Knapp Medical Center

COMMUNITY HEALTH NEEDS ASSESSMENT
2022

TABLE OF CONTENTS

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

Michael Swartz
Regional Manager for Communications & Grant Writing
Knapp Medical Center
1401 E. 8th Street
Weslaco, Texas 78596
mswartz@primehealthcare.com
(956) 973-5142

EXECUTIVE SUMMARY

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

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

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

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

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

Knapp Medical Center is an acute care hospital located in Weslaco, Texas. For the purposes of this CHNA, the Medical Center has defined its "community" as Hidalgo County located in south Texas, which accounts for 85% of the Medical Center's patients. While the Medical Center may serve patients across a broader region, defining its community will allow it to more effectively focus its resources to address identified significant health needs, targeting areas of greatest need and health disparities.

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

Below is a summary of the Medical Center's prioritized health needs identified in this CHNA. These community health needs are based on the information gathered throughout this CHNA and the prioritization process described later in this report. Opportunities for health improvement exist in each area. The Medical Center will work to identify areas where it can most effectively focus its resources to have significant impact and develop an Implementation Strategy for 2023-2025 for each of priority areas.

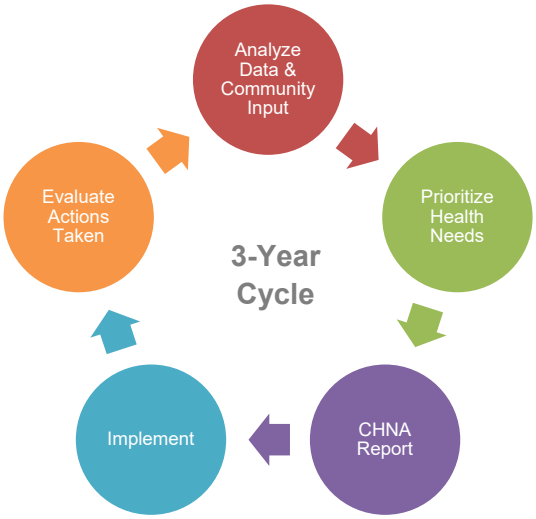
Prioritized Health Needs:

- Need Access to Care and Access to Primary Care Physicians
- Treatment and Management of Chronic Conditions, including Obesity and Diabetes
- Shortage of Healthcare Workers

COMMUNITY HEALTH NEEDS ASSESSMENT GOALS

EVALUATION OF PROGRESS SINCE PRIOR CHNA

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



PRIORITY AREAS FROM PRECEDING CHNA

The implementation strategy for fiscal years ending December 31, 2020 through December 31, 2022, focused on three priorities to address identified health needs. Based on the Medical Center's most recent evaluation, the Medical Center has made significant progress in meeting their goals and strategies outlined in their prior implementation strategy as reported below.

The 2019 implementation strategy focused on three priorities for action between 2020 and 2022:

1. Improve access to primary care services and specialists
2. Improve education and services around chronic diseases
3. Collaborate with community organizations on health and wellness

PRIORITY 1: INCREASE ACCESS TO PRIMARY CARE

The priority area was adopted to address the following identified health needs:

- Lack of Primary Care Physicians / Access to Primary Care Physicians
- Uninsured / Limited Insurance / Access
- Affordability of Healthcare Services
- Lack of Mental Health / Addiction Providers and Services

- Lack of Specialists / Access to Specialists

The Medical Center's 2020-2022 Implementation Plan established following goals to measure the progress in addressing the priority area.

- Goal 1: Increase the number of primary care physicians in the Mid-Valley Area
- Goal 2: Operate clinics to provide primary care in the Mid-Valley Area

PRIORITY 2: IMPROVE EDUCATION AND SERVICES AROUND CHRONIC DISEASES

The priority area was adopted to address the following identified health needs:

- Healthy Behaviors / Lifestyle Choices
- Obesity
- Chronic Diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)
- Poor Nutrition / Limited Access to Healthy Food Options
- Lack of Health Knowledge / Education

The Medical Center's 2020-2022 Implementation Plan established following goals to measure the progress in addressing the priority area.

- Goal 1: Provide free healthcare educational opportunities
- Goal 2: Work with elected representatives to encourage extension of health insurance to uninsured residents

PRIORITY 3: COLLABORATE WITH COMMUNITY ORGANIZATIONS ON HEALTH AND WELLNESS

The priority area was adopted to address the following identified health needs:

- Healthy Behaviors / Lifestyle Choices
- Obesity
- Chronic Diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)
- Poor Nutrition / Limited Access to Healthy Food Options
- Lack of Health Knowledge / Education

The Medical Center's 2020-2022 Implementation Plan established the following goals to measure the progress in addressing the priority area.

- Goal 1: Create greater awareness of the epidemic of diabetes in our community, how it can be prevented and how it can be controlled
- Goal 2: Encourage residents to pursue fitness and healthy eating
- Goal 3: Help build a community culture which values exercise and healthy eating
- Goal 4: Offer healthy foods at all hospital-related events.

COMMUNITY FEEDBACK FROM PRECEDING CHNA & IMPLEMENTATION PLAN

Knapp Medical Center's preceding CHNA is available to the public via the website https://knappmed.org/about-us/community-health-assessment/. No substantive comments were received related to the preceding CHNA.

HOW THE ASSESSMENT WAS CONDUCTED

Knapp Medical Center partnered with FORVIS, LLP ("FORVIS") to conduct this community health needs assessment. Ranked among the top 10 public accounting firms in the country, FORVIS has 5,700 dedicated professionals who serve clients in all 50 states as well as across the globe. FORVIS serves hospitals and health care systems across the country. The CHNA was conducted during 2022.

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

- Community benefit initiatives, which were implemented over the course of the last three years, were evaluated.
- The "community" served by the Medical Center was defined by utilizing inpatient and outpatient data regarding patient origin and is inclusive of medically underserved, low-income, minority populations and people with limited English proficiency. This process is further described in the section "Community Served by the Medical Center".
- Population demographics and socioeconomic characteristics of the community were gathered and assessed utilizing various third parties.
- The health status of the community was assessed by reviewing community health status indicators from multiple sources, including those with specialized knowledge of public health and members of the underserved, low-income and minority population or organizations serving their interests.
- Community input was also obtained through surveys of key stakeholders. See Appendix C for a listing of key stakeholders that provided input through surveys.
- Identified health needs were then prioritized considering the community's perception of the significance of each identified need as well as the ability for the Medical Center to impact overall health based on alignment with its mission and the services it provides. The Medical Center's leadership participated in identifying and prioritizing significant health needs.
- An inventory of health care facilities and other community resources potentially available to address the significant health needs identified through the CHNA was prepared.

LIMITATIONS AND INFORMATION GAPS

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

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

As with all data collection efforts, there are limitations related to the CHNA's research methods that should be acknowledged. Years of the most current data available differ by data source. In some instances, 2022 may be the most current year available for data, while 2021 or 2020 may be the most current year for other sources.

GENERAL DESCRIPTION OF KNAPP MEDICAL CENTER

Knapp Medical Center is a 227-bed not-for-profit, acute care hospital, and a member of the Prime Healthcare Foundation, a 501(c)(3) public charity. Located in South Texas, Knapp provides exceptional healthcare services to residents of the Rio Grande Valley. Located in Weslaco, Texas, Knapp works hard to provide state-of-the-art technology, progressive diagnostic and treatment options, and patient-focused care. Knapp employs more than 500 people and has more than 300 physicians serving on its Medical Staff.

DESCRIPTION OF SERVICES PROVIDED BY KNAPP MEDICAL CENTER

Knapp Medical Center serves a broad spectrum of patients in the community and offers numerous services to meet the needs of these patients. Examples of the services provided by the Medical Center include:

- 24-hour Emergency Department – Advanced (Level III) Trauma Center
- Adult Medicine
- Cardiology
- Critical Care/ICU
- Inpatient and Outpatient Surgery
- Pediatrics
- Women's Health
- Obstetrics/Gynecology
- Neonatal Care Level II

The Medical Center's Outpatient Center offers a wide variety of services, including:

- All Digital Imaging
- Cardiopulmonary
- Endoscopy Procedures
- Gastroenterology (GI)
- Laboratory
- Rehabilitation

COMMUNITY SERVED BY KNAPP MEDICAL CENTER

The Medical Center is located in Weslaco, Texas, in Hidalgo County, a half hour from McAllen, Texas and an hour from Brownsville, Texas. The Medical Center is located off Interstate 83. As a regional facility, the Medical Center serves residents in and around the Weslaco area.

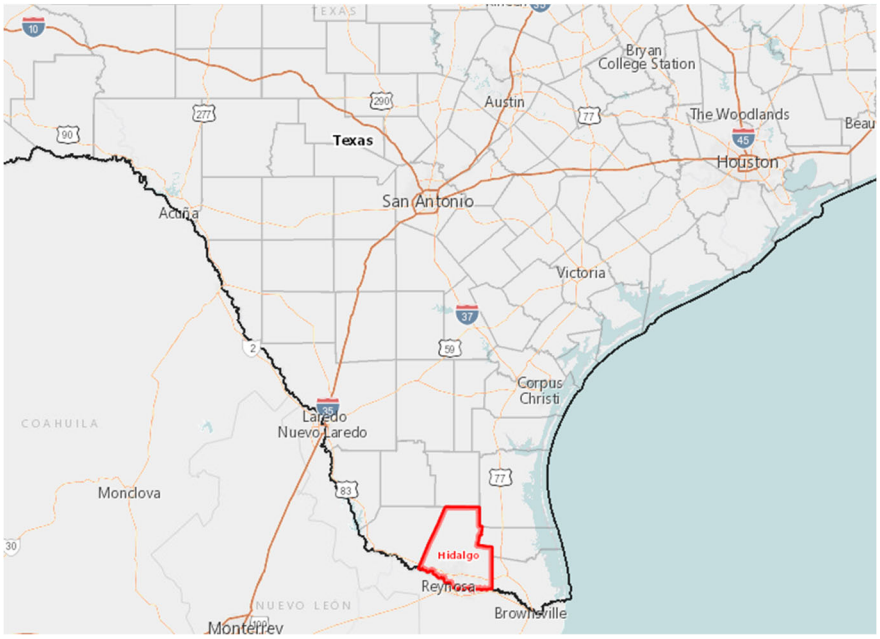
DEFINED COMMUNITY

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

COMMUNITY DETAILS

IDENTIFICATION AND DESCRIPTION OF GEOGRAPHICAL COMMUNITY

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



COMMUNITY POPULATION AND DEMOGRAPHICS

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

Demographic Characteristics

Gender	Hidalgo County	TX	US
Total Population	861,137	28,635,442	326,569,308
Total Male Population	421,929	14,221,720	160,818,530
Total Female Population	439,208	14,413,722	165,750,778
Percent Male	49.00%	49.66%	49.24%
Percent Female	51.00%	50.34%	50.76%

Population Age Distribution

Age Group	Percent of Hidalgo County	Percent of TX	Percent of US
0 - 4	8.94%	6.97%	6.02%
5 - 17	23.69%	18.80%	16.43%
18 - 24	10.98%	9.79%	9.32%
25 - 34	13.48%	14.70%	13.93%
35 - 44	12.62%	13.58%	12.66%
45 - 54	10.92%	12.37%	12.72%
55 - 64	8.30%	11.24%	12.89%
65+	11.07%	12.55%	16.03%
Total	100.00%	100.00%	100.00%

Total Population by Race Alone

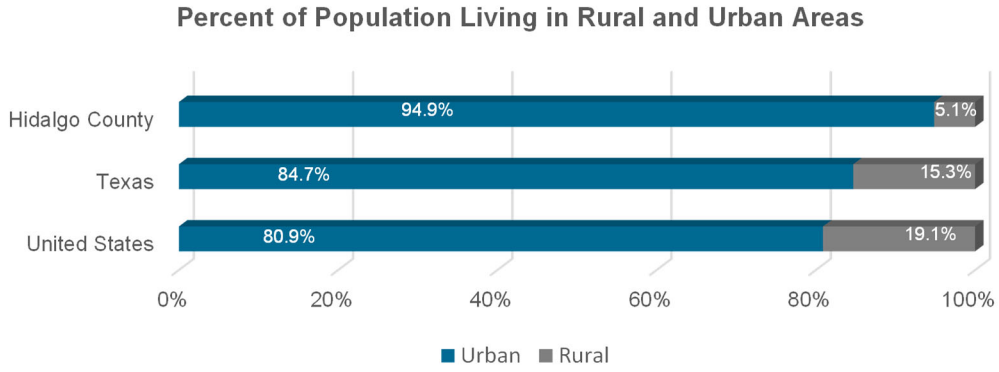
Race	Percent of Hidalgo County	Percent of TX	Percent of US
White	75.94%	69.16%	70.42%
Black	0.56%	12.10%	12.62%
Asian	0.98%	4.94%	5.64%
Native American / Alaska Native	0.16%	0.48%	0.82%
Native Hawaiian / Pacific Islander	0.03%	0.09%	0.19%
Some Other Race	10.89%	6.25%	5.14%
Multiple Race	11.44%	6.98%	5.17%
Total	100.00%	100.00%	100.00%

Total Population by Ethnicity Alone

Ethnicity	Percent of Hidalgo County	Percent of TX	Percent of US
Hispanic or Latino	92.31%	39.44%	18.18%
Non-Hispanic or Latino	7.69%	60.56%	81.82%
Total	100.00%	100.00%	100.00%

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

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



SOCIOECONOMIC CHARACTERISTICS OF THE COMMUNITY

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

INCOME AND EMPLOYMENT

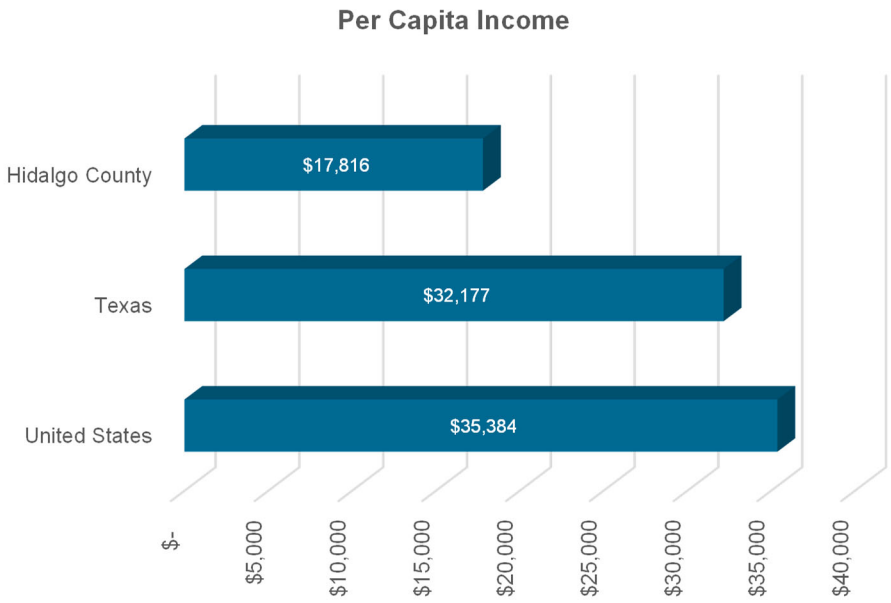
INCOME

The median household income includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. The CHNA Community has a median household income below Texas and the United States.

