EVANGELICAL™
COMMUNITY HOSPITAL

2024 Community Health Needs Assessment





About Evangelical Community Hospital

Beginning in 1926 as the vision of three local physicians, Evangelical Community Hospital has been providing for the healthcare needs of the Greater Susquehanna Valley residents for nearly a century. Our nonprofit mission to provide exceptional healthcare, accessible to all, in the safest and most compassionate atmosphere possible to build a healthy community, guides our service and commitment as the community's Hospital.

At the heart of Evangelical's mission is providing the community with easier access to care and connecting its residents and members to resources to keep them healthy. In fiscal year 2023 alone, Evangelical provided more than $59 million in uncompensated healthcare and community health and wellness services. With the pandemic ending, the doors reopened to breathe life into these efforts and several Evangelical Community Health and Wellness initiatives returned to answer the needs of different community groups, including the Children's Health Fair at The Miller Center and the Talk with the Doc series of lectures.

The Hospital held its inaugural Evangelical Honors the Community banquet in November 2022 as an outward sign of appreciation for the way the Hospital and the community work together to build a place where people want to live, work, and raise families. "As we begin our march toward our centennial anniversary in 2026, we felt it was vital to recognize and appreciate some of our most extraordinary community members, who have influenced one or more of the foundational community pillars through their own philanthropy, leadership, and services," said Kendra Aucker, President and CEO, Evangelical. The event was held again in November 2023 and will continue to be an annual honoring of those who support the Hospital and make its continued service possible.

As our population mix becomes more varied and richer in culture, the Hospital has reinforced its efforts toward diversity, equity, and inclusion (DEI) for all staff and patients who enter its doors. The initiative focuses on what patients and staff need in addition to an excellent care and work environment – a welcoming and accepting place to land regardless of background and belief. Key DEI developments in 2023 included establishing a workgroup to guide the process focused on four pillars (talent, patients, providers, and community members); creating a dashboard to better understand trends in staff and patient demographics for the region; including DEI questions on the Employment Engagement Survey; and hosting a PRIDE panel discussion to aid in connecting with the LGBTQ+ community; among others.

As part of our commitment to the community, Evangelical conducts a Community Health Needs Assessment (CHNA) every three years. The CHNA findings are used by Evangelical for the development of a Community Health Improvement Plan focused on the top concerns for residents, as well as for ongoing, meaningful engagement with the community.

Please join Evangelical, and partnering agencies, as we work together to improve the health and quality of life for all who live, work, and play in our community.

2024 CHNA Collaborative

The 2024 CHNA was conducted collaboratively by Evangelical Community Hospital, Geisinger, and Allied Services. The three health systems have partnered since 2012 to create a CHNA for their overlapping service areas spanning central and northeast Pennsylvania. Partnering in this way conserves vital community resources while fostering a platform for collective impact that aligns community efforts toward a common goal or action.

The CHNA focused on the primary service county(ies) of each participating hospital to identify health trends and unique disparities within these communities. Hospitals with overlapping service areas were grouped into regions for comparisons of health and socioeconomic data. Common priorities were determined to address widespread health needs. Specific strategies were outlined in each hospital's community health improvement plan to guide local efforts and collaboration with community partners.

The 2024 CHNA study area included 18 counties across central and northeast Pennsylvania:

Region	Primary Service Counties	Hospitals
Central	Columbia County Montour County Northumberland County Schuylkill County Snyder County Union County	Geisinger Bloomsburg Hospital Geisinger Medical Center Geisinger Shamokin Area Community Hospital Geisinger Encompass Health Rehabilitation Hospital Evangelical Community Hospital
North Central	Clinton County Lycoming County Sullivan County	Geisinger Jersey Shore Hospital Geisinger Medical Center Muncy
Northeast	Lackawanna County Luzerne County Susquehanna County Wayne County Wyoming County	Allied Services Rehab Hospital Geisinger Community Medical Center Geisinger South Wilkes-Barre Geisinger Wyoming Valley Medical Center Heinz Rehab Hospital
Western	Centre County Huntingdon County Juniata County Mifflin County	Geisinger Lewistown Hospital

The 2024 CHNA builds upon the collaborative's 2012, 2015, 2018, and 2021 regional reports in accordance with the timeline and requirements set out in the Affordable Care Act (ACA). A wide variety of methods and tools were used to analyze the data collected from community members and other sources throughout the regions. The findings gathered through this collaborative and inclusive process will engage the participating hospitals and other community partners to address the identified needs.

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2024 CHNA Background

Since 2012, Evangelical Community Hospital, Geisinger, and Allied Services have combined efforts to better understand the factors that influence the health of the people living in central and northeast Pennsylvania. By working together, sharing strengths, and generating ideas, the collaborative fosters a common understanding of the resources and challenges facing their communities. Leveraging the collective and individual strengths across each institution, the health systems are working toward a healthier, more equitable community for all.

Advisory Committees

The 2024 CHNA was overseen by a Planning Committee of representatives of Evangelical Community Hospital, Geisinger, and Allied Services, as well as a Regional Advisory Committee of hospital and health system representatives. Representatives met bi-weekly or monthly to lend expertise, insight, and collaborative action toward the creation of this CHNA report.

CHNA Planning Committee

Ryan McNally, Director, Miller Center and Community Health Initiatives, Evangelical Community Hospital
Sheila Packer, Manager, Community Health and Wellness, Evangelical Community Hospital
John Grabusky, Senior Director, Community Relations, Geisinger
Bethany Homiak, Strategist, Community Engagement, Geisinger
Benjamin Morano, Administrative Fellow, Geisinger
Barb Norton, Director, Corporate & Foundation Relations, Allied Services

Regional Advisory Committee

Brenda Albertson, Operations Manager, Nursing, Geisinger
Tammy Anderer, CAO, Geisinger
Wendy Batschelet, VP and Chief Nursing Officer, Geisinger
Patricia Brofee, Training Coordinator, Geisinger
Cheryl Callahan, Director, Geisinger
Sherry Dean, Operations Manager, Geisinger
Mike DiMare, Administrative Director, Geisinger
Kirsten Fordahl, Project Manager, Geisinger
Regina Graham, Program Manager, Geisinger
AJ Hartsock, Operations Director II, Geisinger
Kristy Hine, AVP and Chief Financial Officer, Geisinger
Rachel Manotti, Associate Chief Strategy Officer, Geisinger
Chase McKean, Community Engagement Coordinator, Geisinger
Mike Morgan, Administrative Director, Geisinger
Joanne Quaglia, Manager, Internal Communications, Geisinger
Val Reed, Marketing Strategist, Geisinger
Tori Reinard, Administrative Fellow I, Geisinger
Joe Stender, Marketing Strategist, Geisinger

Deb Swayer, Marketing Strategist, Geisinger
Tina Westover, Senior Tax Accountant, Geisinger
Amy Wright, Business Development Director, Geisinger
Lynn Yasenchak, Compliance Specialist III, Geisinger
Dave Argust, Vice-President, Financial Services, Allied Services
Jim Brogna, Vice-President, Strategic Partnership Development, Allied Services
Karen Kearney, Vice-President, Inpatient Rehabilitation, Allied Services

Our Research Partner

Evangelical Community Hospital, Geisinger, and Allied Services contracted with *Build Community* to conduct the CHNA. *Build Community* is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and underlying inequities and transform data into practical and impactful strategies to advance health and social equity. Our interdisciplinary team of researchers and planners have worked with hundreds of health and human service providers and their partners to reimagine policies and achieve measurable impact. Learn more about our work at buildcommunity.com.

2024 CHNA Research Methods

The 2024 CHNA was conducted from January to December 2023, and included quantitative and qualitative research methods to determine health trends and disparities in central and northeast Pennsylvania. Our process was in line with IRS Tax Code 501(r) requirements to conduct a CHNA every three years as set forth by the Patient Protection and Affordable Care Act (PPACA).

Through a comprehensive view of statistical health indicators and community stakeholder feedback, a profile of priority areas was determined. The findings will guide healthcare services and health improvement efforts, as well as serve as a community resource for grantmaking, advocacy, and to support the many programs provided by health and social service partners.

Secondary Data Analysis

Secondary data, including demographic, socioeconomic, and public health indicators, were analyzed for service area counties to measure key data trends and priority health issues and to assess emerging health needs. Data were compared to state and national benchmarks and Healthy People 2030 (HP2030) goals, as available, to assess areas of strength and opportunity. Healthy People 2030 is a national initiative establishing 10-year goals for improving the health of all Americans.

All reported demographic and socioeconomic data were provided by the US Census Bureau, American Community Survey, unless otherwise noted. Public health data were compiled from a variety of sources like the Pennsylvania Department of Health and Centers for Disease Control and Prevention (CDC), among others. A comprehensive list of data sources can be found in Appendix A. A glossary of terms for data references used throughout the report is available in Appendix D.

The most recently available data at the time of publication is used throughout the report. Reported data typically lag behind “real time.” It is important to consider community feedback to both identify significant trends and disparities and to better understand new or emerging health needs.

Primary Research and Community Engagement

Community engagement was an integral part of the 2024 CHNA. Input was solicited and received from individuals who represent the broad interests of the community, as well as underserved, low-income, and minority populations. These individuals provided perspectives on health needs, existing resources to meet those needs, and service delivery gaps that contribute to health disparities and inequities.

Primary research and community engagement study methods included:

- An online Key Stakeholder Survey completed by 180 individuals serving the Central Region, who represent healthcare providers, social services professionals, educators, faith-based leaders, and community leaders, among others;
- Regional Community Forum bringing together 39 diverse community representatives to review CHNA data and collectively define challenges and meaningful strategies for improvement; and
- Conversations with health system leaders to align community health planning with population health management and community engagement strategies.

Building Health Equity: Context for the Creation of this CHNA

Health challenges and disparities do not impact all people equally. Rather, certain structural and systemic issues, such as unequal access to physical or financial resources, contribute to higher levels of disease burden and worse health outcomes for select populations. Health disparities are not new, and often reflect long-standing issues of discrimination, racism, and lack of investment in communities.

Health equity, as defined by the Centers for Medicare and Medicaid Services (CMS), is "The attainment of the highest level of health for all people, whereby every person has a fair and just opportunity to attain their optimal health regardless of their race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, preferred language, and geography." Achieving health equity is key to improving our nation's overall health and reducing unnecessary healthcare costs.

COVID-19 exacerbated existing disparities within the health and social service systems and exposed long-standing inequities in power and socioeconomic opportunities within our society. The pandemic taught us that we need a more equitable healthcare response. This understanding informed the CHNA process and the development of Community Health Improvement Plans to advance health equity.

Determining Community Health Priorities

In 2023, the collaborating health systems worked alongside the *Build Community* team to update statistical data, develop and administer the Key Stakeholder Survey, and conduct Community Forums. From this process, the following specific health needs were confirmed as priorities:

Consistent Community Priorities and Contributing Factors

Access to Care	Chronic Disease Prevention & Management	Mental Health & Substance Use Disorder
Ability to afford care	Aging, rural population	Availability of providers
Availability of providers	Comorbidities	Comorbidities
Cultural competence	Disparities in disease, mortality	Depression and stress
Digital access	Early detection, screening	Impact of COVID pandemic
Healthcare navigation	Health education	Opioid and alcohol use
Health insurance	Healthy food access	Social isolation
Medical home	Physical activity	Stigma
Transportation	Tobacco use	Suicide attempts, death

Focus on underlying Social Drivers of Health

The priority areas are consistent with those identified as part of the 2021 CHNA and continue to be the leading health issues for residents across the region. In developing its Community Health Improvement Plan, Evangelical sought to target underlying disparities in social drivers of health and inequities that contribute to priority area issues. This focus is consistent with a health equity approach to look beyond the healthcare system to build healthier communities for all people now and in the future.

