

Vision

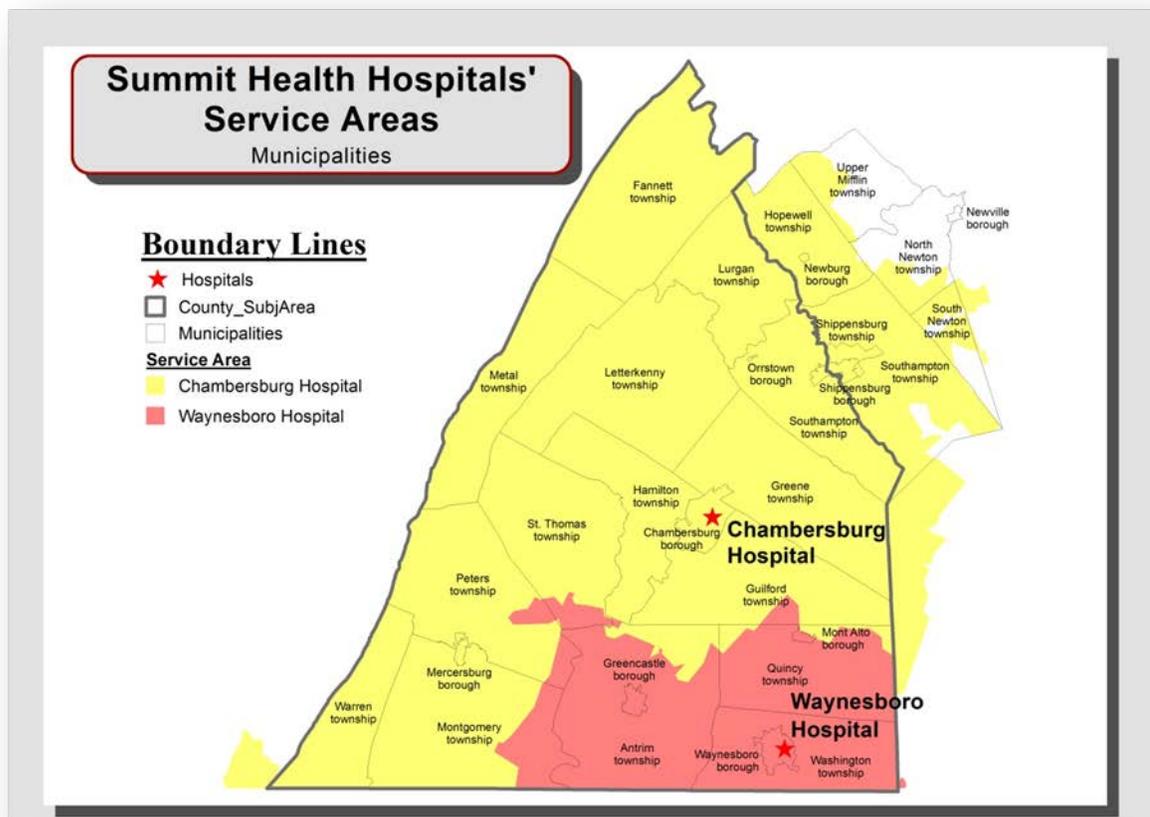
*“The residents of Franklin County will live physically and environmentally healthy lives”*

Prepared for Summit Health by Penn State Harrisburg's Center for Survey Research

# 2012 Summit Health Community Health Needs Assessment

*Conducted for Chambersburg and Waynesboro Hospitals, Affiliates of Summit Health*

March 2013



### *About the 2012 Community Health Needs Assessment*

Summit Health engaged the Institute of State and Regional Affairs (ISRA) at Penn State Harrisburg to conduct the research and assist in the completion of the 2012 Community Health Needs Assessment (CHNA). Some of the research resulted in specific stand-alone technical reports (listed below) and is summarized along with all other elements of the project in this **2012 Summit Health Community Health Needs Assessment** report.

Individual stand-alone research reports include:

**Summit Health Community Focus Groups: Technical Report**

**Summit Health Community Health Survey: Volume 1 – Technical Report and Findings**

**Summit Health Community Health Survey: Volume 2 – Data Frequencies and Cross-tabulations**

The project team from Penn State Harrisburg included:

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Stephanie Wehnau, *Associate Director, Center for Survey Research; Lead on Community Survey*

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Tim Servinsky, *Research Associate, Center for Survey Research; Survey tabulation and analysis, Report review*

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Larry Meyers, *Project Associate, Pennsylvania State Data Center; GIS/Mapping*

Skip Brown, *Principal, ConnectSynergy; Advisory Group Facilitation and Strategic Planning*

The decisions on what health and healthcare issues were important and how to address them was made by an energetic, and dedicated, community-wide Advisory Group comprised of key leaders. As a result of the CHNA, this Advisory Group formed **Healthy Franklin County**, which will continue the work of the CHNA under the direction of the Advisory Group. Advisory Group members include:

Cindy Ash, Franklin County Head Start

Ann Baker, PA Department of Health - Franklin County  
State Health Center

Joanne Cochran, Keystone Health

\***Barb Constable**, Summit Health

Tammy Cornman, Summit Physician Services

Wendy Cowan, Menno Haven

Manny Diaz, Brethren Fellowship Church

Cathy Dusman, Chambersburg Area School District

\***Nickie Fickel**, Summit Health

Dr. Jim Freeman, PA Board of Medicine

Melanie Furlong, Lutheran Home Care & Hospice/LIFE  
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Gary Gembe, Greencastle Community

Charlene Gingrich, Keystone Health

Carrie Gray, Franklin County, Director of Grants Mgmt.

Amy Hicks, United Way of Franklin County

Carol Hughes, Lutheran Social Services

Karen Johnston, Healthy Community Partnership

Jack Jones, BOPIC, Inc. / Elm Street Program

David Keller, Franklin County Commissioner

Christa Lohr, Home Nursing Agency Hospice

Enid Madaras, The Lyme Education Project

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Lou Varella, Quincy Village

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**\*Leadership Team from Summit Health**

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**ADDITIONAL STAND-ALONE REPORTS**

To obtain copies of these additional reports, please contact Summit Health Community Health Department at 717-262-4472.

- Community Focus Groups: Technical Report
- Community Health Survey: Volume 1 – Technical Report and Findings
- Community Health Survey: Volume 2 – Data Frequencies and Cross-tabulations



## EXECUTIVE SUMMARY

In May 2012, Summit Health contracted with Penn State Harrisburg's Institute of State and Regional Affairs (ISRA) to conduct their 2012 Community Health Needs Assessment (CHNA) for the Chambersburg Hospital and Waynesboro Hospital service areas. The CHNA was designed to identify the strengths, gaps, and opportunities in meeting the health-related needs of the Summit Health Service Area. Under the guidance of a community Advisory Group, appointed by Summit Health, Penn State conducted a series of focus groups, a community survey, and a thorough analysis of secondary demographic and health data. The Advisory Group utilized both the results of the research and the expertise and insights of its membership to inform the development of a comprehensive view of the strengths of and areas of improvement for the health and healthcare of Summit Health Service Area residents. Summit Health then facilitated a process through which the Advisory Group identified the most important health and healthcare needs of the Summit Health Service Area and subsequently developed implementation plans for each hospital's individual service area (Chambersburg and Waynesboro), along with strategies to address the needs identified by the CHNA.

### Health and Healthcare Priorities

With input from the Advisory Group, Summit Health used all of the data collected, including the results of the community survey and secondary demographic and health data analyses, to compile a list of the 13 health- and healthcare-related items that affect the highest proportions of Summit Health Service Area community members. A list of selected health and healthcare items considered in identifying priorities is presented in Appendix A.

Summit Health staff then conducted an exercise using the Simplex Method with the Community Health Needs Assessment Advisory Group to prioritize the health and healthcare needs of the community. The Simplex Method is a widely used process that provides a means of scoring multiple items to determine which have the most relative importance to participants.

The results of this exercise determined that Nutrition, Education, Access to Healthcare and Mental Health were the highest priorities to the CHNA Advisory Group. Members of the CHNA Advisory Group then self-selected into one of the four priority areas for the purpose of developing implementation plans.

#### *Nutrition (Impacting an estimated 87,000 Summit Health Service Area residents)*

Factors considered in determining this priority included the following:

- Grocery store access, defined as establishment rate per 100,000 population, was 19.8 for Franklin County in 2010, compared to over 21 for the state and the United States.
- The population living in food deserts, defined as low-income census tracts where a substantial number of residents have low access to a supermarket, was 8.1 percent for Franklin County in 2009, compared to 4.9 percent for Pennsylvania and 9.1 percent for the United States.
- Access to Women, Infant and Children (WIC) -authorized food stores, defined by food store WIC acceptance rate per 100,000 population, was 10.6 for Franklin County in 2012, compared to 16.6 for Pennsylvania and 15.6 for United States.

- Inadequate food and vegetable consumption, defined as the proportion of individuals not eating five or more fruits and vegetables a day, was reported by almost two-thirds of Summit Health Service Area residents in 2012.

*Education (Impacting an estimated 19,000 Franklin County residents)*

Healthy People 2020 has found that higher education attainment is directly related to life expectancy, health, and quality of life. Factors considered in determining this priority included the following:

- The high school graduation rate for Franklin County residents in 2012 was 81.7 percent, compared to 80.5 percent for Pennsylvania and 75.5 percent for the United States.
- During the 2006-2010 time period, the percentage of persons not having a high school diploma was 16.6 percent for Franklin County residents compared to 12.6 percent for Pennsylvania and 15.0 percent for the United States.

*Access to Healthcare (Impacting an estimated 12,000 Summit Health Service Area residents)*

Factors considered in determining this priority included the following:

- Primary Care Physician Access, defined by the number of primary care providers per 100,000 population in 2011, was 61.4 for Franklin County, compared to 95.9 for Pennsylvania and 84.7 for the United States. Franklin County's rate was 36.0 percent lower than that of Pennsylvania's.
- The percentage of Summit Health Service Area residents reporting in the Community Survey that they had a family doctor in 2012 was 81.8 percent.
- Population living in a health professional shortage area (HPSA,) defined as the percent of the designated population that was underserved in 2012, was 100 percent for Franklin County compared to 56.7 percent for Pennsylvania and 60.8 percent for the United States.

*Mental Health (Impacting an estimated 80,000 Summit Health Service Area residents)*

Factors considered in determining this priority included the following:

- A high level of stress, as defined by individuals having a self-reported moderate, high, or very high stress level on a typical day in 2012, affected over half (59.3 percent) of Summit Health Service Area residents according to the Community Survey.
- The suicide rate, as defined by the rate per 100,000 population during the 2005-2009 time period, was 11.0 in Franklin County compared to 11.4 for Pennsylvania.

## **Key Demographic Findings**

Analysis of secondary demographic data identified the following key underlying demographic characteristics that play a role in the health and healthcare issues impacting the Summit Health Service Area:

- The total population is growing faster than Pennsylvania's population as a whole. The Summit Health Service Area was home to 176,442 residents in 2011, an increase of 16.3 percent since 2000, and projections show a continued increase to the year 2030. The Chambersburg Hospital Service Area is growing faster than the Waynesboro Hospital Service Area; the population in the Chambersburg Hospital Service Area increased 16.0 percent from 2000 to 2010 compared to 13.7 percent for the Waynesboro Hospital Service Area.

- The racial/ethnic composition was less diverse than that of the commonwealth's population in 2010. Those in the Service Area were overwhelmingly white (92.3 percent compared to 81.9 percent for the commonwealth overall). Although the African-American and Hispanic populations in the Summit Health Service Area were a small percentage of the total population (3.1 percent and 4.0 percent respectively), their numbers have grown since 2000, with African-Americans increasing by 57.1 percent and Hispanics increasing by 179.9 percent. Additionally, the racial/ethnic composition of the Waynesboro Hospital Service Area was less diverse than that of the Chambersburg Hospital Service Area in 2010. The African-American population was 2.2 percent of the total population in the Waynesboro Hospital Service Area compared to 3.4 percent in the Chambersburg Hospital Service Area. The percentage of Hispanics was also smaller in the Waynesboro Hospital Service Area than in the Chambersburg Hospital Service Area (2.3 percent compared to 4.6 percent).
- The Service Area's percentage of the population under age 18 was greater than Pennsylvania's percentage and grew from 22.0 percent in 2005-2007 to 23.4 percent in 2010. The proportion of elderly population (65 and older) is slightly higher in the Service Area compared to Pennsylvania (15.8 percent versus 15.4 percent).
- A smaller proportion of the population was in poverty in the Summit Health Service Area when compared to Pennsylvania as a whole (8.9 percent versus 12.4 percent) during the 2006-2010 time period. The poverty rate in the Summit Health Service Area has not changed since 2000. A larger proportion of the population was in poverty in the Chambersburg Hospital Service Area than in the Waynesboro Hospital Service Area (9.6 percent compared to 7.3 percent) during the 2006-2010 time period. This pattern was consistent with the 2000 data, but the gap has narrowed from 10.2 percent versus 6.2 percent, respectively.
- Median household income for Franklin County was \$51,035 for the 2006-2010 time period, which was slightly higher than the statewide median of \$50,398.
- Service Area workers had lower rates of unemployment than those across the commonwealth (5.9 percent versus 7.3 percent) during the 2006-2010 time period. This rate has risen since 2000, when the unemployment rate was 3.9 percent in the Service Area.
- The percentage of residents with a bachelor's degree or higher increased from 14.9 percent in 2000 to 18.3 percent during the 2006-2010 time period. However, this improvement continues to be lower than Pennsylvania's statewide averages (22.4 percent in 2000 up to 26.4 percent in 2006-2010). The percentage of residents with a bachelor's degree or higher was larger in the Chambersburg Hospital Service Area than the Waynesboro Hospital Service Area (18.8 percent compared to 17.1 percent) in 2006-2010. This is a continued trend from 2000, when the rates were 15.8 percent in the Chambersburg Hospital Service Area compared to 13.0 percent in the Waynesboro Hospital Service Area. Nearly 60 percent of the population in the Summit Health Service Area ages twenty-five and older had attained a high school diploma/GED equivalent or less in 2006-2010. This is a decline from 66.2 percent in 2000.

## INTRODUCTION

In May 2012, Summit Health contracted with the Pennsylvania State University's Institute of State and Regional Affairs (ISRA) to assist with the development of the 2012 Community Health Needs Assessment (CHNA). The Assessment, conducted in collaboration with an Advisory Group of community leaders and healthcare providers appointed by Summit Health, was designed to develop a comprehensive view of the most important health and healthcare issues affecting both the Summit Health Service Area as a whole and the individual Chambersburg and Waynesboro Hospital Service Areas. The CHNA identified strengths of and areas of improvement for the health and healthcare of Summit Health Service Area residents using current demographic and health indicators, comparative data from previous CHNAs, and community feedback gathered through Advisory Group discussions, a community survey, and focus groups. This is the third such assessment initiated by Summit Health, having conducted CHNAs in both 2008 and 1996.

This report is a culmination of the work completed to date, which will be used to develop and monitor community collaboration efforts designed to improve health service offerings and disease prevention efforts in the Chambersburg and Waynesboro Hospitals' service areas. Additionally, ISRA prepared stand-alone research reports, which provide more detailed information on methodology, analysis, and results from the CHNA Focus Groups and Community Survey.



The Advisory Group members and their respective organizations have committed to conducting regular meetings to address and monitor the priority health concerns identified through this Assessment. In addition to the implementation plans outlined by the Advisory Group, and in concordance with the 2010 Patient Protection and Affordable Care Act, Chambersburg and Waynesboro Hospitals have formulated specific action/implementation plans to address the health-related priorities identified by the CHNA. The plans will be included with their respective IRS 990 submissions.

***Note to readers:** Throughout the report, we sometimes provide data for the Summit Health Service Area and sometimes provide data for Franklin County. See Map 1 for an overlay of the Service Area and the counties contained in the Service Area on Page 11. Some secondary data sources were available for the entire Service Area, while others were only available at the county level. Data collected through the Focus Groups and Community Survey are descriptive at the Service Area level. We have attempted to note which geography is being referenced when reporting data.*

## METHODOLOGY

To guide its assessment effort, Summit Health formed an Advisory Group that strategically participated in the CHNA by: 1) sharing insights from areas of professional expertise, 2) reviewing and analyzing demographic and health data to identify and prioritize community health issues, and 3) developing action plans to address these defined needs. Throughout the assessment process, the group placed an emphasis on collaboration, partnership development, and widespread community participation in order to create and implement community health improvement plans for the Chambersburg and Waynesboro Hospitals. The initiative was organized into five components, described below:

### **I: Advisory Group Role Development and Selection**

The Summit Health team formed an Advisory Group composed of a core group of agencies and community leaders who represented the spectrum of the community and healthcare infrastructures in Franklin County. Their selection was based on professional expertise, geographic diversity and demonstrated service to the community.

The Advisory Group met monthly from June 2012 to March 2013 to monitor progress, analyze data, and reach consensus decisions. Advisory Group members also planned and participated in various assessment exercises ranging from key informant discussions to prioritizing the health and healthcare needs of the community through use of the Simplex Method.

### **II: Strategic Plan Development**

Over a series of several facilitated discussions, the Advisory Group developed a project name, vision, mission, overarching goals, and project guiding principles to guide the planning and assessment process.

### **III: Community Assessment**

#### *Focus Groups*

Based on the CHNA Advisory Group recommendation, the Institute conducted four focus groups of community members in the Summit Health Service Area. The goal of the focus groups was to gather information about health and healthcare issues from the perspective of local community residents. Focus groups were held with four different populations: 1) seniors age 65 or older, 2) young adults age 18-25, 3) un-insured and under-insured adults, and, 4) Spanish-speaking Hispanic adults. The Spanish-speaking group was led by Dr. José Ricardo-Osario, a professor at Shippensburg University and a member of the Community Health Needs Assessment Advisory Group.

#### *Community Survey*

The Institute also conducted a Community Health Survey, based on most recent BRFSS data. The purpose of the survey was to gather information about a variety of health topics from residents in the Summit Health Service Area. A total of 831 telephone interviews were conducted between September 4 and October 20, 2012. Completed telephone interviews were divided equally between residents who lived in the Chambersburg Hospital and Waynesboro

Hospital Service Areas. The Community Survey used a dual-frame design consisting of a representative landline sample augmented by a cell phone sample supplement.

#### *Secondary Data Analysis*

Health, socio-economic and demographic information was compiled and analyzed by the Institute and Summit Health staff for this initiative. Data sources included: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), National Diabetes Surveillance System, National Vital Statistics Systems, and National Environmental Public Health Tracking Network; Pennsylvania Department of Health, Healthy People 2020; U.S. Census Bureau, 2000 and 2010 Decennial censuses, the 2006-2010 American Community Survey (ACS), and County Business Patterns; the Pennsylvania Youth Survey; U.S. Department of Agriculture, Food Desert Locator and Food Environment Atlas; U.S. Health Resources and Services Administration, Area Resource File and Health Professional Shortage Area File; University of Wisconsin, Population Health Institute, County Health Rankings; National Center for Education Statistics, Common Core of Data, Public School Universe Survey Data; National Highway Traffic Safety Administration, Fatality Analysis Reporting System. (Brief descriptions data sources can be found in Appendix B).

Note: Callouts are used throughout the report to share information from the Healthy People 2020 website (<http://healthypeople.gov/2020/LHI/2020indicators.aspx>) regarding why certain indicators are important.

#### **IV: Health/Healthcare Priority Identification**

The Advisory Group utilized both the results of the research and the expertise and insights of its membership to inform the development of a comprehensive view of the strengths of and areas of improvement for the health and healthcare of Summit Health Service Area residents.

To accomplish this, Summit Health selected a list of 13 health and healthcare items where a higher percentage of the population was affected. The list of the health and healthcare items considered is presented in the Community Assessment section of this report.

Summit Health staff then led a facilitated meeting with the Advisory Group, utilizing the Simplex Method to prioritize the health and healthcare needs of the community. The Simplex Method is a widely used process that provides a means of scoring multiple items to determine which have the most relative importance to participants.

#### **V: Implementation Strategy Development**

This report is a culmination of the work completed to date, which will be used to develop and monitor community collaboration efforts designed to improve health service offerings and disease prevention efforts in the Chambersburg and Waynesboro Hospital Service Areas.

The Advisory Group members and their respective organizations have committed to conducting regular meetings to address and monitor the priority health concerns identified through this Assessment. In addition to the implementation plans outlined by the Advisory Group, and in concordance with the 2010 Patient Protection and Affordable Care Act, Chambersburg and

Waynesboro Hospitals have formulated specific action/implementation plans to address the health-related priorities identified by the CHNA. The plans will be included with their respective IRS 990 submissions.

## ADVISORY GROUP COMPOSITION

An Advisory Group composed of a core group of agencies and committed community leaders who represent the spectrum of the community and healthcare infrastructures in Franklin County provided immeasurable assistance throughout the CHNA and have committed to conducting regular meetings to address and monitor the priority health concerns identified through this Assessment. Members of the Advisory Group included:

Cindy Ash, Franklin County Head Start  
Ann Baker, PA Department of Health - Franklin County State Health Center  
Joanne Cochran, Keystone Health  
\*Barb Constable, Summit Health  
Tammy Cornman, Summit Physician Services  
Wendy Cowan, Menno Haven  
Manny Diaz, Brethren Fellowship Church  
Cathy Dusman, Chambersburg Area School District  
\*Nickie Fickel, Summit Health  
Dr. Jim Freeman, PA Board of Medicine  
Melanie Furlong, Lutheran Home Care & Hospice/LIFE Lutheran Services  
Gary Gembe, Greencastle Community  
Charlene Gingrich, Keystone Health  
Carrie Gray, Franklin County, Director of Grants Mgmt.  
Amy Hicks, United Way of Franklin County  
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Jack Jones, BOPIC, Inc. / Elm Street Program  
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Pat McCulloh, Summit Physician Services and Chambersburg/Waynesboro Hospitals  
Danny Morel, Hospitalist, Summit Health  
Daphne Murray, CH Discharge Services  
Dawn Orndorff, LINK  
\*Claudia Peet, Education, Waynesboro Hospital (Summit Health)  
José Ricardo, Shippensburg University of PA  
Randall, Sellers, Waynesboro Community  
Megan Shreve, South Central Community Action Programs, Inc.  
Marilyn Smith, Community Mobilizer, Waynesboro CTC  
\*Ann Spottswood, Summit Health  
Lou Varella, Quincy Home  
Lori Young, Franklin/Fulton County MH/ID/EI  
Bonnie Zehler, Franklin County Housing Authority

*\*Leadership Team from Summit Health*

## **STRATEGIC PLANNING**

The decisions on what health and healthcare issues were most important and how to address them were made by an energetic and dedicated, community-wide Advisory Group. As a result of this CHNA, the Advisory Group formed *Healthy Franklin County*, which will continue the work of the CHNA under the direction of the Advisory Group.

Over a series of several focused discussions, the Advisory Group developed a project name, vision, mission, overarching goals and project-guiding principles to direct the planning and assessment process.

### **Project Name**

“Healthy Franklin County”

### **Vision**

The residents of Franklin County will live physically and environmentally healthy lives.

### **Mission**

Engage and partner Franklin County communities to create healthy behaviors and lifestyles through education, awareness, programming and access to services.

### **Overarching Strategic Goals** (to achieve over the next 3 years)

1. Foster, ensure and enhance social and physical environments and community policies that promote healthy behaviors, lifestyles and access to services for every individual across Franklin County.
2. Establish an ongoing mechanism for communities and healthcare organizations to continually educate, communicate, update, monitor and evaluate progress to address healthcare needs of the community, neighborhoods, and residents.
3. Promote models of interrelated health and multi-dimensional wellness that integrate health throughout the community.

### **Project Guiding Principles**

- Apply effective processes for community health planning and problem solving.
- Analyze community-wide data for decision-making.
- Seek community-wide consensus building.
- Seek and replicate proven effective health programs.
- Be cost-effective while providing for the needs of the community.
- Celebrate success.

## COMMUNITY ASSESSMENT

A community's strength can be described and measured, in part, by its health and socio-economic characteristics. The following discussion focuses on such key characteristics, including community members' access to care, prevalent health conditions, and demographic profile. Building on previous CHNAs, this Assessment explored the latest statistics available from the U.S. Bureau of the Census and the Pennsylvania Department of Health, as well as new data obtained through Community Focus Groups and a Survey of Community Residents, both conducted by Penn State. This CHNA utilizes both primary and secondary data sources and community expertise and feedback to develop a comprehensive view of the strengths of and opportunities for improvement of the health and healthcare of Summit Health Service Area residents.

