Penn Highlands Healthcare

Empowering Communities:

Unveiling Health Needs, Driving Positive Change

EXECUTIVE SUMMARY FOR PENN HIGHLANDS HEALTHCARE

2024

PREPARED BY **TRIPP UMBACH**


Penn Highlands DuBois

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MESSAGE TO THE COMMUNITY

Steven M. Fontaine
Chief Executive Officer

Penn Highlands Healthcare

June 2024

Dear Friends of Penn Highlands Healthcare,

At Penn Highlands Healthcare, it is our greatest privilege to continue serving the residents of Northwestern/Central and Southwestern Pennsylvania as non-profit, community healthcare organizations. A commitment we value and cherish. Penn Highlands Healthcare was established on the principles that our community-based and controlled healthcare system would exist to improve regional access to a wide array of premier primary care and advanced healthcare services while supporting a reverence for life and the worth and dignity for each individual accessing Penn Highlands Healthcare.

To truly provide a meaningful impact on the overall wellness of our community, we must fully understand the many factors affecting the health of the people we serve and continue to work to address their greatest needs.

Our 2024 Community Health Needs Assessment provides an in-depth analysis on the social, economic, environmental, and healthcare determinants of health. This includes access to care, critical care, mental health, employment, housing, chronic disease, longevity, nutrition, and physical fitness.

This assessment allows us to identify opportunities and develop innovative ways of working together to provide programs and services with the greatest impact. Through effective partnerships, we may improve the health of our community and influence the well-being of our families, friends, and neighbors now and for generations to come.

As CEO of Penn Highlands Healthcare, I believe profoundly in what we are setting forth in support of the Community Health Needs Assessment. Penn Highlands Healthcare employees, friends of Penn Highlands Healthcare, and local community members have been the health system's voice in educating and gaining support for initiatives, programs, and services throughout our footprint. For that, I express my sincere gratitude.

Penn Highlands Healthcare remains steadfast in the delivery of care and outreach efforts. The COVID-19 pandemic has considerably impacted program initiatives, and the healthcare system continues to be dedicated to all healthcare services that are imperative to the community residents. Today, our goals are even more "concrete" as we look with considerable hope and anticipation toward the future. We have improved healthcare for all of us, which reflects the excellence of care that has already been provided and demonstrates the need for the whole community's support of this vital resource.

I invite you to join in the continued support of the Penn Highlands Healthcare Community Health Needs Assessment, along with the vision and the future of healthcare in our communities.

Gratefully,

Steven M. Fontaine

Chief Executive Officer

Questions or comments regarding the CHNA can be emailed to Danyell Bundy @ DLBundy@phhealthcare.org

Penn Highlands Healthcare provides residents of the communities with access to the region's best hospitals, physicians, home care agencies, nursing homes, and other affiliates who believe that healthcare should be managed by local board members. Each Penn Highlands Healthcare facility is the largest employer in its hometown and is deeply rooted in the community's popular and economic culture. Penn Highlands Healthcare's vision is to be an integrated healthcare delivery system that provides premier care with a personal touch, no matter where one lives in the region.

MISSION STATEMENT

To provide you with exceptional care through our community-based health system while maintaining a reverence for life.

VISION STATEMENT

To be the integrated health system of choice through excellent quality, service, and outcomes.

VALUE STATEMENT

- **Quality & Safety** — Provide a safe environment with high-quality outcomes.
- **Teamwork** — Foster a culture of teamwork, support, trust, and loyalty.
- **Integrity** — Practice the principles of honesty, confidentiality, respect, and transparency.
- **Person-Centered** — Recognize those we serve as equal partners.
- **Service** — Demonstrate compassion by listening, engaging, anticipating, and exceeding needs and expectations.
- **Stewardship** — Commit to investing in our human and material resources while practicing fiscal responsibility.
- **Partnership** — Offer services and programs through partnerships with our physicians, providers, stakeholders, and other organizations.
- **Education** — Expand our emphasis on education and enhance our position as a learning organization.

FREQUENTLY ASKED QUESTIONS

WHAT IS A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)?

A CHNA is a systematic process used to identify and evaluate the health needs and issues of a specific population or community. This assessment aims to gather comprehensive data and insights about the community's health status, disparities, and factors affecting health outcomes. CHNA results are used to inform and guide the development of strategies, programs, and policies to improve the overall health and well-being of the community.

WHY IS A CHNA PERFORMED?

A CHNA is performed to systematically identify and evaluate the unmet health needs and issues within a community. The process provides valuable data-driven insights that help healthcare providers, policymakers, and community leaders make informed decisions about resource allocation, program development, and policy implementation. By prioritizing the most pressing health issues based on their prevalence and impact, a CHNA ensures that efforts are focused where they are needed most. It also engages community members and stakeholders, ensuring their voices and concerns are integral to health planning and interventions.

The ultimate goal of a CHNA is to develop targeted strategies that improve health outcomes, reduce health disparities, and enhance the overall quality of life for community members. Additionally, for some organizations, such as non-profit hospitals, conducting a CHNA is a regulatory requirement to maintain tax-exempt status and demonstrate community benefit. By establishing baseline data and monitoring changes in community health over time, a CHNA allows for the assessment of the effectiveness of implemented programs and strategies.

HOW WAS DATA FOR THE CHNA REPORTS COLLECTED?

In January 2024, a dedicated working group was established to complete the CHNA and advance its related initiatives. This team gathered a comprehensive dataset that provided a detailed snapshot of the health status of residents in Northwestern, Southwest, and Central Pennsylvania. This encompassed a broad range of data, including socioeconomic factors, health statistics, demographic profiles, and mental health issues, among other relevant metrics. With unwavering passion and tireless effort, the working group strived to represent and advocate effectively for the needs and concerns of the communities they served.

PENN HIGHLANDS HEALTHCARE
AT-A-GLANCE

Established
OCTOBER 1, 2011

742 INPATIENT BEDS
388 LONG-TERM CARE BEDS
276 PERSONAL CARE BEDS
174 INDEPENDENT LIVING UNITS

9 Hospitals

HOME HEALTH AGENCY

5 CANCER TREATMENT CENTERS

11 QCare WALK-IN CLINICS

2 HEART CENTERS

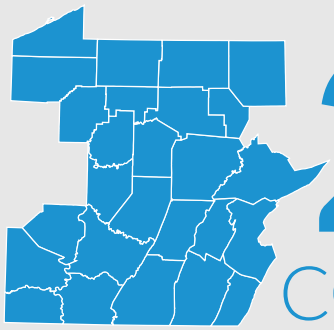
3 SURGERY CENTERS

9 EMERGENCY ROOMS

30 LAB COLLECTION SITES

1 LUNG CENTER

Our Team
6,123 EMPLOYEES
764 PHYSICIANS
389 ADVANCED PRACTICE PROVIDERS



26 COUNTY SERVICE AREA
21,148 SQUARE MILES

23 IMAGING LOCATIONS

26 OUTPATIENT THERAPY LOCATIONS

1 BRAIN AND SPINE CENTER

11 RETAIL PHARMACY LOCATIONS

3 LONG TERM CARE FACILITIES

50+ PRIMARY CARE LOCATIONS

Penn Highlands Healthcare

OUR HISTORY

Established on October 1, 2011, Penn Highlands Healthcare's roots extend far beyond this date, with its hospitals and organizations serving their communities for more than a century. The system was formally created through the 2011 merger of Clearfield Hospital, DuBois Regional Medical Center (DRMC), and Brookville Hospital, with the latter already managed as a DRMC subsidiary. On July 1, 2013, Elk Regional Health Center and its affiliates joined Penn Highlands Healthcare. The network expanded further in 2019 when Jefferson Manor Health Center, a continuing care retirement community in Brookville, became part of Penn Highlands Healthcare on April 1, followed by the integration of J.C. Blair Memorial Hospital as Penn Highlands Huntingdon in June. On April 1, 2020, Penn Highlands acquired Helpmates Inc., a home care agency based in Ridgway serving central Pennsylvania. On November 1, 2020, Tyrone Regional Health Network joined, transforming into Penn Highlands Tyrone and expanding the system to six hospitals. In October 2021 and April 2022, Penn Highlands Mon Valley, a 200-bed non-profit community hospital, and Penn Highlands Connellsville, a 64-bed non-profit community hospital, joined Penn Highlands Healthcare, becoming the eighth hospital in the healthcare system and the second in Southwestern Pennsylvania.

Penn Highlands Healthcare is committed to delivering high-quality care, ensuring every community member receives the attention and treatment they deserve. With a focus on continuous improvement, Penn Highlands Healthcare integrates the latest medical advancements to enhance patient outcomes and satisfaction. The dedicated medical staff works diligently to provide compassionate, personalized care, reflecting the hospital's deep dedication to the well-being of its community. Through collaborative efforts and community engagement, the hospital strives to meet the diverse health needs of all its patients, affirming its role as a cornerstone of health and wellness in the area.

INTRODUCTION

In its ongoing commitment to community service, Penn Highlands Healthcare undertook an extensive Community Health Needs Assessment beginning in January 2024. Situated in Northwestern, Southwest, and Central Pennsylvania, Penn Highlands Healthcare focused this in-depth analysis on understanding the health needs of residents in the region. With nine hospitals – Penn Highlands Brookville, Penn Highlands Clearfield (a campus of Penn Highlands DuBois), Penn Highlands Connellsville, Penn Highlands DuBois, Penn Highlands Elk, Penn Highlands Huntingdon, Penn Highlands Mon Valley, Penn Highlands Tyrone, and Penn Highlands State College (a campus of Penn Highlands Huntingdon) – Penn Highlands Healthcare strives to provide exceptional quality, safety, and service.

Penn Highlands Healthcare is dedicated to enhancing regional access to a comprehensive range of premier primary care and specialized services. This commitment is rooted in a mission emphasizing respect for life and the intrinsic value of everyone. The strategic integration of these hospitals ensures local governance and offers numerous community benefits including, increased access to specialist physicians, enhanced quality of care, improved coordination of services, and more effective physician recruitment and retention. The system has also achieved significant cost reductions across all facilities through debt consolidation, increased purchasing power in the supply chain, and focused coordination of several key service lines.

As a recognized leader in providing high-quality, patient-centered care in its rural communities, Penn Highlands Healthcare boasts a medical staff of 764 physicians, 389 advanced practice providers, and 6,123 employees. The network serves a multi-county area with 742 inpatient beds, 388 long-term care beds, 276 personal care beds, and 174 independent living units.

The Patient Protection and Affordable Care Act (PPACA)

The PPACA, which went into effect on March 23, 2010, requires tax-exempt hospitals to conduct community health needs assessments and implement strategy plans to improve residents' health and well-being within their communities. These strategies, created by hospitals and institutions, consist of programs, activities, and plans specifically targeted toward community populations. The execution of the implementation strategy plan is designed to increase and track the impact of each hospital's efforts.

The requirements imposed by the IRS for tax-exempt hospitals and health systems must include the following:

- Conduct a CHNA every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report on how the strategy is addressing the needs identified in the CHNA, describe the needs that are not being addressed, and explain the reasons why.

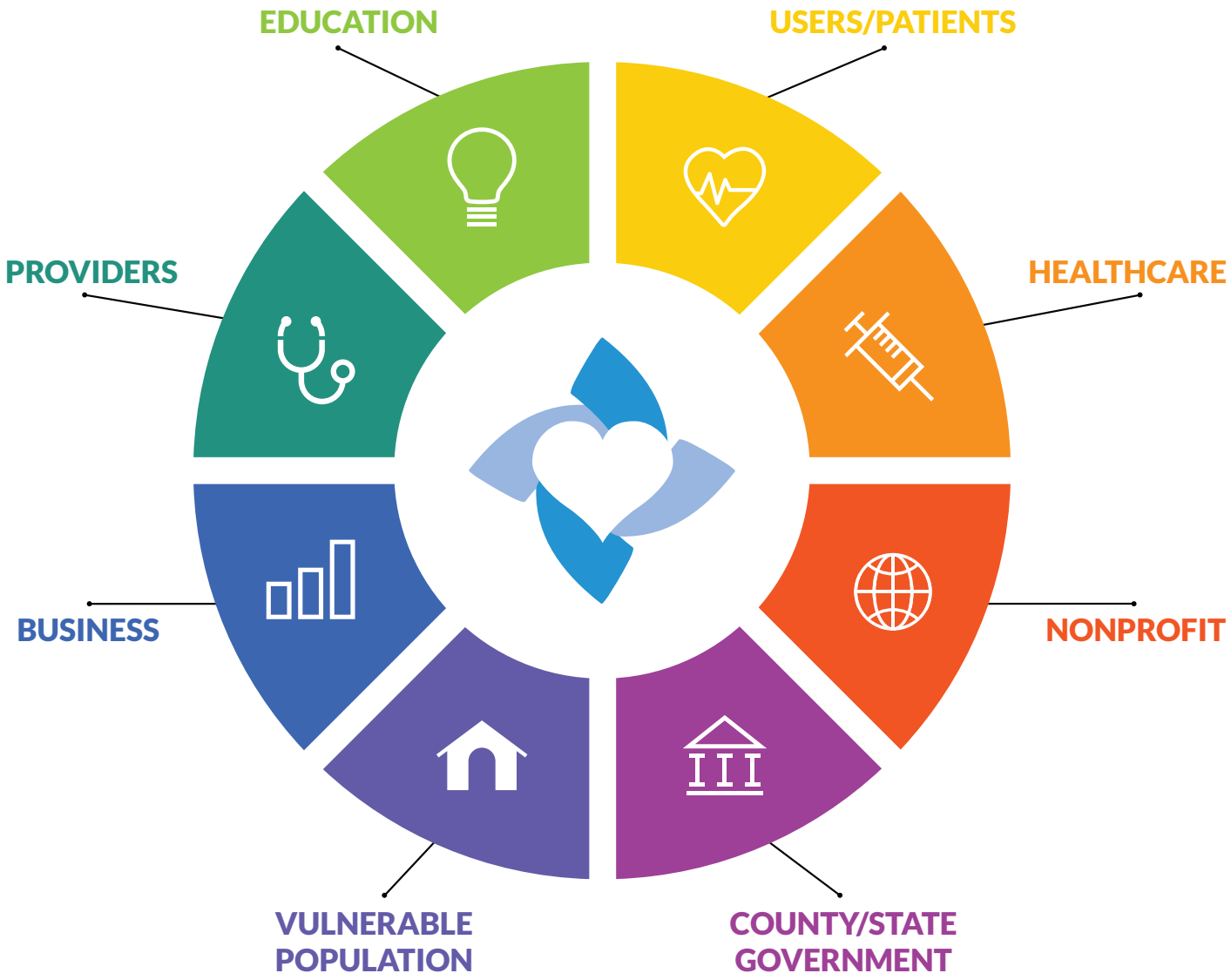
COMMUNITY ENGAGEMENT

The CHNA process commenced in the winter of 2024. Residents, educators, government officials, healthcare professionals, and health and human services leaders within the Penn Highlands Healthcare service area participated in this needs assessment. Insights gathered from these leaders offered a comprehensive understanding of community issues, health equity factors, and needs. Penn Highlands Healthcare engaged the community by collecting surveys, conducting stakeholder and low-income resident interviews, and facilitating focus groups to capture diverse perspectives.

