Community Health Needs Assessment & Strategic Implementation Plan

for 2025-2027

THE MEDICAL CENTER AT FRANKLIN

Med Center Health®

The Medical Center at Franklin

Community Health Needs Assessment & Strategic Implementation Plan

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Organizational Description

Commonwealth Health Corporation (CHC), a non-profit holding company, was formed in 1984. Over the years, CHC has expanded and continues to encompass many other subsidiaries that impact the quality of lives in South Central Kentucky. In 2016, CHC's brand name began as Med Center Health. Within Med Center Health, there are several nonprofit hospital entities under the ownership of Bowling Green-Warren County Community Hospital Corporation (the "Corporation") which include the following: Commonwealth Regional Specialty Hospital; The Medical Center at Franklin (Critical Access Hospital (CAH)); The Medical Center at Scottsville (CAH); The Medical Center at Caverna (CAH); The Medical Center at Albany (CAH); and most recently added in 2024, The Medical Center at Russellville.

The Medical Center at Franklin proudly serves the residents of southern Kentucky and northern Tennessee with the services that allow them to remain close to home for medical care. The hospital's roots reach back to the Franklin-Simpson Memorial Hospital (Hospital) which opened in December 1968. In April 2000, CHC established The Medical Center at Franklin, Inc., as a non-stock, nonprofit Kentucky corporation to acquire the Hospital. In April 2024, The Medical Center at Franklin changed its ownership name within its nonprofit Kentucky Corporation to Bowling Green-Warren County Community Hospital Corporation d/b/a The Medical Center at Franklin.

Bowling Green-Warren County Community Hospital Corporation has been determined by the Internal Revenue Service (the "IRS") to be a charitable organization as described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code") and is exempt from federal income taxation by virtue of Sections 501(a) and 501(c)(3) of the Code.

Since 2000, major facility additions, interior renovations and site development to and within The Medical Center at Franklin facility have been made. They include (1) construction of a replacement 25-bed inpatient care unit to include private rooms with private baths, isolation rooms, a nurse's station, clean and soiled utility rooms and other improvements to meet safety and accessibility requirements; (2) renovation of public and common areas and upgrades of the imaging areas, including the MRI Suite; (3) construction of a new surgery department with two operation suites and an endoscopy room; and (4) upgrading and modernization of the physical plant including a new chiller system, new air handlers, electrical service upgrade and replacement of the emergency generator and fire alarm systems. In addition, a separate office building was constructed to provide office space for specialty clinics and physician services. Also,

additional building space had been constructed to house certain ancillary services and to provide physician office space. In 2016, a building was purchased that houses both a primary care clinic and a physical therapy clinic of CHC.

The Medical Center at Franklin is a Joint Commission accredited, 25-bed dual licensed critical access hospital. The hospital's Emergency Department is staffed with physicians and registered nurses 24 hours per day, 7 days per week. We offer CT, MRI, Digital Mammography, Ultrasound, and Nuclear Medicine services. Radiologists are available to read exams in real time via PACS. The Laboratory and Respiratory Therapy Departments are staffed daily 24 hours per day. Our facility also provides physical rehabilitation services including Physical Therapy, Speech Therapy, and Occupational Therapy. Other services offered include outpatient Cardiopulmonary Rehabilitation, an outpatient behavioral health program and an outpatient chemotherapy program. Telemedicine services are also utilized to provide access to care to various specialty physicians.

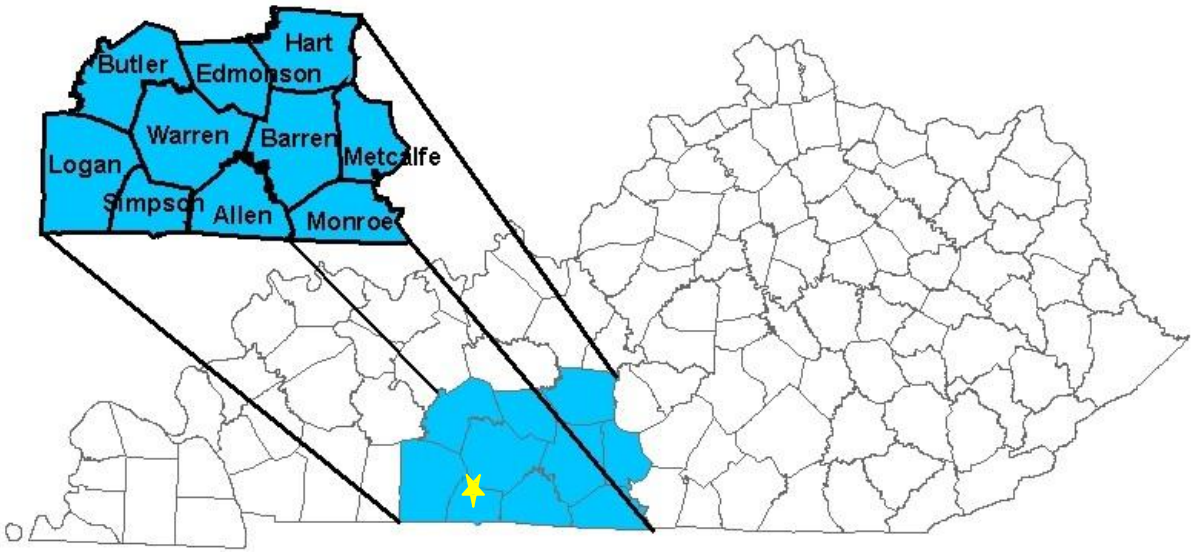
The surgery department includes two operating suites, one endoscopy suite and a six-bed PACU. Services include general surgery, podiatry surgery, otolaryngology surgery, cataract surgery, refractive surgery, orthopedic surgery and urology surgery. There are plans to provide additional specialties in the future.

Currently, we have 3 full-time primary care physicians who have private practices in Franklin. In addition, The Medical Center at Franklin has a provider-based rural health clinic, Med Center Health Primary Care Franklin, that is located off campus. The clinic is staffed with one nurse practitioner and will onboard two full time primary care physicians, 2 part time primary care physicians specializing in Sports Medicine, and 2 full time nurse practitioners in January, 2025. Along with primary care, several specialists hold clinics on the hospital campus to accommodate the local residents. Those specialists include Psychiatry, Obstetrics/Gynecology, Orthopedics, Dermatology, Cardiology, General Surgery, Hematology/Oncology, Neuro Surgery, Vascular Surgery, Urology and Otolaryngology.

Service Area Description

The Medical Center at Franklin is located in South-central Kentucky off Interstate 65, between exits 2 and 6, 2 miles north of the Tennessee state line. Our hospital provides inpatient and outpatient services for residents in Franklin and Simpson County, Kentucky which makes up approximately 66.74% of our discharges. Other patient origins come from Warren County, Kentucky, 12%; Logan County, Kentucky 7%; and Allen County, Kentucky 4%. The other Kentucky counties identified include the following: Adair; Barren; Breathitt; Breckinridge; Bullitt; Butler; Caldwell; Campbell; Christian; Clinton; Cumberland; Daviess; Edmonson; Fayette; Grayson; Hardin; Hart; Hopkins; Madison; Marshall; Mclean; Meade; Metcalfe; Monroe; Montgomery; Muhlenberg; Ohio; Pulaski; Russell; and Shelby. These counties combined account for 2.06% of discharges. During 2022-2024, The Medical Center at Franklin's out-of-state discharges were 6.3%. Of the 6.3%, 89% of these discharges were from Tennessee. Some of the other states included were Alabama, Florida, Georgia, Indiana, Michigan, New York, Ohio and Texas.

☆ The Medical Center at Franklin



Cities and Towns:

The following towns are located in Simpson County, Kentucky with Franklin being the County Seat:

- Franklin
- Gold City
- Middleton
- Prices Mill
- Providence
- Salmons
- Rapids

Adjacent Counties:

- Warren County (north)
- Allen County (east)
- Sumner County, Tennessee (southeast)
- Robertson County, Tennessee (southwest)
- Logan County (west)

Mission, Vision & Values

MISSION

The Medical Center at Franklin's mission is to care for people and improve the quality of life in the communities we serve.

VISION

The Medical Center at Franklin will be an innovative leader in healthcare delivery and outcomes.

WHAT WE VALUE

Quality	We are committed to providing the highest level of care and service at every opportunity.
People	People are our most valuable resource. We work together to achieve our organization's goals. We treat everyone with honor, dignity and respect.
Accountability	Each of us is responsible for managing our resources ethically and wisely.

Community Definition & Description

The City of Franklin is a prosperous community located in Simpson County, Kentucky. Access to a major interstate (I-65) is a major asset for our businesses. The community has been able to maintain a low cost of living while keeping a high quality of life in a "small town America" setting. Franklin, Kentucky is in close proximity to Bowling Green, Kentucky and Nashville, Tennessee which allows for big city amenities nearby. We have state-of-the-art healthcare, arts, culture and recreation opportunities for youth and adults. In addition, an excellent local school system, technical school, nearby universities, colleges and other institutions provide opportunities for higher education.

Demographics

	Simpson County	Kentucky
Population 2024	19,949	4,512,310
% Below 18 Years of Age	22.9%	22.30%
% 65 and Older	17.1%	17.60%
% Non-Hispanic Black	9.0%	8.40%
% American Indian or Alaska Native	0.4%	0.30%
% Asian	0.9%	1.80%
% Native Hawaiian or Other Pacific Islander	0.1%	0.10%
% Hispanic	3.1%	4.30%
% Non-Hispanic White	84.7%	83.20%
% Not Proficient in English	0%	1%
% Female	50.3%	50.30%
% Rural	40.6%	41.30%

https://www.countyhealthrankings.org/health-data/kentucky/simpson?year=2024

According to County Health Rankings, the population estimate for Simpson County was 19,949, a 1.2% growth from 2023 and a 7.8% growth from 2020. There has been an approximate 0.5% increase of individuals at and over the age of 65, and a 1.2% decrease of ages 18 and under.

County Health Rankings

Health

County Health Outcomes/Factors (2024)	Simpson County	Kentucky
Poor or fair health	20%	21%
Poor physical health days	4.6	4.5
Poor mental health days	5.8	5.5
Low birthweight	10%	9%
Adult smoking	21%	20%
Adult Obesity	39%	41%
Physical Inactivity	29%	30%
Access to exercise opportunities	53%	70%
Excessive drinking	15%	15%
Alcohol-impaired driving deaths	21%	26%
Drug overdose death rate	25	43
Sexually transmitted infections	187.6	410.3
Teen births	28	26
Frequent Physical Distress	13%	14%
Frequent Mental Distress	19%	18%
Life Expectancy	72.9	74.0
Premature death (2019-2021)	11,500	11,100
Child Mortality	80	60
Diabetes Prevalence	10%	12%
Food Insecurity	10%	13%
Limited Access to Healthy Foods	7%	6%

https://www.countyhealthrankings.org/health-data/kentucky/simpson?year=2024

Social & Economic Factors

Social & Economic Factors	Simpson County	Kentucky
High School Completion	96%	91%
Some College	57%	63%
Unemployment	3.4%	3.90%
Children in poverty	19%	21%
Children in single-parent household	19%	25%

Median household income	$58,600	$59,200
Suicides	19	17

https://www.countyhealthrankings.org/health-data/kentucky/simpson?year=2024

Clinical Care	Simpson County	Kentucky
Uninsured	6%	7%
Primary-Care Physicians	3940:1	1,600:1
Dentists	1990:1	1,500:1
Mental-Health Providers	1000:1	340:01:00
Preventable Hospital Stays (2021)	3139	3,457
Mammography Screening (2021)	35%	42%
Flu Vaccinations	46%	44%

https://www.countyhealthrankings.org/health-data/kentucky/simpson?year=2024

Physical Environment	Simpson County	Kentucky
Severe housing issues	10%	13%
Broadband access	84%	86%

https://www.countyhealthrankings.org/health-data/kentucky/simpson?year=2024

Purpose

The Community Needs Assessment has been completed for the following reasons:

- To help meet the hospital's mission to care for people and improve the quality of life in the communities we serve.
- To comply with the Patient Protection and Affordable Care Act of 2010 and maintain the hospital's tax-exempt status.
- To establish community health needs for the hospital's service area, to determine areas of greatest need and for the hospital to develop a strategic plan to address those needs.
- To involve internal and external resources in order to ensure needs of individuals are met and that efforts are not duplicated.
- To create a sustainable process for conducting Community Health Needs Assessment that can be continued for future assessments.

Executive Summary

The Patient Protection and Affordable Care Act of 2010 includes a provision that requires every tax exempt, non-governmental hospital to:

- Conduct a Community Health Needs Assessment (CHNA) at least every three years;
- Adopt a Strategic Implementation Plan that includes how the needs identified in the assessment are being met;
- Report to the Internal Revenue Service via its 990-tax form how it is meeting its implementation plan.

The Community Health Needs Assessment Report details the process used to collect, disseminate and prioritize the information in the assessment. Med Center Health used primary data obtained from a community survey in partnership with the BRIGHT Coalition, Barren River Health Department and Grantibly, a local leader in evaluation research consulting.

The end result of the assessment process was the development by the hospital of a strategic plan to address the major needs identified.

The Medical Center at Franklin Implementation Strategies for Addressing Community Health Needs During 2022-2024

Through information received from the Community Health Needs Assessment, feedback from hospital staff and executive leadership, the following strategies were implemented to address our community's health needs during 2022-2024 in the following areas: Obesity/overweight; high blood pressure; diabetes/prediabetes; smoking/vaping; and access to care. In addressing community needs, The Medical Center at Franklin collaborated with other community stakeholders in efforts to improve health in Simpson County and surrounding areas.

Priority Issue: Obesity/overweight with children and adults.

Goals:

- Increase knowledge of healthy eating habits to assist with reducing obesity in children and adults.
- Assist with reducing obesity rates with children and adults.

Community Partners:

- Barren River District Health Department
- Medicaid Managed Care Program/Case Management
- Franklin Simpson Boys & Girls Club
- Franklin Simpson Schools
- Local Industries
- Franklin Simpson Chamber of Commerce
- Med Center Health Work Life Program
- Med Center Health Primary Care Franklin
- Franklin-Simpson Chamber of Commerce

Activities/Outcomes 2022-2024:

- April 7, 2022: Social media post on "Making Family Fitness Fun" to provide ideas for family activity while promoting health and preventing chronic conditions, reached 106 people.
- July 26, 2022: Social media post, "Surgical Weight Loss Program", reached 98 people.
- August 13, 2022: Sponsored the Annual Garden Spot 5K Run/Walk with over 500 participants.

- October 2022: Med Center Health 10K Classic, 1100 participants
- October 2022: Body Fat Analysis and healthy recipe handouts at SKYCTC Health Fair, 45 participants.
- August 12, 2023: Sponsored Garden Spot 5K Run/Walk in Simpson County, over 500 participants.
- February 6, 2024: Social media post on diet and exercise to help prevent heart disease, reached 82 people.
- February 17, 2024: Social media post on a heart-healthy lifestyle with a healthy weight and physical activity, reached 112 people.
- March 2, 2024: Resources and information provided on surgical weight loss at Franklin-Simpson Community Health Fair, along with body mass index screenings, 300 participants.
- April 3, 2024: Social media post on walking, reached 123 people.
- August 10, 2024: Sponsored the Annual Garden Spot 5K Walk/Run, over 800 participants.
- October 15-16, 2024: Onsite biometric testing at industry that included body mass index screenings and education, 248 encounters.