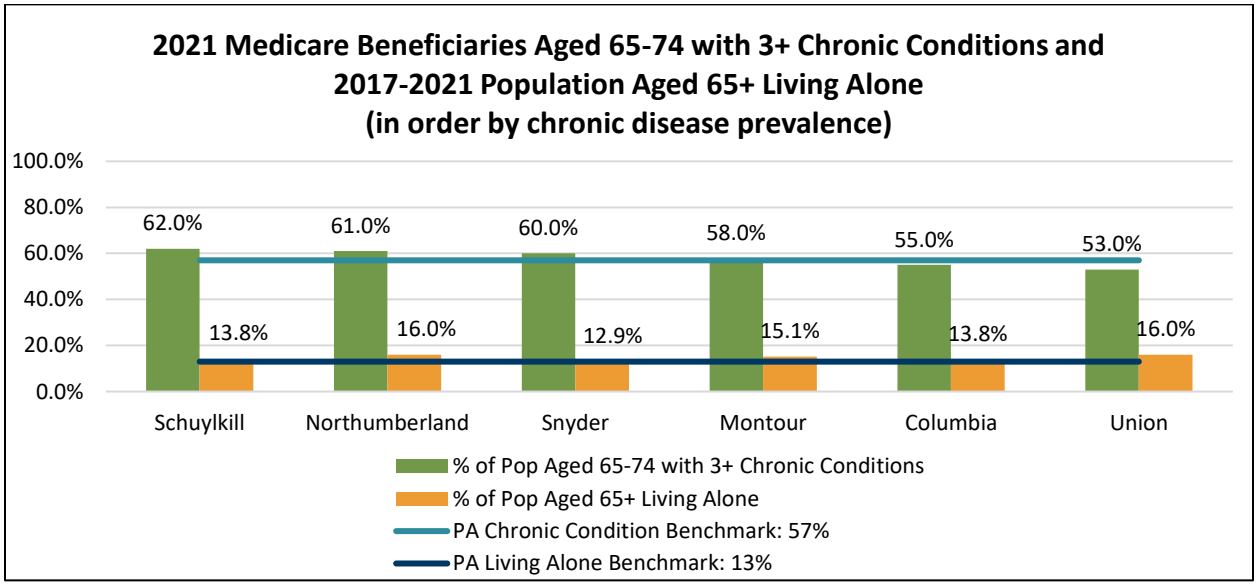
Executive Summary of CHNA Findings

Demographic and Priority Population Trends

The Central Region is comprised of six rural Pennsylvania counties: Columbia, Montour, Northumberland, Schuylkill, Snyder, and Union. The Center for Rural Pennsylvania defines a county as rural when population density, or the number of people per square mile within the county, is fewer than 291. Northumberland and Schuylkill counties are the most population dense (206 and 190, respectively) counties. Other Central Region counties have similar population density of 121 to 142.

Population growth over the past decade was stagnant in Montour and Snyder counties and declined in all other counties. Union County saw the largest population decline of -3.9% from 2010 to 2021. In contrast, the region saw significant growth in older adults. From 2010 to 2021, Snyder, Columbia, and Union counties saw 20%-28% growth in adults aged 65 or older.

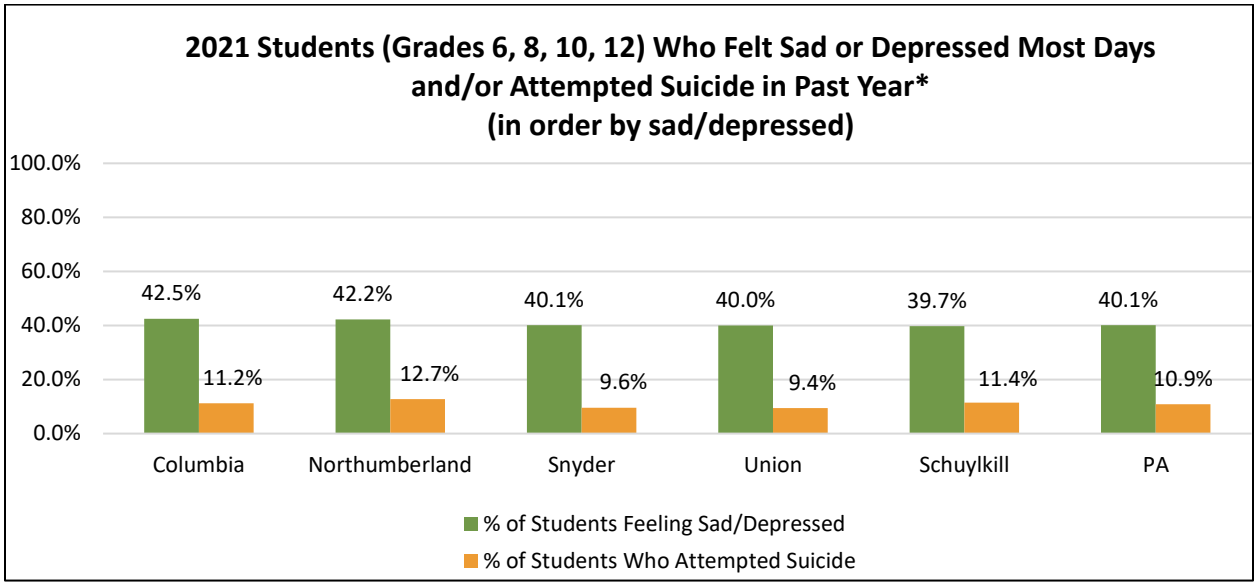
The growth of older adult populations will challenge communities to provide adequate support for aging residents, many of whom live alone and choose to age in place. Consistent with the state overall, approximately 50%-60% of Medicare beneficiaries aged 65-74 residing in the Central Region had three or more chronic conditions in 2021, and disease prevalence increased with older age groups 75+. Within the region, Northumberland County is an area of opportunity for improving older adult health and well-being. Approximately 21% of residents in the county are aged 65 or older, creating demand for services, and 16% of older adults live alone, potentially impeding wellness efforts.



Source: US Census Bureau, American Community Survey & CMS

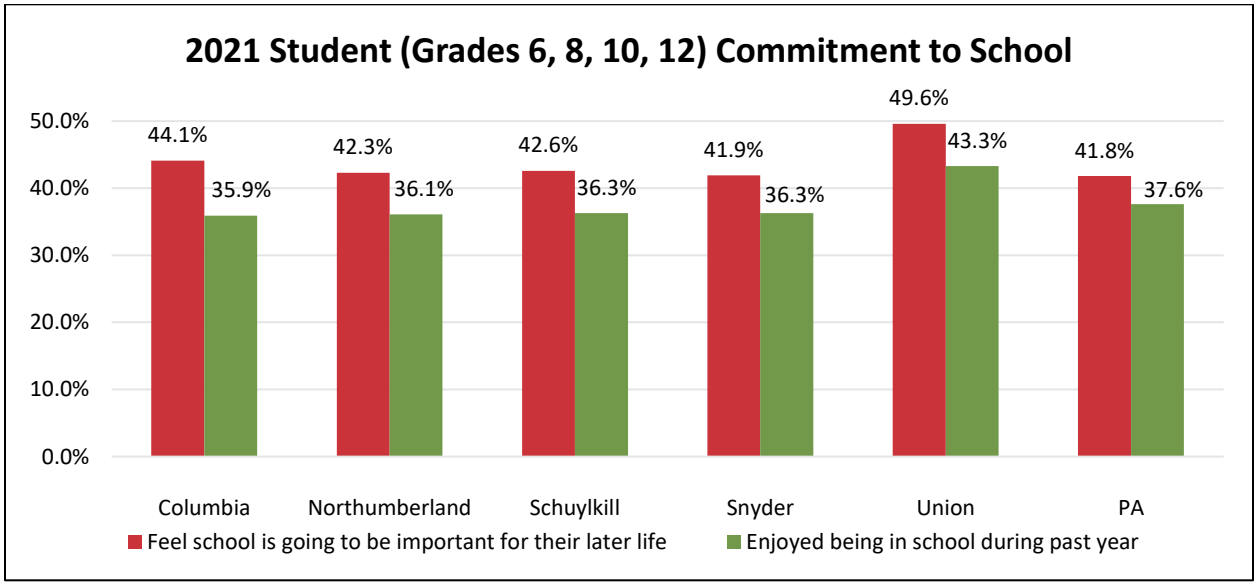
Central Region counties are aging, but children comprise approximately 1 in 5 residents, reinforcing the potential for upstream, preventive action. Critical to these upstream efforts is addressing social drivers of health (SDoH) barriers that have historically disproportionately affected children. For example, while poverty levels generally declined across the region, approximately 18%-19% of children in Columbia, Schuylkill, and Northumberland counties experience poverty compared to 12%-15% of all residents.

Top health concerns for children in the Central Region, and statewide, include mental health issues. Child mental health was a growing concern before the pandemic, and in 2021, approximately 2 in 5 students reported feeling consistently sad or depressed and 1 in 10 reported an attempted suicide.



Source: Pennsylvania Youth Survey *Data are reported by county as available.

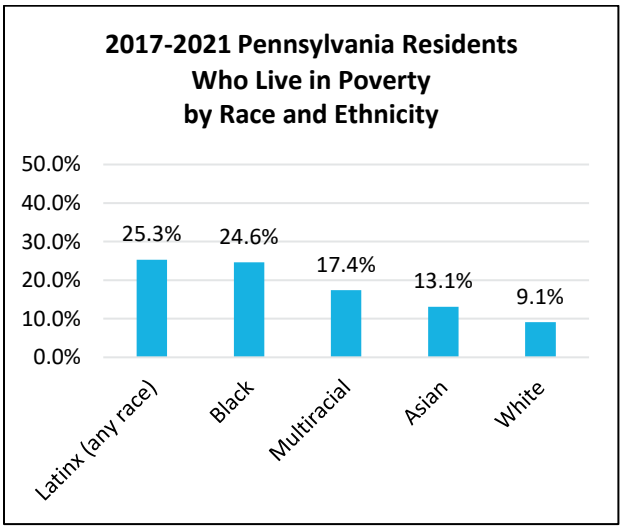
Commitment to school, measured by factors like how important students feel school is to later life or how much they enjoy the experience, can be protective for youth, reducing the likeliness of health concerns. School commitment has declined statewide; the percentage of youth who feel school is important for their later life fell from 57.5% in 2017 to 41.8% in 2021. In the Central Region, students in Northumberland County reported both lower school commitment and poorer mental health, including attempted suicide. These findings present an opportunity to foster youth engagement and future orientation to improve overall health and well-being.

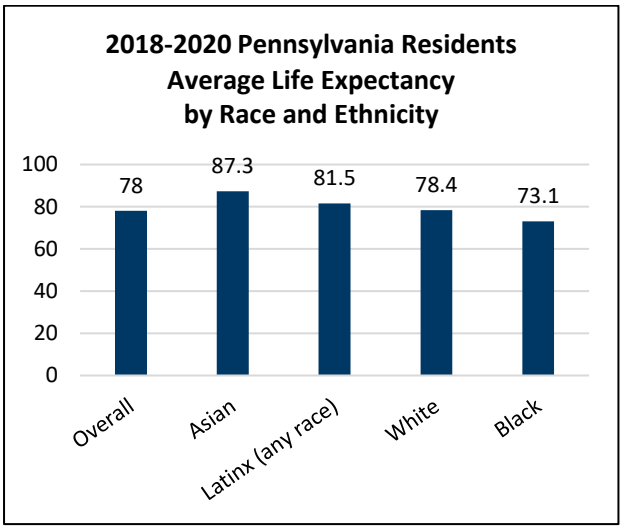


Source: Pennsylvania Commission on Crime and Delinquency Note: Data are not reported for Montour County.

The Central Region is a majority white community, but consistent with state and national trends, people of color are the only growing populations. This demographic shift is slow across counties, accounting for a 1-4 percentage point change over the last decade. Growth among populations of color was most evident for individuals who identify as multiracial and/or Latinx.

While populations of color are growing, they comprise a small proportion of the total population, limiting local-level data and often masking their community experience. Statewide trends demonstrate wide disparities affecting people of color, starting with upstream SDoH like poverty and ultimately downstream outcomes like life expectancy. Statewide and nationally, Black people have experienced more adverse health outcomes, largely due to historic social inequities like racism. In PA, Black people are more than twice as likely to experience poverty as white people and live an average of 5 years less.