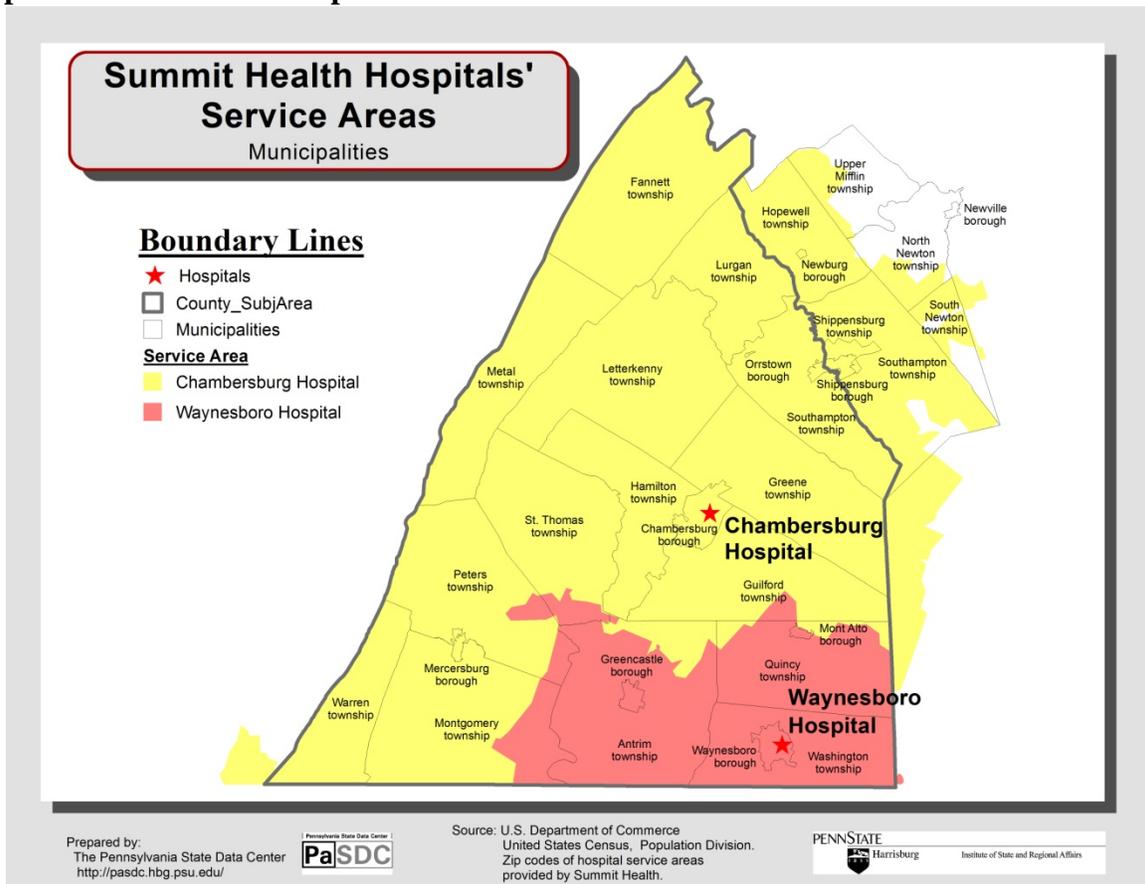
The Assessment begins with a description of the Summit Health Service Area, as determined by analyzing the frequency of the zip codes of patients discharged from Chambersburg and Waynesboro Hospitals. Following that is an in-depth analysis of demographic indicators affecting service provision, including the latest trends on population growth, age, race/ethnicity, poverty and income, education, employment, household composition, marital status, and work commutes for the Summit Health Service Area, each hospital's service area, and Pennsylvania as a whole. Finally, the Assessment discusses health, social and environmental indicators for those topical areas that the Advisory Group determined to be priorities to be addressed. Topics include access to healthcare, clinical preventive services, cancer, diabetes, heart disease and stroke, mental health, nutrition, physical activity and obesity, youth tobacco and substance abuse, infant mortality, teen births, accidents/mortality, and environmental conditions.

## Summit Health Hospitals' Service Areas

Summit Health defines its total Service Area as the combination of the Chambersburg and Waynesboro Hospital service areas, as shown in Map 1 below. Summit Health determined the hospitals' service areas by analyzing where the majority of their discharged patients resided. Demographic data for the hospitals' service areas is an aggregation of data by municipalities. Appendix C lists the zip codes/municipalities in Franklin and Cumberland Counties that comprise the hospitals' service areas. A detailed analysis of the demographic indicators identified by Summit Health and the Advisory Group is presented in this section.

*Note to readers: Throughout the report, we sometimes provide data for the Summit Health Service Area and sometimes provide data for Franklin County. Map 1 shows an overlay of the Service Area and the counties contained in the Service Area. Some secondary data sources were available for the entire Service Area, while others were only available at the county level. Data collected through the Focus Groups and Community Survey are descriptive at the Service Area Level. We have attempted to note which geography is being referenced when reporting data.*

**Map 1. Summit Health Hospitals' Service Areas**



## Demographic Indicators

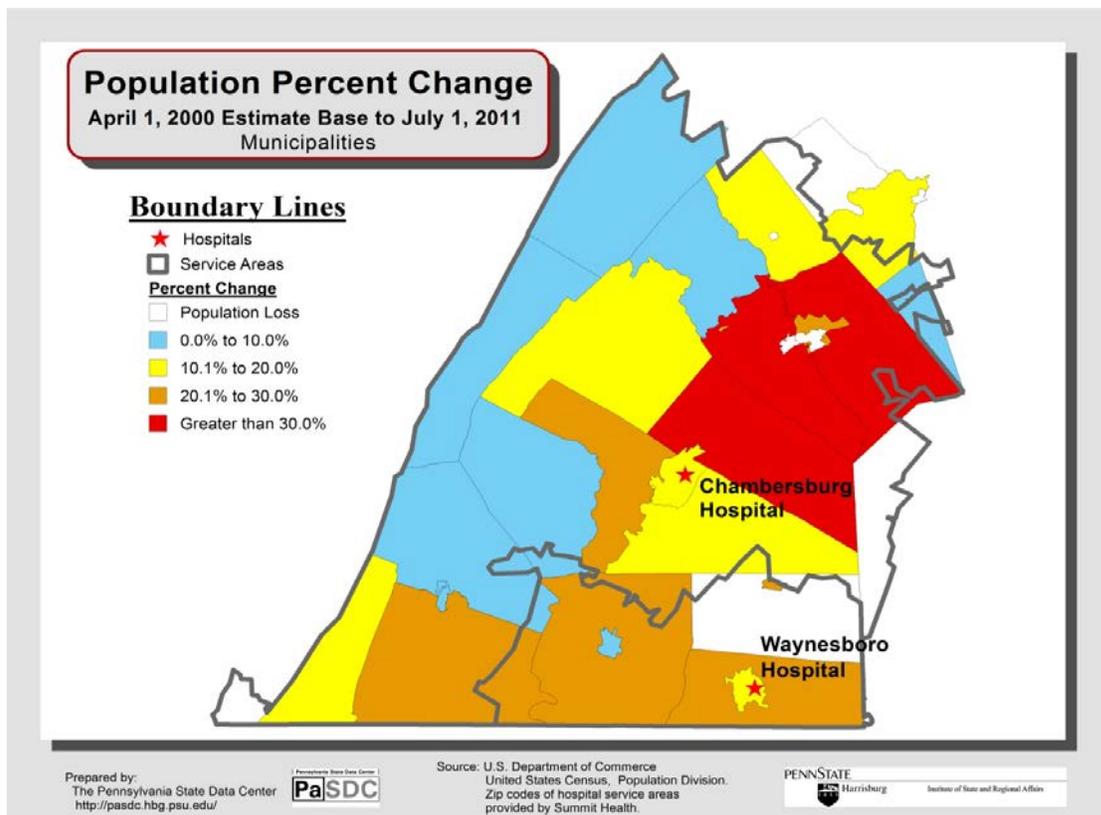
ISRA compiled and analyzed information from various sources to document demographic changes in both the Summit Health Service Area and the individual hospitals' service areas. While highlights from this information are presented below, more detailed demographic statistics can be found in Appendix D. Brief descriptions of the data sources referenced below can be found in Appendix B.

*Note: Callouts are used throughout the report to share information from the Healthy People 2020 website (<http://healthypeople.gov/2020/LHI/2020indicators.aspx>) regarding why certain indicators are important.*

### Population

The total population growth rate for the Summit Health Service Area and Franklin County outpaced the growth rates of both Pennsylvania and the nation from 2000 to 2011. The Service Area population grew from 151,712 in 2000 to 176,442 in 2011, an increase of 16.3 percent. In comparison, Pennsylvania's population grew by 3.8 percent, while the nation's grew 10.7 percent during this same time period. The population of the Chambersburg Hospital Service Area increased 17.0 percent from 107,110 in 2000 to 125,324 in 2011. The Waynesboro Hospital Service Area's population grew by 14.6 percent from 44,602 in 2000 to 51,118 in 2011. Projections to the year 2030 anticipate a continued growth rate of 5.0 percent for Franklin County.

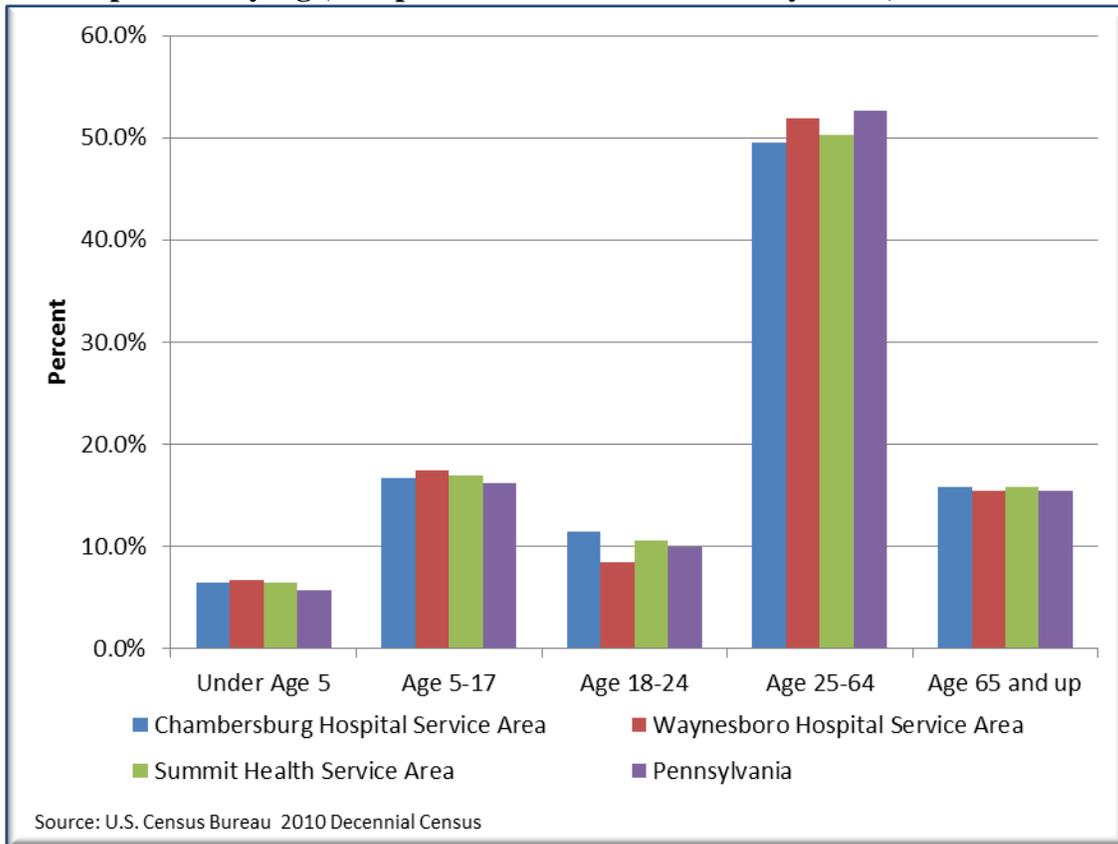
**Map 2. Population Percent Change by Municipality, 2000-2011**



*Age*

The percent of the population under age 18 in the Summit Health Service Area was greater than Pennsylvania’s percentage and grew from 22.0 percent in 2005-2007 to 23.4 percent in 2010. The Waynesboro Hospital Service Area had a slightly larger school-age population (ages 5-17) than the Chambersburg Hospital Service Area (17.5 percent compared to 16.7 percent). The Chambersburg Hospital Service Area had a larger young adult population (ages 18-24), at 11.5 percent, than the Waynesboro Hospital Service Area, at 8.4 percent. The proportion of the population age 65 and older in both hospitals’ service areas was similar (Chambersburg – 15.9 percent, Waynesboro – 15.5 percent) and was slightly higher than Pennsylvania’s (15.4 percent) proportion, where the population is generally growing older.

**Figure 1. Population by Age, Hospital Service Area and Pennsylvania, 2010**



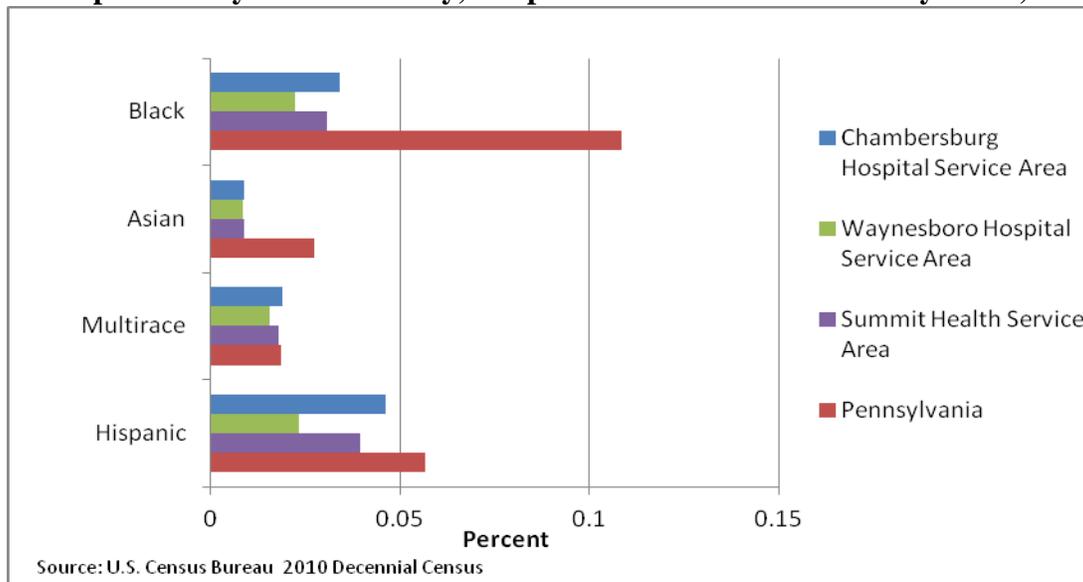
*Race/Ethnicity*

The population living in the Summit Health Service Area was less diverse than the state’s overall population in 2010. Those in the Service Area were overwhelmingly White (92.3 percent compared to 81.9 percent for the state overall). Although the African-American and Hispanic populations in the Summit Health Service Area were a small percentage of the total population, they have grown in proportion since 2000. African-Americans made up 3.1 percent of the Service Area in 2010 compared to 2.3 percent in 2000. Pennsylvania’s African-American population grew from 10.0 percent in 2000 to 10.8 percent in 2010. Hispanics accounted for 4.0

percent of residents in the Service Area and 5.7 percent of residents statewide in 2010, compared to 1.6 percent of the Service Area and 3.2 percent statewide in 2000.

Between the individual hospitals’ service areas, the Chambersburg Hospital Service Area had more racial and ethnic diversity in 2010. Chambersburg Hospital’s service area had a greater percentage of African Americans (3.4 percent compared to 2.2 percent) and Hispanics (4.6 percent versus 2.3 percent) than Waynesboro Hospital’s service area. The difference in diversity among the two hospitals can be attributed to the racial and ethnic diversity in the borough of Chambersburg. In 2010, Blacks accounted for 9.2 percent of the total population, while Hispanics made up 15.7 percent. These figures accounted for the highest percentage of Blacks and Hispanics of any municipality in either hospital’s service area.

**Figure 2. Population by Race/Ethnicity, Hospital Service Area and Pennsylvania, 2010**



While Chambersburg Hospital’s service area is more diverse, it is also more linguistically isolated. Approximately 1.7 percent of the population age five and older speaks English less than “very well”. Of all people who speak Spanish in the Chambersburg Hospital Service Area, 44 percent speak English less than “very well”. This is compared to the Waynesboro Hospital Service Area, where 0.3 percent of the total population age five and older (and 21.6 percent of Spanish speaking people) speak English less than “very well”. The Chambersburg Service Area has a slightly higher percentage of linguistically isolated population compared to Pennsylvania.

*Poverty and Income*

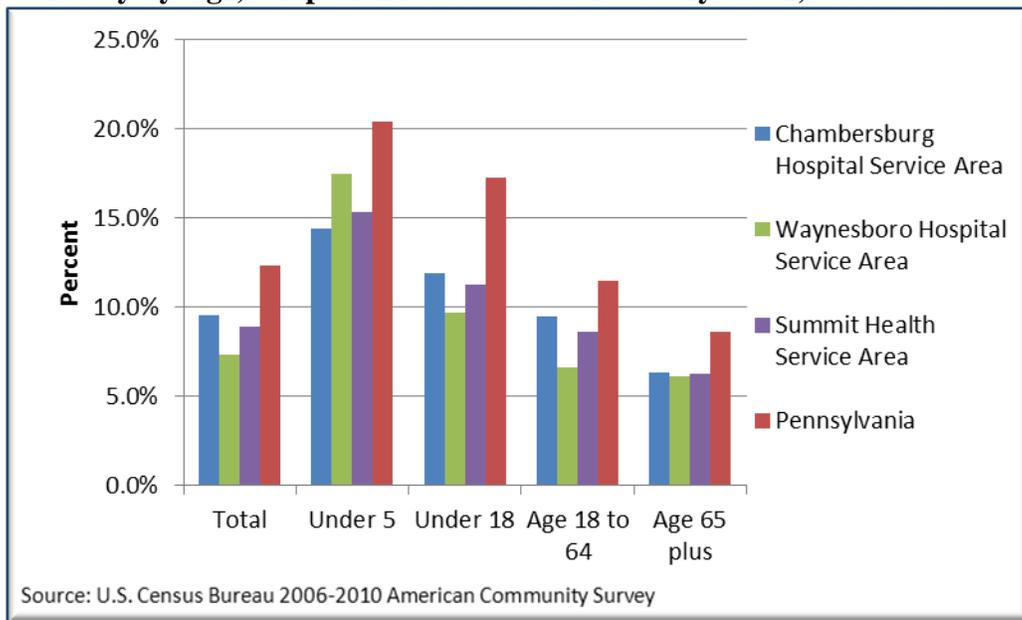
The total Summit Health Service Area had a smaller proportion of its population in poverty<sup>1</sup> than Pennsylvania as a whole (8.9 percent versus 12.4 percent).

<sup>1</sup> The Census Bureau uses a set of income thresholds that vary by family size and composition to determine poverty status. If the total income for a family or unrelated individual falls below the relevant poverty threshold, then the family or unrelated individual is classified as being “below the poverty level”. For reference, the poverty threshold for a family of four was \$22,314 in 2010.

The percent of the population below the poverty level is greater in the Chambersburg Hospital Service Area than in the Waynesboro Hospital Service Area for all age groups except children under age five. Although the total poverty rate for the Summit Health Service Area remained unchanged from 2000 to the 2006-2010 time period (8.9 percent), the poverty rate for children under age 18 increased from 10.2 percent in 2000 to 11.3 percent in 2006-2010, while rates for children under age five increased from 12.3 percent to 15.3 percent. Poverty rates for those aged 65 and older declined during this time period.

The Chambersburg Hospital Service Area had a higher poverty rate than the Waynesboro Hospital Service Area (9.6 percent compared to 7.3 percent); however, children under five years of age in the Waynesburg Hospital Service Area were more likely to live in poverty than those in the Chambersburg Hospital Service Area (17.5 percent [from chart below] versus 14.4 percent). In comparison, the statewide poverty rate for children 18 years of age and under was 17.3 percent, while the rate for those less than five years of age was 20.4 percent.

**Figure 3. Poverty by Age, Hospital Service Area and Pennsylvania, 2006-2010**

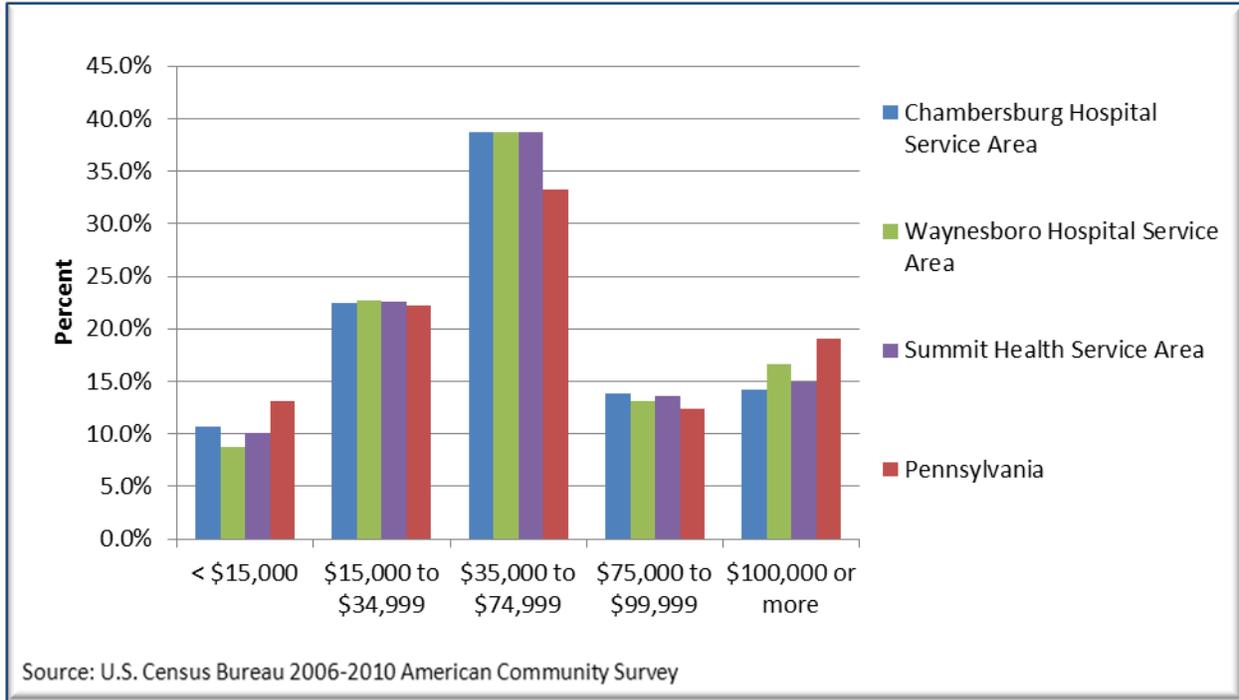


Various types of families experienced poverty at different rates: Overall, 5.3 percent of families in the Service Area lived below the federal poverty level in 2006-2010. In Pennsylvania, the family poverty rate reached 8.5 percent during the same time period. Married-couple families with related children under the age of 18 were far less likely to experience poverty than single-parent, male or female, headed households (3.8 percent compared to 12.0 percent and 25.7 percent, respectively).

Nearly 40 percent (38.8 percent) of households in the Service Area had household incomes between \$35,000 and \$74,999 in 2006-2010. Overall in Pennsylvania, one-third of households had incomes in this range during the same time period. A higher proportion of households in the Chambersburg Service Area had incomes of \$14,999 or less compared to the Waynesboro

Service Area (10.7 percent versus 8.8 percent). Households in the Waynesboro Hospital Service Area were also more likely to have incomes of \$100,000 or more (16.7 percent compared to 14.2 percent). Across the commonwealth, 19.0 percent of households had incomes of \$100,000 or more in 2006-2010.

**Figure 4. Household Income by Hospital Service Area and Pennsylvania, 2010**



*Education (Note: This item was identified as a priority by the Advisory Group)*

Although the percent of residents in the Summit Health Service Area with a bachelor’s degree or higher increased from 14.9 percent in 2000 to 18.3 percent in 2010, the educational attainment of Summit Health Service Area residents continues to be lower than Pennsylvania’s statewide averages. This continues a trend noted in the 2008-2009 Community Health Needs Assessment.

A larger proportion of those ages 25 or older and living in the Service Area lacked a high school diploma compared to the overall Pennsylvania population in 2006-2010 (16.6 percent versus 12.6 percent). In addition to having a smaller proportion of people who have earned a high school diploma than in Pennsylvania overall (83.4 percent compared to 87.4 percent), a smaller percentage of residents in the Service Area went on to obtain a bachelor’s or advance degree (18.3 percent versus 26.4 percent). Nationally, 27.9 percent of the population ages 25 years and over had attained a bachelor’s degree or higher.