Secondary data, including county demographics and chronic disease prevalence, was sourced from local, state, and federal databases. Community surveys and stakeholder interviews were distributed throughout the primary service area to ensure broad participation from residents and workers. The collected data highlighted the needs, high-risk behaviors, barriers, societal issues, and concerns of underserved and vulnerable populations. Additionally, focus groups with hospital leadership and community partners provided valuable information about services and care in the region.

Throughout the CHNA process, Tripp Umbach collaborated closely with working group members to collect, analyze, and interpret the data, ultimately completing the health system's assessment.

Figure 1: Community Engagement



2024 PENN HIGHLANDS HEALTHCARE
FINDINGS

In 2024, Tripp Umbach's review of existing and primary data confirmed key community health needs served by Penn Highlands Healthcare. The research findings highlight critical areas such as access to care, behavioral health, chronic diseases/conditions, and women's health, with each main need having specific subareas of focus. Building on the current CHNA needs is essential in the implementation phase.

Table 2 below depicts the 2024 CHNA needs. The following health needs will be further addressed in the implementation strategy phase, exploring ways Penn Highlands Healthcare can assist in meeting the community's needs. The identified needs below are in no particular order.

Table 2: 2024 CHNA Needs[1]

	Access to Care			Behavioral Health[2]	Chronic Diseases/ Conditions [3]	
	Infrastructure[4]	Lack of PCP/Specialist[5]	Specialty care[6]		Health Behaviors[7]	SDOH[8]
Penn Highlands Brookville	X	X	X	X	X	X
Penn Highlands DuBois/Penn Highlands Clearfield[9]	X	X	X	X	X	
Penn Highlands Elk	X	X	X	X	X	
Penn Highlands Huntingdon/Penn Highlands State College[10]	X	X	X	X	X	X
Penn Highlands Tyrone	X	X	X	X	X	X
Penn Highlands Connellsville	X	X	X	X	X	X
Penn Highlands Mon Valley[11]	X	X	X	X	X	X

[1] Penn Highlands Healthcare opened a new facility in State College in the summer of 2024; therefore, PH State College did not have previous needs. However, once the 2024 cycle is complete, PH State College will address needs in the Central region along with PH Huntingdon and PH Tyrone.

[2] Behavioral health (Mental health & Substance abuse)

[3] Chronic diseases/Conditions (e.g., diabetes, chronic obstructive pulmonary diseases, high blood pressure)

[4] Infrastructure (e.g., care coordination, navigation, and transportation)

[5] Lack of primary care physicians (PCP)/Physician specialists

[6] Specialty care services (e.g., cancer care, women's health)

[7] Health behaviors (e.g., nutrition, physical activity, obesity)

[8] Social determinants of health (e.g., education, income etc.)

[9] Penn Highlands Clearfield is a campus of Penn Highlands DuBois.

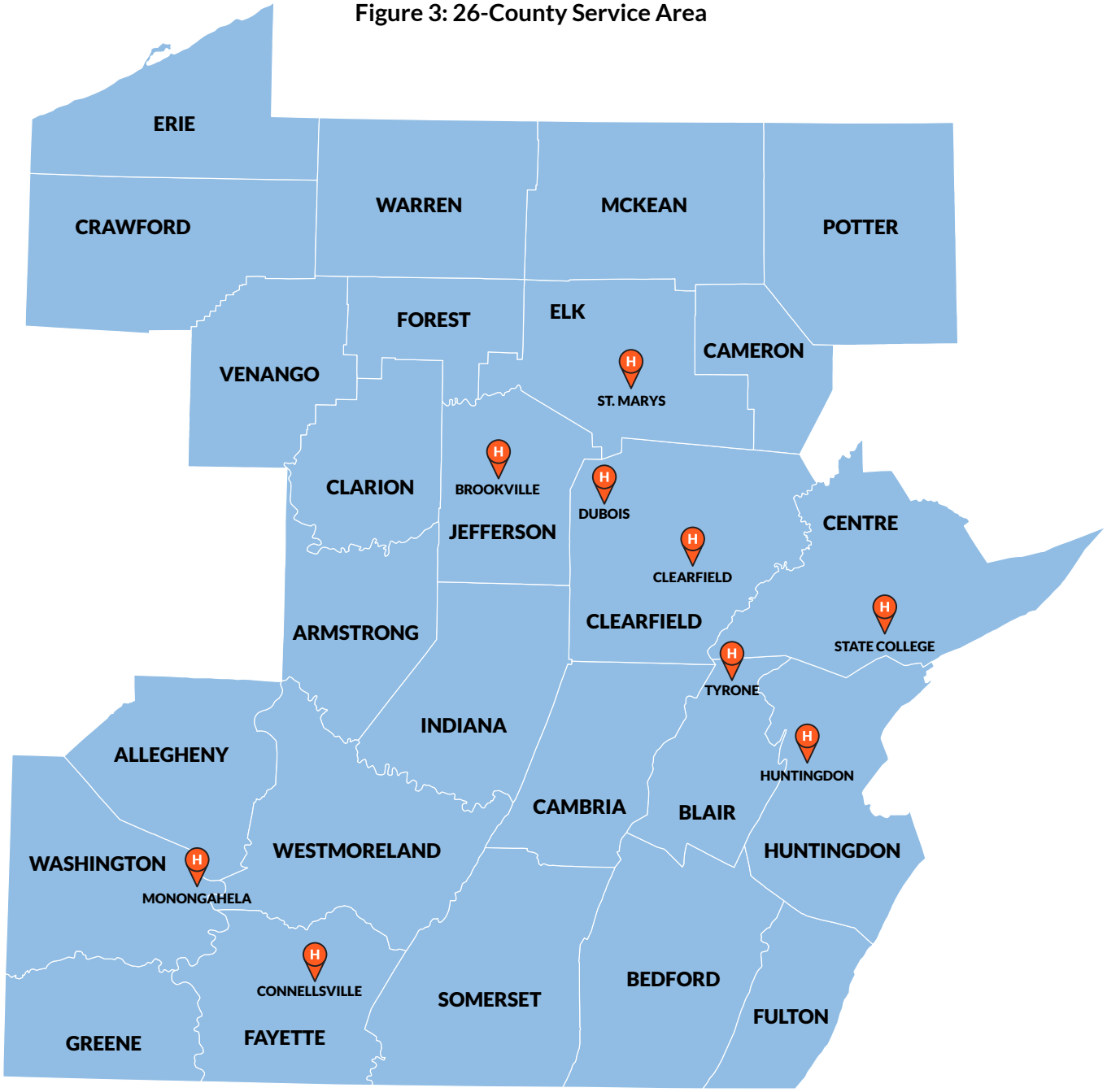
[10] Penn Highlands State College is a campus of Penn Highlands Huntingdon.

[11] PH Mon Valley CHNA needs are diabetes deaths, stroke seaths, mammography/breast cancer, and colorectal cancer deaths. Therefore, it has been classified under Chronic diseases/Conditions.

THE COMMUNITY
WE SERVE

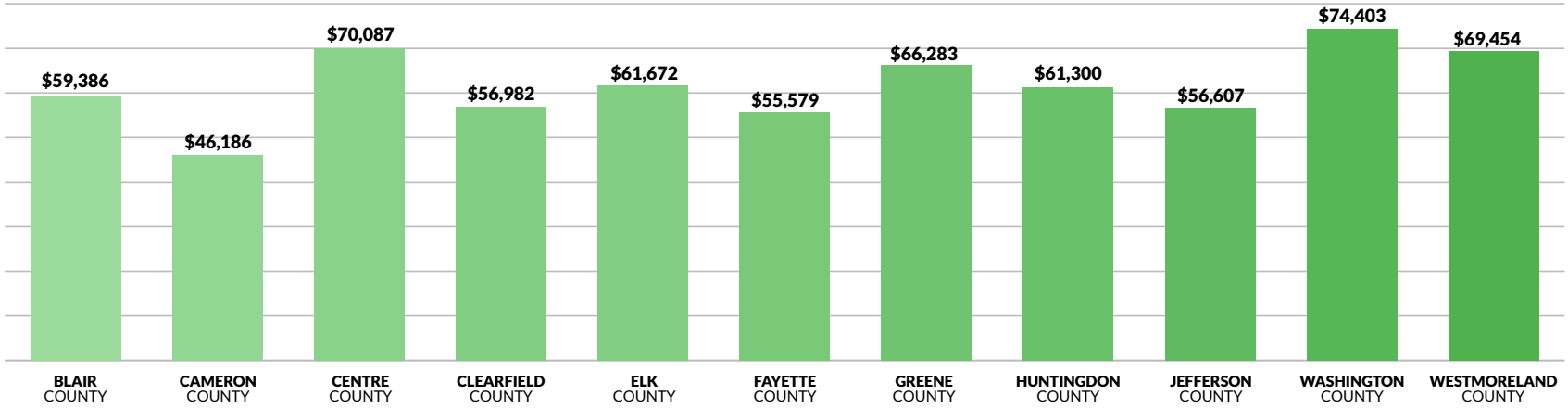
The community served by our hospital is a tapestry of diverse cultures, ages, and backgrounds, making it a truly unique environment. This diversity is reflected in the patient population and the varied health needs and preferences that come through our doors daily. Our hospital prides itself on adapting to these differences, offering specialized programs and services tailored to the specific needs of each subgroup within the community. From multilingual staff to culturally sensitive care plans, the hospital is a microcosm of the broader community it serves, dedicated to fostering health and wellness for all, regardless of their unique circumstances.

Figure 3: 26-County Service Area



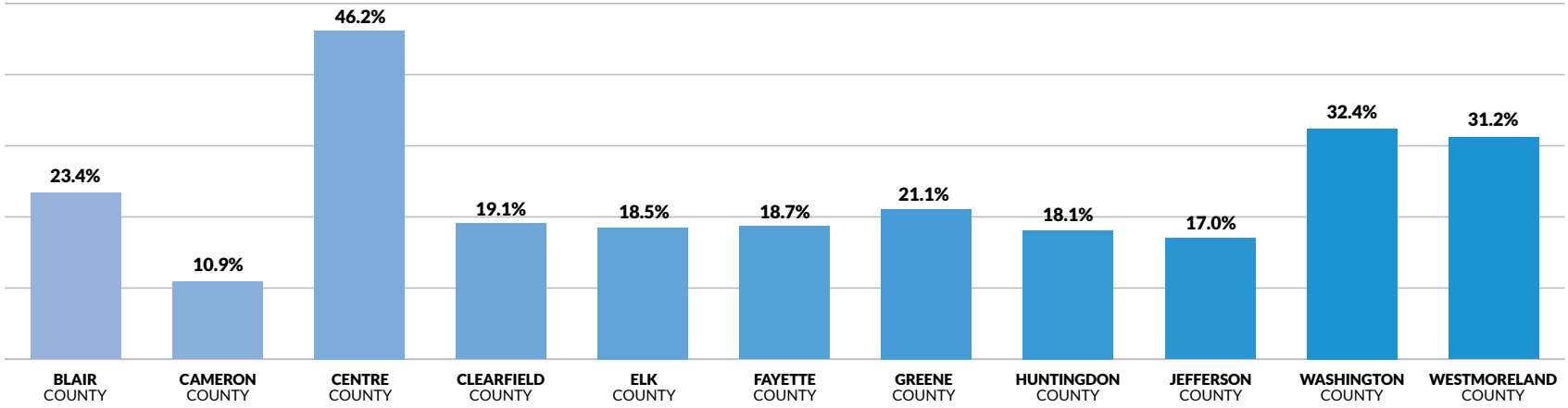
COMMUNITY AT-A-GLANCE

Figure 4: Median Household Income



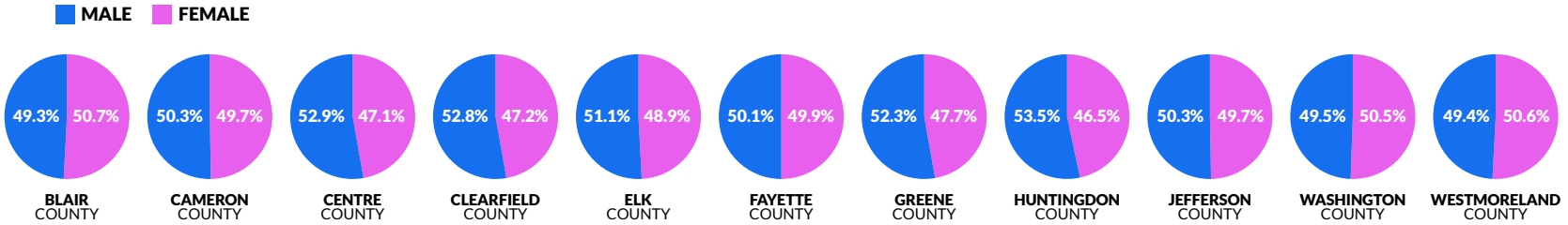
Source: U.S. Census Bureau, American Community Survey. 2018-2022