Priority Issue: High Blood Pressure

Goals:

- Increase knowledge of the effects of high blood pressure.
- Increase knowledge of management of high blood pressure along with follow- up visits with a primary care physician.
- Assist with community education to reduce health risks for a heart attack or stroke.

Community Partners:

- National Stroke Association
- Barren River District Health Department
- Kentucky Heart Disease and Stroke Prevention Task Force
- American Heart Association
- American College of Cardiology
- Local Industries

Activities/Outcomes 2022-2024:

- April 9, 2022: Social media post on "Major Heart Attack Symptoms", reached 155 people.

- April 14, 2022 & April 21, 2022: Social media post "Manageable Stroke Risk Factors", reached 88 and 108 people.
- May 3, 2022 & May 5, 2022: Social media post "High blood pressure increases your risk of stroke", reached 65 and 112 people.
- May 26, 2022: Social media post on "BE FAST" acronym for stroke symptoms, reached 86 people.
- June 2, 2022: Social media post on "Excess sodium can increase your blood pressure...", reached 89 people.
- June 23, 2022: Social media post on "High blood pressure increases the risk of heart disease and stroke", reached 101 people.
- July 6, 2022: Social media post, "Signs of Stroke", reached 138 people.
- August 30, 2022: Social media post, "8 Ways to Help Prevent a Second Stroke", reached 84 people.
- August 24, 2022: Social media post, "Behaviors That Increase Risk for Stroke", reached 79 people.
- Social media post, August 4, 2022, "Manage High Blood Pressure", reached 102 people.
- September 22, 2022: Local Industry Event, 28 participants received blood pressure screenings. Education also given to follow up with primary care physician and education provided on compliance with medication.
- September 26, 2022: Social media post, "Stroke Symptoms, BE-FAST", reached 50 people.
- September 21, 2022: Social media post, "High Blood Pressure: Beyond the Numbers", reached 79 people.
- December 10, 2022: Social media post on risk factors of high blood pressure, reached 56 people.
- April 6, 2023: Social medial post on symptoms of a heart attack, reached 118 people.
- May 3-4 & 17, 2023: Social media post on stroke risks, reached 188 people.
- May 9, 2023: Social media post on appropriate food preparation to reduce high blood pressure, reached 100 people.
- May 17, 2023: Social media post on keeping blood pressure in a healthy range, reached 162 people.
- May 29, 2023: Social media post on heart attack signs and symptoms, reached 80 people.
- May, 2023: Participated in local industry health fair. Provided information on diabetes management, blood glucose checks, nutrition, blood pressure/stroke education and chronic care management. Approximately 70 participants.
- June 15, 2023: Social media video on high blood pressure, reached 70 people.
- June 22, 2023: Social media post on the effects of high blood pressure, reached 72 people.

- June 1,8,29, 2023: Social media posts on stroke education, reached 200 people.
- August 1, 2023: Provided health event at Franklin Simpson Farmers Market. Performed blood pressure checks and provided cardio education, 8 participants.
- August 10, 2023: Social media post on signs and symptoms of a stroke, reached 87 people.
- October 17, 2023: Social media post on what to do if cardiac arrest happens, reach 129 people.
- December 3, 2023: Social media post on symptoms of a heart attack, reached 205 people.
- January 10, 2024: Social media post on risk factors of high blood pressure, reached 183 people.
- January 19, 2024: Social media post on symptoms of a stroke, reached 211 people.
- January 26, 2024: Social media post discussing risks of a heart attack, reached 107 people.
- January 27, 2024: Social media post discussing high blood pressure with pregnancies, reached 169 people.
- February 3, 2024: Social media post on instructions to monitor blood pressure at home, reached 87 people.
- February 7 & 9, 2024: Social media post on percentage of women with high blood pressure, reached 114 people and 113 people.
- February, 10-15, 2024: Multiple social media posts on heart health and controlling high blood pressure, reached a total of 475 people.
- March 2, 2024: Blood pressure screenings and education at the Franklin-Simpson Community Health Fair, 300 participants.
- May 6 & 17, 2024: Social media post on ways to lower high blood pressure according to the American Stroke Association, reached 160 & 176 people.
- May 18 & 19, 2024: Social media video and post on understanding of symptoms of a stroke, reached 106 and 152 people.
- June 5, 2024: Social media post on lower high blood pressure according to the American Heart Association, reached 124 people.
- June 13, 2024: Social media post on heart related illnesses, reached 334 people.
- June 30, 2024: Social media post on heart attacks and symptoms, reached 157 people.
- August 3, 2024: Social media post on routine health visits with primary care provider to manage high blood pressure, reached 134 people.
- August 18, 2024: Social media post on heart attack symptoms and risks, reached 115 people.
- September 29, 2024: Social media post on knowing your numbers for blood pressure to help prevent heart disease, reached 81 people.

- October 5, 2024: Social media post on know signs of a heart attack, reached 122 people.
- October 14 & 17, 2024: Social media post on high blood pressure and heart disease, reached 138 & 121 people.
- October 15-16, 2024: Onsite biometric testing at industry that included blood pressure screenings and education, 248 encounters.

Priority Issue: Diabetes/Prediabetes

Goals:

- Assist with reducing the incidence of Type 2 diabetes in the community.
- Provide education on prevention and management of diabetes.
- Provide education on prediabetes.

Community Partners:

- Barren River District Health Department
- Medicaid Managed Care Program/Case Management
- Med Center Health Primary Care Franklin
- Franklin-Simpson Chamber of Commerce
- Local Lion's Club
- Local Industries

Activities/Outcomes 2022-2024:

- Social media post for Diabetes Support Group registration. Meeting held the 2nd Tuesday of each month, 3-4 pm, reached 97 people.
- September 27, 2022: Provided health fair at Franklin-Simpson Farmers Market, 17 participants received glucose screenings and 15 participated received counseling recommendations from dietician. Participants were recommended to follow up with their primary care providers.
- November 2, 2022: Social media post on risk factors of diabetes, reach 75 people.
- May, 2023: Participated in local industry health fair. Provided information on diabetes management, blood glucose checks, nutrition, blood pressure/stroke education and chronic care management. Approximately 70 participants.
- August 1, 2023: Provided health even at Franklin Simpson Farmers Market. Performed glucose checks and provided nutrition education, 8 participants.
- August 3, 2023: Social media post on diabetes and stroke risks, reached 134 people.

- November 8, 2023: Social media post on diabetes increasing the risk of stroke and heart attack, reached 144 people.
- November 8, 2023: Social media post on American Diabetes Month and information on access to care, reached 363 people.
- March 2, 2024: Glucose tests performed and nutrition education at the Franklin-Simpson Community Health Fair, 300 participants.
- May 20, 2024: Social media post on diabetes increasing the risk of a stroke, reached 155 people.
- October 15-16, 2024: Onsite biometric testing at industry that included glucose screenings and education, 248 encounters.
- November 4, 2024: Social media post on heart health for individuals with diabetes, reached 105 people.

Priority Issue: Access to Care

Goals:

- Receive certification thru The Joint Commission as an Acute Stroke Ready Hospital. Continue to utilize Med Center Health Primary Care Franklin to manage chronic disease conditions within the community.
- Continue to utilize telemedicine services to provide access to specialists and primary care.
- Continue to provide the nurse program to the local school system and onsite nurse practitioner services.
- Continue to provide outpatient chemotherapy program at the hospital.
- Continue to develop strategies and resources in the treatment and prevention of COVID-19.
- Support organizations that provide treatment for mental health and substance abuse.

Community Partners:

- Med Center Health Primary Care-Franklin
- Med Center Health
- Barren River District Health Department
- Franklin-Simpson Schools
- The Joint Commission
- Franklin-Simpson EMS
- Kentucky Public Health
- Centers for Disease Control and Prevention

- Caravan Health

Activities/Outcomes 2022-2024:

- Received certification thru The Joint Commission as an Acute Stroke Ready Hospital in March 2022.
- A total of 37 COVID-19 vaccines were administered during April-June 2022 at MCH Primary Care Franklin.
- Social media post providing information on the Senior Perspectives program, an outpatient counseling program to assist senior adults in coping with life changes, April 8, 2022 & May 6, 2022, reached 110 and 455 people.
- Standardized workflow processes at Med Center Health Primary Care Franklin that resulted in a 72% volume increase with performing annual wellness visits to help address chronic conditions.
- July 25, 2022: Social media post, "Calling 911 for Strokes", reached 152 people.
- July 20, 2022: Social media post, "COVID-19 Vaccinations", reached 182 people.
- July 5, 2022: Social media post, "Primary Care Franklin Services", reached 252 people.
- August 8, 2022: Social media post, "Calling 911 for Strokes", reached 191 people.
- August 2, 2022: Social media post, "Calling 911 for Symptoms of Heart Attack", reached 138 people.
- September 14, 2022: Social media post, "Need to see your provider?", reached 87 people.
- September 22, 2022: Local Industry Event, 28 participants included with blood pressure screenings. Education also given to follow up with primary care physician and education provided on compliance with medication.
- September 27, 2022: Local Farmer's Market health fair, Provided information on outpatient behavioral health program, Sr. Perspectives, 18 participants.
- October 6 & 25, 2022: Social media post on timely treatment for stroke symptoms, reached 167 people.
- October 10, 2022: Social media post on seeking treatment for mental health, reached 69 people.
- October 24, 2022: Social media post on access to care with 3D mammography, reached 206 people.
- October 29, 2022: Social media post on stroke signs and symptoms, reached 150 people.
- November 8, 2022: Social media post on low dose lung cancer screening, reached 3.3K people.
- November 8 & 28, 2022: Social media post on timely treatment for strokes, reached 131 people.

- October-November 2022: Administered flu vaccines at various local industries and school districts, a total of 600 vaccines.
- December 22 & 29, 2022: Social media post on BE FAST warning signs for stroke, reached 101 people.
- October-December 2022: Rural health clinic administered a total of 51 COVID-19 vaccines.
- April 13, 2023: Social media post on recognizing stroke symptoms and taking action, reached 96 people.
- April 20, 2023: Social media post on calling 911 with signs of stroke, reached 118 people.
- May 1, 2023: Social media post and video on stroke preventative programs, reached 80 people.
- May 24, 2023: Social media post on calling 911 with signs of stroke, reached 94 people.
- June 12, 2023: Social media post on quality preventative care and health screenings, reached 121 people.
- June 19, 2023: Social media post on various services offered by the hospital, reached 144 people.
- June 19, 2023: Provided 131 free sports physicals at Orthopedics Plus Physical Therapy to students of Simpson County
- July 6, 2023: Social media post on warning signs of a stroke, reached 107 people.
- July 11, 2023: Social media post on Senior Perspectives program for outpatient counseling for elderly adults, reached 3.2 K people.
- July 13, 2023: Social media post on access to care for a stroke, reached 92 people.
- August 17, 2023: Social media post on primary care services, reached 81 people.
- August 28, 2023: Social media post on annual wellness visits with primary care, reached 71 people.
- August 31, 2023: Social media post on calling 911 with signs of stroke, reached 91 people.
- September 7 & 28, 2023: Social media post on calling 911 with signs of stroke, reached 65 & 104 people.
- September 19, 2023: Social media post on telemedicine access with providers, reached 86 people.
- October 2, 2023: Social media post on signs and symptoms of a stroke, reached 109 people.
- October 19, 2023: Calling 911 with signs of a stroke, reached 100 people.
- October 29, 2023: Social media post on signs of a stroke, reached 110 people.
- October, 2023: Provided 119 flu & COVID vaccinations to local industries.

- November 10 & 16, 2023: Social media post on access to services with primary care, reached 484 people.
- November, 2023: Provided 70 flu & COVID vaccinations to local industries.
- December 14 & 28, 2023: FAST warning signs of a stroke and what to do, reached 394 people.
- December 15, 2023: Social media post on primary care services thru school-based clinics, reached 465 people.
- December 22, 2023: Social media post on primary care services at Med Center Health Primary Care Franklin, reached 294 people.
- January 2 & 9, 2024: Social media post on primary care services offered thru Med Center Health Primary Care Franklin, reached 240 people and 1.2K people.
- January 4 & 9, 2024: Social media post on calling 911 with symptoms of a stroke, reached 185 people and 143 people.
- January 18, 2024: Social media post on access to care at The Medical Center at Franklin, reached 658 people.
- March 2, 2024: BE FAST stroke education provided and local resources available, along with local access to care to outpatient behavioral health, cardiology, long term care, ophthalmology, surgical weight loss, general surgery, ENT, neurology and home care services at the Franklin-Simpson Community Health Fair, 300 participants.
- March 7 & 20, 2024: Social media post on access to stroke care, reached 143 and 151 people.
- May 8, 2024: Social media post on utilizing Annual Wellness Visits, reached 123 people.
- May 13, 2024: Social media post on finding a primary care provider, reached 329 people.
- May 30, 2024: Social media post on calling 911 with signs of a stroke, reached 144 people.
- July 6 & 11, 2024: Social media post on calling 911 with signs of a stroke, reached 122 & 117 people.
- August 2, 2024: Social media post on utilizing primary care services for preventive, wellness and disease management, reached 530 people.
- August 8 & 15 & 29, 2024: Social media post on calling 9-1-1 with signs of stroke to save lives, reached 140 & 108 & 129 people.
- September 5, 2024: Social media post on calling 9-1-1 with signs of stroke to save lives, reached 92 people.
- September 26, 2024: Social media post on calling 9-1-1 with signs of stroke to save lives, reached 121 people.
- October 10 & 25, 2024: Social media post on calling 9-1-1 with signs of a stroke, reached 127 & 168 people.
- November 2024: Added a monthly cardiology clinic on hospital campus.

- November 2, 2024: Social media post on calling 9-1-1 with signs of cardiac arrest, reached 142 people.

Priority Issue: Smoking/Vaping specifically targeting middle and high school students, as well as parents.

Goals:

- Support smoking/tobacco cessation programs for the community.
- Enhance public understanding of the dangers of smoking, specifically targeting e-cigarettes.
- Provide education to schools around smoking, vaping and tobacco use dangers.

Community Partners:

- Barren River District Health Department
- Franklin-Simpson Schools
- Get Healthy Simpson Coalition
- Franklin-Simpson Boys and Girls Club

Activities/Outcomes 2022-2024:

- April 14, 2022: Get Healthy Simpson County meeting. Group involving various community stakeholders met with focus on a "Stop Vaping Program" for the schools. Discussions supporting a smoke-free city ordinance.
- May 12, 2022: Social media post "How Quitting Helps Women's Health", reached 126 people.
- May 25, 2022: Social media post on the harmful effects of smoking, reached 82 people.
- *Note: There was an 86% increase in providing tobacco abuse counseling and support for tobacco-dependent treatment with patients at Med Center Health Primary Care Franklin, April-June 2022.*
- July 2022: Smoking cessation calls with Med Center Health employees, 28 participants throughout the month.
- August 1, 2022: Social media post, "Lung Cancer", reached 85 people.
- September 13, 2022: Social media post, "Lung Cancer Screening", reached 80 people.
- October 2022: Dangers on vaping handouts at SKYCTC Health Fair, 45 participants
- November 1, 2022: Social media post on smoking causing lung cancer, reached 72 people.