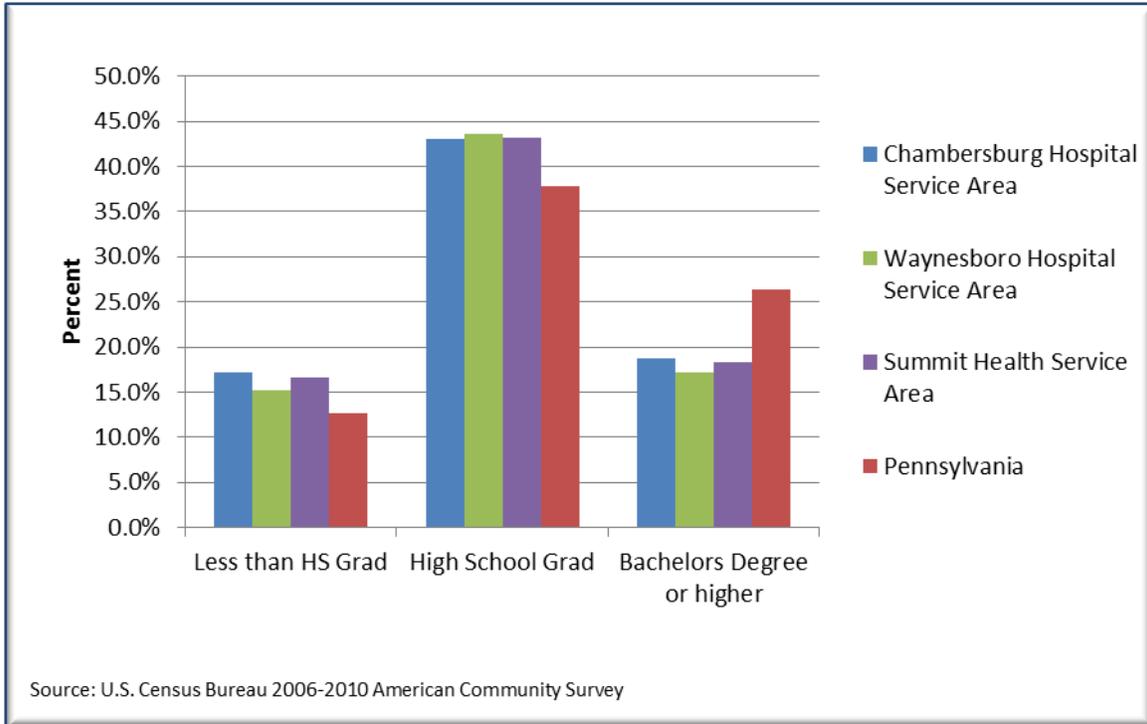
**Why does education matter?**

Healthy People 2020 has found that higher education attainment is directly related to life expectancy, health, and quality of life.

The Chambersburg Hospital Service Area had a smaller percentage of its population aged 25 years and over achieve a high school diploma as compared to Waynesboro Hospital Service Area’s residents (82.8 percent versus 84.8); however, the Chambersburg Hospital Service Area

had a greater proportion of people with a bachelor’s degree or higher (18.8 percent compared to 17.1 percent).

**Figure 5. Educational Attainment by Hospital Service Area and Pennsylvania, 2006-2010**



*Employment*

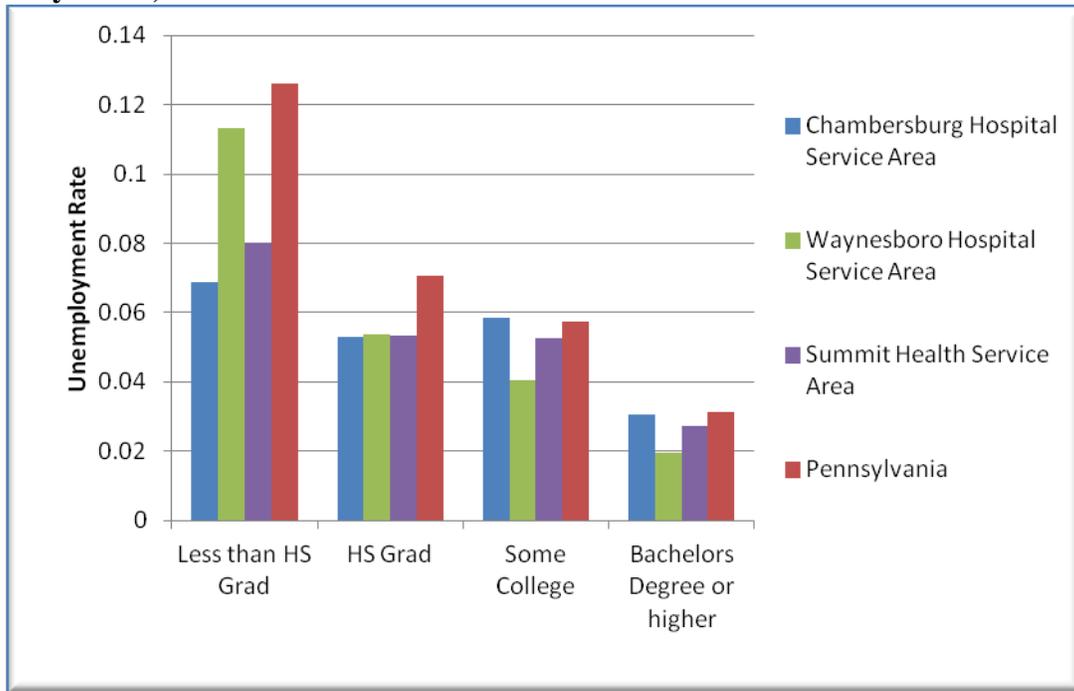
Workers in the Summit Health Service Area experienced lower rates of unemployment than those across the commonwealth. Blacks in the Service Area experienced unemployment at a much higher rate than Whites (11.8 percent versus 5.7 percent) in 2006-2010. However, Blacks in the Service Area had lower rates of unemployment than Blacks statewide (11.8 percent compared to 14.9 percent).

**Why does employment matter?**

According to Healthy People 2020, employment stability can play a critical role in improving health and helping people live healthier lives.

Not surprisingly, workers ages 16 years of age and older in the Service Area with a bachelor’s degree or higher experienced much lower rates of unemployment than those who failed to attain a high school diploma (2.7 percent compared to 8.0 percent). At all levels of educational attainment, workers 16 years and older in the Service Area were less likely to be unemployed than those statewide during the time period.

**Figure 6. Unemployment Rate by Educational Attainment, Hospital Service Area and Pennsylvania, 2006-2010**



*Households*

In 2006-2010, there were 67,196 households in the Summit Health Service Area. The average household size was 2.57 people.

Families (also called family households) are defined as those households that include people who are related to one another. In 2010, families made up 69.4 percent of the households in the Service Area. This figure includes both married-couple families (55.7 percent) and other families (13.7 percent). The average household size for a family household was 3.00 people.

Nonfamily households made up 30.6 percent of all households in the Service Area. Nearly eight out of 10 nonfamily households consisted of people living alone. The population aged 65 years and older living alone accounted for 42.8 percent of householders living alone in the Service Area – slightly higher than the statewide figure of 39.9 percent in 2010. For the Chambersburg Hospital Service Area, 43.3 percent of all householders that lived alone were 65 years of age and older, while Waynesboro Hospital Service Area’s percentage was 41.7 percent.

The total group quarters<sup>2</sup> population in the Summit Health Service Area was 5,306 in 2010. Nearly three-quarters (73.9 percent) of the group quarters population was living in non-institutional group quarters. Statewide, the proportion of group quarters population was more evenly split between institutionalized and non-institutionalized (46.3 percent compared to 53.7

<sup>2</sup> The group quarters population is defined as those persons not living in housing units. The Census Bureau recognizes two categories of group quarters: institutional and non-institutional. Institutional populations include people living under formally supervised care or custody such as a correctional facility or nursing home. Non-institutional populations include persons living in college dormitories or military barracks.

percent respectively). The Waynesboro Hospital Service Area more closely matched the overall state institutionalized/non-institutionalized split (46.8 percent/53.2 percent) than the Chambersburg Hospital Service Area (21.4 percent/78.6 percent).

#### *Marital Status*

People 15 years of age and older living in the Summit Health Service Area were more likely to be married than those living in Pennsylvania overall (55.1 percent compared to 49.0 percent statewide) during the 2006-2010 time period. Residents in the Service Area were also slightly less likely to be divorced or separated (10.9 percent versus 11.4 percent). The number of people widowed in the Service Area was 9,223, comprising 6.8 percent of persons 15 years of age and older.

Of the population 15 years of age and older, 56.8 percent in the Waynesboro Hospital Service Area and 54.4 percent in the Chambersburg Hospital Service Area identified as married during the 2006-2010 time period.

The proportion of divorcés in the Waynesboro Hospital Service Area (9.7 percent) was slightly larger than that of the Chambersburg Hospital Service Area's proportion (8.9 percent).

#### *Commuting to Work*

Eight out of ten workers living in the Summit Health Service Area drove alone to work in 2006-2010, 10.5 percent carpooled, 3.3 percent walked, less than 0.4 percent took public transportation, and 0.5 percent utilized other means of transportation. The remaining 4.2 percent worked from home. Among those who live in the Summit Health Service Area and commute to work, it took them on average 23.4 minutes to get to work.

One-third of workers 16 years of age and older in the Summit Health Service Area had commute times of less than 15 minutes in 2006-2010. Statewide, 29.3 percent of workers had similar commutes. A plurality of workers (37.3 percent) in the Service Area had a commute time of 15 to 29 minutes. Only, 6.3 percent of workers in the Service Area took one hour or more to get to work. Statewide, a larger percentage of workers (8.1 percent) had commute times of over 1 hour.

## Health, Social and Environmental Indicators

Healthy People 2020 is an initiative lead by the U.S. Department of Health and Human Services that outlines a comprehensive set of 10-year goals and objectives designed to help improve the health of all Americans. Goals of the Healthy People 2020 Initiative include:

- Attaining high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieving health equity, eliminating disparities, and improving the health of all groups.
- Creating social and physical environments that promote good health for all.
- Promoting quality of life, healthy development, and healthy behaviors across all life stages.

To achieve these goals, the Initiative identified 42 Topic Areas (TAs) that were broken into nearly 600 objectives. From these 600 objectives, the Initiative further identified 26 Leading Health Indicators (LHIs), specially selected to communicate high-priority health issues and the actions that can address them. The LHIs are a subset of objectives that relate to 12 of the original 42 Topic Areas initially identified by Healthy People 2020. In addition, each LHI has an associated set of measures that are used to track success with meeting these key objectives.

The broader Topic Areas that encompass the Leading Health Indicators identified by Healthy People 2020 include:

- |                                       |  |
|---------------------------------------|--|
| 1. Access to Health Services          | 7. Nutrition, Physical Activity, and Obesity |
| 2. Clinical Preventive Services       | 8. Oral Health                               |
| 3. Environmental Quality              | 9. Reproductive and Sexual Health            |
| 4. Injury and Violence                | 10. Social Determinants                      |
| 5. Maternal, Infant, and Child Health | 11. Substance Abuse                          |
| 6. Mental Health                      | 12. Tobacco                                  |

For a complete list of the Leading Health Indicators associated with each Topic Area, see Appendix E.

The Pennsylvania Department of Health (PaDOH) identified measures of the Healthy People 2020 objectives for which data was available. A comparison of data for selected objectives and their accompanying measures for Pennsylvania and Franklin County was developed, where available. In addition, current and historical survey and focus group data for Franklin County and the Summit Health Service Area were included to supplement and expand on the richness of the analysis.

ISRA staff analyzed an assortment of available secondary data for Franklin County on Pennsylvania's selected objectives and accompanying measures in four distinct ways. First, analysis focused on looking at the available data to determine if Franklin County's measures were above or below the established Healthy People 2020 LHI goal. Next, the focus turned toward determining if Franklin County was above or below the statewide data. Then, determinations were made as to whether Franklin County data showed improvement or decline

over time. Finally, the data was reviewed to approximate the total number of Franklin County residents affected by each health objective and measure (see Figure 7).

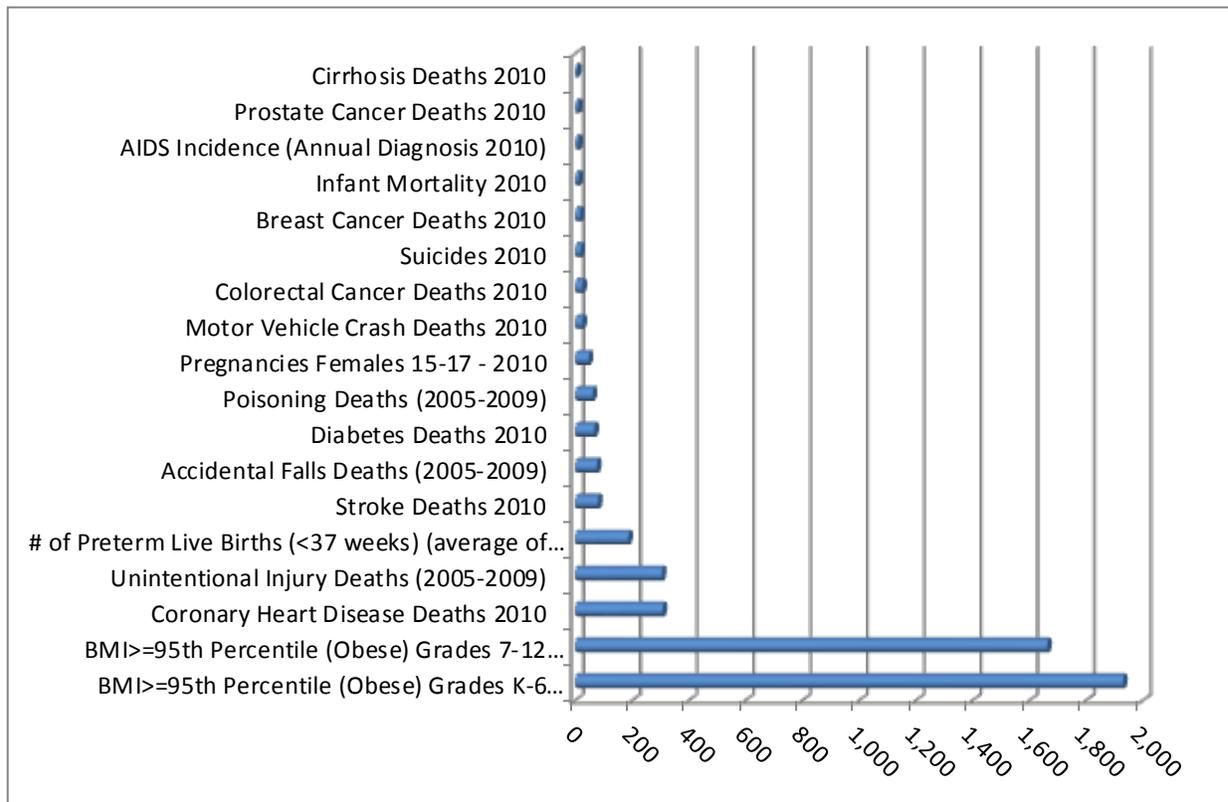
Based on that analysis, measures of the Healthy People 2020 objectives that either 1) did not meet the Healthy People 2020 goals, 2) were below the statewide rate, or 3) trended in an unfavorable direction were identified and are discussed below (in terms of the first three views of analysis). These include:

- Coronary heart disease
- Stroke
- Diabetes
- Some cancers
- Suicide
- Obesity
- Lack of health insurance coverage

Secondary data for Leading Health Indicators and measures of related Healthy People 2020 objectives is provided in Appendices F and G. For a list of selected Healthy People 2020 objectives with data available for Franklin County by all views, see Appendix H.

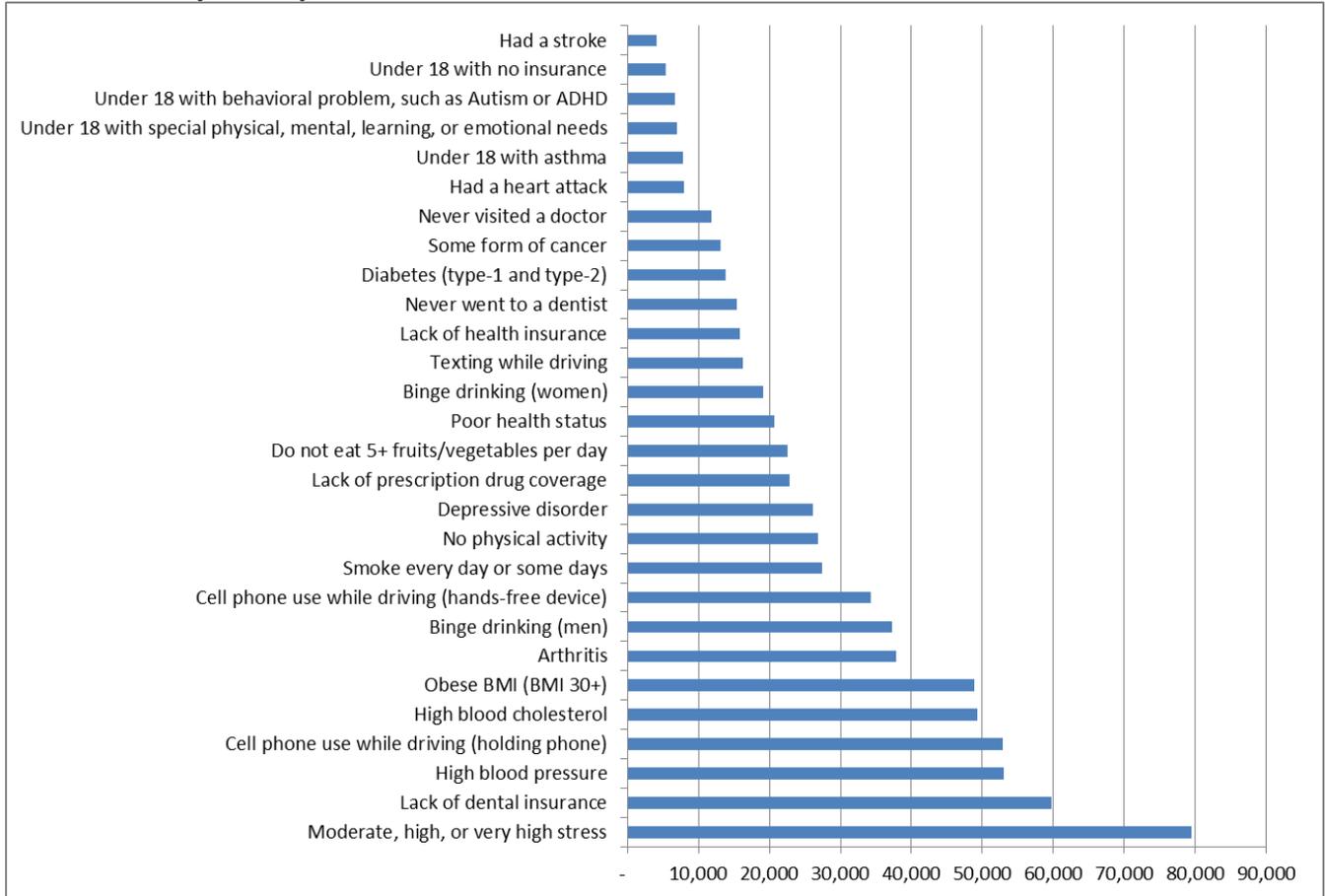
Figure 7 identifies the total number of Franklin County residents affected by the Healthy People 2020 objectives selected by the Pennsylvania Department of Health. (fourth view).

**Figure 7. Franklin County Residents Impacted by Healthy People Objectives and Measures**



Using Community Survey data, similar estimates of the number of Franklin County residents affected by selected health objectives and measures were developed for the entire Summit Health Service Area. Results of this analysis are in Figure 8 below.

**Figure 8. Summit Health Service Area Residents Impacted by Health Indicators, Community Survey 2012**



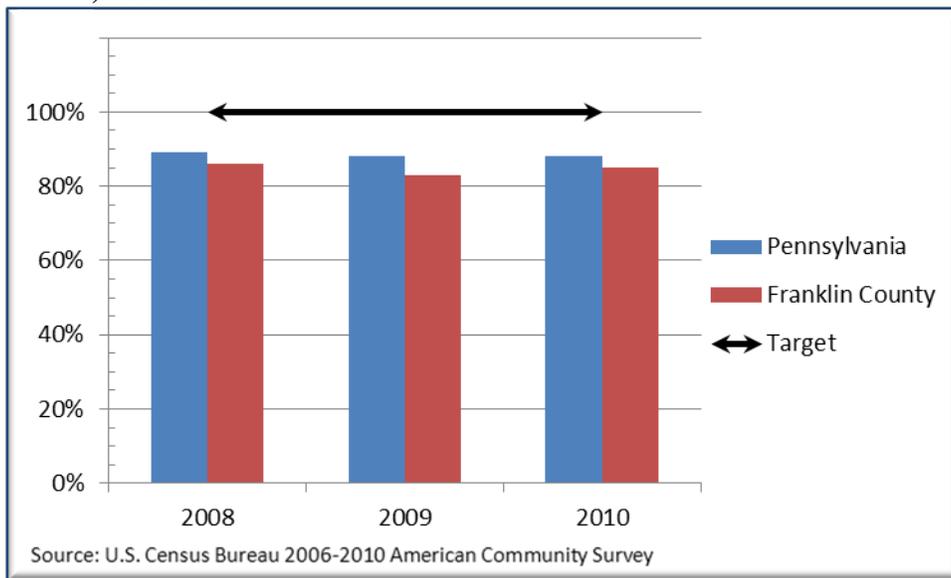
A detailed analysis of the health related objectives and measures identified by Summit Health and the Advisory Group is presented by topical area in the following section. In addition to **Education** (see page 16), **Nutrition**, **Mental Health** and **Access to Healthcare** were also considered priority topical areas by the Advisory Group and are noted within the analysis. Unless otherwise noted, the analysis in this section focuses on data obtained through the 2012 CHNA Community Survey.

*Access to Healthcare (Note: This item was identified as a priority by the Advisory Group)*  
 Access to healthcare continues to be a serious issue facing Summit Health Service Area residents. The following sections discuss issues related to health insurance, health provider utilization, cost of care, dental care, and prescription drug access affecting those living in the Summit Health Service Area. In addition to the data presented throughout this section, a lack of dental, vision, and prescription coverage was also a major concern for focus group participants. Even those with coverage noted that they still had significant out-of-pocket costs.

Health Insurance

Franklin County had a lower percentage of insured residents (85 percent) than the commonwealth (88 percent) had in 2006-2010, according to American Community Survey data. The county did not meet the Healthy People 2020 goal of 100 percent health insurance coverage for both adults and children.

**Figure 9. Adults 18-64 with Health Insurance Coverage, Franklin County and Pennsylvania, 2008-2010**



The American Community Survey data was supported by Community Survey data showing that 87.0 percent of Service Area residents had health insurance in 2012. Of those with health insurance, most had employer-based insurance or Medicare. More than two-thirds (67.9 percent) of respondents who had Medicare indicated that they had a supplemental plan.

The top three reasons reported for not having health insurance included:

- Can't afford health insurance (39.0 percent)
- Other reason (religious reasons, work does not offer, etc.) (34.5 percent)
- Not qualified for Medical Assistance (25.4 percent)

**Sex, age, BMI category, education level, and income level have statistically significant relationships with health insurance status, as determined by the Community Survey. There were no statistically significant differences between the two hospitals' service areas.**

- Men were more likely to have employer-based insurance than women (56.9 percent versus 48.1 percent, respectively), while women were more likely to have Medicare (23.5 percent versus 19.0 percent) and/or purchased health insurance (11.3 percent versus 6.2 percent).
- Individuals with normal BMIs were more likely not to have any health insurance as compared to other BMI groups. Specifically, 19.0 percent of normal BMI respondents did not have health insurance, followed by very obese (11.3 percent), overweight (10.7 percent), and obese (7.4 percent).
- Respondents with a bachelor's degree or higher were most likely to have employer-based insurance (71.5 percent). (Respondents who reported that their level of education was vocational/some college were next (54.5 percent), followed by high school graduate/equivalent (42.7 percent), and less than high school diploma/equivalent (16.0 percent).) Conversely, those with less than a high school diploma or equivalent were much more likely to be uninsured versus those with a bachelor's degree or higher (34.4 percent and 4.5 percent respectively).
- Respondents that reported greater household incomes were more likely to have employer-based health insurance. Specifically, 83.8 percent of respondents with household incomes of \$100,000 per year or more had employer-based insurance compared to only 24.1 percent of those with household incomes of less than \$25,000 per year. Further, respondents with lower household incomes were more likely to have no insurance as compared to their more wealthy counterparts. For example, 27.3 percent of respondents with household incomes of less than \$25,000 per year had no health insurance versus only 4.4 percent of those living in households earning \$100,000 or more per year.