Figure 5: Population Aged 25+ with Bachelor's Degree or More



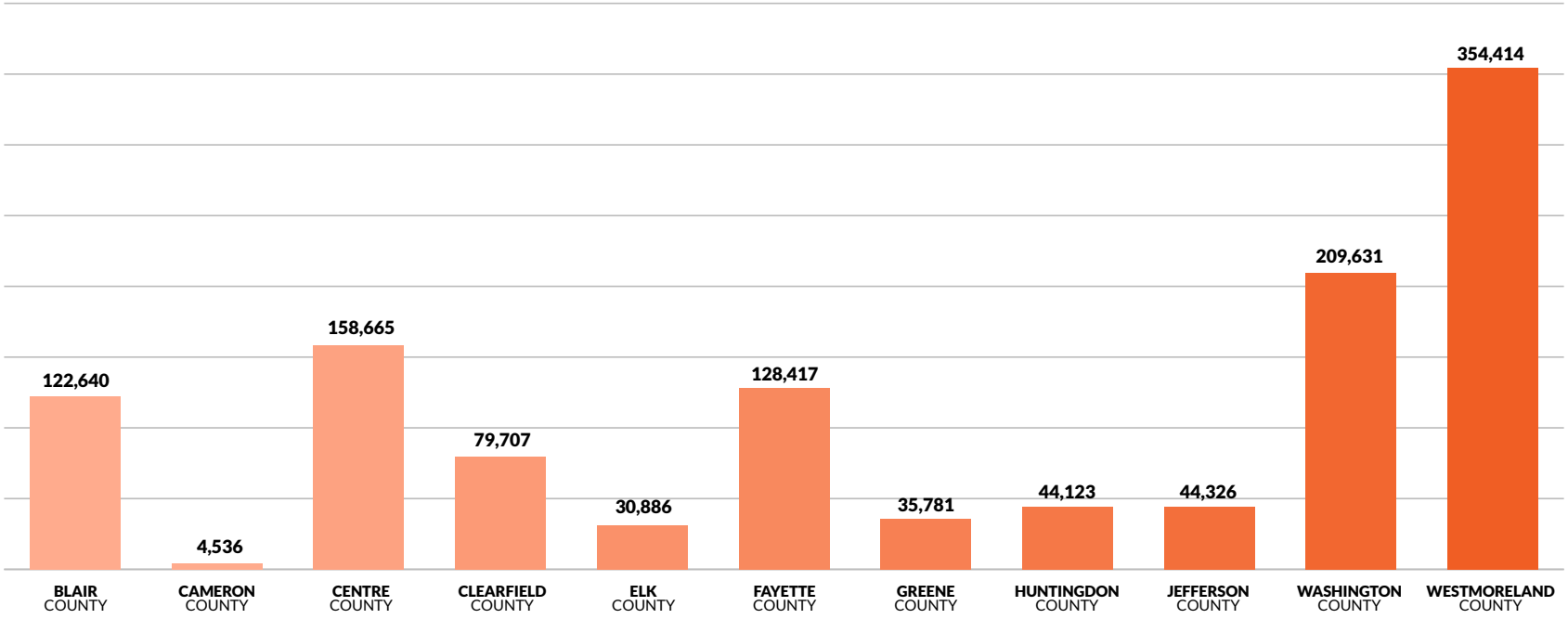
Source: U.S. Census Bureau, American Community Survey. 2018-2022

Figure 6: Gender



Source: U.S. Census Bureau, American Community Survey. 2018-2022

Figure 7: Population



Source: U.S. Census Bureau, American Community Survey. 2018-2022

Figure 8: Race

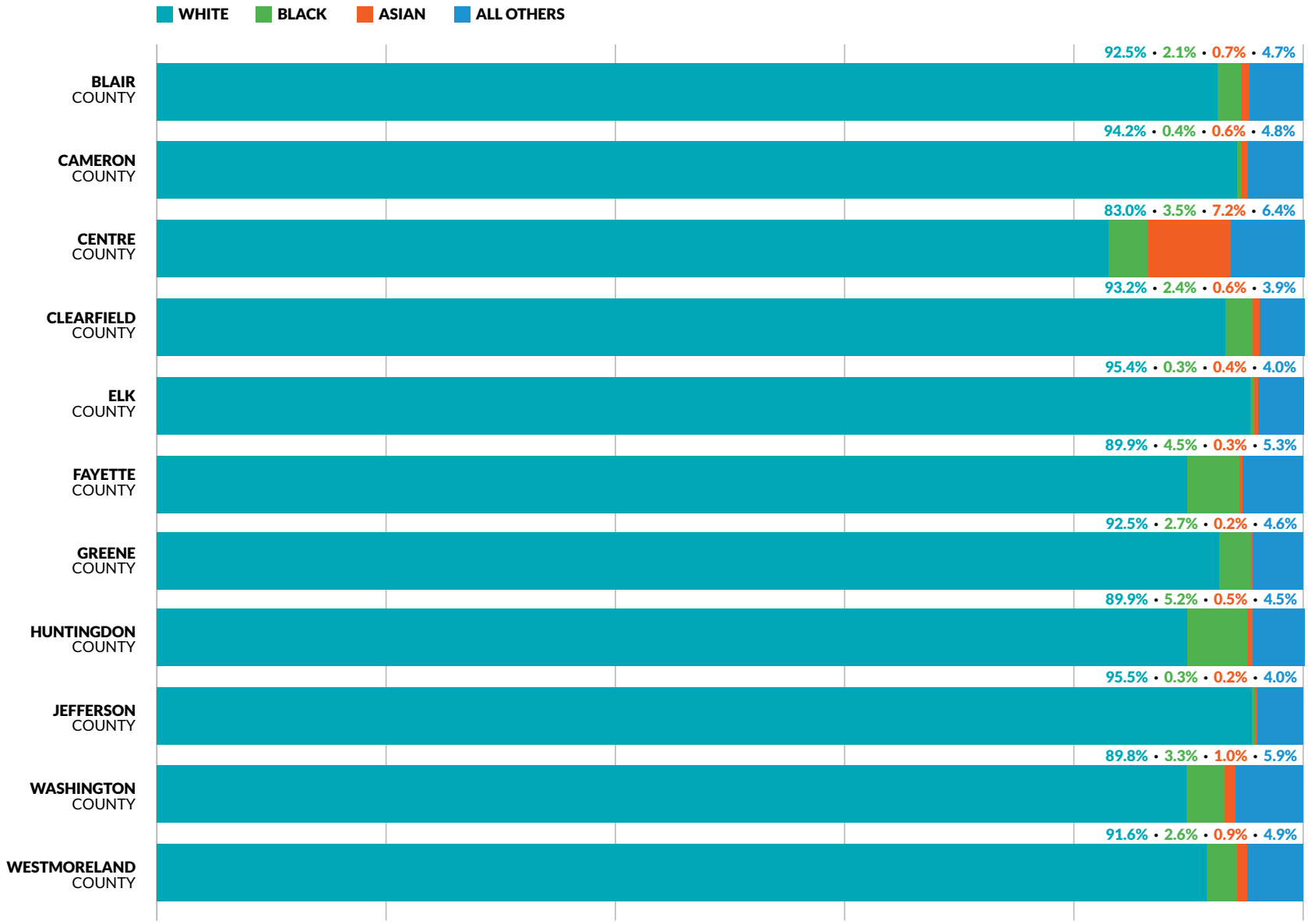
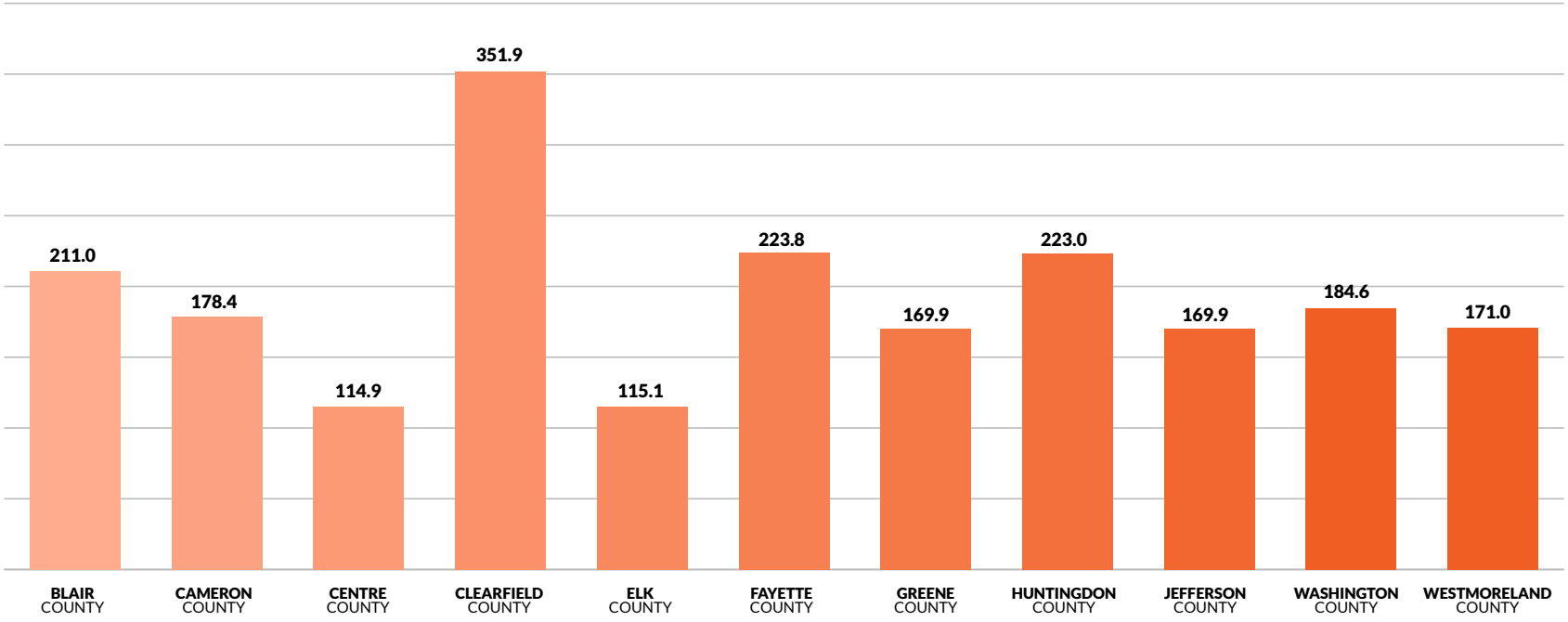
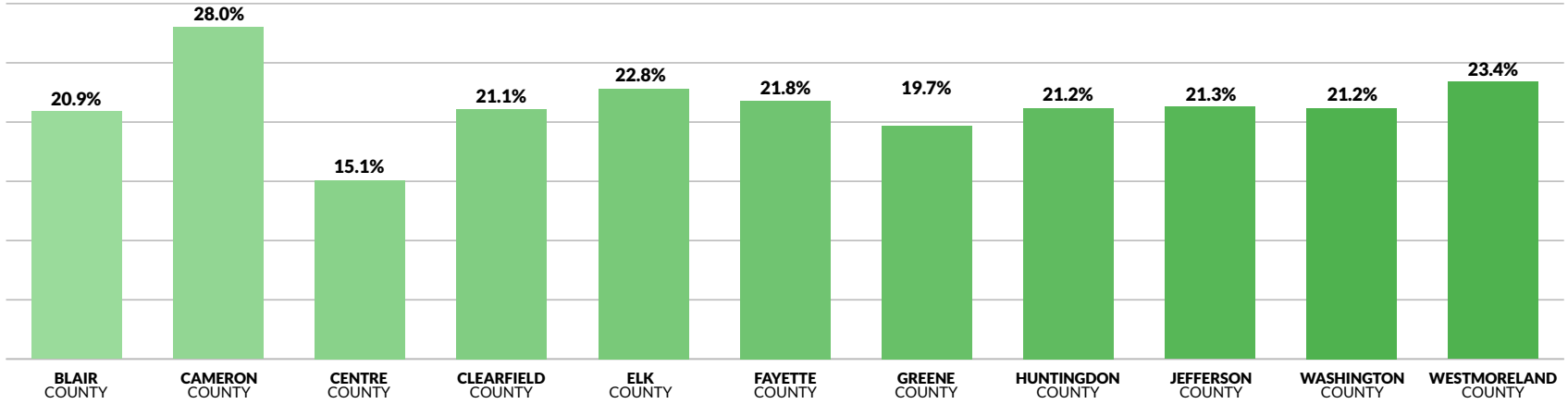


Figure 9: Annual Violent Crimes (Rate Per 100,000 Population)



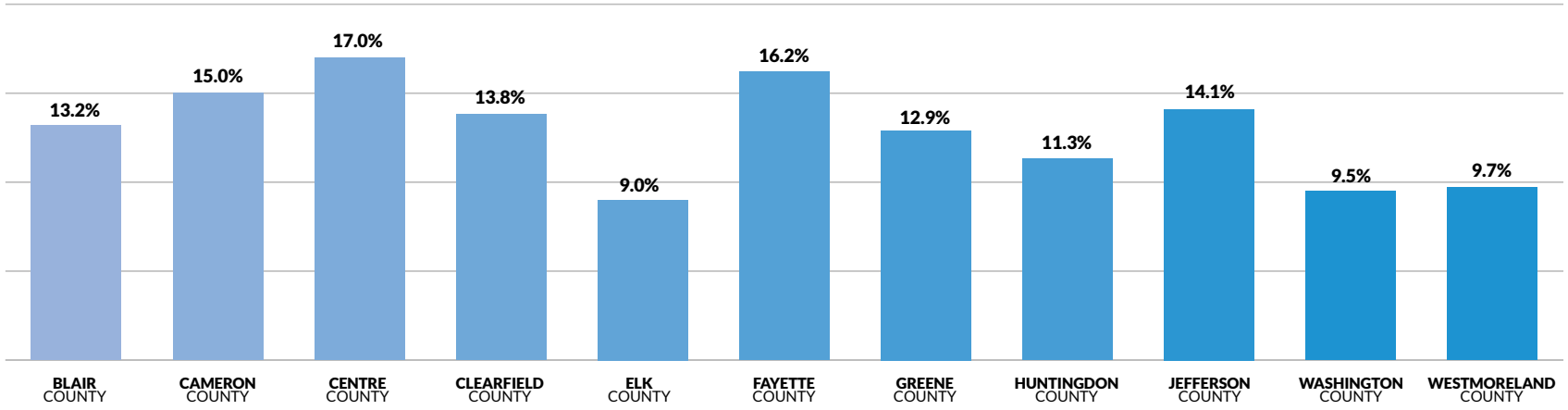
Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. 2015-2017