- November 16 & 24, 2022: Social media post on information to quit smoking, reached 124 people.
- December 1, 2022: Social media post on effects of vaping, reached 65 people.
- December 5 & 12, 2022: Social media post on risk factors of smoking, reached 120 people.
- April 2023: Med Center Health provided smoking cessation calls to a total of 20 employees throughout the month.
- May 2023: Med Center Health provided smoking cessation calls to a total of 40 employees throughout the month.
- June 8, 2023: Social media post on effects on second hand smoke, reached 62 people.
- June 2023: Med Center Health performed 32 smoking cessation calls to employees throughout the month.
- August 7 2023: Social media post on smoking risk factors with lung cancer, reached 67 people.
- November 1, 2023: Social media post on early detection of lung cancer, reached 82 people.
- November 6 & 10, 2023: Social media post on lung cancer screenings available at Med Center Health, reached 95 people.
- November 7, 2023: Social media post on cigarette smoking, reached 82 people.
- November 14 & 16, 2023: Social media post with information on lung cancer and smoking as main risk factor, reached 776 people.
- November 20 & 27, 2023: Social media post on steps to quit smoking, reached 363 people.
- December 13, 2023: Social media post on vaping versus smoking, reached 230 people.
- December 15 & 21, 2023: Social media post on smoke free success, reached 353 people.
- March 2, 2024: Resources and education provided on long nodule program for early cancer detection at the Franklin-Simpson Community Health Fair, 300 participants.
- March 2, 2024: Vaping information and education at the Franklin-Simpson Community Health Fair, 300 participants.
- September, 2024: Social media post on smoking as main risk factor with lung cancer, reached 134 people.
- October, 2024: Social media post on smoking as main risk factor with lung cancer, reached 187 people.
- November 1, 2024: Social media post on Lung Nodule Program offered by Med Center Health for early diagnoses and treatment of lung cancer, reached 119 people.

- November 8, 2024: Social media post on resources available for becoming smokefree, reached 96 people.
- November 11, 2024: Social media post on effects on the body initially after quitting smoking, reached 101 people.
- November 12 & 14, 2024: Social media post on smoking and lung cancer, reached 107 & 96 people.
- November 22, 2024: Social media post on the benefits of quitting smoking, reached 82 people.
- December 5 & 28, 2024: Social media post on calling 9-1-1 with signs of stroke, reached 139 & 208 people.

Reflection of Previous Cycle

At an organizational level, Med Center Health provides ongoing programs that address some of the barriers to health services within the counties it serves. For example, the Med Center Health Community Clinic located in Warren County currently operates two programs that ease the financial burden to patients in need of basic medical and dental care. The Community Clinic coordinates basic medical and referral services for eligible patients while The Dental Clinic offers a low-cost alternative for those in need of basic dental care. Basic medical services for eligible patients are provided by Medical Center Primary Care located on The Medical Center campus. Guidelines for these services are outlined on the Med Center Health website: https://medcenterhealth.org/location/community-clinic/.

Through the WorkLife program, Med Center Health places registered nurses and advanced practice registered nurses in schools and industry throughout the BRADD region. The WorkLife Primary Care Program offers primary care services to meet both sick/sudden onset illnesses as well as preventive and wellness screenings. In addition, the organization has provided school nurses to rural county school districts including Simpson, Logan and Hart County schools. Also, school-based health clinics with onsite nurse practitioners have been developed in Simpson, Logan and Allen County schools. These clinics provide another avenue for primary care services to children and faculty.

The Medical Center at Bowling Green and The Medical Center at Albany were certified as Sexual Assault Nurse Examiner (SANE)-ready hospitals. The two hospitals now maintain a Sexual Assault Nurse Examiner on call at every moment. The Medical Center at Bowling Green has more than tripled its credentialed SANE nurses in the past two years, giving the hospital the capacity to provide 24/7 SANE coverage in its Emergency Department.

MCH has not only added providers to existing practices-we have added multiple physician specialty practices including cardiology and pulmonology, urology, gastroenterology, neurology, gynecologic, oncology, hospital medicine as well as

inpatient pediatric hospitalists.

Moving forward, Med Center Health is in the process of building the region's first combination urgent care and emergency department in Warren County. The goal is to alleviate pressure on the hospitals' current emergency departments and improve care response time for patients.

Med Center Health has partnered with the Barren River District Health Department, Barren River Area Development District and LifeSkills to execute the Anchor Project. A regional office of Drug Control Policy will be established for the entire region. The office will serve as point guard for all projects within the region and help local decision makers maximize the use of federal, state and local dollars. A mental health crisis intake center will be established. The center will house a 24/7 triage that will be located within LifeSkills umbrella of services. The center will mitigate countless expenses in man-hours and create thousands of dollars in savings to communities experiencing substance use and mental health crisis.

At a local level, the 2022-2024 implementation strategies from The Medical Center at Franklin are on pages 14-24 of this document. The Medical Center at Franklin collaborated with other stakeholders and with other departments within the organization to help address the needs of the community. Education and communication with all of the listed priority issues were provided through social media and through other activities within the community.

Our hospital's rural health clinic streamlined processes to increase their annual wellness exams to identify and manage chronic conditions such as obesity, diabetes, and high blood pressure. Education on diabetes self-management was provided through Med Center Health in Bowling Green. In addition, screenings were provided at various industry health fairs and community activities that measured BMI, HBP, and glucose levels. Education on prevention and management were provided at these events.

The Medical Center at Franklin also worked with stakeholders in educating the community on smoking/vaping facts and resources that are available. Smoking cessation classes were also available through Med Center Health in Bowling Green.

The Medical Center at Franklin strives to provide access to care while utilizing best practices. One way this was accomplished was by receiving Acute Stroke ready Hospital certification through The Joint Commission. This certification requires hospitals to utilize best practices in the treatment of strokes.

In addition, specialty services were added to improve access to care within the community. This included the areas of hospital medicine, cardiology clinics, vascular surgery clinic, and pulmonology. During 2025, our provider-based rural health clinic will be adding six new providers to provide primary care services.

There are also efforts being made to provide mental health care in the rural health clinic.

Over the 2022-2024 cycle, it was known that social determinants of health (SDOH) are a factor in recovery after a patient is discharged from the hospital. Knowing an individual's neighborhood, access to affordable housing and healthy food, sense of community and belonging can impact their overall health and health outcomes. Questions pertaining to SDOH were asked to all patients admitted to the hospital. Resources are provided to individuals when issues are identified. If resources cannot be met by Med Center Health, a list of community resources are provided to the patient. Collaborations with other community stakeholders have continued in order to meet the needs of patients.

Survey Process

Med Center Health continues to play an active role with the BRIGHT Coalition. The BRIGHT Coalition is a non-profit coalition made up of multiple entities serving the ten county Barren River region. The BRIGHT Coalition wants every resident in the Barren River Area Development District (BRADD) to have the best quality of life possible by ensuring a safe place to live, work and play. Healthy individuals, families and communities are the cornerstone of this vision. BRIGHT strives to create equal opportunities to be healthy with an emphasis on personal responsibility for health and wellness through collaboration among all stakeholders.

From the previous community health assessment, the BRIGHT Coalition had determined five areas of focus including nutrition, diabetes, substance use (including tobacco), physical activity and mental health. The current survey was designed to understand the community's strengths and barriers as well as community members' thoughts related to those five priorities.

The BRIGHT Coalition's Board approved to bring on Dr. Lauren McClain with Grantibly to help with survey development, dissemination and analysis of the data collected. In addition, a data committee was formed from membership within the BRIGHT Coalition to help guide the development of the survey, aid with individual interviews, focus groups, dissemination, etc.

The data committee consisted of the following BRIGHT members:

Amanda Reckard	Barren River District Health Department
Dr. Kim Link	Western Kentucky University
Dr. Susan Eagle	Western Kentucky University
Sarah Widener	Med Center Health
Annette Runyon	Med Center Health

Susan Willis	Barren River District Health Department
Olivia McGhee	Barren River District Health Department
Ashli McCarty	Barren River Health Department
Dr. Qingfang Song	Western Kentucky University
Lynn Blankenship	UK Extension Office
Dr. Lauren McClain	Grantibly

The data committee chose to use the Community Health Assessment Toolkit (https://www.healthycommunities.org/resources/community-health-assessment-toolkit) as a guide to executing the survey. The goal with this survey was to reach as many people and populations as possible within our communities, being intentional with the data we gathered and voices we heard. We wanted to not only increase the number of surveys completed but more importantly ensure the survey responses represented the diversity of our community.

The survey committee reviewed several surveys used by other health departments across the state and used some of the questions from those surveys in addition to questions determined by the data committee based on the end goal.

Methodology

The survey was created and administered in Alchemer, an online survey platform used by health departments around the country. While the Data Committee reviewed similar surveys by other health departments around the state and used some questions, most of the questions in this survey were created by Dr. Lauren McClain in consultation with the Data Committee. The goal of the survey is to learn about community members' thoughts and experiences related to the priorities of BRIGHT, namely physical health, nutrition, diabetes, tobacco use, substance use, mental health, and other community health needs. We focused on both community strengths and barriers to good health as well as respondents' attitudes and knowledge of certain health issues and sociodemographic

background indicators. Questions were written at an 8th grade reading level. All questions were closed-ended. Data analysis was conducted in SAS and Excel.

The survey launched on August 15, 2024 and closed on November 13, 2024. The survey link was shared in a variety of ways: through the BRIGHT Coalition membership who shared it on their social media pages and with their networks, the BRIGHT social media pages, through email listservs of community nonprofits, at community events, on table tents or small flyers at Graves Gilbert and Med Center Health locations and at a few local businesses, as stickers on pizza boxes at Papa John's in Bowling Green, and through the local newspapers. Direct mailing invitations were sent to a random selection of 50 addresses in the 10 counties (350+ invitations) to encourage participation. Not all efforts to share the survey were successful or have unknown levels of success. We asked a number of school districts to send announcements to their families, but that was not permitted. We reached out to a number of organizations specifically to increase participation of hard-to-reach groups and asked them to send the survey invitation, out but we are not sure if that happened consistently.

During the survey window, Med Center Health had the survey posted as a pop on their website, displayed on Visix boards in the hospital and physician offices, had table tents in the cafeteria and on their social media pages. The table tents were used at other events including as displays on tables at the pasta party for the MCH 10K Classic. Flyers with a QR code were included in race packets for the MCH 10K Classic participants. At The Medical Center at Franklin, inpatients were asked to participate in the survey along with some outpatients at various registration locations.

In addition to the above efforts, numerous events, including industry health fairs, were attended by Med Center Health staff where the survey QR code and/or paper versions of the survey were available. The BRIGHT Coalition also attended numerous events throughout the BRADD region to distribute the survey.

Furthermore, members of the BRIGHT Coalition's data committee conducted individual interviews with leaders from The Foundry Bowling Green and The International Center of Kentucky in addition to two Family Resource Youth Services Center directors from local schools. In addition to the interview, a focus group was held with eight participants at The International Center of Kentucky.

Survey Respondents Demographics

There were a total of 1783 surveys that were completed and analyzed within the 10 counties of the Barren River Area Development District. Warren County represented the

majority of the surveys at 41%, followed by Allen County at 10%. Seven percent of the surveys were completed by residents of Simpson County.

Ages of individuals that completed the survey ranged from 18 years to 93 years old, with the average age being 43 years old. The majority of the respondents identified as female at 74.7%, while 23.3% identified as male, 0.4% identified as trans male/transman, 0.3% genderqueer, and 0.8% preferred not to answer.

Survey respondents were asked their race/ethnicity. The majority of the respondents were white (80.4%), and 9.6% identified their race as black or African American. In addition, 7.9% comprised of the following: American Indian or Alaska Native; Hispanic, Latino(a) or Spanish; Asian; Native Hawaiian or other Pacific Islander; and other. There were 2.1% who preferred not to answer.

Most participants, 85.8%, identified his/her sexual orientation as straight. Less than 5% in each category included the following: Bisexual; lesbian, gay or homosexual; another identity; not sure; and prefer not to answer.

The relationship status of the survey participants included the majority being married (62.7%). Twelve percent have never been married. There were 10.9% of the respondents that were divorced, 5.3% were widowed, 2.2% separated, and 4.9% were living with a partner. Less than 2% chose not to answer that question.

Employment data showed that 56.9% of the respondents were employed, while the other respondents included the following: Retired 12%; self-employed 11%; students 6%; unable to work 4%; and unemployed 5%.

Furthermore, 56% of the respondents had health insurance coverage thru their employer. Seven percent pay for their own health insurance, such as through COBRA or KYNECT. There were 29% who had health coverage through government programs (Medicare or Medicaid), and 6% of the respondents did not have health insurance.

Survey Results

The survey asked participants about community strengths that assist in positively impacting a healthy community. Having adequate medical services available was a top-rated answer as 43.8% referred to access to health care. Healthy behaviors and lifestyles along with good jobs and a healthy economy rated as 2nd and 3rd area that helps individuals stay healthy.