Median Household Income		
Hidalgo County	$	41,846
Texas	$	63,826
United States	$	64,994

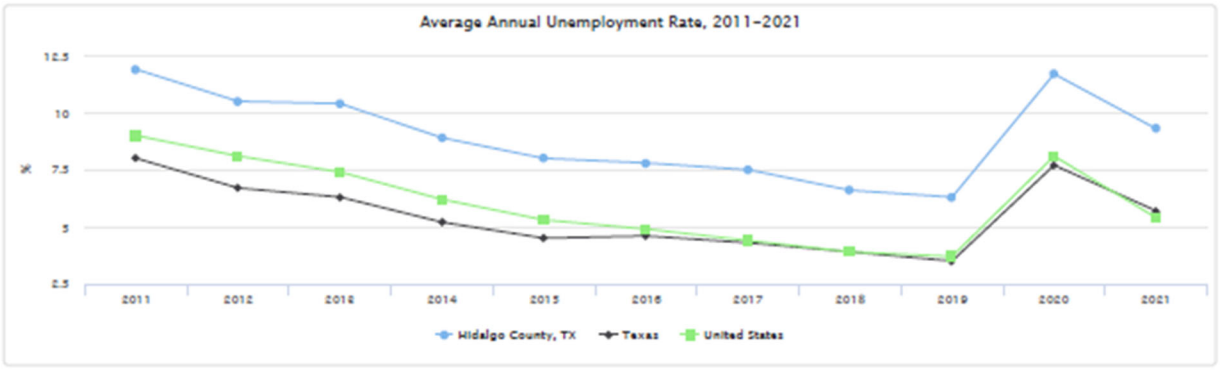
The per capita income for the CHNA Community is $17,816. This includes all reported income from wages and salaries as well as income from self-employment, interest or dividends, public assistance, retirement, and other sources. The per capita income in this report area is the average (mean) income computed for every man, woman, and child in the specified area. The per capita

income for the CHNA Community is below the per capita income for both Texas and the United States.



UNEMPLOYMENT RATE

The following graph presents the average annual unemployment rate from 2011 through 2021 for the CHNA Community, as well as the trend for Texas and the United States. The unemployment rates for the CHNA Community are higher than the rates for Texas and the United States. In general, unemployment was decreasing until 2019, increasing through 2020, and then began decreasing starting in 2020.



POVERTY

Poverty is considered a key driver of health status.

Within the CHNA Community 28.44% or 242,121 individuals are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status. The CHNA Community compares unfavorably to both Texas and United States percentages of individuals living in households below 100% of FPL.

Percent Population Below 100% FPL	
Hidalgo County	28.44%
Texas	14.22%
United States	12.84%

In the CHNA Community, 39.63% or 110,790 children aged 0-17 are living in households with income below the FPL. Like the percentages for total poverty, the CHNA Community, compares unfavorably to both Texas and United States percentages of individuals under age 18 living in households below 100% of FPL.

Percent Population Under Age 18 in Poverty	
Hidalgo County	39.63%
Texas	20.05%
United States	17.48%

UNINSURED

The percentage of the total civilian non-institutionalized population without health insurance coverage is represented in this graphic. The rate of uninsured persons in the report area is greater than the state average of 17.31%. This indicator is relevant because lack of insurance is a primary barrier to health care access, including regular primary care, specialty care and other health services that contribute to poor health status. Approximately 260,885 persons are uninsured in the CHNA community. The uninsured rate is estimated to be 30.58% for the CHNA Community compared to 17.31% for Texas and 8.73% for the United States.

EDUCATION

Within the CHNA community, 13.4% of the population ages 25 and older have obtained a bachelor's degree or higher, compared to 19.9% in Texas and 20.2% in the United States. This indicator is relevant because educational attainment has been linked to positive health outcomes.

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

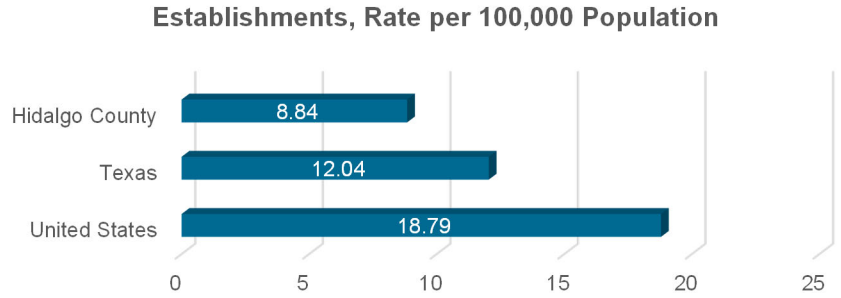
PHYSICAL ENVIROMENT OF THE COMMUNITY

A community's health is also affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining

and improving community health. This section will touch on a few of the elements that relate to various needs mentioned throughout the report.

GROCERY STORE ACCESS

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

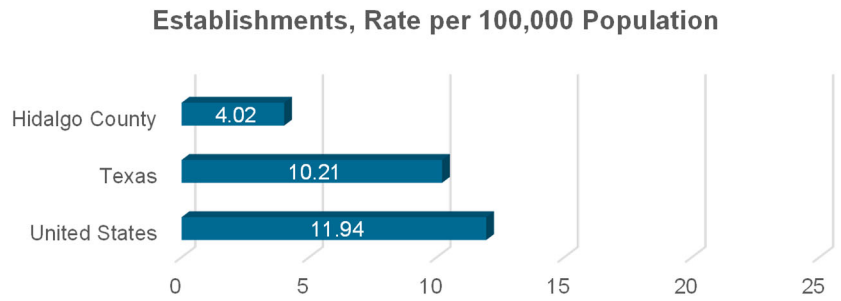


FOOD ACCESS/FOOD DESERTS

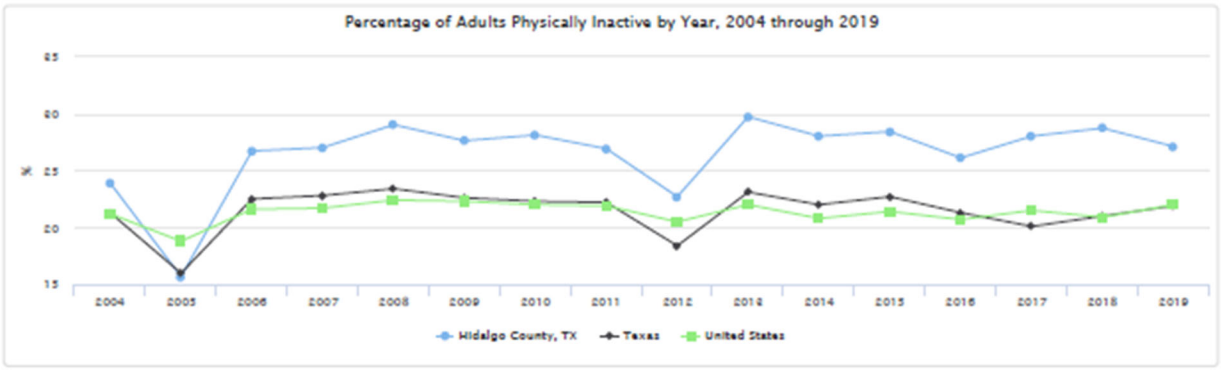
This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as a low-income census tract where a substantial number or share of residents has low access to a supermarket or large grocery stores. The information in is relevant because it highlights populations and geographies facing food insecurity. The CHNA Community has a population of 461,260 or 59.54% living in food deserts compared to 19.59% for Texas and 12.66% for the United States.

RECREATION AND FITNESS FACILITY ACCESS

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



The trend graph below shows the percentage of adults who are physically inactive by year (2004 through 2019) for the CHNA Community and compared to Texas and the United States. For 2019, the rate for the CHNA Community was 27.1% compared to 21.9% for Texas and 22.0% for the United States.



CLINICAL CARE OF THE COMMUNITY

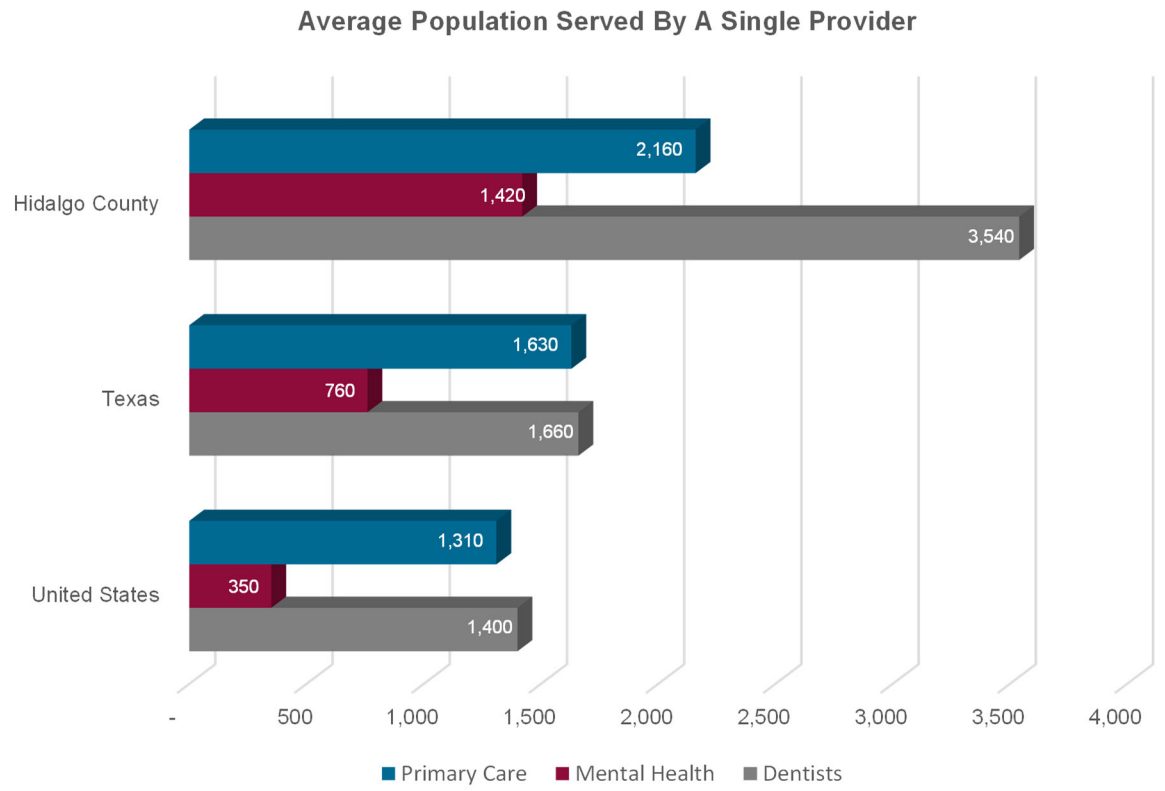
A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of uninsured, financial hardship, transportation barriers, cultural competency and coverage limitations affect access.

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

ACCESS TO CARE

Doctors classified as “primary care physicians” by the American Medical Association include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs and general pediatrics MDs. Physicians aged 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. The primary care physician ratio for the CHNA Community compares unfavorably to the ratios for both Texas and

the United States. In addition, the number of mental health providers and dentists practicing in the CHNA Community compares unfavorably to the ratios for both Texas and the United States.



HEALTH STATUS OF THE COMMUNITY

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

Good health can be defined as a state of physical, mental, and social well-being, rather than the absence of disease or infirmity. According to Healthy People 2030, the national health objectives released by the U.S. Department of Health and Human Services, individual health is closely linked to community health. Community health, which includes both the physical and social environment in which individuals live, work and play, is profoundly affected by the collective behaviors, attitudes, and beliefs of everyone who lives in the community. Healthy people are among a community's most essential resources.

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

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

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

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

LEADING CAUSES OF DEATH

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

Area	Hidalgo County	Texas	United States
Cancer	97.30	143.40	183.50
Heart Disease	100.50	91.10	112.50
Lung Disease	17.10	36.80	48.00
Stroke	22.30	38.20	45.70
Unintentional Injury	21.20	39.30	53.40
Motor Vehicle	9.30	13.20	11.90
Drug Poisoning	4.90	12.40	23.90
Homicide	3.40	6.10	6.20
Suicide	6.30	13.30	14.30

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

The table above shows leading causes of death within the CHNA Community as compared to the state of Texas and the United States. The crude death rate is shown per 100,000 residents. The rates of the CHNA Community compare favorably to the national rates.

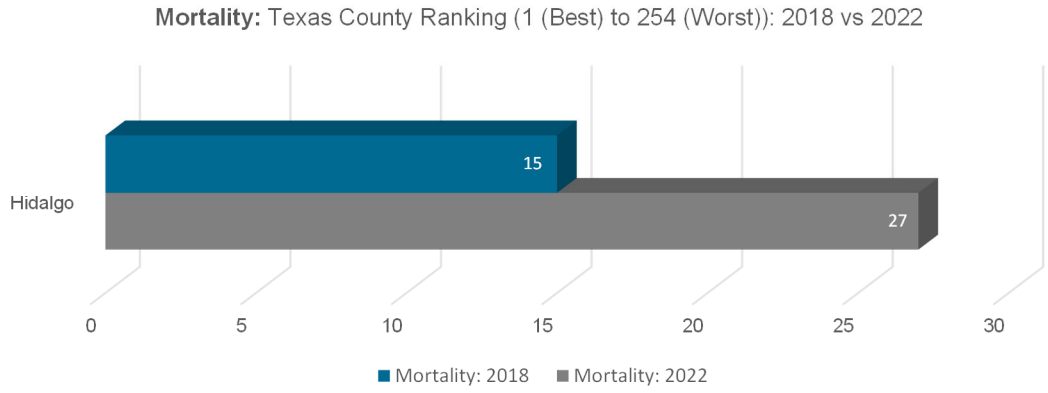
HEALTH OUTCOMES AND FACTORS

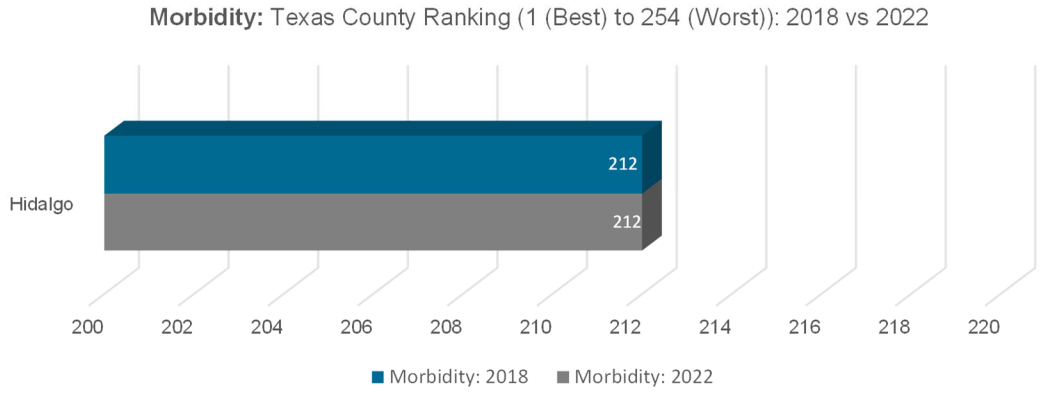
An analysis of various health outcomes and factors for a community can, if improved, help make the community a healthier place to live, learn, work and play. A better understanding of the factors that affect the health of the community will assist with how to improve the community's habits, culture,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