Figure 10: Population Aged 65+



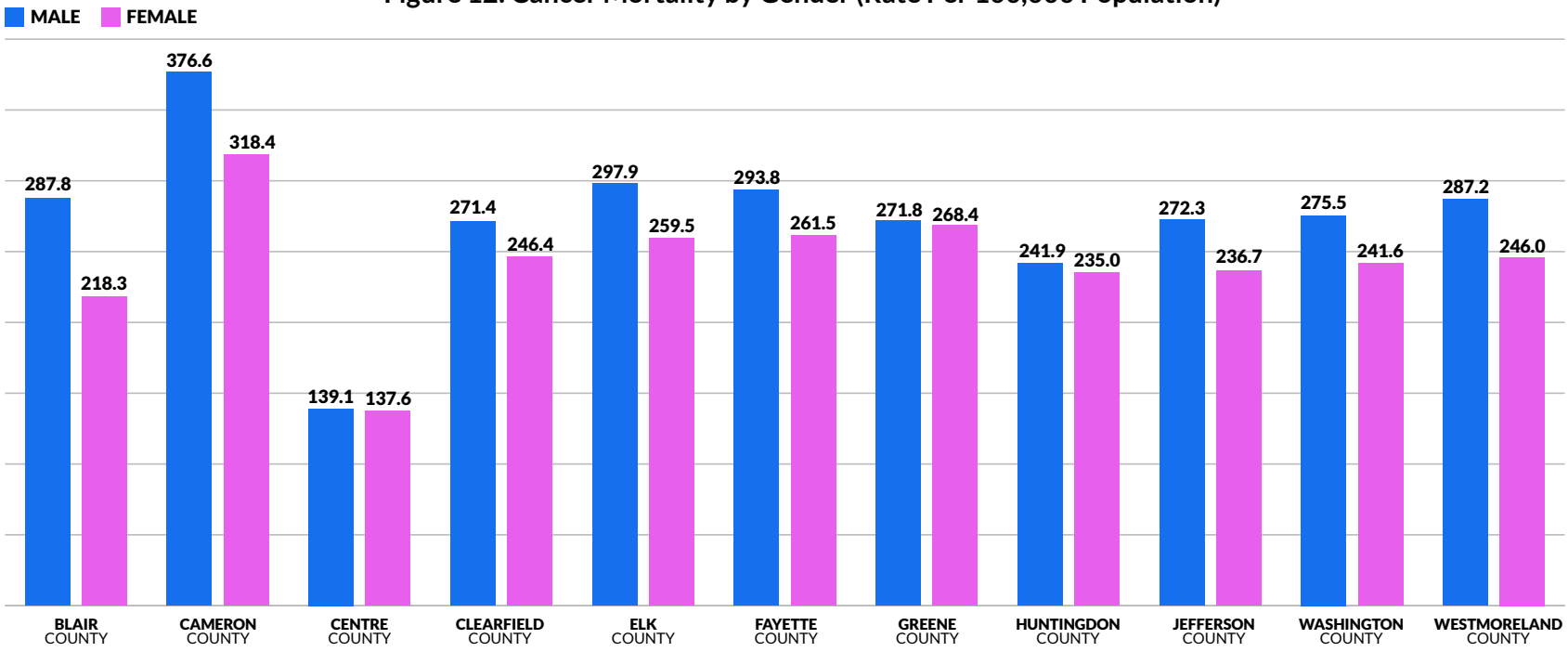
Source: U.S. Census Bureau, American Community Survey. 2018-2022

Figure 11: Population Below 100% in Poverty



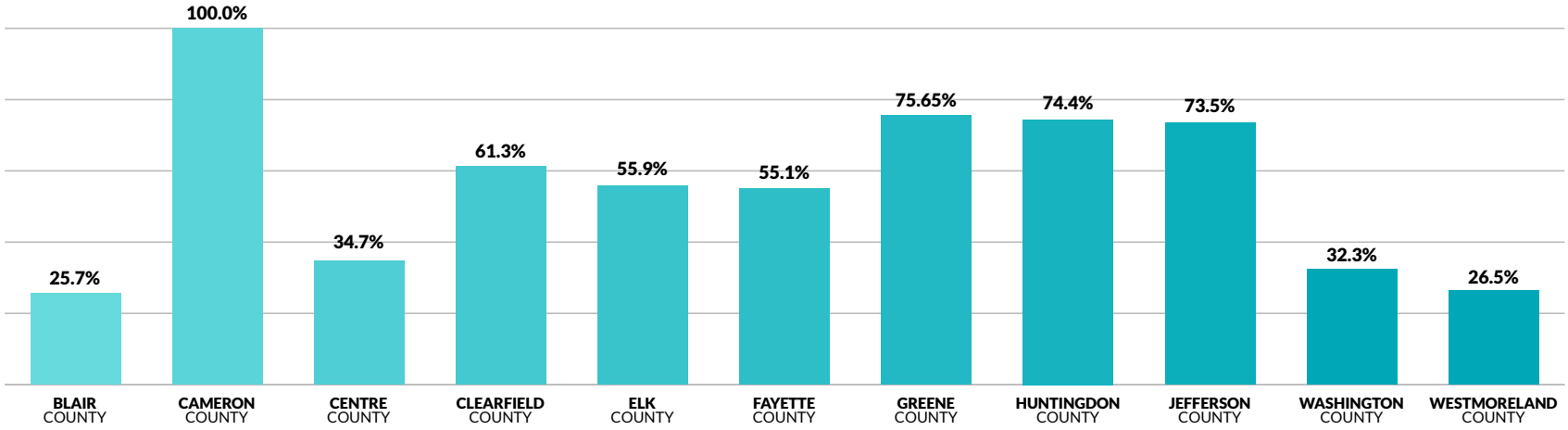
Source: U.S. Census Bureau, American Community Survey. 2018-2022

Figure 12: Cancer Mortality by Gender (Rate Per 100,000 Population)



Source: Centers for Disease Control and Prevention. 2018-2022

Figure 13: Rural Population



Source: U.S. Census Bureau, American Community Survey. 2018-2022

Table 14: County Health Rankings (1-67 Counties in Pennsylvania; 1= Healthiest County)

	Health Outcomes	Health Factors	Mortality	Morbidity	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Blair County	44	26	47	33	25	43	21	58
Cameron County	55	**61**	30	**66**	**64**	**62**	50	8
Centre County	2	5	1	5	6	9	2	51
Clearfield County	52	55	49	55	49	39	54	47
Elk County	36	22	33	32	30	14	30	12
Fayette County	**66**	**65**	**66**	**62**	**66**	45	**65**	37
Greene County	**63**	**64**	**60**	**64**	**60**	**67**	**63**	19
Huntingdon County	29	53	25	29	45	59	53	14
Jefferson County	47	49	36	58	59	33	37	42
Washington County	30	15	50	12	14	23	20	13
Westmoreland County	20	14	43	10	19	20	19	3

Note: Rankings highlighted in **red** denote an unhealthy score in the measure.

Source: County Health Rankings & Roadmaps 2023

EXECUTIVE SUMMARY

PROJECT OVERVIEW INTRODUCTION

Penn Highlands Healthcare conducted a CHNA by gathering primary and secondary data. Organizations and community leaders from the main service area participated to pinpoint the community's needs. This included community organizations, government agencies, educational institutions, and health and human service groups throughout the CHNA process. The primary data collection involved more than 1,200 community leaders, organizational representatives, residents, and stakeholders.

The primary data collection featured multiple project elements. Thirty-five interviews with community stakeholders represented the broader community interests, populations in need, and those with specialized public health knowledge. Additionally, community residents completed 1,254 online surveys. Focus groups with seniors and providers of residents with chronic conditions and interviews with low-income residents were completed as part of the assessment. A prioritization session was conducted and a resource inventory was also completed as the final project piece for the CHNA.

A key aspect of the CHNA was assembling a regional profile through secondary data analysis. This profile was built using local, state, and federal data, providing insights into various health, clinical, and social issues. Tripp Umbach and the working group allowed members to explore and discuss different socioeconomic factors, health outcomes, and behaviors influencing residents' health, particularly those affecting their well-being.

For more than 100 years, Penn Highlands Healthcare's hospitals have served the residents of Northwestern, Southwest, and Central Pennsylvania as a non-profit community organization. The founders established Penn Highlands Healthcare with a commitment to being a community-based, controlled healthcare system that enhances regional access to top-tier primary care and advanced health services.

The vision is to be the preferred integrated health system through outstanding quality, service, and outcomes. While many quality services are accessible in or near every community, some advanced services are available at affiliate locations. The health system's facilities include acute, long-term care, and behavioral health beds:

1. Penn Highlands Brookville: 35 beds
2. Penn Highlands Clearfield: 50 beds
3. Penn Highlands Connellsville: 64 beds
4. Penn Highlands DuBois: 216 beds
5. Penn Highlands Elk: 173 beds
6. Penn Highlands Huntingdon: 71 beds
7. Penn Highlands Mon Valley: 200 beds
8. Penn Highlands Tyrone: 25 beds
9. Penn Highlands State College: Opened Summer 2024

The CHNA determines the community's health status and develops direct initiatives and planning strategies to advance it. The CHNA undoubtedly connected new partners and solidified relationships with local and regional agencies, aiming to improve the health outcomes of residents in the region.

The CHNA involved multiple steps, as the flow chart below depicts.

Figure 15: Methodology Flow Chart

ACCESS
TO CARE

Access to care profoundly impacts the health of community residents by ensuring they receive timely and appropriate medical services, which is essential for maintaining and improving overall health. When individuals have adequate access to healthcare, they benefit from early detection and prevention of diseases, enabling prompt intervention that can prevent conditions from becoming severe or chronic. This includes regular screenings, vaccinations, and health education that promote healthier lifestyles and reduce the incidence of preventable illnesses. Access to continuous and comprehensive care is particularly crucial for managing chronic conditions such as diabetes, hypertension, and asthma, as it allows for consistent monitoring, effective treatment plans, and necessary adjustments to prevent complications. Furthermore, equitable healthcare access helps mitigate health disparities across socioeconomic and racial groups, fostering a more balanced and healthier community. Mental health services, often integrated into accessible healthcare systems, are vital for addressing psychological well-being, reducing stigma, and providing support for those facing mental health challenges. Access to acute care services ensures community members receive timely life-saving treatments in emergencies, significantly lowering mortality rates. Health education and promotion activities that are part of accessible healthcare services empower individuals with the knowledge to make informed health decisions, ultimately leading to healthier behaviors and reduced healthcare costs. The availability, affordability, and quality of healthcare services are critical in building resilient communities where residents are healthier, more productive, and better equipped to handle health crises.

The availability and accessibility to physicians significantly enhance the quality of care by ensuring that residents receive timely and professional medical attention. When communities have sufficient access to primary care physicians, specialists, and other healthcare providers, they benefit from comprehensive and continuous care that addresses health needs. Primary care physicians play a pivotal role in early detection and prevention, conducting regular checkups, screenings, and immunizations that help identify health issues before they escalate. This continuity of care is crucial for managing chronic diseases, as it allows for consistent monitoring, personalized treatment plans, and necessary interventions that prevent complications and hospitalizations. Specialist access is equally important for providing expert care for specific conditions, ensuring patients receive the best possible treatment and advice for their unique health challenges. Access to physicians improves the management of acute health issues, as residents can seek prompt medical attention for urgent conditions, reducing the risk of severe outcomes and enhancing recovery times. Equitable access to healthcare providers also contributes to reducing health disparities within the community, ensuring that all residents, regardless of socioeconomic status or geographical location, receive high-quality care. This comprehensive access supports better health outcomes, enhances the quality of life, and contributes to the overall well-being and resilience of the community.

The Office of Disease Prevention and Health Promotion underscores the importance of comprehensive, quality healthcare services in promoting and maintaining health, preventing, and managing diseases, reducing unnecessary disability and premature death, and achieving health equity for all Americans. In line with this, Penn Highlands Healthcare is dedicated to addressing access to care based on the specific needs of its communities. Penn Highlands Healthcare is committed to improving access by increasing the number of primary and specialty physicians and enhancing specialty services, including cancer care. According to the Association of American Medical Colleges (AAMC), a shortage of 86,000 physicians by 2036 is predicted across the United States because of a growing older patient population and physicians retiring.[12] The Robert Graham Center reports that to maintain current utilization rates, Pennsylvania will need an additional 1,039 primary care physicians by 2030, an 11% increase compared to the state's (as of 2010) 9,096 PCP workforce.[13]

Primary care professionals serve as the front line of healthcare services, acting as the initial point of contact for many patients within the healthcare system. Their direct interaction with patients allows them to be the first to identify signs of diseases, mental health issues, and other health concerns. These physicians ensure patients receive appropriate care tailored to their needs and values in the right setting. Primary care professionals are essential to the effective delivery of healthcare services.

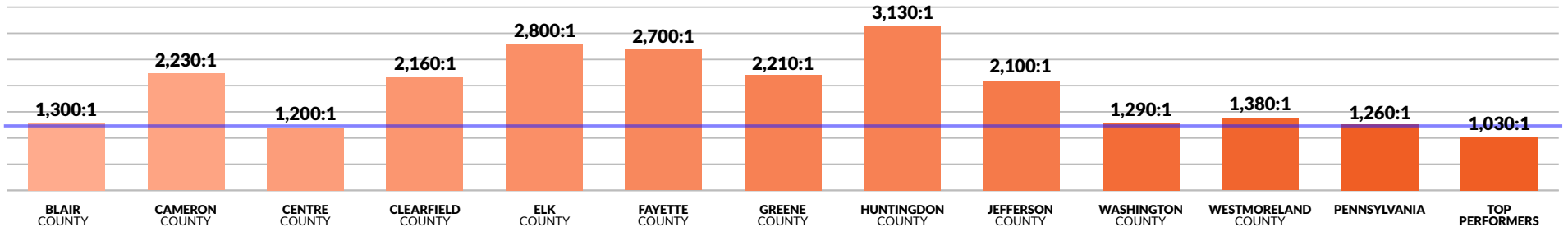
Transportation challenges often hinder access to physicians in rural areas, making it difficult for residents to receive timely medical care. Transportation issues significantly impact access to care in rural areas. Many rural residents face challenges reaching healthcare facilities due to long distances, limited public transportation options, and reliance on personally owned vehicles. These transportation barriers can delay or prevent individuals from receiving timely medical care, worsening health outcomes. The high vehicle ownership and maintenance costs, coupled with a lack of driver's licenses or physical disabilities, further exacerbate these issues. As a result, efficient and affordable transportation solutions are crucial for improving access to healthcare services, ensuring that rural populations can receive the care they need without undue hardship.

