FRANKLIN COUNTY
COMMUNITY HEALTH IMPROVEMENT PLAN
2018 – 2019 ANNUAL REPORT

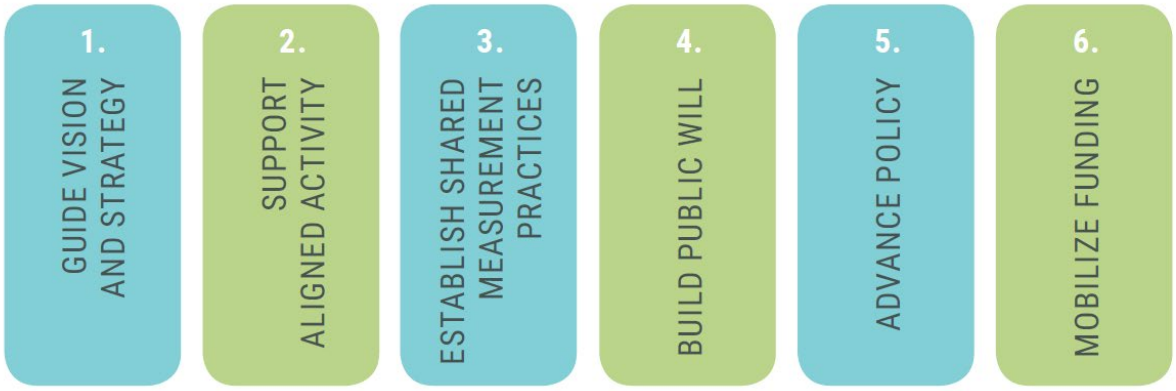
*Revised May 2020

The Franklin County Community Health Improvement Plan (CHIP) was possible thanks to the collaborative efforts of numerous members of Franklin County Public Health (FCPH) staff, local stakeholders, partners and members of *Health Works Franklin County*. *Health Works Franklin County* is a broad-based coalition sponsored by the Franklin County Board of Commissioners and Franklin County Public Health, in support of the "health in all policies" (HiAP) initiative sponsored by the Aetna Healthiest Cities/Counties Challenge. The contributions, expertise, time and resources of all parties involved in the CHIP were critical to the completion of this assessment. The FCPH Board of Health, Health Commissioner and Senior Leadership would like to acknowledge and thank everyone for their contribution to this process.

A community health improvement plan, or CHIP, is a strategic listing of priority health areas with targeted outcomes and measurable indicators. The CHIP reflects the findings of the community health assessment (CHA), which is the foundation for improving and promoting the health of community members. Community health improvement plans are action-oriented and focus on priority community health issues. A CHIP demonstrates how these priority issues will be addressed and measured.

The Franklin County CHIP was developed using the concept of **collective impact**. Collective impact is based on the idea that in order for organizations to create lasting solutions to social problems, they need to coordinate their efforts and work together around a specific goal. Collective impact moves away from organizations working in isolation and supports organizations forming cross-sector coalitions in order to have sustainable progress. Ongoing support for collective impact work is provided by a backbone organization dedicated to the initiative. The backbone organization for the Franklin County CHIP is Franklin County Public Health.

The background organization plays six roles in moving the initiative forward:



In October of 2018, FCPH released the Franklin County CHIP and identified:

- ***Chronic Disease***
- ***Mental/Behavioral Health and Addiction***
- ***Access to Overall Healthcare, and***
- ***Maternal and Infant Health***

As the top four priority issues for franklin county communities. In alignment with the collective impact process, Franklin County Public Health engaged *Health Works Franklin County* to create and implement the CHIP process. *Health Works*

Franklin County is a partnership led by the Franklin County Board of Commissioners and Franklin County Public Health. The goal is to integrate and coordinate social determinants of health data, policy and planning efforts with the public health system recognizing equity as the foundation of the work completed. *Health Works Franklin County* continues a theme of highlighting the strong connection between social and economic conditions and population health. The highlights below are meant to provide an update and represent work that has been accomplished to address the four priority areas beginning in late 2018 and throughout 2019.

2018 Highlights

Priority Area 1: Chronic Disease (Collective Impact Lead, Hypertension - American Heart Association; Diabetes - Central Ohio Diabetes Association; Obesity/Physical Activity/Nutrition - Franklin County Public Health)

Outcomes:

1. Reduce Heart Disease
    a. **Formation of Hypertension Workgroup:** Convened stakeholders from local and state organizations to address disparities in populations vulnerable to heart disease, heart attack and stroke.
    b. **Established partnership with OSU Center for Clinical and Translational Science:** Whitehall Community Health Action Team (CHAT) hosted community presentations on Life's Simple 7, an education model defined by the American Heart Association to help people identify the 7 risk factors they should improve, through lifestyle changes, to achieve ideal cardiovascular health, reaching 16 residents.