Source: US Census Bureau, American Community Survey & National Vital Statistics System

Social Drivers of Health Opportunities

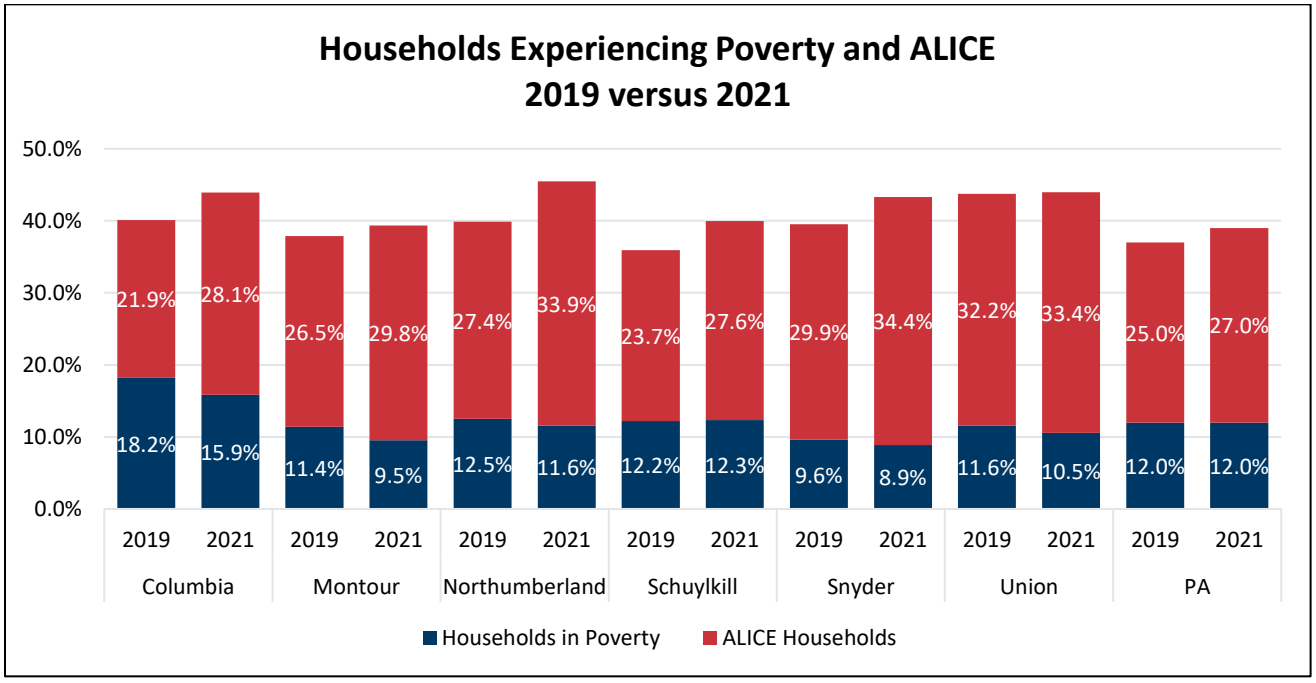
The Key Stakeholder Survey was completed by 180 Central Region representatives. As part of the survey, respondents were asked to share the top five priorities that their community should address to improve health and well-being of the populations they serve. While most respondents selected mental health conditions, the majority of the top five identified priorities were SDoH like lack of transportation, housing, and childcare.

Key Stakeholder Survey: In your experience, what top five priorities should our community address in order to improve health and well-being of the populations your organization serves?

Top Five Priority Responses	Percent of Responses
Mental health conditions	60.5%
Lack of transportation	46.1%
Housing (affordable, quality)	35.9%
Substance use disorder	35.3%
Childcare (affordable, quality)	34.7%

Feedback from key stakeholders and others addressed the need to better serve the working poor or ALICE (Asset Limited Income Constrained Employed) households. Households that are designated as ALICE have incomes that are above the federal poverty level, but below the threshold necessary to meet all basic needs. Across Central Region counties in 2021, one-quarter to one-third of households were ALICE, and contrary to poverty trends, the percentage of ALICE households increased from prior years.

The opportunity to address financial hardship for ALICE households is demonstrated in Northumberland County. In 2021, 34% of Northumberland County households were ALICE, a nearly 7-point increase from 2019. Northumberland County households also struggled with basic needs like housing and childcare. Despite lower housing costs, 21.5% of homeowners and 42% of renters were cost burdened, spending 30% or more of their income on housing-related expenses. For households with children, the average cost of childcare for two children was 27% of median household income.



Source: United for ALICE

The CHNA used several indexes to illustrate the impact of SDoH on health outcomes and identify targeted areas of opportunity. Indexes included the Health Resources and Services Administration Unmet Need Score (UNS) and Centers for Disease Control and Prevention Social Vulnerability Index (SVI), depicted on the following page.

The UNS measures access to primary and preventive healthcare services based on disparities in health status and SDoH. Scores range from 0 (least) to 100 (most) unmet need. Central Region counties have similarly high UNS values of 61-65 and these scores increase to 80-96 in select areas shown in the table below, indicating potentially significant disparities in health and well-being.

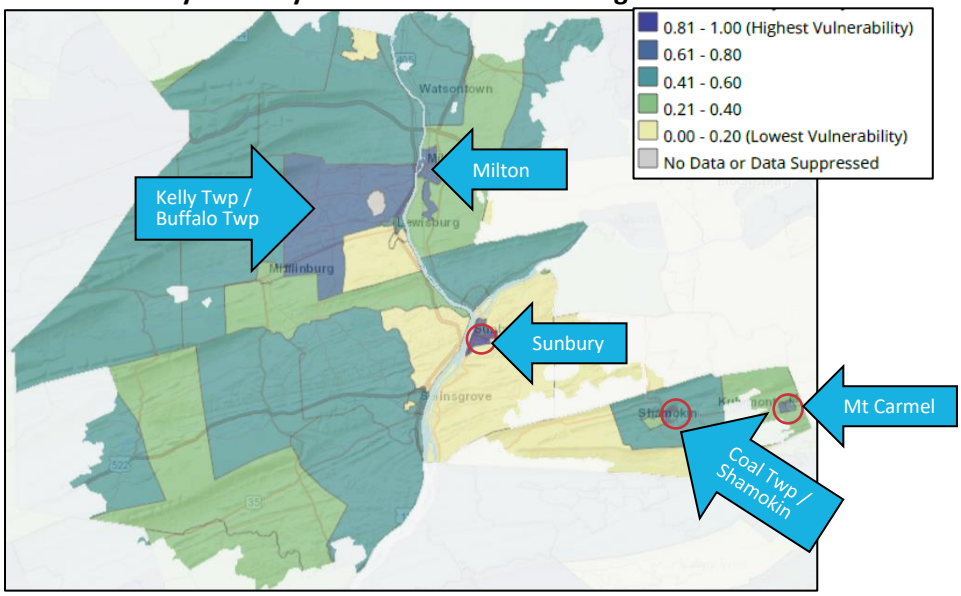
2017-2021 Social Drivers of Health for Central Region Zip Codes with HRSA Unmet Need Score >80 out of 100

Zip Code (County)	Population in Poverty	Children in Poverty	No High School Diploma	No Health Insurance	UNS Score
17948, Mahanoy (Schuylkill)	27.9%	37.4%	10.8%	12.4%	95.7
17935, Girardville (Schuylkill)	26.1%	55.5%	15.8%	15.3%	87.7
17976, Shenandoah (Schuylkill)	29.1%	54.4%	15.8%	9.4%	86.7
17954, Minersville (Schuylkill)	24.3%	43.6%	12.0%	8.2%	83.4
17864, Port Trevorton (Snyder)	13.0%	23.3%	36.6%	39.9%	82.2
17810, Allenwood (Union)*	36.6%	46.6%	16.1%	34.5%	81.4
17813, Beavertown (Snyder)	11.8%	22.4%	12.9%	11.9%	81.2
Pennsylvania	11.8%	16.4%	8.6%	5.6%	NA

Source: US Census Bureau, American Community Survey; Health Resources and Services Administration
*Allenwood is home to a federal prison with an inmate population of nearly 3,000 people, impacting community-wide socioeconomic factors.

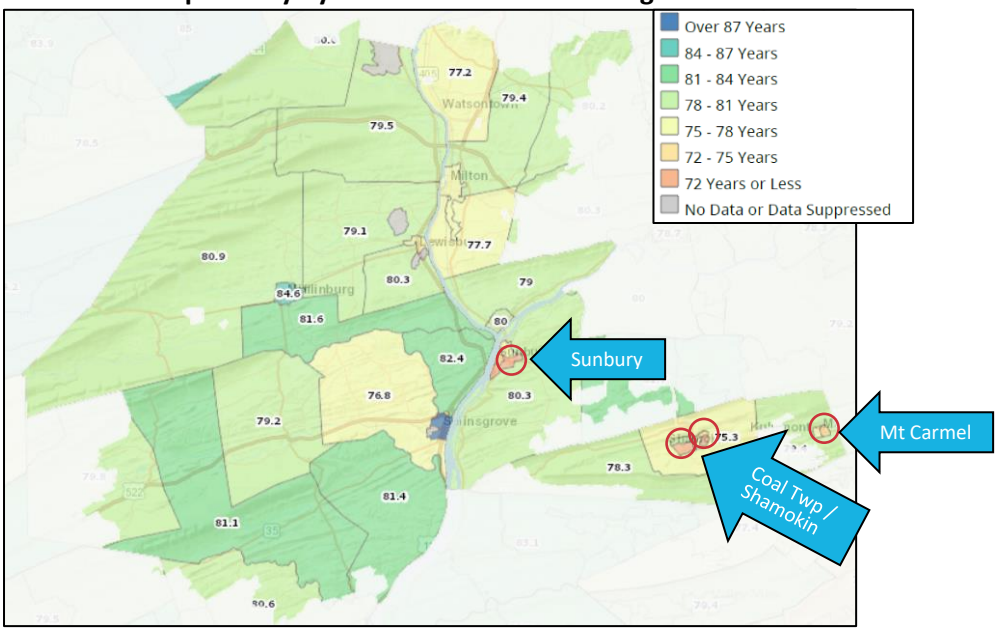
The SVI provides a deeper analysis, scoring census tracts on a scale from 0.0 (lowest) to 1.0 (highest) vulnerability based on SDoH factors. Within the Evangelical service area, areas of social vulnerability that are also associated with health disparities are concentrated in Northumberland County. In the communities of Coal Township, Mount Carmel, Shamokin, and Sunbury, SVI values exceed 0.60 and residents may live an average of 72 years or less compared to 78 years or more in surrounding areas.

Social Vulnerability Index by Census Tract within Evangelical Service Area*



Source: Centers for Disease Control and Prevention & Center for Applied Research and Engagement Systems
*Highlighted areas have a SVI value of 0.61 or higher.

2010-2015 Life Expectancy by Census Tract within Evangelical Service Area*



Source: Centers for Disease Control and Prevention & Center for Applied Research and Engagement Systems

*Highlighted areas have an average life expectancy of 72 years or less.

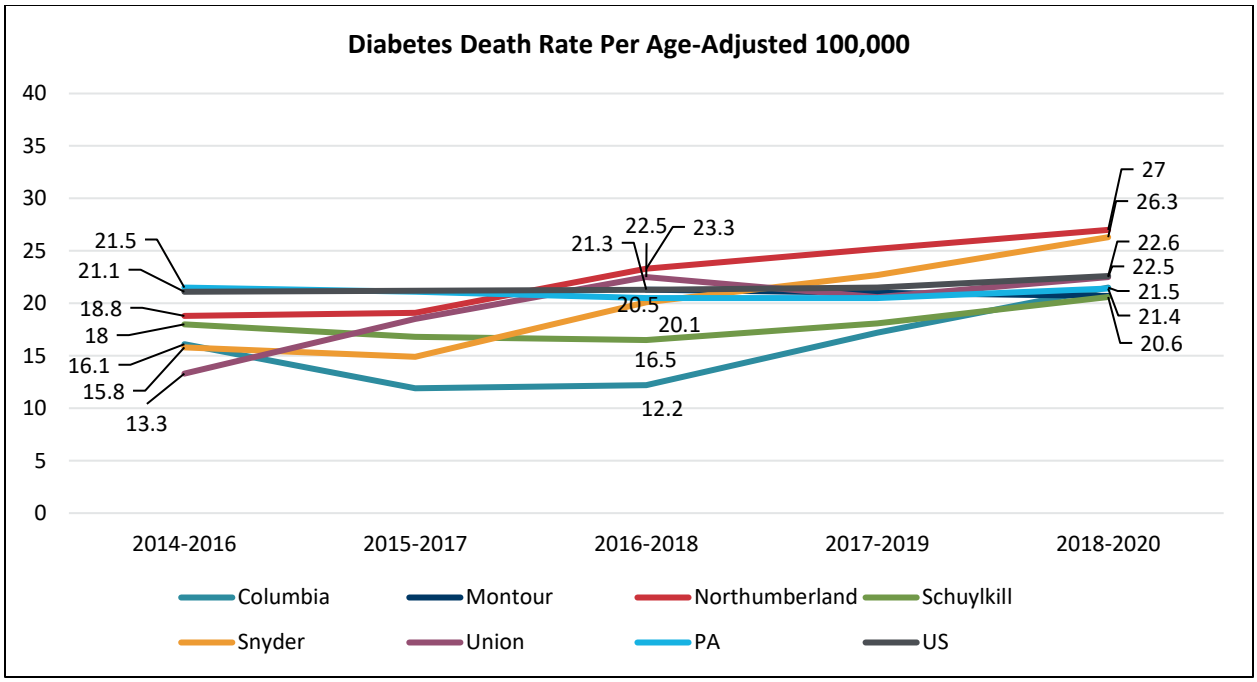
Priority Health Needs

The top health concerns for the Central Region and the Evangelical primary service area were confirmed as access to care, chronic disease prevention and management, and behavioral health. Central to addressing these areas is improving upstream SDoH and underlying inequities.