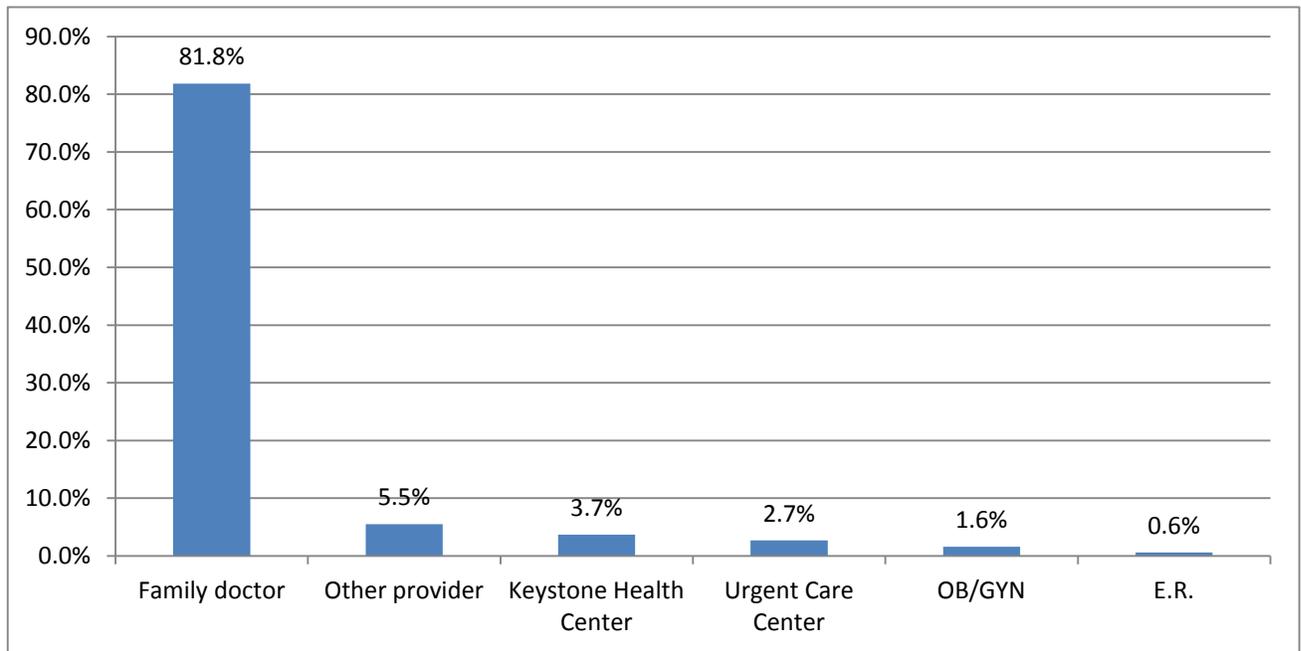
The number of individuals who report having health insurance has decreased consistently since the 2008 and 1996 CHNAs (87.0 percent in 2012, 92.6 percent in 2008, and 94.7 percent in 1996).

The participants in the focus group with Spanish-speaking adults also identified lack of health insurance as a concern.



### Health Provider Utilization and Seeking Care

In terms of where Service Area residents receive healthcare, a vast majority of Community Survey respondents (81.8 percent) indicated that they go to a family doctor for their healthcare most of the time (see Figure 10). There were no statistically significant differences between the hospitals' service areas.

**Figure 10. Type of Provider Used for General Healthcare Needs, Community Survey 2012**

Few respondents (n=28, 3.3 percent) indicated that they do not get regular medical care. Those individuals were younger (18-24 years) and had normal BMIs, lower education levels, and lower income levels. The top reasons that these respondents did not get regular medical care included:

- Don't need a healthcare provider (50.1 percent)
- Can't pay for a provider visit (28.2 percent)
- Can't find a provider you like or trust (5.0 percent)
- Other reasons, such as dissatisfied with the last doctor's office or no health insurance (16.8 percent)

Overall, most respondents (72.9 percent) indicated that they visited a doctor at least once per year for a regular check-up. Another 18.3 percent of respondents indicated that they visited a doctor every two years or more. However, 8.8 percent of respondents indicated that they never visit a doctor for a regular check-up. These individuals were younger (18-44 years), had normal BMIs, were less educated (less than a bachelor's degree), and had lower household incomes (less than \$60,000/year).

**Age and BMI category were found to have statistically significant relationships with seeing a doctor for regular check-ups. There were no statistically significant differences between the hospitals' service areas.**

- Older individuals were more likely to see their family doctor at least once per year. For example, 90.7 percent of individuals 65-74 years of age and 94.2 percent of individuals 75 years of age or older see a doctor once per year versus 59.5 percent of 18-24 year olds.

- Individuals with higher BMIs were also more likely to see their doctor at least once per year for a regular check-up. Almost all (90.0 percent) very obese individuals saw their family doctor at least once per year or every two years for a check-up, compared to 76.3 percent of normal BMI respondents.

#### Cost of Care

**Sex, age, education level, and income level were found to have statistically significant relationships with not seeking care because of cost. There were no statistically significant differences between the hospitals' service areas.**

- Cost prohibited 11.5 percent of respondents from seeing a doctor in the past year when they needed to do so. Respondents reported that the following were most frequently delayed due to lack of money or insurance:
  - Sickness/injury appointment (32.2 percent)
  - Yearly physical (19.0 percent)
  - Other care, such as dental work, blood tests, etc. (16.3 percent)
  - Lab/blood work (13.1 percent)
  - Preventative screenings, such as mammograms, colonoscopy, etc. (10.2 percent)
- Women were more likely not to seek care as compared to men (13.6 percent versus 9.3 percent, respectively).
- Younger individuals were more likely not to see a doctor because of the cost. For example, 25.8 percent of young adults (ages 18-24) reported not seeking care due to cost, as compared to 1.2 percent of 65-74 year olds and 0.7 percent of individuals 75 years of age or older.
- Individuals with lower levels of education were more likely to avoid seeing a doctor due to cost. Specifically, 6.3 percent of individuals with a bachelor's degree or higher did not see a doctor, as compared to 17.3 percent of those with vocational/some college, 12.0 percent of high school graduates, and 9.8 percent of those without a high school diploma.
- Respondents with higher household income levels were less likely to avoid seeking medical care because of the cost. In fact, only 1.4 percent of individuals with a household income of \$100,000 per year or greater did not see a doctor because of the cost, compared to 29.7 percent of individuals with a household income less than \$25,000 per year.

### Dental Care

**Sex, age, BMI category, education level, and income level were found to have statistically significant relationships with having dental insurance. There were no statistically significant differences between the two hospitals' service areas.**

- Over half of survey respondents (54.6 percent) reported having dental insurance. This is almost identical to results found in the 2008 CHNA (55.8 percent).
- Men were more likely to have dental insurance than woman (57.8 percent versus 51.6 percent).
- Respondents younger than 65 years of age were more likely to have dental insurance than their older counterparts. Specifically, 62.4 percent of those younger than age 65 had dental insurance, compared to 23.9 percent of those 65 years of age and older.
- Those with higher levels of education were more likely to have dental insurance. Nearly three-quarters (70.9 percent) of respondents with a bachelor's degree or higher had dental insurance, compared to only about one-quarter (26.4 percent) of respondents with less than a high school diploma.
- Individuals with higher household incomes were more likely to have dental insurance than their less wealthy counterparts. Specifically, more than three-quarters (77.5 percent) of those with household incomes of \$100,000 year or greater had dental insurance, compared to about one-third (32.8 percent) of those earning less than \$25,000 per year.

Most respondents (70.7 percent) reported visiting a dentist at least once per year for a regular check-up. Another 17.7 percent went to the dentist at least every two years or more. However, 11.5 percent of respondents reported that they never go to the dentist. These individuals indicated that they never visit the dentist regularly because:

- It is too expensive – they can't afford a dental visit (17.2 percent)
- They do not have dental insurance (15.8 percent)
- Other reasons, such as having dentures, false teeth, or no teeth (63.6 percent)

**Hospital service area, sex, age, education level, and income level were found to have statistically significant relationships with seeing a dentist for regular check-ups.**

- Individuals in the Chambersburg Hospital Service Area were less likely to see a dentist regularly. Specifically, 14.2 percent of residents living in the Chambersburg Hospital Service Area reported never seeing a dentist for a regular check-up, as compared to 8.5 percent of Waynesboro Hospital Service Area residents.
- Men were also less likely to see a dentist on a regular basis. In fact, 14.6 percent of men never saw a dentist for a regular appointment, compared to 8.6 percent of women.
- Older individuals were less likely to visit the dentist regularly. For example, 20.0 percent of individuals 65-74 years of age and 24.8 percent of individuals 75 years of age or older never saw a dentist.

- Respondents with higher levels of education (bachelor's degree or higher) were more likely to see a dentist at least once per year as compared to individuals with less than a high school diploma (90.6 percent versus 47.2 percent, respectively).
- Likewise, individuals living in households with higher income brackets were more likely to see a dentist at least once per year than their lower income counterparts. For example, 89.7 percent of individuals living in households earning \$100,000 or more per year saw a dentist at least once per year, compared to only 46.1 percent of respondents with household incomes of less than \$25,000 per year.

#### Prescription Drug Access

More than four out of five (82.1 percent) of survey respondents reported having prescription drug coverage.

**Age, education level, and income level were found to have statistically significant relationships with having prescription drug coverage. There were no statistically significant differences between the two hospitals' service areas.**

- Older individuals were more likely to have prescription drug coverage than their younger counterparts.
- Those with a bachelor's degree or higher were more likely to have prescription drug coverage as compared to those with less education. For example, almost all (92.5 percent) of those with a bachelor's degree or higher had prescription coverage, compared to a little over half (57.4 percent) of those with less than a high school diploma.
- Respondents living in households with higher incomes were more likely to have prescription drug coverage than those living in households with lower incomes. Specifically, nearly all (93.7 percent) of those living in households with incomes of \$100,000 per year or greater had prescription coverage, compared to 70.2 percent of those living in households earning less than \$25,000 per year.

More than one out of eight respondents (12.7 percent) did not fill a prescription at least one time in the previous year because they could not pay for it.

**Age, BMI category, education level, and income level were found to have statistically significant relationships with not filling a prescription because of the cost. There were no statistically significant differences between the two hospitals' service areas.**

- Younger individuals were more likely to avoid filling a prescription due to cost. For example, 15.1 percent of those less than 65 years of age avoided filling a prescription in the previous year because of the cost, as compared to only 3.0 percent of those 65 years of age or older.
- Respondents with less than a high school diploma or a bachelor's degree or higher were more likely to report that they never had to avoid filling a prescription due to cost (91.9 percent and 92.2 percent, respectively). Further, 83.2 percent of those with vocational school/some college and 84.0 percent of high school graduates indicated that they never avoided filling a prescription due to the cost.

- Individuals living in households with lower income levels were more likely to avoid filling a prescription due to cost. For example, 10.3 percent of those living in households earning less than \$25,000 per year did not fill a prescription five or more times in the previous year due to cost, compared to only 1.4 percent of those living in households with incomes of \$100,000 or more.

**Age, education level, and income level were found to have statistically significant relationships with going without food or other purchases in order to get necessary prescriptions. There were no statistically significant differences between the two hospitals' service areas.**

- A total of 4.9 percent of respondents reported going without food or other purchases in order to get necessary prescriptions in the previous year.
- Younger individuals were more likely to go without key purchases in order to get necessary prescriptions. Specifically, 9.1 percent of those 25-34 years of age and 9.5 percent of those 35-44 years of age reported going without food or other purchases, compared to 2.2 percent of those 65-74 years of age and 0.7 percent of those 75 years of age or older.
- Respondents with less than a high school diploma or those with a bachelor's degree or higher were least likely to go without key purchases for their prescriptions (both 2.1 percent). More high school graduates (6.2 percent) and those with vocational school/some college (7.4 percent) reported going without food or other purchases in order to fill prescriptions.
- Individuals living in households with incomes of less than \$25,000 per year were more likely (11.7 percent) to go without food or other purchases to get prescriptions than those living in households with incomes of \$100,000 or more (2.7 percent).

A comparison of the current and former CHNAs also shows that the number of individuals who could not pay for prescriptions when they needed them has continued to increase over time (12.7 percent in 2012, 10.9 percent in 2008, and 7.4 percent in 1996).

*Clinical Preventive Services*

Clinical preventive services are concerned with preventing disease, promoting health, and reducing healthcare costs.

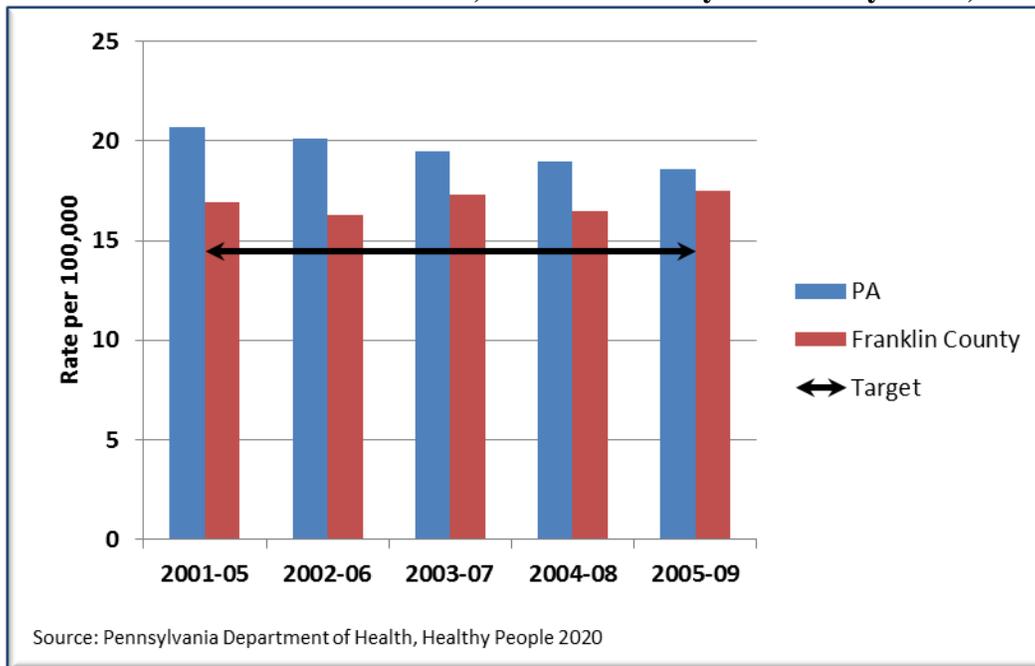
“Prevention is aimed at preventing the onset of disease. One way of doing this is by controlling risk factors in healthy people that may lead to disease. Examples of prevention include 1) immunizations to prevent communicable diseases such as influenza or polio, and 2) the promotion of physical activity to prevent conditions such as obesity that can lead to disease (e.g., type 2 diabetes).”<sup>3</sup>

Some health conditions that are often targets of preventative services include cancer, diabetes, heart disease, stroke, mental health issues, obesity, and infant mortality. The following section discusses the most recent Community Survey and secondary data available that relates to the prevalence of these conditions and the various factors potentially affecting their rates of incidence.

Cancer

Secondary data from the Pennsylvania Department of Health’s Healthy People 2020 showed that the age-adjusted death rate for all cancers in Franklin County (176.2 per 100,000) was lower than the statewide rate (190.4 per 100,000) in 2005-2009. The age-adjusted death rates for colorectal cancer, breast cancer and prostate cancer in Franklin County were all lower than statewide rates. The death rates for colorectal cancer did not meet the Healthy People 2020 goal; however, the death rates for breast cancer and prostate cancer surpassed their respective goals.

**Figure 11. Colorectal Cancer Death Rates, Franklin County and Pennsylvania, 2001-2009**



<sup>3</sup> The Role of Clinical Preventive Services in Disease Prevention and Early Detection, <https://www.businessgrouphealth.org/pub/f31603f5-2354-d714-5126-a6d440aa2f8a>

Survey data showed that almost 10 percent of respondents (9.8 percent) were told by a doctor or other health professional that they had some form of cancer at some point in their lives.

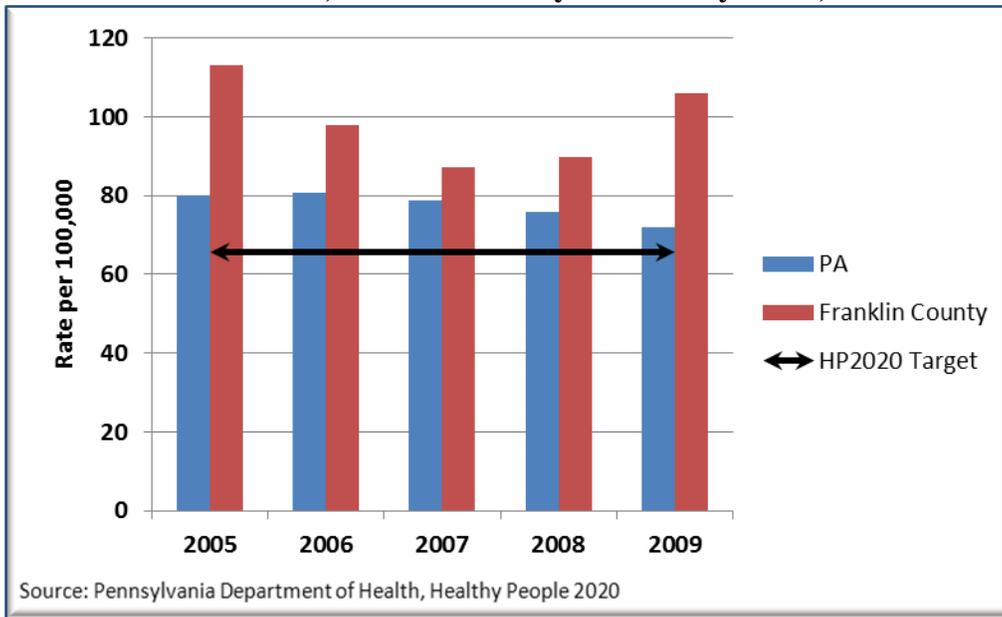
**Age has a statistically significant relationship with incidence rates of cancer. There were no statistically significant differences between the two hospitals' service areas.**

- Older respondents were more likely to have reported having any form of cancer at some point in their lives as compared to younger respondents. Nearly one-quarter (22.7 percent) of those 65 years of age or older reported having had cancer at some point in their lives versus 6.5 percent of those younger than age 65.

Diabetes

The age-adjusted diabetes death rates for Franklin County did not meet the Healthy People 2020 goal in any of the years from 2005-2009. In addition, the Franklin County rates were higher than the statewide rates and have increased since 2007, while the statewide rates declined during the same time period.

**Figure 12. Diabetes Death Rates, Franklin County and Pennsylvania, 2005-2009**



The 2012 Community Survey results revealed that about one-sixth of respondents (16.8 percent) were told by a doctor or other health professional that they had diabetes or pre-diabetes. Excluding those with gestational diabetes and pre-diabetes, 10.3 percent of respondents reported having type-1 or type-2 diabetes.

Of the individuals who indicated that their diabetes was not due to pregnancy (N=86), more than three-quarters (n=72, 83.7 percent) had type-2 diabetes and 16.3 percent of respondents (n=14) had type-1 diabetes. Due to the small number of respondents in these subgroups, no statistically

significant relationships could be determined between any demographics, including hospital service area and the type of diabetes.

This data shows that the percentage of individuals with diabetes has decreased since the 2008 CHNA (10.3 percent in 2012 versus 14.1 percent in 2008). However, in terms of comparison, the wording in the 2008 CHNA used a “past 2 years” time frame versus an “ever” time frame in the 2012 CHNA. Also, the 2008 CHNA did not report whether or not the diabetes was gestational diabetes only.

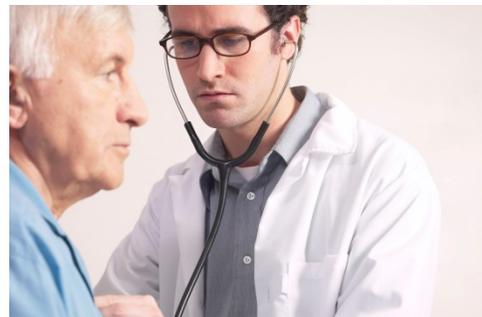
### Heart Disease and Stroke

Franklin County’s age-adjusted coronary heart disease and stroke death rates during the 2005-2009 reporting period did not meet the Healthy People 2020 goals; yet they were lower than the statewide rates. In addition, Franklin County rates for both heart disease and stroke have both been steadily declining since 2001.

Survey data showed that 6.0 percent of respondents reported having had a heart attack at some point in their lives. Even fewer respondents indicated that they had ever had a stroke (3.1 percent).

**Sex, age, education category, and income level were found to have statistically significant relationships with reported heart attack incidences. There were no statistically significant differences between the two hospitals’ service areas.**

- Men were more likely than women, to have reported having survived a heart attack (8.8 percent versus 3.4 percent).
- Individuals 65 years of age or older were more likely to have reported having had a heart attack than those younger than 65 years of age. Specifically, 13.5 percent of those who reported having survived a heart attack were 65 years of age or older, compared to 4.1 percent of those younger than 65 years of age.
- Respondents with lower education levels were more likely to have reported having had a heart attack than those with higher education. For example, 12.1 percent of those with less than a high school diploma and 8.0 percent of high school graduates reported having had a heart attack, as compared to only 1.3 percent of those with a bachelor’s degree or higher.
- Those living in households with lower income levels were more likely to have reported having had a heart attack than those living in households with higher income levels. Specifically, 8.8 percent of those living in households earning less than \$25,000 per year and 10.3 percent of those living in households earning between \$25,000 and \$39,999 per year reported having survived a heart attack, versus 0.7 percent of individuals living in a household with an income level of \$100,000 per year or more.



**Age was found to have a statistically significant relationship with reported stroke incidences. There were no statistically significant differences between the two hospitals' service areas.**

- Individuals 65 years of age or older were more likely to have reported having had a stroke than those less than 65 years of age (8.5 percent versus 1.8 percent).

Mental Health *(Note: This item was identified as a priority by the Advisory Group)*

The suicide rate in Franklin County (11.0 per 100,000) was slightly below the state rate (11.4 per 100,000) during 2005-2009. Although the 2001-2005 Franklin County rate (9.0 per 100,000) was lower than both the statewide 2001-2005 rate and the Healthy People 2020 goal (10.6 and 10.2 per 100,000, respectively), the rate has increased since that time. Neither the Franklin County nor Pennsylvania age-adjusted suicide death rates met the Healthy People 2020 goal in 2005-2009.

In terms of general mental health issues, survey data showed that close to one-fifth (19.5 percent) of respondents had been told by a health professional at some point in their lives that they had a depressive disorder, which included depression, major depression, dysthymia, or minor depression.

**Sex, age, BMI category, and income level were found to have statistically significant relationships with incidence of depressive disorders. There were no statistically significant differences between the two hospitals' service areas.**

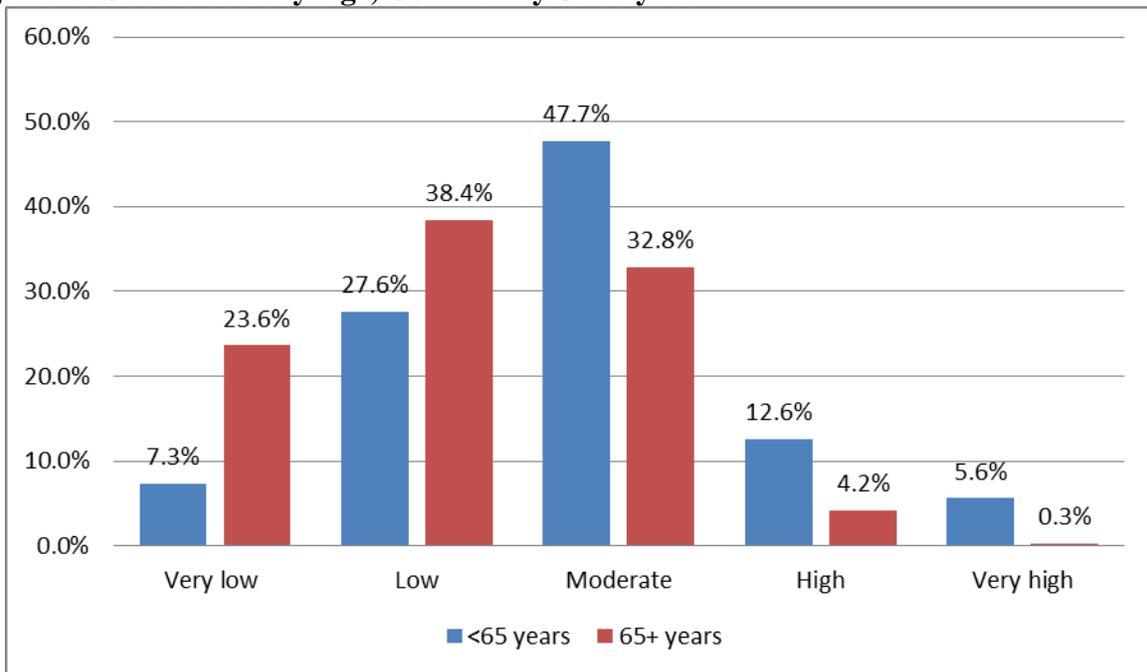
- Women were more likely than men, to have been told by a health professional that they had a depressive disorder (25.3 percent versus 13.2 percent).
- Overall, 21.5 percent of those who were less than 65 years of age had been told by a health professional that they had a depressive disorder, compared to 11.8 percent of individuals 65 years of age or older. Individuals 18-24 years old were most likely to have been told by a health professional that they had a depressive disorder (28.0 percent).
- Individuals with a normal BMI were less likely than very obese respondents to be diagnosed with a depressive disorder by a health professional. (18.3 percent versus 35.2 percent, respectively).
- Respondents with lower household incomes were more likely to have been told, by a health professional, that they had a depressive disorder. For example, 38.6 percent of individuals living in household with incomes of less than \$25,000 per year indicated they had been told by a health professional that they had a depressive disorder, compared to 13.7 percent of those living in households with incomes of \$100,000 per year or more.