2. Reduce Diabetes:
    a. **Formation of diabetes workgroup:** Convened stakeholders form local and state organizations to develop a Franklin County Diabetes Work Plan. The draft plan has three priority areas which include: Community Environment (primary prevention), Infrastructure Development (secondary prevention) and Connections & Support (tertiary prevention). The goals, metrics and outcomes across these priority areas align with one or more social determinants of health as outlined in the Health Works Franklin County SDoH framework.

3. Reduce Obesity through Physical Activity and Improved Nutrition
    a. **Tower Gardens:** In partnership with Mt. Carmel, 13 tower gardens were provided to four of our public school districts. Six were placed in Whitehall Schools, five at Groveport-Madison Schools, one at Canal Winchester Schools and one at Reynoldsburg Schools. A total of $14,401.00 was invested.
    a. **Ohio Days:** My Plate, My State program has reached over 62,000 students preK-12 in five FCPH school districts (Bexley, Upper Arlington,

New Albany-Plain, Grandview and Columbus City Schools) and one child care center.

b. **Fresh Produce Distribution:** Prairie Township CHAT hosted a produce market and served 424 families in 2018.
c. **Community Cookbook:** Prairie Township CHAT created and distributed community cookbooks to 3 agency partners to pass out to community members.
d. **Community in Motion Initiative:** Southwest CHAT launched a new initiative to educate the community on the 9 dimensions of wellness and recruited 14 local businesses and organizations to provide discounted or free wellness resources.

Priority Area 2: Mental/Behavioral Health/Addiction (Collective Impact Lead Franklin County Public Health)

Outcomes:

1. Reduce Unintentional Drug Overdose Deaths
    a. **FCPH Naloxone trainings**: Hosted 34 naloxone trainings and distributed a total of 956 naloxone kits to community members
    b. **FCPH Agency trainings**: Trained 14 local agencies seeking education and prevention measures from FCPH and distributed a total of 70 naloxone kits
    c. **Franklin County Office of Justice Policy and Programs (FCOJPP) Naloxone distribution**: Provided 254 naloxone kits to community members (referred to as clients) transitioning from jail facilities.
    d. **FCOJPP Pathways to Women's Healthy Living**: Linked 57 clients transitioning from incarceration to a Peer Support Specialist (P2P)

2. Reduce Tobacco Use
    a. **FCPH was awarded the Tobacco Use Prevention Program grant:** This ODH grant will support efforts to; Increase the number of smoke-free units in multi-unit housing sites; and Increase tobacco-free public space or outdoor space policies.

3. Increase education and resources regarding violence in schools
    a. **Awarded the Franklin County Commissioners Community Partnership Grant** in the amount of $52,800.00 to aid in the completion of Stop the Bleed trainings as well as purchase of Public Treatment Kits to be disseminated to the 15 local school districts within Franklin County.

Priority Area 3: Access to Overall Healthcare (Collective Impact Lead FCPH)

Outcomes:

1. Increase Access to Dental Care
    a. **Nothing to report**

2. Increase Access to Medical Care
    a. **Health Fairs:** CHAT partners hosted 1 health fair, targeting Whitehall to connect 300 residents to medical and wellness resources.

3. Increase Access to Mental/Behavioral Healthcare
    a. **Generation Rx Program Collaboration:** Forged a partnership with Generation Rx to distribute a toolkit intended for teen audiences to educate about opiate use and encourages teens to share their own story of how they safely use medication and prevent misuse.

Priority Area 4: Maternal and Infant Health (Collective Impact Lead CelebrateOne)

Outcomes:

1. Reduce Pre-Term Births
    a. **Community Cessation Initiative:** Franklin County Public Health, in partnership with the Franklin County Tobacco Free Collaborative and several area public, nonprofit and healthcare agencies, launched a new tobacco cessation program to help Franklin County residents kick the habit. Called the Community Cessation Initiative (CCI), the program provided free and accessible tobacco cessation services to any Franklin County resident, but was specifically targeting pregnant women, people of low socioeconomic status and individuals with mental health issues.

2. Reduce Low Birth Weight Births
    a. **Safe Sleep Education:** Conducted 33 home visits; provided positive smoking education to participants.