Chronic conditions are the leading causes of morbidity and mortality statewide and nationally. In the Central Region, disease prevalence is generally comparable to state and national trends, but death rates due to conditions like heart disease, diabetes, and lower respiratory disease are disproportionately higher in Northumberland and Schuylkill counties. These findings are consistent with SDoH barriers experienced by residents of these communities.

Diabetes is among the fastest growing chronic conditions nationally, as well as one of the most expensive conditions to treat. Consistent with the state and nation, approximately 1 in 10 Central Region adults have been diagnosed with diabetes, and prevalence has increased.

Diabetes death rates also increased across the region, demonstrating access to care barriers. While the number of residents without health insurance declined and a similarly high percentage of adults report having an annual physical checkup (~75%), these factors alone do not ensure access to comprehensive healthcare when it is needed. Many other factors—like affordability, transportation, language, provider availability, and trust—can keep people from receiving the care they need.

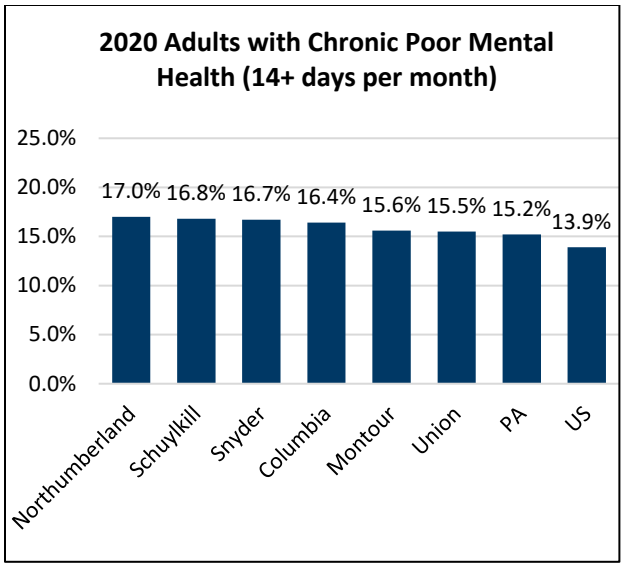


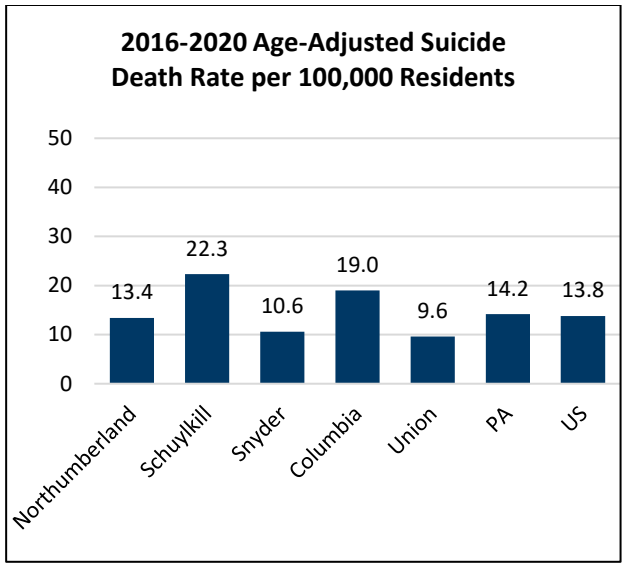
Source: Centers for Disease Control and Prevention
Note: Montour County data are not trended due to missing data (2018-2020 death rate = 20.7).

Behavioral health, including mental health and substance use disorder, was a growing concern before the pandemic and was generally exacerbated by the experience. Most recent data for 2020 show that consistent with Pennsylvania residents overall, Central Region adults are more likely to report chronic poor mental health (14 or more poor mental health days per month) than their peers nationwide. Residents of Schuylkill and Columbia counties also exceed state and national suicide death rates.

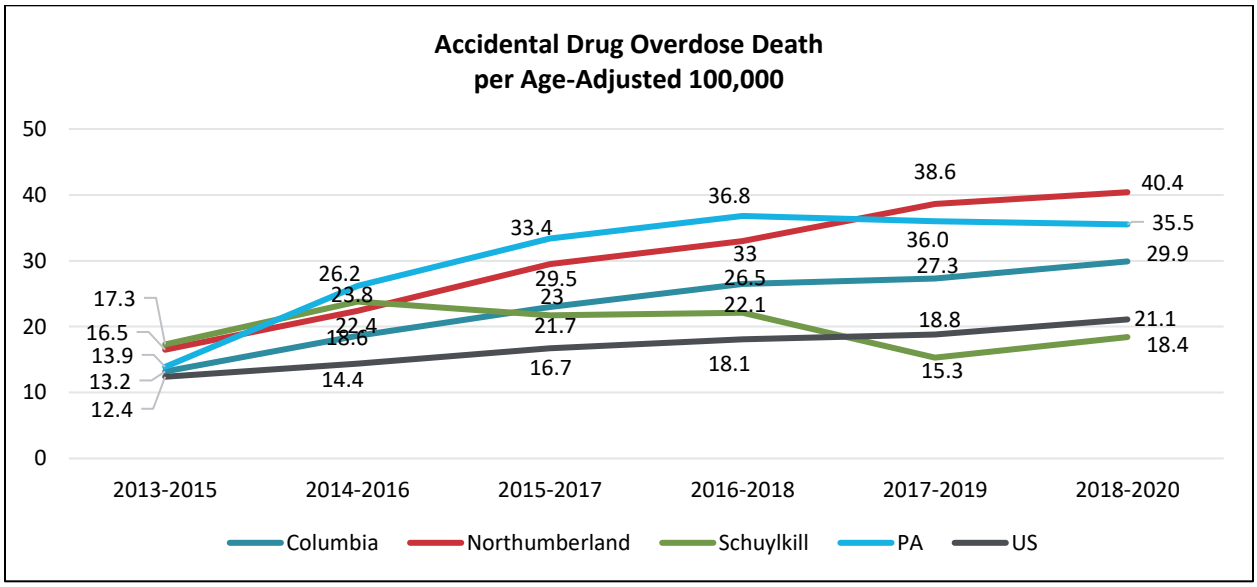
Opioid overdose hospitalizations generally declined, but accidental overdose deaths remain high and increased in Columbia and Northumberland counties. The use of amphetamines should also continue to be monitored within the region. Contrary to statewide trends, the rate of amphetamine use disorder hospitalizations in 2019 in Columbia, Montour, and Schuylkill counties outpaced those for opioids.

Alcohol use disorder is a growing concern for the region, as measured by both self-reported indicators and hospitalization statistics. All counties exceed state and national benchmarks for the percentage of adults who report binge drinking, and in all counties, the rate of alcohol-related hospitalizations far outpaces the rate for other reported substances.





Source: Centers for Disease Control and Prevention
Note: Montour County suicide death data are not reported due to low counts.



Source: Centers for Disease Control and Prevention
Note: Data are not reported for Montour, Snyder, and Union counties due to low counts.

Recommendations to Improve Health

Community representatives were engaged throughout the CHNA to reflect on health and social needs for the region and offer recommendations for improvement. These conversations were anchored in building on identified community strengths, including access to healthcare, good schools, and safe neighborhoods. These strengths can be drawn upon to improve the quality of life for all people in the Central Region.

Key Stakeholder Survey respondents and Community Forum participants shared feedback on what the community can do differently to address health and social concerns, better serve community members,

and facilitate cross-sector collaboration. Consistent themes included addressing SDoH barriers, efforts to increase the capacity and quality of healthcare and social service providers, and improved community partnerships to collectively affect health. Select feedback and verbatim comments by representatives are included below, grouped by overarching theme.

Health Improvement Themes and Supporting Feedback by Community Representatives

Themes	Verbatim Comments by Community Representatives
Support multi-sector collaboration for better communication and non-competitive partnership, and to affect policy and funding	*"Work more collaboratively with nonprofits and agencies whose missions align with solving these challenges. Move beyond ownership to a greater good model. Too much competition over limited resources and with the excuse of we are doing it for the greater good."* *"Continuum of care and referrals to partnering organizations. Collaborative funding applications to address systemic issues."*
Go beyond addressing the immediate need, invest in upstream factors	*"The partnership at the Miller Center is a prime example of successful efforts to address Social Drivers of Health by collaborating on healthy food initiatives to ensure no one goes hungry."*
Bring services to the community, integrate/co-locate where residents naturally frequent	*"Bring health and wellness programs into the communities via church groups, schools and community centers to offer help in a neutral space – not clinic/doctor office."*
Address cultural biases with staff training	*"Relate to a variety of ethnic and cultural differences; provide public health screenings targeted to minorities, immigrants and refugees; help people navigate difficult and confusing public systems to qualify for assistance and healthcare; get out into the community – community health workers."* *"Keep resource lists for LGBTQ+ people of all ages, and their families and keep them updated. Make it easy for people to search and find gender affirmative care. Work with LGBTQ+ groups, family groups such as PFLAG and Trans Central PA. Make medical record gender affirming."*
Invest in supports for those historically placed at risk (youth, seniors, ALICE, etc.)	*"Poverty is a cycle. Many of the young people I work with come from poverty and are desperately trying to get out. The odds are usually against them. Many lack family stability and support at home, especially when it comes to education. Without proper education, participants are left working entry-level jobs, struggling to make ends meet, and relying on assistance programs in order to survive; therefore, making it extremely difficult to end the cycle of poverty."* *"Support and employ more support staff positions – health navigators, CHWs, etc. who can bridge the gaps between those in need and the healthcare and social services providers."*

Approval and Adoption of CHNA

The 2024 CHNA was conducted in a timeline to comply with IRS Tax Code 501(r) requirements to conduct a CHNA and develop a corresponding Community Health Improvement Plan (CHIP) every three years as set forth by the Affordable Care Act (ACA). The research findings and plan will be used to guide community benefit initiatives for Evangelical Community Hospital and engage local partners to collectively address identified health needs.

Evangelical Community Hospital is committed to advancing initiatives and community collaboration to support the issues identified through the CHNA. The 2024 CHNA report was presented to the Board of Directors and approved in March 2024.

Following the Board's approval, the CHNA report was made available to the public via the hospital's website at https://www.evanhospital.com/HealthNeedsAssessment/.