Furthermore, more than half (59.3 percent) of survey respondents rated their stress levels as moderate, high, or very high on a typical day. Conversely, 40.4 percent of respondents rated their stress levels as very low or low.

**Sex, age, and income level have statistically significant relationships with reported stress levels. There were no statistically significant differences between the two hospitals' service areas.**

- Women were more likely to rate their stress high (13.0 percent) or very high (7.1 percent), compared to men (8.6 percent and 1.6 percent respectively).
- Younger individuals were more likely to indicate a higher level of stress (see Figure 13).
- Individuals living in households with higher incomes reported more stress than those with lower incomes. For example, 5.3 percent of individuals living in households with incomes of \$100,000 per year or more reported having very low stress levels as compared to 13.4 percent of those living in households earning less than \$25,000 per year. Further, over half (51.1 percent) of those living in households with incomes of \$100,000 per year or more reported having moderate stress as compared to 43.9 percent of those living in households earning less than \$25,000 per year.

**Figure 13. Stress Level by Age, Community Survey 2012**



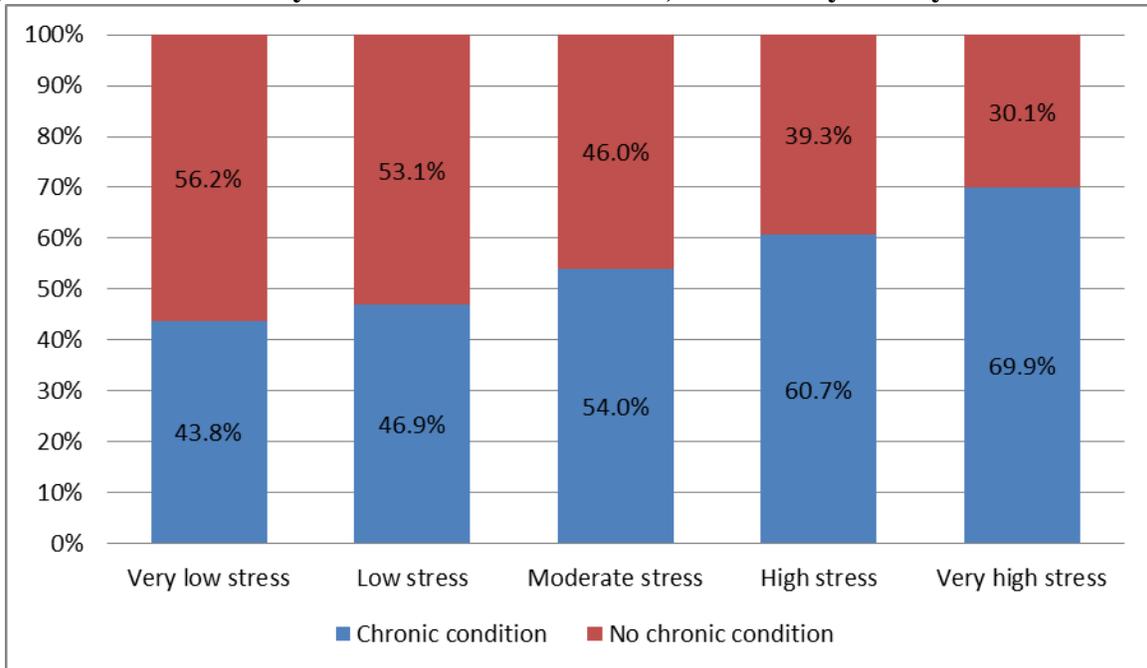
The top ways respondents reported dealing with stress included:

- Talking to someone they trust (friends, relatives, etc.) (59.7 percent)
- Other responses included praying, reading, and sleeping (31.0 percent)
- Exercising (29.4 percent)
- Eating more or less than normal (28.1 percent)

**Chronic condition status, having a depressive disorder, type of diabetes, and frequency of physical activity and exercise were found to have statistically significant relationships with reported stress level.**

- Individuals with who had been told by a health professional that they had a chronic health condition had much higher levels of reported stress compared to those who had not been told they had a chronic health condition (see Figure 14). Specifically, 69.9 percent of those who rated their stress level as very high had been told by a health professional that they had a chronic condition, as compared to just 30.1 percent of those who had not been told they had a chronic condition.
- Those with high stress levels were more likely to report having been told by a health professional that they had a depressive disorder. For example, 59.2 percent of those reporting very high stress levels had been told by a health professional that they had a depressive disorder. Further, 93.7 percent of individuals who rated their stress as very low did not indicate that they were told by a health professional that they had a depressive disorder.
- Many individuals reporting very high stress also had some form of diabetes or pre-diabetes (28.5 percent of those with type-1 diabetes, 32.1 percent of those with type-2 diabetes, and 39.4 percent of those with pre-diabetes).
- Generally, those reporting lower stress tended to exercise more frequently. For example, two-thirds (66.7 percent) of those reporting very low stress exercised three or more days per week. Less than one-fifth (17.0 percent) of those reporting very low stress exercised one to two days per week, and the remaining individuals reporting very low stress (15.1 percent) did not exercise at all.

**Figure 14. Stress Level by Chronic Condition Status, Community Survey 2012**



Nutrition, Physical Activity, and Obesity (*Note: This item was identified as a priority by the Advisory Group*)

According to both Community Survey and secondary data, obesity was the health indicator that affected the largest number of Franklin County residents. Secondary data from the Pennsylvania Department of Health, Division of School Health shows that the rates of obesity for Franklin County children are above the statewide rates and did not meet the Healthy People 2020 goals.

Pennsylvania met the Healthy People 2020 obesity<sup>4</sup> goal for adults (30.6 percent) in 2010. The state rate was 29 percent in 2010 and has been consistent since 2007. Secondary data reporting on obesity rates for adults was not available at the Franklin County level. However, 36.5 percent of Community Survey respondents had a BMI in the obese range<sup>5</sup>, which does not meet the Healthy People 2020 goal.

**Sex and age have statistically significant relationships with body mass index. There were no statistically significant differences between the two hospitals' service areas.**

- Generally, females had healthier BMIs as compared to males. Specifically, 35.7 percent of females had a normal BMI versus just 26.3 percent of males. Further, nearly three-quarters (72.4 percent) of males had an unhealthy BMI compared to 62.8 percent of females. The remaining respondents did not provide the information needed to calculate BMI.
- Younger adults were more likely to be in the normal BMI range. In fact, 60.4 percent of individuals 18-24 years of age and 40.5 percent of individuals 25-34 years of age were in the normal BMI range. Individuals in the 55-64 year old age range were least likely to have a normal BMI, with only 14.3 percent falling in the healthy BMI range.

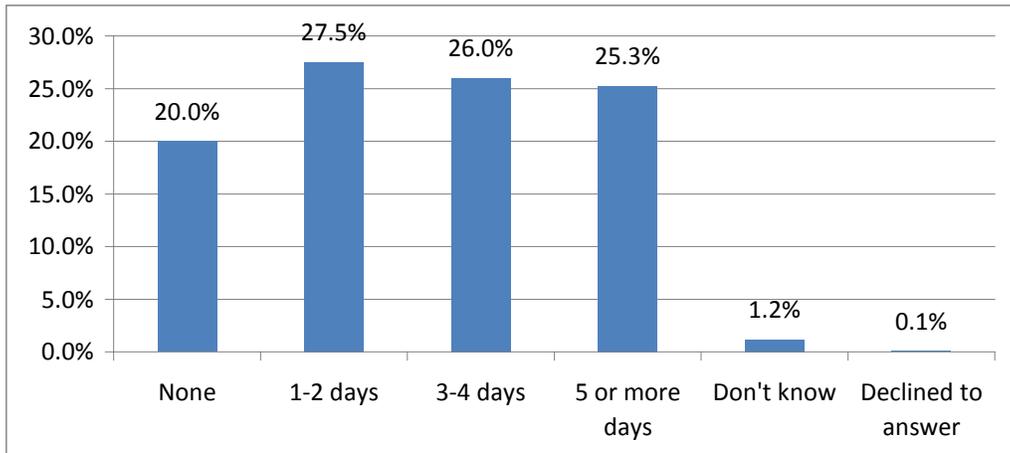
A comparison of current and past CHNA data reveals that the percentage of individuals with BMIs in the obese range consistently increased since the previous CHNAs (36.5 percent in 2012, 32.8 percent in 2008, and 23.5 percent in 1996). While there are many factors that can affect an individual's BMI, certain key measures, including physical activity and nutritional habits, were included in the Community Survey and are discussed in the following section. In addition, secondary data is provided, describing food access for Franklin County residents, including food store availability, population numbers in food desert areas, and number of stores accepting WIC and providing WIC-approved foods.

During a normal week, one-fourth (25.3 percent) of Community Survey respondents indicated that they engaged in physical activity or exercise five or more days per week. On the other hand, one-fifth (20.0 percent) of survey respondents reported that they do not exercise at all during a normal week (see Figure 15). Most survey respondents (51.5 percent) indicated that they exercise either one to two days (27.5 percent) or three to four days (26.0 percent) during a typical week.

<sup>4</sup> Individuals with a BMI of 25 to 29.9 are considered overweight, while individuals with a BMI greater than or equal to 30 are considered obese.

<sup>5</sup> BMIs for the survey data were calculated using a respondent's reported height and weight.

**Figure 15. Physical Activity in a Normal Week of Summit Health Service Area Residents, Community Survey 2012**



**Age, BMI category, and education level were found to have statistically significant relationships with the reported frequency of physical activity or exercise. There were no statistically significant differences between the two hospitals' service areas.**

- Individuals 65 years of age or older were more likely to get no exercise at all compared to those less than 65 years of age (25.3 percent versus 18.6 percent). Further, younger respondents reported being more likely to exercise five or more days per week (38.1 percent of 18-24 year olds and 34.8 percent of 25-34 year olds, as compared to 21.4 percent of 65-74 year olds and 24.3 percent of those 75 years of age or older).
- Those with normal BMIs were more likely to report exercising five or more days per week than their healthier counterparts. Specifically, 37.6 percent of those with normal BMIs exercised five or more days per week, compared to 20.2 percent of overweight, 17.7 percent of obese, and 21.1 percent of very obese respondents.
- Respondents with less education were more likely to exercise five or more days per week than those with more education. For example, almost one-third (31.5 percent) of those with less than a high school diploma exercised this much weekly basis, compared to less than one-quarter (24.1 percent) of those with a bachelor's degree or higher.
- The top reasons for never participating in physical activity or exercise in a typical week as given by survey respondents were:
  - Not having enough time to exercise (42.8 percent)
  - Being too tired to exercise (39.4 percent)
  - Their job is physically demanding or hard labor (30.6 percent)
  - They don't like to exercise (22.3 percent)



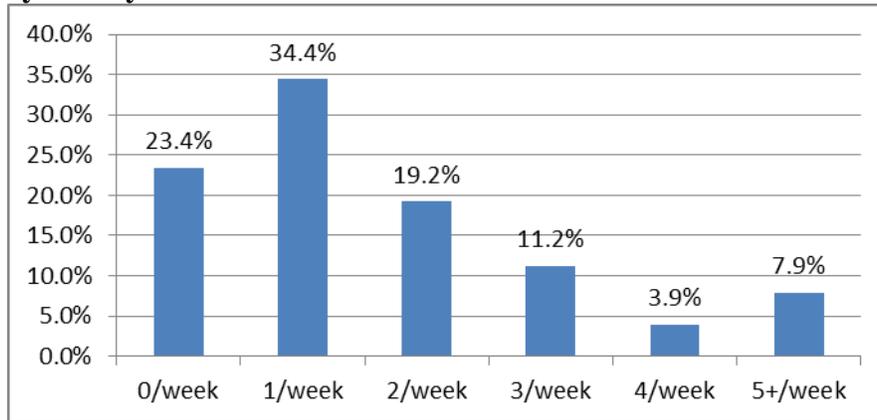
**Sex, age, BMI category, and education level were found to have statistically significant relationships with reasons for not participating in physical activity or exercise. There were no statistically significant differences between the two hospitals' service areas.**

- Men were more likely to indicate that they did not exercise at all because their job was physically demanding or hard labor (44.6 percent versus 14.2 percent). Women were more likely to cite family caregiver responsibilities as a reason for not exercising (12.1 percent versus 5.2 percent).
- Younger respondents (less than 65 years of age) were more likely to indicate that lack of time was a reason for never exercising as compared to those 65 years of age or older (50.8 percent versus 19.8 percent). These same younger respondents were also more likely to say they were too tired to exercise (45.5 percent versus 21.5 percent for their older counterparts). Lastly, older respondents were more likely to state that being physically disabled was a reason for not engaging in physical exercise. In fact, more than one-fifth (21.2 percent) of those 65 years of age or older cited this reason, compared to 10.8 percent of those younger than age 65.
- Those with normal BMIs were most likely to cite not having enough time (56.1 percent), being too tired to exercise (42.1 percent), or having a job that is physically demanding or hard labor (39.0 percent) as reasons for never exercising in a typical week. Very obese respondents were most likely to state that being too tired to exercise (41.6 percent), not liking to exercise (32.9 percent), and not having enough time (30.0 percent) were reasons for never exercising in a typical week.
- Individuals with less formal education had different reasons for never exercising during a typical week, as compared to those with more formal education. For example, those with less than a high school diploma most frequently indicated the following reasons for not exercising at all during a typical week: their job is physically demanding or hard labor (39.4 percent), they are too tired to exercise (34.7 percent), and they do not have enough time to exercise (28.8 percent). Further, those with a bachelor's degree or higher most frequently stated the following reasons for not exercising: they did not have enough time to exercise (53.9 percent), they were too tired to exercise (38.7 percent), their job is physically demanding or hard labor (25.3 percent), and they do not like to exercise (19.3 percent).

In addition to fitness habits, eating habits and nutritional habits can also have profound effects on a person's BMI. Measures used to assess nutritional habits in the Community Survey included frequency of eating out at restaurants and number of days per week that respondents ate at least five or more fruits and vegetables.

In terms of nutritional habits, survey respondents reported that they typically ate out anywhere between zero and 25 times per week. Eating out was defined as eating both fast food and food at sit-down restaurants. In addition, respondents ate out an average of 1.75 times per week and a plurality of respondents (34.4 percent) ate out one time per week on average. See Figure 16 for a depiction of how often respondents reported eating out during a typical week.

**Figure 16. Times Per Week That Summit Health Service Area Residents Eat Out, Community Survey 2012**

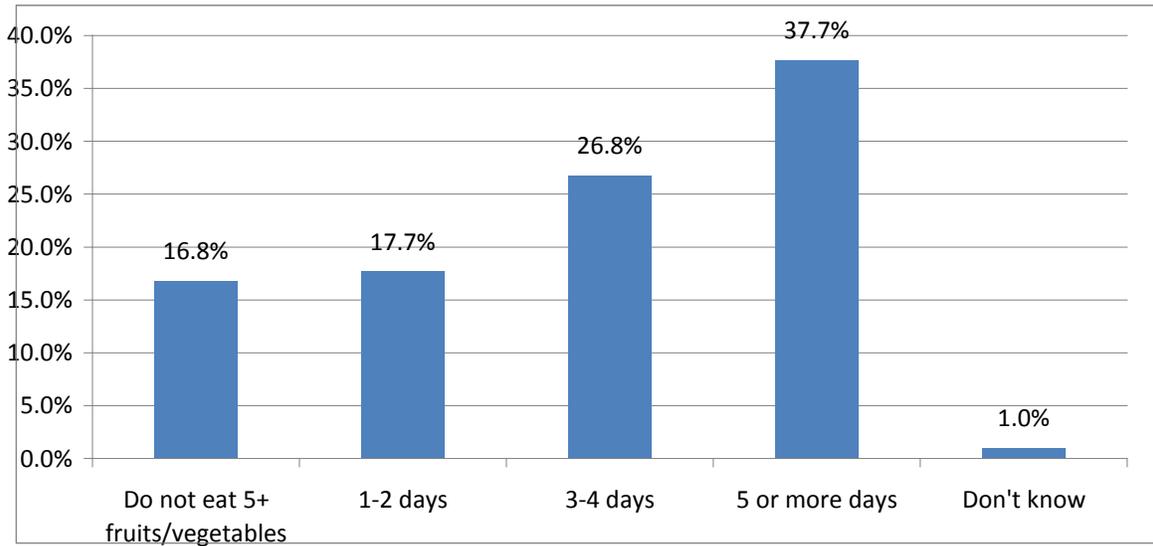


**Hospital service area, sex, age, BMI category, education level, and income level were all found to have statistically significant relationships in the frequency with which respondents reported eating out each week.**

- Chambersburg Hospital Service Area residents tended to eat out less often than those in the Waynesboro Hospital Service Area. For example, over one-quarter (25.5 percent) of Chambersburg Hospital Service Area residents never ate out during a typical week, compared to just over one-fourth (21.1 percent) of Waynesboro Hospital Service Area residents.
- Women ate out less frequently than men. Specifically, over one-quarter (25.1 percent) of women never ate out during a typical week, compared to 21.6 percent of men. Additionally, 10.3 percent of men ate out five or more times per week, compared to 5.6 percent of women.
- Most respondents ate out one time per week on average. Nearly half (47.3 percent) of respondents 35-44 years of age ate out one time per week, followed by 40.0 percent of 25-34 year olds and 36.9 percent of 45-54 year olds. Those 18-24 years of age were least likely to eat out one time per week (11.3 percent).
- Individuals with normal BMIs were more likely than those with unhealthy BMIs to never eat out. One-third (32.6 percent) of those with a normal BMI never ate out, compared to 17.4 percent of overweight, 14.0 percent of obese, and 23.0 percent of very obese respondents.
- Respondents with lower education levels were more likely to never eat out compared to those with higher education levels. For example, nearly half (48.2 percent) of those with less than a high school diploma never ate out, compared to just 14.9 percent of those with a bachelor's degree or higher.
- Those with lower household income levels were more likely to never eat out than those with higher incomes. Specifically, 40.8 percent of those living in households earning less than \$25,000 per year never ate out versus 12.0 percent of those living in households earning \$100,000 per year or more.

Regarding fruit and vegetable consumption, 37.7 percent of respondents reported eating five or more fruits and vegetables per day five or more days per week. Figure 17 outlines how often respondents ate five or more fruits and vegetables per day in the previous week.

**Figure 17. Days Summit Health Service Area Residents Ate Five or More Fruits and Vegetables in the Past Week, Community Survey 2012**



**Age, education level, and income level were found to have statistically significant relationships with the reported frequency of eating five or more fruits and vegetables in the previous week. There were no statistically significant differences between the two hospitals' service areas.**

- Older respondents were more likely to report having eaten five or more fruits and vegetables five or more days in the previous week. Nearly half (47.3 percent) of those 65 years of age or older ate five or more fruits and vegetables daily in the previous five days, compared to just over one-third (35.2 percent) of those less than 65 years of age.
- Individuals with lower formal educational levels were more likely to eat the appropriate amount of fruits and vegetables five or more days per week. For example, over half (54.5 percent) of those with less than a high school diploma ate five or more fruits and vegetables, versus 40.8 percent of those with a bachelor's degree or higher.
- Respondents with higher household income levels were more likely to eat five or more fruits and vegetables five or more days per week as compared to those with lower household income levels. Nearly half (48.1 percent) of those with household incomes of \$100,000 per year or more ate the appropriate number of fruits and vegetables, compared to just over one-third (35.1 percent) of those earning less than \$25,000 per year.

Over one-sixth (16.8 percent) of respondents indicated they did not eat five or more fruits and vegetables any day in the previous week. The top reasons for not having eaten five or more fruits and vegetables five or more days of the week included:

- Other reasons, such as being lazy, not having fruits/vegetables on hand, not liking fruits/vegetables, or not being responsible for preparing meals (58.8 percent)
- Not having time to cook (24.4 percent)
- Fruits and vegetables are too expensive (18.4 percent)
- Not knowing how to prepare them (3.7 percent)

**Hospital service area, age, BMI category, education level, and income level have statistically significant relationships with reasons why respondents did not eat the appropriate amount of fruits and vegetables per day.**

- Chambersburg Hospital Service Area residents were more likely than Waynesboro Hospital Service Area residents to cite cost as a reason for not eating five or more fruits and vegetables per day (20.0 percent versus 16.6 percent). Further, Waynesboro Hospital Service Area residents were more likely than Chambersburg Hospital Service Area residents to indicate that not having time to prepare fruits and vegetables was a reason for not eating an appropriate amount of each per day (27.1 percent versus 21.9 percent).
- Younger individuals (less than 65 years of age) were more likely than older individuals (65 years of age or older) to state that cost and time prevented them from eating five or more fruits and vegetables per day. Specifically, 20.5 percent of younger respondents cited cost versus 8.1 percent of older respondents. Also, 27.5 percent of younger respondents indicated that time prevented them from eating an appropriate amount of fruits and vegetables five or more days per week as compared to 9.4 percent of older respondents.
- Individuals with unhealthy BMIs (overweight, obese, and very obese) were much more likely to cite cost as a reason for not eating an appropriate amount of produce as compared to those with a normal BMI (47.9 percent versus 24.8 percent). The same was true for not having enough time to cook (75.9 percent of those with an unhealthy BMI versus 23.9 percent of those with a normal BMI cited this as a reason for not eating five or more fruits and vegetables five or more days per week).
- Respondents with lower formal education levels were more likely to state that cost was a factor in preventing them from eating an appropriate number of fruits and vegetables five or more days per week. Specifically, 29.1 percent of those with less than a high school diploma cited this reason, compared to 8.2 percent of those with a bachelor's degree or higher. Further, time was a greater factor for those with higher education levels, as nearly one-third (29.4 percent) of those with a bachelor's degree or higher cited not having time to cook, compared to 18.4 percent of those with less than a high school diploma.
- Those with lower household income levels were more likely to indicate that cost was a factor in not eating five or more fruits and vegetables per day. Specifically, just over one-third (33.6 percent) of those living in households earning less than \$25,000 per year stated this reason, compared to only 6.0 percent of those living in households earning \$100,000 per year. Additionally, time was cited more often as a reason for not eating five or more fruits and vegetables, five or more days per week by those with higher income levels. For example, nearly one-third (31.2 percent) of those living in households earning \$100,000 per year or more indicated that this was a reason for not eating an appropriate amount of fruits and vegetables, compared to 21.1 percent of those earning less than \$25,000 per year.



An integral part of maintaining good nutrition is having access to grocery stores that offer fresh fruits, vegetables, meats, fish, and poultry, as well as canned and frozen foods. According to 2010 data obtained from the U.S. Census Bureau's County Business Patterns, Franklin County had 19.4 such establishments per 100,000 people, compared to 21.3 for Pennsylvania and 21.8 for the United States, leaving Franklin County under the statewide and nationwide averages.

A similar measure of food insecurity is percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract where a substantial number or share of residents has low access to a supermarket or large grocery store. According to the U.S. Department of Agriculture's Food Desert Locator, 8.2 percent of Franklin County's population (10,536 people) lived in food deserts in 2009, compared to just 4.9 percent of Pennsylvania residents. On the other hand, Franklin County's percentage was lower than the United State rate of 9.1 percent.

A final measure often used to assess a population's food insecurity is the number of food stores and other retail establishments per 100,000 population that are authorized to accept WIC program benefits (Special Supplemental Nutrition Program for Women, Infants, and Children), and that carry WIC-designated foods and food categories. According to the U.S. Department of Agriculture's Food Environment Atlas, in 2012, Franklin County had a rate of 10.6 such food stores and retail establishments per 100,000 population, compared to 16.6 for Pennsylvania and 15.6 for the United States, leaving Franklin County's population significantly below the statewide and national rates.

#### Infant Mortality

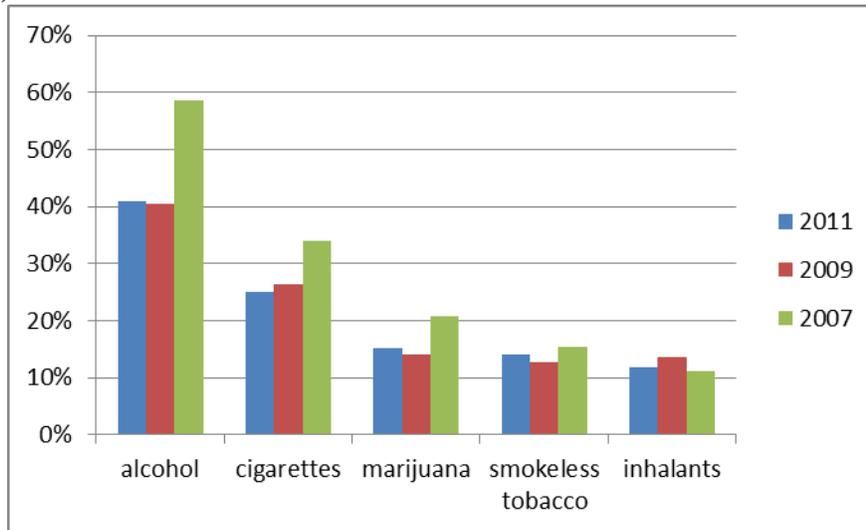
A final important clinical measure used to monitor a community's health status is the infant mortality rate. According to the Centers for Disease Control and Prevention's National Vital Statistics System, Franklin County's death rate of infants less than one year of age per 1,000 births was 6.2 for 2003-2009, compared to 7.4 for Pennsylvania and 6.7 for the United States. Franklin County's rate was below both the statewide and national rates.