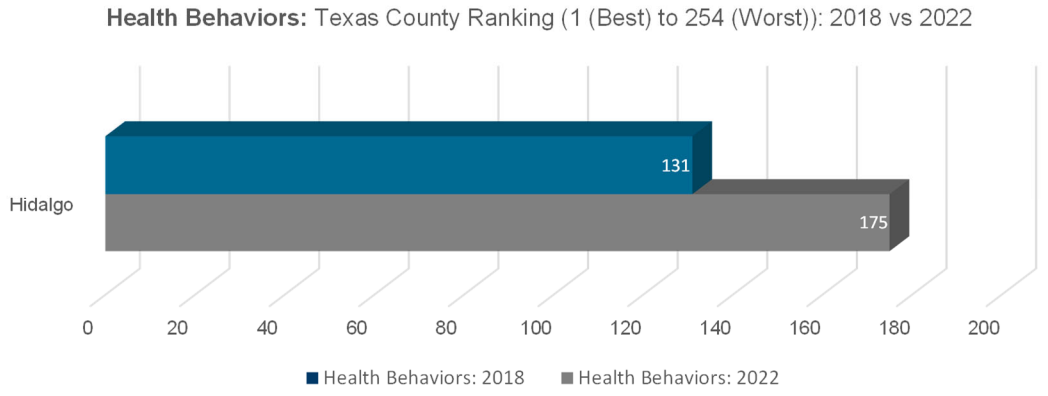
The County Health Rankings model is grounded in the belief that programs and policies implemented at the local, state, and federal levels have an impact on the variety of factors that, in turn, determine the health outcomes for communities across the nation. The model provides a ranking method that ranks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

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

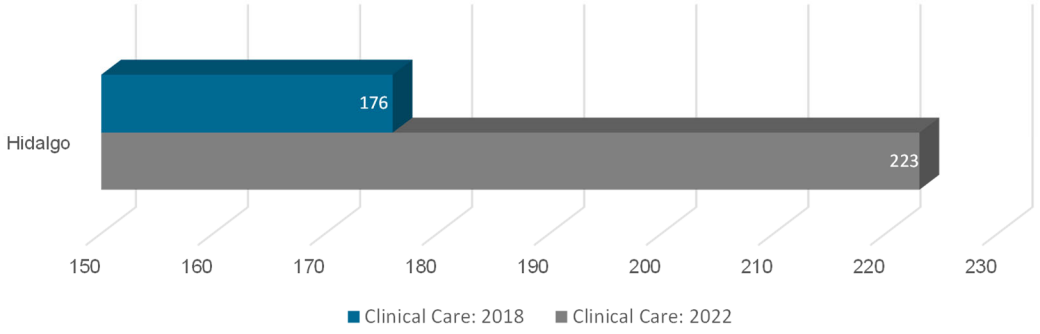
A number of different health factors shape a community's health outcomes. The County Health Rankings (www.countyhealthrankings.org) model includes four types of health factors: health behaviors, clinical care, social and economic and the physical environment. The following graphs include the 2018 and 2022 indicators reported by County Health Rankings for Hidalgo County. A complete table of all community health rankings is provided at Appendix B.



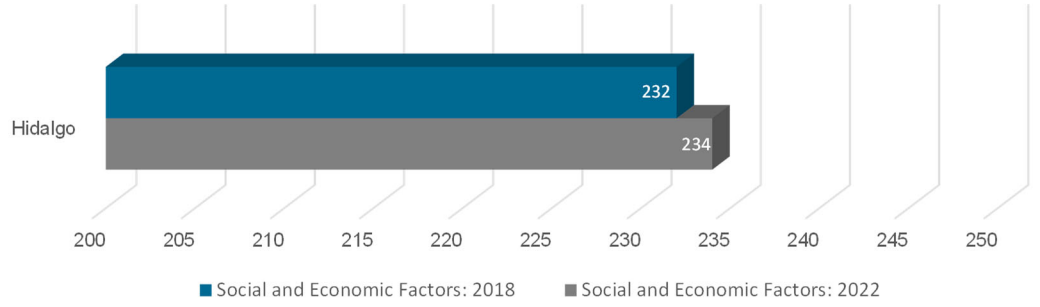




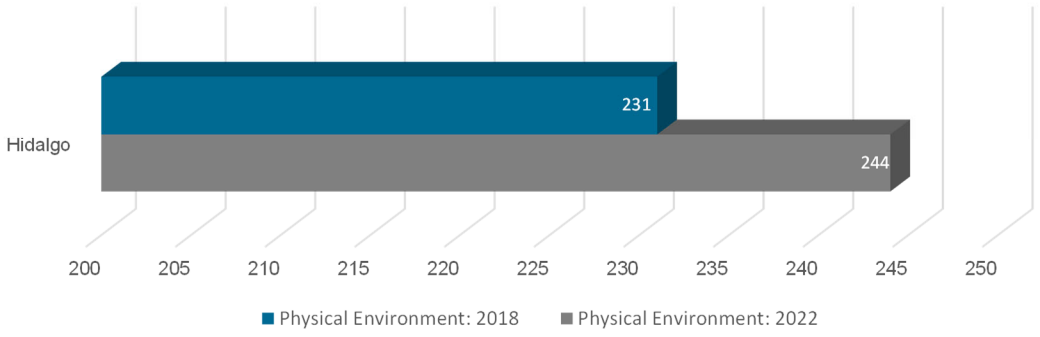
Clinical Care: Texas County Ranking (1 (Best) to 254 (Worst)): 2018 vs 2022



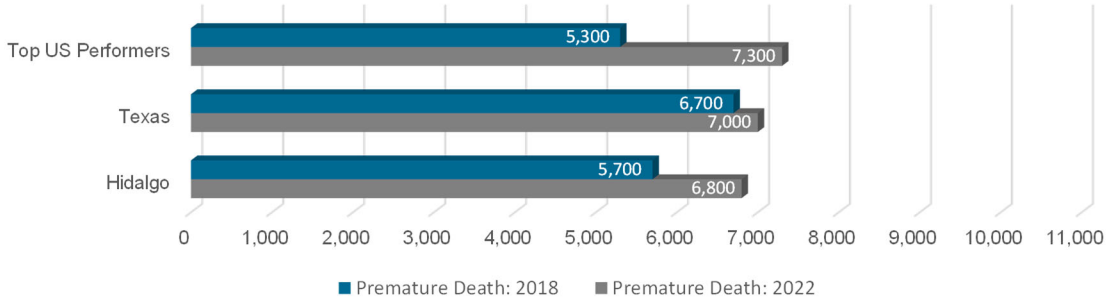
Social and Economic Factors: Texas County Ranking (1 (Best) to 254 (Worst)): 2018 vs 2022



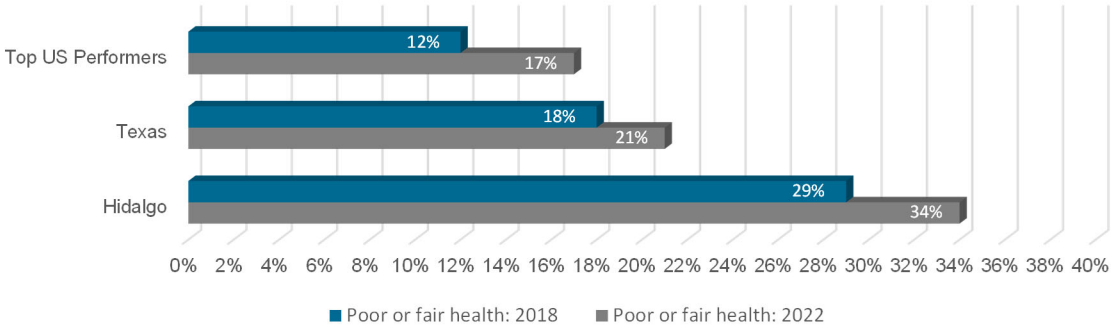
Physical Environment: Texas County Ranking (1 (Best) to 254 (Worst)): 2018 vs 2022



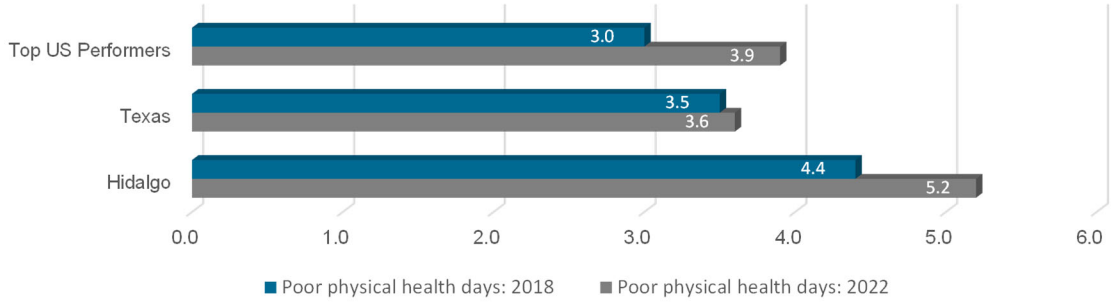
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted): 2018 vs 2022



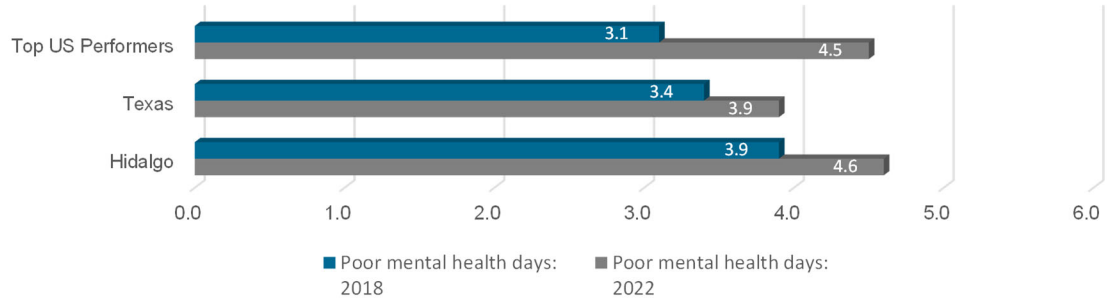
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)



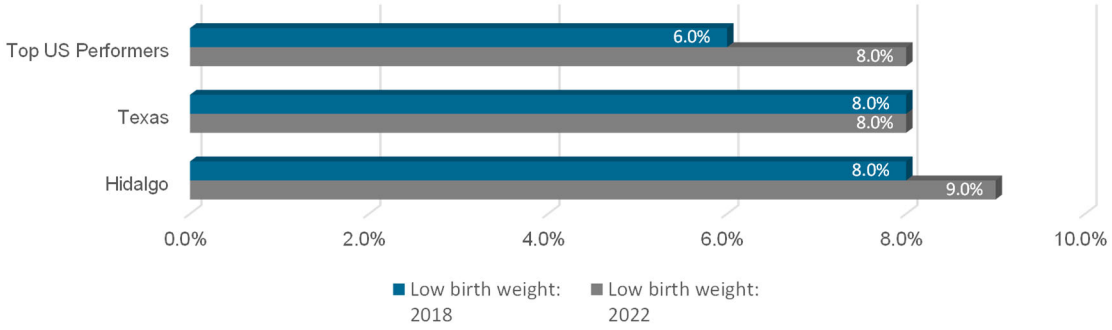
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)



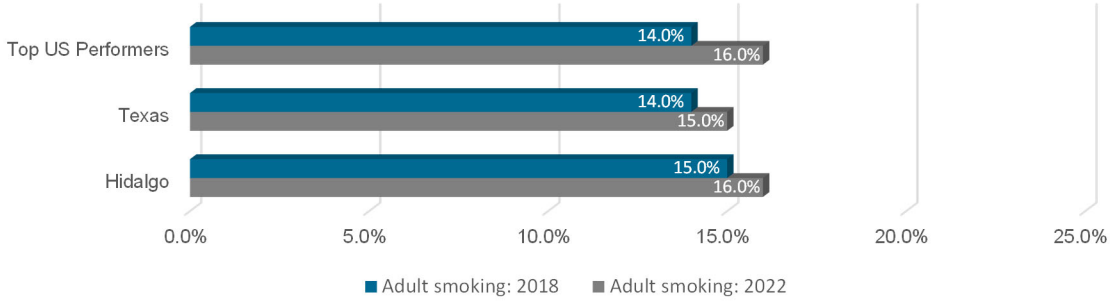
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)



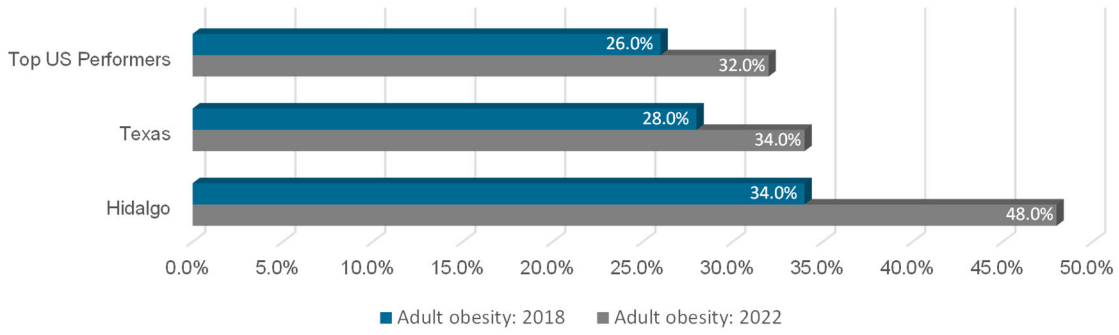
Low birth weight – Percent of live births with low birth weight (<2500 grams)



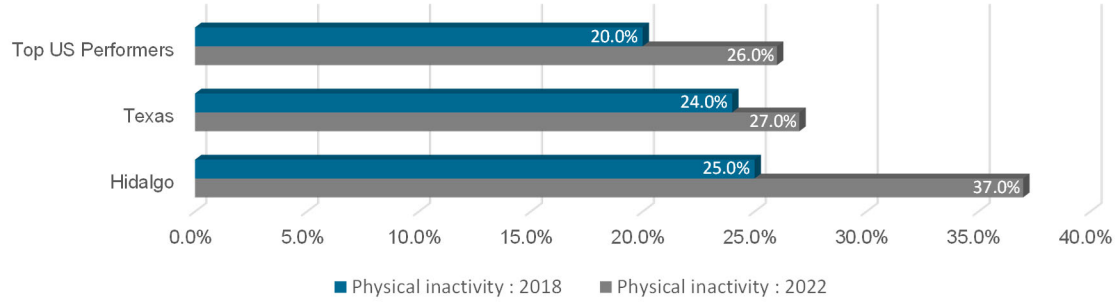
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke)