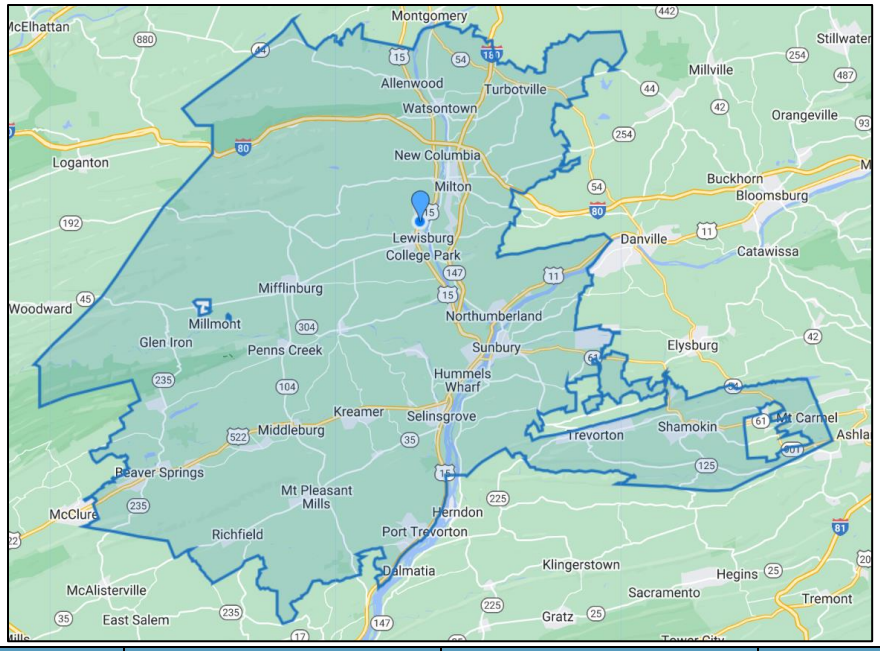
A full summary of CHNA data findings for the Central Region and Evangelical Community Hospital service area, with state and national comparisons, follows.

Evangelical Community Hospital Service Area

Evangelical Community Hospital (Evangelical) is located in Lewisburg, Union County. The Borough of Lewisburg is a hub of cultural and economic vitality in the heart of Central Pennsylvania's beautiful Susquehanna River Valley. Home of Bucknell University and many of the area's leading businesses and organizations, Lewisburg continues to serve as one of the region's brightest spots. The downtown, listed on the National Register of Historic Places, offers a unique Art Deco theatre, the Lewisburg Children's Museum, and many unique restaurants and boutiques. Lewisburg is the primary commercial center of the area, with the greatest density of persons anywhere in Union County.

Evangelical primarily serves residents of Union County and surrounding communities in Northumberland and Snyder counties. For the purposes of the 2024 CHNA, Evangelical defined its service area as 39 zip codes, primarily within the Central Region. The service area was identified based on the patient zip codes of origin comprising 80% or more of hospital discharges in 2021.

Evangelical Community Hospital Service Area Map and Zip Codes



Juniata County	Northumberland County	Snyder County	Union County
17086, Richfield	17730, Dewart 17749, McEwensville 17772, Turbotville 17777, Watsontown 17801, Sunbury 17847, Milton 17850, Montandon 17851, Mount Carmel 17857, Northumberland 17865, Pottsgrove 17866, Coal Township 17872, Shamokin 17881, Trevorton	17812, Beaver Springs 17813, Beavertown 17827, Freeburg 17831, Hummels Wharf 17833, Kreamer 17842, Middleburg 17843, Beaver Springs 17853, Mount Pleasant Mills 17861, Paxtonville 17862, Penns Creek 17864, Port Trevorton 17870, Selinsgrove 17876, Shamokin Dam	17810, Allenwood 17835, Laurelton 17837, Lewisburg 17844, Mifflinburg 17845, Millmont 17855, New Berlin 17856, New Columbia 17883, Vicksburg 17885, Weikert 17886, West Milton 17887, White Deer 17889, Winfield

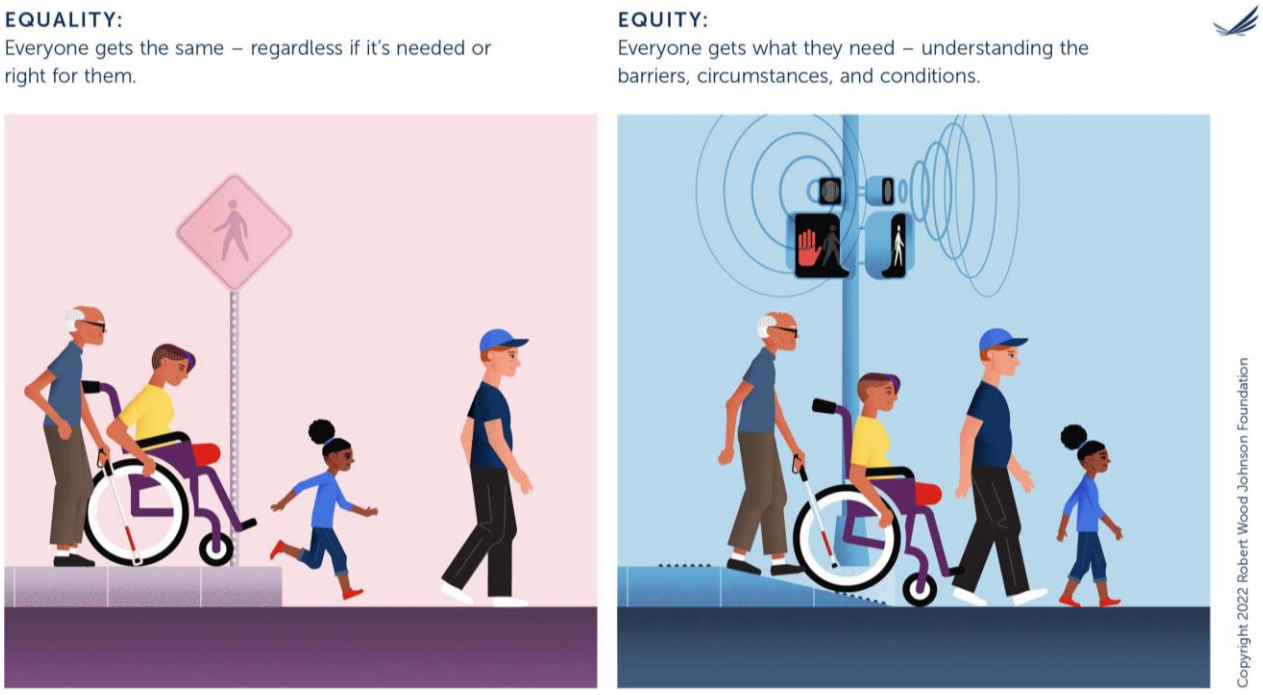
Social Drivers of Health and Health Equity:

Where we live impacts the choices available to us

Social drivers of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health risks and outcomes. Healthy People 2030, the nation's benchmark for health, recognizes SDoH as central to its framework, naming "social and physical environments that promote good health for all" as one of the four overarching goals for the decade. Healthy People 2030 outlines five key areas of SDoH: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.

While health improvement efforts have historically targeted health behaviors and clinical care, public health agencies, including the CDC, widely hold that **at least 50% of a person's health profile is influenced by SDoH**.

Addressing SDoH is a primary approach to achieving *health equity*. **Health equity can be simply defined as "a fair and just opportunity for every person to be as healthy as possible."** To achieve health equity, we need to look beyond the healthcare system to dismantle systematic inequities born through racism and discrimination like power and wealth distribution, education attainment, job opportunities, housing, and safe environments, to build a healthier community for all people now and in the future.

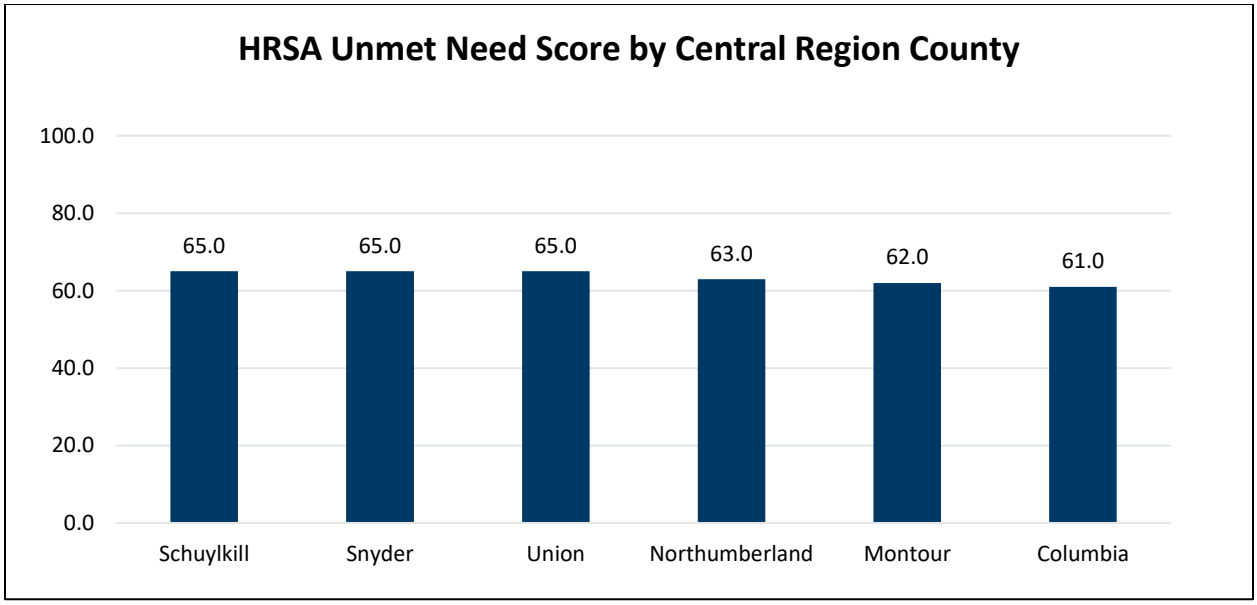


A host of indexes and tools are available to illustrate the potential for health disparities and inequities at the community-level based on SDoH. The following pages depict several available indexes and related data visualizations to show how well the Evangelical Community Hospital service area fares compared to state and national benchmarks. Additional information regarding the indexes is available in Appendix D.

Unmet Need Score and Social Vulnerability Index

The HRSA Unmet Need Score (UNS) is a zip code-level measure of access to primary and preventive healthcare services based on disparities in health status, as well as the upstream and downstream drivers that lead to health disparities. Scores are displayed on a scale from 0 (least unmet need) to 100 (most unmet need).

Central Region counties have similarly high UNS values of 61-65. This finding is reflective of both upstream social drivers of health like availability of care providers, educational attainment, and transportation, and downstream health outcomes like chronic disease prevalence and overall life expectancy. **While UNS values are similarly high across the region, residents of Northumberland and Schuylkill counties have lower overall life expectancy of 75-76 years, a 3–7-year difference from other counties in the region. This finding indicates additional health and social barriers affecting residents of these communities.**



Source: Health Resources and Services Administration

2018-2020 Life Expectancy by Race and Ethnicity

	Overall Life Expectancy	Asian	Black	White	Latinx Origin (any race)
Columbia	78.3	NA	NA	78.3	88.7
Montour	78.0	NA	NA	NA	NA
Northumberland	76.1	NA	72.2	76.2	78.8
Schuylkill	75.0	NA	71.8	74.7	104.7
Snyder	80.8	NA	NA	NA	NA
Union	82.1	NA	86.3	81.4	97.0
Pennsylvania	78.0	87.3	73.1	78.4	81.5

Source: National Vital Statistics System

Note: Latinx life expectancy has historically exceeded other racial and ethnic groups, a finding that has generally been hypothesized to be a result of genetic factors and better networks of social support and health habits.

The following table analyzes zip codes within the Central Region with an UNS of 75 or higher, indicating more unmet need. These zip codes are predominantly located in Northumberland and Schuylkill counties, although communities in Snyder and Union counties are also affected.

The communities of Mahanoy City, Girardville, and Shenandoah in Schuylkill County have UNS values exceeding 85 out of a maximum score of 100. Residents of these communities, as demonstrated throughout this report, experience more poverty, receive fewer preventive care services, and experience more negative health outcomes, creating an opportunity for targeted interventions.

