With the help of a consultant, National Rural Health and our community benefit advisors the zip codes were identified as the communities we serve.

Community Benefit Advisors again validated and approved the selected zip codes with our current Community Health Needs Assessment. To help guide the process used for the assessment, a CHNA Steering Committee was convened. This committee's role was to provide input on: (a) identification of existing data sources for the study; (b) content of the community online survey questionnaire; (c) interpretation of survey findings; (d) review of recommendations, and; (e) data dissemination and a follow-up plan. The committee met over a 9 month period to review, consider, and prioritize survey data and secondary data collected during this process. The committee will continue to meet quarterly with the focus leaders that have been identified to ensure progress is being made under each identified priority.

In addition to the CHNA Steering Committee, Cole Memorial's Community Benefit Advisory committees which represent public health, government, former and present board members, foundations, pastors, school nurses, and various other organizations, provided critical input into the needs assessment, from initial concept to how the data would be shared with communities in our fall and spring meetings in 2015-2016.

The set of measures used in this assessment was selected to reflect evolving national and state benchmarks for chronic disease management, access to care, mental health, substance abuse and obesity. Most indicators were derived from public data sources, including U.S. Census data, Healthy People 2020 and County Health Rankings. (A complete list of data sources and years is included in the Appendix section) Other indicators were derived from an online and paper survey conducted specifically for this community health needs assessment.

Community Health Needs Assessment Survey Methods

The online-based and paper form survey was developed by the CHNA Steering Committee in June 2015. An initial review of elements contained in prior community health needs assessment back in 2010 was used. The three surveys (Appendix E) was approved and programmed for data collection on August 3, 2015. The surveys gathered information from Cameron, McKean, Potter and Tioga counties. The data collection phase began on August 3, 2015 and was completed by August 14, 2016.

A. Community Survey

The purpose of this survey was to collect both subjective (opinion) and incidence data from people who live within the counties we serve. The survey included questions regarding demographics, neighborhood/ community strengths, community concerns, issues within the household and healthcare challenges and needs. We received 1,282 completed community surveys.

The Steering Committee determined the scope and data collection method for the household survey. The survey and cover letter clarified definitions for "neighborhood," "community," and "household" and asked to specify their municipality, borough, or city. The survey is included as Appendix E.

According to the 1,282 community members surveyed, the greatest issues effecting community members, after combining what they felt to be major and moderate issues were:

- Lack of jobs -84.41%
- Unemployment/Underemployment -82.29%
- Obesity -76.51%
- Smoking/Tobacco Use -75.82%
- Poverty -75.80%
- Drug Abuse -75.22%
- Alcohol Abuse- 69.00%
- Lack of affordable medical care -64.89%
- Mental Health/Emotional Issues -64.46%

When community members in the region were asked what the greatest issues effecting their households were, they stated:

- Obesity- 47.39%
- Anxiety/Stress/Depression -42.77%
- Difficulty Budgeting -36.89%
- Not enough money to meet daily needs -33.81%
- No Work -32.76%
- Adults experiencing behavior, mental health or emotional issues -27.33%

B. Key Leader Survey

A survey was distributed to 41 key informants in Cameron, McKean, Potter, and Tioga Counties (e.g. state, county, and local government officials, school superintendents, media, human resource directors for major employers, executive directors of other groups such as the library, planning offices, etc.) to obtain their input on strengths and issues that impact residents and neighbor-hoods. The key informant survey and cover letter which were emailed in August 2015 (Appendix C).

The key leaders were asked to rank from major to moderate what they felt were issues in their communities they serve where. They were ranked as follows:

- Unemployment/Underemployment-92.68%
- Obesity -92.68%
- Alcohol- 90.25%
- Poverty -87.8%

- Lack of Jobs- 87.18%
- Smoking/Tobacco Use- 85.37%
- Individuals with Mental Health diagnosis- 80.49%

C. Service Provider Survey

The purpose of the service provider survey was to learn about the community assets, programs, and services that are already in place to serve the community. The survey also asked questions related to access to health care, gaps, and prevention/education needs. A total of 10 Cole Memorial service providers were asked to participate. This survey was emailed in August 2015 with a cover letter included as Appendix D.

Service Providers ranked mental health, drugs and alcohol and obesity as the most serious issues in the communities. They felt the greatest gaps in health care services were outpatient mental health care for adults and children. It was expressed that the barriers preventing residents from getting the necessary health care needs was due to insurance, co-pays, and deductibles.

Secondary Indicator Data

The purpose of collecting and analyzing secondary indicator data is to track changes and trends over time for a given population. It is also useful as a mechanism to answer whether research supports or does not support the perceptions of key informants and the general public as reflected in survey results. The steering committee collected state and local secondary indicator data on demographics, economy, education, environment, health, housing, leisure activities, safety, social issues, and transportation. Data were obtained from a variety of federal, state, and local sources, including but not limited to: U.S. Census, Pennsylvania Department of Health, Center for Disease Control, County Health Ranking Report, BRFSS, etc.

Demographic Highlights for Cameron, McKean, Potter and Tioga Counties

Cole Memorial serves 55,000 residents in its primary and secondary service areas, encompassing Potter, Cameron, McKean, and Tioga Counties in Pennsylvania, and portions of New York's southern.

**Figure 2: Map of Primary Medical Service Area by Zip Codes (red border and numbers.)
Secondary Medical Service Area by Zip Codes (brown numbers)**

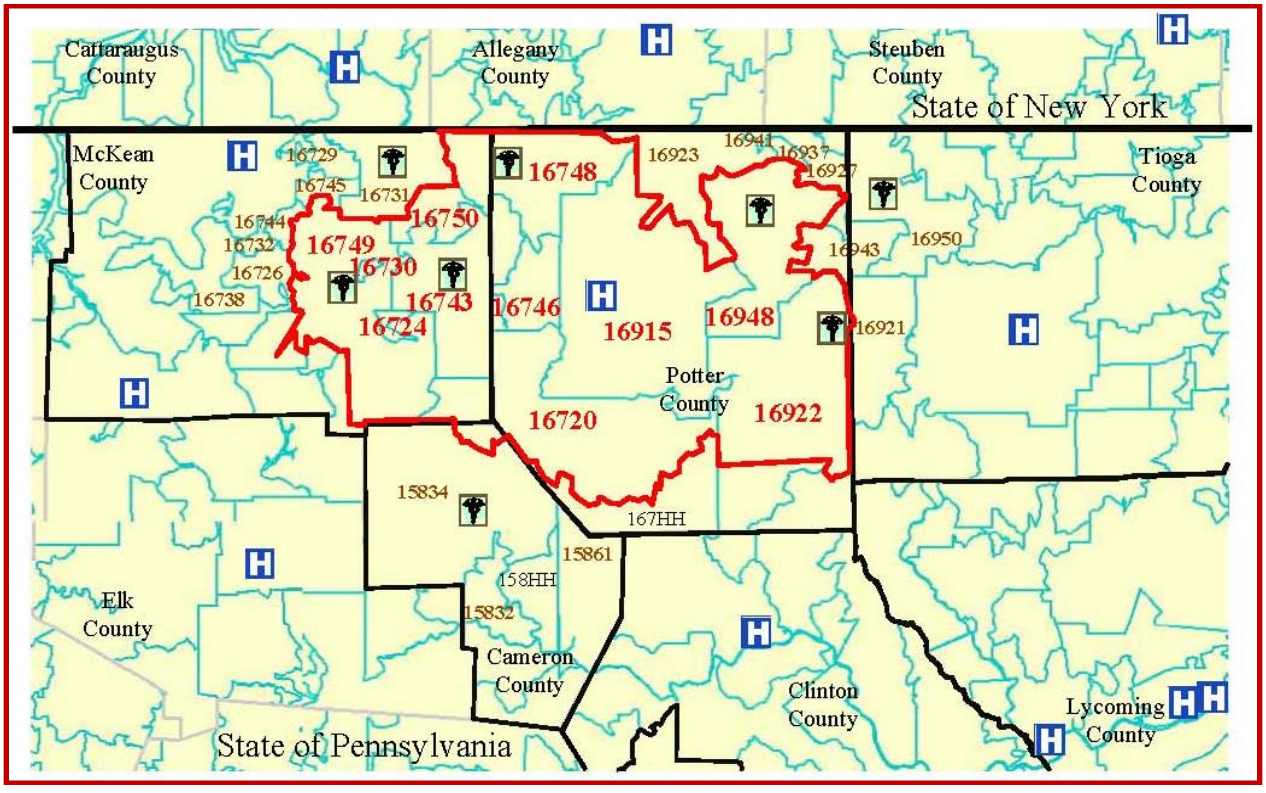


Table 1: Primary Service Area Population

ZIP CODE	TOWN	2010	2014
16720	Austin	1,392	1286
16724	Crosby	143	90
16730	East Smethport	121	65
16743	Port Allegany	3,967	3,959
16746	Roulette	1,265	1,305
16748	Shinglehouse	2,997	2,770
16749	Smethport	4,319	4,171
16750	Turtlepoint	417	378
16915	Coudersport	5,929	5,816
16922	Galeton	2,002	1,976
16948	Ulysses	1,634	1,732

Source: US Census Bureau

Table 2: Secondary Service Area Population

ZIP CODE	TOWN	2010	2014
15832	Driftwood	382	336
15834	Emporium	4,533	4,428
15861	Sinnamahoning	174	106
16726	Cyclone	542	496
16729	Duke Center	761	773
16731	Eldred	2,818	2,803
16732	Gifford	293	332
16738	Lewis Run	2,679	2,522
16744	Rew	332	552
16745	Rixford	611	608
16921	Gaines	475	593
16923	Genesee	1,470	1,590
16927	Harrison Valley	651	759
16937	Mills	172	312
16941	Genesee	69	116
16943	Sabinsville	562	402
16950	Westfield	3,378	3,517

Source: US Census Bureau

Social & Economic Factors

Our social and economic factors came from Robert Wood Johnson Foundation with their county health rankings data. Out of 67 counties in Pennsylvania, Cameron County was ranked 64, McKean was 51, Potter was 62, and Tioga was 33 with 67 being the worst county ranked under the social and economic factors. See figure 3 below as it shows the different factors that are measured to determine how the counties are ranked.

Figure 3: County Health Rankings Approach

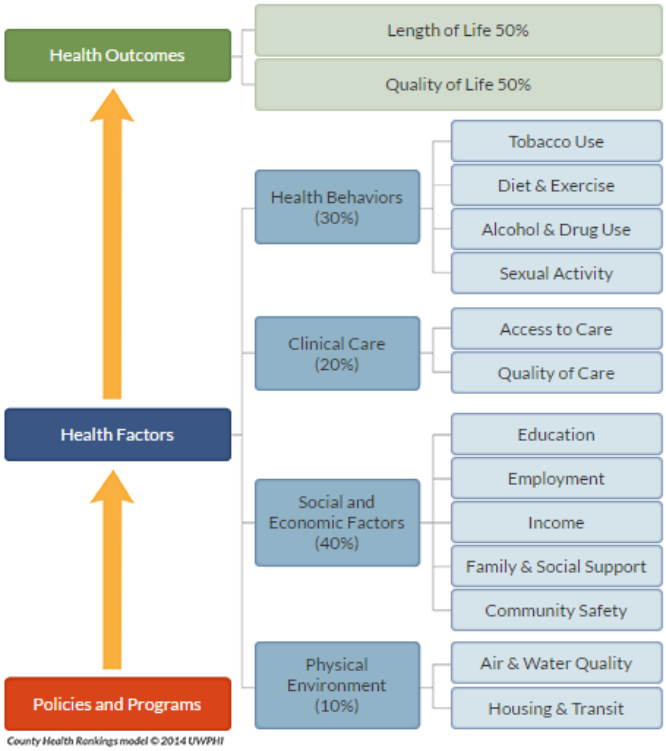


Table 3: Unemployment

State	Cameron	McKean	Potter	Tioga
5%	11.6%	8.2%	9.1%	7.5%

Table 4: Mental Health Providers

State	Cameron	McKean	Potter	Tioga
623:1	NDA	1592:1	2187:1	1036:1

Table 5: Smoking Rate

State	Cameron	McKean
20%	39%	27%

Table 6: Alcohol Impaired Driving Deaths

State	Cameron	McKean
34%	50%	35%

Table 7: Excessive Drinking

State	Potter	McKean
17%	18%	18%

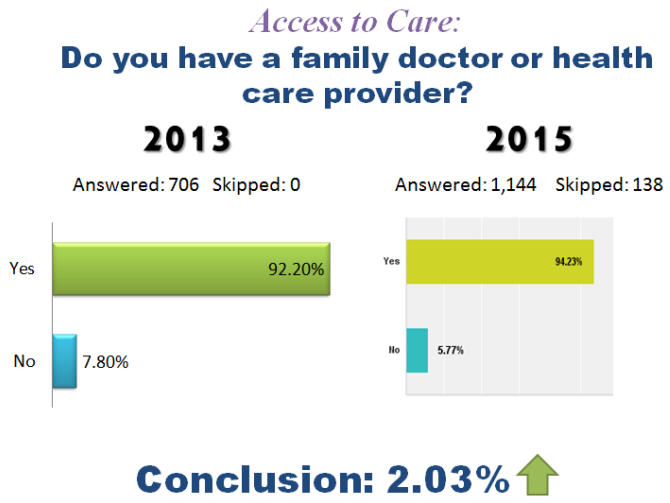
Table 8: Adult Obesity

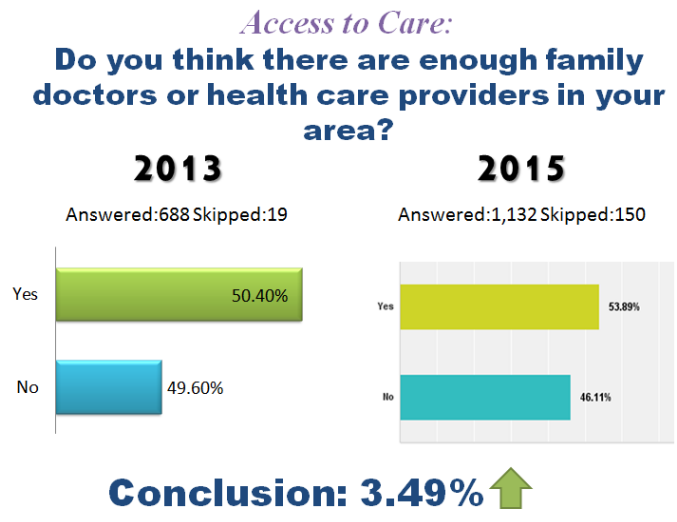
State	Cameron	McKean	Potter	Tioga
29%	27%	32%	32%	33%

Table 9: Physical Inactivity

State	Cameron	McKean	Potter	Tioga
24%	26%	27%	28%	26%

Over the course of the last three years, Cole Memorial and the surrounding communities have been focusing on obesity, access to care, diabetes, dental, smoking and heart disease. The data below shows from our primary and secondary data if improvements have been:

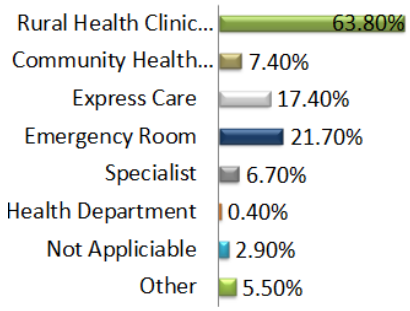




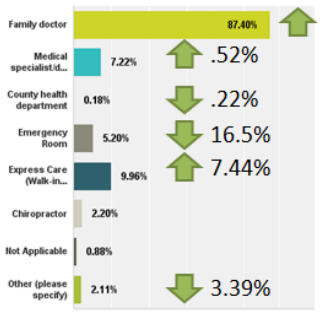
Access to Care:

Where do you go when you need medical care?