Penn Highlands Healthcare recognizes the critical importance of addressing transportation issues because of the pressing need for reliable access to healthcare, employment, and essential services in rural areas. Penn Highlands Healthcare aims to enhance residents' quality of life and economic opportunities by prioritizing transportation solutions.

[12] Association of American Medical Colleges

[13] The Robert Graham Center

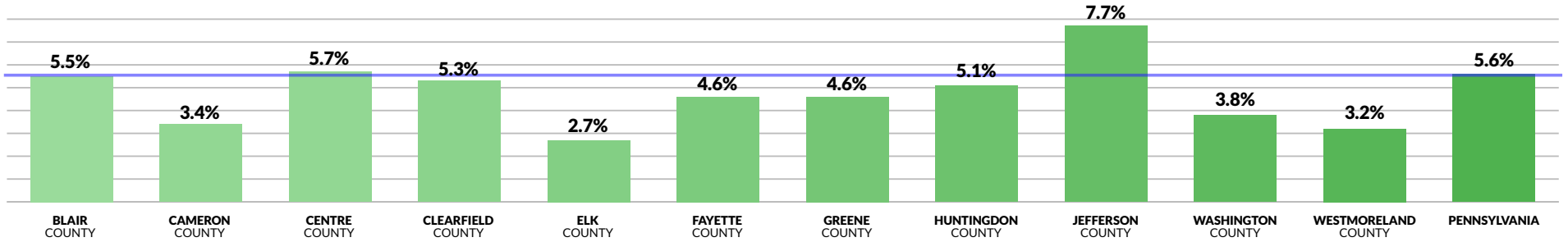
Figure 16: Ratio of Residents to Available Primary Care Physicians



Note: Top performers are the top 10% of counties in the United States doing better in a particular value. Top U.S. performers are calculated by the 90th percentile or 10th percentile, depending on whether the measure is framed positively (where a high value is better than a lower value) or negatively (where a low value is better than a higher value). The blue line in Figure 16 and the preceding figures compare Pennsylvania to the report counties.

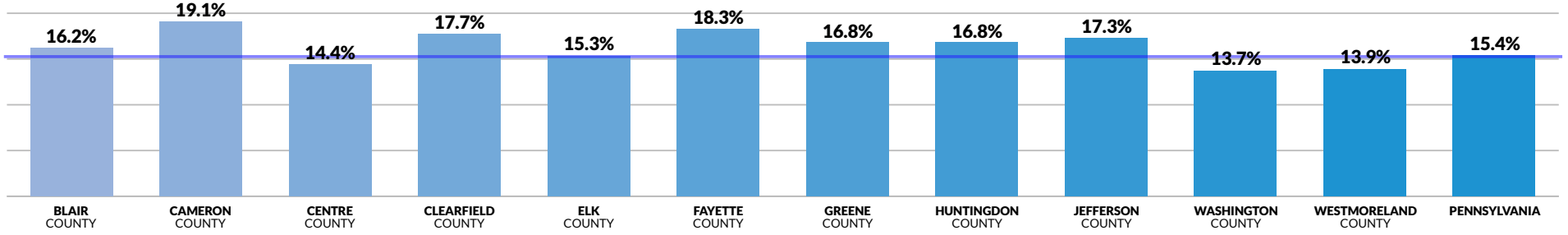
Source: County Health Rankings 2024

Figure 17: Uninsured Population



Source: U.S. Census Bureau, American Community Survey 2018-2022

Figure 18: Adults Aged 18+ with Poor or Fair General Health



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2021

Graduate Medical Education (GME) is paramount for communities and hospitals, as it ensures a steady pipeline of well-trained physicians equipped to meet the healthcare needs of diverse populations. For communities, GME programs often place residents in local healthcare settings, which increases access to medical care, especially in underserved and rural areas where physician shortages are common. This improves immediate healthcare access and encourages new doctors to establish their practices in these communities after training, contributing to long-term health improvements and stability. For hospitals, GME programs enhance the quality of care by integrating the latest medical knowledge and practices into everyday patient care. The presence of GME programs can elevate a hospital's status, attract top medical talent, and increase its capacity to offer specialized services. This symbiotic relationship among GME, communities, and hospitals ultimately leads to better healthcare outcomes, more equitable healthcare distribution, and medical education and practice advancement.

GME opportunities are offered to address the growing physician shortage in Pennsylvania and improve healthcare access and quality of life for Penn Highlands Healthcare service area residents. These programs aim to enhance physician retention and recruitment, improve health outcomes, and reduce healthcare costs. Penn Highlands Healthcare is committed to meeting community needs; as such, it offers a residency program in family medicine and psychiatry and a fellowship program in sports medicine.

Pennsylvania urgently needs more physicians, particularly in underserved areas. Residents in rural regions face significant health challenges, as the distance from healthcare providers creates disparities that are difficult to overcome. Issues such as lack of health insurance, insufficient available providers, and healthcare affordability contribute to increased risks of illness and death.

Penn Highlands Healthcare is at the forefront of addressing this physician shortage. Recognizing that GME supports underserved areas, Penn Highlands Healthcare offers ACGME-accredited programs, including family medicine and psychiatry residency programs. These initiatives aim to educate and produce the next generation of high-quality physicians while increasing the number of healthcare professionals who choose to remain and practice in Pennsylvania. Northwestern, Southwest, and Central Pennsylvania have a significant need for healthcare providers, as population health indicators in these areas are among the worst in the state. (Click here to learn more about Penn Highlands Healthcare residency programs.)

BEHAVIORAL HEALTH

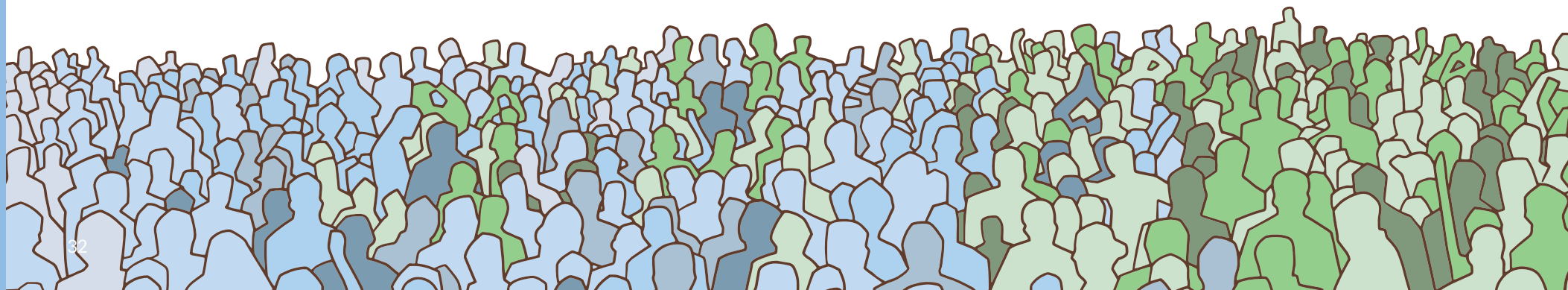
Behavioral health encompasses the spectrum of mental health and substance use disorders, as well as the promotion of emotional well-being and the prevention and treatment of these conditions. It involves a comprehensive approach to understanding and addressing the psychological, emotional, and behavioral factors influencing an individual's overall health and quality of life.

The health outcomes for individuals who do not receive necessary behavioral health services can be severe and far-reaching. Untreated mental health conditions, such as depression, anxiety, bipolar disorder, and schizophrenia, can lead to significant impairments in daily functioning, reducing an individual's ability to work, maintain relationships, and perform everyday activities. Without proper treatment, these conditions often worsen over time, increasing the risk of chronic physical health issues, such as cardiovascular disease, diabetes, and obesity, caused by poor self-care and lifestyle choices linked to mental health struggles.

Similarly, untreated substance use disorders can have devastating effects on an individual's health and well-being. Substance abuse can lead to a host of physical health problems, including liver disease, heart disease, respiratory issues, and infectious diseases. Moreover, substance use disorders often co-occur with mental health conditions, creating a cycle of worsening health that is difficult to break without professional intervention.

The absence of behavioral health services also has significant social implications. Individuals with untreated mental health and substance use disorders are at a higher risk of experiencing homelessness, unemployment, and involvement with the criminal justice system. These social determinants further exacerbate health disparities, leading to a lower quality of life and reduced life expectancy.

Additionally, the direct impact of an individual's untreated behavioral health issues places a substantial burden on families and communities. Family members often experience emotional stress, financial strain, and disruptions in their daily lives as they attempt to support their loved ones without professional guidance. Communities may face increased healthcare costs, higher rates of emergency room visits, and a greater demand for social services and law enforcement resources.

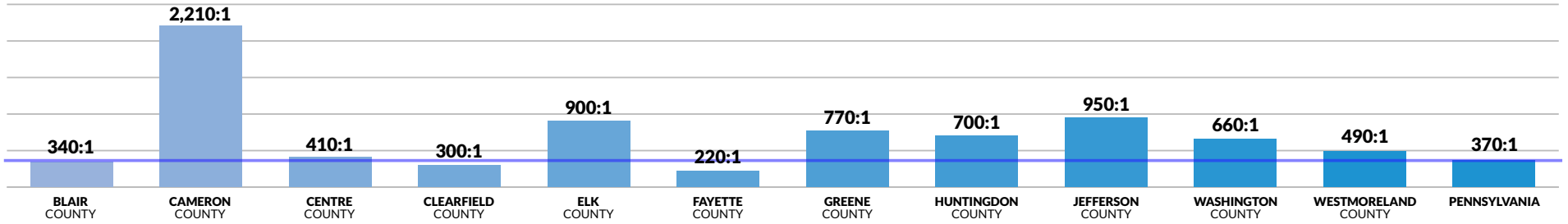


Addressing behavioral health effectively requires a multifaceted approach that tackles systemic barriers, enhances access to care, and reduces stigma. One of the primary steps is increasing public awareness and education to combat the stigma associated with mental health and substance use disorders. This involves community outreach, school programs, and media campaigns that promote understanding and acceptance, encouraging individuals to seek help without fear of judgment. Improving access to care is crucial and can be achieved by expanding the healthcare workforce through incentives and training programs for mental health professionals. Additionally, integrating behavioral health services into primary care settings can make it easier for individuals to receive comprehensive care. Enhancing telehealth services can also bridge the gap for those in remote or underserved areas, providing timely access to counseling and therapy. Policy measures should focus on increasing funding for behavioral health programs and ensuring that insurance coverage includes mental health and substance use treatment. Collaborating with community organizations, schools, and workplaces can create supportive environments that facilitate early intervention and ongoing support. We can create a more inclusive and effective system for managing behavioral health by addressing these key areas.

Penn Highlands Healthcare has the opportunity to address behavioral health by partnering with community-based organizations (CBOs) to provide comprehensive and coordinated care. By integrating services, hospitals can create multidisciplinary teams that include mental health and substance use disorder specialists from CBOs, ensuring patients receive holistic treatment that addresses their physical and behavioral health needs. Collaborating on outreach and education programs can help raise awareness about mental health issues, reduce stigma, and inform the community about available resources. Jointly organized workshops, support groups, and educational seminars can empower individuals to seek help and access services. Additionally, hospitals and CBOs can work together to improve access to care by leveraging telehealth services, providing assistance, and offering support in navigating the healthcare system. By fostering strong partnerships with CBOs, Penn Highlands Healthcare can enhance the community's overall well-being, ensuring that behavioral health needs are met with compassion and efficiency.

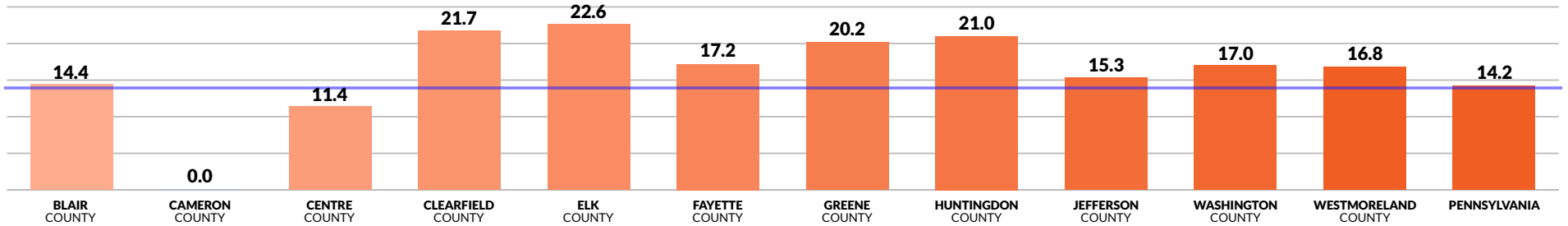
Addressing behavioral health needs through timely and appropriate services can significantly improve health outcomes. Effective treatment and support can help individuals manage their conditions, reduce symptoms, and lead fulfilling lives. Access to behavioral health services promotes better physical health, enhances social functioning, and contributes to overall community well-being. By investing in behavioral health care, societies can reduce the long-term costs associated with untreated mental health and substance use disorders and foster healthier, more resilient populations.