#### *Youth Tobacco and Substance Abuse*

Assessing prevalence of tobacco use and substance abuse among youth is an important tool in gauging not only social factors affecting a community's health status, but also potential health trends as the upcoming generation ages. The Pennsylvania Youth Survey (PAYS) is a survey of secondary school students on their behavior, attitudes and knowledge concerning alcohol, tobacco, other drugs, and violence. Questions are asked of 6th, 8th, 10th and 12th grade public school students. The survey is sponsored by the Pennsylvania Commission on Crime and Delinquency (PCCD) and is conducted every two years. For a list of findings from the Pennsylvania Youth Survey, see Appendix I.

Prevalence-of-use rates in Franklin County dropped between 2007 and 2011 for alcohol, cigarettes and marijuana (both lifetime and past-30-day usage). However, the rates for smokeless tobacco and inhalants varied over the time period. For each drug in the questionnaire, the prevalence-of-use rates increased with grade level in 2011. Alcohol use among Franklin county 12<sup>th</sup> graders was lower than usage rates in both Pennsylvania and the nation in 2011. See Figure 18 for a depiction of alcohol, tobacco and other drug use by year.

**Figure 18. Alcohol, Tobacco and Other Drug Use by Year (highest lifetime prevalence-of-use rates), 2007-2011**



As the report noted, focusing prevention planning in high risk and low protection areas could be especially beneficial. The highest risk factors identified included community disorganization, perceived availability of handguns, and a prevalence of parental attitudes that are favorable toward antisocial behavior. Each of these factors had high risk scores in Franklin County in each of the three years analyzed: 2007, 2009 and 2011.

Community disorganization (students' feelings and perceptions regarding their communities and other external attributes) was the highest risk factor in each of the three years. This risk factor also had a greater variance across grade levels than the other two risk factors in 2011 (from a low of 62 among 8th graders to a high of 74 among 6th graders). This variance was smaller in both 2009 and 2007.

Protective factors are conditions that help youth by reducing risk impact or changing a person's response to risk. The lowest protection area in both 2011 and 2009 was Community Opportunities for Prosocial Involvement, such as sports teams, scouting, boys and girls clubs, 4-H clubs, and service clubs. Religiosity, or how often students attend religious services or activities, was also a low protection area in each of the three years.

### *Teen Births*

Because of the unique social, economic, and health support services needed for teen mothers, a number of indicators related to teen births were explored. According to the Centers for Disease Control and Prevention's National Vital Statistics Systems, the rate of total births to women ages 15-19 per 1,000 female population ages 15-19 for Franklin County was 42.8 during the 2003-2009 time period. This was much higher Pennsylvania's rate and slightly higher than the nation's rate (30.8 and 41.2, respectively).

A related measure provided by the Pennsylvania Department of Health for the 2007-2009 time period indicated that the pregnancy rate among females ages 15-17 per 1,000 female population ages 15-17 in Franklin County was 18.3, compared to 23.2 for Pennsylvania.

A final measure provided by the Pennsylvania Department of Health’s County Health Profiles shows that the percent of births to women under the age of 18 in Franklin County was 2.7 percent, which was the same percent for Pennsylvania.

*Accidents/Mortality*

Accidents can be prevented and are an important consideration to monitor when assessing the health of a community. Various accident types are reported here for purposes of better understanding what areas warrant attention.

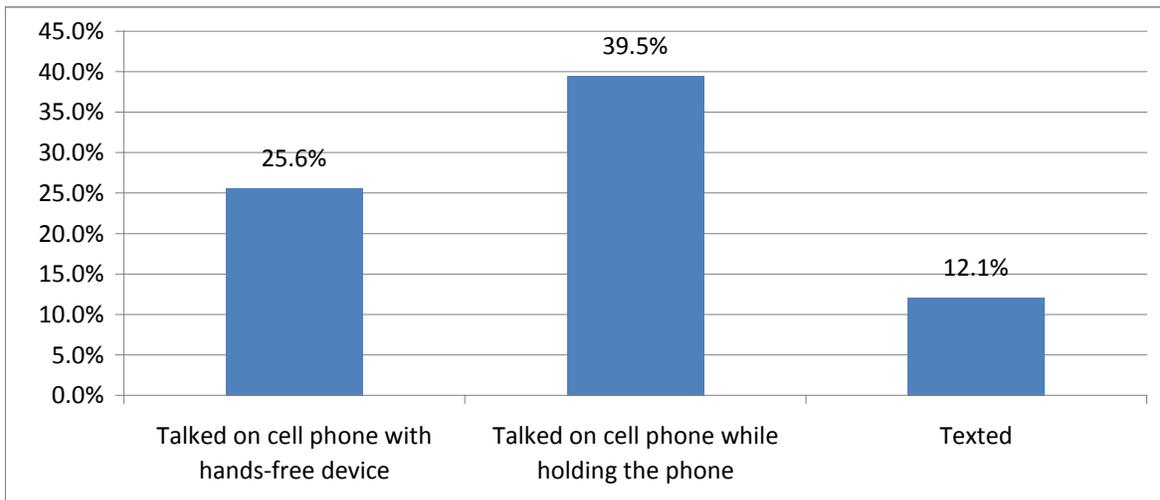
The motor vehicle crash death rate per 100,000 population includes: collisions with another motor vehicle, a non-motorist, a fixed object, or a non-fixed object; overturned vehicles; and any other non-collision reported by the National Highway Traffic Safety Administration Fatality Analysis Reporting System. For the 2008-2010 time period, Franklin County experienced a rate of 12.9 motor vehicle crash deaths per 100,000 population. This was higher than the motor vehicle crash death rates for both Pennsylvania and the United States (10.5 and 11.1 deaths per 100,000 population, respectively).

Another important measure considered is accidental falls that result in death. The Pennsylvania Department of Health reports for the 2005-2009 time period that the accidental fall death rate per 100,000 population for Franklin County was 8.5, compared to 7.3 for Pennsylvania.

Another related measure is unintentional injury which results in death. The Pennsylvania Department of Health reports for the 2005-2009 time period that the unintentional injury death rate per 100,000 population for Franklin County was 39.5, compared to 40.3 for Pennsylvania.

In addition to reviewing accidental death rates, it is also important to look at risky behaviors that can lead to unintentional injuries and deaths. Cell phone behaviors while driving is one such behavior, since it can lead to motor vehicle accidents and deaths. Figure 19 outlines Community Survey 2012 respondents’ reported cell phone behaviors while driving in the previous month.

**Figure 19. Cell Phone Use While Driving in the Past Month, Community Survey 2012**



More than one-quarter (25.6 percent) of survey respondents stated that they have talked on their cell phone with a hands-free device (such as a Bluetooth wireless headset or in-car hands-free device) while driving in the previous month.

**Sex, age, BMI category, education level, and income level were found to have statistically significant relationships with talking on a cell phone with a hands-free device while driving. There were no statistically significant differences between the hospitals' service areas.**

- Males (28.8 percent) were more likely than females (22.7 percent) to report having talked on their cell phone with a hands-free device while driving in the previous month.
- Younger respondents were more likely to use a hands-free device while driving than older respondents. Specifically, respondents 25-34 years old (35.3 percent), 35-44 years old (33.1 percent), 45-54 years old (31.5 percent), and 18-24 years old (22.8 percent), were most likely to do so.
- Respondents with a higher education level were more likely to report that they used a cell phone with a hands-free device while driving in the previous month. Over one-third (38.6 percent) of those with a bachelor's degree or higher and almost one-quarter (24.7 percent) of individuals with vocational school/some college used a cell phone with a hands-free device while driving. This was in contrast to respondents with less than a high school education (14.1 percent) and high school graduates (17.4 percent).
- Individuals residing in households with lower incomes were less likely to talk on a cell phone using a hands-free device than those with greater household incomes. For example, only 12.5 percent of those living in households earning less than \$25,000 per year reported used a hands-free device versus 43.5 percent of those living in households earning \$100,000 or more per year.

Nearly two out of five (39.5 percent) survey respondents indicated that they have talked on their cell phone while holding the phone when driving in the previous month.

**Sex, age, education level, and income level were found to have statistically significant relationships with talking on a cell phone while holding the phone when driving in the past month. There were no statistically significant differences between the hospitals' service areas.**

- Males (44.2 percent) were more likely than females (35.2 percent) to talk on their cell phone while holding the phone when driving.
- Younger respondents were much more likely to talk on their cell phone while holding the phone when driving. For example, over half of respondents ages 25-34 (60.4 percent) and 35-44 (51.7 percent) indicated that they talked on their cell phone while holding the phone when driving in the previous month, compared to just 15.4 percent of those 65 years of age or older.
- Those with higher education levels were more likely to talk on their cell phone while holding the phone and driving than those with lower education levels. Specifically, over

half (54.9 percent) of respondents with a bachelor's degree or higher did this versus only one-quarter (25.1 percent) of those with less than a high school education.

- Individuals living in households with higher household incomes were much more likely to talk on their cell phone while holding the phone when driving than those living in households with lower incomes. In fact, over two-thirds (70.7 percent) of respondents living in households with incomes of \$100,000 or more and over half (56.4 percent) of those living in households with incomes of \$60,000 to \$99,999 indicated that they talk on their cell phone while holding the phone and driving. In contrast, less than one-quarter (23.9 percent) of respondents living in households earning less than \$25,000 reported talking on their cell phone while holding the phone and driving in the previous month.

Further, 12.1 percent of respondents reported texting while driving in the previous month.

**Age, education level, and income level were found to have statistically significant relationships with texting while driving in the past month. There were no statistically significant differences between the hospitals' service areas.**

- Younger respondents, specifically those ages 18-24 (19.3 percent) and those ages 25-34 (36.2 percent), were much more likely to text while driving than older respondents. Only 2.6 percent of respondents ages 55-64 and less than one percent (0.6 percent) of respondents ages 65-74 reported that they texted while driving in the previous month.
- Respondents with higher education levels were more likely to report texting while driving than those with less education. For example, those with a bachelor's degree or higher were most likely to indicate that they texted while driving (19.7 percent) versus those with less than a high school education (4.5 percent) and high school graduates (5.2 percent).
- Individuals living in households with higher household incomes were more likely to text while driving than those living in households earning less. Specifically, individuals living in a household with an income of \$100,000 or more were much more likely to report texting while driving than those who lived in a household with an income of less than \$25,000 (22.4 percent versus 6.4 percent respectively).

#### *Environmental Conditions*

Environmental conditions can significantly impact overall health and health conditions and must be monitored as part of assessing a community's health status. Air quality, for example, can play a role in causing serious respiratory issues. According to the Centers for Disease Control and Prevention's National Environmental Public Health Tracking Network, the percentage of days with particulate matter 2.5 levels above the National Ambient Air Quality Standard (35 micrograms per cubic meter) per year was 1.0 percent for Franklin County as compared to 0.8 percent for Pennsylvania and 1.2 percent for the United States.

## HEALTH/HEALTHCARE PRIORITIES

With input from the Advisory Group, Summit Health used all of the data collected, including the results of the community survey and secondary demographic and health data analyses, to compile a list of the 13 health- and healthcare-related items that affect the highest proportions of Summit Health Service Area community members. A list of selected health and healthcare items considered in identifying priorities is presented in Appendix A. The 13 priority items identified for future action were:

- Nutrition
- Education
- Access to Healthcare
- Mental Health
- Uninsured/Underinsured Populations
- Obesity
- Chronic Conditions
- Physical Activity Promotion
- Cancer Prevention
- Teen Births/Infant Mortality
- Dental Care
- Accident/Mortality Prevention
- Poor Air Quality

Summit Health staff then conducted an exercise using the Simplex Method with the Community Health Needs Assessment Advisory Group to prioritize the health and healthcare needs of the community. The Simplex Method is a widely used process that provides a means of scoring multiple items to determine which have the most relevance to participants.

The results of this exercise determined that **Nutrition, Education, Access to Healthcare** and **Mental Health** were the highest priorities to the CHNA Advisory Group. Members of the CHNA Advisory Group then self-selected into one of the four priority areas to develop implementation plans.

### **Nutrition** (*Impacting an estimated 87,000 Summit Health Service Area residents*)

Factors considered in determining this priority included the following:

- Grocery store access, defined as establishment rate per 100,000 population, was 19.8 for Franklin County in 2010, compared to over 21 for the state and the United States.
- The population living in food deserts, defined as low income census tracts where a substantial number of residents have low access to a supermarket, was 8.1 percent for Franklin County in 2009, compared to 4.9 percent for Pennsylvania and 9.1 percent for the United States.
- Access to Women, Infant and Children (WIC) -authorized food stores, defined by food store WIC acceptance rate per 100,000 population, was 10.6 for Franklin County in 2012, compared to 16.6 for Pennsylvania and 15.6 for United States.
- Inadequate food and vegetable consumption, defined as the proportion of individuals not eating five or more fruits and vegetables a day, was reported by almost two-thirds of Summit Health Service Area residents in 2012.

**Education** (*Impacting an estimated 19,000 Franklin County residents*)

Healthy People 2020 has found that higher education attainment is directly related to life expectancy, health, and quality of life. Factors considered in determining this priority included the following:

- The high school graduation rate for Franklin County residents in 2012 was 81.7 percent, compared to 80.5 percent for Pennsylvania and 75.5 percent for the United States.
- During the 2006-2010 time period, the percentage of persons not having a high school diploma was 16.6 percent for Franklin County residents compared to 12.6 percent for Pennsylvania and 15.0 percent for the United States.

**Access to Healthcare** (*Impacting an estimated 12,000 Summit Health Service Area residents*)

Factors considered in determining this priority included the following:

- Primary Care Physician Access, defined by the number of primary care providers per 100,000 population in 2011, was 61.4 for Franklin County, compared to 95.9 for Pennsylvania and 84.7 for the United States. Franklin County's rate was 36.0 percent lower than that of Pennsylvania.
- The percentage of Summit Health Service Area residents reporting in the Community Survey that they had a family doctor in 2012 was 81.8 percent.
- Population living in a health professional shortage area (HPSA,) defined as the percent of the designated population that was underserved in 2012, was 100 percent for Franklin County compared to 56.7 percent for Pennsylvania and 60.8 percent for the United States.

**Mental Health** (*Impacting an estimated 80,000 Summit Health Service Area residents*)

Factors considered in determining this priority included the following:

- A high level of stress, as defined by individuals having a self-reported moderate, high, or very high stress level on a typical day in 2012, affected over half (59.3 percent) of Summit Health Service Area residents according to the Community Survey.
- The suicide rate, as defined by the rate per 100,000 population during the 2005-2009 time period, was 11.0 in Franklin County compared to 11.4 for Pennsylvania.

## **IMPLEMENTATION STRATEGIES**

This report is a culmination of the work completed to date, which will be used to develop and monitor community collaboration efforts designed to improve health service offerings and disease prevention efforts in the Chambersburg and Waynesboro Hospital Service Areas.

The Advisory Group members and their respective organizations have committed to continuing regular meetings to address and monitor the priority health concerns identified through this Assessment. In addition to the implementation plans outlined by the Advisory Group, and in concordance with the 2010 Patient Protection and Affordable Care Act, Chambersburg and Waynesboro Hospitals have formulated specific action/implementation plans to address the health-related priorities identified by the CHNA. The plans will be included with their respective IRS 990 submissions.

**APPENDIX A. SUMMARY OF KEY CHNA FINDINGS AND DATA SOURCES**

*NOTE: A number in red indicates that it has increased or is higher for Franklin County than the state and/or United States.*

	Franklin Co.	PA	US	HP2020 Target	Data Source	# of Residents Affected	Trend
<b>Obesity</b>							
Adults with a BMI of 30.0+ (self-reported)	31.10%	28.82%	27.35%		1	33,768	
Adults with a BMI of 30.0+	30.30%	n/a	n/a		2		Increasing
Adults with a BMI of 30.0+	32.80% (2008) 36.50% (2012)	n/a	n/a		17, 3	48,914	
BMI>=95th Percentile (obese) Grades K-6	18.20%	16.80%	n/a	14.60%	4	1,930	Steady
Child BMI>=95th Percentile (obese) Grades 7-12	20.00%	18.20%	n/a	14.60%	4	1,663	Increasing
<b>Nutrition</b>							
Grocery store access:							
Establishment rate per 100,000 pop	19.38	21.3	21.83		5		
Population living in food deserts	8.15%	4.91%	9.10%		6	10,536	
WIC authorized food access stores:							
Food store rate per 100,000 pop	10.6	16.6	15.6		7		
Consume less than 5 servings of fruit and vegetables each day (self-reported)	79.90%	72.62%	71.96%		8	86,750	
Did NOT eat 5+ fruits/vegetables in past week	61.30%	n/a	n/a		3	22,514	
<b>Physical Activity</b>							
Recreation and facility access:							
Establishment rate per 100,000 pop	10.69	11.07	9.68		9		
Percent physically inactive	25.60%	24.00%	24.60%		10	27,795	
No physical activity in a normal week	20%	n/a	n/a		3	26,802	
<b>Heart Disease</b>							
Death rate per 100,000 pop	110.5	143.9	n/a	100.8	11	308	Decreasing
Had heart attack	6.00%	n/a	n/a		3	8,041	
Age adjusted death rate per 100,000 pop	104.18	132.93	134.65	<=100.8	12	200	
Percent of adults with heart disease	4.88%	5.12%	4.26%		13	5,438	
<b>Stroke</b>							
Have ever had a stroke	3.10%	n/a	n/a		3	4,154	
Death rate per 100,000 pop	37.15	41.88	41.78	<=33.8	14	72	
<b>Blood Cholesterol</b>							
High blood cholesterol	25.00% (1996) 38.80% (2008) 36.80% (2012)	n/a	n/a		16, 17, 3	49,316	Decreasing
Adults told blood cholesterol is high	n/a	38%	n/a		15		
<b>Blood Pressure</b>							
High blood pressure	25.90% (1996) 34.40% (2008) 39.60% (2012)	n/a	n/a		16, 17, 3	53,069	Increasing
Percent of adults not taking blood pressure medication	19.06%	18.55%	21.74%		18	21,241	
<b>Diabetes</b>							
Death rate	105.8	71.8	n/a	65.8	19	67	Increasing
Have diabetes (Type I and II)	10.30%	n/a	n/a		3	13,803	Decreasing
Percent with diabetes	8.60%	8.87%	8.77%		20	10,692	
<b>Asthma Prevalence</b>							
Percent of adults with asthma	14.35%	13.15%	13.09%		21	15,992	
Percent of children with asthma	19%	n/a	n/a		3	7,774	
<b>Mental Health</b>							
Moderate, high, or very high stress level on a typical day	63.30% (2008) 59.3% (2012)	n/a	n/a		17, 3	79,469	Increasing
Depression	19.50%	n/a	n/a		3		
Suicide death rates	12.32	11.57	11.57		22	19	Increasing
Suicide rates per 100,000 pop	11	11.4	n/a	10.2	11	19	
<b>Uninsured/Underinsured</b>							
No health insurance	5.3% (1996) 7.4% (2008) 11.8% (2012)	n/a	n/a		16, 17, 3	15,813	Increasing
Lack of health insurance	15%	n/a	n/a		23	18,737	Steady
Health insurance coverage	85%	88%	n/a		24	105,253	
Under age 65	15.10%	n/a	n/a		25		
Percentage of the total civilian non-institutionalized population without health insurance coverage	12.77%	9.67%	15.05%		26	18,662	
Children without health insurance	7.10% (2008) 13.40% (2012)	n/a	n/a		17, 3	5,483	Increasing
<b>Dental</b>							
Had dental insurance	55.8% (2008) 54.6% (2012)	n/a	n/a		17, 3	73,170	
Did NOT visit dentist on regular basis	9.4% (2008) 11.5% (2012)	n/a	n/a		17, 3	15,411	
Poor dental health	19.97%	18.41%	15.57%		27	22,255	
<b>Healthcare Access</b>							
Primary care provider rate per 100,000	61.4	95.9	84.7		28		
Have healthcare provider	95.90%	n/a	n/a		3	128,518	Steady
Population living in a health professional shortage area (HPSA) - percentage underserved	100%	56.67%	60.80%		29	1,564	
Walk-in/Urgent care usage	71.00%	n/a	n/a		3		

**SUMMARY OF KEY CHNA FINDINGS AND DATA SOURCES (Continued)**

<b>Prescription Drug Coverage</b>								
Have prescription drug coverage		82.10%		n/a	n/a		3	
Did not fill a prescription because of cost	7.4% (1996)	10.90% (2008)	12.70% (2012)	n/a	n/a		16, 17, 3	
<b>Education</b>								
High school graduation rate		81.7		80.5	75.5	>82.4	30	
No high school diploma		16.23%		12.59%	14.97%		31	16,168
No high school diploma for persons 25+ in service area		16.60%		12.60%	14.97%		32	18,782
								Decreasing
<b>Births</b>								
Pregnancy rate among females 15-17 per 1,000 females		18.3		23.2	n/a	36.2	33	47
								Steady
Percent of births to women under 18		2.70%		2.70%	n/a		34	
Teen mothers 15-19 per 1,000 births		42.8		30.80	41.20		35	1,288
Infant mortality Rate per 1,000 births		6.24		7.38	6.71	<=6.0	36	81
Infant mortality rate per 1,000 live births		5.8		7.3	n/a	6	11	
								Steady
<b>Accident/Mortality</b>								
DUI		497.89		420	n/a		37	
Cell phone use while driving and holding the phone		39.50%		n/a	n/a		3	52,935
Cell phone use while driving and using a hands-free device		25.60%		n/a	n/a		3	34,307
Texting while driving		12.10%		n/a	n/a		3	16,215
Motor vehicle crash Death rate per 100,000 pop		17.2		11.9	n/a	12.4	11	25
								Decreasing
Motor vehicle crash Average annual death rate per 100,000 pop		12.92		10.5	11.13	<=12.4	38	19
Accidental falls Death rate per 100,000 pop		8.5		7.3	n/a	7	11	76
								Steady
Unintentional injury Death rate per 100,000 pop		39.5		40.3	n/a	36	11	305
								Decreasing
Unintentional injury Age adjusted death rate per 100,000 pop		40.15		40.59	39.07	<=36.0	39	63
<b>Poor Air Quality</b>								
Particulate matter 2.5		1.02%		0.75%	1.16%		40	146,558

	Franklin Co.				PA				US	HP2020 Target	Data Source	Trend
	2005-2009	2008	2009	2010	2005-2009	2008	2009	2010				
<b>Breast</b>												
Breast cancer death rate	19.2	n/a	n/a	n/a	24.4	n/a	n/a	n/a	n/a	20.6	11, 4	Steady
# of cancer deaths (top 5, 4 out of 5)	n/a	8	23	17	n/a	2,083	2,111	2,071	n/a		11, 4	
# of cancer cases (top 5, 3 out of 5)	n/a	122	110	117	n/a	9,708	10,255	10,421	n/a		11, 4	
Annual incidence rate per 100,000 pop	126.4	n/a	n/a	n/a	125.8	n/a	n/a	n/a	122		11	
<b>Cervical</b>												
# of cancer deaths	n/a	1	3	2	n/a	166	176	149	n/a		11, 4	
# of cancer cases	n/a	6	12	8	n/a	560	535	559	n/a		11, 4	
Annual incidence rate per 100,000 pop	11.3	n/a	n/a	n/a	8	n/a	n/a	n/a	8	7.1	11	
<b>Lung</b>												
# of cancer deaths (top 5, 1 out of 5)	n/a	100	89	74	n/a	7868	7702	7729	n/a		11, 4	
# of cancer cases	n/a	130	120	117	n/a	10671	10593	10608	n/a		11, 4	
<b>Pancreas</b>												
# of cancer deaths	n/a	19	28	23	n/a	1768	1773	1882	n/a		11, 4	
# of cancer cases	n/a	21	26	22	n/a	1916	1973	1948	n/a		11, 4	
<b>Colon/Rectal</b>												
Death rate per 100,000 pop	17.5	n/a	n/a	n/a	18.6	n/a	n/a	n/a	n/a	14.5	11, 4	Steady
# of cancer deaths	n/a	30	36	25	n/a	2783	2749	2755	n/a		11, 4	
# of cancer cases	n/a	87	109	87	n/a	7738	7480	7316	n/a		11, 4	
Annual incidence rate per 100,000 pop	49.4	n/a	n/a	n/a	50.9	n/a	n/a	n/a	40.2	38.6	11, 4	
<b>Prostate</b>												
Death rate per 100,000 pop	18.3	n/a	n/a	n/a	24.7	n/a	n/a	n/a	n/a	21.2	11, 4	Decreasing
# of cancer deaths	n/a	10	13	10	n/a	1451	1338	1363	n/a		11, 4	
# of cancer cases	n/a	124	140	117	n/a	11150	10098	9742	n/a		11, 4	
Annual incidence rate per 100,000 pop	146.9	n/a	n/a	n/a	154.1	n/a	n/a	n/a	151.4		11, 4	
<b>Bladder</b>												
# of cancer deaths	n/a	12	10	5	n/a	754	787	792	n/a		11, 4	
# of cancer cases	n/a	36	39	47	n/a	3850	3906	3845	n/a		11, 4	
<b>Leukemia</b>												
# of cancer deaths	n/a	19	16	14	n/a	1193	1157	1127	n/a		11, 4	
# of cancer cases	n/a	35	27	21	n/a	1806	1769	1937	n/a		11, 4	
<b>Melanoma</b>												
Annual incidence rate per 100,000 pop	27.6 Males 24.0 Females	n/a	n/a	n/a	22.5 Males 15.7 Females	n/a	n/a	n/a	n/a		11, 4	
<b>Cancer Mortality</b>												
Age adjusted death rate per 100,000 pop	172.77	n/a	n/a	n/a	185.2	n/a	n/a	n/a	176.66	160.6	11, 4	