2013 Answered:688 Skipped:18



2015 Answered:1,135 Skipped:147



23.6%
.52%
.22%
16.5%
7.44%
3.39%

Conclusion: 23.6% ↑ PCP
16.5% ↓ ED

Secondary Data:

Access to Care

- Primary Care Physicians
  - Population to Provider Ratio

	Pennsylvania	Cameron	McKean	Potter	Tioga
2015	**1,249:1**	**1,646:1**	**2,054:1**	**1,758:1**	**1,935:1**
2013	**1,273:1**	**1,691:1**	**1,886:1**	**1,942:1**	**2,001:1**

Source: County Health Rankings 2015

Conclusion:

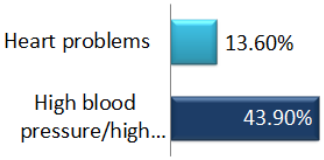
Pennsylvania	Cameron	McKean	Potter	Tioga
↓ 24:1	↓ 45:1	↑ 168:1	↓ 184:1	↓ 66:1
1.9% inc.	2.7% inc.	8.2% dec.	10.5% inc.	3.4% inc.
Overall total improvement of:				2.1%

Heart Disease:

Please check if you have ever been told by a doctor or other health professional (s) that you have: (check all that apply)

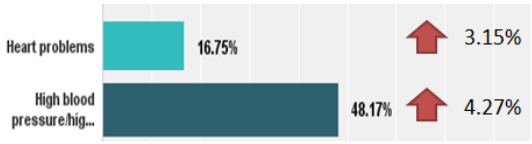
2013

Answered:686 Skipped:20



2015

Answered:1,009 Skipped:273



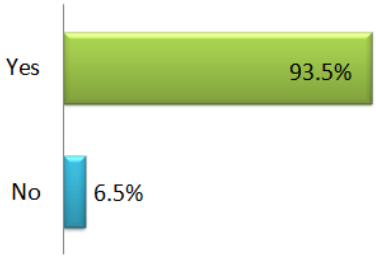
Conclusion: 3.15% ↑ Heart Problems
4.27% ↑ Blood Pressure

Heart Disease:

Are you receiving routine medical care for your chronic condition?

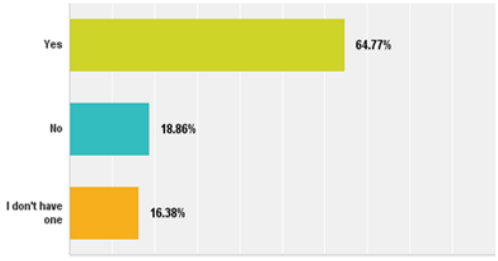
2013

Answered:308 Skipped:398



2015

Answered:1,110 Skipped:172



Conclusion: 27.73% ↓

Secondary Data:

Heart Disease

- Coronary heart disease death rate per 100,000

	Pennsylvania	Cameron	McKean	Potter	Tioga
2008	124.8	102.2	162.5	95.3	103.6
2007	130.4	114.3	148.6	106.3	104.8

- Stroke death rate per 100,000

	Pennsylvania	Cameron	McKean	Potter	Tioga
2008			36.3	33.8	38.6
2007			41.9	32.5	38.5

Source: Healthy People 2020

Diabetes:

Please check if you have ever been told by a doctor or other health professional (s) that you have: (check all that apply)

2013

Answered:686 Skipped:20

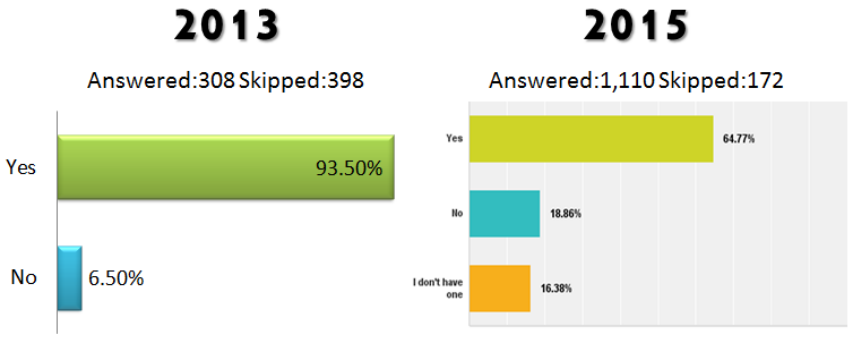
2015

Answered:1,009 Skipped:273

Conclusion: 3.24% ↑

Diabetes:

Are you receiving routine medical care for your chronic condition?



Conclusion: 27.73% ↓

Secondary Data:

Diabetes

- Percentage of adults aged 20 and above with diagnosed diabetes

	Pennsylvania	Cameron	McKean	Potter	Tioga
2015	**10%**	**12%**	**10%**	**12%**	**11%**
2013	**10%**	**11%**	**11%**	**11%**	**10%**

Source: County Health Rankings 2015

Conclusion:

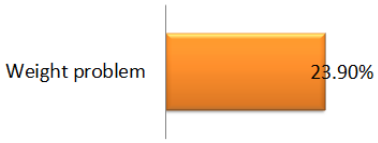
Pennsylvania	Cameron	McKean	Potter	Tioga
0%	↑ 1%	↓ 1%	↓ 1%	↓ 1%
Overall total improvement of:				.5%

Obesity:

Please check if you have ever been told by a doctor or other health professional (s) that you have: (check all that apply)

2013

Answered:686 Skipped:20



2015

Answered: Skipped:

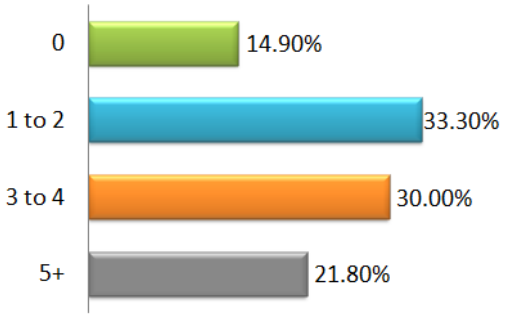
Conclusion: 8.31% ↑

Obesity:

How many days per week do you eat at least 5 servings of fruits and/or vegetables?

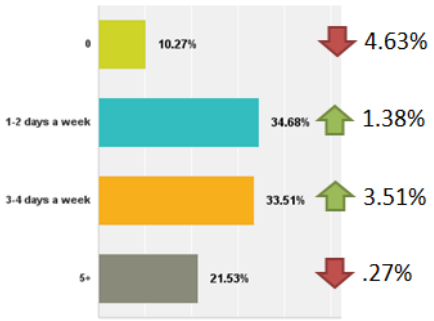
2013

Answered:679 Skipped:27



2015

Answered:1,110 Skipped:172



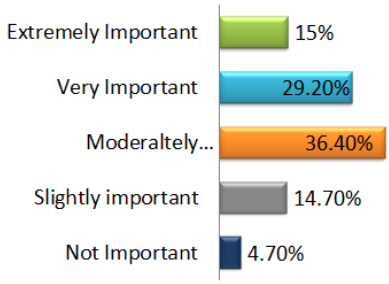
Conclusion: 4.63% ↓ **for None**
4.89% ↑ **for 1-4**

Obesity:

How many important is exercise to you?

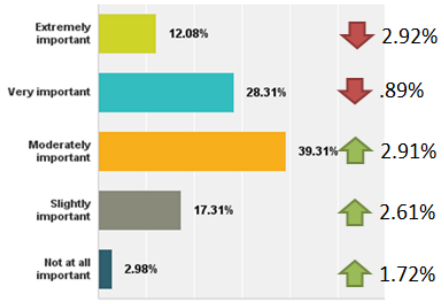
2013

Answered:679 Skipped:27



2015

Answered:1,109 Skipped:173



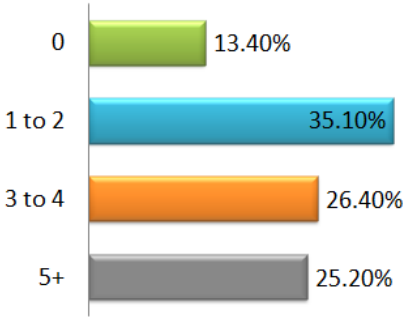
Conclusion: 3.81% ↓ Very/Extremely
5.52% ↑ Mod./Slightly

Obesity:

How many days per week do you engage in physical activity for at least 30 minutes?

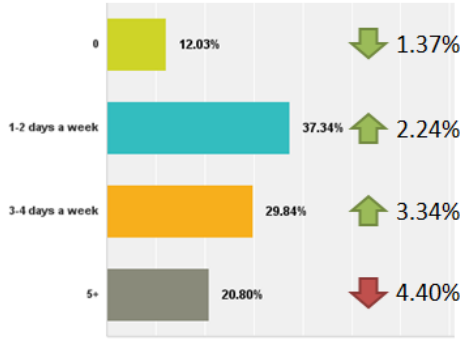
2013

Answered:679 Skipped:27



2015

Answered:1,106 Skipped:176



Conclusion: 4.40% ↓ 5+
5.58% ↑ for 1-4 & 1.37 ↓ 0

Secondary Data:
Obesity

- Adults the report obesity 30+

	Pennsylvania	Cameron	McKean	Potter	Tioga
2015	29%	27%	32%	32%	33%
2013	29%	29%	32%	31%	32%

Source: County Health Rankings 2015

Conclusion:

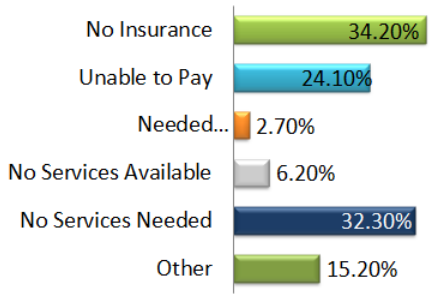
Pennsylvania	Cameron	McKean	Potter	Tioga
0%	↓ 2%	0%	↑ 1%	↑ 1%

Dental:

If you have not been to the dentist in the last 12 months, what would you say is the main reason?

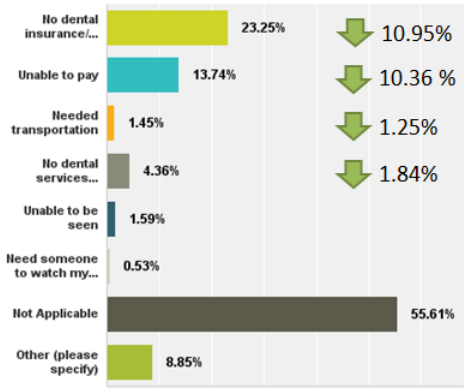
2013

Answered:680 Skipped:26



2015

Answered:1,104 Skipped:178

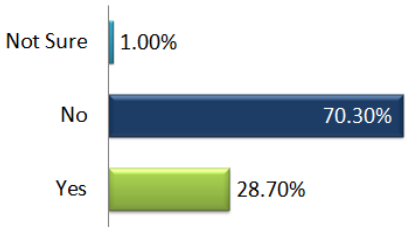


Tobacco Use:

Are you aware of anyone over the age of 18 in your household currently use any of the following tobacco-related products on a daily basis (check all that apply):

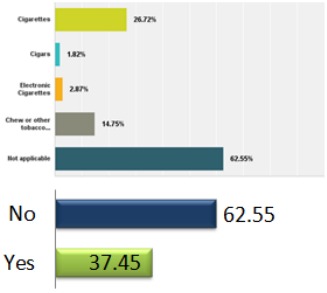
2013

Answered:680 Skipped:26



2015

Answered:1,104 Skipped:178



Conclusion: 8.75% Yes

Tobacco Use:

Please check if you have ever been told by a doctor or other health professional (s) that you have: (check all that apply)

2013

Answered:686 Skipped:20

2015

Answered:1,009 Skipped:273

Conclusion: 2.45%

Secondary Data:

Tobacco Use

- Percentage of adults that smoke

	Pennsylvania	Cameron	McKean	Potter	Tioga
2015	20%	39%	27%	18%	20%
2013	21%		33%	22%	20%

Source: County Health Rankings 2015

Conclusion:

Pennsylvania	Cameron	McKean	Potter	Tioga
↓ 1%		↓ 6%	↓ 4%	0%
Overall total improvement of:				3.3%

Evaluation of Prior Needs Identified and Actions Taken

Through each of these priorities much work has been accomplished especially in dental. Initiatives that have been done over the last three years have been listed below. Take a look at the secondary data to see the trends over the course of the three years in these areas in the previous section.