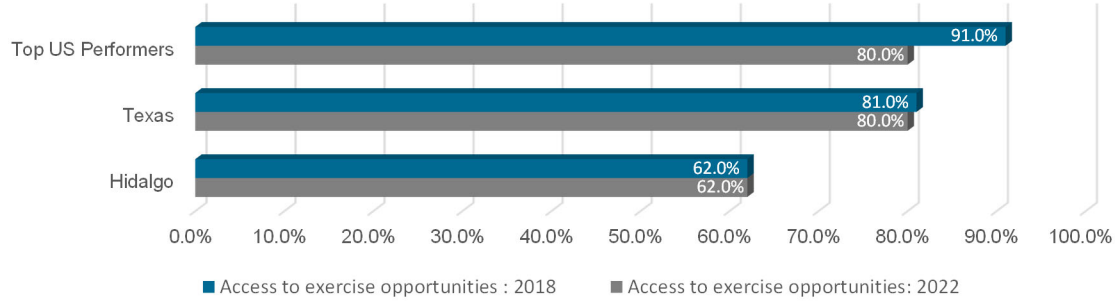
Adult obesity – Percent of adults that report a BMI >= 30



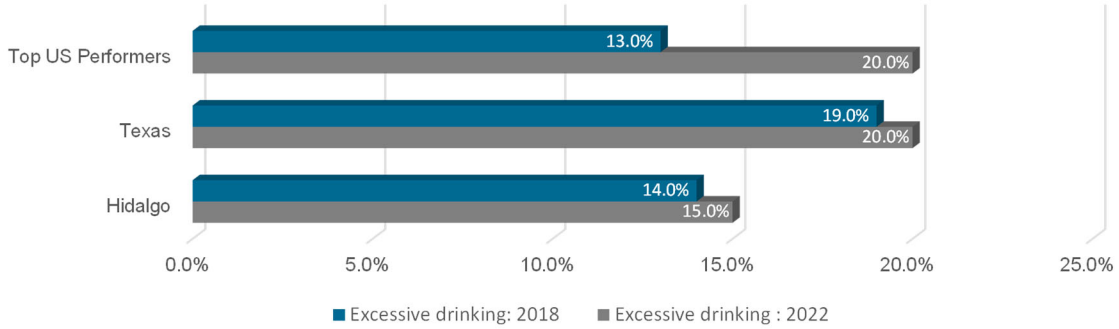
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity



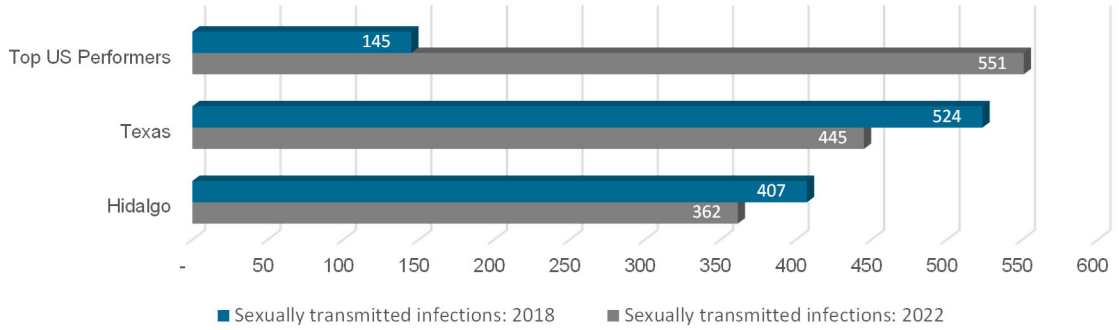
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity



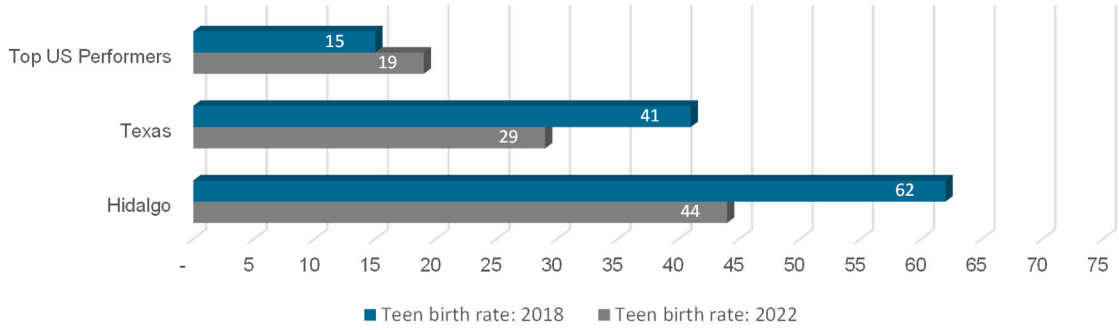
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days



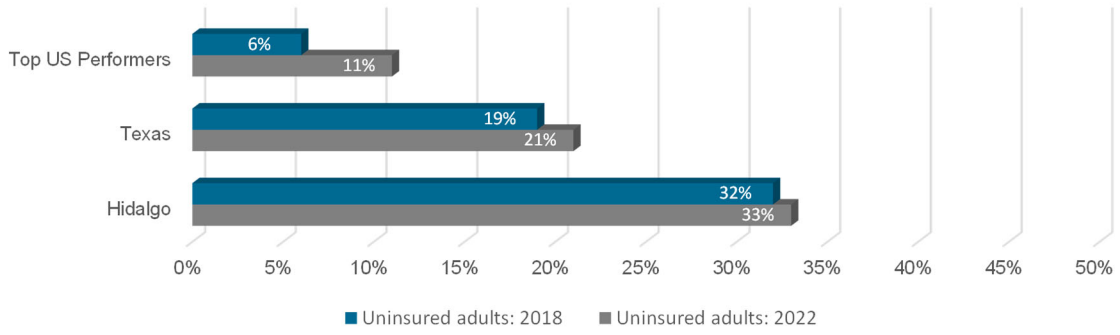
Sexually transmitted infections – Chlamydia rate per 100K population



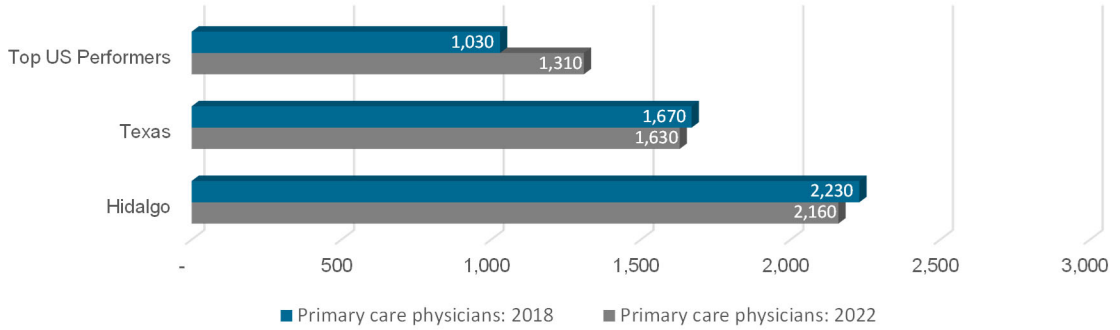
Teen birth rate – Per 1,000 female population, ages 15-19



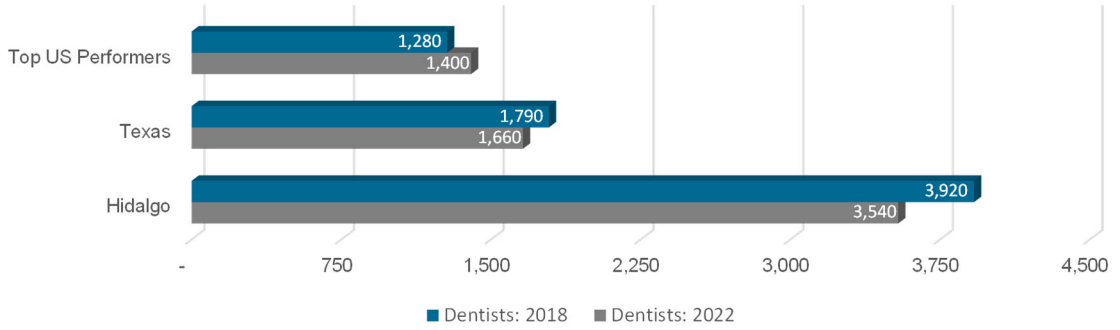
Uninsured adults – Percent of population under age 65 without health insurance



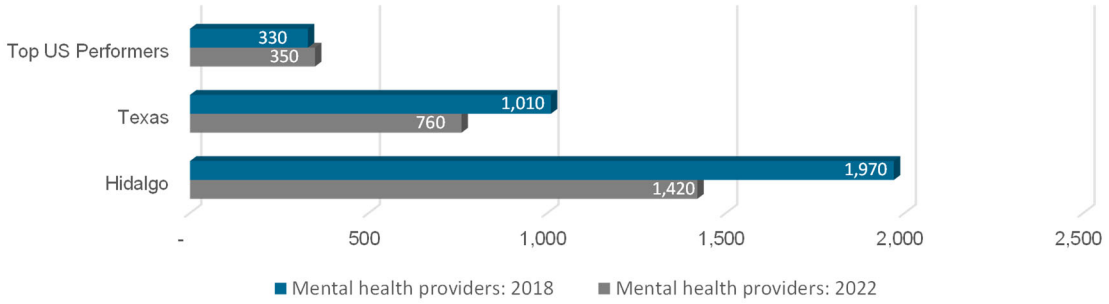
Primary care physicians – Ratio of population to primary care physicians (# of physicians: 1)



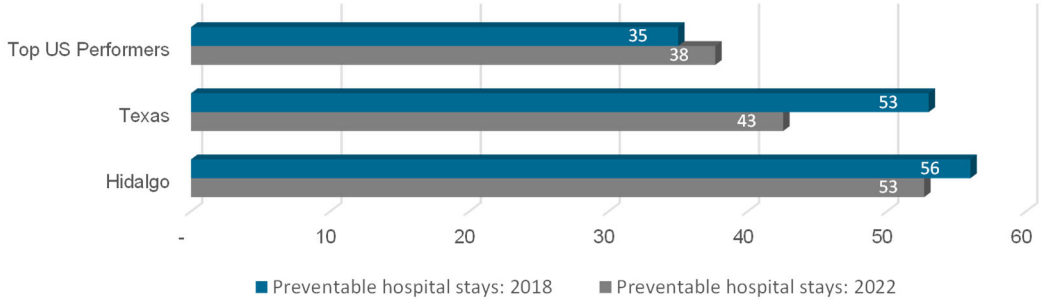
Dentists – Ratio of population to dentists (# of dentists: 1)



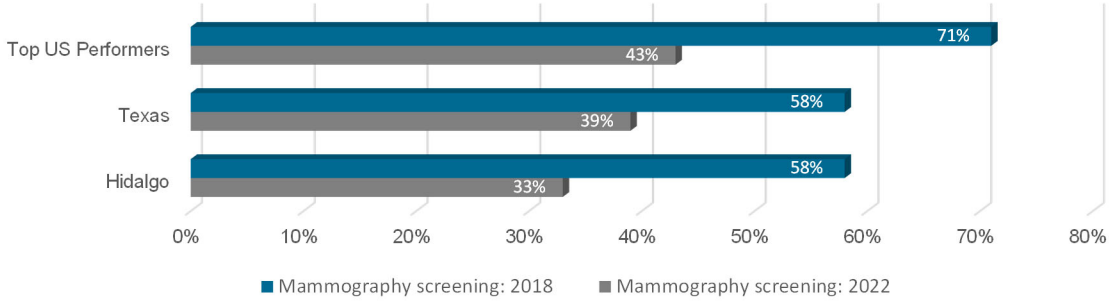
Mental health providers – Ratio of population to mental health providers (# of mental health providers: 1)



Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees



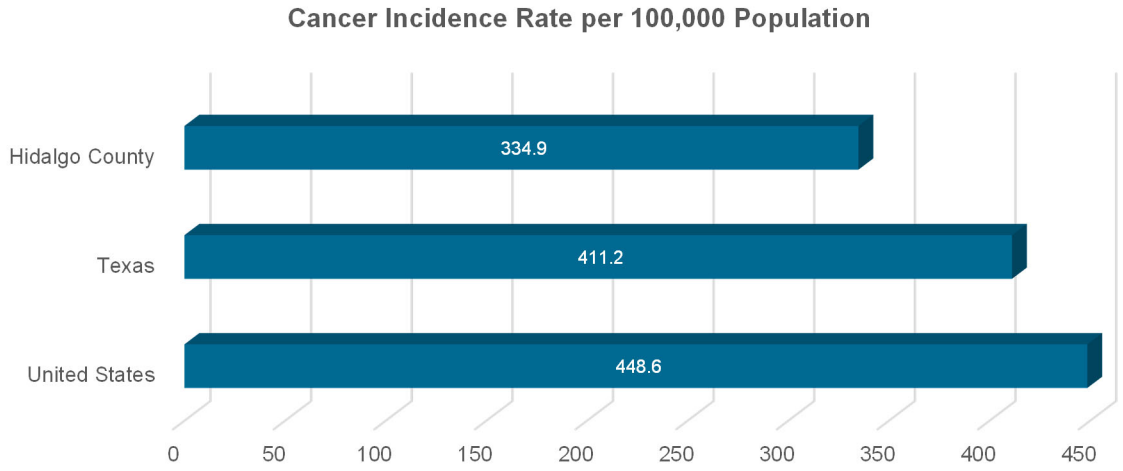
Mammography screening – Percent of female Medicare enrollees that receive mammography screening



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

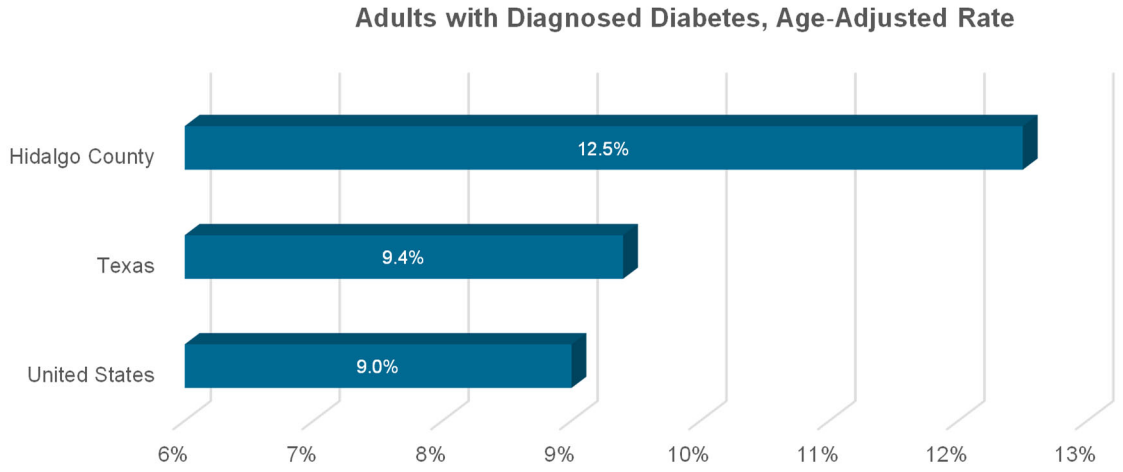
CANCER INCIDENCE

The CHNA Community's cancer incidence rate is 334.9 for every 100,000 of total population. Within the CHNA Community, there were 2,433 new cases of cancer reported. This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancer (all sites) adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older).