2017-2021 Social Drivers of Health for Central Region Zip Codes with Unmet Need Score of >75 out of 100 in Descending Order by Unmet Need Score

Zip Code (County)	Population in Poverty	Children in Poverty	No High School Diploma	No Health Insurance	UNS Score
17948, Mahanoy City (Schuylkill)	27.9%	37.4%	10.8%	12.4%	95.7
17935, Girardville (Schuylkill)	26.1%	55.5%	15.8%	15.3%	87.7
17976, Shenandoah (Schuylkill)	29.1%	54.4%	15.8%	9.4%	86.7
17954, Minersville (Schuylkill)	24.3%	43.6%	12.0%	8.2%	83.4
17864, Port Trevorton (Snyder)	13.0%	23.3%	36.6%	39.9%	82.2
17810, Allenwood (Union)*	36.6%	46.6%	16.1%	34.5%	81.4
17813, Beavertown (Snyder)	11.8%	22.4%	12.9%	11.9%	81.2
17886, West Milton (Union)	49.4%	78.5%	12.4%	35.4%	79.8
17845, Millmont (Union)	16.3%	29.6%	23.1%	25.4%	79.6
17853, Mount Pleasant Mills (Snyder)	4.6%	8.9%	17.9%	13.5%	78.6
17851, Mount Carmel (Northumberland)	17.3%	35.6%	12.9%	3.9%	78.3
17872, Shamokin (Northumberland)	27.4%	46.4%	15.2%	3.6%	77.4
17964, Pitman (Schuylkill)	10.1%	10.5%	19.9%	14.5%	77.1
17901, Pottsville (Schuylkill)	15.9%	20.9%	9.9%	5.5%	76.9
17801, Sunbury (Northumberland)	13.4%	16.1%	9.5%	4.0%	76.5
17981, Tremont (Schuylkill)	9.5%	8.9%	14.9%	6.4%	75.7
17866, Coal Township (Northumberland)	10.6%	5.1%	15.4%	3.5%	75.1
Pennsylvania	11.8%	16.4%	8.6%	5.6%	NA

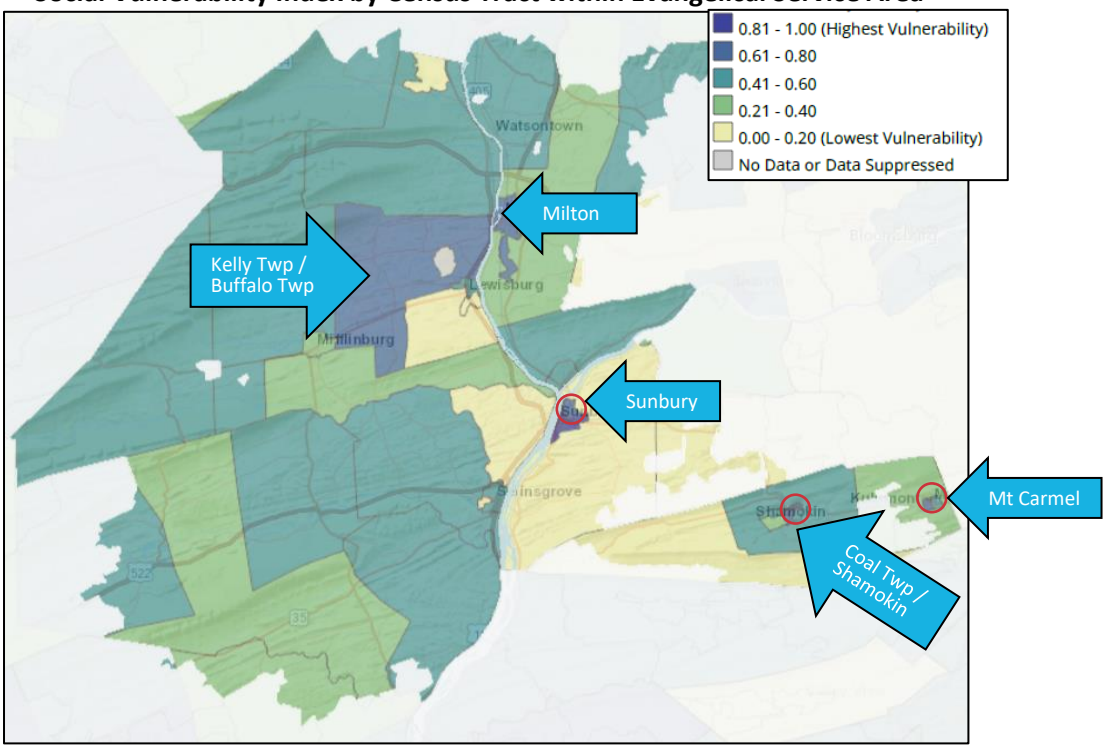
Source: US Census Bureau, American Community Survey

*Allenwood is home to a federal prison with an inmate population of nearly 3,000 people, impacting community-wide socioeconomic factors.

Social factors like economics, education, and access to healthcare can ultimately affect life expectancy. The following maps depict a census tract assessment of social risk, based on the Social Vulnerability Index (SVI), and average life expectancy for the Evangelical primary service area.

Evangelical primarily serves Northumberland, Snyder, and Union counties. **Areas of social vulnerability within the Evangelical primary service area are concentrated in Northumberland County, including Coal Township, Milton, Mount Carmel, Shamokin, and Sunbury. Residents in many of these communities may experience significant health disparities, including average life expectancy of 72 years or less, as much as a 10-year difference compared to surrounding communities.**

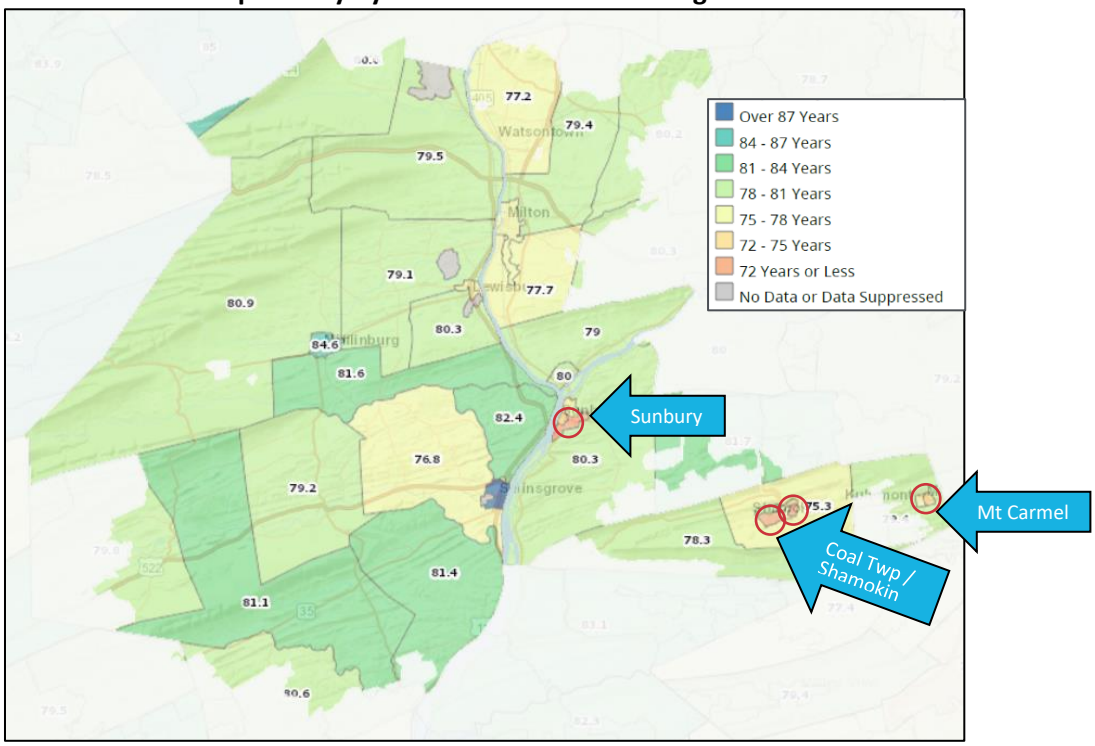
Social Vulnerability Index by Census Tract within Evangelical Service Area*



Source: Centers for Disease Control and Prevention & Center for Applied Research and Engagement Systems

*Highlighted areas have a SVI value of 0.61 or higher.

2010-2015 Life Expectancy by Census Tract within Evangelical Service Area*



Source: Centers for Disease Control and Prevention & Center for Applied Research and Engagement Systems

*Highlighted areas have an average life expectancy of 72 years or less.

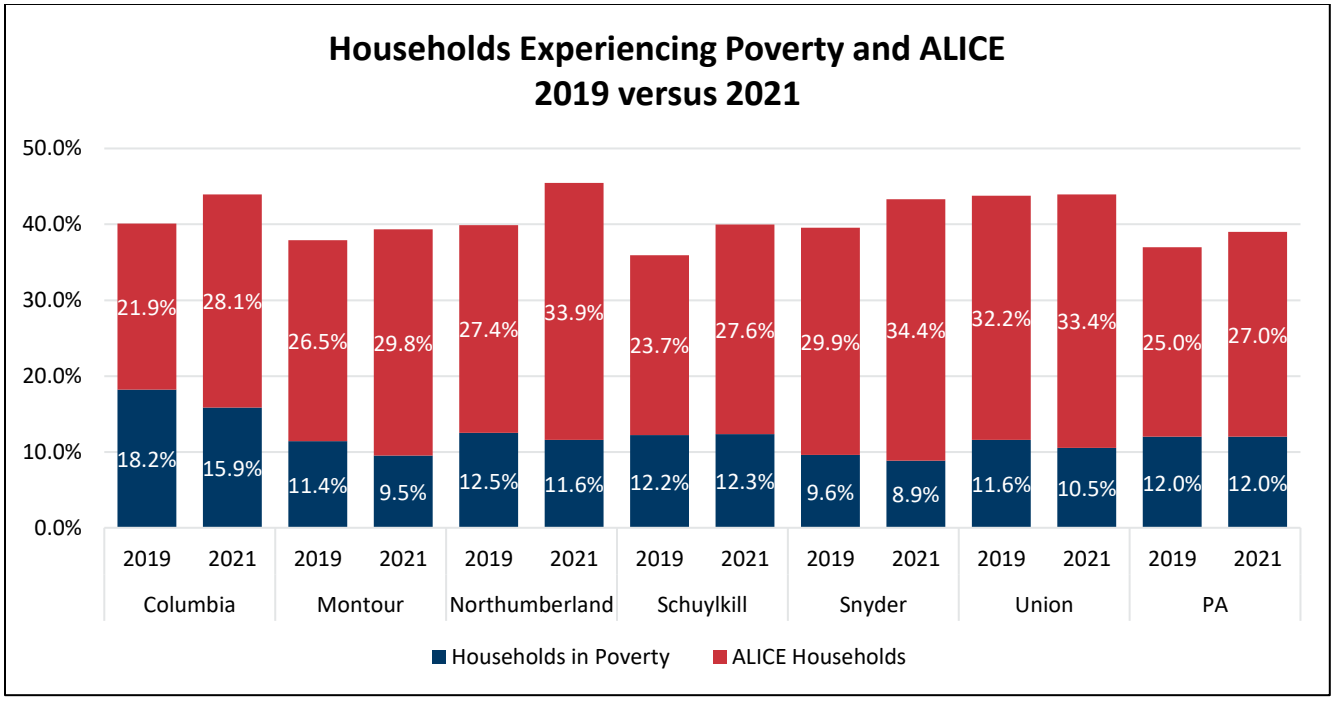
Asset Limited Income Constrained Employed (ALICE)

The ALICE index captures the percent of households whose income is above the federal poverty level, but below the threshold necessary to meet all basic needs based on localized cost of living and average household sizes. ALICE measures the proportion of households who struggle to meet basic needs and are a paycheck or two away from acute financial strife.

Across Central Region counties in 2021, at least one-quarter of households were ALICE. **In Northumberland, Snyder, and Union counties, more than one-third of households were ALICE; when combined with households living in poverty, nearly half of all households in these counties may have experienced financial hardship.**

Pre- and post-COVID-19 pandemic trends in ALICE and poverty data demonstrate that while people have returned to work, many still do not have enough money to meet their basic needs, or to do so without the fear of an unexpected expense, such as a car repair.

The percentage of people in the region experiencing poverty continued to slowly decrease, but ALICE households increased, as people's personal financial statuses experienced little change, or returned to pre-pandemic statuses, but the world around them grew more expensive. **In Columbia and Northumberland counties, the proportion of ALICE households increased more than 6 percentage points from 2019 to 2021.** People's *experience* of financial hardship feels more acute than ever.