Figure 19: Ratio of Residents to Mental Health Providers



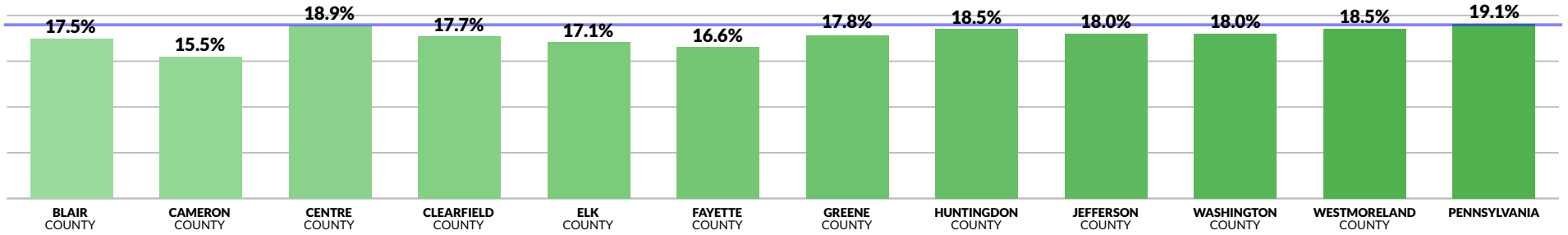
Source: County Health Ranking & Roadmaps 2024

Figure 20: Suicide (Rates Per 100,000)



Source: Centers for Disease Control and Prevention, National Vital Statistics System 2016-2020

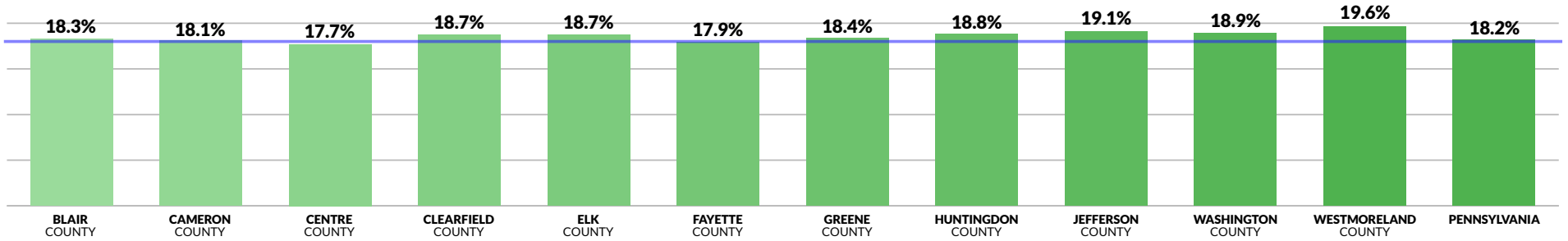
Figure 21: Adults Reporting Excessive Drinking



Note: Excessive drinking is defined as the percentage of the population who report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same period.

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System

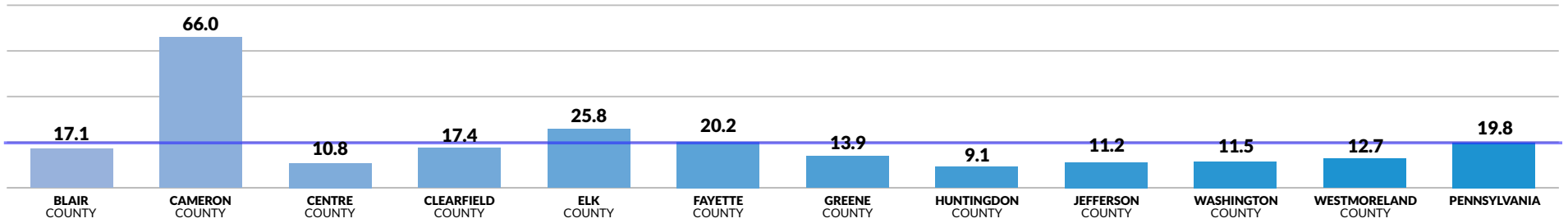
Figure 22: Adults Binge Drinking in the Past 30 Days



Note: Adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

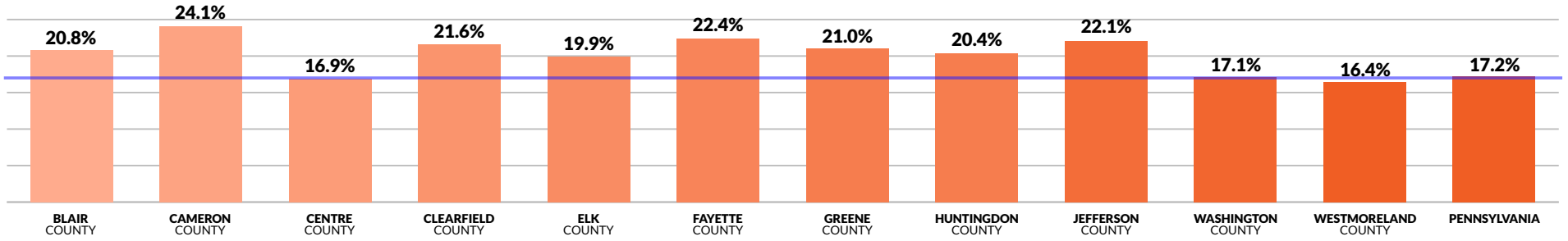
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2021

Figure 23: Grocery Stores (Rate Per 100,000 Population)



Source: U.S. Census Bureau, County Business Patterns 2021

Figure 24: Adults Age 18+ as Current Smokers



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2021

CHRONIC
DISEASES/CONDITIONS

Chronic diseases are long-lasting conditions that progress slowly and can significantly impact an individual's quality of life. Broadly defined, chronic conditions are health issues that last more than a year, require ongoing medical attention, or limit daily activities. Common chronic diseases include heart disease, diabetes, cancer, and respiratory diseases. These conditions are among the leading causes of death and disability worldwide, often resulting from a combination of genetic, environmental, and lifestyle factors. Risk factors such as poor nutrition, lack of physical activity, smoking, and excessive alcohol consumption play a crucial role in the development and exacerbation of chronic diseases.

Heart disease, cancer, and diabetes are among the leading causes of death and disability in the United States and are significant drivers of the nation's healthcare costs. Ninety percent of the $4.5 trillion in annual healthcare expenditures, up from $3.8 trillion in 2021, are for people with chronic and mental health conditions.[14] Engaging in healthy behaviors and positive habits, such as regular physical activity, adequate sleep, a healthy diet, and eliminating tobacco and alcohol use, can significantly reduce disease risk and improve quality of life. A healthy lifestyle is essential for addressing specific health problems, maintaining overall health, and reducing the likelihood of being diagnosed with a chronic disease.

An estimated 129 million people in the United States have at least one major chronic disease, according to the U.S. Department of Health and Human Services.[15] Regular physical activity can help people live longer and reduce the risk of serious health problems such as heart disease, type 2 diabetes, obesity, and certain cancers. For those already living with chronic diseases, physical activity can aid in managing these conditions and preventing complications. However, only one in four U.S. adults meets the physical activity guidelines for aerobic and muscle-strengthening activities. Insufficient physical activity carries high health and financial costs, totaling $117 billion nationally in annually related healthcare expenses.[16]

[14] Centers for Disease Control and Prevention

[15] Centers for Disease Control and Prevention

[16] Centers for Disease Control and Prevention

Obesity impacts 20% of children and 42% of adults in the United States, raising their risk for chronic diseases. Furthermore, more than 25% of young people aged 17 to 24 are too overweight to qualify for military service.[17] Healthy eating is a cornerstone of well-being and significantly prevents and manages chronic conditions. A diet rich in fruits, vegetables, whole grains, lean proteins, and healthy fats provides essential nutrients that support bodily functions and enhance immune response. These nutrient-dense foods help maintain a healthy weight, reduce inflammation, and improve cardiovascular health, lowering the risk of chronic diseases. Conversely, poor dietary choices, such as high consumption of processed foods, sugary beverages, and unhealthy fats, can lead to obesity, hypertension, and elevated blood sugar levels, exacerbating chronic conditions.

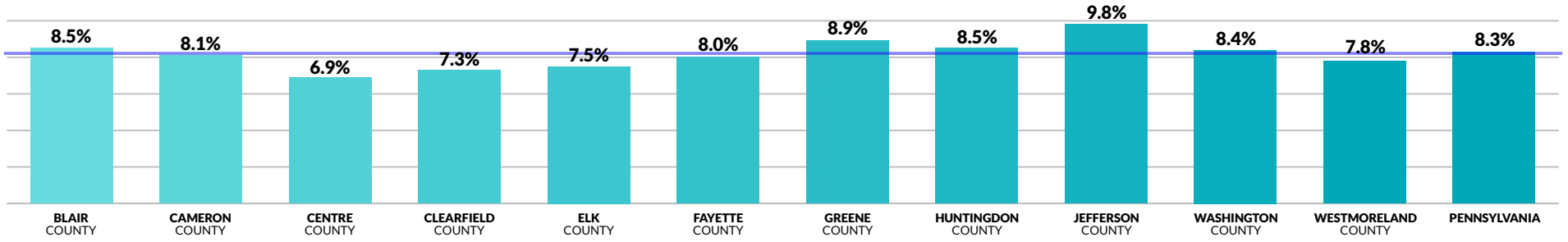
Chronic diseases, though prevalent, are among the most preventable health problems. Proper management of chronic diseases involves a combination of regular screenings, routine checkups, and vigilant monitoring of treatment plans. These proactive measures help in early detection and effective management of conditions, thereby improving patient outcomes. Patient education is also crucial, as it empowers individuals to manage their conditions better, adhere to prescribed treatments, and make lifestyle changes that promote overall well-being.

[17] Centers for Disease Control and Prevention

SOCIAL DETERMINANTS OF HEALTH (SDOH)

Social determinants of health are the conditions in which people are born, grow, live, work, and age, profoundly impacting health outcomes. These determinants include socioeconomic status, education, neighborhood and physical environment, employment, social support networks, and access to healthcare. Residents living in poverty may experience higher levels of stress, limited access to nutritious food, inadequate housing, and reduced opportunities for physical activity, all of which can contribute to poorer health outcomes. Educational attainment influences health literacy and the ability to navigate the healthcare system effectively. Employment conditions affect physical health through exposure to workplace hazards and mental health through job-related stress. Social support networks provide emotional and practical assistance, which can help individuals cope with health challenges. Access to healthcare determines the ability to receive preventive services, manage chronic conditions, and obtain timely treatment for illnesses. Collectively, these social determinants create a complex interplay of factors that significantly influence an individual's health, contributing to disparities and inequities within and between communities.

Figure 25: Adults 21 years and Older with Diabetes



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion 2021

Table 26: Cancer Incidence Rates

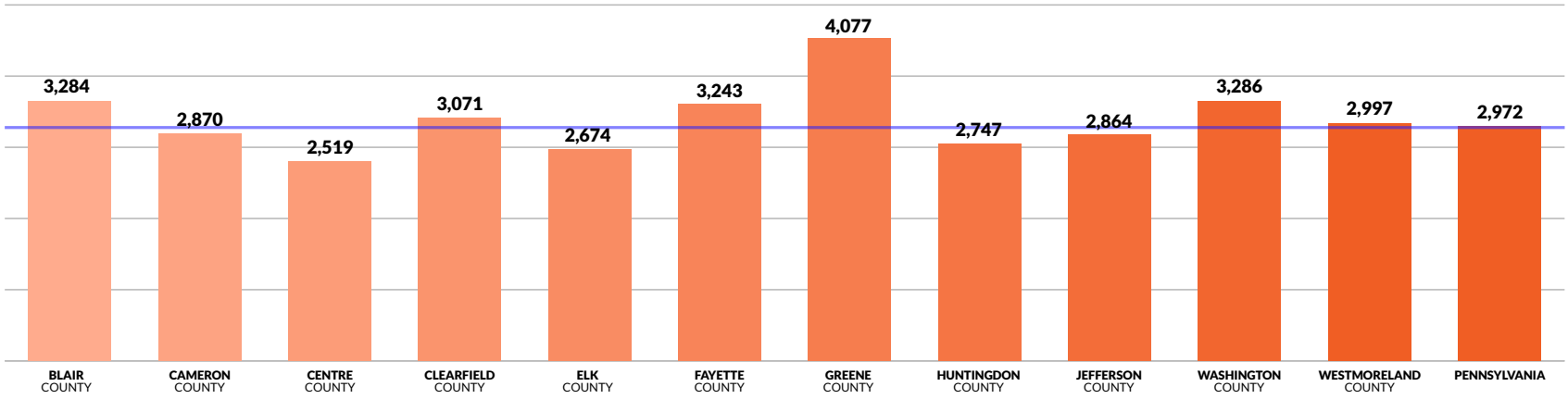
Pennsylvania (per 100,000 population)	**Breast Cancer Incidence** (Women only)	**Colon/Rectum Cancer Incidence** (All genders)	**Lung Cancer Incidence** (All genders)	**Prostate Cancer Incidence** (Men only)
Blair County	**494.0**	**43.8**	**67.0**	**112.1**
Cameron County	**509.1**	**63.7**	**53.7**	96.2
Centre County	411.5	30.7	41.8	102.4
Clearfield County	456.4	**42.4**	**63.4**	**115.6**
Elk County	**485.0**	**43.1**	51.5	**147.9**
Fayette County	458.7	**45.5**	**67.1**	73.4
Greene County	126.5	**50.2**	**69.3**	60.8
Huntingdon County	447.9	34.9	**61.7**	101.2
Jefferson County	**474.3**	**38.4**	**61.7**	**111.5**
Washington County	**496.7**	**41.5**	**68.3**	98.6
Westmoreland County	436.3	37.0	55.2	91.9
Pennsylvania	**467.4**	**38.2**	**59.5**	**108.9**

Note: Figures in **red** indicate higher rates when compared to state rates.

Source: State Cancer Profiles 2016-2020

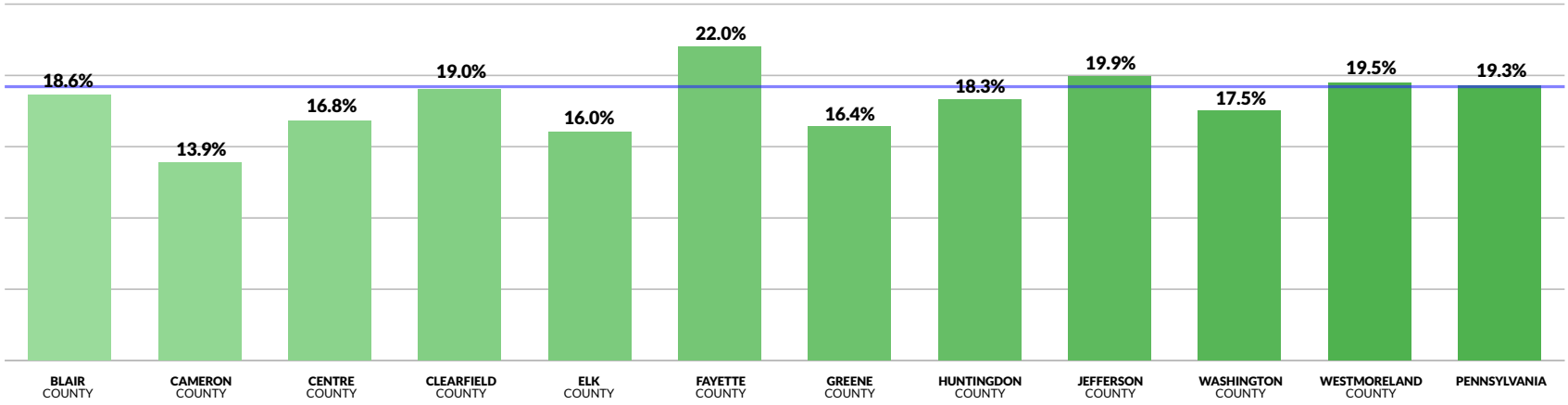
Figure 27 shows the preventable hospitalization rate among Medicare beneficiaries. Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection.