**SUMMARY OF KEY CHNA FINDINGS AND DATA SOURCES (Continued)**

#	Data Source	Notes	Website (if applicable)
1	Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009. Source geography: County.	This indicator reports the percentage of adults aged 18 and older who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese).	<a href="http://www.chna.org">www.chna.org</a>
2	Franklin Co. Prosperity Index Report (rank 4-5 of 5) CDC, Behavioral Risk Factor Surveillance System: BMI 30+ - 2010		
3	2012 CHNA Community Survey		
4	PADOH 2009-2010		
5	U.S. Census Bureau, County Business Patterns, 2010	This indicator reports the number of grocery stores per 100,000 population. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Included are delicatessen-type establishments. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores are excluded.	<a href="http://www.chna.org">www.chna.org</a>
6	U.S. Department of Agriculture, Food Desert Locator, 2009. Source geography: Tract (2000).	This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract (where a substantial number or share of residents has low access to a supermarket or large grocery store).	<a href="http://www.chna.org">www.chna.org</a>
7	U.S. Department of Agriculture, Food Environment Atlas, 2012. Source geography: County.	This indicator reports the number of food stores and other retail establishments per 100,000 population that are authorized to accept WIC Program (Special Supplemental Nutrition Program for Women, Infants, and Children) benefits and that carry designated WIC foods and food categories.	<a href="http://www.chna.org">www.chna.org</a>
8	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2003-2009.	This indicator reports the percentage of adults aged 18 and older who self-report consuming less than 5 servings of fruits and vegetables each day.	<a href="http://www.chna.org">www.chna.org</a>
9	U.S. Census Bureau, County Business Patterns, 2010. Source geography: County.	This indicator reports the number per 100,000 population of recreation and fitness facilities as defined by North American Industry Classification System (NAICS) Code 713940.	<a href="http://www.chna.org">www.chna.org</a>
10	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2004-2010. Source geography: County.	This indicator reports the percentage of adults aged 18 and older who self-report no leisure time for activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"	<a href="http://www.chna.org">www.chna.org</a>
11	PADOH 2005-2009		
12	Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010. Accessed through CDC WONDER. Source geography: County.	This indicator reports the rate of death due to coronary heart disease per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummairized for report areas from county level data, only where data is available.	<a href="http://www.chna.org">www.chna.org</a>
13	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010. Source geography: County.	This indicator reports the percentage of adults aged 18 and older who have ever been told by a doctor that they have coronary heart disease or angina.	<a href="http://www.chna.org">www.chna.org</a>
14	Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010. Accessed through CDC WONDER. Source geography: County.	This indicator reports the rate of death due to cerebrovascular disease (stroke) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummairized for report areas from county level data, only where data is available.	<a href="http://www.chna.org">www.chna.org</a>
15	PADOH 2011		
16	1996 CHNA Report		
17	2008 CHNA Report		
18	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010. Source geography: County.	This indicator reports the percentage of adults aged 18 and older who self-report that they are not taking medication for their high blood pressure.	<a href="http://www.chna.org">www.chna.org</a>
19	PADOH 2009		
20	Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009. Source geography: County.	This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes.	<a href="http://www.chna.org">www.chna.org</a>

**SUMMARY OF KEY CHNA FINDINGS AND DATA SOURCES (Continued)**

#	Data Source	Notes	Website (if applicable)
21	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010. Source geography: County.	This indicator reports the percentage of adults aged 18 and older who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma.	<a href="http://www.chna.org">www.chna.org</a>
22	Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010. Accessed through CDC WONDER. Source geography: County.	This indicator reports the rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummairized for report areas from county level data, only where data is available.	<a href="http://www.chna.org">www.chna.org</a>
23	Census Data, 2010		
24	PADOH 2010		
25	Franklin co. Prosperity Index, Census, Small Area Health Insurance Estimates; American Community Survey 1 yr. est's - 2010.		
26	U.S. Census Bureau, 2008-2010 American Community Survey 3-Year Estimates. Source geography: PUMA.	This indicator reports the percentage of the total civilian non-institutionalized population without health insurance coverage.	<a href="http://www.chna.org">www.chna.org</a>
27	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-2010. Source geography: County.	This indicator reports the percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection.	<a href="http://www.chna.org">www.chna.org</a>
28	U.S. Health Resources and Services Administration Area Resource File, 2011 . Source geography: County.	This indicator reports the number of primary care physicians per 100,000 population.	<a href="http://www.chna.org">www.chna.org</a>
29	U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012. Source geography: HPSA.	This indicator reports the percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals.	<a href="http://www.chna.org">www.chna.org</a>
30	The University of Wisconsin, Population Health Institute, County Health Rankings, 2012 and the U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe Survey Data, 2005-06, 2006-07 and 2007-08. Source geography: County.	This indicator reports the average freshman graduate rate, which measures the percentage of students receiving their high school diploma within four years.	<a href="http://www.chna.org">www.chna.org</a>
31	U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates. Source geography: Tract.	This indicator reports the percentage of the population aged 25 and older without a high school diploma (or equivalency) or higher.	<a href="http://www.chna.org">www.chna.org</a>
32	Census Data U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates. (MCD summary).		
33	PADOH 2007-2009		
34	Franklin Co. Prosperity Index Report (rank 4-5 of 5), PA Dept. of Health , County Health Profiles - 2011.		
35	Centers for Disease Control and Prevention, National Vital Statistics Systems, 2003-2009. Accessed through the Health Indicators Warehouse. Source geography: County.	This indicator reports the rate of total births to women under the age of 15 - 19 per 1,000 female population age 15 - 19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.	<a href="http://www.chna.org">www.chna.org</a>
36	Centers for Disease Control and Prevention, National Vital Statistics System, 2003-2009. Source geography: County.	This indicator reports the rate of deaths to infants less than one year of age per 1,000 births.	<a href="http://www.chna.org">www.chna.org</a>
37	Franklin Co Prosperity Index report (rank 5 of 5) Pa State Police , Uniform Crime Reporting System: Part 2 Offenses; rate per 100,000 - 2010.		
38	National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2008-2010. Source geography: County.	This indicator reports the rate of death due to motor vehicle crashes per 100,000 population, which include collisions with another motor vehicle, a nonmotorist, a fixed object, and a non-fixed object, an overturn, and any other non-collision.	<a href="http://www.chna.org">www.chna.org</a>
39	Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010. Accessed through CDC WONDER. Source geography: County.	This indicator reports the rate of death due to unintentional injury (accident) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummairized for report areas from county level data, only where data is available.	<a href="http://www.chna.org">www.chna.org</a>
40	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008. Source geography: Tract.	This indicator reports the percentage of days with particulate matter 2.5 levels above the National Ambient Air Quality Standard (35 micrograms per cubic meter) per year, calculated using data collected by monitoring stations and modeled to include counties where no monitoring stations occur.	<a href="http://www.chna.org">www.chna.org</a>

## **APPENDIX B. DESCRIPTION OF DATA SOURCES UTILIZED**

A brief description of each data source utilized in the CHNA follows:

### **American Community Survey (ACS), U.S. Census Bureau**

The American Community Survey (ACS) is a monthly survey conducted by the Census Bureau to replace the census long form in 2010. The 2005-2009 file is the first release of data for all geographic areas that provided the data at the municipal level. The next release of data will be the 2006-2010 file, which is scheduled for release in December of this year and then each year after that.

<http://www.census.gov/acs/www/>

### **Behavioral Risk Factor Surveillance System**

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual telephone survey implemented nationwide under a grant from the Centers for Disease Control and Prevention. Since 1989, the Pennsylvania Department of Health has released annual reports using BRFSS data on various health risk behaviors, such as smoking, drinking, seatbelt usage, and health status. Data is available at the state and regional levels. Franklin County is in the Adams, Franklin and Fulton counties region.

### **Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death, 2006-2010**

The Underlying Cause of Death data available on Center for Disease Control WONDER are county-level national mortality and population data spanning the years 1999-2010. Data are based on death certificates for U.S. residents. Each death certificate identifies a single underlying cause of death and demographic data. The number of deaths, crude death rates or age-adjusted death rates, and 95% confidence intervals and standard errors for death rates can be obtained by place of residence (total U.S., region, division, state, and county), age group (single-year-of age, 5-year age groups, 10-year age groups and infant age groups), race, Hispanic ethnicity, gender, year, month and week day of death, and cause-of-death (4-digit ICD-10 code or group of codes). Data are also available for injury intent and injury mechanism, drug/alcohol induced causes and urbanization categories, as well as place of death and whether an autopsy was performed.

<http://wonder.cdc.gov/wonder/help/ucd.html>

### **Centers for Disease Control and Prevention, National Diabetes Surveillance System, 2009**

The National Diabetes Surveillance System provides resources documenting the public health burden of diabetes and its complications in the United States. The surveillance system includes county-level estimates of diagnosed diabetes and selected risk factors for all U.S. counties to help target and optimize the resources for diabetes control and prevention.

<http://apps.nccd.cdc.gov/DDTSTRS/default.aspx>

## DESCRIPTION OF DATA SOURCES UTILIZED (Continued)

### **Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network**

The National Environmental Public Health Tracking Network (Tracking Network) is a system of integrated health, exposure, and hazard information and data from a variety of national, state, and city sources.

<http://ephtracking.cdc.gov/showHome.action>

### **County Health Rankings & Roadmaps**

<http://www.countyhealthrankings.org/app/pennsylvania/2012/franklin/county/1/overall>

### **Healthy People 2020, Pennsylvania Department of Health**

Healthy People 2020 Pennsylvania projects health risks using information from BRFSS and the Pennsylvania Health Care Cost Containment Council for Franklin County.

<http://www.portal.state.pa.us/portal/server.pt?open=514&objID=590079&mode=2>

### **National Highway Traffic Safety Administration, Fatality Analysis Reporting System (FARS), 2008-2010**

FARS is a nationwide census providing NHTSA, Congress and the American public yearly data regarding fatal injuries suffered in motor vehicle traffic crashes.

<http://www.nhtsa.gov/FARS>

### **Pennsylvania Department of Health County Health Profiles 2011**

<http://www.portal.state.pa.us/portal/server.pt?open=514&objID=596007&mode=2>

### **Pennsylvania State Police, Uniform Crime Reporting System**

<http://www.paucrs.pa.gov/UCR/ComMain.asp?SID=>

### **Pennsylvania Youth Survey (PAYS)**

The Pennsylvania Youth Survey (PAYS) is a survey of secondary school students on their behavior, attitudes and knowledge concerning alcohol, tobacco, other drugs and violence. Questions are asked of 6th, 8th, 10th and 12th grade public school students. The survey is sponsored by the Pennsylvania Commission on Crime and Delinquency (PCCD) and is conducted every two years.

<http://portal.co.franklin.pa.us/WebLink8public/Browse.aspx?startid=2089497&dbid=0>

## DESCRIPTION OF DATA SOURCES UTILIZED (Continued)

### **University of Wisconsin, Population Health Institute, County Health Rankings, 2012**

The *County Health Rankings* rank the health of nearly every county in the nation and show that much of what affects health occurs outside of the doctor's office. The *County Health Rankings* confirm the critical role that factors such as education, jobs, income, and environment play in how healthy people are and how long they live.

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

### **U.S. Census Bureau, County Business Patterns, 2010**

County Business Patterns (CBP) is an annual series that provides subnational economic data by industry. This series includes the number of establishments, employment during the week of March 12, first quarter payroll, and annual payroll. This data is useful for studying the economic activity of small areas; analyzing economic changes over time; and as a benchmark for other statistical series, surveys, and databases between economic censuses.

<http://www.census.gov/econ/cbp/>

### **U.S. Census Bureau Decennial Census**

The April 2000 and 2010 U.S. Decennial Censuses were used to extract information at the municipal level on total population, age, and race/ethnicity.

<http://census.gov/>

### **U.S. Department of Agriculture, Food Desert Locator, 2009**

The Food Desert Locator has been replaced by the Food Access Research Atlas, a mapping tool that allows users to investigate multiple indicators of food store access. This new tool expands upon the Food Desert Locator by updating previous estimates of food desert census tracts, incorporating alternative estimates of low-income and low-access census tracts, and offering contextual information for all census tracts in the United States.

<http://www.ers.usda.gov/data-products/food-desert-locator.aspx#.UUddCBverKM>

### **U.S. Department of Agriculture, Food Environment Atlas, 2012**

Food environment factors--such as store/restaurant proximity, food prices, food and nutrition assistance programs, and community characteristics--interact to influence food choices and diet quality. Research is beginning to document the complexity of these interactions, but more is needed to identify causal relationships and effective policy interventions.

The objectives of the Atlas are to assemble statistics on food environment indicators to stimulate research on the determinants of food choices and diet quality, and to provide a spatial overview of a community's ability to access healthy food and its success in doing so.

<http://www.ers.usda.gov/data-products/food-environment-atlas.aspx#.UUddIByerKM>

## **DESCRIPTION OF DATA SOURCES UTILIZED (Continued)**

### **U.S. Department of Education, National Center for Education Statistics (NCES), Common Core of Data, Public School Universe Survey Data, 2005-06, 2006-07, and 2007-08**

The primary purposes of the Public Elementary/Secondary School Universe Survey are to provide a complete listing of all public elementary and secondary schools in the country; and to provide basic information and descriptive statistics on all schools, their students, and their teachers.

<http://nces.ed.gov/ccd/pubschuniv.asp>

### **U.S. Department of Health and Human Services Leading Health Indicators**

<http://www.healthypeople.gov/2020/LHI/Default.aspx>

### **U.S. Health Resources and Services Administration Area Resource File, 2011**

The basic county-specific Area Resource File (ARF) is the nucleus of the overall ARF System. It is a database containing more than 6,000 variables for each of the nation's counties. ARF contains information on health facilities, health professions, measures of resource scarcity, health status, economic activity, health training programs, and socioeconomic and environmental characteristics. In addition, the basic file contains geographic codes and descriptors which enable it to be linked to many other files and to aggregate counties into various geographic groupings.

<http://arf.hrsa.gov/>

### **U.S. Health Resources and Services Administration, Health Professional Shortage Area File, 2012**

Health Resources and Services Administration develops shortage designation and uses them to decide whether or not a geographic area, population group or facility is a Health Professional Shortage Area or a Medically Underserved Area or Population.

<http://hrsainyourstate.hrsa.gov/hpsadetail.aspx>

### **1996 Summit Health Community Health Needs Assessment Report**

### **2008 Summit Health Community Health Needs Assessment Report**

### **2012 CHNA Focus Groups**

### **2012 CHNA Community Survey**

## APPENDIX C. HOSPITAL SERVICE AREA DEFINITIONS

### Zip Codes Included in Service Areas

#### *Chambersburg Hospital Service Area*

17201	Chambersburg	Franklin, PA
17202	Chambersburg	Franklin, PA
17210	Amberson	Franklin, PA
17217	Concord	Franklin, PA
17219	Doylesburg	Franklin, PA
17220	Dry Run	Franklin, PA
17221	Fannettsburg	Franklin, PA
17222	Fayetteville	Franklin, PA
17224	Fort Loudon	Franklin, PA
17231	Lemasters	Franklin, PA
17232	Lurgan	Franklin, PA
17235	Marion	Franklin, PA
17236	Mercersburg	Franklin, PA
17240	Newburg	Cumberland, PA
17244	Orrstown	Franklin, PA
17246	Pleasant Hall	Franklin, PA
17251	Roxbury	Franklin, PA
17252	Saint Thomas	Franklin, PA
17254	Scotland	Franklin, PA
17257	Shippensburg	Cumberland, PA
17262	Spring Run	Franklin, PA
17265	Upper Strasburg	Franklin, PA
17270	Williamson	Franklin, PA
17271	Willow Hill	Franklin, PA

#### *Waynesboro Hospital Service Area*

17214	Blue Ridge Summit	Franklin, PA
17225	Greencastle	Franklin, PA
17237	Mont Alto	Franklin, PA
17247	Quincy	Franklin, PA
17250	Rouzerville	Franklin, PA
17256	Shady Grove	Franklin, PA
17261	South Mountain	Franklin, PA
17263	State Line	Franklin, PA
17268	Waynesboro	Franklin, PA
17272	Zullinger	Franklin, PA

**HOSPITAL SERVICE AREA DEFINITIONS (Continued)**

**Municipalities Included in Service Areas**

*Chambersburg Hospital Service Area*

Hopewell township	Cumberland
Newburg borough	Cumberland
Newville borough	Cumberland
North Newton township	Cumberland
Shippensburg borough	Cumberland
Shippensburg township	Cumberland
Southampton township	Cumberland
South Newton township	Cumberland
Upper Mifflin township	Cumberland
Chambersburg borough	Franklin
Fannett township	Franklin
Greene township	Franklin
Guilford township	Franklin
Hamilton township	Franklin
Letterkenny township	Franklin
Lurgan township	Franklin
Mercersburg borough	Franklin
Metal township	Franklin
Montgomery township	Franklin
Orrstown borough	Franklin
Peters township	Franklin
St. Thomas township	Franklin
Shippensburg borough	Franklin
Southampton township	Franklin
Warren township	Franklin

*Waynesboro Hospital Service Area*

Antrim township	Franklin
Greencastle borough	Franklin
Mont Alto borough	Franklin
Quincy township	Franklin
Washington township	Franklin
Waynesboro borough	Franklin

**APPENDIX D. SUMMIT HEALTH SERVICE AREA DEMOGRAPHIC PROFILE**

	2010			
	Chambersburg Hospital Service Area	Waynesboro Hospital Service Area	Summit Health Service Area	Pennsylvania
<b>Population (Census 2010, SF1)</b>				
Total	124,218	50,712	174,930	12,702,379
<b>Population by Age</b>				
Under 5	7,964	3,371	11,335	729,538
Age 5 to 9	7,762	3,306	11,068	753,635
Age 10 to 14	7,938	3,461	11,399	791,151
Age 15 to 17	5,013	2,103	7,116	517,831
Age 18 to 19	4,663	1,551	6,214	387,235
Age 20 to 21	4,605	1,108	5,713	375,199
Age 22 to 24	4,999	1,614	6,613	498,947
Age 25 to 29	7,134	2,982	10,116	781,527
Age 30 to 34	6,919	2,909	9,828	729,592
Age 35 to 39	7,669	3,283	10,952	764,287
Age 40 to 44	7,778	3,611	11,389	851,382
Age 45 to 49	8,511	3,876	12,387	955,763
Age 50 to 54	8,578	3,518	12,096	984,641
Age 55 to 59	7,928	3,254	11,182	879,048
Age 60 to 64	7,035	2,918	9,953	743,296
Age 65 to 69	5,885	2,389	8,274	553,002
Age 70 to 74	4,495	1,743	6,238	426,536
Age 75 to 79	3,752	1,419	5,171	362,332
Age 80 to 84	2,900	1,226	4,126	311,761
Age 85 and older	2,690	1,070	3,760	305,676
<b>Population by Race (Census 2010, SF1)</b>				
White Alone	113,669	47,878	161,547	10,406,288
Black or African American Alone	4,234	1,131	5,365	1,377,689
American Indian and Alaska Native Alone	222	111	333	26,843
Asian Alone	1,098	428	1,526	349,088
Native Hawaiian and Other Pacific Islander Alone	23	7	30	3,653
Some Other Race Alone	2,604	372	2,976	300,983
Two or More Races	2,368	785	3,153	237,835
Hispanic or Latino Ethnicity	5,731	1,183	6,914	719,660
<b>Households (Census 2010, SF1)</b>				
Total Households	47,526	19,670	67,196	5,018,904
<b>Family households</b>				
Husband-wife family	26,294	11,153	37,447	2,417,765
with children under 18	10,111	4,461	14,572	974,627
Male householder, no wife present	2,120	937	3,057	229,495
with children under 18	1,402	632	2,034	124,658
Female householder, no husband present	4,274	1,867	6,141	614,047
with children under 18	2,865	1,247	4,112	380,265
Nonfamily households	14,838	5,713	20,551	1,757,597
Householder living alone	11,607	4,726	16,333	1,433,415
<b>Households with one or more people 65 years and over</b>				
65 years and over Not Living Alone	8,397	3,427	11,824	826,037
65 years and over Living Alone	5,022	1,972	6,994	572,625
Average household size	2.58	2.50	2.57	2.45
Average family size	3.01	2.96	3.00	3.02
<b>Group Quarters (Census 2010, SF1)</b>				
Institutionalized population	922	463	1,385	197,112
Noninstitutionalized population	3,394	527	3,921	229,001
<b>Marital Status (ACS 2006-2010 5-year Estimates)</b>				
Never married	27,338	9,777	37,115	3,245,176
Now married, except separated	52,752	22,325	75,077	4,963,368
Separated	1,568	817	2,385	226,570
Widowed	6,641	2,582	9,223	766,481
Divorced	8,653	3,808	12,461	933,335

**SUMMIT HEALTH SERVICE AREA DEMOGRAPHIC PROFILE (Continued)**

	2010			
	Chambersburg Hospital Service Area	Waynesboro Hospital Service Area	Summit Health Service Area	Pennsylvania
<b>Language Spoken at Home (ACS 2006-2010 5-year Estimates)</b>				
Population 5 years and over	113,908	46,421	160,329	11,885,430
Speak English only	105,062	44,668	149,730	10,710,239
Speak Spanish	4,457	575	5,032	490,488
Speak English less than "very well" (linguistically isolated)	1,961	124	2,085	193,689
<b>Educational Attainment (ACS 2006-2010 5-year Estimates)</b>				
Population 25 years and over	79,965	33,166	113,131	8,558,693
Less than high school graduate	13,752	5,030	18,782	1,077,224
High school graduate (includes equivalency)	34,464	14,471	48,935	3,236,194
Some college or Associates degree	16,744	7,986	24,730	1,987,219
Bachelor's degree	9,273	3,538	12,811	1,396,618
Graduate or professional degree	5,732	2,141	7,873	861,438
Percent high school graduate or higher	82.8	84.8	83.4	87.4
Percent bachelor's degree or higher	18.8	17.1	18.3	26.4
<b>Unemployment Rate (ACS 2006-2010 5-year Estimates)</b>				
<b>Population 16 years and over</b>				
<b>AGE</b>				
Total	6.0	5.5	5.9	7.3
16 to 19 years	16.9	10.9	15.0	22.8
20 to 24 years	7.3	9.9	8.0	13.2
25 to 44 years	5.7	6.4	5.9	6.5
45 to 64 years	4.6	3.0	4.1	5.0
65 years and over	3.2	2.3	2.9	4.8
<b>RACE</b>				
White alone	5.8	5.4	5.7	6.3
Black or African American alone	12.8	9.1	11.8	14.9
Other race alone	6.1	8.9	6.7	10.5
Hispanic or Latino Origin	9.3	25.9	10.3	12.8
<b>EDUCATIONAL ATTAINMENT</b>				
Less than high school graduate	6.9	11.3	8.0	12.6
High school graduate (includes equivalency)	5.3	5.4	5.3	7.1
Some college or Associate's degree	5.9	4.1	5.2	5.7
Bachelor's degree or higher	3.1	1.9	2.7	3.1
<b>Household Income (ACS 2006-2010 5-year Estimates)</b>				
Total households	47,379	19,578	66,957	4,940,581
Less than \$10,000	2,443	828	3,271	358,330
\$10,000 to \$14,999	2,629	893	3,522	289,547
\$15,000 to \$24,999	5,121	2,201	7,322	559,425
\$25,000 to \$34,999	5,535	2,251	7,786	539,934
\$35,000 to \$49,999	8,305	3,055	11,360	705,090
\$50,000 to \$74,999	10,063	4,525	14,588	938,866
\$75,000 to \$99,999	6,532	2,565	9,097	610,403
\$100,000 to \$149,999	4,976	2,202	7,178	577,062
\$150,000 to \$199,999	1,024	571	1,595	188,172
\$200,000 or more	751	487	1,238	173,752
<b>Percent Below Poverty (ACS 2006-2010 5-year Estimates)</b>				
<b>By Age</b>				
Total	9.6	7.3	8.9	12.4
Under 5 years	14.4	17.5	15.3	20.4
Under 18 years	11.9	9.7	11.3	17.3
18 to 64 years	9.5	6.7	8.7	11.5
65 years and older	6.3	6.1	6.3	8.6