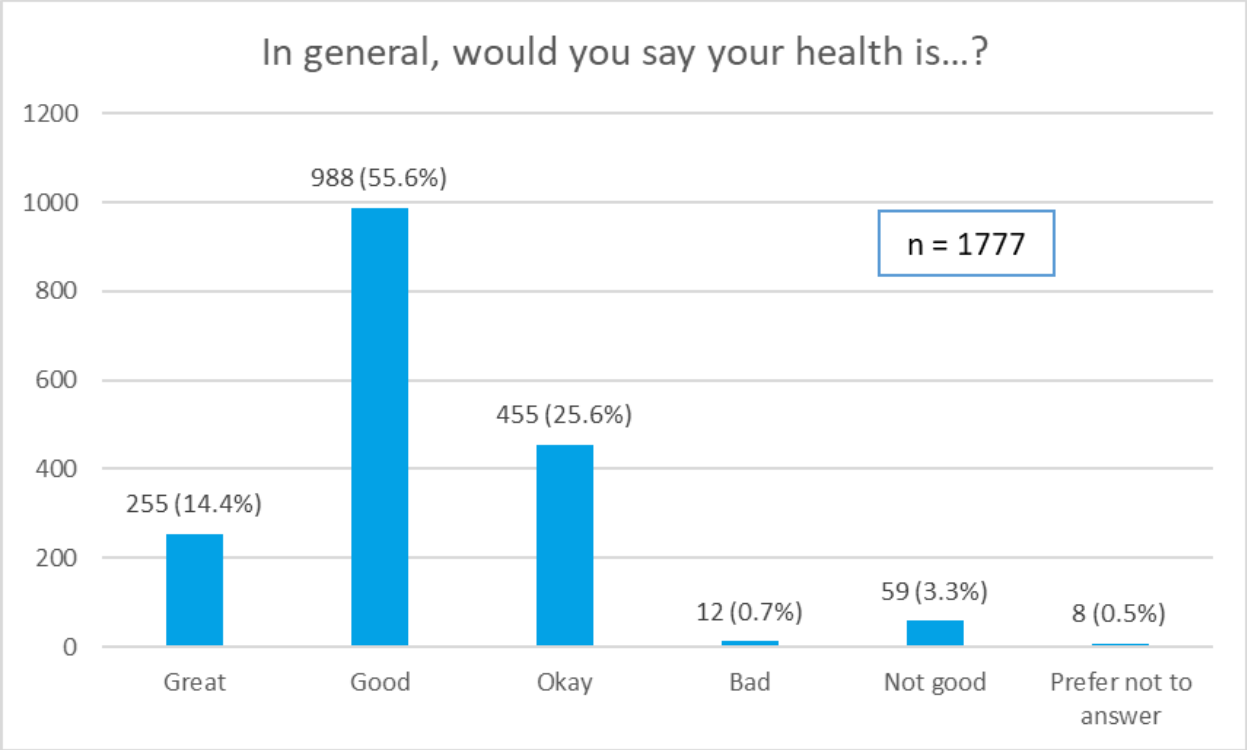
Respondents were also asked to identify three issues that they believed had a negative impact on the health of the community. The top three barriers included the following: Poor eating habits (32.4%); lack of exercise (26.8%); and lack of a livable wage (25.6%). Substance misuse rated close to livable wage at 25.2% along with limited access to healthcare at 20.8%.

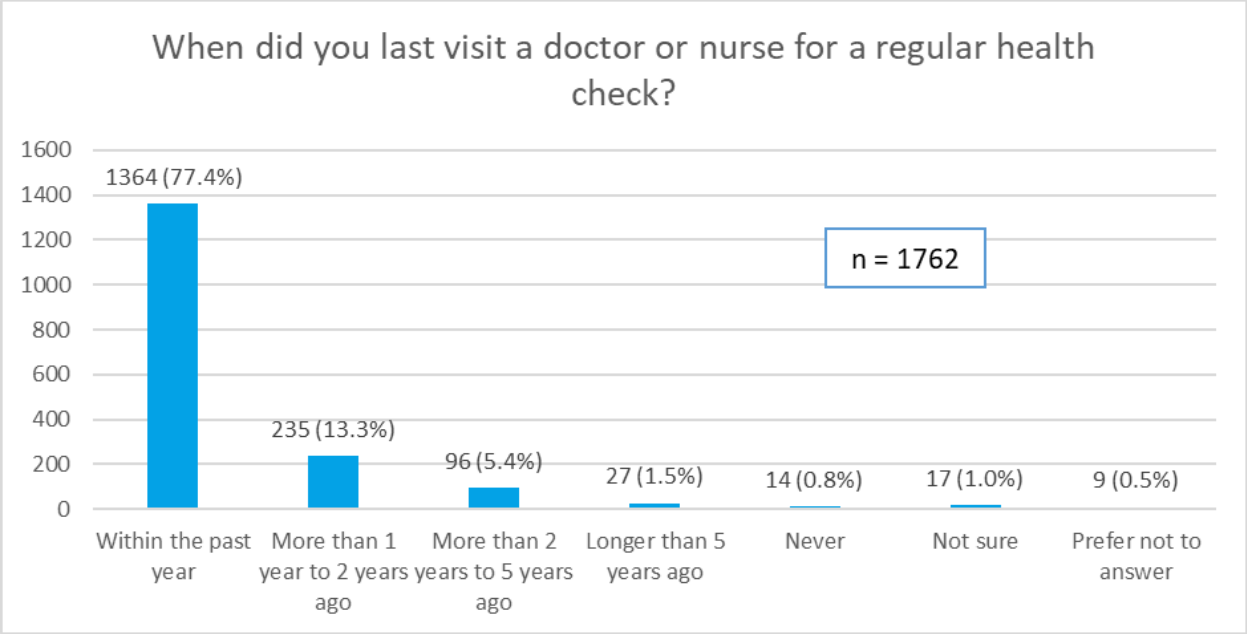
When participants were asked to list specific unmet health needs (I.e.: mental health care, food, housing, transportation, clothing, et cetera), approximately 50% stated that the items on the list did not apply to them. For those that had unmet needs, it was noted that 14% identified mental health care as a barrier. In addition, 12% declared unmet needs in healthcare. Other areas included food insecurity, housing, childcare, utilities and employment.

Questions related to barriers of good health was also included on the survey. Forty percent reported that they did not have barriers. However, 24% identified the cost of healthcare has a major barrier. Fifteen percent stated that it was difficult to get appointments around their work schedule, and 12% stated that they cannot get off work. Interestingly, 12% also worried that the doctor would not take them seriously.

Physical Health:

The following graphs and charts represent the responses related to the physical health of the survey respondents.



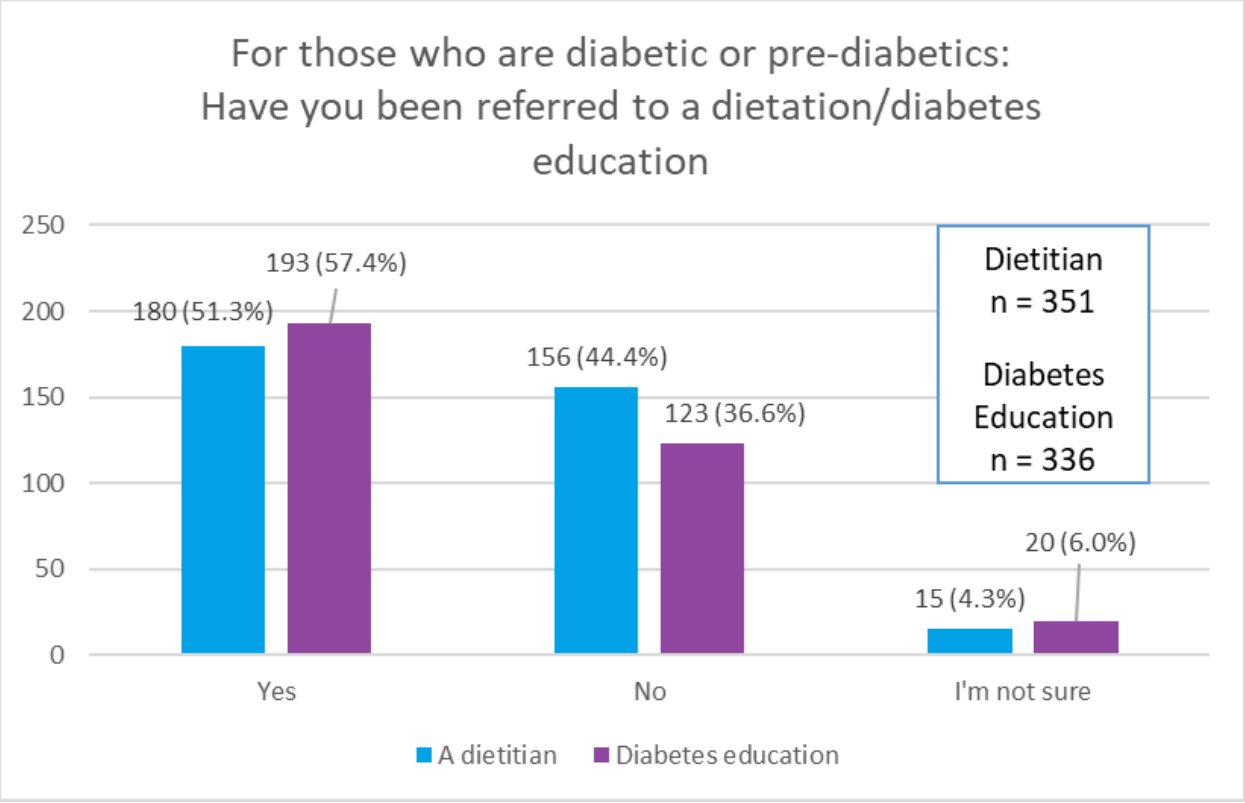


Overall, the general physical health was rated by most respondents as good (56%) and 25.6% reporting it as okay. Approximately half of the respondents reported that their health did not prevent them from carrying out their daily activities.

Most respondents reported visiting a doctor within the past year. For those that had not visited a doctor, the most frequent barrier included the cost of healthcare. Other barriers included work schedules and the lack of health insurance.

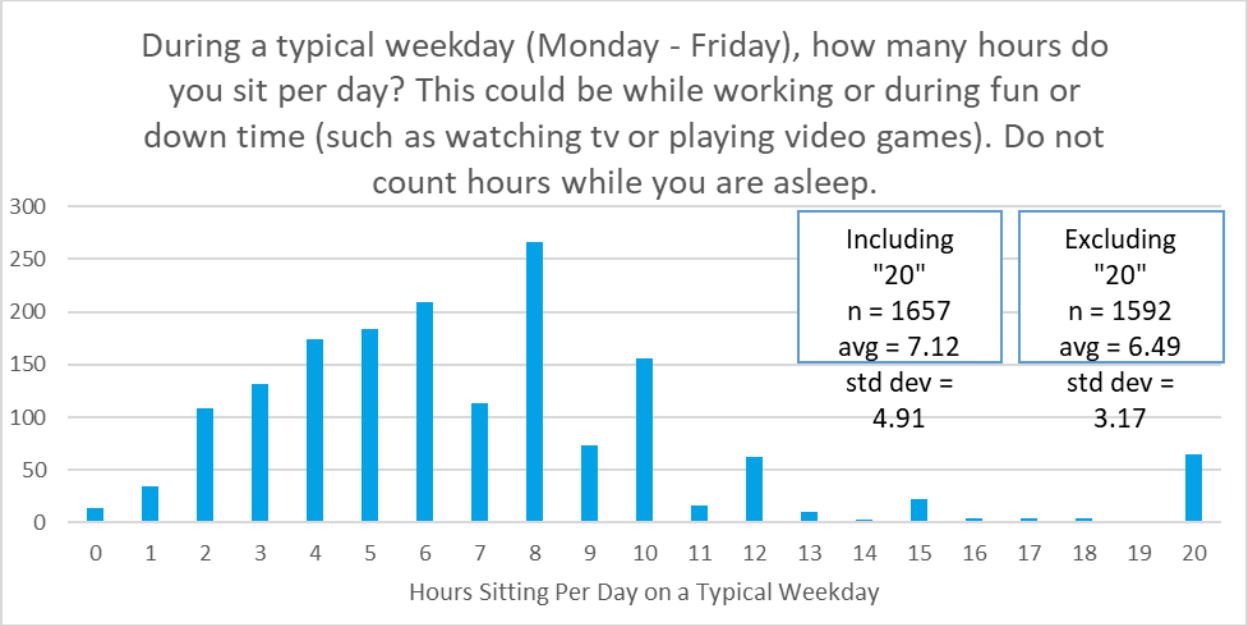
Diabetes:

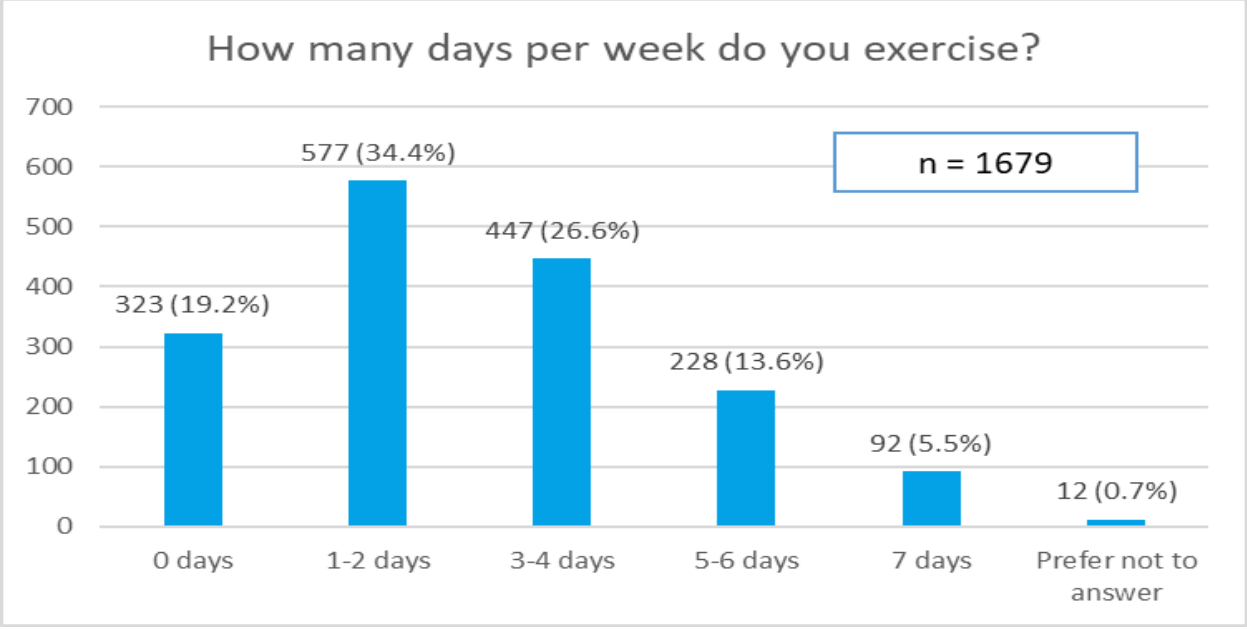
Diabetes/pre-diabetes questions were also included in the survey. Overall, 20% of the respondents stated that they were either pre-diabetic or had diabetes. Of the 20%, 57% reported having knowledge of diabetes education opportunities, and 36% stated that they had not been informed of educational resources.



The survey also explored respondents sleep and exercise patterns. Analysis of the responses revealed an average of 6-7 hours of sleep per day. The most common answer related to the frequency of exercises each week was 1-2 days per week (34.4%), followed by 26% exercising 3-4 days per week (refer to graphs below).