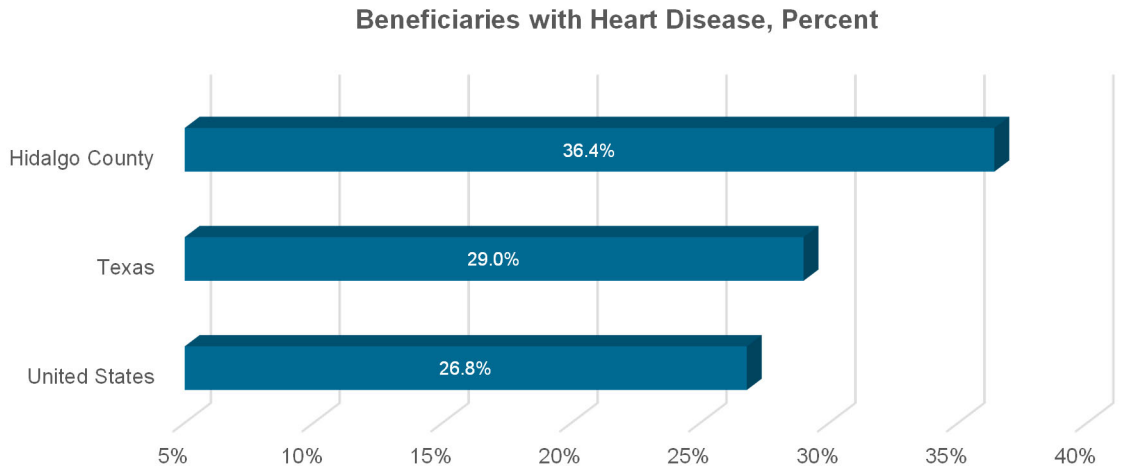
DIABETES (ADULT)

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



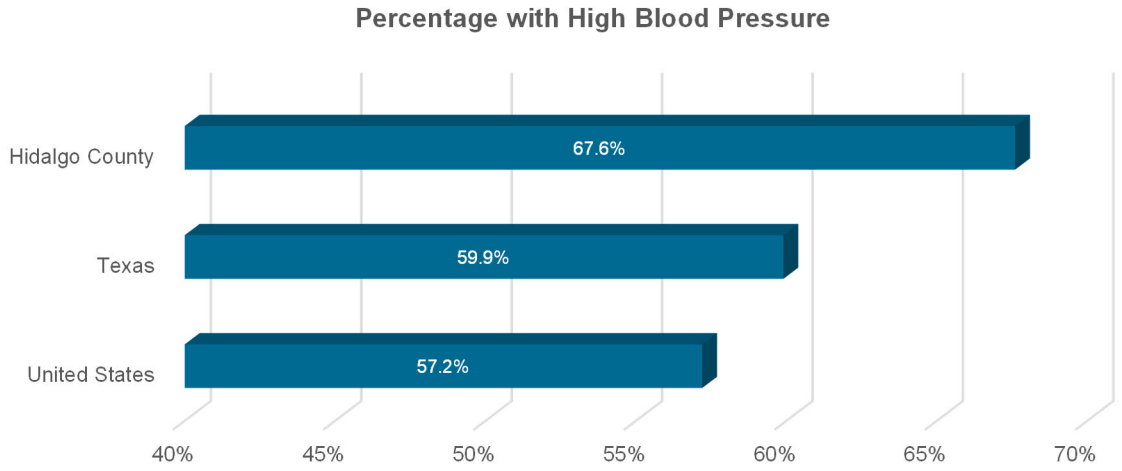
HEART DISEASE (MEDICARE POPULATION)

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



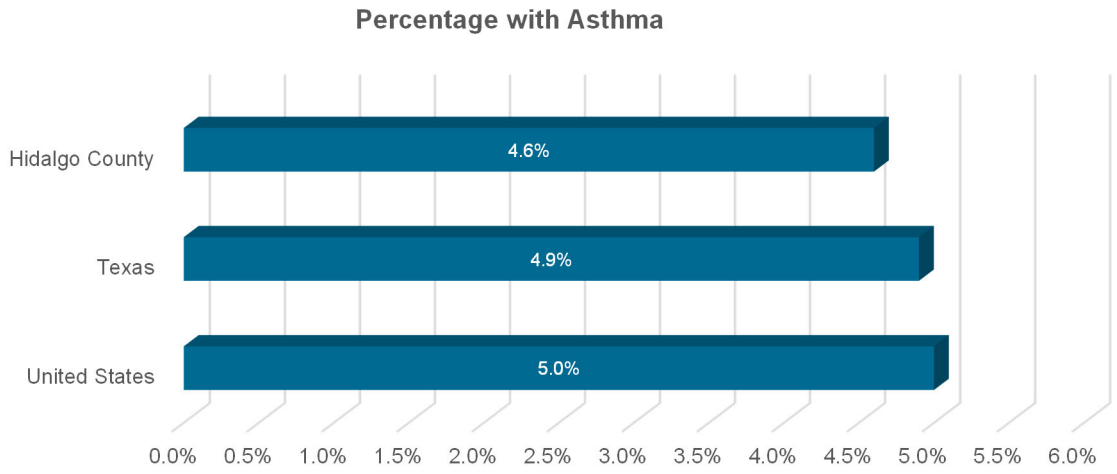
HIGH BLOOD PRESSURE (MEDICARE POPULATION)

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



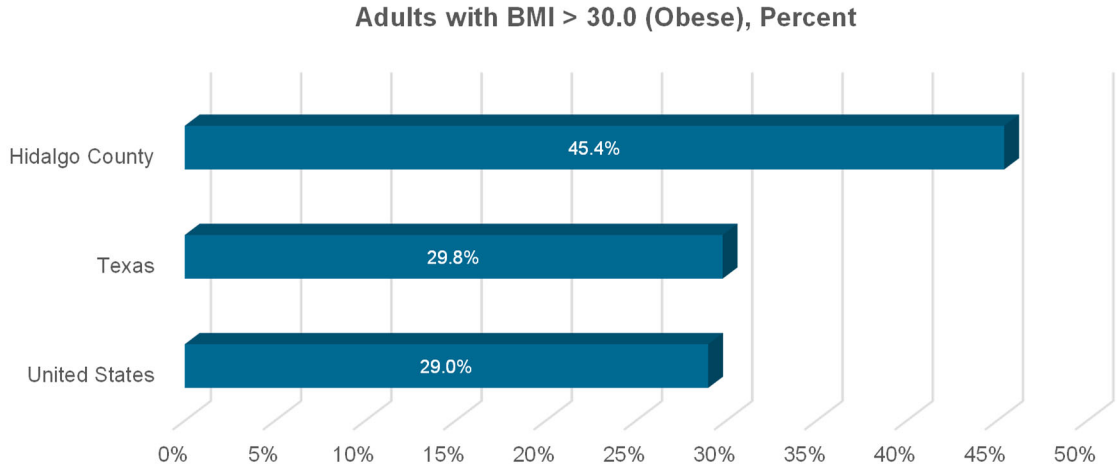
ASTHMA (MEDICARE POPULATION)

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



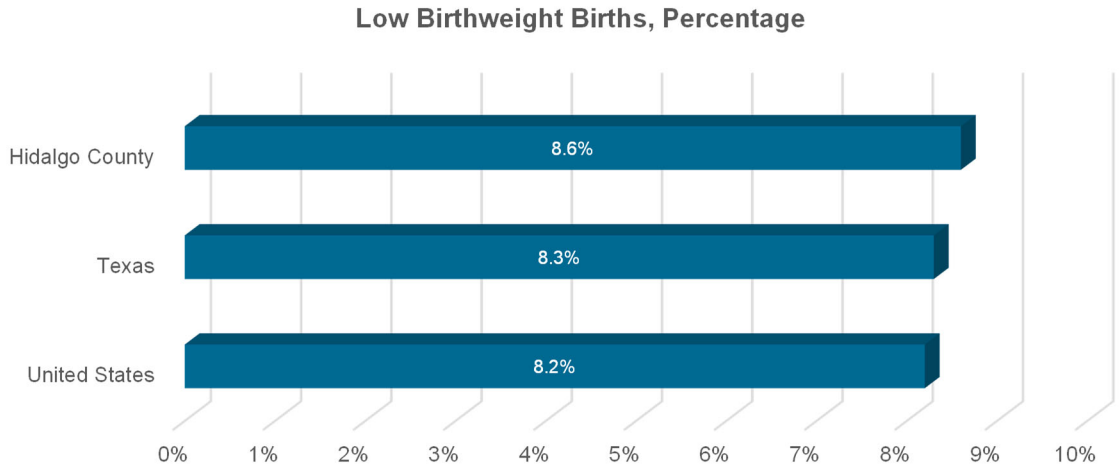
OBESITY

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



LOW BIRTH WEIGHT

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



PRIMARY DATA ASSESSMENT

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

METHODOLOGY

Surveys of eighteen key informants were conducted in 2022. The survey participants were determined based on their a) specialized knowledge or expertise in public health, b) their affiliation with local government, schools, or c) their involvement with underserved and minority populations and represent a broad aspect of the community.

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

- Health and quality of life for residents of the community
- Barriers to improving health and quality of life for residents of the community
- Opinions regarding the important health issues that affect the residents of the CHNA Community and the types of services that are important for addressing these issues

- Delineation of the most important health care issues or services discussed and actions necessary for addressing those issues

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

KEY INFORMANT PROFILES

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

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

Input from these health care and non-health care professionals was obtained utilizing a standard 10 question interview format.

KEY INFORMANT SURVEY QUESTIONS

Input from these health care and non-health care professionals was obtained utilizing a standard 10-question interview format. The questions included were as follows:

1. Name, organization/title, and county of residence?
2. In general, how would you rate the health and quality of life in the community served by Knapp Medical Center?
3. In your opinion, in the past three years has the health and quality of life in the community served by Knapp Medical Center improved, declined, or stayed the same?
4. Please provide what factors influenced your answer in the previous question and describe why you feel the health and quality of life has improved, declined or stayed the same?
5. What barriers, if any, exist to improving health and quality of life of patients served by Knapp Medical Center?
6. In your opinion, what needs to be done to address the barriers identified in the previous question?
7. How could the services provided by Knapp Medical Center be improved to better meet the needs of its patients and patient's families?
8. In your opinion, what groups of people in the community served by Knapp Medical Center have the most serious unmet health care needs? Describe the causes? What should be done to address the needs of these groups of people?

9. In your opinion, what are the three most critical health needs in the community served by Knapp Medical Center?
10. What needs to be done to address the critical health needs issues identified in the previous question?

RESULTS FROM COMMUNITY INPUT

Key stakeholder interview responses were grouped into four major categories. A summary of the stakeholders' responses by each of the categories follows. This section of the report summarizes what the key stakeholders provided without assessing the credibility of their responses.

GENERAL OPINIONS REGARDING HEALTH AND QUALITY OF LIFE IN THE COMMUNITY

The key stakeholders were asked to rate the health and quality of life in the community. They were also asked to provide their opinion whether the health and quality of life had improved, declined or stayed the same over the past few years. Lastly, key stakeholders were asked to provide support for their answers.

Key stakeholders were asked to rate the health and quality of life in CHNA Community. The survey respondents vary greatly in their responses: 36% rated the health and quality of life in CHNA Community as "very good"; 29% rated the health and quality of life in CHNA Community as "average"; and 35% rated the health and quality of life in CHNA Community as "below average". When asked whether the health and quality of life had improved, declined or stayed the same, 50% of survey respondents indicated the health and quality of life had "improved" over the last three years. Whereas 36% indicated the health and quality of life had "stayed the same" over the last three years and 14% indicated it had "declined".

UNDERSERVED POPULATIONS AND COMMUNITIES OF NEED

Through the key stakeholder surveys, specific populations and groups of people whose health or quality of life may not be as good as others were identified. Survey respondents identified persons living with low-incomes or unemployed are most likely to be underserved due to lack of access to services. Other identified groups are the uninsured and under-insured, elderly, and undocumented population.

BARRIERS

The key stakeholders were asked what barriers or problems keep community residents from obtaining necessary health services and improving health in their community. Key stakeholders noted the following barriers in the CHNA Community:

- Community members that are uninsured or under-insured
- Community members that lack the financial resources to access care
- Community members that do not have transportation
- Community members that face language barriers when accessing or receiving medical care

- Community members that do not have access to childcare thereby limiting their access to medical care
- Cultural practices that lead to unhealthy lifestyles
- Lack of education regarding the available healthcare resources in the community
- Limited access to preventative and wellness care in the community
- Limited access to exercise opportunities
- Shortage of healthcare workers in the community
- Poor coordination of care between healthcare providers in the community.

MOST IMPORTANT HEALTH AND QUALITY OF LIFE ISSUES

Key stakeholders were asked to provide their opinion as to the most critical health and quality of life issues facing the county and the most critical issues the Medical Center should address over the next three to five years. Responses included:

- Access to health care
- Lack of insurance (and under-insured)
- Chronic diseases (Heart Disease, Stroke, Kidney, Cancer, Diabetes)
- Obesity
- Lack of health knowledge and education
- Poverty and lack of financial resources
- Access to mental health services - adults and children
- Poor nutrition / limited access to healthy food options
- Access to primary care and specialists
- Access to preventative care
- Services for the aging
- Transportation
- Language and cultural barriers
- Shortage of healthcare workers
- Healthy behaviors / lifestyle choices
- Access to affordable prescription medications
- Access to exercise and fitness opportunities.