1. **Heart Disease & Stroke**
    a. Vascular screenings extended into our secondary market area
    b. Comprehensive Blood Analysis are being held 5 times a year partnering with 4 local rotary clubs and one library organization. The screenings include over 30 commonly requested blood tests including CBC, comprehensive, coronary risk, and liver function profiles. We added A1C testing to the screening.
    c. E-blasts are being sent out to educate the community residents on heart disease
2. **Dental**
    a. Fluoride varnish provided in our pediatric offices to our M/A patients.
    b. Mobile Dentist program being held at local schools that provide cleaning, x-rays and sealants.
    c. Hired a public health hygienist in our pediatrics offices.
    d. Opened a dentist office with currently one dentist overseeing the practice as well as took over an existing dentist practice.
    e. Established a regional dental collaborative.
3. **Tobacco Use and Secondhand Smoking**
    a. Identifying patients that use tobacco at office visit encounters and offering cessation options.
    b. Partnered with Clinical Outcomes Group Inc. to host 2 smoking and tobacco cessation workshops throughout the year that provides four free weeks to nicotine patches, gum, and lozenges to those who attend.
4. **Diabetes**
    a. Patient registry work is being done in the Primary Care Network to identify existing patients that may be overdue for care.
    b. Utilizing standards for screening and prevention which are imbedded within the Health Maintenance/Disease Management tool in the outpatient electronic medical record.
    c. Diabetic Support Group each month at Cole Memorial.
    d. Glucose screening was added to our comprehensive blood analysis.
5. **Obesity**
    a. 24/7 access to our Wellness Centers available for use to the general public in four locations.
    b. Personal Nutritional Coaching available to all Highmark members.
    c. Family Fitness Challenge and Pediatric Wellness Clinics
    d. After School Kids Program for at risk children.
    e. Implement an “outcomes based” employee wellness program and now have expanded to offer workplace wellness to our local employers.

6. **Access to Primary Care Services**

a. Assessed primary care capacity and adjusted clinic hours to better meet patient needs.
b. Implemented a walk-in clinic designed to meet the urgent medical needs of patients who are not able to see their regular medical provider during routine business hours. We have now expanded the hours to weekends.
c. Same day appointments are now offered in the clinics.
d. On-going marketing and outreach for physician offices & services at Cole Memorial.
e. Offering telemedicine to our Cole patients.

Implementation Strategy

Based off the primary and secondary data, the CHNA steering committee has decided that over the next three years they will be focusing on obesity/nutrition/physical inactivity, mental health and substance abuse. The steering committee also recognized that a lot of great work has been done with dental and want to continue monitoring that priority to ensure that we don't lose focus of what has been done.

Although the steering committee recognizes the importance of all the needs identified by the community, such transportation, we will not directly design strategies for this issue in the implementation plan. Transportation did not rank high in the needs assessment and the steering committee felt that there is not enough funding and available resources to make this a high priority at this time.

A major challenge in the CHNA process was using county data for health needs and measuring the impact that has been made in Cameron County. Since the county is so small, it was hard to get good data/statistics that proves its significances to that health need.

The health needs that were acknowledged by the Community Health Needs Assessment have been integrated into the design of a three-year implementation plan. After reviewing current community collaborations and partnerships, and internal resources, the steering committee formed 3 committees to help identify its existing resources and create innovative programs. The committees were broken up into obesity/nutrition/physical inactivity, mental health and substance abuse. Each of the three identified priorities will be facilitated by a key leader in the region. Jessica Rohrer, Coudersport Area School District Nurse and Rich Neefe, Coudersport Area School District Food Services Director will oversee the Obesity, Physical Inactivity, and Nutrition focus group, Heidi Eastman, Potter County Operations Manager for Dickinson Center, Inc. heads up the mental health focus group and Colleen Wilber, Drugs and Alcohol Administrator for Potter County Human Services will manage the substance abuse focus group.

Over the course of the next three years, these three committees will be committed to enhancing the culture of health for our communities by promoting healthy lifestyle, improving access to integrated, and holistic behavioral health care and substance abuse services.

The steering committee also recognized the importance of a community collaborative and working together in meeting the needs of the communities we serve. It's just not the work of the hospital but with community partners and we can't do this alone. We decided that we would like to form a community collaborative called the Northern Tier Community Health Collaboration. The Northern Tier Community Health Collaborative will develop a care coordination network across behavioral health, drug & alcohol, and physical health providers to produce the following outcomes:

a) Conduct a gap analysis for mental health and drug & alcohol services;
b) Design an operational framework for a patient-centered physical, behavioral health and drug & alcohol system;
c) Develop a network plan for physical, behavioral health and drug & alcohol services improvement (i.e., goals, strategies, outcomes and measures for evaluation of progress toward network goals);
d) Assess Health Literacy training needs for network partners and develop an educational plan for network partners.
e) Formalize and approve the Northern Tier Community Health Collaborative infrastructure

f) Develop a communication plan for dissemination of behavioral health and D & A "roadmap" of services that speaks to providers and users of behavioral health and D & A services.

It's the work of this collaborative that will help us with the work that has been established below by meeting quarterly to ensure that progress is being made. Below is the implementation plan that has been established.

Priority Issue 1: Obesity, Physical Inactivity, and Nutrition

Priority Statement: To enhance the culture of health for our communities by promoting good nutrition, regular physical activity, and healthy lifestyle through education, policy, and environment.

Goal 1: Decrease the percentage of adults and children who meet the criteria for overweight and obesity.	
Objective 1.1 Decrease the percentage of community residents who reported on the CHNA survey that they have been told by a doctor or a health professional that they have a weight problem from 32 % in August 2015 to 30 % by June 2019. Objective 1.2 Decrease obesity rates by 1% in McKean (31%), Potter (32%) and Tioga (31) Counties by June 2019 to closer align with the current state obesity rate of 29%. Maintain improvement with Cameron County (28%). (Robert Woods Johnson Foundation)	
Potential Strategies	1. Develop a plan that identifies community resources for adults and children for healthy eating and activity choices. 2. Implement programs that reach parents to improve the nutrition and physical activity levels at their home as well as at school. 3. Increase and/or expand on school based policies around nutrition and physical activity. 4. Work with our healthcare system to provide health coaches in our primary care setting that will work on weight loss strategies and chronic disease management. 5. Collaborate with employers to offer wellness and preventive services for their employees.
Performance Measures	• Number of requests from parents for information on resources for nutrition and physical activity. • Number of parents who participate in the programs.

	• Review resources for completeness and usage of the developed tool. • Evaluate and review the requests from employers who were engaged with offering wellness and preventive services. • Number of schools that revise and/or develop a new policy around nutrition and physical activity. • Number of people who are trained through the Healthy Habits 4 Life program.
Suggest Activities	• Increase healthy cooking classes • Healthy Habits for Life • Workplace Wellness for employers • Team Building Seminars • Link with Penn-State Extension on their programs • Support/Publicize existing programs
Goal 2: Increase opportunities for access to and consumption of health foods and beverages.	
Objective 2.1 Increase the percentage of community residents who reported on the CHNA survey on eating at least 5 servings of fruits and/or vegetables from 21 % in August 2015 to 23 % by June 2019.	
Potential Strategies	1. Increase access and promote fruits and vegetables through a variety of outreach efforts such as gardens, farms, home and school programs, farmer markets and local grocery stores.
Performance Measures	• Number of farmers markets that accept SNAP or FMNP • Number of FMNP checks that are not cashed
Suggest Activities	• Promote and increase local farmers markets • Community Gardens • "How to make a meal" class with Penn State Co-op • Whole Share Program • "Produce Happy Hour" with farm markets • Change drink and food options at the vending machines for school and

	workplaces
Goal 3: Increase opportunities for and engagement in physical activity.	
Objective 3.1 Increase the percentage of community residents who reported on the CHNA survey to engage in at least 30 minutes of physical activity per week from 20% in August 2015 to 22% by June 2019. Objective 3.2 Decrease physical inactivity percentage by 1% in Cameron (27%), McKean (26%), Potter (30%), and Tioga (27%) Counties by June 2019. (Robert Woods Johnson Foundation)	
Potential Strategies	1. Provide and promote affordable and accessible opportunities such as parks, trails, fitness events, and recreational facilities to help be physically active. 2. Work with our school districts and community organizations/agencies to implement physical activity as their culture. 3. Encourage other ways for transportation and recreation such as walking and bicycling. 4. Explore the idea of using virtual fitness at our local wellness centers to make fitness more accessible for individuals.
Performance Measures	• Number of school districts and community organization/agencies who implement physical activity in their culture. • Review the number of opportunities to engage community members on other means for transportation and recreation.
Suggest Activities	• Sponsored guided hikes • Educate on existing resources • Employee worksite wellness • Increasing walking and running opportunities • Promote after school activities/programs

Priority Issue 2: Mental Health

Priority Statement: We are committed to fighting mental health stigma by educating the community and improving access to integrated/holistic behavioral health care. We will use legislative advocacy to help us reach our goals.

Goal 1: Raise awareness in our local a communities regarding mental health issues, needs and available resources.	
Objective 1.1 Collaboratively raise awareness of mental health issues through multi-media and other shared communication outlets.	
Potential Strategies	1. Post short videos on Social media/ websites- Agency responsible- Dickinson/ Drop-in Center information 2. Gather testimonials from willing people to share via brochures- Agency responsible 3. Community events (IE- 5K run, library events, movie night, paper tigers documentary, Maple Festival, Family Fun fair) Agency responsible- multiple agencies/committee members depending on what activity/ event 4. Have resources at the Maple Festival- Agency responsible Dickinson /committee members 5. Endorse developed trainings for various community members (IE: Mental Health First Aid) 6. Develop a paper and/or on-line resource list with all mental health services included
Performance Measures	• Facebook statistics/insights, number of people educated/reached • Committee will track volume of people educated and reached at the events • Number of website hits • Increased use of services/referrals
Suggest Activities	• 5k for Wellness • Paper Tigers
Objective 1.2 Raise legislative awareness regarding mental health.	
Potential Strategies	1. Plan for a free workshop to come to our area such as, “The Advocacy for Everyone”
Performance Measures	• Number of people reached • Number of letters written • Number of legislators contacted

Goal 2: Promote health and quality of life by preventing, and controlling mental health disease	
Objective 1.1 Maintain the number of poor mental health days in Cameron (4.0), McKean (4.1), Potter (4.1) and Tioga (4.1) Counties to continue the alignment of the state rate of 4.1 (Robert Woods Johnson Foundation)	
Potential Strategies	1. Bring primary care services to a mental health setting
Performance Measures	
Goal 3. Decrease those who've reported in the CHNA survey that they have contemplated suicide from 10.10% to 9.10% and didn't seek help from 35.78% to 34.78% by June 2019.	
Objective 3.1 Increase awareness of psychological distress symptoms and risk factors for suicide in the counties we serve.	
Potential Strategies	1. Examine differences in suicide rates by county. 2. Encourage suicide prevention education in schools. 3. Host suicide prevention presentations at area agencies on aging/senior centers. 4. Provide access to free suicide prevention and health literacy education 5. Utilize social media as a vehicle to educate about suicide prevention.
Performance Measures	• Change in suicide rate in each county • Number of public service announcements promoted • Number of school participated • Results of a pre- and post- tests to assess knowledge of suicide prevention following the awareness campaigns
Objective 3.2 Increase access to educational programs about suicide risk for all community residents	
Potential Strategies	1. Utilize public service announcements more for the topic of suicide prevention 2. Increase education at events such as walks, runs, booths 3. Use social media to educate
Performance Measures	• Number of educational events • Number of social media and public announcement posts.

Priority Issue 3: Substance Abuse

Priority Statement: We are committed to ensuring that area residents will have access to the best practices in screening, support, and treatment for substance use disorders in order to achieve and maintain optimal health outcomes.

Goal 1: Reduce and raise awareness regarding substance abuse in the communities we service through various educational program and activities, training, and outreach efforts.	
Objective 1.1 Promote public education and awareness for preventing prescription drug and opioid misuse, abuse and overdose.	
Potential Strategies	1. Develop overdose prevention resources for use in community,, prevention and treatment 2. Maintain up-to-date fact sheet on prescription drug misuse/abuse/addiction and related consequences. 3. Promote and disseminate the development to STOP Opiate Abuse and related campaigns. 4. Educate other county Judges, District Attorneys and law enforcement about the success of the various specialty courts such as the DUI (Driving Under the Influence) and C.L.E.A.N. (Concerned Law Enforcement Against Narcotics) programs in an effort to replicate. 5. Develop a "roadmap" of available substance abuse services and supports and identify and develop a plan for distribution of the "roadmap" 6. Establish a communications team, using corporate advisors affiliated with media such as newspaper and radio to advance community health and identified priorities. Invite other media venues to participate.
Performance Measures	• Number of informational resources developed or updated. • Number of communities using the STOP campaign program • Number of "roadmaps" distributed • Number of assessments given • Team established and meeting at least quarterly. Three published articles per year.