PhysicalActivity/Sleep:

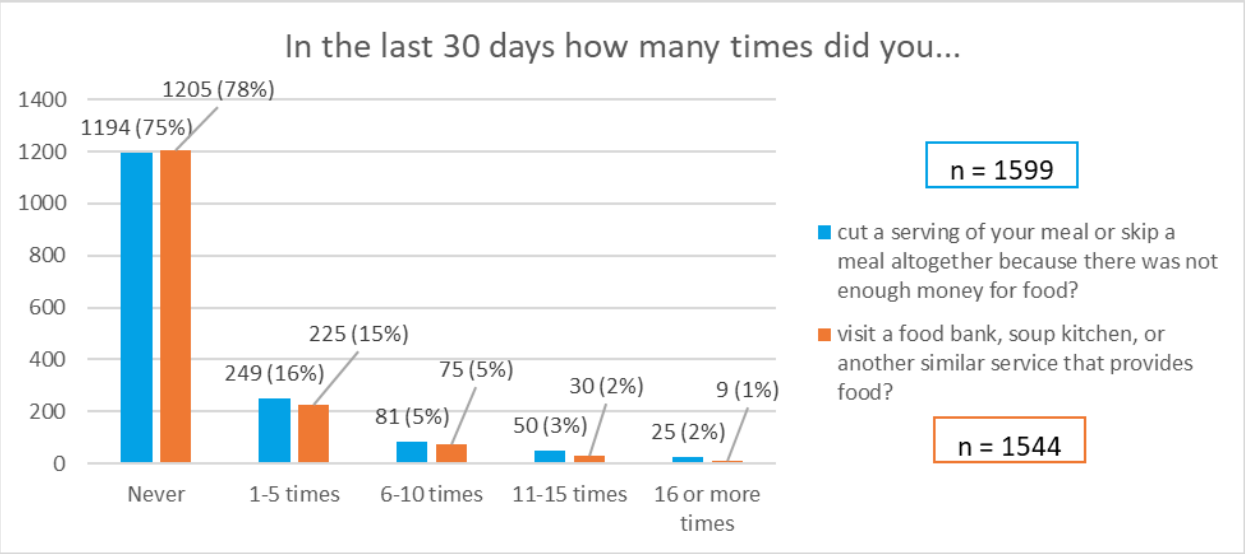




Nutrition:

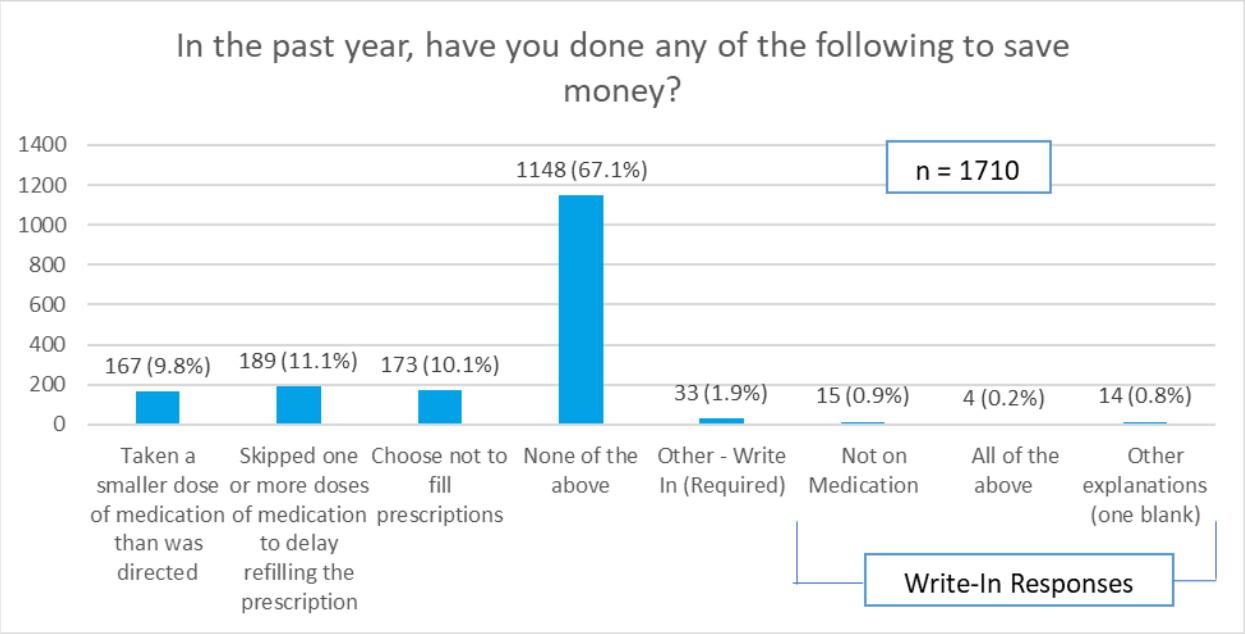
The survey also asked questions related to nutrition with food insecurity. The graph below asked if they went without food due to a lack of resources of if they visited a food bank in the last 30 days. The majority stated that they had not gone without food in the last 30

days (75%), and 78% replied that they did not need to visit a food bank during that time. Of the respondents who reported food insecurity, the most common reply (16%) reported either cutting a serving or a meal or skipping the entire meal 1-5 times during that period due to lack of resources, and 15% visited a food bank during that time period.



Prescription Insecurity:

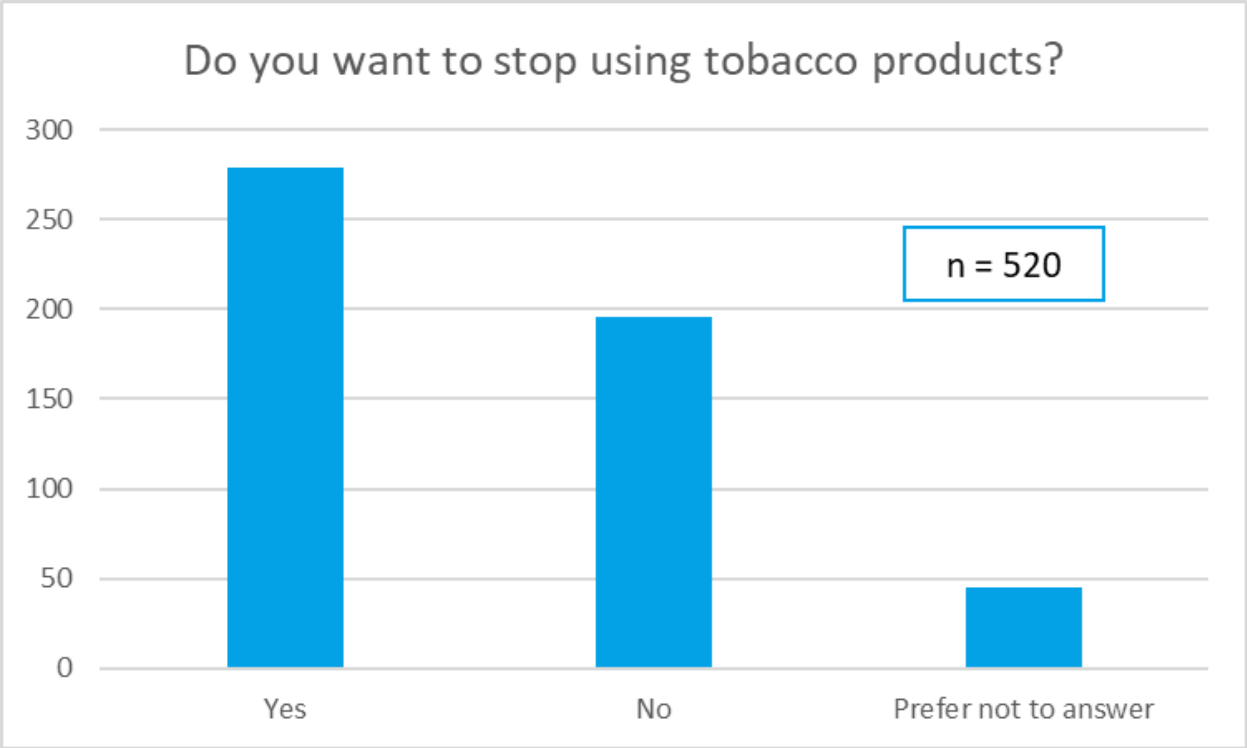
Prescription insecurity was also address by asking participants if they had taken their prescriptions in ways to save money. While the majority responded that they had not (67.1%), the most common ways included the following: Taken a smaller dose than was directed (9.8%); skipping one or more doses (11.1%); and not refilling prescriptions (10.1%).



Tobacco Use:

How often do you use each of the following? (Count/%)					
	Everyday	Some Days	Not at All	Prefer not to Answer	Total
Smoke cigarettes	224 (13.7%)	186 (11.4%)	1199 (73.4%)	25 (1.5%)	1634 (100%)
Use chewing tobacco or snuff	47 (2.9%)	99 (6.1%)	1453 (89.5%)	25 (1.5%)	1624 (100%)
Use e-cigarettes or other electronic vaping products	109 (6.7%)	176 (10.8%)	1318 (80.9%)	26 (1.6%)	1629 (100%)

In regards to tobacco use, the majority of respondents stated that they did not smoke, use tobacco or vape. Of the respondents that reported using tobacco products, 53.7% stated that they would like to stop using tobacco, and 37.7% did not wish to quit.



Alcohol & Substance Use:

Overall, there were 1598 individuals who responded to the questions related to alcohol consumption. Forty-two percent of those respondents reported not consuming any alcohol in the last 30 days. Twenty-one of the respondents indicated that they consumed alcohol daily. When respondents were asked if they felt the need to reduce alcohol consumption, 67% did not feel that they needed to cut back.

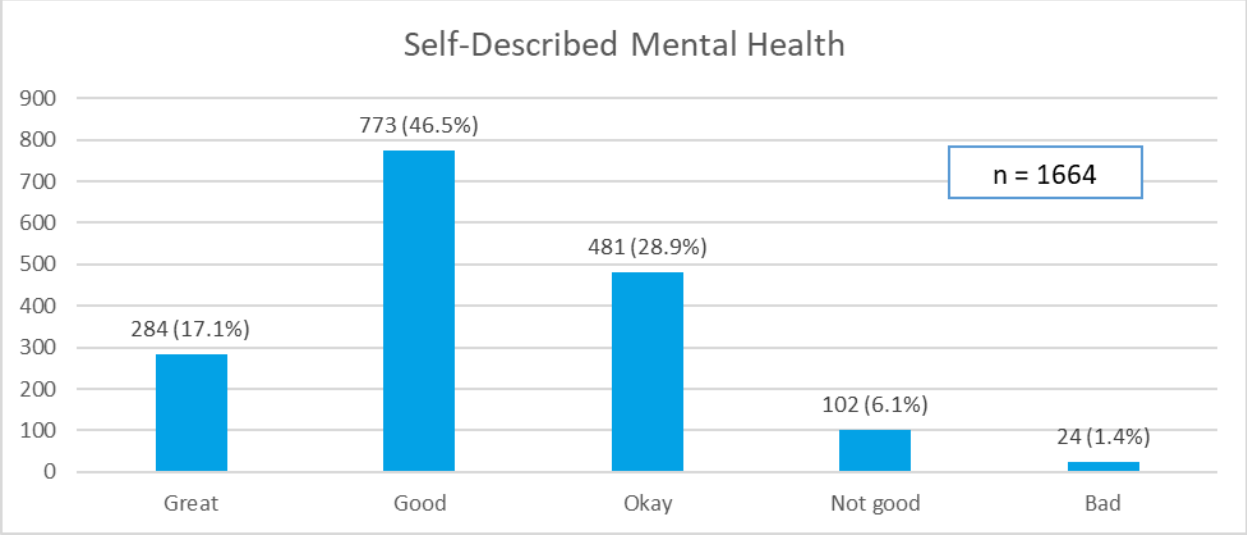
Participants were also asked if they were aware of the resources available in their community for addressing drug or alcohol use. Many respondents were aware of resources, such as going to support groups (763 respondents), seeking a counselor/therapist (690 respondents), or seeking a treatment center (682 respondents). However, 296 respondents did not know if there were resources, and 104 did not feel there were any resources within their community.

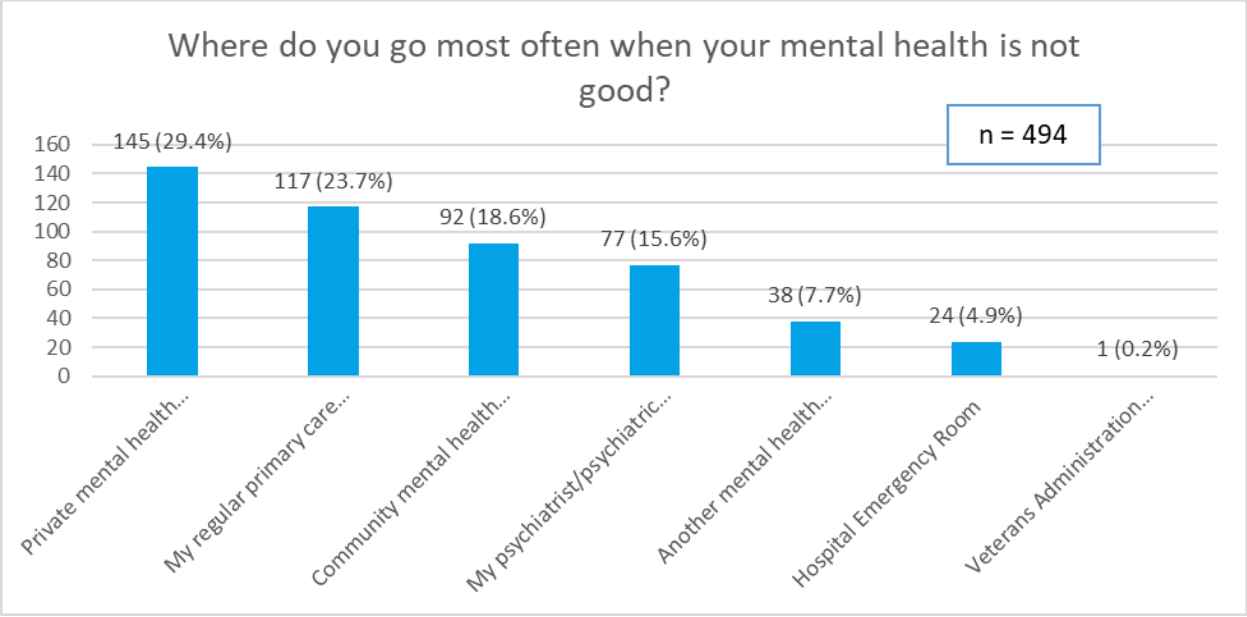
Mental Health:

Questions in this area pertained to perceptions of mental health, access to care and seeking opinions about mental health needs within their communities. While the graph below indicates that the vast majority rated their self-described mental health as good and great, there was a significant percentage of individuals who rated themselves as intermediate.

When asked where they obtain help when their mental health is not good, 29.4% reported going to a private mental health practice, followed by utilizing their primary care provider (23.7%) (see graph below).

A question was also asked if respondents had received any type of mental health help. Sixty two percent reported they had not received any help, and 35% stated that they had utilized support. Furthermore, participants were asked if they wanted help but were unable to obtain it. The majority (83%) stated that they did not want help, and 17% stated they wanted help but were unable to access it due to cost of care, service availability or stigma.





The final question in this section asked participants to select the top three mental health needs in the community that needed to be addressed. The top three needs included the following: Affordable health insurance that includes mental health care (42.2%); affordable mental health services (37.3%); and addressing the stigmatization of those with mental health issues (28.5%). Other needs included affordable prescriptions (25.7%), substance abuse prevention/treatment (19.4%), children's mental health services (19.0%), among other needs.