3. Reduce Infant Mortality
    a. **Grants:** In an effort to increase its focus on infant mortality FCPH applied for multiple grants over the course of 2018 and into 2019 such as the CDC REACH Grant and others to specifically expand our home visiting efforts.

4. Improve Immunization Rates for Vaccine Preventable Diseases
    a. **Funding from the Ohio Department of Health's, "Get Vaccinated Ohio-Public Health Initiative" Grant**
        - FCPH analyzed multiple indicators of significant immunization disparities and created a plan to focus on increasing immunization rates in two zip codes with the largest numbers of kindergarten through 12th grade students who have not received all of their required school vaccines.
        - Partnered with 8 physician offices to provide education on best immunization practices and feedback and immunization coverage rate assessments.

2019 Highlights

Priority Area 1: Chronic Disease (Collective Impact Lead(s) Hypertension - American Heart Association; Diabetes - Central Ohio Diabetes Association; Obesity/Physical Activity/Nutrition - Franklin County Public Health)

Outcomes:

1. Franklin County will reduce mortality related to Heart Disease by 5%
   a. **Pathways Hub**: FCPH became a Care Coordination Agency (CCA) with the Central Ohio Pathways Hub Program. Approximately 202 paths opened, 52 pathways completed and 39 community members were served. FCPH Reimbursed $3,330 through Medicaid Manage Care Plans (April – September)
   b. **Expand Community Health Worker (CHW) Capacity**: hired 4 Community Health Workers; have secured 15 new referral partnerships across Franklin County for FCPHs CCA program.
   c. **Partnership with OSU Center for Clinical and Translational Science:** Southwest CHAT hosted community presentations on Life's Simple 7, an education model defined by the American Heart Association to help people identify the 7 risk factors to improve health through lifestyle changes to achieve ideal cardiovascular health, reaching 10 residents.

2. Franklin County will reduce mortality rates related to Diabetes by 5%
   a. **Diabetes Workgroup completed infographic:** the infographic was designed to visually display the workgroup's Workplan activities including metrics and strategies focusing on Primary, Secondary and Tertiary outreach
   b. **Established a partnership with the African American Male Wellness Walk Initiative**: provided FCPH the opportunity to conduct an onsite survey with participants of the walk, distribute information and refer participants to partners and interagency services (Breathing Association, Community Cessation Initiative, recruit as partner in Hypertension Workgroup, etc.).

3. Reduce Obesity through increasing access to Physical Activity and Nutrition Programs
   a. **Continuing the partnership with Mt. Carmel:** 3 additional tower gardens were purchased. These towers were placed at a Reynoldsburg High School. A total of $3,685.85 was invested.
   b. **FCPH awarded the Farm to School Grant:** from the United States Department of Agriculture for a total of $99,332 to expand the Ohio Days: My Plate, My State program.

c. **Whitehall community food survey:** The Whitehall CHAT distributed surveys to 117 residents to identify potential barriers to practicing healthier eating habits.
d. **Fresh produce distribution:** Clinton Township CHAT launched a new produce market in partnership with Mid-Ohio Food bank. The produce markets in Clinton and Prairie Townships served 1,708 families in 2019.
e. **Cooking demonstration:** Prairie Township CHAT hosted 2 cooking demonstrations for Minority Health Month reaching 100 people.
f. **Community in Motion Initiative:** Southwest CHAT connected with 300 residents at 7 community events to promote the Community in Motion initiative.

Priority Area 2: Mental/Behavioral Health/Addiction (Collective Impact Lead Franklin County Public Health)

Outcomes:

1. Reduce Unintentional Drug Overdose Deaths by 5%
   a. **FCPH Naloxone trainings:** Hosted 54 naloxone trainings, distributed 1,315 naloxone kits, and distributed 496 Drug Disposal Bags.
   b. **Medication disposal bag distribution:** CHAT partners distributed 806 drug disposal bags total over 15 community events.
   c. **FCPH collaboration with law enforcement agencies**: Four permanent drug disposal boxes purchased through the Prescription Drug Overdose funding was successfully implemented at Madison Township Police Department, Franklin Township Police Department, Clinton Township Police Department and Columbus Police Department.
   d. **Partnership with ADAMH**: resulted in 300 additional drug disposal bags being provided and distributed by FCPH, drug disposal bags can be requested by Franklin County residents through FCPH website. Once a request is submitted, free disposal bags are mailed in 1-2 business days.
   e. **FCPH Opiate Crisis Media Campaign**: Through Radio One, an opioid campaign including a community interview, broadcast radio, social media, streaming and behavioral targeting was launched resulting in over 310, 743 impressions in the FC community.
   f. **FCPH Drug Disposal Flyers**: In collaboration with the Franklin County Office on Aging (FCOA), 4,000 flyers highlighting the proper drug disposal process were mailed out to Franklin County senior citizens by FCOA.
   g. **Completion of the ODH Prescription Drug Overdose (PDO) Grant**: FCPH received a total of 1.3 million dollars as part of the PDO grant to influence areas of policy development and education, environmental and healthcare changes, and further education, training and professional development related to the opioid crisis. Funding went to 2 distinct purposes:
      - Partner with FCOJPP in hiring and sustaining 4 peer support specialist; and
      - Partner with the OSU Wexner Medical Center on an Emergency Department (ED) Care Coordination Project to increase ED initiation of Medication-Assisted Treatment (MAT), integration of

supportive services and linkage to care addressing the SDOH into OSU's health system based on evidence based clinical practices in the ED setting.

- "DATA 2000 permits qualified physicians to obtain a waiver from the Narcotic Addict Treatment Act to treat opioid addiction with Schedule III, IV, and V opioid medications or combinations of such medications that have been specifically approved by the Food and Drug Administration (FDA) for that indication. Such medications may be prescribed and dispensed." As a result of the ED project:
    1. Data 2000 waived ED providers: 55
    2. MAT initiated in ED (per manual logs): 155
    3. Number of referrals to linkage to care services: 3,881
    4. Patients who received naloxone kits: 425

h. **Awarded the ODH (Project Dawn) IN20/21 Grant:** Utilizing the $113,000 award, FCPH will work in collaboration with Office of Justice Policy and Programs, 1DivineLine2Health, Jordan's Crossing, and Whitehall Division of Fire to build an evidence-based, sustainable infrastructure that will increase the access to naloxone among Franklin County residents (particularly those who are at high risk of overdose or residents whom are likely to be in a position to respond to an overdose).

i. **Awarded the CDC Overdoes Data 2 Action Grant:** FCPH was awarded a three-year Centers for Disease Control and Prevention (CDC) Overdose Data to Action Grant, which will bring $3.9 million dollars a year to our community to fight the opiate crisis. The purpose of the funding is to obtain high quality, more comprehensive, and timelier data on overdose morbidity and mortality, and use the data to inform prevention and response efforts.

2. Reduce Tobacco Use by 5%
    a. **Co-hosted Vaping Seminar:** Along with The Breathing Association, Buckeye Health Plan, American Heart Association, and the Educational Service Center of Central Ohio, the use of e-cigarettes and vaping devices is growing exponentially, especially in youth who have never used tobacco products. This seminar was designed to prepare professionals working with youth and adults to understand the impact of vaping and e-cigarette use. The final attendee count was 113 people and 85 attendees received CEUs.
    b. **Created Vaping Task Force** comprised of community leaders to develop an action plan combatting vape trends as part of the ODH.
    c. **FCPH was awarded an additional $12,000** in funding from the Ohio Department of Health (ODH) Tobacco Use Prevention and Cessation grant to address vaping.
    d. **Community Cessation Initiative (CCI):** Received 776 referrals for individuals wanting to quit tobacco use and enrolled 354 individuals into the

program. Over 204 individuals reported to have reduced their tobacco use, while 65 reported to have quit for at least 30 days.

e. **FCPH was awarded the Tobacco Use Prevention and Cessation Program grant:** This ODH grant will support efforts to; Increase the number of smoke-free units in multi-unit housing sites; Strengthen K-12 tobacco school policies in Grove City and other jurisdictions throughout the county; Adoption of Point of Sale (POS) policies within tobacco retail establishments; and Increase tobacco-free public space or outdoor space policies.