Objective 1.2 Reduce access to prescription drugs for misuse and abuse.	
Potential Strategies	1. Support collaborative drug disposal efforts 2. Encourage the ongoing placement of additional drug disposal drop boxes 3. Provide educational training and materials to dispensers and prescribers 4. Develop a crosswalk of treatment services and educate consumers, key clinical and agency personal. 5. Implement Narcan training across region and train key personal/families of users on the administration of Narcan 6. Pilot SBIRT screening in the Shinglehouse Rural Health Clinic, identify other primary care provider offices to implement screening tool.
Performance Measures	• Crosswalk developed and twenty individuals educated per year • Monitor drug disposal process and totals incinerated • Number of active drug disposal boxes • Number of training sessions provided • At least ten individuals trained with Narcan • Shinglehouse effectively implements tool. At least one additional office is approached per year.
Objective 1.3 Using network partners, develop a group of experienced grant writers to look for funding for identified priorities.	
Potential Strategies	1. Using the Northern Tier Community Collaborative partners, identify resources within agencies that can partner to research and write grants to improve community health.
Performance Measures	• Using the Northern Tier Community Collaborative partners • Identify resources within agencies that can partner to research and write grants to improve community health.
Goal 2: Improve health literacy and understand basic health information and services needed	

for informed health decision-making	
Objective 2.1 Establish a method of determining the health literacy of our community residents.	
Potential Strategies	1. Perform a Health Literary Assessment for the Northern Tier Community Collaborative Partners.
Performance Measures	• An assessment will be completed which will be followed up with an introductory talk and town hall discussion, SHARE approach workshop, Plain-Language Writing and Teach-Back Training • Seven Collaborative Partners assessed and trained.

What are we doing now?

Cole Memorial and the participating organizations and agencies have created numerous programs and services to positively impact our patients and communities we serve to better suit each individual's needs. Existing resources that are currently available to the addressed health needs are listed below.

1. **Obesity/Nutrition/Physical Inactivity**
    a. 24/7 access to our Wellness Centers available for use to the general public in four locations.
    b. Personal Nutritional Coaching available to all Highmark members.
    c. Family Fitness Challenge and Pediatric Wellness Clinics
    d. After School Kids Program for at risk children.
    e. Implement an "outcomes based" employee wellness program and now have expanded to offer workplace wellness to our local employers.

2. **Mental Health**
    a. Paper Tigers- Trauma Informed Education
    b. Mental Health Panel- People in recovery and professionals share information about mental health
    c. Wellness 5K in partnership with DCNR-Sinnemahoning Park
    d. Suicide Prevention 5K
    e. Depression screenings
    f. Employee Assistance Program
    g. Mobile Psychiatric Rehabilitation Program
    h. Autism Program
    i. HOPE- school outpatient program
    j. Children's Partial Hospitalization Program
    k. Peer Support Services
    l. Recovery Program
    m. Total Health- Behavioral Health/Physical Health Services

3. **Substance Abuse**
    a. Prevention for 5 school districts
    b. Tobacco Education and Cessation for high school students
    c. Community Prevention
    d. Screening
    e. Assessment
    f. Outpatient Treatment
    g. Intensive Outpatient Treatment
    h. Partial Hospitalization Treatment
    i. Non hospital Residential Treatment
    j. Non hospital Residential Detoxification
    k. Halfway House

l. DUI Treatment Court
m. Drug Treatment Court
n. C.L.E.A.N. Program
o. Certified Recovery Support Services
p. Substance Abuse Re-entry services from Potter County Jail and Potter County Women's Residential Rehabilitation Center
q. Case Management Services
r. Buprenorphine Medication Assisted Treatment Program

APPENDICES

Appendix: A

Community Health Needs Assessment Committee		COLE Memorial
June 30, 2015	Cole Memorial's Main Conference Room	Called to Order: 4:05 Adjournment: 5:19

Meeting Facilitator	Kari Kurtz
In Attendance	Scott Christie, Samantha Cossman, Heidi Eastman, Sarah Fry, Caitlin George, David Hyde, Kristin Kratzer, Patrice Levavasseur, Jessica Miller, Dean Predmore, MaryAnn Rigas, MD, Pam Ruane and Jim Russell.
Absence	Cliff Clark, Lora Cope, Liselle Esposito, Alanna Huck, Barb Keil, Mark Moore, Suzan Paisley, Tina Solak, Kari Stake, Colleen Wilbur.
Agenda Item	**Introductions**

Kari Kurtz invited the committee members in attendance to introduce themselves and where they are from: Scott Christie, Sena Kean Manor; Samantha Cossman, Potter County Link; Heidi Eastman, Dickenson Mental Health Center; Sarah Fry, Coudersport Elementary School Nurse; Caitlin George, Cole Memorial; David Hyde, A Way Out Executive Director; Kristin Kratzer, Cole Memorial Medical Group; Patrice Levavasseur, Cole Foundation; Jessica Miller, Slippery Rock Public Health Student; Dean Predmore, Potter County Department of Emergency Services; MaryAnn Rigas, Cole Memorial MD; Pam Ruane, Cole Memorial Lock Haven Program and Jim Russell, Potter County Education Council.

Agenda Item	**Overview of the CHNA Process**

The Community Health Needs Assessment is a federal requirement stemming out of the Patient Protection and Affordable Care Act (PPACA) for all non-profit hospitals. The goal of this assessment is to get an insight into the lives of our community members and help meet the needs of the area. The 2016 Community Health Needs Assessment is due June 2016. Please see appendix I for more information.

Agenda Item	**Discussion of CHNA Process**

The "*2013 Community Health Needs Assessment*" was strictly focused on the hospital and healthcare needs. After reviewing similar assessments, it was decided the plan for the 2016 should have a community focus. This will be accomplished through the addition of questions around social and environmental needs. **The committee members were tasked with reviewing the survey and pulling questions out that seemed unnecessary, rewording questions that could be confusing or misleading and creating questions that may achieve valuable insights into the needs of our communities.** The goal of this assessment is to get an understanding of the needs of the area. This needs to be completed and sent to Kari Kurtz by **July 15, 2015.** Given the population being assessed, the committee would still like to keep the survey relatively short,

at a 6th grade education level and without any jargon, when jargon is unavoidable to give a definition or to have a glossary in the document. Other changes to the survey include adding Germania and Oswayo. Kristin volunteered to run a report of zip codes of patients accessing the health clinics.	
The second meeting of this committee will be held on July 21, 2015 to review the secondary data. It was recommended to review the assessments done by Lancaster County (http://lancastergeneralhealth.org/lgh/lgh/documents/12LG176_HealthAssessmentSummary_FINAL_Rev.pdf), Blair County (http://healthyblaircountycoalition.org/wp-content/uploads/2015/04/blair-county-profile-2013.pdf), and York/Adams County (http://www.healthyyork.org/pdf/Healthy_York_Healthy_Adams_CHNA_Summary_and_Appendices_June_11_2012.pdf). See appendix II for more information.	
Agenda Item	**Strategy and Survey Approach**
In order to achieve a holistic approach, the committee would like to distribute three surveys; one to local providers, a survey specific to local business owners and an overarching community survey. The goal of the three surveys is to collect information from different perspectives.	
The committee discussed a variety of locations and distribution sites for the survey which currently includes; banks, churches, post offices, library, borough and chamber offices, jail, human services, A Way Out, Martian Causer's office, senior expo and posted electronically to Facebook (various committee members offered to share), and Cole Memorial's web page.	
Agenda Item	**Next Steps**
The committee members were tasked with reviewing the survey and pulling questions out that seemed unnecessary, rewording questions that could be confusing or misleading and creating questions that may achieve valuable insights into the needs of our communities. The goal of this assessment is to get an understanding of the needs of the area. This needs to be completed and sent to Kari Kurtz by **July 15, 2015.**	
Review secondary data. Possibly sources include County Health Rankings (http://www.countyhealthrankings.org), Healthy People 2020 (http://www.healthypeople.gov), Pennsylvania Health Care Cost Containment Council (http://www.phc4.org), U.S. Census Data and Statistics (http://census.org), Pennsylvania Department of Health (http://www.health.pa.gov/Pages/default.aspx#.VZqTV_lViko).	
Meeting Adjourned	**5:19 P.M.**

Community Health Needs Assessment Committee

COLE Memorial

September 8, 2015	Cole Memorial's Main Conference Room	Called to Order: 4:00 Adjournment: 5:25

Meeting Facilitator	Patrice Levavasseur
In Attendance	Lora Cope, Samantha Cossman, Heidi Eastman, Sarah Fry, Caitlin George, Kristin Kratzer, Jim Russell and Colleen Wilbur.
Absence	Cliff Clark, Scott Christie, Liselle Esposito, Alanna Huck, David Hyde, Barb Keil, Kari Kurtz Mark Moore, Suzan Paisley, Dean Predmore, MaryAnn Rigas, MD, Pam Ruane, Tina Solak, and Kari Stake.
Agenda Item	**Introductions**

Patrice Levavasseur introduced Colleen Wilbur to the committee. Colleen is from the Potter County Drug and Alcohol Administration.

Agenda Item	**Overview of the Survey Results**

Patrice Levavasseur thanked everyone who helped get surveys turned in as well as those who helped with data entry. There were 10 Provider surveys returned, 41 key leader surveys returned and 1,282 of the community surveys returned for a total of 1,333 returned surveys.

Agenda Item	**Listing and Prioritizing Health Issues**

According to Cole Memorial's medical providers:

The greatest need regarding health education and prevention services in our communities are:

1. Drug and Alcohol
1. Obesity
2. Mental Health
2. Dental/Oral Health

**60% stated Healthy Lifestyle*

When asked what they believe is the most serious issue in the communities, they responded with:

1. Mental Health
1. Drugs and Alcohol
2. Obesity
2. Children's Issues (Mental Health, High-Risk Households, Neglect)

When asked what they believe are the greatest gaps in health care services, they stated:

1. Outpatient mental health care for adults
2. Outpatient mental health care for children

3. Dental

When asked what barriers prevent residents from getting necessary health care needs, they responded:

1. Insurance
2. Co-pays
3. Deductibles

According to the 41 Key Community Leaders surveyed the major issues effecting community members, after combining major and moderate issues are:

1. Unemployment/Underemployment (92.69%)
2. Obesity (92.68%)
3. Alcohol (90.25%)
4. Poverty (87.8%)
5. Lack of Jobs (87.18%)
6. Smoking/Tobacco Use (85.37%)
7. Diabetes (80.49%)
7. Individuals with Mental Health Diagnosis (80.49%)

The committee agreed that these are just perceptions, and aren't necessarily accurate. Everything needs to be backed up by secondary data.

According to the 1,282 community members surveyed, the greatest issues effecting community members, after combining major and moderate issues are:

1. Lack of Jobs (84.41%)
2. Unemployment/Underemployment (82.29%)
3. Obesity (76.51%)
4. Smoking/Tobacco Use (75.82%)
5. Poverty (75.80%)
6. Drug Abuse (75.22%)
7. Alcohol Abuse (69.00%)
8. Lack of affordable medical care (64.89%)
9. Mental Health/ Emotional Issues (64.46%)

When asked what they greatest issues effecting them in their homes, they stated:

1. Obesity (47.39%)
2. Anxiety/Stress/Depression (42.77%)
3. Difficulty Budgeting (36.89%)
4. Not enough money to meet daily needs (33.81%)
    - Difficulty paying utility bills (25.0%)
    - Unable to afford entertainment (27.36%)
    - Unable to afford recreational activities (28.06%)
5. No work (32.76%)
6. Adults experiencing behavior, mental health or emotional issues (27.33%)

As a final note the team reviewed the mental health results from the community survey that stated 18.89% of respondents felt down, depressed or hopeless more than 10 days in the last year. 10.10% have contemplated suicide and of that 10.10%, 35.78% haven't sought out help. The primary response as to why help wasn't sought out was they didn't think it would help at 26.97%, followed by the cost at 20.22%. The team was also concerned about the rising obesity rates which have gone from 23.9% having been told by a health professional they were obese in 2013 to 32.21% in 2015. An 8.31% increase in 3 years.	
Agenda Item	**Secondary Data Collection**
The individual below have volunteered to collect the following secondary data: • Teen Pregnancy Rates – Project Rapport – Sarah Fry • Teen Pregnancy Rates – County Health Rankings – Caitlin George/Patrice Levavasseur • State SAP Data – Heidi Eastman • Drug and Alcohol Data (all four counties) – Colleen Wilbur • Dental – County Health Rankings – Caitlin George/Patrice Levavasseur • Adult Mental Health – County Health Rankings – Caitlin George/Patrice Levavasseur • Obesity – County Health Rankings/Healthy People 2020 – Caitlin George/Patrice Levavasseur • Economic Data – Jim Russell • School BMI Rates – Sarah Fry • School Lunch Assistance Data – Sarah Fry • Diabetes Rates – Kristin Kratzer • Obesity Rates – Kristin Kratzer • Any related information – Department of Health – Lora Cope	
Agenda Item	**Next Steps**
The committee members (above) who have tasked with pulling secondary data are asked to do so and be prepared to discuss their findings at the next meeting.	
If not tasked above, please review secondary data related to some of the priorities noted above, possible sources include County Health Rankings (http://www.countyhealthrankings.org), Healthy People 2020 (http://www.healthypeople.gov), Pennsylvania Health Care Cost Containment Council (http://www.phc4.org), U.S. Census Data and Statistics (http://census.org), Pennsylvania Department of Health (http://www.health.pa.gov/Pages/default.aspx#.VZqTV_lViko).	
The next meeting will be held on September 22, 2015 at the Potter County Education Council at 4:00 p.m.	
Meeting Adjourned	**5:25 P.M.**

Community Health Needs Assessment Committee

COLE Memorial

September 22, 2015	Potter County Education Council	Called to Order: 4:00 Adjournment: 5:29

Meeting Facilitator	Patrice Levavasseur
In Attendance	Samantha Cossman, Heidi Eastman, Sarah Fry, Caitlin George, Alanna Huck, David Hyde, Barb Keil, Kristin Kratzer, Pam Ruane, Jim Russell and Colleen Wilbur.
Absent	Cliff Clark, Scott Christie, Lora Cope, Liselle Esposito, Kari Kurtz Mark Moore, Suzan Paisley, Dean Predmore, MaryAnn Rigas, MD, Tina Solak, and Kari Stake.
Agenda Item	**Introductions**

Heidi Eastman introduced Marcia Nupp to the committee who is also from Dickenson Mental Health.