Where Health Information Comes From:

Results of the survey showed that people obtain health information through various resources that include both traditional and modern paths. While the majority (74%) stated that they receive information from their healthcare provider, 46% utilized internet sources (I.e.: Google or WebMD). Other channels included receiving information from friends/family (42%), social media (39%), public health officials (37%), television (20%), et cetera…

Survey Results Specific to Simpson County:

Healthy Community Factors: There were some consistencies amongst the counties pertaining to factors that contribute to good health. Within Simpson County, the top five health community factors were identified in order: Access to healthcare (50.0%); healthy behavior (27.87%); low crime (30.33%); good jobs (22.95%); and community parks (22.13%).

Table 16: Top 5 Healthy Community Factors by County					
County	**1st Factor (% Selected)**	**2nd Factor (% Selected)**	**3rd Factor (% Selected)**	**4th Factor (% Selected)**	**5th Factor (% Selected)**
Allen	Access to Healthcare (41.12%)	Healthy Behaviors (28.93%)	Strong Families (24.37%)	Good Jobs (23.35%)	Low Crime (20.81%)
Barren	Access to Healthcare (40.86%)	Healthy Behaviors (34.41%)	Strong Families (17.74%)	Good Schools (16.67%)	Low Crime (24.19%)
Butler	Access to Healthcare (32.88%)	Belonging (26.03%)	Low Crime (28.77%)	Healthy Behaviors (24.66%)	Good Jobs (23.29%)
Edmonson	Access to Healthcare (29.92%)	Good Place to Raise Kids (29.13%)	Belonging (26.77%)	Low Crime (25.98%)	Healthy Behaviors (23.62%)
Hart	Low Crime (35.0%)	Access to Healthcare (33.33%)	Healthy Behaviors (26.67%)	Strong Families (25.00%)	Good Jobs (23.33%)
Logan	Access to Healthcare (42.37%)	Healthy Behaviors (27.68%)	Belonging (27.12%)	Good Place to Raise Kids (24.29%)	Low Crime (22.60%)
Metcalfe	Access to Healthcare (41.67%)	Healthy Behaviors (33.33%)	Belonging (29.17%)	Farmers' Market (23.61%)	Affordable Housing (Tied, Clean Environment) (20.83%)
Monroe	Belonging (31.11%)	Access to Healthcare (31.11%)	Healthy Behaviors (28.89%)	Low Crime (24.44%)	Good Schools (24.44%)
Simpson	Access to Healthcare (50.00%)	Healthy Behavior (27.87%)	Low Crime (30.33%)	Good Jobs (22.95%)	Community Parks (22.13%)

Warren	Access to Healthcare (49.86%)	Healthy Behaviors (35.91%)	Good Jobs (28.18%)	Clean Environment (20.99%)	Community Parks (19.34%)

Barriers to Health:

Barriers that impact good health was also addressed in the survey. The most common response with Simpson County resident respondents was "I don't have any barriers" (41.0%). Other barriers are included in the chart below.

Barriers to Health Services
Simpson County

Number of Barriers	Frequency	Percent	Cumulative Frequency	Cumulative Percent
0	62	54.9	62	54.9
1	23	20.4	85	75.2
2	19	16.8	104	92.0
3	5	4.4	109	96.5
4	3	2.7	112	99.1
5	1	0.9	113	100.0
Frequency Missing = 9				

Top Five Barriers to Health Services
Simpson County

Barrier	Percent
I don't have any barriers	41.0
Costs too much for appointments, procedures, or medications	17.2
Can't take time off work	10.7
Worried the doctor won't take me seriously	9.0
Can't get an appointment that works for my schedule	8.2
Worried the doctor doesn't like caring for or treating with people like me	7.4

Family Health Needs:

Over 50% of Simpson County residents stated there were no needs. Of the needs that were selected, mental health rated at the top, followed by food, childcare, utilities, healthcare, elder care, employment, clothes, adult education, addiction support services and domestic violence resources.

Table 37: Family Needs by County

County	1st Need (% Selected)	2nd Need (% Selected)	3rd Need (% Selected)	4th Need (% Selected)	5th Need (% Selected)	6th Need (% Selected)	7th Need (% Selected)
Allen	No Needs (40.10%)	Mental Health Care (20.30%)	Housing (16.24%)	Health Care (15.74%)	Employment (14.72%)	Utilities (14.74%)	Elder Care (13.20%)
Barren	No Needs (49.46%)	Mental Health Care (14.52%)	Health Care (13.44%)	Food (11.29%)	Housing (10.22%)	Utlilites (10.22%)	Employment (9.14%)
Butler	Child Care (27.40%)	Mental Health Care (26.03%)	No Needs (20.55%)	Health Care (19.18%)	Domestic Violence Resources (19.18%)	Clothes (17.80%)	Food (16.44%)
Edmonson	No Needs (31.50%)	Mental Health Care (19.69%)	Employment (17.32%)	Health Care (15.75%)	Addiction Support Services (15.75%)	Health Care (15.75%)	Utilities (15.75%)
Hart	No Needs (33.33%)	Health Care (18.33%)	Transport-ation (18.33%)	Mental Health Care (13.33%)	Food (13.33%)	Elder Care (11.67%)	Clothes (11.67%)
Logan	No Needs (57.63%)	Mental Health Care (10.73%)	Elder Care (9.06%)	Food (9.04%)	Employment (7.91%)	Health Care (7.34%)	Child Care (7.34%)
Metcalfe	No Needs (45.83%)	Mental Health Care (15.28%)	Housing 15.28%	Elder Care (13.89%)	Health Care (12.50%)	Child Care (12.50%)	Transport-ation (11.11%)
Monroe	No Needs (31.11%)	Mental Health Care (20.00%)	Elder Care (15.56%)	Transport-ation (15.56%)	Child Care (15.56%)	Addiction Support Services (15.56%)	Employment (13.33%)
Simpson	No Needs (52.46%)	Mental Health Care (9.02%)	Food (8.20%)	Child Care (8.20%)	Food (8.20%)	Utilities (8.20%)	Health Care (7.38%)
Warren	No Needs (60.64%)	Mental Health Care (10.77%)	Health Care (10.36%)	Food (8.98%)	Child Care (6.77%)	Housing (6.63%)	Employment (6.08%)

Table 37: Family Needs by County, Cont'd

County	8th Need (% Selected)	9th Need (% Selected)	10th Need (% Selected)	11th Need (% Selected)	12th Need (% Selected)	13th Need (% Selected)	14th Need (% Selected)
Allen	Adult Education (13.20%)	Food (12.69%)	Clothes (10.15%)	Child Care (9.14%)	Transport-ation (8.62%)	Domestic Violence Resources (7.11%)	Addiction Support Services (6.09%)
Barren	Transport-ation (9.14%)	Adult Education (7.53%)	Domestic Violence Resources (6.99%)	Clothes (6.45%)	Child Care (5.91%)	Elder Care (5.38%)	Addiction Support Services (4.84%)
Butler	Housing (16.44%)	Adult Education (16.44%)	Utilities (16.44%)	Elder Care (15.07%)	Employment (15.07%)	Addiction Support Services (13.70%)	Transport-ation (12.33%)
Edmonson	Child Care (14.96%)	Elder Care (15.75%)	Adult Education (11.81%)	Food (11.02%)	Housing (10.24%)	Domestic Violence Resources (7.87%)	Clothes (7.09%)
Hart	Housing (11.67%)	Utilities (10.00%)	Adult Education (8.33%)	Employment (6.67%)	Addiction Support Services (5.00%)	Child Care (5.00%)	Domestic Violence Resources (3.33%)
Logan	Housing (6.78%)	Transport-ation (6.21%)	Addiction Support Services (5.08%)	Clothes (3.39%)	Utilities (3.39%)	Adult Education (2.82%)	Domestic Violence Resources (1.69%)
Metcalfe	Adult Education (9.72%)	Clothes (8.33%)	Domestic Violence Resources (8.33%)	Employment (8.33%)	Utilities (8.33%)	Addiction Support Services (6.94%)	Food (6.94%)
Monroe	Utilities (13.33%)	Domestic Violence Resources (11.11%)	Food (8.89%)	Housing (8.89%)	Adult Education (8.89%)	Clothes (6.67%)	Health Care (6.67%)
Simpson	Housing (7.38%)	Elder Care (3.28%)	Employment (3.28%)	Clothes (2.46%)	Adult Education (2.46%)	Addiction Support Services (1.64%)	Domestic Violence Resources (1.64%)
Warren	Transport-ation (6.08%)	Utilities (5.25%)	Clothes (4.42%)	Adult Education (3.87%)	Elder Care (3.59%)	Addiction Support Services (2.49%)	Domestic Violence Resources (1.38%)

Housing Stability:

Housing is one of the social determinants of health which plays an important factor in a healthy community. For example, the results of the survey showed a relationship between tobacco/alcohol use and housing, as those who consume those type of products more often are more likely to have instability with housing. With Simpson County, over 90% of the county resident respondents reported stable housing. Nine out of the 87 respondents reported insecure or no housing.

Housing Stability by County

County	Stable housing	Insecure housing	No housing	Total
Allen	136	30	7	173
	78.6	17.3	4.1	100%
Barren	129	27	5	161
	80.12	16.77	3.11	100%
Butler	52	8	2	62
	83.9	12.9	3.2	100%
Edmonson	88	14	9	111
	79.3	12.6	8.1	100%
Hart	36	10	6	52
	69.23	19.23	11.54	100%
Logan	133	12	3	148
	89.9	8.1	2.0	100%
Metcalfe	43	13	5	61
	70.5	21.3	8.2	100%
Monroe	27	9	5	41
	65.9	22.0	12.2	100%
Simpson	87	4	5	96
	90.6	4.2	5.2	100%
Warren	548	45	10	603
	90.9	7.5	1.7	100%
Total	1279	172	57	1508

Financial Wellbeing:

In addition to housing, financial wellbeing is important as it can contribute to a healthy or unhealthy community. In Simpson County, approximately 1/3 of the respondents stated

that they are living comfortably, while the majority stated they were getting by or having more difficulty. This relates to the top five barriers of health that were reported by respondents.

Table 40: Financial Wellbeing by County

	Living comfortably		Getting by		Finding it difficult to get by		Finding it **very** difficult to get by		Total	
	Count	% of County	Count	% of County	Count	% of County	Count	% of County	Count	% of Respondents
Allen	52	30.1	76	43.9	28	16.2	17	9.8	173	11.4
Barren	60	37.7	73	45.9	15	9.4	11	6.9	159	10.5
Butler	13	20.6	41	65.1	7	11.1	2	3.2	63	4.2
Edmonson	32	28.3	59	52.2	18	15.9	4	3.5	113	7.5
Hart	16	29.1	26	47.3	6	10.9	7	12.7	55	3.6
Logan	63	42.9	65	44.2	15	10.2	4	2.7	147	9.7
Metcalfe	7	11.7	40	66.7	10	16.7	3	5.0	60	4.0
Monroe	11	26.2	25	59.5	3	7.1	3	7.1	42	2.8
Simpson	31	33.3	42	45.2	15	16.1	5	5.4	93	6.2
Warren	239	39.4	270	44.5	67	11.0	31	5.1	607	40.2
Total	524	100%	717	100%	184	100%	87	100%	1512	100%

Key Informant Interviews & Focus Groups:

For each interview or focus group, the data committee used the following format:

Key Informant Interview Protocol
Introduction Script and Interview Questions:

Thank you for meeting with me today. As I explained in the email, I am working with the BRIGHT Coalition to collect data for the Community Health Assessment. This interview is part of a larger data collection effort. We will be talking to other people throughout the region like you who have expertise in community health issues. We will also be meeting

with small groups of community members who are often hard to reach or who are less likely to participate in surveys. Finally, we will be administering an online survey through a variety of outlets to hear from as many community members as possible throughout the BRADD region. All of this data will be combined and analyzed to tell the story of community health in the region with the goal of celebrating the strengths and addressing the areas of opportunity to improve. The questions I will be asking you today are not about you and your health specifically but about the health and wellbeing of the community, strengths and barriers to health care and health resources, and changes you would like to see in the community that could contribute to better health among citizens. I expect this interview to take between 45 minutes to one hour. Your name will not be used in reports although we may use non-identifiable quotes. This sheet (hand out consent document) has more information about the project and your role as a participant. With all of that in mind, do you voluntarily consent to continuing this interview, which will be recorded?

We'll start with a couple of general questions on health and wellbeing in [community].

- What do you hear from people in [community] saying about their health and wellbeing?
    - Probe: Is it largely positive or negative?
- What do you think are the most significant health issues people face in [community]?
    - Probe to elaborate on the issue(s) mentioned: Why is that?

Now we've got a few questions on bridges and barriers to good health in [community].

- What makes [community] special—What are its best resources for health and wellbeing?
    - Probe for impact of resources: What is the result of this resource? Who benefits the most? Do all people in [community] benefit equally? Who can that resource be credited to?
- What are the main barriers you see in achieving optimum health and wellbeing in [community]?
    - Probe for impact of barriers: What is the result of this barrier? Who does it affect most? Does it affect some people in [community] unequally?
- Who has the authority to address the barrier/these barriers?

Continuing on, we've got a couple of questions about short-term and long-term change you'd like to see in [community]

- What health issues do you think need immediate attention or improvement in [community]?
    - Probe for why these issues are selected; who in [community] is affected most/least?
- What long-term health and wellbeing goals would you like to see [community] achieve?
    - Probe for why these goals are selected—What would the outcome be? Who would benefit most?

To finish up, we're going to ask a few questions about who else you think we should talk to in [community]

- Who is taking action to improve health and wellbeing in [community]?
    - Probe for detail on organizations/people doing this work (names, actions, results, etc.)
- Who should we talk to if we want to learn more about what people in [community] are thinking? (Examples if needed to prompt responses: members of particular community organizations, folks either providing or receiving specific community services, farmer's market attendees, churches/religious orgs)

Finally, is there anything we should have asked you that we did not? What do you think is most important for us to know about [community]?

Key Informant Interview & Focus Group Results:
The qualitative data gathered in the following interviews further validates the results of the overall survey.

International Center of Kentucky:
A focus group was held at the International Center of Kentucky. Six community members representing 4 different cultures participated. There was a running theme identified during the session of healthcare providers not listening, not spending enough time translating and not being focused on mental health. They did express that mental health for many refugees, because of what they have been through before relocating and having to assimilate quickly to a new country, is often the root cause of other health conditions.

Diabetes and high blood pressure were identified in the group as the top chronic disease issues for all the refugees represented. The participants expressed concern that again, not enough time is spent with the patient during healthcare appointments and not enough time is spent educating patients on their diagnosis. They identified a gap in knowledge between acute vs. chronic disease management. The group expressed that it is not uncommon for a refugee to be put on a blood pressure or blood sugar medication and stop the medication at the end of the 30-day prescription because they did not understand the need to continue the medication on an ongoing basis.

Regarding food security, many refugees use food assistance programs and find it difficult to find foods they are familiar with, know how to cook, etc. due to cultural differences. They expressed a desire to see more of a cultural variety in the foods provided.

Another important need identified was educating patients on why they are attending or need to attend further appointments, what to expect during the appointment, why certain tests are being performed and anything else that may be important to help the refugees feel more safe, secure and understand the importance of their regular healthcare appointments.