HEALTH ISSUES OF VULNERABLE POPULATIONS

According to Dignity Health's Community Need Index (see *Appendix D*), the zip codes within the Medical Center's CHNA Community have CNI scores ranging from 4.2 to 5.0. The CNI score is an average of five different barrier scores that measure socioeconomic indicators of each community (income, cultural, education, insurance, and housing). The scores range from 1 (lowest) to 5 (highest). The zip codes within the Medical Center's CHNA Community are detailed on the following table:

Zip Code	CNI Score	Population	City	County
78501	5.0	63,703	McAllen	Hidalgo
78503	5.0	24,563	McAllen	Hidalgo
78541	5.0	48,789	Edinburg	Hidalgo
78577	5.0	82,895	Pharr	Hidalgo
78543	4.8	5,630	Elsa	Hidalgo
78560	4.8	5,454	La Joya	Hidalgo
78570	4.8	36,441	Mercedes	Hidalgo
78573	4.8	41,937	Mission	Hidalgo
78516	4.6	36,502	Alamo	Hidalgo
78537	4.6	49,183	Donna	Hidalgo
78538	4.6	17,311	Edcouch	Hidalgo
78539	4.6	35,854	Edinburg	Hidalgo
78557	4.6	13,936	Hidalgo	Hidalgo
78572	4.6	87,200	Mission	Hidalgo
78574	4.6	64,559	Mission	Hidalgo
78589	4.6	42,073	San Juan	Hidalgo
78596	4.6	41,501	Weslaco	Hidalgo
78599	4.6	34,778	Weslaco	Hidalgo
78542	4.4	79,700	Edinburg	Hidalgo
78595	4.4	7,091	Sullivan City	Hidalgo
78504	4.2	58,149	McAllen	Hidalgo
78549	4.2	890	Hargill	Hidalgo
78563	4.2	278	Linn	Hidalgo
78576	4.2	11,889	Penitas	Hidalgo

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

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

- Low income
  - Cost of health care prevents needs from being met
  - Healthy lifestyle and health nutrition education
  - Access to services
- Undocumented Population
  - Language barriers
  - Transportation
  - Lack of health knowledge regarding how to access services
  - Cost of health care prevents needs from being met
  - Healthy lifestyle and health nutrition education

PRIORITIZATION OF IDENTIFIED HEALTH NEEDS

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

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

LEADING CAUSES OF DEATH

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

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

HEALTH OUTCOMES AND FACTORS

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

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

PRIMARY DATA

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

HEALTH NEEDS OF VULNERABLE POPULATIONS

Health needs of vulnerable populations were included for ranking purposes.

PRIORITIZATION METHODOLOGY

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

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

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

Identified Health Needs	How Many People Are Affected by the Issue? (1 Low - 5 High)	What Are the Consequences of Not Addressing This Problem? (1 Low - 5 High)	What is the Impact on Vulnerable Populations? (1 Low - 5 High)	How Important is it to the Community? (1 Low - 5 High)	Prevalence of Common Themes (1 Low - 2 High)	Alignment with Mission (1 Low - 5 High)	Alignment with Programs & Strategic Priorities (1 Low - 5 High)	Total Score
Access to care	5	4	5	4	2	5	5	30
Access to primary care physicians	5	4	4	4	2	5	5	29
Treatment of & mgmt of chronic diseases & conditions	4	5	4	4	2	5	5	29
Shortage of healthcare workers	5	4	4	4	1	5	5	28
Obesity	5	5	3	5	2	4	3	27
Healthy behaviors and healthy lifestyle choices	4	4	4	5	2	3	3	25
Uninsured and under-insured individuals	5	3	5	4	2	3	3	25
Affordability of healthcare services	5	3	5	4	1	3	3	24
Poverty and lack of financial resources	4	4	5	3	2	3	3	24
Access to mental health services - adults and children	5	4	5	4	1	3	2	24
Access to and use of preventative care treatments	4	3	2	3	1	5	5	23
Access to medical specialists	3	3	3	3	2	4	4	22
Access to services for the aging	3	3	4	2	1	5	4	22
Language and cultural barriers	2	2	3	3	1	5	5	21
Health education	5	2	3	3	2	3	3	21
Poor nutrition / limited access to healthy food options	5	3	4	2	1	3	3	21
Transportation	3	3	5	2	2	3	2	20
Preventable hospital stays	2	2	2	3	1	5	4	19
Access to affordable prescription medications	3	3	3	3	2	3	2	19
Access to exercise and fitness opportunities	5	3	3	2	1	3	2	19
Children in poverty	2	3	5	3	1	3	2	19
Physical inactivity	4	3	3	3	1	3	2	19
Access to childcare	3	2	3	2	1	3	2	16
Teen birth rate	1	2	2	1	1	4	4	15
Access to dental health services	3	2	2	1	1	3	2	14

MANAGEMENT'S PRIORITIZATION PROCESS

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

Current area of Hospital focus

Established relationships with community partners to address the health need

Organizational capacity and existing infrastructure to address the health need

This data was reviewed to identify health issues of uninsured persons, low-income persons and minority groups, and the community. As a result of the analysis described above, A listing of prioritized health needs has been identified. The prioritized health needs are the following:

- Access to Care and Access to Primary Care Physicians
- Treatment and Management of Chronic Conditions, including Obesity and Diabetes
- Shortage of Healthcare Workers

The Hospital's next steps include developing an implementation strategy to address these prioritized health needs.

COMMUNITY RESOURCES

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

HOSPITALS

The Knapp Medical Center is a 227-bed acute care hospital located within the CHNA Community. Residents of the community can take advantage of services provided by other hospitals within the CHNA Community, as well as services offered by other facilities and providers.

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

Facility Name	Type of Facility	City, State Zip
Mission Regional Medical Center	Hospital	Mission, TX 78572
South Texas Health System McAllen	Hospital	McAllen, TX 78503
Solara Specialty Hospitals McAllen	Hospital	McAllen, TX 78503
Rio Grande Regional Hospital	Hospital	McAllen, TX 78503
Doctor's Hospital at Renaissance	Hospital	Edinburg, TX 78539
Cornerstone Regional Hospital	Hospital	Edinburg, TX 78539
South Texas Health System Edinburg	Hospital	Edinburg, TX 78539
Weslaco Reegional Rehabilitation Hospital	Hospital	Weslaco, TX 78596
Knapp Medical Center	Hospital	Weslaco, TX 78596
South Texas Health System Heart	Hospital	McAllen, TX 78503
The Women's Hospital at Renaissance	Hospital	Edinburg, TX 78539

OTHER HEALTH CARE FACILITIES

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

Facility Name	Type of Facility	City, State Zip
Nuestra Clinica del Valle - Mission	Health Center	Mission, TX 78572
Nuestra Clinica del Valle - Memorial	Health Center	Mission, TX 78573
Nuestra Clinica del Valle - Women's Health Clinic	Health Center	San Juan, TX 78589
Nuestra Clinica del Valle - San Juan	Health Center	San Juan, TX 78589
Nuestra Clinica del Valle - PSJA School Based Clinic	Health Center	San Juan, TX 78589
Nuestra Clinica del Valle - San Carlos	Health Center	Edinburg, TX 78541
Nuestra Clinica del Valle - Donna	Health Center	Donna, TX 78537
Nuestra Clinica del Valle - Edcouch	Health Center	Edcouch, TX 78538
Nuestra Clinica del Valle - Mercedes	Health Center	Mercedes, TX 78570
Su Clinica - Santa Rosa Dental	Health Center	Santa Rosa, TX, 78593
Su Clinica - Santa Rosa Medical	Health Center	Santa Rosa, TX, 78593

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

APPENDICES

APPENDIX A – ANALYSIS OF DATA

ANALYSIS OF HEALTH STATUS-LEADING CAUSES OF DEATH

Area	United States	(A) 10% of United States Crude Rate	Hidalgo County	(B) County Rate Less U.S. Adjusted Crude Rate	If (B)>(A), then "Health Need"
Cancer	183.50	18.35	97.30	-86.20	
Heart Disease	112.50	11.25	100.50	-12.00	
Lung Disease	48.00	4.80	17.10	-30.90	
Stroke	45.70	4.57	22.30	-23.40	
Unintentional Injury	53.40	5.34	21.20	-32.20	
Motor Vehicle	11.90	1.19	9.30	-2.60	
Drug Poisoning	23.90	2.39	4.90	-19.00	
Homicide	6.20	0.62	3.40	-2.80	
Suicide	14.30	1.43	6.30	-8.00	

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

ANALYSIS OF HEALTH OUTCOMES

Health Outcomes	Top US Performers: 2022	(A) 30% of National Benchmark	Hidalgo County: 2022	(B) County Rate Less National Benchmark 2022	If (B)>(A), then "Health Need"
Adult smoking	16.0%	4.8%	16.0%	0.0%	
Adult obesity	32.0%	9.6%	48.0%	16.0%	Health Need
Food environment index	7.8	2.3	5.3	(2.5)	
Physical inactivity	26.0%	7.8%	37.0%	11.0%	Health Need
Access to exercise opportunities	80.0%	24.0%	62.0%	-18.0%	
Excessive drinking	20.0%	6.0%	15.0%	-5.0%	
Alcohol-impaired driving deaths	27.0%	8.1%	33.0%	6.0%	
Sexually transmitted infections	551.0	165.3	361.5	(189.5)	
Teen birth rate	19.0%	5.7%	44.0%	25.0%	Health Need
Uninsured adults	11.0%	3.3%	33.0%	22.0%	Health Need
Primary care physicians	1,310	393	2,160	850	Health Need
Dentists	1,400	420	3,540	2,140	Health Need
Mental health providers	350	105	1,420	1,070	Health Need
Preventable hospital stays	37.7	11.3	52.7	15.0	Health Need
Mammography screening	43.0%	12.9%	33.0%	-10.0%	
Children in poverty	16.0%	4.8%	33.0%	17.0%	Health Need
Children in single-parent households	25.0%	7.5%	31.0%	6.0%	

ANALYSIS OF PRIMARY DATA – KEY INFORMANT SURVEYS

Identified Needs
Access to care
Lack of insurance (uninsured and under-insured)
Shortage of healthcare workers
Access to and use of preventative care treatments
Treatment of & mgmt of chronic diseases & conditions
Access to primary care physicians
Access to medical specialists
Healthy behaviors and healthy lifestyle choices
Access to mental health services - adults and children
Health education
Obesity
Access to exercise and fitness opportunities
Access to services for the aging
Poverty and lack of financial resources
Poor nutrition / limited access to healthy food options
Language and cultural barriers
Transportation
Access to affordable prescription medications

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

Population	Issues
Uninsured and under-insured population	• Transportation • Access to specialty services • Health education • Cost of health care prevents needs from being met • Healthy lifestyle and health nutrition education
Elderly	• Transportation • Cost of prescriptions and medical care • Lack of health knowledge regarding how to access services • Shortage of physicians (limit on patients who are on Medicare)
Low Income	• Cost of health care prevents needs from being met • Healthy lifestyle and health nutrition education • Access to services
Undocumented Population	• Language barriers • Transportation • Lack of health knowledge regarding how to access services • Cost of health care prevents needs from being met • Healthy lifestyle and health nutrition education

APPENDIX B – COUNTY HEALTH RANKINGS DATA

Health Outcomes	Hidalgo County: 2018	Hidalgo County: 2022	Change	Texas: 2022	Top US Performers: 2022
Mortality: Texas County Ranking	**15**	**27**	-		
Premature death – Years of potential life lost before age 75 per 100,000 population (age-adjusted)	5,700	6,800	-	7,000	7,300
Morbidity: Texas County Ranking	**212**	**212**	NC		
Poor or fair health – Percent of adults reporting fair or poor health (age-adjusted)	29%	34%	-	21%	17%
Poor physical health days – Average number of physically unhealthy days reported in past 30 days (age-adjusted)	4.4	5.2	-	3.6	3.9
Poor mental health days – Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.9	4.6	-	3.9	4.5
Low birth weight – Percent of live births with low birth weight (<2500 grams)	8.0%	9.0%	-	8.0%	8.0%

Health Outcomes	Hidalgo County: 2018	Hidalgo County: 2022	Change	Texas: 2022	Top US Performers: 2022
Health Behaviors: Texas County Ranking	**131**	**175**	-		
Adult smoking – Percent of adults that report smoking at least 100 cigarettes and that they currently smoke	15.0%	16.0%	-	15.0%	16.0%
Adult obesity – Percent of adults that report a BMI >= 30	34.0%	48.0%	-	34.0%	32.0%
Food environment index – Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	7.1	5.3	-	6.1	7.8
Physical inactivity – Percent of adults age 20 and over reporting no leisure time physical activity	25.0%	37.0%	-	27.0%	26.0%
Access to exercise opportunities – Percentage of population with adequate access to locations for physical activity	62.0%	62.0%	NC	80.0%	80.0%
Excessive drinking – Percent of adults that report excessive drinking in the past 30 days	14.0%	15.0%	-	20.0%	20.0%
Alcohol-impaired driving deaths – Percentage of driving deaths with alcohol involvement	28.0%	33.0%	-	25.0%	27.0%
Sexually transmitted infections – Chlamydia rate per 100K population	407.3	361.5	+	445.1	551.0
Teen birth rate – Per 1,000 female population, ages 15-19	62.0	44.0	+	29.0	19.0
Clinical Care: Texas County Ranking	**176**	**223**	-		
Uninsured adults – Percent of population under age 65 without health insurance	32.0%	33.0%	-	21.0%	11.0%
Primary care physicians – Ratio of population to primary care physicians	2,230:1	2,160:1	+	1,630:1	1,310:1
Dentists – Ratio of population to dentists	3,920:1	3,540:1	+	1,660:1	1,400:1
Mental health providers – Ratio of population to mental health providers	1,970:1	1,420:1	+	760:1	350:1
Preventable hospital stays – Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	56.0	52.7	+	42.6	37.7
Mammography screening – Percent of female Medicare enrollees that receive mammography screening	58.0%	33.0%	-	39.0%	43.0%

Health Outcomes	Hidalgo County: 2018	Hidalgo County: 2022	Change	Texas: 2022	Top US Performers: 2022
Social and Economic Factors: Texas County Ranking	**232**	**234**	-		
High school graduation – Percent of ninth grade cohort that graduates in 4 years	87.0%	67.0%	-	84.0%	89.0%
Some college – Percent of adults aged 25-44 years with some post-secondary education	47.0%	51.0%	+	63.0%	67.0%
Unemployment – Percent of population age 16+ unemployed but seeking work	8.0%	11.6%	-	7.6%	8.1%
Children in poverty – Percent of children under age 18 in poverty	43.0%	33.0%	+	19.0%	16.0%
Income inequality – Ratio of household income at the 80th percentile to income at the 20th percentile	5.6	5.6	NC	4.8	4.9
Children in single-parent households – Percent of children that live in household headed by single parent	35.0%	31.0%	+	26.0%	25.0%
Social associations – Number of membership associations per 10,000 population	3.7	3.5	-	7.5	9.2
Violent crime rate – Violent crime rate per 100,000 population (age-adjusted)	312.0	312.0	NC	420.0	386.0
Injury deaths – Number of deaths due to injury per 100,000 population	30.0	32.0	-	60.0	76.0
Physical Environment: Texas County Ranking	**231**	**244**	-		
Air pollution-particulate matter days – Average daily measure of fine particulate matter in micrograms per cubic meter	8.9	11.5	-	9.0	7.5
Severe housing problems – Percentage of household with at least one of four housing problems: overcrowding, high housing costs or lack of kitchen or plumbing facilities	28.0%	25.0%	+	17.0%	17.0%
Driving alone to work – Percentage of the workforce that drives alone to work	80.0%	79.0%	+	79.0%	75.0%
Long commute, driving alone – Among workers who commute in their car alone, the percentage that commute more than 30 minutes	22.0%	23.0%	-	39.0%	37.0%