Agenda Item	**Review Secondary Data Collection**

Teen Pregnancy:
Caitlin George announced that the data from the "County Health Rankings" on teen pregnancy was for all teens 15-19 years old. The team would like data specific to the number of high school age pregnant teens. The team will look into data from Project Rapport and Alana Huck will reach out to other area school Superintendents to get a yearly estimate from their observations and report back next meeting. The team agreed that this area could be a small population, but a high impact area. Further discussion was tabled until the next meeting.

Obesity Epidemic:
Kristin Kratzer led the discussion on the obvious obesity epidemic in all four counties. Some of the data discussed was the 8% increase from the 2013 to the 2015 Community Health Needs Assessment question, have you been told by your healthcare professional that you are obese. The County Health Rankings were cited as showing Potter, Tioga and McKean counties being above the state average in obesity. Cameron County was 2% below the state average and almost 10% above the state average reporting access to exercise opportunities. This led to a discussion that education on available exercise opportunities may be beneficial in making an impact. Patrice Levavasseur shared a conversation she had with the Community Health Needs Assessment team in Blair County who instead of listing obesity as a priority, naming the priority improving healthy lifestyles. The team agreed a Healthy Lifestyles priority was appropriate. Some of the priorities could be promoting walking paths, 5ks and other local exercise events, implementing a walkable communities program, and educational programs on nutrition. The team agreed that this area could be another high impact area. Further discussion was tabled until the next meeting.

Mental Health:
The team overall discussed the surprising results from the 2015 Community Health Needs Assessment relating to mental health. Heidi Eastman shared data she found for Mental/Behavioral Disorders Death Rate Per 1,000 Residents. Pennsylvania was at .52%; Cameron County, .26%; McKean, .51%; Potter, .77% and Tioga, .61%. The team question how big of a problem this is and if we are able to have an impact. The team discussed looking at a holistic approach. The discussion was tabled until the next meeting pending more data.

Economics:
Jim Russell shared the data he was able to collect; he prefaced the conversation by stating most of the data is only through 2012/2013. Some of the main points that were discussed included the median household income in all four counties being below the state average; all four counties being above the state average for the number of residents living in poverty and 16% living on under $20,000 a year. Those accessing medical assistance and food stamps are above the state average, but there has been a decrease in cash assistance. Sarah Fry shared the free and reduced lunches through the school have continued to increase. Some of the possible solutions discussed included working on implementing a simpler process for accessing state aid programs, since this is controlled at the county level. Educate those at access points on how to properly fill out paperwork and steps to take if resident is denied access. Have budgeting workshops similar to the one "A Way Out" is hosting on October 1.

Child Abuse:
The team discussed a graph Jim shared from the Pennsylvania Department of Human Services which show a significant increase in all four counties of founded child abuse cases. In 2012, the state average of substantiated cases of abuse per 1,000 children was 1.3; Cameron County, 4.3; McKean County, 2.7; Potter, 3.5; Tioga, 3.0. Patrice Levavasseur referenced the provider survey response that shared a similar concern of children living in high-risk households. Jim offered to look into this further to try to find more recent data. The team agreed and discussion was tabled pending further data.

Alcohol and Drugs:
The team reviewed some of the statistics relating to drugs and alcohol in the counties. According to the "County Health Rankings" the alcohol- impaired driving deaths are 16% above the state average in Cameron County; 1% above the state average in McKean County; 4% below the state average in Tioga County; 12% below the state average in Potter County. In excessive drinking, no data was collected for Cameron County; Potter and McKean were 1% above the state average and Tioga was 3% below the state average. Alanna Huck and Sara Fry reported an increase of heroin and marijuana in the schools. Colleen Wilbur offered to pull treatment data reports, but agreed that heroin is a rising issue in the area.

Agenda Item	Next Steps
	The committee members (above) who have tasked with pulling secondary data are asked to do so and be prepared to discuss their findings at the next meeting.
	If not tasked above, please review secondary data related to some of the priorities noted above, possible sources include County Health Rankings (http://www.countyhealthrankings.org), Healthy People 2020 (http://www.healthypeople.gov), Pennsylvania Health Care Cost Containment Council (http://www.phc4.org), U.S. Census Data and Statistics (http://census.org), Pennsylvania Department of Health (http://www.health.pa.gov/Pages/default.aspx#.VZqTV_lViko).

The next meeting will be held on October 14, 2015 at the Coudersport High School Library at 4:00 p.m.	
Meeting Adjourned	**5:29 P.M.**

Community Health Needs Assessment Committee		COLE Memorial
September 22, 2015	**Potter County Education Council**	**Called to Order: 4:00** **Adjournment: 5:29**

Meeting Facilitator	Patrice Levavasseur
In Attendance	Samantha Cossman, Heidi Eastman, Sarah Fry, Caitlin George, Alanna Huck, Kari Kurtz, Jim Russell and.
Absent	Cliff Clark, Scott Christie, Lora Cope, Liselle Esposito, David Hyde, Barb Keil, Kristin Kratzer, Mark Moore, Suzan Paisley, Dean Predmore, MaryAnn Rigas, MD, Pam Ruane, Tina Solak, and Kari Stake.
Agenda Item	**Compare Six Priorities Results from 2013 to 2015**
Caitlin George and Kari Kurtz presented a PowerPoint titled "Community Health Needs Assessment Results 2013 to 2015" to the group which showed primary and secondary data that related to the six priorities. See appendix I to view the PowerPoint.	
Access to Care: Overall Access to care showed improvement. "Do you have a family doctor or health care provider" increased 2.03% since 2013; "Do you think there are enough family doctors or health care providers in your area?" increased 3.49% since 2013; proper use of facilities has increased with a 23.6% increase in those responding they have a primary care provider and a 16.5% decrease in emergency department usage. Secondary data reflects a similar picture with an overall increase in number of patients per primary care provider.	
Heart Disease: Data relating specifically to heart disease rates were scarce. According to the primary survey data, those who reported that a health professional told them they had heart problems increased 3.15% and high blood pressure increased 4.27%. The only secondary data that was found was from 2007-2008 and coincided with an increase in prevalence.	
Diabetes: Primary survey data relating to diabetes reported a 3.24% increase in those reporting a health professional told them they had diabetes. Secondary data from "*County Health Rankings*" shows a 1% increase in those diagnosed with diabetes in Cameron, Potter and Tioga Counties.	
Noteworthy: Those who reported receiving routine medical care for their chronic condition dropped 27.73%.	
Obesity: There was an 8.31% increase in those who reported a health professional told them they had a weight problem. There was a 4.63% decrease in those who reported they don't eat any fruits or vegetables and an increase of 4.89% increase in those who said they do 1-4 days per week. As it relates to the importance of exercise, those who self-reported exercise was very	

important or extremely important decreased 3.81%, but those who said it was moderately or slightly important increased 5.52%. Those who reported how many days they engage in at least 30 minutes of activity, there was a 4.40% decrease in those who reported 5+, but and 5.58% increase in those reporting 1-4 days per week and a 1.37% decrease in those reporting 0. Secondary data from "*County Health Rankings*" shows a 1% increase in obesity in Potter and Tioga counties, McKean maintained the same rates and Cameron County decrease by 2%. Jim Russell cautioned the group that data rates in Cameron County can fluctuate greatly due to the small population.

Dental: There was a 6.06% decrease in those reporting they had a dental check-up, but when asked why they did not see a dentist there was a 10.95% decrease in those stating insurance barriers; a 10.36% decrease in those stating they were unable to pay; a 1.25% decrease in those who needed transportation and a 1.84% decrease in those who stated dental services weren't available. The majority of respondents stated the question was not applicable at 55.61%. One possible conclusion was those who have dentures not feeling they need to go to the dentist.

Tobacco Use: There was an 8/75% increase in those who self-reported using tobacco products, a 2.45% increase in those who have had a health professional discuss their tobacco habit with them and according to the secondary data from "*County Health Rankings*" tobacco rates have decreased 6% in McKean County, 4% in Potter County and remained the same in Tioga. Cameron County came in with data for the first year at 39%, 19% higher than the state average.

Agenda Item	Discuss and Prioritize Health Issues and Identify Appropriate Community Partners

Access to Care: The committee believes the biggest impacts in this area are from the implementation of Express Care, the increase in providers and the increased education around the role of physician assistants and nurse practitioners. The team decided to continue to monitor this area, but to focus on improving other areas.

Teen Pregnancy: In previous meetings the team pinpointed that teen pregnancy may be an issue due to the secondary data pulled from "*County Health Rankings.*" The team felt the data was too broad because it included women up to 19 years of age. Due to the lack of other data sources and legal hurdles preventing the number of those school aged women who are pregnant, the team felt that this issue was smaller than the data originally suggested.

Dental: The team reviewed the dental statistics and was pleased with the results. Cole Memorial will continue to work in this area as an organization. They are currently looking to expand and are actively recruiting a dentist. The committee will continue to monitor this area.

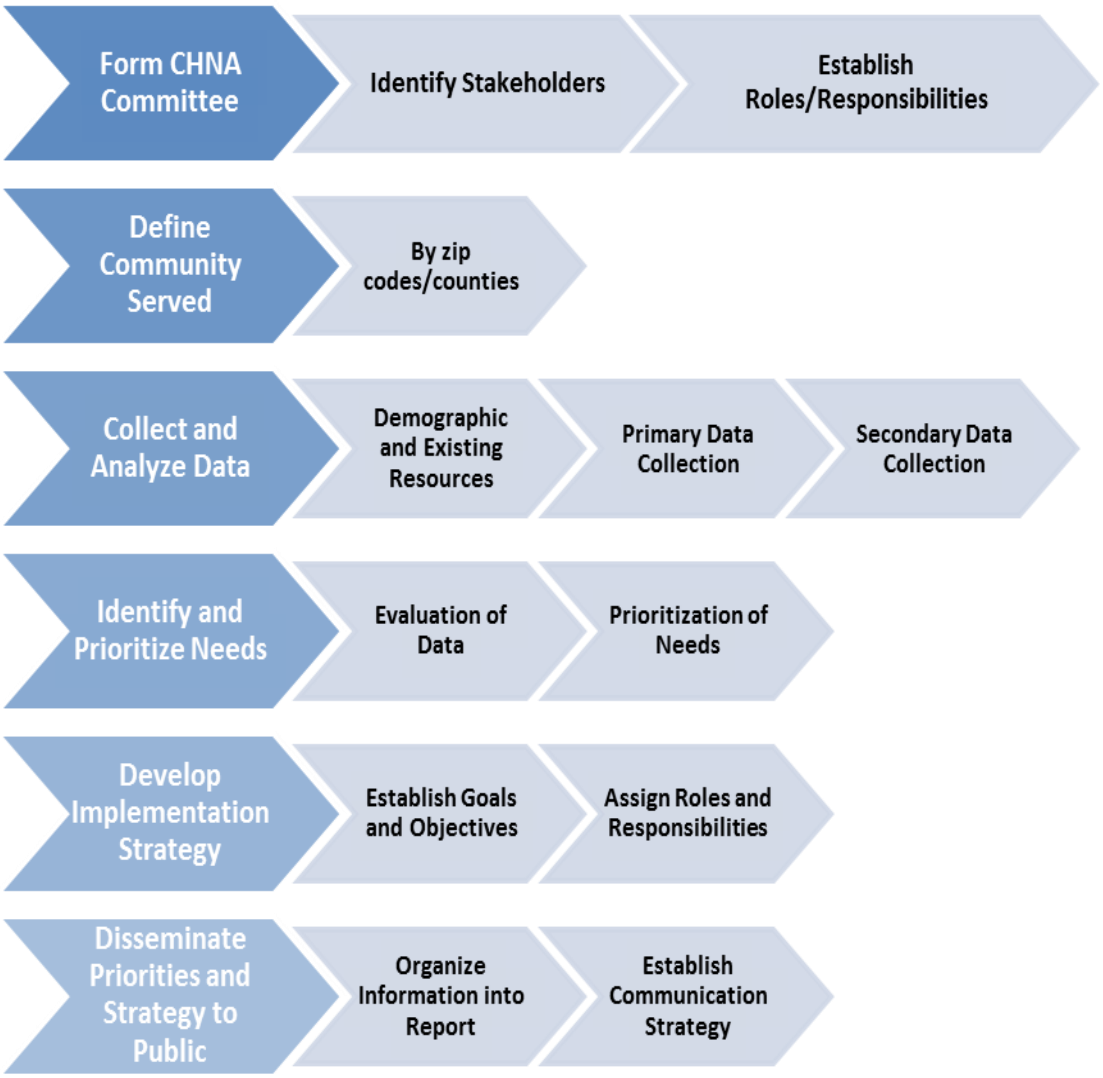
2015-2018 Community Health Needs Assessment Priorities:
The team wanted to take a holistic approach and decided on three main focus areas; Obesity and Chronic Disease Management, Mental Health and Substance Abuse.

> **Obesity and Chronic Disease Management:** The members present discussed the relationships between the majority of chronic diseases and how interrelated they are. As a group, the consensus was if committee was formed to take on each chronic disease separately, they would be duplicating efforts. The decision was to group them together for a single committee to tackle. The heart disease, diabetes and obesity work from 2013 will continue under this new title.
>
> **Mental Health:** Due to the overwhelming need shown in for mental health care in the primary and secondary data the team wanted to focus on this area.