Kayla Byrd, Operations Manager for the International Center of Kentucky was also interviewed. She identified high blood pressure and diabetes as the biggest health issues facing those they serve. She also stated that due to a lack of education there is a perception among the refugee population that they are in good health even if they have uncontrolled chronic diseases.

Lack of resources to manage chronic disease was identified as a gap including lack of transportation for this population. The refugees often do not take time to take themselves or their children for regular healthcare visits due to again a lack of education, understanding of importance, difference in culture as well as lack of transportation.

The Foundry:

Shawna Woods is the interim director of The Foundry in Bowling Green. The Foundry serves the West End of Bowling Green with a mission to develop leaders among the children and young people through education, health, fitness and spiritual development living in that area. Shawna identified food insecurity and mental health/anxiety as the number one and number two areas of need facing the community they serve. Heart issues and diabetes were identified as the top medical issues. And unsafe housing is another major issue their community members face.

The Foundry works diligently with community partners to bridge gaps in the areas of food, housing, transportation, connection and healthcare as best they can. They hold monthly events with different themes and have community partners provide blood pressure screenings, dental screenings, blood sugar screenings, health education, community resources available, etc.

Transportation and language continue to be challenges in this area. The lack of education, stay at home moms with no car or cell phone, elderly with little benefits continue to be ongoing issues that face their area.

Shawna expressed their long-term goal is food security for those they are serving.

Summary of Identified Needs:

Key findings from the focus groups were consistent with the results from the survey. These findings emphasize the importance of accessible healthcare, healthy lifestyles and economic stability in promoting overall well-being. Critical gaps were identified in mental health services, where issues such as cost and social stigma restrict access to care. Economic barriers further exacerbate difficulties in accessing essential health services, including those related to substance use and tobacco consumption.

The assessment highlights several specific areas needing attention:

1. **Mental Health Services:** High demand across counties underscores the need for affordable and comprehensive mental health care.
2. **Chronic Conditions:** High prevalence of conditions like diabetes and physical inactivity points to the need for improved physical activity options and nutritional education.
3. **Healthcare Accessibility:** Economic instability and employment-related barriers significantly hinder healthcare access. Suggestions include employer-supported health time-off and expanded service hours in rural areas.
4. **Vaccination and Preventative Health:** Despite a general acknowledgment of the importance of vaccines, skepticism persists, necessitating enhanced public education and outreach.
5. **Provider-Patient Relationships:** Concerns about discrimination in healthcare suggest a need for provider sensitivity training and community outreach to build trust.

The BRIGHT Coalition is positioned to lead collaborative efforts with local organizations, government entities, and healthcare providers to address these issues. By focusing on enhancing access to care, improving economic stability, and educating the community on health practices, the Coalition can significantly uplift public health standards and ensure equitable health outcomes for all residents in the BRADD region.

The Medical Center at Franklin Implementation Strategies for Addressing Community Health Needs 2025-2027

After thorough review of the survey data, county statistics and feedback from local healthcare professionals, The Medical Center at Franklin has prioritized the following community health issues that will be addressed over the next three years:

- Physical Health
- Access to Care
- Social Determinants of Health

According to data from the County Health Rankings, 39% of adults are obese in Simpson County. Obesity can increase an individual's risk for other chronic conditions such as type 2 diabetes or high blood pressure. The Medical Center at Franklin will continue to partner with other businesses to assist with increasing knowledge of healthy eating and reducing obesity.

According to the Centers for Disease Control and Prevention (CDC), approximately 795,000 people in the United States suffer from strokes each year. Likewise, around 805,000 people have a heart attack. According to the Kentucky Heart Disease and Stroke Prevention Task Force's 2024 Annual Report, the leading cause of death in Kentucky is heart disease with strokes ranking as the 5th leading cause of death (https://www.chfs.ky.gov/agencies/dph/dpqi/cdpb/KHDSP/Kentucky%20Stroke%20Registry%20Annual%20Report%202024.pdf).

High blood pressure, physical inactivity and obesity are the primary risk factors for heart disease and stroke. Chronic high blood pressure increases the risk for heart attacks, stroke, and other conditions. It is important for individuals to be educated on normal blood pressure ranges, managing high blood pressure and understanding the effects and seeking medical help for elevated blood pressure. Education is needed on signs and symptoms of stroke and heart attack along with knowledge of the steps to take if symptoms occur.

Prediabetes and Type 2 diabetes are issues in the BRADD area. The results of the survey showed over 20% having Type 2 diabetes or prediabetes with 10% of the adult population being in Simpson County. Overall, diabetes can lead to other chronic health conditions such as high blood pressure, heart disease and obesity. Appropriate diet and physical activity can help reverse prediabetes from progressing into Type 2 diabetes, along with helping to manage the health of individuals with diabetes. The Medical Center at Franklin

will partner with other stakeholders to provide education to the community with the overall goal of reducing the incidence of Type 2 diabetes.

According to the County Health Rankings, 20% of adults smoke in Kentucky. Likewise, 21% of the adult population in Simpson County smoke. In addition, the use of electronic vapor products is a growing issue. We plan to collaborate our efforts with the BRIGHT Coalition and other organizations to help reduce the incidence of smoking/vaping by providing education to the community.

Access to care, along with quality of care, is vital for a community for optimal health. The Medical Center at Franklin will continue to work with local community partners in providing various programs and services. This will include the use of telemedicine services. During the next three years, we plan to obtain Acute Heart Attack Ready certification through The Joint Commission. In addition, our goal is to obtain our Trauma IV Designation Level which will require our hospital to utilize best practices with trauma patients. There will be a focus on onboarding additional primary care providers and mental health services to meet needs of the community.

Social determinants of health are factors that can negatively impact health within the community. The survey results portrayed various determinants that are perceived to impact health such as food insecurity, housing, childcare, utilities and employment/wages. During interviews with hospital professionals at The Medical Center at Franklin, it was noted that food insecurity education and transportation play a role in patients' abilities to take care of their health. It is interesting to note that 16.4% of Simpson County survey participants stated barriers to access to health included the perceptions of either physicians not taking the patient's seriously or not wanting to treat their conditions.

In regards to a livable wage, Med Center Health began planning investments in its entry level workforce in 2021 following the need for a more livable wage. The organization first made a multi-million dollar investment in 2021 by increasing its minimum wage from $7.25 to $10.50 in April 2021 and from $10.50 to $14.00 in November 2021. We continued investing in livable wages in 2022 with a 3% average wage increase and in 2023 by increasing our minimum wage to $15.00. These increases were done through careful planning and analysis of regional and state livable wages, healthcare industry, and general industry market data as well as the on-going impact to the organization's recruitment and retention of entry level and support positions. Med Center Health's current minimum wage is $15.25, and we continue to evaluate and plan for future increases to our minimum wage through an evaluation of the organization's compensation program.

Source:
https://www.countyhealthrankings.org/health-data/kentucky/simpson?year=2024
https://cdc.gov

Identified Need: Physical Health

Goal:

- To provide education to the community to increase knowledge of healthy eating habits that can assist with reducing obesity.
- To provide education to the community on prevention and management of diabetes.
- To improve negative outcomes, to provide education on signs and symptoms of heart attack and stroke and steps to take if signs were to occur.
- To identify ways to provide counseling services for mental health.
- To continue to support organizations that provide treatment for mental health and substance use.

Partners:

- Barren River District Health Department
- Medicaid Managed Care Program/Case Management
- Med Center Health Primary Care Franklin
- Franklin Simpson Schools
- Local Industries
- Franklin Simpson Chamber of Commerce
- Med Center Health WorkLife Program
- BRIGHT Coalition
- Get Healthy Simpson County

Plan:

- Promote the offering of Medical Nutrition Therapy by a Registered Dietitian at the Med Center Health Health & Wellness.
- Provide nutrition education and body fat analysis to local industries through the WorkLife program.
- Provide education and screenings at community/industry health fairs.

- Sponsor the annual Franklin Simpson Garden Spot 5K Run/Walk and the Community Health Fair.
- Post educational information on the hospital's social media page.
- Collaborate with rural health clinics of Med Center Health to provide mental health professionals for counseling services through the rural health clinics.

Identified Need: Access to Care

Goal:

- To onboard additional primary care providers at the rural health clinic.
- To obtain Acute Heart Attack Ready Certification through The Joint Commission.
- To take steps in obtaining Trauma Level IV designation.

Partners:

- Med Center Health Primary Care Franklin
- National Stroke Association
- Barren River District Health Department
- Kentucky Heart Disease and Stroke Prevention Task Force
- American Heart Association and American College of Cardiology
- The Joint Commission
- Med Center Health
- American Trauma Society
- Kentucky State Trauma Registry
- Norton's Healthcare
- University of Louisville
- UK Healthcare
- AMN Healthcare

Plan:

- Continue to work with providers in expanding telemedicine services with various medical specialties.
- Work with the organizations WorkLife Program to determine needs in providing onsite medical services at local industries.

- Work with other stakeholder groups to provide education to the community on resources available in mental health and substance use.
- Work with other stakeholder groups to provide education to the community on resources available in mental health and substance abuse.
- Successful completion of initial survey and ongoing surveys to receive certification as an Acute Heart Attack Ready Hospital.
- Collaborate with primary care providers at Med Center Health Primary Care Franklin in addressing chronic health needs of patients and closing gaps to maximize health.
- To increase the number of primary care providers at the rural health clinic.
- To collect data and take steps toward obtaining Level IV Trauma Designation.
- To provide mental health counseling services through the rural health clinic.

Identified Need: Social Determinants of Health

Goal:

- To assist with providing education to patients and the community on available food resources.
- To work with community stakeholders to identify the possibility for additional local transportation services that could assist patients with having improved access to health options.

Partners:

- Barren River District Health Department
- City of Franklin
- Community Action
- LKLP of Medicaid
- Department of Community Based Services
- Room at the Inn
- Salvation Army
- St. Vincent De Paul
- Life's Better Together

- United Way
- National Research Center Health

Plan:

- To provide a packet of resources to patients and at community events that includes food, housing, utility assistance, mental health assistance, personal care items, et cetera., within the county and surrounding counties.
- To provide information on resources to local community healthcare providers for them to share with their patients.
- To collaborate with community leaders on the feasibility of providing additional local transportation (bus service, etc.…).
- Continue establishing hospital performance improvement goals to maximize customer service scores to assist with reducing negative perceptions of patients towards providers.
- To provide education to healthcare professionals as needed on enhancing customer service skills.

Explanation of priorities that will not be addressed at this time:

Substance use is an ongoing issue in the BRADD region. While this will not be a direct priority for The Medical Center at Franklin, it will be supported through the organization. Med Center Health has partnered with the Barren River District Health Department, Barren River Area Development District and LifeSkills to execute the Anchor Project. A regional office of Drug Control Policy will be established for the entire region. The office will serve as point guard for all projects within the region and help local decision makers maximize the use of federal, state and local dollars. A mental health crisis intake center will be established. The center will house a 24/7 triage that will be located within LifeSkills umbrella of services. The center will mitigate countless expenses in man-hours and create thousands of dollars in savings to communities experiencing substance use and mental health crisis.

The Medical Center at Franklin will also not be addressing housing insecurity and livable wages. We are aware that this can be a social determinant of health. Although this will not be the hospital's direct focus during this cycle, we will be supporting efforts made by the BRIGHT Coalition and other stakeholders.

Communication Plan

The Medical Center at Franklin will publish the Community Health Needs Assessment inclusive of the survey results and strategic plan on its website and make hard copies available to the public upon request. In addition, the results will be added in the hospital's annual IRS tax form 990 submission.

Conclusion

The Medical Center at Franklin has been committed to the Community Health Needs Assessment throughout the process. It has served to strengthen relationships with other providers of healthcare and organizations in the community. The surveys conducted lead to data-driven identification of key community health needs. The hospital has developed a detailed strategic plan to address these needs over the next three years with the ultimate goal being to improve the quality of life of the individuals in the community we serve.

FULL BRIGHT SURVEY

Community Health Needs Assessment

1) Which county do you live in? *
( ) Allen
( ) Barren
( ) Butler
( ) Edmonson
( ) Hart
( ) Logan
( ) Metcalfe
( ) Monroe
( ) Simpson
( ) Warren
( ) Another county or state - **Please do not complete the survey if you live in another county or state**

2) What is the ZIP code where you live (or where you most often stay)?
_____

3) What helps people stay healthy in your community? **Pick the top 3.**
[ ] Good place to raise children
[ ] Low crime / safe neighborhoods
[ ] Good schools
[ ] Access to health care (e.g., family doctor)
[ ] Parks and recreation
[ ] Clean environment
[ ] Affordable housing
[ ] Arts and cultural events
[ ] Inclusive community (in other words, people are accepted for who they are)
[ ] Good jobs and healthy economy
[ ] Strong family life
[ ] Healthy behaviors and lifestyles
[ ] Farmer's markets
[ ] Local leaders (such as government or school leaders) who prioritize health
[ ] Sense of community belonging (for example: religious participation, welcoming community events and places)
[ ] Other - Write In (Required): _____
_____
[ ] Prefer not to answer

4) Where do you usually get information about staying healthy? **Check all the places you use.**
[ ] Healthcare provider
[ ] Public health officials (such as your local health department or the CDC)
[ ] Friends/family
[ ] Social media (such as TikTok, Facebook, Instagram, YouTube)
[ ] Internet sources other than social media (sources such as Google or WebMD)
[ ] Television (news programs)
[ ] Radio
[ ] Community Events (such as health fairs or events for particular health concerns)
[ ] Other - Write In (Required): _____

5) In general, would you say your health is…?*
( ) Great
( ) Good
( ) Okay
( ) Not good
( ) Bad
( ) Prefer not to answer

6) In the last month, how many days did being sick, ill, or hurt stop you from your usual activities like taking care of yourself, working, or having fun?*

7) When did you last visit a doctor or nurse for a regular health check?*
( ) Within the past year **– Skip to # 9**
( ) More than 1 year to 2 years ago
( ) More than 2 years to 5 years ago
( ) Longer than 5 years ago
( ) Never
( ) Not sure
( ) Prefer not to answer

8) If you haven't seen a doctor in the last year, why not? **Check all the reasons.**
[ ] Cost of the visit
[ ] Transportation
[ ] Unable to take time off work
[ ] Cost of the treatment
[ ] Don't have health insurance
[ ] Lack of child care
[ ] Lack of available doctors
[ ] Could not find a doctor that accepts my insurance
[ ] I don't like or trust doctors
[ ] Other - Write In (Required): _____

9) Do you have diabetes?*
( ) Yes, I am diabetic
( ) I am pre-diabetic
( ) No, I am not diabetic - Skip to #11
( ) I do not know - Skip to #11
( ) Prefer not to answer - Skip to #11

10) Have you been referred to

	Yes	No	I'm not sure
a dietitian (someone who helps you learn what foods to eat and what foods to avoid)			
diabetes education (to help you learn more about your condition and how to care for yourself)			

11) In the past year, have you done any of the following to save money?
( ) Skipped one or more doses of medication to delay refilling the prescription
( ) Choose not to fill prescriptions
( ) Taken a smaller dose of medication than was directed
( ) Other – Write In (Required): _____
( ) None of the above

12) In the last year, was there anything you or your family needed but couldn't get? **Check all the boxes that apply.***
[ ] Addiction Services
[ ] Mental health care services
[ ] Child Care
[ ] Clothing
[ ] Domestic Violence Assistance
[ ] Elder Care
[ ] Employment
[ ] Food
[ ] Health Care
[ ] Housing
[ ] Adult educational services
[ ] Transportation
[ ] Utilities
[ ] None of the above
[ ] Other - Write In (Required): _____
[ ] Prefer not to answer

13) What makes it hard for you to get health services? **Check any problems you face.** *
[ ] I don't have any barriers
[ ] Costs too much for appointments, procedures, or medications
[ ] I don't have a car or can't afford gas for my car/truck
[ ] Don't have someone to give me a ride
[ ] Can't take time off work
[ ] Disability (mental/physical)
[ ] Worried the doctor won't take me seriously
[ ] Worried the doctor doesn't like caring for or treating with people like me
[ ] Don't know where to obtain services
[ ] Can't get an appointment that works for my schedule
[ ] No doctors available
[ ] I don't have insurance
[ ] Don't have child care
[ ] Language barriers
[ ] Other - Write In (Required): _____
[ ] Prefer not to answer

14) During a typical weekday (Monday - Friday), how many hours do you sit per day? This could be while working or during fun or down time (such as watching tv or playing video games). Do not count hours while you are asleep.*
15) How many hours do you sleep on a normal week night? *

16) How many **days per week** do you exercise? This could include walking, running, riding a bike, lifting weights, doing yoga or Pilates, playing a sport, or any other activity that you do to work out your body. Do NOT include physical activity that is part of your job. *
( ) 0 days
( ) 1-2 days
( ) 3-4 days
( ) 5-6 days
( ) 7 days
( ) Prefer not to answer

17) On days you exercise, how many minutes per day do you usually exercise for?