**SUMMIT HEALTH SERVICE AREA DEMOGRAPHIC PROFILE (Continued)**

	2010			
	Chambersburg Hospital Service Area	Waynesboro Hospital Service Area	Summit Health Service Area	Pennsylvania
<b>Percent below Poverty (ACS2006-2010 5-Year Estimates) (Continued)</b>				
<b>Families</b>				
Total	5.6	4.7	5.3	8.5
Married-couple families	3.5	1.9	3.0	3.6
with related children under 18 years	4.1	3.2	3.8	4.9
Male householder, no wife present	11.0	11.5	11.1	13.4
with related children under 18 years	13.3	8.2	12.0	19.3
Female householder, no husband present	17.2	18.9	17.8	27.7
with related children under 18 years	24.9	27.4	25.7	37.8
<b>Housing (ACS 2006-2010 5-year Estimates)</b>				
Total housing units	47,379	19,578	66,957	4,940,581
Owner-occupied housing units	34,498	14,555	49,053	3,508,612
Renter-occupied housing units	12,881	5,023	17,904	1,431,969
Homeowner vacancy rate	1.6	0.6	1.3	1.8
Rental vacancy rate	5.0	5.6	5.1	6.9
<b>YEAR STRUCTURE BUILT (ACS 2006-2010 5-year Estimates)</b>				
Built 2005 or later	2,105	1,035	3,140	119,718
Built 2000 to 2004	4,087	1,641	5,728	264,485
Built 1990 to 1999	7,614	2,918	10,532	516,857
Built 1980 to 1989	6,482	2,334	8,816	547,902
Built 1970 to 1979	7,456	2,843	10,299	709,691
Built 1960 to 1969	4,826	1,905	6,731	557,650
Built 1950 to 1959	4,854	1,948	6,802	781,952
Built 1940 to 1949	2,548	1,225	3,773	473,674
Built 1939 or earlier	10,588	4,741	15,329	1,565,379
<b>VEHICLES AVAILABLE (ACS 2006-2010 5-year Estimates)</b>				
Occupied housing units	47,379	19,578	66,957	4,940,581
No vehicles available	2,956	755	3,711	561,878
1 vehicle available	13,836	5,687	19,523	1,670,106
2 vehicles available	18,771	7,864	26,635	1,828,956
3 or more vehicles available	11,816	5,272	17,088	879,641
<b>SELECTED MONTHLY COSTS AS A PERCENTAGE OF INCOME (ACS 2006-2010 5-year Estimates)</b>				
Owner-occupied	34,498	14,555	49,053	3,508,612
Less than 20 percent	18,033	7,250	25,283	1,696,183
20 to 34.9 percent	10,609	4,765	15,374	1,092,990
35 percent or more (cost burden)	5,668	2,491	8,159	700,440
<b>GROSS RENT AS A PERCENTAGE OF INCOME (ACS 2006-2010 5-year Estimates)</b>				
Renter-occupied	12,881	5,023	17,904	1,431,969
Less than 20 percent	3,789	1,553	5,342	353,348
20 to 34.9 percent	4,301	1,742	6,043	438,346
35 percent or more (cost burden)	3,852	1,438	5,290	523,669
<b>Means of Transportation to Work (ACS 2006-2010 5-year Estimates)</b>				
Workers 16 years and over	56,033	24,214	80,247	5,799,572
Car, truck, or van -- drove alone	44,641	19,994	64,635	4,433,186
Car, truck, or van -- carpooled	6,321	2,082	8,403	546,102
Public transportation (excluding taxicab)	221	133	354	312,308

**APPENDIX E. HEALTHY PEOPLE 2020 LEADING HEALTH INDICATORS BY TOPIC AREA**

<b>Topic Area</b>	<b>Leading Health Indicator</b>
Access to Health Services	Persons with medical insurance
	Persons with a usual primary care provider
Clinical Preventative Services	Adults who receive a colorectal cancer screening based on the most recent guidelines
	Adults with hypertension whose blood pressure is under control
	Adult diabetic population with an A1c value greater than 9 percent
	Children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines
Environmental Quality	Air Quality Index (AQI) exceeding 100
	Children aged 3 to 11 years exposed to secondhand smoke
Injury and Violence	Fatal injuries
	Homicides
Maternal, Infant, and Child Health	Infant deaths
	Preterm births
Mental Health	Suicides
	Adolescents who experience major depressive episodes (MDE)
Nutrition, Physical Activity, and Obesity	Adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity
	Adults who are obese
	Children and adolescents who are considered obese
	Total vegetable intake for persons aged 2 years and older
Oral Health	Persons aged 2 years and older who used the oral health care system in the past 12 months
Reproductive and Sexual Health	Sexually active females aged 15 to 44 years who received reproductive health services in the past 12 months
	Persons living with HIV who know their serostatus
Social Determinants	Students who graduate with a regular diploma 4 years after starting 9th grade
Substance Abuse	Adolescents using alcohol or any illicit drugs during the past 30 days
	Adults engaging in binge drinking during the past 30 days
Tobacco	Adults who are current cigarette smokers
	Adolescents who smoked cigarettes in the past 30 days

## APPENDIX F. LEADING HEALTH INDICATORS AND RELATED OBJECTIVE DATA FROM HEALTHY PEOPLE 2020

Leading Health Indicators from Healthy People 2020						
<i>Updated: 7/16/2012 - (Green text indicates Franklin County surpassed the target; Red text indicates Franklin County did not meet the target)</i>						
Leading Health Indicators	Target	US	PA	Franklin County	Year of data	Units
<b>Access to Health Services</b>						
Persons with medical insurance (AHS-1.1) - data for persons under age 65 <sup>(1)</sup>	100%	83%	88%	85%	2009	Percent
Persons with a usual primary care provider (AHS-3) - adults with specific source of ongoing care <sup>(2) (3)</sup>	83.9%	75.6%	86.0%		2008/2010	Percent
Ratio of population to primary care physicians from 'County Health Rankings'			838:1	1034:1	2009	Ratio
<b>Clinical Preventive Services</b>						
Adults who receive a colorectal cancer screening based on the most recent guidelines (C-16) <sup>(2)</sup>	70.5%	54.2%			2008	Percent
Colorectal cancer death rate <sup>(3)</sup>	14.5		18.6	17.5	2005-2009	deaths per 100,000 population
Adults with hypertension whose blood pressure is under control (HDS-12) <sup>(2)</sup>	61.2%	43.7%			2005-2008	Percent
Coronary Heart Disease Death Rate <sup>(3)</sup>	100.8		143.9	110.5	2005-2009	deaths per 100,000 population
Stroke Death Rate <sup>(3)</sup>	33.8		44.6	38.6	2005-2009	deaths per 100,000 population
Adult diabetic population with an A1c value greater than 9 percent (D-5.1) <sup>(2)</sup>	14.6%	16.2%			2005-2008	Percent
Diabetes death rate <sup>(3)</sup>	65.8		71.8	105.8	2009	deaths per 100,000 population
Children aged 19 to 35 months who receive the recommended doses of DTaP, polio,MMR,Hib,hepatitis B, varicella, and PCV vaccines (IID-8) <sup>(2) (3)</sup>	80.0%	44.3%	63.9%		2009	Percent
<b>Environmental Quality</b>						
Air Quality Index (AQI) exceeding 100 (EH-1) <sup>(2) (3)</sup>	10	11	26		2008	days
Children aged 3 to 11 years exposed to secondhand smoke (TU-11.1) <sup>(2)</sup>	47.0%	52.2%			2005-2008	Percent
<b>Injury and Violence</b>						
Fatal injuries (IVP-1.1) <sup>(2)</sup>	53.3	56.3			2009	deaths per 100,000 population
Poisoning death rate <sup>(3)</sup>	13.1		15.3	8.7	2005-2009	deaths per 100,000 population
Unintentional injury death rate <sup>(3)</sup>	36.0		40.3	39.5	2005-2009	deaths per 100,000 population
Motor vehicle crash death rate <sup>(3)</sup>	12.4		11.9	17.2	2005-2009	deaths per 100,000 population
Accidental falls death rate <sup>(3)</sup>	7.0		7.3	8.5	2005-2009	deaths per 100,000 population
Homicides (IVP-29) <sup>(2) (3)</sup>	5.5	5.5	5.9	DSU	2009	homicides per 100,000 population
<b>Maternal, Infant and Child Health</b>						
Infant deaths (MICH-1.3) (Per 1,000 live births) <sup>(2) (3)</sup>	6.0	6.8	7.3	5.8	2005-2009	per 1,000 live births
Preterm births (MICH-9.1) (Percent of live births) <sup>(2) (3)</sup>	11.4	12.2	10.2	9.8	2007-2009	% of live births (preterm < 37 weeks)
<b>Mental Health</b>						
Suicides (MHMD-1) <sup>(2) (3)</sup>	10.2	11.6	11.4	11.0	2005-2009	per 100,000 population
Adolescents who experience major depressive episodes (MDE) (MHMD-4.1) <sup>(2)</sup>	7.4%	8.3%			2008	Percent
<b>Nutrition, Physical Activity, and Obesity</b>						
Adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity (PA-2.4) <sup>(2)</sup>	20.1%	19.0%			2009	Percent
Adults who are obese (NWS-9) <sup>(2) (3)</sup>	30.6%	35.7%	29.0%		2009-2010	Percent
Children and adolescents who are considered obese (NWS-10.4) <sup>(2)</sup>	14.6%	16.9%			2009-2010	Percent
Children in grades K-6 who are considered obese <sup>(4)</sup>	14.6%		16.8%	18.2%	2009-2010	Percent
Children in grades 7-12 who are considered obese <sup>(4)</sup>	14.6%		18.2%	20.0%	2009-2010	Percent
Total vegetable intake for persons aged 2 years and older (NWS-15.1) <sup>(2)</sup>	1.1	0.8			2001-2004	cup equivalents per 1,000 calories
<b>Oral Health</b>						
Persons aged 2 years and older who used the oral health care system in the past 12 months (OH-7) <sup>(2)</sup>	49.0%	44.5%			2007	Percent
<b>Reproductive and Sexual Health</b>						
Sexually active females aged 15 to 44 years who received reproductive health services in the past 12 months (FP-7.1) <sup>(2)</sup>	86.5%	78.6%			2006-2010	Percent
Pregnancy rate among adolescent females aged 15-17 <sup>(3)</sup>	36.2		23.2	18.3	2007-2009	per 1,000 females 15-17
Persons living with HIV who know their serostatus (HIV-13) (percent) <sup>(2)</sup>	90.0%	79.0%			2006	Percent
AIDS Incidence Rates <sup>(3)</sup>	13.0		11.0	4.4	2005-2009	cases per 100,000 age 13+

**LEADING HEALTH INDICATORS AND RELATED OBJECTIVE DATA  
FROM HEALTHY PEOPLE 2020 (Continued)**

<b>Leading Health Indicators from Healthy People 2020</b>						
<i>Updated: 7/16/2012 - (Green text indicates Franklin County surpassed the target; Red text indicates Franklin County did not meet the target)</i>						
<b>Leading Health Indicators</b>	<b>Target</b>	<b>US</b>	<b>PA</b>	<b>Franklin County</b>	<b>Year of data</b>	<b>Units</b>
<b>Social Determinants</b>						
Students who graduate with a regular diploma 4 years after starting 9th grade (AH-5.1) <sup>(2)</sup>	82.4%	74.9%			2007-2008	Percent
Percent of persons aged 18-24 who completed high school <sup>(1)</sup>	97.9%		84.0%		2010	Percent
<b>Substance Abuse (data from National Survey on Drug Use and Health)</b>						
Adolescents using alcohol or any illicit drugs during the past 30 days (SA-13.1) <sup>(2)</sup>	16.5%	18.3%			2008	Percent
Adults engaging in binge drinking during the past 30 days (SA-14.3) <sup>(2) (3)</sup>	24.3%	27.0%	15.0%		2008	Percent
<b>Cirrhosis Death Rates <sup>(3)</sup></b>	8.2		7.5	4.6	2005-2009	deaths per 100,000 population
<b>Tobacco</b>						
Adults who are current cigarette smokers (TU-1.1) <sup>(2) (3)</sup>	12.0%	20.6%	18.0%		2008	Percent
Adolescents who smoked cigarettes in the past 30 days (TU-2.2) <sup>(2)</sup>	16.0%	19.5%			2009	Percent
<b>Other</b>						
<b>Breast Cancer Death Rate</b>	20.6	22.9	24.4	19.2	2005-2009	Percent
<b>Prostate Cancer Death Rate</b>	21.6	23.5	24.7	18.3	2005-2009	Percent
Rates are per 100,000 population unless noted otherwise						
DSU - Data statistically unreliable						
<sup>(1)</sup> Source: U.S. Census Bureau American Community Survey						
<sup>(2)</sup> Source: Healthy People 2020 National Indicators						
<sup>(3)</sup> Source: Healthy People 2020 PA Department of Health Indicators - Note: If County data was reported PA data is data reported for "all counties" in County report otherwise PA data is data reported in statewide report						
<sup>(4)</sup> Source: PA Department of Health School Year 2009-10 - Data is reported annually by Educational Institutions						

**APPENDIX G. HEALTHY PEOPLE 2020:  
SELECTED OBJECTIVES WITH FRANKLIN COUNTY DATA AVAILABLE**

Leading Health Indicators from Healthy People 2020 Objectives with Franklin County Data Available														
	Franklin County					Pennsylvania					HP 2020 Target		Number of Franklin County Residents Affected	
<i>green text indicates Franklin County surpassed the target</i>											Number	Difference*	Number	Time Period
<i>red text indicates Franklin County did not meet the target</i>	2005-09	2004-08	2003-07	2002-06	2001-05	2005-09	2004-08	2003-07	2002-06	2001-05				
<b>Coronary Heart Disease Death Rate<sup>1</sup></b>	110.5	117.1	127.7	133.4	135.7	143.9	151.6	159.4	167.1	173.2	100.8	9.7	308	2010
<b>Stroke Death Rate<sup>1</sup></b>	38.6	43	48.9	50.5	52.4	44.6	46.8	49.2	51.1	52.5	33.8	4.8	80	2010
<b>Motor Vehicle Crash Death Rate<sup>1</sup></b>	17.2	18.5	20.7	18.5	17.2	11.9	12.3	12.4	12.6	12.6	12.4	4.8	25	2010
<b>Unintentional Injury Death Rate<sup>1</sup></b>	39.5	40	41.7	38.5	37.6	40.3	40.2	39.2	38	37	36	3.5	305	2005-2009
<b>Colorectal Cancer Death Rate<sup>1</sup></b>	17.5	16.5	17.3	16.3	16.9	18.6	19	19.5	20.1	20.7	14.5	3	25	2010
<b>Accidental Falls Death Rate<sup>1</sup></b>	8.5	6.9	7	6.1	6.3	7.3	7	6.5	6	5.6	7	1.5	76	2005-2009
<b>Suicide Rate<sup>1</sup></b>	11	9.8	9.3	8.7	9	11.4	11.1	10.9	10.8	10.6	10.2	0.8	19	2010
<b>Infant Mortality Rate<sup>2</sup></b>	5.8	5.8	5.6	5.8	5.9	7.3	7.3	7.3	7.4	7.3	6	-0.2	12	2010
<b>Breast Cancer Death Rate<sup>1</sup></b>	19.2	18.4	23.3	22.5	24.4	24.4	25.1	25.7	26.4	27	20.6	-1.4	17	2010
<b>Prostate Cancer Death Rate<sup>1</sup></b>	18.3	19.3	21	23.5	24.3	24.7	25.8	26.7	27.4	27.7	21.2	-2.9	10	2010
<b>Cirrhosis Death Rate<sup>1</sup></b>	4.6	4.2	4	4.9	5.9	7.5	7.4	7.5	7.7	7.9	8.2	-3.6	6	2010
<b>Poisoning Death Rate<sup>1</sup></b>	8.7	8.3	8.2	7.1	6.6	15.3	14.7	13.9	12.8	11.7	13.1	-4.4	61	2005-2009
<b>AIDS Incidence Rate (cases per 100,000 age 13+)</b>	4.4	3.8	4.2	3.9	3.6	11	12	12.8	12.9	13	13	-8.6	11	2010
	2009	2008	2007	2006	2005	2009	2008	2007	2006	2005				
<b>Diabetes Death Rate<sup>1</sup></b>	105.8	89.8	87.1	98	113.1	71.8	75.9	78.6	80.7	80	65.8	40	67	2010
	2009-10	2008-09	2007-08	2006-07	2009-10	2008-09	2007-08	2006-07						
<b>BMI&gt;=95th Percentile (Obese) Grades 7-12</b>	20.0%	19.2%	18.7%			18.2%	17.2%	17.2%			14.6%	5.4%	1,663	2009-2010
<b>BMI&gt;=95th Percentile (Obese) Grades K-6</b>	18.2%	19.7%	18.8%	19.4%		16.8%	16.4%	16.6%	16.7%		14.6%	3.6%	1,930	2009-2010
	2007-09	2006-08	2005-07	2004-06	2003-05	2007-09	2006-08	2005-07	2004-06	2003-05				
<b>% of Preterm Live Births (&lt;37 weeks)</b>	9.8	10	10.2	10.6	10.3	10.2	10.3	10.3	10.4	10.3	11.4	-1.6	187	2007-2009
<b>Pregnancy Rate among Females 15-17<sup>3</sup></b>	18.3	18.1	17.7	16.8	17	23.2	23.4	23.5	23.4	23.7	36.2	-17.9	47	2010
	2010	2009	2008			2010	2009	2008						
<b>Health Insurance Coverage</b>	85%	83%	86%			88%	88%	89%			100%	-15%	105,253	2010
<sup>1</sup> indicates per 100,000 population														
<sup>2</sup> indicates per 1,000 live births														
<sup>3</sup> indicates pregnancy rate per 1,000 females 15-17														
Health Insurance Coverage persons under age 65														
*= Negative is desired for Difference														
0 is desired for Health Insurance Coverage Difference														
BMI=% of students screened for BMI														

Source: PA Department of Health Healthy People 2020 website and the U.S. Census Bureau's American Community Survey

**APPENDIX H. FOUR VIEWS OF SELECTED HEALTHY PEOPLE 2020 OBJECTIVES WITH FRANKLIN COUNTY DATA AVAILABLE**

**View 1: Current Franklin County rate compared to the Healthy People 2020 Target**

Franklin County favorably meets or exceeds the target for the following eight of the 19 objectives:

- |                            |  |
|----------------------------|--|
| Infant Mortality Rate      | Poisoning Death Rate                             |
| Breast Cancer Death Rate   | AIDS Incidence Rates (cases per 100,000 age 13+) |
| Prostate Cancer Death Rate | Percent of Preterm Live Births                   |
| Cirrhosis Death Rates      | Pregnancy Rate Among Females 15-17               |

Franklin County did not meet the target for the following 11 of the 19 objectives:

- |                                   |  |
|-----------------------------------|--|
| Coronary Heart Disease Death Rate | Suicide Rate                               |
| Stroke Death Rate                 | Diabetes Death Rate                        |
| Motor Vehicle Crash Death Rate    | BMI >= 95th Percentile [Obese] Grades 7-12 |
| Unintentional Injury Death Rate   | BMI >= 95th Percentile [Obese] Grades K-6  |
| Colorectal Cancer Death Rate      | Health insurance Coverage                  |
| Accidental Falls Death Rate       |  |

**View 2: Current Franklin County rate compared to Current Pennsylvania rate**

Franklin County had a more desirable rate than the state for the following 13 of the 19 objectives:

- |                                   |  |
|-----------------------------------|--|
| Coronary Heart Disease Death Rate | Prostate Cancer Death Rate                       |
| Stroke Death Rate                 | Cirrhosis Death Rates                            |
| Unintentional Injury Death Rate   | Poisoning Death Rate                             |
| Colorectal Cancer Death Rate      | AIDS Incidence Rates (cases per 100,000 age 13+) |
| Suicide Rate                      | Percent of Preterm Live Births                   |
| Infant Mortality Rate             | Pregnancy Rate Among Females 15-17               |
| Breast Cancer Death Rate          |  |

Franklin County had a less desirable rate than the state for the following six of the 19 objectives:

- Motor Vehicle Crash Death Rate
- Accidental Falls Death Rate
- Diabetes Death Rate
- BMI >= 95th Percentile [Obese] Grades 7-12
- BMI >= 95th Percentile [Obese] Grades K-6
- Health Insurance Coverage

**FOUR VIEWS OF SELECTED HEALTHY PEOPLE 2020 OBJECTIVES  
WITH FRANKLIN COUNTY DATA AVAILABLE (Continued)**

**View 3: Change in Franklin County rate over data collection time period (2001 – 2009)**

Rates favorably declined throughout the period for the following three of the 19 objectives:

Coronary Heart Disease Death Rate  
Stroke Death Rate  
Prostate Cancer Death Rate

Rates declined and then unfavorably increased during the period for the following five of the 19 objectives:

Suicide Rate  
Infant Mortality Rate  
Cirrhosis Death Rates  
Diabetes Death Rate  
Pregnancy Rate Among Females 15-17

Rates declined and then favorably increased during the period for the following one of the 19 objectives:

Health insurance Coverage

Rates increased and then favorably declined during the period for the following three of the 19 objectives:

Motor Vehicle Crash Death Rate  
Unintentional Injury Death Rate  
Percent of Preterm Live Births

Rates unfavorably increased throughout the period for the following two of the 19 objectives:

Poisoning Death Rate  
BMI  $\geq$  95th Percentile [Obese] Grades 7-12

Rates fluctuated throughout the period for the following five of the 19 objectives:

Colorectal Cancer Death Rate  
Accidental Falls Death Rate  
Breast Cancer Death Rate  
AIDS Incidence Rates (cases per 100,000 age 13+)  
BMI  $\geq$  95th Percentile [Obese] Grades K-6

**FOUR VIEWS OF SELECTED HEALTHY PEOPLE 2020 OBJECTIVES  
WITH FRANKLIN COUNTY DATA AVAILABLE (Continued)**

**View 4: Current Number of Franklin County Residents Affected by Health Indicators**

The Health Indicators affecting the largest number of Franklin County Residents:

Lack of Health Insurance Coverage  
BMI  $\geq$  95th Percentile [Obese] Grades K-6  
BMI  $\geq$  95th Percentile [Obese] Grades 7-12  
Coronary Heart Disease Death Rate  
Unintentional Injury Death Rate

The Health Indicators affecting the least number of Franklin County Residents:

Cirrhosis Death Rates  
Prostate Cancer Death Rate  
AIDS Incidence Rates (cases per 100,000 age 13+)  
Infant Mortality Rate  
Breast Cancer Death Rate

**Summary:**

Objectives that fall in a favorable category regardless of the view:

Prostate Cancer Death Rate

Objectives that fall in an unfavorable category regardless of the view:

BMI  $\geq$  95th Percentile [Obese] Grades 7-12  
BMI  $\geq$  95th Percentile [Obese] Grades K-6

**APPENDIX I. PENNSYLVANIA YOUTH SURVEY DATA: FRANKLIN COUNTY**

<b>PAYS Report Summary 2007, 2009, and 2011</b>			
	<b>2011</b>	<b>2009</b>	<b>2007</b>
<b>Alcohol, Tobacco and Other Drug Use</b>			
<b>highest lifetime prevalence-of-use rates</b>			
alcohol	40.9%	40.5%	58.5%
cigarettes	25.1%	26.4%	34.0%
marijuana	15.1%	14.1%	20.8%
smokeless tobacco	14.0%	12.7%	15.4%
inhalants	11.8%	13.5%	11.1%
<b>highest past-30-day prevalence-of-use rates</b>			
alcohol	19.5%	21.3%	25.3%
cigarettes	10.3%	11.1%	17.4%
marijuana	7.6%	7.3%	9.3%
smokeless tobacco	7.9%	6.7%	8.7%
inhalants	6.6%	7.4%	3.5%
<b>protective factor scales</b>			
School Rewards for Prosocial Involvement	67	64	49
Belief in the Moral Order	65	64	65
School Opportunities for Prosocial Involvement	62	65	52
Community Rewards for Prosocial Involvement	50	48	51
Religiosity	48	49	48
Community Opportunities for Prosocial Involvement	35	33	57
<b>risk factor scales</b>			
Community Disorganization	68	70	53
Perceived Availability of Handguns	59	59	53
Parental Attitudes Favorable toward Antisocial Behavior	55	54	47
Laws and Norms Favorable to Drug Use	51	51	52
Favorable Attitudes toward ATOD Use	44	44	41
Favorable Attitudes toward Antosocial Behavior	43	42	39
Poor Family Management	42	44	42
Friends' Delinquent Behavior	41	40	43
Friends' Use of Drugs	40	40	45
Rebelliousness	40	42	46
Early Initiation of Drug Use	39	40	47