Substance Abuse: The primary and secondary data showed a rise in tobacco and substance abuse. The committee wanted to continue to focus on tobacco use but added in alcohol and drugs. The committee felt that by breaking these down into three main areas the most work will be able to be completed. They felt that it gave a holistic approach with a focus on improving community members physically, mentally and their environment.	
Agenda Item	**Identify Appropriate Community Partners**
Obesity: Samantha Cossman, Potter County Link Donna Thomas, Cole Memorial Wellness Center Rich Neff, Coudersport School District Cafeteria Director Adam Clinger, Dr. Wahlers and/or Dr. Rigas, Cole Memorial Providers Betty Wallace, Tina Solak, DCNR Representation Penn State Co-op Representation Someone with first-hand experience	
Mental Health: Dickenson Representation Dr. Neerukanda, Cole Memorial Psychologist Cole Care Manager Representation School Councilors Sagewood Representation Russ Streich ADA's SAP Program Someone with first-hand experience	
Substance Abuse: School Councilors Heidi Eastman, Someone with first-hand experience	
Agenda Item	**Community Partnerships**
Patrice Levavasseur approached members to discuss and go back to their organizations to see if they would be willing to form a partnership stating they are interested in working with Cole Memorial to improve certain areas within the community. This would help Cole Memorial to apply for grants.	
Agenda Item	**Next Steps**
The committee members should review the names of those suggested for committees and try to come up with others who should be added. Names/suggestions should be emailed to Kari Kurtz.	
The next meeting will be announced at a later date.	
Meeting Adjourned	**5:29 P.M.**

Appendix B:

6 Step Approach Outline



Appendix C:

Email to community key leaders

Dear Community Leader:

As part of the effort to build better communities and the health of our region we are conducting a community health needs assessment August 3rd-17th that will target area residents. Our goal is to have 1,000 community residents complete our survey. In addition to this survey we are asking Key Community Leaders like yourself to assist us by completing a separate leader survey to learn more about strengths and issues that impact our residents and neighborhoods. As a leader, many of you have a unique perspective on your community and those you serve. You may be an employer, a government official, a school or community leader. Members of our steering committee view this as an opportunity to assess and hopefully impact all aspects of health in our region, so we encourage participants from all segments of the community to participate.

Please go to the link below and complete the Leader survey through the internet on survey monkey no later than August 17th. Your individual responses will be kept confidential because we are not tracking who completed the survey. However, your participation will help ensure that this is a successful effort.

https://www.surveymonkey.com/r/MKVMT8R

If you believe that there are key leaders in your community that should receive this survey, please email me with their name and email address so it can be checked against our master list and avoid duplication. If you have questions about this survey, or would like to become involved in our steering committee to improve health, please feel free to call or email me anytime.

Thank you in advance for your support in making this a healthier region.

Appendix D:

1001 East Second Street
Coudersport, PA 16915-8161
814-274-9300
www.colememorial.org

COLE Memorial

July 22, 2015

Dear Provider:

As part of the effort to build a better community, we are conducting a community health needs assessment. Surveys are being sent to a variety of groups but we are asking for your help in completing the Service Provider Survey to learn more about the strengths and assets we have available. We are contacting you because we highly value your opinion, and we believe your insights will help improve all aspects of planning the future needs of the communities we serve.

Beginning in 2012, all hospitals are required by the Affordable Care Act to conduct a community health needs assessment and to develop an intervention plan to meet those community health needs. However, members of the Steering Committee view this as an opportunity to assess and hopefully impact all aspects building healthier communities in our region, so we encourage participants from all segments of the communities we serve to participate. Healthy communities' means impacting social, economic, emotional, and physical needs of residents and the communities themselves.

Please go to the link below and complete the survey through the internet on survey monkey no later than August 17, 2015. Be assured that the information gathered will be treated with complete confidentiality.

https://www.surveymonkey.com/r/JX3ZTQJ

Thank you in advance for your support and feedback. A community health needs assessment will be conducted for area residents from August 3 – 17th. We appreciate the willingness of our provider offices to serve once again as a survey distribution site for your patients during this time period. If you have questions about the Service Provider Survey, please call Kari Kurtz, Director of Community Outreach at ext.5550.

Sincerely,

Kari Kurtz
Director of Community Outreach

Mary Ann Rigas, MD

Appendix E:

Community Health Needs Assessment Survey 2015

1. Are you....?

Answer Options	Response Percent	Response Count
Male	21.4%	273
Female	78.6%	1002
answered question		1275
skipped question		7

2. Which category below includes your age?

Answer Options	Response Percent	Response Count
18-20	1.6%	20
21-30	13.6%	174
31-40	17.4%	223
41-50	19.5%	249
51-60	21.2%	271
61-70	14.9%	191
71-80	7.7%	99
81-90	3.6%	46
90+	0.4%	5
answered question		1278
skipped question		4

3. In what county do you live in?

Answer Options	Response Percent	Response Count
Cameron	7.3%	90
McKean	26.6%	330
Potter	62.4%	775
Tioga	3.7%	46
Other (please specify)		35
answered question		1241
skipped question		41

4. In what ZIP code is your home located?

Answer Options	Response Percent	Response Count
15832, Driftwood	0.3%	4
15834, Emporium	6.9%	84

15861, Sinnamahoning	0.2%	3
16720, Austin	5.3%	65
16724, Crosby	0.2%	3
16726, Cyclone	0.1%	1
16729, Duke Center	0.7%	8
16730, East Smethport	0.1%	1
16731, Eldred	2.2%	27
16732, Gifford	0.2%	3
16738, Lewis Run	0.1%	1
16743, Port Allegany	8.9%	109
16744, Rew	0.2%	2
16745, Rixford	0.4%	5
16746, Roulette	4.3%	52
16748, Shinglehouse	11.3%	138
16749, Smethport	5.5%	67
16750, Turtlepoint	1.2%	15
16915, Coudersport	28.0%	341
16921, Gaines	0.7%	8
16922, Galeton	4.1%	50
16923, Genesee	3.7%	45
16927, Harrison Valley	1.1%	14
16937, Mills	0.5%	6
16941, Genesee (North Bingham)	0.0%	0
16943, Sabinsville	0.3%	4
16948, Ulysses	5.9%	72
16950, Westfield	2.6%	32
Other	4.8%	59
Other (please specify)		100
answered question		1219
skipped question		63

5. What is the highest degree or level of school you have completed? If currently enrolled, highest degree received.

Answer Options	Response Percent	Response Count
No schooling completed	0.5%	6
Nursery school to 8th grade	0.2%	3
Some high school, no diploma	4.4%	55
High school graduate, diploma or the equivalent (for example: GED)	31.5%	398
Some college credit, no degree	14.0%	177
Trade/technical/vocational training	8.9%	113
Associate degree	13.3%	168
Bachelor's degree	13.7%	173
Master's degree	10.7%	135
Professional degree	2.1%	26

Doctorate degree	0.8%	10
	answered question	1264
	skipped question	18

6. What is your marital status?

Answer Options	Response Percent	Response Count
Single, never married	16.6%	208
Married or domestic partnership	64.9%	813
Widowed	7.3%	92
Divorced	9.2%	115
Separated	2.0%	25
answered question		1253
skipped question		29

7. Are you currently:

Answer Options	Response Percent	Response Count
Employed for wages	60.6%	770
Self-employed	3.6%	46
Out of work for more than a year	0.9%	12
Out of work for less than a year	1.7%	22
Homemaker	5.1%	65
Student	1.3%	16
Retired	18.6%	237
Unable to work/disability	8.1%	103
answered question		1271
skipped question		11

8. Annual household income from all sources:

Answer Options	Response Percent	Response Count
Less than $20,000	19.3%	234
$20,000-34,999	20.6%	249
$35,000-49,000	18.7%	226
$50,000-99,999	31.6%	382
$100,000+	9.8%	119
answered question		1210
skipped question		72

9. How many children (17 and younger), adults (18-64) and seniors/elders (65 and older) live in your household?

Answer Options	Response Average	Response Total	Response Count
number of children	1.28	1,018	793
number of adults	1.99	2,105	1058
number of seniors/elders	.71	435	613
		answered question	1197
		skipped question	85

10. Please select the best response regarding your transportation situation:

Answer Options	Response Percent	Response Count
I have a car that I personally operate	90.9%	1159
I rely on someone else to drive me in their vehicle	7.0%	89
I use a bicycle	0.1%	1
I rely on a transportation service like ATA or the Human Services office	1.3%	16
I do not have access to reliable transportation when I need it	0.8%	10
answered question		1275
skipped question		7

11. Do you regularly do volunteer work in your community?

Answer Options	Response Percent	Response Count
Yes	38.1%	482
No	61.9%	783
answered question		1265
skipped question		17

12. CHECK ONE IN EACH ROW that you believe may be impacting community members

Answer Options	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't know	Response Count
Unemployment or underemployment	57	81	369	616	74	1197
Poverty	70	139	403	493	77	1182
Lack of jobs	48	87	327	664	48	1174
Children being adequately educated	210	314	376	200	76	1176
Unsafe school environment	485	385	151	58	104	1183
Bullying/harassment	103	340	375	233	130	1181
Use/availability of drugs in school	89	217	373	360	151	1190
Water or air pollution	349	438	202	102	98	1189

Alcohol abuse	94	195	433	388	80	1190
Drug abuse	73	127	367	529	87	1183
Smoking and tobacco use	74	134	416	481	78	1183
Mental health or emotional issues	66	227	446	316	127	1182
Lack of affordable medical care	93	223	321	446	99	1182
HIV/AIDS	352	360	113	41	314	1180
Diabetes	86	201	404	301	180	1172
Obesity	49	122	394	508	106	1179
Shortage of affordable housing	115	279	348	307	141	1190
Substandard housing	125	331	348	175	201	1180
Overcrowded housing	250	355	221	77	269	1172
Shortage of recreational facilities (swimming pools, nature trails, etc.)	246	324	263	265	83	1181
Shortage of cultural activities (concerts, museums, etc.)	109	254	324	406	89	1182
Crime	117	431	410	162	59	1179
Teen Pregnancy	74	287	421	241	151	1174
Racial or ethnic discrimination	276	414	209	115	163	1177
Family violence, abuse of children, adults, or the elderly	109	305	401	210	160	1185
Gambling	228	378	224	79	271	1180
Lack of affordable daycare for children	146	303	315	210	205	1179
Inadequate public transportation	148	288	307	295	142	1180
Poor road and/or traffic conditions	124	303	345	343	66	1181
Difficulty accessing accommodations within local community businesses (wheelchair or walker access, help for hard of hearing/deaf/blind)	227	421	256	98	183	1185
Difficulty paying utility bills (heat, water, electricity)	104	297	410	242	136	1189
Hoarding or cluttered environment	198	378	297	116	190	1179
Too many animals to properly care for (both indoor and outdoor)	223	372	235	135	210	1175
					answered question	1208
					skipped question	74

13. What do you believe are strengths within your community that are not listed?

Answer Options	Response Count
	392
answered question	392

skipped question	890

14. Are there other issues in the community that are not listed?	
Answer Options	Response Count
	266
answered question	266
skipped question	1016

15. CHECK ONE IN EACH ROW						
Answer Options	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/Don't Know	Response Count
Not having enough money for food	528	182	245	125	44	1124
Not having enough money to meet my daily needs	519	187	233	146	36	1121
Finding it difficult to budget	391	272	241	170	40	1114
Not being able to find work	560	111	173	190	74	1108
Children being adequately educated within their school system	532	192	177	86	125	1112
Children being unsafe at school	598	216	116	49	131	1110
Bullied/harassed	447	246	164	124	119	1100
Experiencing water or air pollution	611	233	101	49	105	1099
Having a lot of anxiety, stress, or depression	303	278	258	215	52	1106
Experiencing an alcohol addiction	703	110	134	83	74	1104
Experiencing a drug issue	747	71	121	93	73	1105
Negative effects of smoking/tobacco use	625	158	134	108	76	1101
Adults experiencing behavior, mental health, or emotional issues	528	206	168	134	69	1105
Children or teenagers experiencing behavior, mental health, or emotional issues	553	175	168	110	98	1104
Being overweight	281	253	314	213	51	1112
Having diabetes	572	141	173	130	77	1093
Not having enough room in our house for all the people who live there	746	144	91	39	80	1100
Living in housing that needs major repairs	627	171	154	77	75	1104
Not having enough money to pay for housing	637	152	144	95	73	1101
Not being able to afford recreational activities	508	224	170	139	60	1101

Not being able to afford entertainment activities	511	226	168	134	65	1104
Experiencing crime	697	187	106	49	64	1103
Not being able to afford legal help	641	143	119	105	89	1097
Not being able to get care for a person with a disability or serious illness, or for an elder	670	157	121	78	76	1102
Experiencing racial or ethnic discrimination	775	141	67	38	87	1108
Experiencing family violence	765	142	87	40	74	1108
Negative effects of gambling	779	121	73	37	89	1099
Not being able to find or afford day care for children	702	119	116	61	104	1102
Lack of transportation to get to work, get healthcare, or obtain other basic needs	729	129	106	71	72	1107
Difficulty accessing accommodations within local community businesses (wheelchair or walker access, help for hard of hearing/deaf/blind)	731	160	89	36	91	1107
Difficulty paying utility bills (heat, water, electricity)	571	206	160	118	57	1112
Hoarding or cluttered environment	715	192	80	37	81	1105
Too many animals to properly care for (both indoor and outdoor)	776	121	89	32	86	1104
					answered question	1131
					skipped question	151

16. Do you have a family doctor or health care provider?

Answer Options	Response Percent	Response Count
Yes	94.2%	1078
No	5.8%	66
answered question		1144
skipped question		138

17. If you answered no, why not?

Answer Options	Response Percent	Response Count
Don't know how to find a health care provider	5.7%	3
No health care provider close to where I live	3.8%	2
Don't need a health care provider	34.0%	18

Can't afford for a health care provider visit	11.3%	6
Can't find a health care provider I like or trust	17.0%	9
Can't get an appointment	7.5%	4
Fear of health care providers	1.9%	1
Prefer using emergency room	0.0%	0
No transportation	0.0%	0
Language barrier	0.0%	0
Prefer using Express Care	9.4%	5
Accessibility barrier (lack of wheelchair or walker access, hearing or visual accommodations, physically accessible exam rooms)	0.0%	0
Cannot find a doctor who can treat or handle my specific healthcare situation	9.4%	5
Other (please specify)		20
answered question		53
skipped question		1229

18. Are you able to get an appointment with your family doctor or healthcare provider when you need one?

Answer Options	Response Percent	Response Count
Yes	90.2%	1017
No	6.3%	71
Not Applicable	3.5%	40
answered question		1128
skipped question		154