3. Increase education and resources regarding violence in schools
   a. **Implemented Stop the Bleed:**
      - 100 public treatment Kits have been purchased to be placed within 15 local school districts in Franklin County. (12 Public Treatment Kits have been identified for placement within 2 school districts; New Albany-Plain Local School District and Westerville City School District)
      - Completed 5 In person Stop the Bleed trainings
      - 123 Total persons have been trained in Stop the Bleed
        - 85 School Staff
        - 26 Students
        - 21 New Trainers
      - 1,098 online licensers in partnership with Citizen Aid were purchased to allocate to the 15 school districts to learn more about how to respond to a mass causality incident.
      - Partnership with Franklin County & Columbus Medical Reserve Corp has accounted for:
        - 14 volunteers who have assisted with Stop the Bleed Trainings
        - 27 volunteer hours with an economic value of $681.65 Economic value

Priority Area 3: Access to Overall Healthcare (Collective Impact Lead Franklin County Public Health)

Outcomes:

1. Increase Access to Dental Care by 5%
   a. **Oral Health Workgroup creating Workplan**: stakeholders began establishing Workplan and associated metrics to address gaps in dental care for school-aged children (ages 2-17). The workgroup identified the following as strategies for the workplan:
      - Strategy 1: Assess the availability of dental services by zip code.
      - Strategy 2: Draft an oral health plan that outlines performance measures, collective impact goals and objectives.
      - Strategy 3: Educate policymakers about oral health issues while advocating for better access to oral health care via policy, systems and environmental change.
      - Strategy 4: Improving awareness about the relationship between oral health and overall health care.

- Strategy 5: Providing educational resources and informing to a wide variety of audiences (e.g. professionals, parents, etc.).

2. Increase Access to Medical Care
   a. **Health Fairs:** CHAT partners hosted 4 health fairs, targeting communities in Whitehall, Prairie Township, and Clinton Township to connect residents to medical and wellness resources. 640 people attended, 160 health screenings provided, and 30 flu shots given.

3. Increase Access to Mental/Behavioral Healthcare Resources in Schools by 5%
   a. **Partnered with Hilliard Schools:** to present tobacco prevention, and education an addiction pathway. The intended audience is middle school and up and more than 1,200 attended their Be-Well event.

Priority Area 4: Maternal and Infant Health (Collective Impact Lead CelebrateOne)

Outcomes:

1. Reduce Pre-Term Births
   b. **Received Tobacco Cessation Grant:** Utilizing the $112,000 award, FCPH will continue supporting cessation program to decrease smoking rates for all county residents and focuses on pregnant women, African Americans and those with lower socio-economic status.

2. Reduce Low-Birth Weight Births by 5%
   a. **Safe Sleep:** Conducted 63 home visits; provided positive smoking education to participants; distributed 8 Pack N' Play
   b. **Home Visiting Teams**: determined 5,000 women are eligible for services; working to expand current 10 teams to the goal of 22.
   c. **FCPH Community Health Workers (CHWs) as part of the Central OH Pathways HUB:** 4 CHWs served 21 women of child bearing age and 7 pregnant women; a total of 121 pathways were initiated by women (maternal = 105) and (pregnant women = 16); a total of 31 pathways were completed by women (maternal = 24) and (pregnant women = 7).
   d. **Central OH Pathways HUB:** 28 total CHWs served 279 women; 133 pregnant women, who initiated 1,563 pathways of which 852 were completed. There were also 1,540 pathways initiated by maternal clients of which 1,036 were completed.

4. Reduce Infant Mortality Rate to 6.00 per 1,000 live births
   a. **Senate Bill 121:** The bill requires the State Board of Education to develop and adopt health education standards for grades K-12 by July 1, 2020. The CelebrateOne Teen Reproductive Health Education Committee and the CelebrateOne Policy Committee have been monitoring and are in support of this bill.
   b. **Fetal-Infant Mortality Review Program Data & Recommendations:** The CelebrateOne Policy Committee endorsed the August 2019 FIMR program

recommendations as a result of 33 (20 Fetal, 13 Infant) case reviews (from Jan-Aug 2019)

c. **CelebrateOne Policy Committee Advocacy Agenda:** In 2019, 6 areas of interest regarding advocacy, progress to date on each area and identified leads were created by the Policy Committee and highlighted in a document that organizations could utilize. Those advocacy areas include: transportation, housing, education, employment, mental health and maternal stress.

5. Improve Childhood Immunization Rates by 5%
   a. **Funding from the Ohio Department of Health's, "Get Vaccinated Ohio-Public Health Initiative" Grant**
      - FCPH analyzed multiple indicators of significant immunization disparities and created a plan to focus on increasing immunization rates in two zip codes with the largest numbers of kindergarten through 12th grade students who have not received all of their required school vaccines.
      - Partnered with 111 Franklin County schools to educate them on Ohio's statewide immunization school entry requirements for kindergarten through 12th grade.
      - Partnered with 20 physician offices to provide education on best immunization practices and feedback and immunization coverage rate assessments.