APPENDIX C – ACKNOWLEDGEMENT OF KEY INFORMANTS

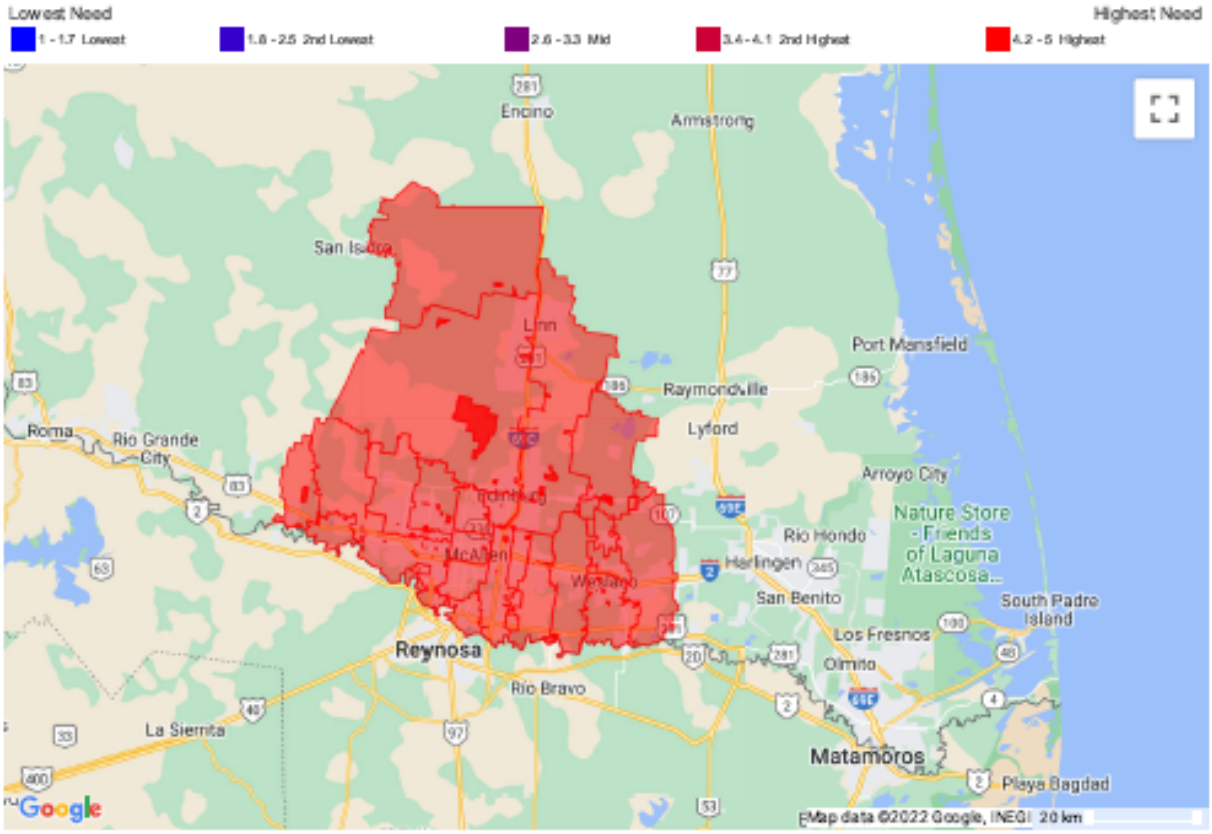
Key Informants

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

Name	Organization
Jeffrey Burton	Weslaco Nursing and Rehabilitation Center
Elizabeth Candanoza	Knapp Medical Center
Michael De La Rosa	Weslaco Independent School District
Mel Escamilla	Knapp Community Care Foundation
Marisela Gonzalez	Aurora House Foundation
Yvonne Gonzalez	Knapp Community Care Foundation
Chief Antonio Lopez, EMC	City of Weslaco
Christian Martinez	Community/Business Leader
Norma Montalvo	Catholic Diocese of Brownsville
Ramon Montalvo III	Community/Business Leader
Daniel Montez	South Texas College
Ramon Resendez	Community/Business Leader
Carlos Robledo	Weslaco Independent School District
Sheila Shidler	Weslaco Museum
Michael Swartz	Knapp Medical Center
Norma Villanueva, PhD	Nueva Luz Foundation
Christina Yepez	Knapp Community Care Foundation
Ralph Zelno	Knapp Community Care Foundation

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

Dignity Health CNI Score Detail – Hidalgo County



Mean(zipcode): 4.6 / Mean(person): 4.7 CNI Score Median: 4.6 CNI Score Mode: 4.6

Zip Code	CNI Score	Population	City	County	State
78501	5	63703	Mcallen	Hidalgo	Texas
78503	5	24563	Mcallen	Hidalgo	Texas
78504	4.2	58149	Mcallen	Hidalgo	Texas
78516	4.6	36502	Alamo	Hidalgo	Texas
78537	4.6	49183	Donna	Hidalgo	Texas
78538	4.6	17311	Edcouch	Hidalgo	Texas
78539	4.6	35854	Edinburg	Hidalgo	Texas
78541	5	48789	Edinburg	Hidalgo	Texas
78542	4.4	79700	Edinburg	Hidalgo	Texas
78543	4.8	5630	Elsa	Hidalgo	Texas
78549	4.2	890	Hargill	Hidalgo	Texas
78557	4.6	13936	Hidalgo	Hidalgo	Texas
78560	4.8	5454	La Joya	Hidalgo	Texas
78563	4.2	278	Linn	Hidalgo	Texas
78570	4.8	36441	Mercedes	Hidalgo	Texas
78572	4.6	87200	Mission	Hidalgo	Texas
78573	4.8	41937	Mission	Hidalgo	Texas
78574	4.6	64559	Mission	Hidalgo	Texas
78576	4.2	11889	Penitas	Hidalgo	Texas
78577	5	82895	Pharr	Hidalgo	Texas
78589	4.6	42073	San Juan	Hidalgo	Texas
78595	4.4	7091	Sullivan City	Hidalgo	Texas
78596	4.6	41501	Weslaco	Hidalgo	Texas
78599	4.6	34778	Weslaco	Hidalgo	Texas

APPENDIX E – SOURCES

Data Indicator	Source
Total Population	US Census Bureau, American Community Survey, 2016-20.
Total Population Change, 2010 - 2020	US Census Bureau, Decennial Census, 2020.
Total Population Change, 2000 - 2010	US Census Bureau, Decennial Census, 2000 - 2010.
Urban and Rural Population	US Census Bureau, Decennial Census, 2010.
Group Quarters Population	US Census Bureau, Decennial Census, 2020.
Median Age	US Census Bureau, American Community Survey, 2016-20.
Female Population	US Census Bureau, American Community Survey, 2016-20.
Male Population	US Census Bureau, American Community Survey, 2016-20.
Population Under Age 18	US Census Bureau, American Community Survey, 2016-20.
Population Age 0-4	US Census Bureau, American Community Survey, 2016-20.
Population Age 5-17	US Census Bureau, American Community Survey, 2016-20.
Population Age 18-64	US Census Bureau, American Community Survey, 2016-20.
Population Age 18-24	US Census Bureau, American Community Survey, 2016-20.
Population Age 25-34	US Census Bureau, American Community Survey, 2016-20.
Population Age 35-44	US Census Bureau, American Community Survey, 2016-20.
Population Age 45-54	US Census Bureau, American Community Survey, 2016-20.

Data Indicator	Source
Population Age 55-64	US Census Bureau, American Community Survey, 2016-20.
Population Age 65+	US Census Bureau, American Community Survey, 2016-20.
Population with Any Disability	US Census Bureau, American Community Survey, 2016-20.
Population in Limited English Households	US Census Bureau, American Community Survey, 2016-20.
Population with Limited English Proficiency	US Census Bureau, American Community Survey, 2016-20.
Population Geographic Mobility	US Census Bureau, American Community Survey, 2016-20.
Foreign-Born Population	US Census Bureau, American Community Survey, 2016-20.
Hispanic Population	US Census Bureau, American Community Survey, 2016-20.
Non-Hispanic White Population	US Census Bureau, American Community Survey, 2016-20.
Black or African American Population	US Census Bureau, American Community Survey, 2016-20.
Citizenship Status	US Census Bureau, American Community Survey, 2016-20.
Veteran Population	US Census Bureau, American Community Survey, 2016-20.
Migration Patterns - Total Population (2010-2020)	IRS - Statistics of Income, 2010-2020.
Migration Patterns - Total Population (2000-2010)	University of Wisconsin Net Migration Patterns for US Counties, 2000 to 2010.
Migration Patterns - Young Adult (2000-2010)	University of Wisconsin Net Migration Patterns for US Counties, 2000 to 2010.
Commuter Travel Patterns - Driving Alone to Work	US Census Bureau, American Community Survey, 2016-20.

Data Indicator	Source
Commuter Travel Patterns - Long Commute	US Census Bureau, American Community Survey, 2016-20.
Commuter Travel Patterns - Overview	US Census Bureau, American Community Survey, 2016-20.
Commuter Travel Patterns - Overview 2	US Census Bureau, American Community Survey, 2016-20.
Commuter Travel Patterns - Public Transportation	US Census Bureau, American Community Survey, 2016-20.
Commuter Travel Patterns - Walking or Biking	US Census Bureau, American Community Survey, 2016-20.
Employment - Business Creation	US Census Bureau, Business Dynamics Statistics, 2019-2020.
Employment - Employment Change	US Census Bureau, Business Dynamics Statistics, 2019-2020.
Employment - Job Sectors, Largest	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Employment - Jobs and Earnings by Sector	US Department of Commerce, US Bureau of Economic Analysis, 2020.
Employment - Jobs Sectors, Highest Earnings	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Employment - Labor Force Participation Rate	US Census Bureau, American Community Survey, 2016-20.
Employment - Unemployment Rate	US Department of Labor, Bureau of Labor Statistics, 2022 - September.
Gross Domestic Product (GDP)	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Income - Earned Income Tax Credit	IRS - Statistics of Income, 2018.
Income - Families Earning Over $75,000	US Census Bureau, American Community Survey, 2016-20.
Income - Income and AMI	US Census Bureau, American Community Survey, 2016-20.

Data Indicator	Source
Income - Inequality (Atkinson Index)	US Census Bureau, American Community Survey, University of Missouri, Center for Applied Research and Engagement Systems, 2007-11.
Income - Inequality (GINI Index)	US Census Bureau, American Community Survey, 2016-20.
Income - Median Family Income	US Census Bureau, American Community Survey, 2016-20.
Income - Median Household Income	US Census Bureau, American Community Survey, 2016-20.
Income - Net Income of Farming Operations	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Income - Per Capita Income	US Census Bureau, American Community Survey, 2016-20.
Income - Proprietor Employment and Income	US Department of Commerce, US Bureau of Economic Analysis, 2016.
Income - Public Assistance Income	US Census Bureau, American Community Survey, 2016-20.
Income - Transfer Payments	US Department of Commerce, US Bureau of Economic Analysis, 2019.
Poverty - Children Below 100% FPL	US Census Bureau, American Community Survey, 2016-20.
Poverty - Children Below 200% FPL	US Census Bureau, American Community Survey, 2016-20.
Poverty - Children Eligible for Free/Reduced Price Lunch	National Center for Education Statistics, NCES - Common Core of Data, 2020-2021.
Poverty - Population Below 100% FPL	US Census Bureau, American Community Survey, 2016-20.
Poverty - Population Below 100% FPL (Annual)	US Census Bureau, Small Area Income and Poverty Estimates, 2020.
Poverty - Population Below 185% FPL	US Census Bureau, American Community Survey, 2016-20.
Poverty - Population Below 200% FPL	US Census Bureau, American Community Survey, 2016-20.

Data Indicator	Source
Poverty - Population Below 50% FPL	US Census Bureau, American Community Survey, 2016-20.
Debt - Student Loan Debt	Debt in America, The Urban Institute, 2022.
Debt - Any Debt in Collections	Debt in America, The Urban Institute, 2022.
Access - Childcare Centers	Department of Homeland Security, Homeland Infrastructure Foundation-Level Data, 2021.
Access - Head Start	US Department of Health & Human Services, HRSA - Administration for Children and Families, 2022.
Access - Childcare Cost Burden	The Living Wage Calculator, Small Area Income and Poverty Estimates, 2021&2020.
Access - Preschool Enrollment (Age 3-4)	US Census Bureau, American Community Survey, 2016-20.
Access - Public Schools	National Center for Education Statistics, NCES - Common Core of Data, 2020-2021.
Attainment - Overview	US Census Bureau, American Community Survey, 2016-20.
Attainment - Associate's Level Degree or Higher	US Census Bureau, American Community Survey, 2016-20.
Attainment - Bachelor's Degree or Higher	US Census Bureau, American Community Survey, 2016-20.
Attainment - No High School Diploma	US Census Bureau, American Community Survey, 2016-20.
Attainment - Some Post-secondary Education	US Census Bureau, American Community Survey, 2016-20.
Attainment - High School Graduation Rate	US Department of Education, EDFacts, 2018-19.
Chronic Absence Rate	U.S. Department of Education, US Department of Education - Civil Rights Data Collection, 2017-18.
Proficiency - Student Math Proficiency (4th Grade)	US Department of Education, EDFacts, 2018-19.

Data Indicator	Source
Proficiency - Student Reading Proficiency (4th Grade)	US Department of Education, EDFacts, 2018-19.
Public School Revenue	National Center for Education Statistics, NCES - Common Core of Data, 2018-19.
Public School Expenditures	National Center for Education Statistics, NCES - Common Core of Data, 2018-19.
School Funding Adequacy	School Finance Indicators Database, SFID - School Finance Indicators Database, 2019.
School Segregation Index	National Center for Education Statistics, NCES - School Segregation Index, 2020-2021.
Households - Overview	US Census Bureau, American Community Survey, 2016-20.
Family Households - Overview	US Census Bureau, American Community Survey, 2016-20.
Families with Children	US Census Bureau, American Community Survey, 2016-20.
Affordable Housing	US Census Bureau, American Community Survey, 2016-20.
Affordable Housing - Low Income Tax Credits	US Department of Housing and Urban Development, 2019.
Affordable Housing - Assisted Housing Units	US Department of Housing and Urban Development, 2021.
Evictions	Eviction Lab, 2016.
Household Structure - Single-Parent Households	US Census Bureau, American Community Survey, 2016-20.
Household Structure - Older Adults Living Alone	US Census Bureau, American Community Survey, 2016-20.
Housing Costs - Cost Burden (30%)	US Census Bureau, American Community Survey, 2016-20.
Housing Costs - Cost Burden, Severe (50%)	US Census Bureau, American Community Survey, 2016-20.