Figure 27: Preventable Hospitalizations (Rate Per 100,000 Beneficiaries)



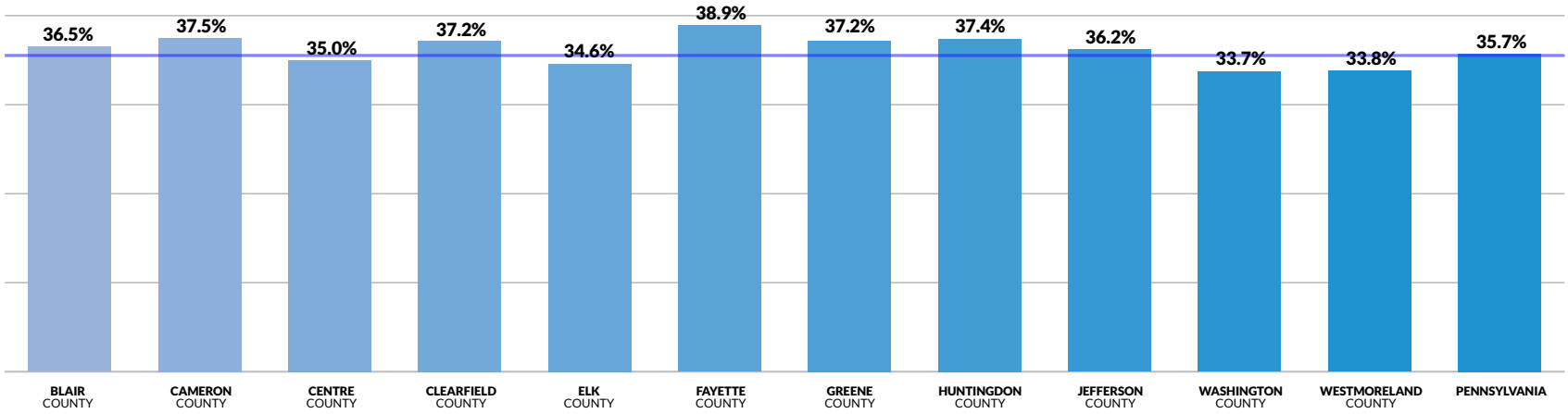
Source: Centers for Medicare and Medicaid Services 2021

Figure 28: Adults with No Leisure Time Physical Activity



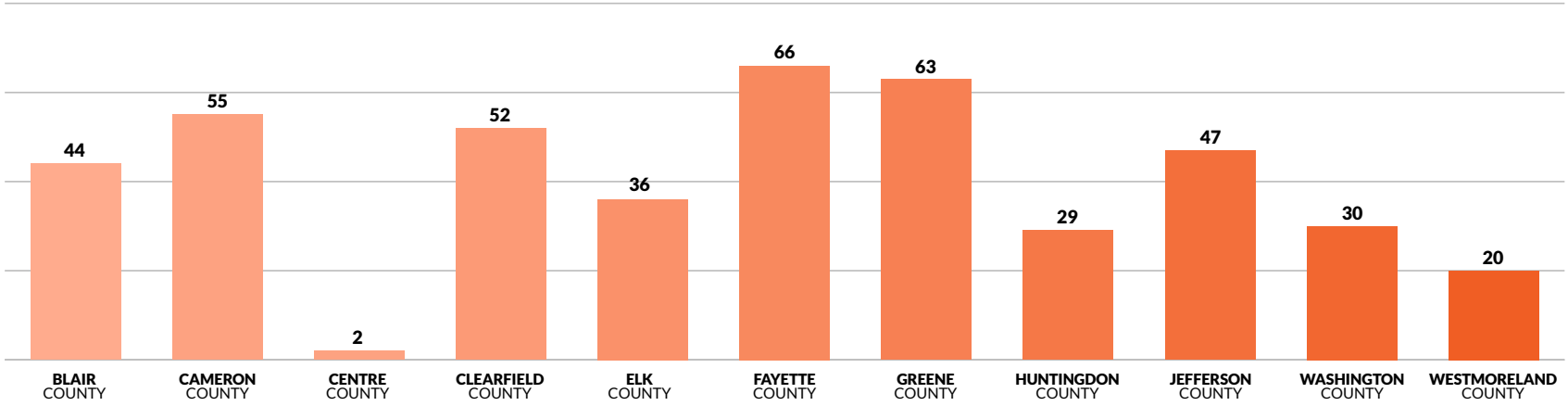
Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion 2021

Figure 29: Adults Sleeping Less Than 7 Hours on Average



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2020

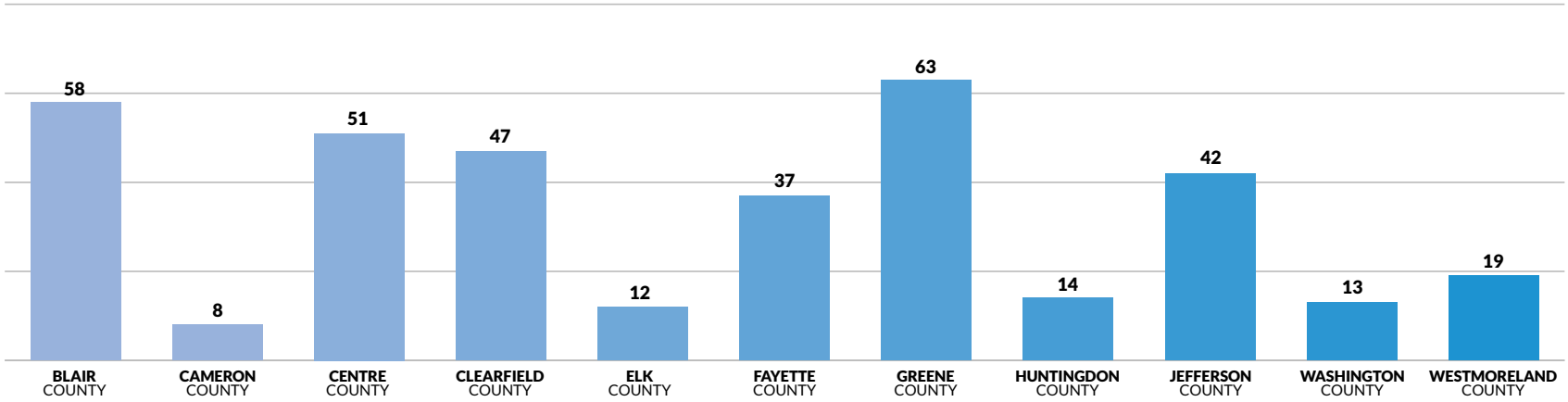
Figure 30: Health Outcomes Rank



Note: Pennsylvania is home to 67 counties. A ranking of 1 indicates that the county is the best for a particular health outcome or factor.

Source: County Health Rankings & Roadmaps

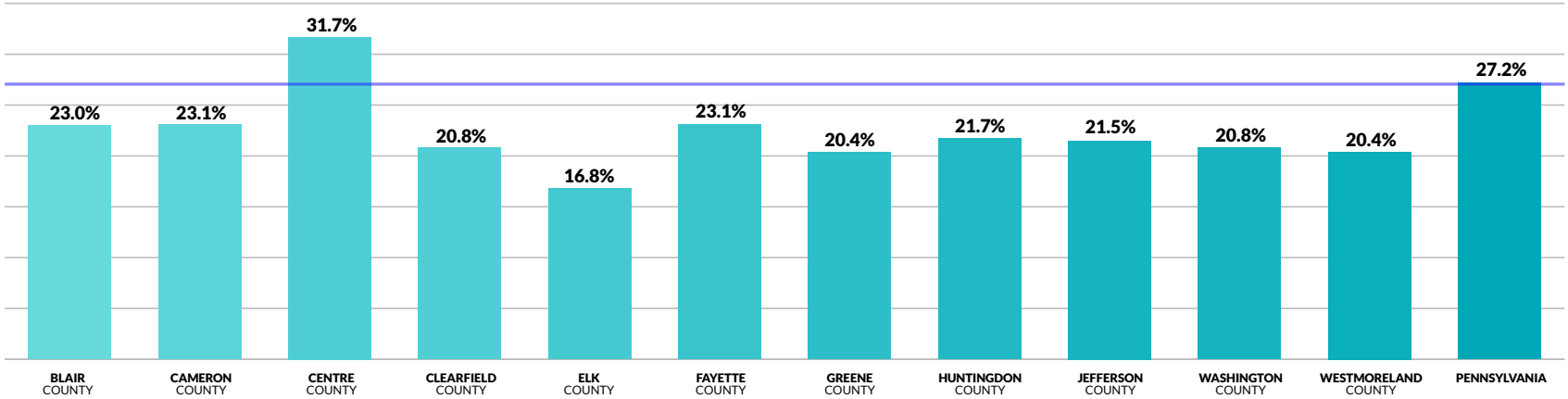
Figure 31: Social and Economic Factors Rank



Note: Pennsylvania is home to 67 counties. A ranking of 1 indicates that the county is the best for a particular health outcome or factor.

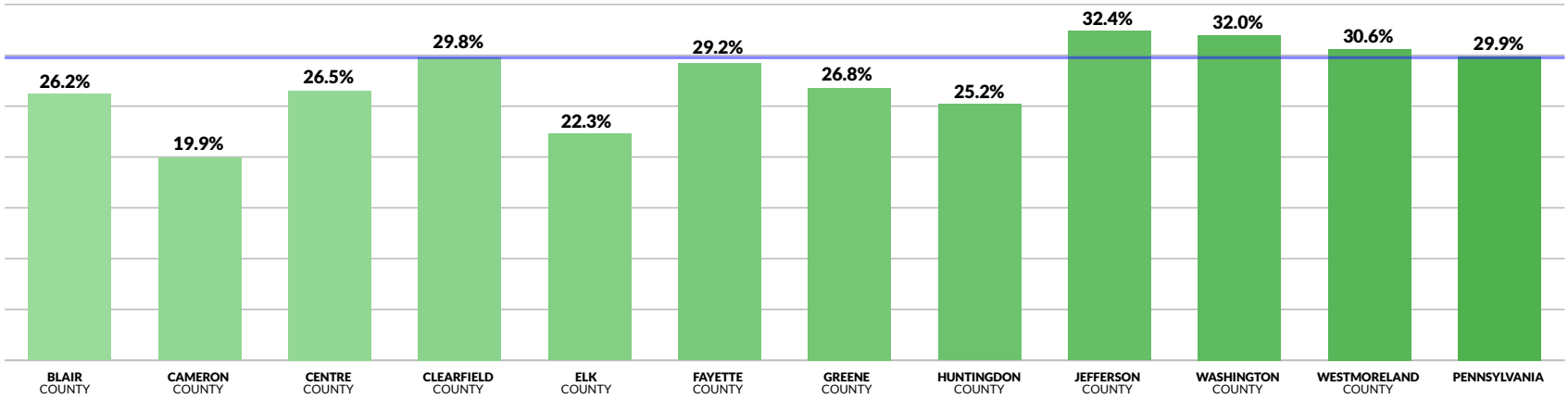
Source: County Health Rankings & Roadmaps

Figure 32: Occupied Housing Units with One or More Substandard Conditions



Source: U.S. Census Bureau, American Community Survey 2018-2022.

Figure 33: Obese Adults with BMI > 30.0



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion 2021

PRIMARY RESEARCH
KEY FINDINGS

METHODOLOGY

Penn Highlands Healthcare contracted Tripp Umbach to conduct the system's 2024 CHNA. The CHNA report complies with the Internal Revenue Service's (IRS) guidelines for charitable 501(c)(3) tax-exempt hospitals and includes input from individuals representing the broad interests of the communities served by Penn Highlands Healthcare, including those with direct knowledge of the needs of the medically underserved, disenfranchised, and chronic disease populations.

The CHNA process began in January 2024 and concluded in June 2024. The data collected allows for further group engagement to inform the CHNA needs and deliverables. While multiple steps made up the overall CHNA process, Tripp Umbach worked closely with members of the CHNA working group to collect, analyze, and identify the results to complete Penn Highlands Healthcare's assessment.

Beginning in January 2024, the working group and Penn Highlands Healthcare's assigned project contact held monthly conference calls. These project calls provided working group members with insights and awareness of all components of the CHNA project. To meet IRS requirements related to the ACA, Penn Highlands Healthcare's study methodology included both qualitative and quantitative data collection methods to identify the needs of underserved and disenfranchised populations.

DEFINED COMMUNITY

In the context of a CHNA, the defined community refers to the specific population or geographic area that is the focus of the assessment. This community can be delineated by factors such as geographic boundaries (e.g., counties, cities, or neighborhoods), demographic characteristics (e.g., age, race, or socioeconomic status), or the population served by a healthcare provider or organization. Clearly defining the community is essential for accurately assessing health needs, as it ensures that the data being collected and analyzed reflects that specific population's unique characteristics and health challenges. By focusing on a well-defined community, the CHNA provides precise and actionable insights, facilitating the development of targeted health interventions, policies, and programs tailored to residents' needs. This approach helps to ensure that health resources are allocated effectively and that efforts to improve health outcomes are concentrated where they are most needed, ultimately enhancing the community's overall well-being.

Penn Highlands Healthcare's defined community is the geographic area from which a significant number of the patients utilizing hospital services reside. While the community health needs assessment considers other healthcare providers, the hospital is the largest provider of acute care services. For this reason, utilizing hospital services provides the clearest definition of the community.