18) How would you describe your overall mental health?*
( ) Great
( ) Good
( ) Okay
( ) Not good
( ) Bad

19) Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health **not** good?*

20) People can get counseling, treatment, or medicine for many different reasons, such as:
For feeling depressed, anxious, or "stressed out"
Personal problems (like when a loved one dies or when there are problems at work)
Family problems (like marriage problems or when parents and children have trouble getting along)
Needing help with drug or alcohol use
For mental or emotional illness

In the last 12 months, did you get counseling, treatment, or medicine for any of these reasons?*
( ) Yes – **Skip to #23**
( ) No – **Continue to #21 & #22 but skip #23**
( ) Prefer not to answer

21) In the last 12 months, did you **want to** get counseling, treatment, or medicine but were unable to?
( ) Yes, I wanted to but couldn't
( ) No, I did not want counseling, treatment, or medicine

22) What stops you from getting mental health services when you need them? **Check all that apply.**
[ ] I am ashamed or uncomfortable talking about personal issues
[ ] I do not have internet access to find a provider
[ ] I can't get in to see a mental health provider
[ ] Don't have a ride or a way to get there
[ ] Language/cultural
[ ] The times they are open do not work with my schedule
[ ] I don't have insurance
[ ] I have insurance but it doesn't cover mental health
[ ] Services cost too much
[ ] Tried before, it didn't work
[ ] Tried before, takes too long to get an appointment
[ ] Other - Write In (Required):

23) Where do you go most often when your mental health is not good?
( ) Community mental health center (ex: LifeSkills)
( ) Private mental health practice (ex: a therapist with their own place or with a small group of other therapists)
( ) My psychiatrist/psychiatric nurse practitioner
( ) Hospital Emergency Room
( ) My regular primary care doctor
( ) Veterans Administration Hospital (VA)
( ) Another mental health service (please specify):_____

24) How often do you feel lonely or like you are by yourself?
( ) Always
( ) A lot
( ) Often
( ) Sometimes
( ) Never

5) How often do you use each of the following?*

	Every day	**Some days**
Smoke cigarettes		
Use chewing tobacco or snuff		
Use e-cigarettes or other electronic vaping products		

If you use any cigarettes, chewing tobacco, snuff, e-cigarettes, or other electronic vaping products, please answer #26. If not, please skip to #27
26) Do you want to stop using tobacco products?*
( ) Yes
( ) No
( ) Prefer not to answer

27) Which of the following options for quitting smoking are available in your community? Check all that apply.
[ ] Nicotine patch
[ ] Nicotine gum or lozenges
[ ] Prescription medication
[ ] Counseling, support groups, or help line
[ ] Switching to electronic or e-cigarettes (vaping)
[ ] Cold turkey or stopping without any other substitute or intervention
[ ] Other - Write In (Required): _____

28) During the past 30 days, how many days per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?

29) Have you ever felt you should cut down on your drinking?
( ) Yes
( ) No

30) In the last 30 days how, many times did you...
cut a serving of your meal or skip a meal altogether because there was not enough money for food?
( ) Never
( ) 1-5 times
( ) 6-10 times
( ) 11-15 times
( ) 16 or more times
visit a food bank, soup kitchen, or another similar service that provides food?
( ) Never
( ) 1-5 times
( ) 6-10 times
( ) 11-15 times
( ) 16 or more times

31) Which of the following caregiving responsibilities do you have on a regular basis? **Check all the boxes that are true for you.***
[ ] One or more children under age 5
[ ] One or more children between the ages of 5 and 11
[ ] One or more children between the ages of 12 and 18
[ ] One or more family members (including children) with disabilities
[ ] One or more family members (including children) with significant health care issues
[ ] Aging parents who live with me
[ ] Aging parents who do not live with me but who I care for regularly
[ ] Other - Write In (Required): _____
[ ] I do not have caregiving responsibilities

If you do not have caregiving responsibilities, skip to #33.

32) Have you had difficulties with any of the following? **Check all the boxes that are true for you.**
[ ] Finding childcare options
[ ] The cost of childcare
[ ] Finding preschools
[ ] The availability of preschool spots
[ ] Afterschool care for children
[ ] Finding doctors for those I care for
[ ] Affording health care costs for those I care for
[ ] Finding someone to help care for aging parents
[ ] Difficulty affording help to care for aging parents
[ ] Finding support for disabled family member
[ ] My own mental health or stress for providing care
[ ] I don't have time for myself due to caregiving responsibilities
[ ] I do not have caregiving difficulties
[ ] Other - Write In (Required): _____

33) To what extent do you agree or disagree with the following statement:
The community has adequate mental health services for people who need them.
( ) Strongly Disagree
( ) Disagree
( ) Neither Agree nor Disagree
( ) Agree
( ) Strongly Agree

34) To what extent do you agree or disagree with the following statement:
All income groups have access to mental health services.
( ) Strongly Disagree
( ) Disagree
( ) Neither Agree nor Disagree
( ) Agree
( ) Strongly Agree

35) Overall, what are the **top three** mental health needs in the community that should be addressed? *
[ ] Addressing the stigmatization of those with mental health issues

[ ] Affordable health insurance that includes mental health care
[ ] Affordable mental health services
[ ] Affordable prescriptions
[ ] Availability of transportation to mental health services
[ ] Care for Caregivers
[ ] Children's mental health services
[ ] High quality mental health services
[ ] More mental health education
[ ] More number of mental health care providers
[ ] Substance abuse prevention/treatment
[ ] Suicide prevention
[ ] Another mental health need (please specify): _____
[ ] I don't know

36) In your opinion, what are the **issues in our community** that have the greatest **negative** impact on our health? **Please select the top 3.**
[ ] Limited access to healthcare
[ ] Limited access to medications
[ ] Not getting vaccines
[ ] Limited access to healthy foods
[ ] Poor eating habits
[ ] Lack of exercise
[ ] Lack of a livable wage
[ ] Homelessness or housing insecurity
[ ] Distracted driving
[ ] Not using seat belts/child safety seats
[ ] Dropping out of school
[ ] Excessive social media use
[ ] Bullying
[ ] Substance misuse (for example, alcohol, opioids, meth)
[ ] Tobacco use
[ ] E-cigarette use (vaping, JUULS)
[ ] Racism
[ ] Child abuse or neglect
[ ] Adult or senior abuse or neglect
[ ] Domestic violence/intimate partner violence
[ ] Community violence
[ ] Unsafe sex
[ ] Human trafficking
[ ] Rape/sexual assault
[ ] Other - Write In (Required): _____

37) What help is available in your community for people who want to stop using drugs or drinking too much alcohol? (Check all that apply)
[ ] Talking to a counselor or therapist
[ ] Going to a place where they help you stop (rehabilitation or treatment centers)
[ ] Meeting groups where people support each other (ex: Alcoholics Anonymous, Narcotics Anonymous)
[ ] Learning programs about not using drugs or drinking
[ ] Doctors who help with stopping
[ ] Programs for exchanging used needles safely
[ ] Help with laws and rules about using drugs (legal aid services related to substance use)
[ ] Outreach and community support services
[ ] None that I am aware of
[ ] Other - Write In (Required): _____
[ ] I don't know

38) To what extent do you agree with the following statement: "Vaccines are important for the health of the community."*
( ) Strongly disagree
( ) Disagree
( ) Neither agree nor disagree
( ) Agree
( ) Strongly agree
( ) Prefer not to answer

39) For each vaccine below, please select the statement that is true for you.
Flu shot
( ) I have gotten this shot – Skip #40
( ) I have not gotten this shot – Got to # 40
( ) I don't know if I've gotten this shot – Skip #40
40) Why didn't you get **the flu shot**?
[ ] I didn't know where to go to get it
[ ] The times to get it didn't work with my schedule
[ ] I couldn't afford it
[ ] I did not have transportation to get it
[ ] I didn't know I needed it or I don't know what it is
[ ] I wanted it but it wasn't available
[ ] I was concerned about the risk
[ ] I don't want to get it
[ ] Other - Write In (Required): _____

TDAP (tetanus, diphtheria, pertussis)
( ) I have gotten this shot – Skip #41
( ) I have not gotten this shot – Got to # 41
( ) I don't know if I've gotten this shot – Skip #41

41) Why didn't you get **the TDAP shot**?

[ ] I didn't know where to go to get it
[ ] The times to get it didn't work with my schedule
[ ] I couldn't afford it
[ ] I did not have transportation to get it
[ ] I didn't know I needed it or I don't know what it is
[ ] I wanted it but it wasn't available
[ ] I was concerned about the risk
[ ] I don't want to get it
[ ] Other - Write In (Required): _____

COVID-19 Vaccine
( ) I have gotten this shot – Skip #42
( ) I have not gotten this shot – Got to # 42
( ) I don't know if I've gotten this shot – Skip #42

42) Why didn't you get **the COVID-19 vaccine**?
[ ] I didn't know where to go to get it
[ ] The times to get it didn't work with my schedule
[ ] I couldn't afford it
[ ] I did not have transportation to get it
[ ] I didn't know I needed it or I don't know what it is
[ ] I wanted it but it wasn't available
[ ] I was concerned about the risk
[ ] I don't want to get it
[ ] Other - Write In (Required): _____

COVID-19 Boosters
( ) I have gotten this shot – Skip #43
( ) I have not gotten this shot – Got to # 43
( ) I don't know if I've gotten this shot – Skip #43

43) Why didn't you get **the COVID-19 booster**?
[ ] I didn't know where to go to get it
[ ] The times to get it didn't work with my schedule
[ ] I couldn't afford it
[ ] I did not have transportation to get it
[ ] I didn't know I needed it or I don't know what it is
[ ] I wanted it but it wasn't available
[ ] I was concerned about the risk
[ ] I don't want to get it
[ ] Other - Write In (Required): _____

44) What kind of health care insurance do you currently have?*
( ) Health insurance through an employer (my own, my spouse's, or my parents)
( ) Health insurance through the government (such as Medicare, Medicaid, or Indian Health Service)
( ) Health insurance I or my spouse pays for on my/our own (such as Cobra or a health plan on the state or federal marketplace such as KYNECT)
( ) I do not have health insurance
( ) Not sure
( ) Prefer not to answer

45) What is your age*

46) Are you...?*
( ) Female
( ) Male
( ) Trans female/Transwoman
( ) Trans male/Transman
( ) Genderqueer/Gender nonconforming
( ) I prefer to describe my identity as... (write in): _____
( ) Prefer not to answer

47) Do you think of yourself as…?*
( ) Straight or heterosexual
( ) Lesbian, gay, or homosexual
( ) Bisexual
( ) Another identity (please specify): _____
( ) Not sure
( ) Prefer not to answer

48) What is your race/ethnicity? **Please select all that are true for you.***
[ ] White
[ ] Black or African American
[ ] American Indian or Alaska Native
[ ] Hispanic, Latino(a), or Spanish
[ ] Asian
[ ] Native Hawaiian or other Pacific Islander
[ ] Other - Write In (Required): _____
[ ] Prefer not to answer

49) What is your marital status?*
( ) Married
( ) Divorced
( ) Widowed
( ) Separated
( ) Never been married
( ) Living with a partner
( ) Prefer not to answer

50) What is the highest grade or year of school you completed?*

( ) Never attended school or only attended kindergarten
( ) Grades 1 through 8 (Elementary)
( ) Grades 9 through 11 (Some high school)
( ) High school graduate
( ) GED or alternative high school credential
( ) Some college credit but no degree
( ) Associates degree
( ) Bachelor's degree (for example, BA, BS)
( ) Master's degree (for example, MA, MS, MBA)
( ) Professional or doctoral degree (for example, MD, JD, PhD)
( ) Prefer not to answer

51) Are you currently…? **Please select all that apply.***
[ ] A Student
[ ] Employed for wages
[ ] Self-Employed
[ ] A stay-at-home parent
[ ] Unemployed and looking for work
[ ] Unemployed and not looking for work (BUT NOT a stay-at-home parent or retired)
[ ] Retired
[ ] Unable to Work
[ ] Prefer not to answer

52) What was your total household income last year before taxes?*
( ) Less than $10,000
( ) $10,001 to $15,000
( ) $15,001 to $20,000
( ) $20,001 to $35,000
( ) $35,001 to $50,000
( ) $50,001 to $65,000
( ) $65,001 to $80,000
( ) $80,001 to $100,000
( ) $100,001 to $120,000
( ) $120,001 to $150,00
( ) More than $150,000
( ) Prefer not to answer

53) How would you describe your financial well-being? *
( ) Living comfortably
( ) Getting by
( ) Finding it difficult to get by
( ) Finding it very difficult to get by
( ) Prefer not to answer

54) What is your housing situation today? *
( ) I have housing
( ) I have housing today, but I am worried about losing housing in the future
( ) I do not have permanent housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
( ) Prefer not to answer

55) How many people, including you, live with you most of the time?
_____

Discrimination
56) How often have you been discriminated against or treated unfairly for any of the following?

	Never	**Sometimes**	**Regularly**
Race/Ethnicity			
Religion			
Age			
Gender			
Sexual Orientation			