19. How long does it generally take to get an appointment with a family doctor or health care provider after you call?

Answer Options	Response Percent	Response Count
Less than a week	49.4%	544
1-2 weeks	39.0%	430
3-4 weeks	9.7%	107
5 weeks or more	1.9%	21
answered question		1102
skipped question		180

20. When was your last visit to a doctor or health care provider?

Answer Options	Response Percent	Response Count
Less than 6 months	75.1%	847

6 months to 1 year	19.2%	217
2 to 5 years ago	4.3%	48
Over 5 years ago	1.4%	16
I have never seen a doctor	0.0%	0
answered question		1128
skipped question		154

21. Where do you go most often when you need medical care?

Answer Options	Response Percent	Response Count
Family doctor	87.4%	992
Medical specialist/doctor other than family doctor	7.2%	82
County health department	0.2%	2
Emergency Room	5.2%	59
Express Care (Walk-in clinic)	10.0%	113
Chiropractor	2.2%	25
Not Applicable	0.9%	10
Other (please specify)	2.1%	24
answered question		1135
skipped question		147

22. Do you think there are enough family doctors or health care providers in your area?

Answer Options	Response Percent	Response Count
Yes	53.9%	610
No	46.1%	522
answered question		1132
skipped question		150

23. In the past year were you unable to afford a prescription medication?

Answer Options	Response Percent	Response Count
Yes	39.1%	442
No	60.9%	689
answered question		1131
skipped question		151

24. Does everyone in your household currently have health insurance?

Answer Options	Response Percent	Response Count
Yes	91.7%	1034
No	8.3%	94

answered question	1128
skipped question	154

25. What kind of health insurance do you have? (check all that apply)

Answer Options	Response Percent	Response Count
Through work	45.8%	515
Through your spouse's work	17.5%	197
Through another household members' work	2.6%	29
Cobra	0.7%	8
Native American/ Tribal benefits	0.0%	0
No coverage of any type	1.4%	16
Self-paid, private insurance	7.6%	85
Medicare	21.6%	243
Medicaid/ Medical Assistance/ Access	17.5%	197
Military health care (Tricare/VA/Champ-VA)	2.6%	29
Other (please specify)	4.7%	53
answered question		1125
skipped question		157

26. Are you or anyone in your household looking for a medical service that is not provided in your area?

Answer Options	Response Percent	Response Count
Yes	19.7%	220
No	80.3%	899
answered question		1119
skipped question		163

27. If yes, please explain:

Answer Options	Response Count
	178
answered question	178
skipped question	1104

28. Have you or someone in your household had a healthcare concern/issue for which you did not seek care within the last year?

Answer Options	Response Percent	Response Count
Yes	18.9%	204

No	81.1%	874
answered question		1078
skipped question		204

29. Why didn't you seek care?

Answer Options	Response Percent	Response Count
No Insurance	21.9%	39
Unable to pay	29.2%	52
Unable to get appointment	12.4%	22
No services available/no doctor who could address my concern	16.9%	30
Needed transportation	6.7%	12
Needed someone to watch the family member I provide care to	1.1%	2
No reason, just didn't seek care	29.2%	52
Not Applicable	2.8%	5
Other (please specify)		39
answered question		178
skipped question		1104

30. Please check if you have ever been told by a doctor or other health professional (s) that you have: (check all that apply)

Answer Options	Response Percent	Response Count
Arthritis	35.8%	361
Heart problems	16.7%	169
Diabetes	17.6%	178
Cancer	7.4%	75
High blood pressure/high blood cholesterol	48.2%	486
Alcohol abuse	1.2%	12
Drug abuse	1.3%	13
Smoking/Tobacco use	16.5%	166
Sexually Transmitted Diseases	1.8%	18
Uncorrectable vision problems	3.9%	39
Hearing loss	14.3%	144
Had a stroke	3.1%	31
Weight problem	32.2%	325
Problems of the stomach or intestines	21.0%	212
Chronic disease(s) of the nervous system (ex. Cerebral Palsy, Multiple Sclerosis, Parkinson's,	3.3%	33

Alzheimer, Huntington and Weber)		
Mental Health/Behavioral Health diagnosis	12.6%	127
Not Applicable	12.8%	129
Other (please specify)	8.2%	83
answered question		1009
skipped question		273

31. Are you receiving routine medical care for the condition?

Answer Options	Response Percent	Response Count
Yes	64.8%	704
No	18.9%	205
I don't have one	16.4%	178
answered question		1087
skipped question		195

32. How would you describe your general health?

Answer Options	Response Percent	Response Count
Excellent	13.5%	151
Good	48.0%	538
Average	26.3%	294
Fair	10.1%	113
Poor	2.1%	24
answered question		1120
skipped question		162

33. How would you describe your children's overall health?

Answer Options	Response Percent	Response Count
Excellent	25.3%	271
Good	30.4%	326
Average	7.8%	84
Fair	1.9%	20
Poor	0.4%	4
Not Applicable	34.2%	366
Other (please specify)		6
answered question		1071
skipped question		211

34. How many days per week do you eat at least 5 servings of fruits and/or vegetables?

Answer Options	Response Percent	Response Count
0	10.3%	114
1-2 days a week	34.7%	385
3-4 days a week	33.5%	372
5+	21.5%	239
answered question		1110
skipped question		172

35. How important is exercise to you?

Answer Options	Response Percent	Response Count
Extremely important	12.1%	134
Very important	28.3%	314
Moderately important	39.3%	436
Slightly important	17.3%	192
Not at all important	3.0%	33
answered question		1109
skipped question		173

36. How many days per week do you engage in physical activity for at least 30 minutes?

Answer Options	Response Percent	Response Count
0	12.0%	133
1-2 days a week	37.3%	413
3-4 days a week	29.8%	330
5+	20.8%	230
answered question		1106
skipped question		176

37. What do you most often do for exercise?

Answer Options	Response Percent	Response Count
Senior Center programming	3.1%	34
Silver Sneakers programming	1.2%	13
Weight lifting	9.7%	106
Indoor cardio equipment (walking, running, stepper, bike)	25.7%	281
Outdoor cardio (walking, running, hiking, biking)	54.8%	598
Swimming	13.4%	146
Golf	3.5%	38
Kayaking/Canoeing	6.7%	73
Skiing/Snowboarding	1.6%	17

Dance/Zumba	5.0%	55
Boxing/Kickboxing	0.7%	8
Martial Arts	0.5%	5
Aerobics	1.9%	21
Pilates/Yoga	6.0%	66
High Intensity Interval Training/ Cross Fit	1.8%	20
Play a team sport (competitively or recreationally)	2.7%	30
Video games that promote fitness/activity	2.7%	29
Gardening/Yard work	38.4%	419
Not Applicable	6.0%	65
Other (please specify)	11.4%	125
answered question		1092
skipped question		190

38. Do you routinely go to a gym, wellness center, or YMCA/YWCA in your community?

Answer Options	Response Percent	Response Count
Yes	11.7%	130
No	88.3%	978
answered question		1108
skipped question		174

39. If it was available in my area, I would participate in the following (select all that apply):

Answer Options	Response Percent	Response Count
Would not participate	36.3%	347
Trail hiking club	18.8%	180
Walking club	33.1%	317
Running club	7.0%	67
Bicycle Club	10.7%	102
Kayaking or Canoe group	16.3%	156
Cross Fit or High Intensity Interval Training group	6.4%	61
Aerobics, Zumba or Yoga classes	21.2%	203
Martial Arts, Kickboxing or Boxing classes	7.2%	69
Wellness/Healthy Life Style support group	22.3%	213
Other (please specify)		52
answered question		957
skipped question		325

40. Has everyone in your household had a dental check-up within the last year?		
Answer Options	**Response Percent**	**Response Count**
Yes	67.7%	747
No	32.3%	357
answered question		1104
skipped question		178

41. If you have not been to the dentist in the last 12 months, what would you say is the main reason?		
Answer Options	**Response Percent**	**Response Count**
No dental insurance/ insurance not accepted	23.2%	176
Unable to pay	13.7%	104
Needed transportation	1.5%	11
No dental services available	4.4%	33
Unable to be seen	1.6%	12
Need someone to watch my family member	0.5%	4
Not Applicable	55.6%	421
Other (please specify)	8.9%	67
answered question		757
skipped question		525

42. Are you aware of anyone over the age of 18 in your household currently use any of the following tobacco-related products on a daily basis (check all that apply):		
Answer Options	**Response Percent**	**Response Count**
Cigarettes	26.7%	279
Cigars	1.8%	19
Electronic Cigarettes	2.9%	30
Chew or other tobacco products	14.8%	154
Not applicable	62.5%	653
Other (please specify)		7
answered question		1044
skipped question		238

43. Are you aware of anyone under the age of 17 in your household currently use any of the following tobacco-related products on a daily basis (check all that apply)		
Answer Options	**Response Percent**	**Response Count**
Cigarettes	2.6%	26
Cigars	0.1%	1

Electronic Cigarettes	0.1%	1
Chew or other tobacco products	1.1%	11
Not applicable	96.7%	984
Other (please specify)		5
answered question		1018
skipped question		264

44. In the past 12 months, has a doctor, nurse, or other health professional advised you to quit smoking or using other tobacco related products?

Answer Options	Response Percent	Response Count
Yes	19.2%	198
No	80.8%	834
answered question		1032
skipped question		250

45. During the past month, on average, how many days per week did you drink any alcoholic beverages?

Answer Options	Response Percent	Response Count
0/ I haven't consumed alcohol in the past month	54.6%	597
1-2	32.6%	357
3-4	7.8%	85
5-6	2.9%	32
Daily	2.1%	23
answered question		1094
skipped question		188

46. On days when you drink, about how many drinks did you have on average?

Answer Options	Response Percent	Response Count
0	42.9%	445
1-2	45.9%	476
3-4	7.9%	82
5 or more	3.3%	34
answered question		1037
skipped question		245

47. In the last 30 days, how many times have you driven under the influence of alcohol or drugs?

Answer Options	Response Percent	Response Count
0	98.1%	1059
1-3	1.5%	16

4-6	0.3%	3
7-10	0.2%	2
11 or more	0.0%	0
answered question		1080
skipped question		202

48. During the past 12 months, have you received treatment or counseling for your use of alcohol?

Answer Options	Response Percent	Response Count
Yes	1.3%	14
No	51.2%	554
Not Applicable	47.5%	514
answered question		1082
skipped question		200

49. During the past 12 months, have you received treatment or counseling for your use of any drugs?

Answer Options	Response Percent	Response Count
Yes	0.9%	10
No	44.9%	479
Not Applicable	54.2%	578
answered question		1067
skipped question		215

50. If so, where did you receive treatment during the past 12 months?

Answer Options	Response Percent	Response Count
ER	35.3%	6
Group Therapy	17.6%	3
Hospital-inpatient	23.5%	4
Individual	47.1%	8
Detox	0.0%	0
AA	29.4%	5
Other (please specify)		18
answered question		17
skipped question		1265

51. Have you had the following in the past 12 months? (check all that apply)

Answer Options	Response Percent	Response Count
Dental Exam	67.0%	691
Physical Exam or Check-up	85.8%	885
Flu Vaccine	59.7%	615

answered question	1031
skipped question	251

52. Have you had any of the following, if applicable: (check all that apply)

Answer Options	Response Percent	Response Count
Age 18 years or over (Hypertension Screening) Blood Pressure checked in the past year	72.8%	681
Age 20 years and older Cholesterol test within the past 5 years	67.1%	627
Age 50-75 (Colon Cancer Screening) Colonoscopy within the past 10 years	36.5%	341
If born between 1945 and 1965 screening for Hepatitis C any time in the past	13.2%	123
Age 65 years or older Pneumonia Vaccine	14.7%	137
Age 65 years or older Fall Risk Assessment	5.7%	53
Female 65 years and older (Osteoporosis Screening) Bone Density test	11.4%	107
Male 70 years and older (Osteoporosis Screening) Bone Density test	1.2%	11
Female age 21-65 (Cervical Cancer Screening) PAP test within the past 3 years	47.0%	439
Female 40 years and older (Breast Cancer Screening) Mammogram within the past 2 years	41.7%	390
answered question		935
skipped question		347

53. During the last 12 months, how many days have you felt down, depressed or hopeless?

Answer Options	Response Percent	Response Count
0	39.4%	427
1-2	20.7%	225
3-4	9.9%	107
5-6	6.5%	70
6-10	4.7%	51
More than 10	18.9%	205
answered question		1085
skipped question		197

54. Has a doctor or other health care provider EVER told you that you have any of the following conditions?

Answer Options	Response Percent	Response Count
Depression	29.3%	288
Anxiety/Stress disorders	27.4%	270
Bipolar Disorder	4.1%	40
Schizophrenia	0.9%	9
Not Applicable	60.1%	591
answered question		984
skipped question		298

55. During the past 12 months, was there any time when you needed mental health treatment or counseling for yourself but didn't get?