Source: United for ALICE

A full summary of demographic, socioeconomic, and health indicators for Central Region communities follows.

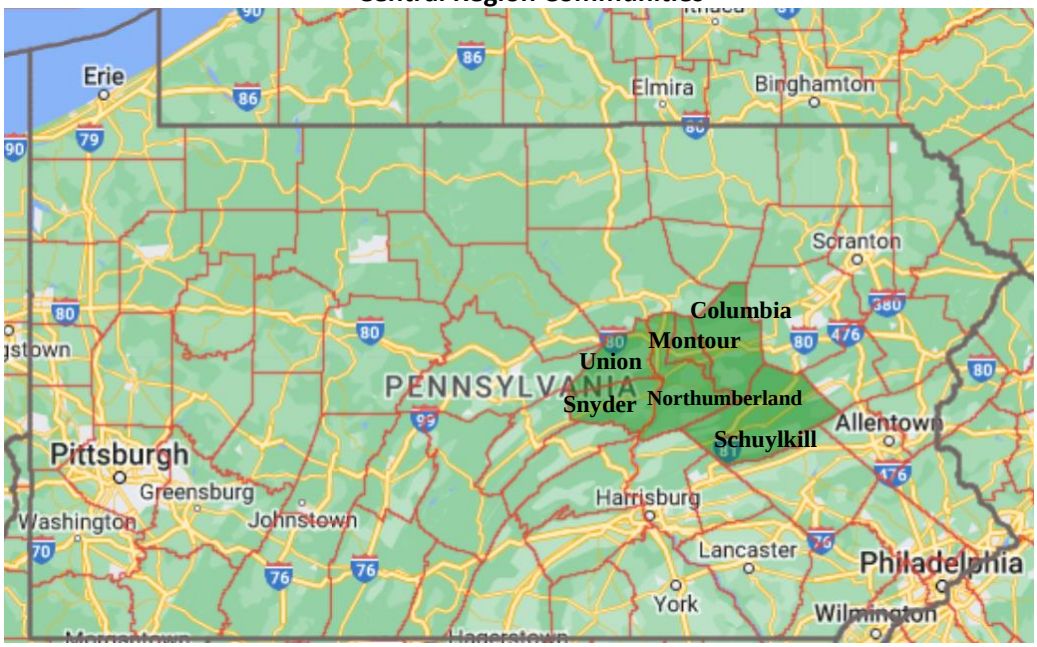
Demographics: Who Lives in the Central Region?

Our Community and Residents

Consistent with Pennsylvania overall, the Central Region is aging, with a significant increase in the number of older adults from 2010 to 2021 in all counties. In contrast, the youth population declined across all counties by an average of approximately 7% from 2010 to 2021. Montour and Snyder counties were the only counties to see population growth, although growth was modest at an estimated <2%.

Montour, Northumberland, and Schuylkill are among the oldest counties in the region; approximately one in five residents are aged 65 or older and median ages are nearly three years older than the state median. **It is worth noting that the population of residents aged 65 or older outpaces the national estimate of 16% in nearly all zip codes across the region.**

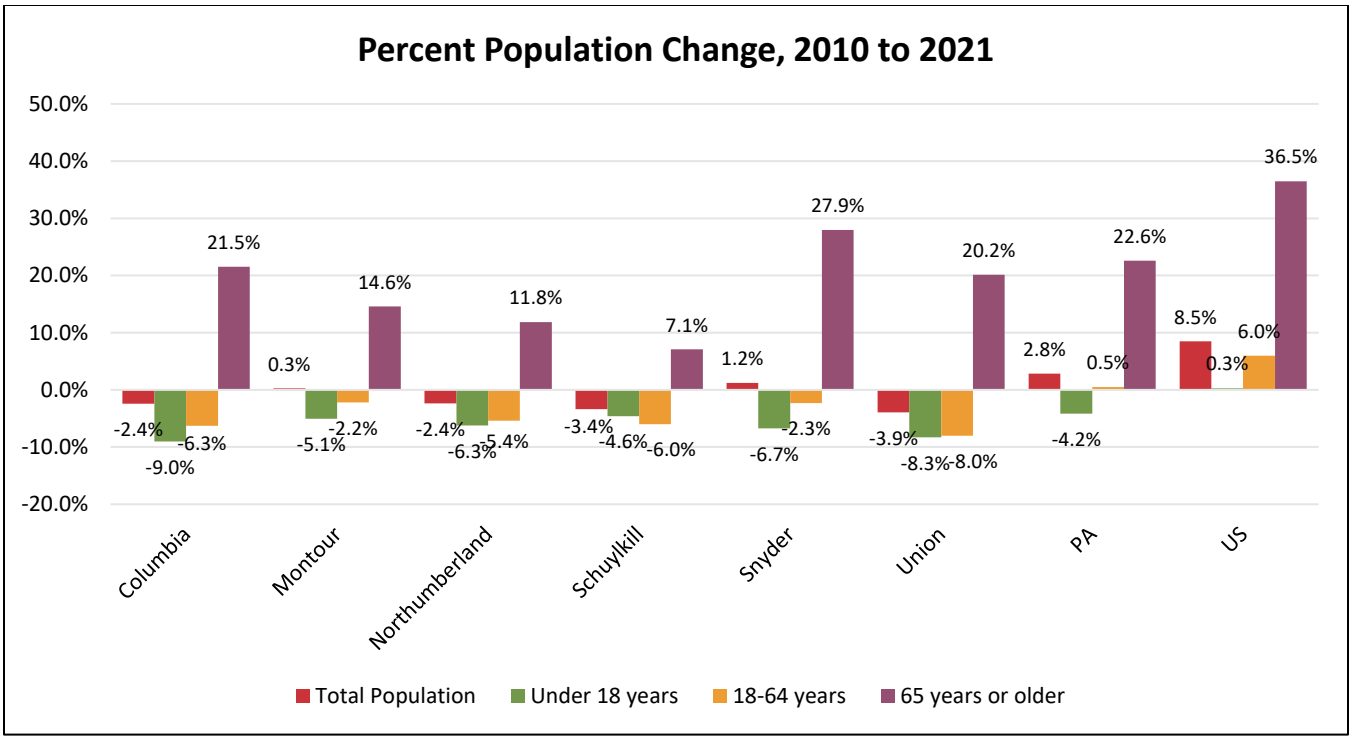
Central Region Communities



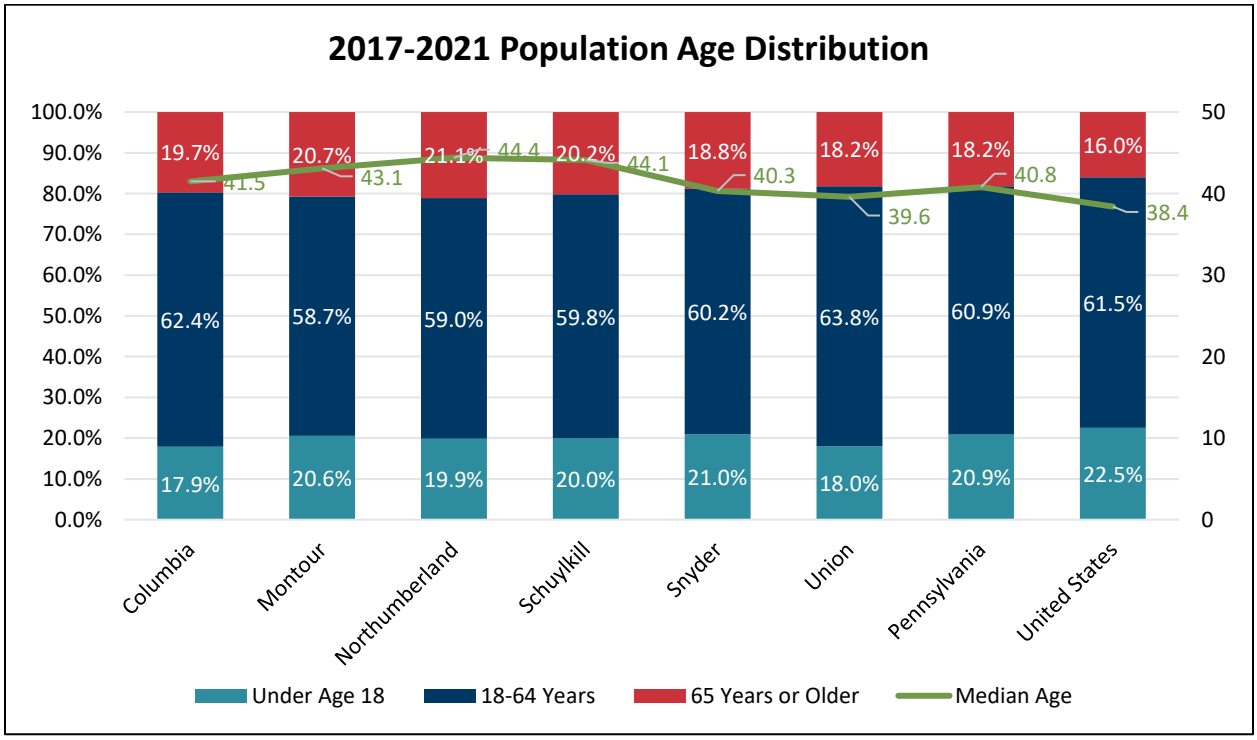
2017-2021 Total Population

	Total Population
Columbia	65,013
Montour	18,198
Northumberland	91,853
Schuylkill	143,308
Snyder	39,877
Union	43,094
Pennsylvania	12,970,650
United States	329,725,481

Source: US Census Bureau, American Community Survey

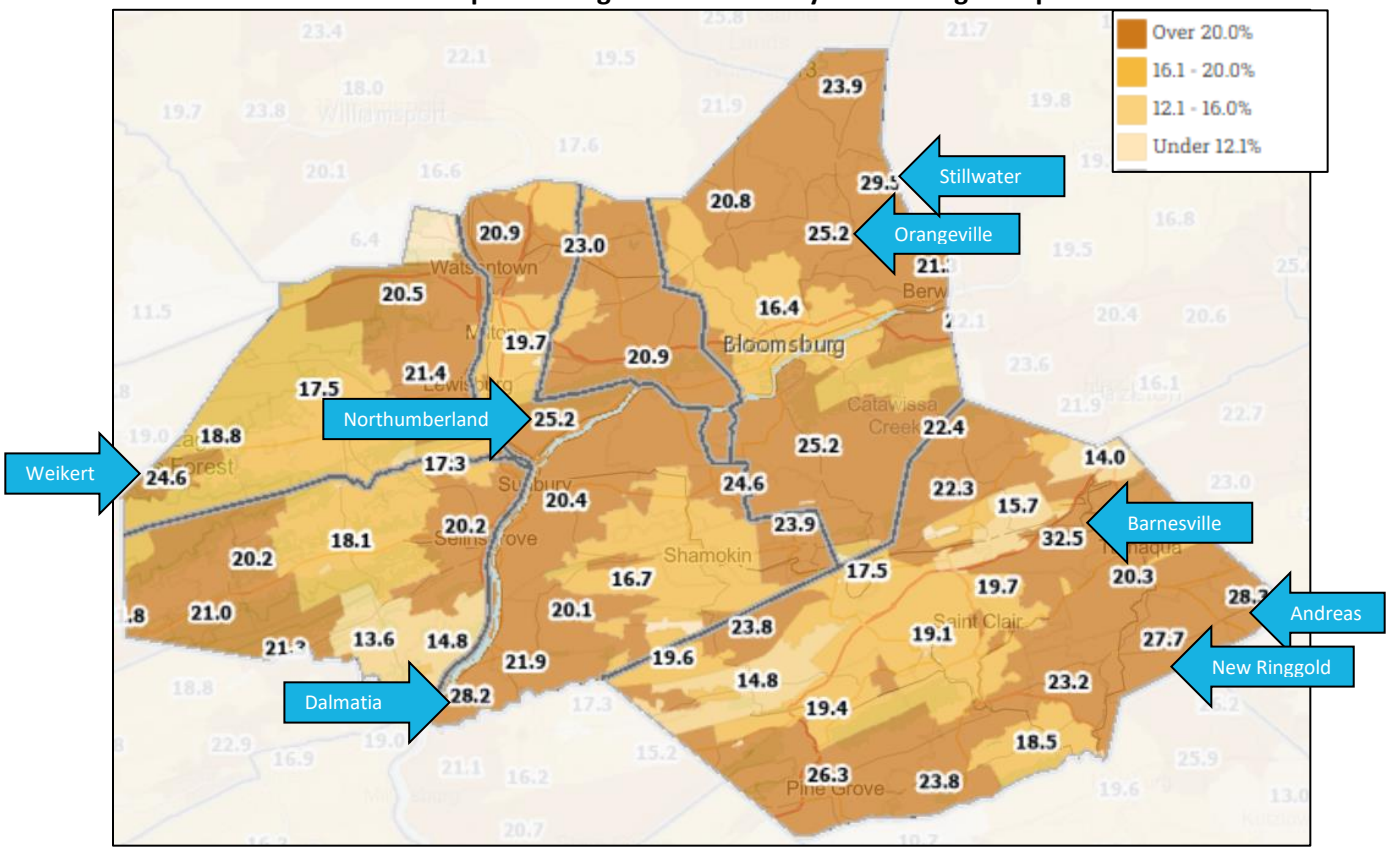


Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

2017-2021 Population Aged 65 or Older by Central Region Zip Code



Source: US Census Bureau, American Community Survey & Center for Applied Research and Engagement Systems

Central Region counties are majority white communities with less racial diversity than state and national benchmarks. Union County benefits from the most population diversity with 13% of residents identifying with a race other than white and 6% identifying as Latinx (any race).