Data Indicator	Source
Housing Costs - Owner Costs	US Census Bureau, American Community Survey, 2016-20.
Housing Costs - Owner Costs by Mortgage Status	US Census Bureau, American Community Survey, 2016-20.
Housing Costs - Renter Costs	US Census Bureau, American Community Survey, 2016-20.
Housing Quality - Overcrowding	US Census Bureau, American Community Survey, 2016-20.
Housing Quality - Substandard Housing	US Census Bureau, American Community Survey, 2016-20.
Housing Quality - Substandard Housing, Severe	US Census Bureau, American Community Survey, 2011-2015.
Housing Stock - Age	US Census Bureau, American Community Survey, 2016-20.
Housing Stock - Housing Unit Value	US Census Bureau, American Community Survey, 2016-20.
Housing Stock - Modern Housing	US Census Bureau, American Community Survey, 2016-20.
Housing Stock - Mortgage Lending	Federal Financial Institutions Examination Council, Home Mortgage Disclosure Act, 2014.
Housing Stock - Net Change	US Census Bureau, American Community Survey, 2016-20.
Housing Stock - Residential Construction	US Department of Housing and Urban Development, 2014.
Housing Units - Overview	US Census Bureau, Census Population Estimates.
Housing Units - Single-Unit Housing	US Census Bureau, American Community Survey, 2016-20.
Tenure - Mortgage Status	US Census Bureau, American Community Survey, 2016-20.
Tenure - Owner-Occupied Housing	US Census Bureau, American Community Survey, 2016-20.

Data Indicator	Source
Tenure - Renter-Occupied Housing	US Census Bureau, American Community Survey, 2016-20.
Vacancy (ACS)	US Census Bureau, American Community Survey, 2016-20.
Vacancy (HUD)	US Department of Housing and Urban Development, 2020-Q4.
Area Deprivation Index	University of Wisconsin-Madison School of Medicine and Public Health, Neighborhood Atlas, 2020.
Food Insecurity Rate	Feeding America, 2020.
Homeless Children & Youth	US Department of Education, EDFacts, 2019-2020.
Households with No Motor Vehicle	US Census Bureau, American Community Survey, 2016-20.
Incarceration Rate	Opportunity Insights, 2018.
Insurance - Insured Population and Provider Type	US Census Bureau, American Community Survey, 2016-20.
Insurance - Medicare Enrollment Demographics	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Insurance - Population Receiving Medicaid	US Census Bureau, American Community Survey, 2016-20.
Insurance - Uninsured Adults	US Census Bureau, Small Area Health Insurance Estimates, 2019.
Insurance - Uninsured Children	US Census Bureau, Small Area Health Insurance Estimates, 2019.
Insurance - Uninsured Population (ACS)	US Census Bureau, American Community Survey, 2016-20.
Insurance - Uninsured Population (SAHIE)	US Census Bureau, Small Area Health Insurance Estimates, 2019.
Racial Diversity (Theil Index)	US Census Bureau, Decennial Census, University of Missouri, Center for Applied Research and Engagement Systems, 2020.

Data Indicator	Source
Racial Segregation (Interaction Index)	US Census Bureau, Decennial Census, University of Missouri, Center for Applied Research and Engagement Systems, 2010.
SNAP Benefits - Households Receiving SNAP (ACS)	US Census Bureau, American Community Survey, 2016-20.
SNAP Benefits - Population Receiving SNAP (SAIPE)	US Census Bureau, Small Area Income and Poverty Estimates, 2019.
Social Capital - Social Capital Index	Pennsylvania State University, College of Agricultural Sciences, Northeast Regional Center for Rural Development, 2014.
Social Capital - 501c3 organizations	IRS - Exempt Organizations Business Master File, 2020.
Social Capital - ACS Self-response Rate	Census Planning Database; ACS 2015-19; CARES, 2021.
Social Capital - Voter Participation Rate	Townhall.com Election Results, 2020.
Social Vulnerability Index (SoVI)	Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2018.
Teen Births	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2014-2020.
Teen Births (ACS)	US Census Bureau, American Community Survey, 2016-20.
Arrests - Juvenile Arrest Rate	Office of Juvenile Justice and Delinquency Department, Easy Access to State and County Juvenile Court Case Counts (EZACO), 2019.
Property Crime - Total	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2014&2016.
Violent Crime - Assault	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.
Violent Crime - Rape	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.
Violent Crime - Robbery	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.
Violent Crime - Total	Federal Bureau of Investigation, FBI Uniform Crime Reports, 2015-2017.

Data Indicator	Source
Housing + Transportation Affordability Index (H+T Index)	Center for Neighborhood Technology, 2022.
Young People Not in School and Not Working	US Census Bureau, American Community Survey, 2016-20.
Gender Pay Gap	US Census Bureau, American Community Survey, 2016-2020.
Opportunity Index	Opportunity Nation, 2018.
Air & Water Quality - Drinking Water Safety	US Environmental Protection Agency, 2018-19.
Air & Water Quality - Ozone	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2015.
Air & Water Quality - Particulate Matter 2.5	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2016.
Air & Water Quality - Respiratory Hazard Index	EPA - National Air Toxics Assessment, 2018.
Air & Water Quality - RSEI Score	US Environmental Protection Agency, 2019.
Built Environment - Banking Institutions	US Census Bureau, County Business Patterns, 2020.
Built Environment - Broadband Access	Federal Communications Commission, National Broadband Map, June 2021.
Built Environment - Households with No Computer	US Census Bureau, American Community Survey, 2016-20.
Built Environment - Households with No or Slow Internet	US Census Bureau, American Community Survey, 2016-20.
Built Environment - Liquor Stores	US Census Bureau, County Business Patterns, 2020.
Built Environment - Recreation and Fitness Facility Access	US Census Bureau, County Business Patterns, 2020.
Built Environment - Social Associations	US Census Bureau, County Business Patterns, 2020.

Data Indicator	Source
Built Environment - Tobacco Product Compliance Check Violations	US Department of Health & Human Services, US Food and Drug Administration Compliance Check Inspections of Tobacco Product Retailers, 2018-2020.
Climate & Health - Climate-Related Mortality Impacts	Climate Impact Lab.
Climate & Health - Dominant Land Cover	Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2016.
Climate & Health - Drought Severity	US Drought Monitor, 2017-2019.
Climate & Health - Flood Vulnerability	Federal Emergency Management Agency, National Flood Hazard Layer, 2011.
Climate & Health - High Heat Index Days (Absolute)	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking, 2019-21.
Climate & Health - High Heat Index Days (Relative)	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking, 2019-21.
Climate & Health - National Risk Index	Federal Emergency Management Agency, National Risk Index, 2021.
Climate & Health - Tree Canopy	Multi-Resolution Land Characteristics Consortium, National Land Cover Database, 2016.
Community Design - Park Access (CDC)	Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network, 2015.
Community Design - Park Access (ESRI)	US Census Bureau, Decennial Census, ESRI Map Gallery, 2013.
Food Environment - Fast Food Restaurants	US Census Bureau, County Business Patterns, 2020.
Food Environment - Food Desert Census Tracts	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Food Environment - Grocery Stores	US Census Bureau, County Business Patterns, 2020.
Food Environment - Leading Agricultural Products (1)	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.
Food Environment - Leading Agricultural Products (2)	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2017.

Data Indicator	Source
Food Environment - Low Food Access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Food Environment - Low Income & Low Food Access	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2019.
Food Environment - Modified Retail Food Environment Index	Centers for Disease Control and Prevention, CDC - Division of Nutrition, Physical Activity, and Obesity, 2011.
Food Environment - SNAP-Authorized Food Stores	US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator, 2021.
Orchards	US Department of Agriculture, National Agricultural Statistics Service, Census of Agriculture, 2012.
Threatened and Endangered Species	US Fish and Wildlife Service, Environmental Conservation Online System, 2019.
Access to Exercise Opportunities	Business Analyst, ESRI, YMCA & US Census Tigerline Files, 2010&2021.
Cancer Screening - Mammogram (Medicare)	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Cancer Screening - Mammogram (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Cancer Screening - Pap Smear Test	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Cancer Screening - Sigmoidoscopy or Colonoscopy	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Dental Care Utilization	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Diabetes Management - Hemoglobin A1c Test	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2019.
Hospitalizations - Preventable Conditions	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2020.
Hospitalizations - Emergency Room Visits	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Hospitalizations - Inpatient Stays	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.

Data Indicator	Source
Hospitalizations - Heart Disease	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2017-2019.
Hospitalizations - Stroke	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2017-2019.
Late or No Prenatal Care	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic
Opioid Drug Claims	Centers for Medicare & Medicaid Services, CMS - Part D Opioid Drug Mapping Tool, 2019.
Prevention - Annual Wellness Exam (Medicare)	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Prevention - Seasonal Influenza Vaccine	Centers for Disease Control and Prevention, CDC - FluVaxView, 2019-20.
Prevention - Cholesterol Screening	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Prevention - High Blood Pressure Management (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Prevention - High Blood Pressure Management (Medicare)	Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke , 2018.
Prevention - Recent Primary Care Visit (Medicare)	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2019.
Prevention - Core Preventative Services for Men	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Prevention - Recent Primary Care Visit (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Prevention - Core Preventative Services for Women	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Readmissions - All Cause (Medicare Population)	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020.
Readmissions - Chronic Obstructive Pulmonary Disease	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Readmissions - Heart Attack	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.

Data Indicator	Source
Readmissions - Heart Failure	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Readmissions - Pneumonia	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Timely and Effective Care - Heart Attack	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Timely and Effective Care - Elective Delivery	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Timely and Effective Care - Stroke	Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2018-20.
Alcohol - Heavy Alcohol Consumption	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Alcohol - Binge Drinking	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Alcohol - Expenditures	Nielsen, Nielsen SiteReports, 2014.
Breastfeeding - Ever	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Breastfeeding (Any)	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Breastfeeding (Exclusive)	Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, 2018.
Fruit/Vegetable Expenditures	Nielsen, Nielsen SiteReports, 2014.
Physical Inactivity	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Soda Expenditures	Nielsen, Nielsen SiteReports, 2014.
STI - Chlamydia Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.
STI - Gonorrhea Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.

Data Indicator	Source
STI - HIV Incidence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.
STI - HIV Prevalence	Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2020.
Tobacco Expenditures	Nielsen, Nielsen SiteReports, 2014.
Insufficient Sleep	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Tobacco Usage - Current Smokers	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Walking or Biking to Work	US Census Bureau, American Community Survey, 2016-20.
Birth Outcomes - Infant Mortality (CDC)	University of Wisconsin Population Health Institute, County Health Rankings, 2014-2020.
Birth Outcomes - Low Birth Weight (CDC)	University of Wisconsin Population Health Institute, County Health Rankings, 2014-2020.
Cancer Incidence - All Sites	State Cancer Profiles, 2014-18.
Cancer Incidence - Breast	State Cancer Profiles, 2014-18.
Cancer Incidence - Cervical	State Cancer Profiles, 2014-18.
Cancer Incidence - Colon and Rectum	State Cancer Profiles, 2014-18.
Cancer Incidence - Lung	State Cancer Profiles, 2014-18.
Cancer Incidence - Prostate	State Cancer Profiles, 2014-18.
Chronic Conditions - Alcohol Use Disorder (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Alzheimer's Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.

Data Indicator	Source
Chronic Conditions - Asthma (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Asthma Prevalence (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - Cancer (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions – Chronic Obstructive Pulmonary Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Chronic Obstructive Pulmonary Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - Depression (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Diabetes Incidence (Adult)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2018.
Chronic Conditions - Diabetes Prevalence (Adult)	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Chronic Conditions - Diabetes Prevalence (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Heart Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - Heart Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - High Blood Pressure (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - High Blood Pressure (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - High Cholesterol (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Chronic Conditions - High Cholesterol (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Kidney Disease (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.

Data Indicator	Source
Chronic Conditions - Kidney Disease (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Mental Health and Substance Use Conditions	Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool, 2019.
Chronic Conditions - Substance Use Disorder (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Chronic Conditions - Multiple Chronic Conditions (Medicare Population)	Centers for Medicare and Medicaid Services, 2018.
Deaths of Despair (Suicide + Drug/Alcohol Poisoning)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Cancer	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Mortality - Coronary Heart Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Firearm	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Heart Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Homicide	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Influenza & Pneumonia	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Life Expectancy	Institute for Health Metrics and Evaluation, 2014.
Mortality - Life Expectancy	University of Wisconsin Population Health Institute, County Health Rankings, 2018-2020.
Mortality - Life Expectancy (Census Tract)	Centers for Disease Control and Prevention and the National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project, 2010-15.
Mortality - Liver Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Mortality - Lung Disease	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.

Data Indicator	Source
Mortality - Motor Vehicle Crash (NVSS)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Mortality - Motor Vehicle Crash (NHTSA)	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2018-2020.
Mortality - Motor Vehicle Crash, Alcohol-Involved	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2016-2020.
Mortality - Motor Vehicle Crash, Pedestrian	US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System, 2016-2020.
Mortality - Drug Overdose (All Substances)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Opioid Overdose	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Poisoning	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Premature Death	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2018-2020.
Mortality - Stroke	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-2020.
Mortality - Suicide	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Mortality - Unintentional Injury (Accident)	Centers for Disease Control and Prevention, CDC - National Vital Statistics System, 2016-20.
Obesity	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.
Poor Dental Health - Teeth Loss	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018.
Poor or Fair Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Poor Mental Health - Days	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Poor Mental Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.

Data Indicator	Source
Poor Physical Health - Days	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Poor Physical Health	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Stroke (Adult)	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019.
Stroke (Medicare Population)	Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions, 2018.
Access to Care - Addiction/Substance Abuse Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), November 2022.
Access to Care - Buprenorphine Providers	US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Feb. 2022.
Access to Care - Dental Health	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2020.
Access to Care - Dental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), November 2022.
Access to Care - Mental Health	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2021.
Access to Care - Mental Health Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), November 2022.
Access to Care - Nurse Practitioners	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), November 2022.
Access to Care - Primary Care	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File, 2019.
Access to Care - Primary Care Providers	Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), November 2022.
Federally Qualified Health Centers	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, September 2020.
Hospitals with Cardiac Rehabilitation Units	US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, 2019.
Health Professional Shortage Areas - All	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021.

Data Indicator	Source
Health Professional Shortage Areas - Dental Care	US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database, May 2021.
Population Living in a Health Professional Shortage Area	US Census Bureau, American Community Survey, 2016-20.
COVID-19 - Confirmed Cases	Johns Hopkins University, 2022.
COVID-19 - Mortality	Johns Hopkins University, 2022.
COVID-19 Fully Vaccinated Adults	Centers for Disease Control and Prevention and the National Center for Health Statistics, CDC - GRASP, 2022.
Social Distancing - Mobility Reports (Google)	Google Mobility Reports, Feb 01, 2022.
Discharges by Zip Code	Knapp Medical Center
County Health Rankings	County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute. https://www.countyhealthrankings.org/explore-health-rankings
Sparkmap Data Analysis	https://sparkmap.org/report/
Dignity Health Community Need Index	http://cni.dignityhealth.org/