Answer Options	Response Percent	Response Count
Yes	9.8%	104
No	90.2%	956
answered question		1060
skipped question		222

56. If so, why didn't you get the care you needed?

Answer Options	Response Percent	Response Count
Couldn't afford it	20.2%	18
Didn't know where to go	15.7%	14
Took too much time	10.1%	9
Embarrassed	14.6%	13
Too Far Away	5.6%	5
Didn't think it would help	27.0%	24
No services provided	6.7%	6
Other (please specify)		15
answered question		89
skipped question		1193

57. Has anyone in your household thought or contemplated suicide?

Answer Options	Response Percent	Response Count
Yes	10.1%	106
No	89.9%	943
answered question		1049
skipped question		233

58. Was help sought out?		
Answer Options	Response Percent	Response Count
Yes	64.2%	70
No	35.8%	39
Other (please specify)		4
answered question		109
skipped question		1173

59. We appreciate you taking the time and filling out our survey. Please let us know how you heard about this survey?	
Answer Options	Response Count
	665
answered question	665
skipped question	617

Key Community Leader Survey

1. Please mark the county you currently work in that you would be answering the following questions about?		
Answer Options	Response Percent	Response Count
Cameron	20.0%	8
McKean	20.0%	8
Potter	67.5%	27
Tioga	15.0%	6
If you serve a single community, please type in that community below:		6
answered question		40
skipped question		1

2. Communities have strengths that help people make their community a better place to live. Here is a list of common strengths. For each one, please indicate whether you strongly agree, somewhat agree, somewhat disagree or strongly disagree that the strength exists in your community.						
Answer Options	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	No Opinion/Don't Know	Response Count
Our community is one where leaders from business, labor,government, education, religious,neighborhood, non-profit and all other sectors come together and work	14	20	6	0	1	41

productively to address critical community issues.						
Our community is one that actively promotes positive relations among people from all races, genders, ages, and cultures.	10	23	6	2	0	41
Our community is one where all religious groups come together to address pressing social concerns.	6	25	5	0	5	41
Our community is one that actively promotes participation in the political process from all races, genders, ages, cultures, including persons with disabilities.	8	18	7	2	6	41
Our community is one in which there exists a great deal of mutual respect among leaders from all sectors of the community.	9	21	7	3	1	41
Our community is one where leaders from all sectors of the community share common goals and uphold a common vision for the following: reducing alcohol/drug abuse, reducing crime, promoting good health, reducing poverty, addressing economic development	12	19	7	1	2	41
					answered question	**41**
					skipped question	**0**

3. People experience challenges and issues sometimes in the community where they live. Here is a list of common issues. For each one, please indicate whether you believe it is not an issue, is a minor issue, is a moderate issue or is a major issue for people in your community.

Answer Options	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't know	Response Count
Unemployment or underemployment	0	3	14	24	0	41
Poverty	0	5	18	18	0	41
Lack of jobs	1	4	10	24	0	39
Children being adequately educated	6	16	10	6	3	41
Unsafe school environment	22	9	8	0	2	41
Bullying/harassment	2	17	12	4	6	41
Use/availability of drugs in school	2	10	13	10	6	41
Water or air pollution	20	14	3	1	3	41
Noise or other pollution	24	11	2	1	3	41
Alcohol	0	3	13	24	1	41
Drug abuse	0	3	5	32	1	41

Smoking and tobacco	1	5	11	24	0	41
Individuals with unmet mental health diagnoses	2	6	13	20	0	41
Lack of affordable medical care	3	13	16	9	0	41
HIV/AIDS	14	8	4	2	13	41
Diabetes	0	3	14	19	5	41
Obesity	0	2	10	28	1	41
Shortage of affordable housing	6	7	12	10	4	39
Substandard housing	2	15	12	6	5	40
Overcrowded housing	14	7	6	3	11	41
Shortage of recreational facilities (swimming pools, workout facilities, nature trails, etc.)	11	7	11	10	2	41
Shortage of cultural activities (concerts, museums, etc.)	4	8	13	14	2	41
Crime	6	12	18	4	1	41
Teen Pregnancy	1	12	17	7	4	41
Racial or ethnic discrimination	5	22	6	4	4	41
Family violence, abuse of children, adults, or the elderly	1	9	16	11	3	40
Gambling	5	14	10	1	11	41
Lack of affordable daycare for children	2	14	10	8	6	40
Inadequate public transportation	2	7	11	17	2	39
Poor road and/or traffic conditions	5	15	12	8	0	40
Lack of accessibility into buildings and around community for people using wheelchairs/walkers or for deaf/heard-of-hearing/blind – i.e. curb cuts, widened doorways, designated parking, electric doorways	2	10	9	0	3	24
Hoarding Issues (inside and outside of homes)	1	11	6	2	3	23
					answered question	41
					skipped question	0

4. Are there other issues in the community that are not listed?

Answer Options	Response Count
	16
answered question	16
skipped question	25

5. Which issue do you believe is the most serious in your community?

Answer Options	Response Count
	35
answered question	35
skipped question	6

6. Which issue do you believe is the second most serious in your community?

Answer Options	Response Count
	30
answered question	30
skipped question	11

7. Which issue do you believe is the third most serious in your community?

Answer Options	Response Count
	28
answered question	28
skipped question	13

8. Please share briefly any comments you may have on community strengths, challenges, and issues.

Answer Options	Response Count
	19
answered question	19
skipped question	22

9. Please share briefly any suggestions you may have concerning how current community resources might be redesigned or redirected to be more effective.

Answer Options	Response Count
	14
answered question	14
skipped question	27

10. Which of these problems do you believe prevent residents from getting necessary health care? CHECK ALL THAT APPLY

Answer Options	Response Percent	Response Count
No health insurance	78.0%	32
Insurance didn't cover what is needed	75.6%	31
Deductible/co-pay is too high	73.2%	30
Doctor/hospital/pharmacy/dentist won't take insurance or Medicaid	63.4%	26
No way to get there	61.0%	25
Didn't know service was available and who offered it	31.7%	13
Service not provided/not available in our area	26.8%	11
Other (please specify)		1
answered question		41
skipped question		0

11. What are the greatest gaps in health care services for the communities we serve? CHECK ALL THAT APPLY.

Answer Options	Response Percent	Response Count
Dental Care	74.4%	29
Care for senior citizens	15.4%	6
Ability to serve different languages/cultures	15.4%	6
End-of-life care (hospice, palliative care)	20.5%	8
In-patient mental health services for adults	51.3%	20
Out-patient mental health services for adults	38.5%	15
In-patient mental health services for children/adolescents	41.0%	16
Out-patient mental health services for children/adolescents	25.6%	10
Prescription drug assistance	30.8%	12
Family physician	41.0%	16
Services for low income residents	33.3%	13
Services for alcohol and other drug abuse	46.2%	18
Services for persons with disabilities	20.5%	8
Other (please specify)		3
answered question		39
skipped question		2

12. What are the greatest needs regarding health education and prevention services in the communities we serve? CHECK ALL THAT APPLY.

Answer Options	Response Percent	Response Count
Tobacco prevention and cessation	47.4%	18
Mental health/depression/suicide prevention	63.2%	24
Disease specific information	13.2%	5
Obesity prevention	78.9%	30
Diabetes prevention/education	50.0%	19
Oral/dental health	42.1%	16
Healthy lifestyles	60.5%	23
Alcohol and other drug abuse prevention	63.2%	24
Teen pregnancy	36.8%	14
Emergency preparedness	15.8%	6
Other (please specify)		2
answered question		38
skipped question		3

13. Which of the following categories describes your primary occupation?

Answer Options	Response Percent	Response Count
Civic group (e.g. Rotary, Lion's Club, etc.)	0.0%	0
Mayor, township supervisor, board member, or city/borough manager	0.0%	0
Local, county, or state political representative	6.3%	1
Police department	0.0%	0
School administrator/school board member	12.5%	2
Media (newspaper, radio, television)	0.0%	0
Emergency services	6.3%	1
Library	0.0%	0
Human Resources Director	0.0%	0
Other task force/community organization	62.5%	10
Planning commission/economic development	12.5%	2
Other (please specify)		23
answered question		16
skipped question		25

14. Please select below any of the organizations with which you are actively involved. CHECK ALL THAT APPLY.		
Answer Options	**Response Percent**	**Response Count**
Civic group (e.g. Rotary, Lion's Club, Women's Club, etc.)	40.5%	15
Potter County Care Transitions Team	10.8%	4
PA Link to Aging and Disability Resources	18.9%	7
Faith-based	45.9%	17
Nonprofit board of directors	43.2%	16
Educational organization	29.7%	11
Youth program	32.4%	12
Cultural	5.4%	2
Historical	8.1%	3
Emergency services	8.1%	3
Health/disease related	37.8%	14
Environmental	2.7%	1
Political organization	8.1%	3
Recreational	18.9%	7
Other (please specify)		3
answered question		**37**
skipped question		**4**

Service Provider Asset Survey

1. Which of these problems do you believe prevent residents from getting the necessary health care? CHECK ALL THAT APPLY		
Answer Options	**Response Percent**	**Response Count**
No health insurance	60.0%	6
Insurance didn't cover what is needed	70.0%	7
Deductible/co-pay is too high	80.0%	8
Doctor/hospital/ pharmacy/dentist won't take insurance or Medicaid	60.0%	6
No way to get there	40.0%	4
Didn't know where to go	10.0%	1
Couldn't get an appointment	50.0%	5

The wait was too long	50.0%	5
Services not provided in my community	40.0%	4
Patient refused or failed to follow through with care	50.0%	5
Other (please specify)		0
answered question		10
skipped question		0

2. What are the greatest gaps in health care services for the communities we serve? CHECK ALL THAT APPLY.

Answer Options	Response Percent	Response Count
Dental Care	60.0%	6
Care for senior citizens	20.0%	2
Ability to serve different languages/cultures	20.0%	2
End-of-life care (hospice, palliative care)	30.0%	3
In-patient mental health services for adults	30.0%	3
Out-patient mental health services for adults	70.0%	7
In-patient mental health services for children/adolescents	40.0%	4
Out-patient mental health services for children/adolescents	60.0%	6
Prescription drug assistance	30.0%	3
Family physician	10.0%	1
Services for low income residents	10.0%	1
Services for alcohol and other drug abuse	50.0%	5

Services for persons with disabilities	0.0%	0
Other (please specify)		1
	answered question	10
	skipped question	0

Number	Response Date	Other (please specify)	Categories
1	Jul 27, 2015 4:37 PM	perscription drug abuse assistance	

3. What are the greatest needs regarding health education and prevention services in our communities we serve? CHECK ALL THAT APPLY.

Answer Options	Response Percent	Response Count
Tobacco prevention and cessation	30.0%	3
Mental health/depression/suicide prevention	70.0%	7
Disease specific information	20.0%	2
Obesity prevention	90.0%	9
Diabetes prevention/education	30.0%	3
Oral/dental health	70.0%	7
Healthy lifestyles	60.0%	6
Alcohol and other drug abuse prevention	90.0%	9
Teen pregnancy	30.0%	3
Emergency preparedness	0.0%	0
Other (please specify)		0
	answered question	10
	skipped question	0

4. What resources/programs are you aware of in our community that serve the needs of your patients?

Answer Options	Response Count

	3
answered question	3
skipped question	7

Number	Response Date	Response Text	Categories
1	Aug 26, 2015 1:15 PM	Outpatient diabetes education	
2	Jul 27, 2015 9:21 PM	Head Start Parents as TEachers	
3	Jul 27, 2015 4:37 PM	smoking cessation . silver sneakers. myasthenia gravitas support. grief support. diabetes support.	

5. What resources/programs are currently not available in our community and would like to see become available to your patients?

Answer Options	Response Count
	6
answered question	6
skipped question	4

Number	Response Date	Response Text	Categories
1	Aug 26, 2015 1:15 PM	Endocrinologist Neurologist	
2	Jul 29, 2015 11:51 AM	More mental health services, counselors, psychologists, psychiatrists.	
3	Jul 28, 2015 1:06 PM	I would like to see detox/rehab facilities for drug and alcohol. I would like to see more access to psychiatry and counseling.	
4	Jul 27, 2015 9:21 PM	Daycare Jobs for parents	
5	Jul 27, 2015 5:46 PM	dental care meds for those who have no insurance or whose insurances do not cover meds mental health for kids	
6	Jul 27, 2015 4:37 PM	out patient drug rehab	

6. What issue do believe is the most serious in the communities we serve?	
Answer Options	Response Count
	8
answered question	8
skipped question	2

Number	Response Date	Response Text	Categories
1	Aug 26, 2015 1:15 PM	Narcotic drug addiction	
2	Aug 3, 2015 12:40 PM	Drug/ETOH abuse education	
3	Jul 29, 2015 11:51 AM	Lack of mental health services available	
4	Jul 28, 2015 1:06 PM	Mental Health problems.	
5	Jul 27, 2015 10:19 PM	mental health services just not enough Poverty, need to be on disability to make ends meet (no incentive to get better--if health improves may lose only source of income)	
6	Jul 27, 2015 9:21 PM	Not enough jobs Children are being raised in socially high risk households	
7	Jul 27, 2015 5:46 PM	Kids who need counseling-limited services for any child with needs. No place locally for evaluation and/or counseling.	
8	Jul 27, 2015 4:37 PM	Drug use	

7. What issue do believe is the second most serious in the communities we serve?	
Answer Options	Response Count
	7
answered question	7
skipped question	3

Number	Response Date	Response Text	Categories

1	Aug 26, 2015 1:15 PM	Coronary artery disease development
2	Aug 3, 2015 12:40 PM	Obesity counseling
3	Jul 29, 2015 11:51 AM	Patient engagement and compliance
4	Jul 27, 2015 10:19 PM	mental health
5	Jul 27, 2015 9:21 PM	see above
6	Jul 27, 2015 5:46 PM	Drug abuse care and counseling
7	Jul 27, 2015 4:37 PM	child neglect

8. What issue do believe is the third most serious in the communities we serve?

Answer Options	Response Count
	5
answered question	5
skipped question	5

Number	Response Date	Response Text	Categories
1	Aug 26, 2015 1:15 PM	prevalence of obesity	
2	Aug 3, 2015 12:40 PM	Psychiatric treatment/support	
3	Jul 27, 2015 10:19 PM	mental health	
4	Jul 27, 2015 5:46 PM	availability to help people get meds when they have no coverage.	
5	Jul 27, 2015 4:37 PM	life still, ie obesity tobacco poor nutrition.	

References

I. County Health Rankings & Roadmaps. Collaboration of Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Retrieved from http://www.countyhealthrankings.org/

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III. United States Census Bureau. 2010 Census. 2010. http://2010.census.gov/2010census/

IV. Pennsylvania Health Care Cost Containment Council. County Profiles 2012. www.phc4.org

V. Pennsylvania Department of Health. http://www.portal.health.state.pa.us/