Baseline Data updated from the 2017 Franklin County Community Health Assessment

Chronic Disease			
	Columbus	Franklin County	Ohio
Diabetes Rate per 100,000[3]	11.3	10.9*	12.2
Overweight/Obesity Prevalence (%)[3]	65%	69%*	68%
Hypertension Rate (Medicare Population)[2]	57%	58%	60%
Mental Health/Addiction			
	Columbus	Franklin County	Ohio
Smoking Rates (%)[3]	25%	21%*	21%
Overdose Mortality Rate per 100,000[3]	34	31*	38
Access to Care			
	Columbus	Franklin County	Ohio
Uninsured (%)[7]	11%	5%	7%
Primary Care Physicians Rate per 100,000[9]	N/a	100.1*	76.2
Federally Qualified Health Centers Rate per 100,000[10]	3.31	0.8	3.09
Primary Care Facilities designated as "Health Professional Shortage Areas" (HPSAs)[11]	6	7*	98
Mental Health Care Facilities designated as "Health Professional Shortage Areas" (HPSAs)[11]	7	8*	91
Dental Health Care Facilities designated as "Health Professional Shortage Areas" (HPSAs)[11]	7	8*	83
Total HPSA Facility Designations[11]	20	23*	272
Maternal and Infant Health			
	Columbus	Franklin County	Ohio
Overall Infant Mortality Rate per 1,000 Births[3]	7.7	7.6*	6.9
White Infant Mortality Rate per 1,000 Births[4]	4.8	5.1*	5.4
Black Infant Mortality Rate per 1,000 Births[4]	12.1	12.0*	13.9
Hispanic Infant Mortality Rate per 1,000 Births[5]	6.9	8.3*	6.9

Demographics & Social Determinants of Health			
	Columbus	Franklin County	Ohio
Total Population[7]	852,144	401,246	11,609,756
Total Land Area (Square Miles)[7]	218.6	176.34	40,862.46
Population Density (Per Square Mile)[7]	3898.15	2275.47	284.12
Percent Population Change, 2000-2010[8]	9%	13%	2%
Percent Linguistically Isolated Population[7]	4%	2%	1%
Percent Urban[8]	100%	98%	78%
Percent Rural[8]	0.4%	2%	22.%
New Americans Population (%)[7]	12%	10%	4%
Grandparents Raising Children (60+)[7]	1%	2%	2%
Low Food Access[6]	23%	32%	25%
Households with no Motor Vehicle[7]	9%	4%	8%
Physical Inactivity[1]	23%	23%	25%

Appendix

* =Franklin County Populations including the city of Columbus data

1. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2016
2. Centers for Medicare and Medicaid Services. 2017
3. Columbus Public Health Department Office of Epidemiology. Key Community Health Indicators 2019.
4. Ohio Department of Vital Statistics, 2018
5. National Center for Health Statistics, period linked birth/infant death data, 2015-2017
6. Low-Income and Low-Supermarket-Access Census Tracts, 2010-2015
7. United States Census Bureau, American Community Survey. 2013-17
8. United States Census Bureau, Decennial Census. 2000 – 2010
9. United States Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2017.
10. United States Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. November 2019
11. United States Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. February 2019

Access to Dentists: This indicator includes all dentists - qualified as having a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.), who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

Federally Qualified Health Centers: Federally Qualified Health Centers are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients. Federally Qualified Health Centers may be Community Health Centers, Migrant Health Centers, etc.

Health Shortage Professionals Area: A Health Professional Shortage Area (HPSA) is a geographic area, population, or facility with a shortage of primary care, dental, or mental health providers and services.

High Blood Pressure (Medicare Population): This indicator reports the percentage of the Medicare fee-for-service population with hypertension (high blood pressure).

Linguistically Isolated Household: A "Linguistically Isolated household" or "Limited English speaking household" is one in which no member 14 years old and over (1) speaks only English at home or (2) speaks a language other than English at home and speaks English "Very well."

Low Food Access: Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Mental Health Providers: This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

New American: The portion of the population who identify as being foreign born or as a "New American"

Overweight or Obese: Percent of adults 18+ reporting a BMI greater than or equal to 25.0

Physical Inactivity: Based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Primary Care Physicians: This indicator reports the number of primary care physicians per 100,000 population. Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Rural Area: Rural areas are identified using population density, count, and size thresholds containing less than 2,500 people.

Urban Area: Urban areas are identified using population density, count, and size thresholds containing 2,500-49,000 people

Please forward questions and comments to:

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