In 2024, Penn Highlands Healthcare covered 148 ZIP codes. The ZIP codes represent the focus study areas for Penn Highlands Healthcare's 2024 CHNA. They are based on 80% of all hospital patient discharges.

SECONDARY DATA

Secondary data sources at the local, state, and national levels included information on disparities, public health priorities related to disease prevalence, socioeconomic factors, health outcomes, and health determinants. This data was used to create a regional community health profile based on the location and service areas of Penn Highlands Healthcare. The primary and secondary data source was Community Commons, a publicly available dashboard of multiple health indicators drawn from various national data sources, which allowed for the review of past developments and changes in demographics, health, social, and economic factors. Additional data sources included County Health Rankings and the U.S. Census Bureau. The data was peer-reviewed and substantiated, providing a high level of validity.

The comprehensive community profile generated a deeper understanding of regional issues, particularly in identifying regional and local health and socioeconomic challenges. The secondary quantitative data collection process included:

1. America's Health Rankings
2. Centers for Disease Control and Prevention (CDC)
3. Centers for Medicare and Medicaid Services
4. Community Commons Data
5. County Health Rankings
6. Dartmouth College Institute for Health Policy & Clinical Practice
7. Federal Bureau of Investigation
8. Feeding America
9. Kids Count Data Center
10. National Center for Education Statistics
11. Pennsylvania Department of Health
12. U.S. Department of Agriculture
13. U.S. Census Bureau
14. U.S. Department of Health & Human Services
15. U.S. Department of Housing and Urban Development
16. U.S. Department of Labor

EVALUATION OF PREVIOUS IMPLEMENTATION STRATEGY

Penn Highlands Healthcare has worked over the last three years to develop and implement strategies to address the health needs in the study area and evaluate the strategy's effectiveness in meeting goals and combatting health problems in the community.

The evaluation process determines the effectiveness of the previous plan. The working group tackled the problem statements for each past priority and strategy and developed ways to address its effectiveness. The self-assessments on each strategy are internal markers that denote how to improve and track each goal and strategy over the next three years. Specific metric information/measurable indicators can be obtained from Penn Highlands Healthcare's administrative department.

COMMUNITY LEADER INTERVIEWS

During the CHNA process, telephone interviews were conducted with community stakeholders in the service area to better understand the evolving environment. These interviews allowed community leaders to offer feedback on community needs, suggest secondary data resources for review, and share other relevant information for the study. The interviews with community stakeholders took place from February to April 2024 and included individuals from professional backgrounds, including:

1. Government leaders
2. Professionals with access to community health-related data
3. Public health experts
4. Representatives of underserved populations
5. Social service representatives

Thirty-six interviews were conducted with community leaders and stakeholders as part of Penn Highlands Healthcare. The qualitative data gathered from these interviews reflect the opinions, perceptions, and insights of the CHNA participants. This information provided valuable insights and added significant depth to the qualitative data.

Overall health needs, themes, and concerns were identified during the interview and discussion. Each overarching theme encompassed several specific topics. Below are key themes that community stakeholders highlighted as the largest health concerns in their community.

1. Transportation issues
2. Lack of available services
3. Healthcare coordination (lack of healthcare coordination services)
4. Insurance coverage/issues
5. Affordability
6. Behavioral health (mental health and substance abuse)
7. Economic disparities
8. Mobility issues (physical difficulty getting around)
9. Lifestyle and health habits (unhealthy eating habits and inadequate physical activity)
10. Aging problems
11. Chronic conditions/diseases (heart disease, diabetes, cancers, etc.)
12. Lack of education

PUBLIC COMMENTARY

As part of the CHNA, Tripp Umbach solicited comments related to the 2021 CHNA and Implementation Strategy Plan on behalf of Penn Highlands Healthcare. Feedback was solicited from community stakeholders identified by the working group. Observations allowed community representatives to react to the methods, findings, and subsequent actions taken because of the 2021 CHNA and ISP process. Stakeholders have posed questions developed by Tripp Umbach. The public comments below summarize stakeholders' feedback regarding the former documents. The collection period for the study occurred from February to April 2024.

- When asked whether the assessment "included input from community members or organizations," 48.4% reported it did.
- In the survey reviewed, 38.7% reported that the report did not exclude community members or organizations that should have been involved.
- In response to the question, "Are there needs in the community related to health that were not represented in the CHNA?" 40.0% reported that there weren't.
- Slightly less than one-third, 32.3% of respondents, indicated that the ISP was directly related to the needs identified in the CHNA.

According to respondents, the CHNA and the ISP benefited them and their community in the following manner (in no specific order):

- The more data, the better. Data drives areas of improvement and helps determine how to improve and utilize better services.
- It's a good starting point for individuals and organizations to examine and implement ideas. It contains a lot of information.
- It did not. They took care away. Distance to care is a problem — complete assessments to check.
- There is great information in sharing the plan with participating organizations. This can create more collaborative meetings.
- It implemented adding a pulmonologist.
- Transportation is talked about but not addressed.
- A lot of implementations surrounding education, but infrastructure is still lacking.
- Improvements to healthcare and services.
- It benefited our community. Anything we can do to help our community is a hand up, not a handout — it is the messaging of the people you are trying to connect with.
- The whole county faces disparities.
- Continue to build the services and the care in the region. Better access to quick care.
- We do not have tracks to evaluate all of the programs. The hospital lost some of its behavioral health capacity, but I understand the logistics of being cost-effective and having it relocated.
- Better collaboration and more effective partnerships.

COMMUNITY SURVEY

A community survey was conducted to gather data from residents within Penn Highlands Healthcare's service area and the region. The survey identified the community's specific health needs and concerns, including those of vulnerable populations that might not be evident through other means. By gathering detailed feedback from community members and stakeholders, organizations can make more informed decisions about where to allocate resources and how to develop targeted interventions. The survey also provides valuable insights into how health needs have evolved, especially during significant events such as the COVID-19 pandemic. Overall, the community survey ensured that health and social initiatives are responsive to the community's actual needs, leading to more effective and efficient healthcare delivery.

Working with the CHNA working group, a quality-of-life survey instrument was created and distributed to patients and community residents using Penn Highlands Healthcare services. The survey was also sent to residents identified from the Elk County Family Resource Network, St. Marys Area United Way, the Stackpole-Hall Foundation, and the Stackpole-Hall Foundation's William C. Conrad Summer Jobs Program employers.

The community survey was active from March to April 2024, and 1,254 surveys were collected. Below are the top health problems providers reported in their community, descending from the most identified to the least identified.

1. Aging problems
    - Arthritis
    - Eldercare
2. Behavioral health, mental health, and substance abuse
3. Chronic disease prevention/management
    - Cancers
4. Overweight/obesity
    - Eating well/nutrition
    - Lack of exercise
    - Managing weight

FOCUS GROUPS

Qualitative data was collected from two focus groups representing the Northwest and Southwest regions of Penn Highlands Healthcare. The focus groups were seniors, who represented the Northwest Region, which had nine participants, and providers of residents with chronic conditions, with six participants. The working group agreed upon the focus groups based on secondary and primary data presented. Feedback from key informants, secondary data, and community surveys provided information through the lens of representatives who provide services and directly interact with community residents.

PROVIDERS OF RESIDENTS WITH CHRONIC CONDITIONS FOCUS GROUP

Providers discussed rural healthcare's challenges and opportunities, including access to care, specialist shortages, and the importance of community-based initiatives. They highlighted the need for walkability and accessibility, youth programs that promote exercise, and resources for the geriatric population. Speakers also addressed transportation issues, affordable personal care homes, and educating patients about available resources. To attract and retain high-quality healthcare providers, speakers proposed ideas such as competitive salaries, opportunities for professional growth, and investment in new technology. Overall, the conversation emphasized the need for a comprehensive approach to address rural healthcare's unique challenges, particularly for residents who face chronic diseases.

The theme from the focus group included:

- Positive aspects of living in a rural community and its impact on health outcomes.
- Community needs in rural Western Pennsylvania, including access to care, behavioral health, and transportation issues.
- Transportation and chronic condition management challenges in a healthcare setting.
- Recruiting and retaining healthcare professionals in a rural area.
- Lack of mental health and substance abuse services in the community.
- Improving mental health support systems.
- Improving patient access to healthcare services.
- Telemedicine, technology, and patient population in healthcare.
- Health challenges in a rural community.

SENIOR FOCUS GROUP

The focus group identified health issues, needs, and concerns affecting community residents and identified ways to address those concerns. Seniors specifically discussed challenges and opportunities in healthcare services for seniors in rural Pennsylvania, including transportation, affordability, and accessibility. They highlighted the importance of understanding residents' experiences to inform programming efforts and address health and social needs. Seniors also discussed the limited availability of senior housing in rural areas and the need for more affordable and accessible housing options. Additionally, they emphasized the importance of mental health services and the challenges seniors face in accessing telemedicine platforms and healthy food options.

The themes from the focus group included:

- Health and social needs in a rural area.
- Transportation challenges in rural Pennsylvania.
- Transportation barriers to medical appointments and potential solutions such as home visits by healthcare providers.
- Affordable senior housing options.
- Building trust in healthcare organizations through advocacy and word of mouth.
- Healthcare access and transportation barriers in a small town.
- Mental health services in rural Pennsylvania.
- Food access and healthy eating habits among older adults.

INTERVIEWS WITH LOW-INCOME RESIDENTS

Tripp Umbach conducted eight interviews with low-income residents in Central Pennsylvania. This is critical in understanding and addressing this demographic's unique health challenges. The interviews provide valuable firsthand insights into the barriers and disparities experienced by low-income individuals, such as limited access to healthcare, inadequate housing, food insecurity, and chronic stress. By engaging directly with residents, researchers can gather nuanced data that quantitative methods alone may not capture, ensuring that the assessment reflects the true needs and priorities of the community. The interviews empowered residents by giving them a voice in the assessment process and continued to build trust with the community-based organization that recruited them for the interview. The information gleaned from these interviews informs targeted interventions and policies, ultimately leading to more equitable and effective health outcomes for all community members.

The themes from the interviews included:

- Healthcare access issues
- Adequate health insurance coverage
- Specific health services and programs that are lacking in the community
- Challenges in accessing medical care and services
- Insufficient mental health resources

PRIORITIZATION PLANNING SESSION

Tripp Umbach conducted an internal hospital prioritization session with working group members to present the CHNA findings and gather input on the community's overall needs and concerns. A 90-minute virtual prioritization meeting took place to rank, target, and align resources while focusing on achievable goals and strategies to address community needs. The priorities were identified by examining data and overarching themes from the CHNA findings. During the virtual meeting on Teams, attendees received a brief presentation on the key findings from the CHNAs.

CONSENSUS DEVELOPMENT STEPS

1. Group discussions on the top health need to identify similarities and differences.
2. Sharing the health needs identified by working group members.
3. Clustering similar health needs into themes.
4. Determine the final health need.
5. Comparing and discussing new needs with those from the previous CHNA.

CRITERIA FOR PRIORITIZATION

The following decision-making criteria were used to guide prioritization processes for the assessment cycle.

- Consider the CHNA needs from the previous assessment. Were those needs addressed? Or are they still being addressed?
- What were the top needs/issues from the community stakeholder's data?
- What were the top needs/issues from the community surveys?
- What were the top needs/issues from the secondary data?
- What is the magnitude/severity of the problem?
- What are the needs of vulnerable populations?
- What is the community's capacity and willingness to act on the issue?
- What is the hospital's ability to have a measurable impact on the issue?
- What hospital and community resources are available?

PRIORITIZATION PROCESS

The prioritization process was designed to be inclusive, participatory, and data-driven. Meeting participants were encouraged to reflect on and discuss the data, provide narratives relevant to each community need, and offer their perspectives on issues. After a thorough group data review and reaching a consensus, the group identified and agreed upon the 2024 CHNA needs. The collaborative process ensured that all perspectives were considered, comprehensively understanding the community's health priorities. These agreed-upon needs reflect the collective commitment to addressing the most pressing health concerns in Penn Highlands Healthcare's community.

COMMUNITY RESOURCE INVENTORY

Tripp Umbach created a comprehensive inventory of programs and services available in the region. The inventory highlighted programs and services within the service areas corresponding to each priority need area. It identified the organizations and agencies serving the target populations within these priority needs, provided detailed program descriptions, and gathered information on the potential for coordinating community activities and establishing linkages among agencies.

DATA LIMITATIONS

It is important to note that the data collected for the 2024 CHNA has limitations. Secondary data utilized for the report is not specific to Penn Highlands Healthcare's primary service area but provides a larger geographic region scope. Primary data obtained through interviews, community surveys, and focus groups are also limited in representing Penn Highlands Healthcare's service area, as information was collected through convenience sampling.

ADDITIONAL INFORMATION

Penn Highlands Healthcare will create implementation plans that utilize their organization's strengths and resources to effectively meet the health needs of their communities and enhance the overall health and well-being of residents in Northwestern, Southwest, and Central Pennsylvania. For more details about the CHNA and its specific findings, please contact:

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MEETING
OUR MISSION

The CHNA is indispensable for comprehensively understanding a community's health challenges and needs. By systematically collecting and analyzing data on health indicators such as socioeconomic status, access to healthcare, prevalent diseases, and lifestyle choices, a CHNA provides an in-depth overview of public health. This thorough assessment is essential for tailoring health interventions, policies, and programs to the population's unique needs. Its influence extends beyond immediate healthcare delivery, impacting long-term planning and resource allocation, ensuring equity in health services, and fostering community engagement and empowerment. Ultimately, a CHNA enhances overall community well-being by guiding targeted actions that address the root causes of health disparities and promote sustainable health improvements. Penn Highlands Healthcare is proud to have engaged in the assessment, underscoring our commitment to enhancing the health and well-being of the community we serve.

NEXT STEPS

After completing and finalizing the CHNA, Penn Highlands Healthcare is poised to establish comprehensive goals and strategic approaches for the implementation phase. Penn Highlands Healthcare will leverage its strengths, extensive resources, and broad outreach capabilities to forge effective collaborations with community partners. Together, Penn Highlands Healthcare will identify and implement the most impactful strategies to address the unique health needs of its communities. This concerted effort aims to enhance overall health, address urgent health needs, and improve the well-being of residents within their service areas. The careful prioritization of identified needs will shape and drive community health improvement initiatives, ensuring that the efforts of Penn Highlands Healthcare benefit the residents they serve.

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