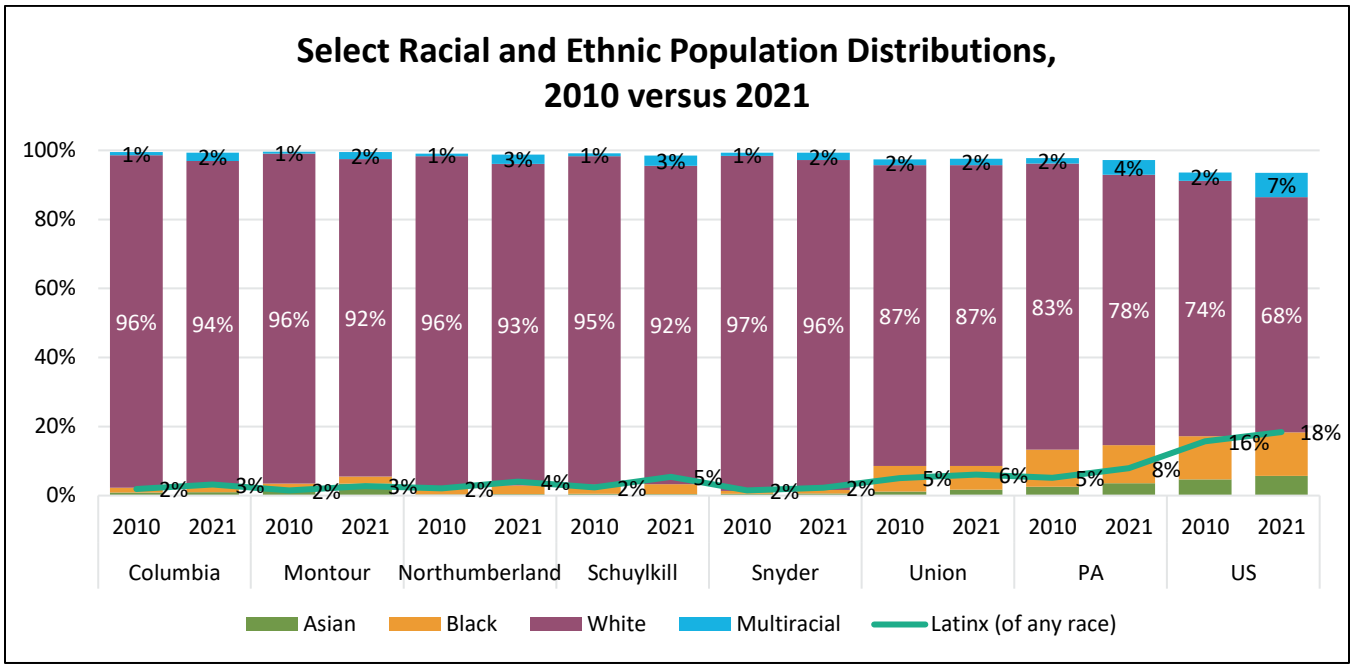
Union County is home to federal prisons in Allenwood and Lewisburg with an estimated inmate population of nearly 4,000 people. Population diversity and socioeconomic disparities between racial groups in Union County reflect, in part, deeper institutional inequities. Available data provided by The Sentencing Project reveal that Black Americans are imprisoned at a rate that is roughly five times the rate of white Americans. Latinx individuals are incarcerated in state prisons at a rate that is 1.3 times the incarceration rate of whites.

Consistent with state and national trends, population diversity is increasing within the region, though only marginally. Montour County experienced a four-percentage point decline in the white population from 2010 to 2021, the largest of any county in the region.

2017-2021 Population by Race and Ethnicity

	American Indian / Alaska Native	Asian	Black or African American	Native Hawaiian / Pacific Islander	White	Other Race	Two or More Races	Latinx Origin (any race)
Columbia	0.0%	1.0%	1.7%	0.3%	94.2%	0.4%	2.4%	3.2%
Montour	0.1%	3.5%	2.0%	0.0%	92.0%	0.4%	2.0%	2.7%
Northumberland	0.1%	0.4%	2.5%	0.0%	93.2%	1.2%	2.7%	4.0%
Schuylkill	0.1%	0.4%	2.9%	0.0%	92.2%	1.2%	3.0%	5.4%
Snyder	0.0%	0.6%	1.0%	0.0%	95.6%	0.7%	2.1%	2.3%
Union	0.3%	1.7%	6.9%	0.0%	87.1%	2.1%	1.9%	6.1%
Pennsylvania	0.2%	3.6%	11.0%	0.0%	78.3%	2.7%	4.3%	7.9%
United States	0.8%	5.7%	12.6%	0.2%	68.2%	5.6%	7.0%	18.4%

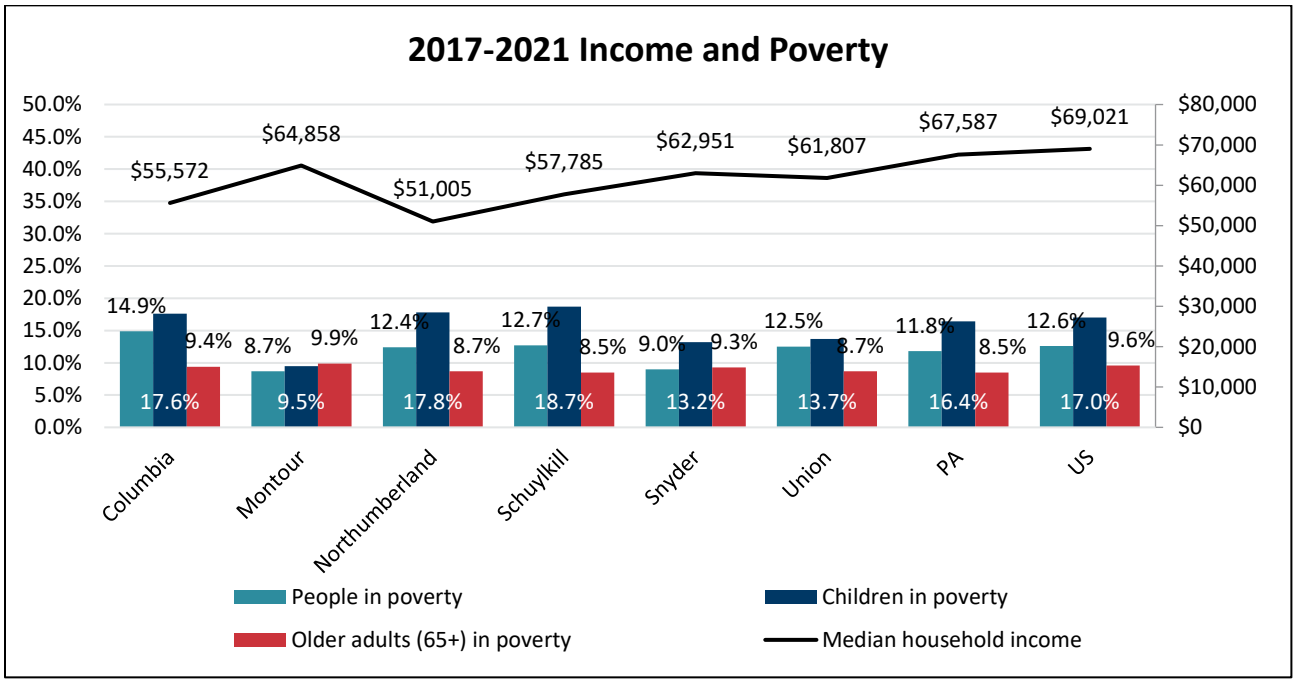
Source: US Census Bureau, American Community Survey



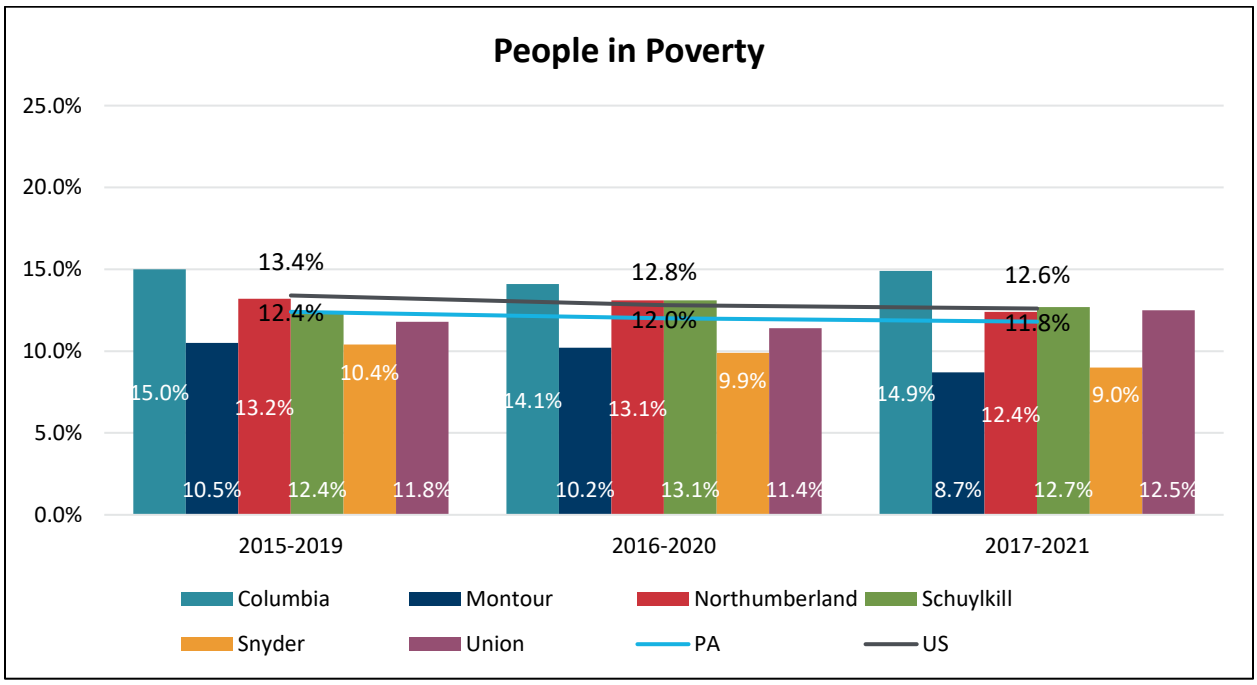
Source: US Census Bureau, American Community Survey

Income and Work

All Central Region counties have lower median household incomes than state and national medians, although county-wide poverty levels are only elevated in Columbia (15% compared to 12% and 13% respectively). **Columbia and Schuylkill counties have the highest percentages of children in poverty, outpacing the state and the nation, at 18% and 19% respectively.**

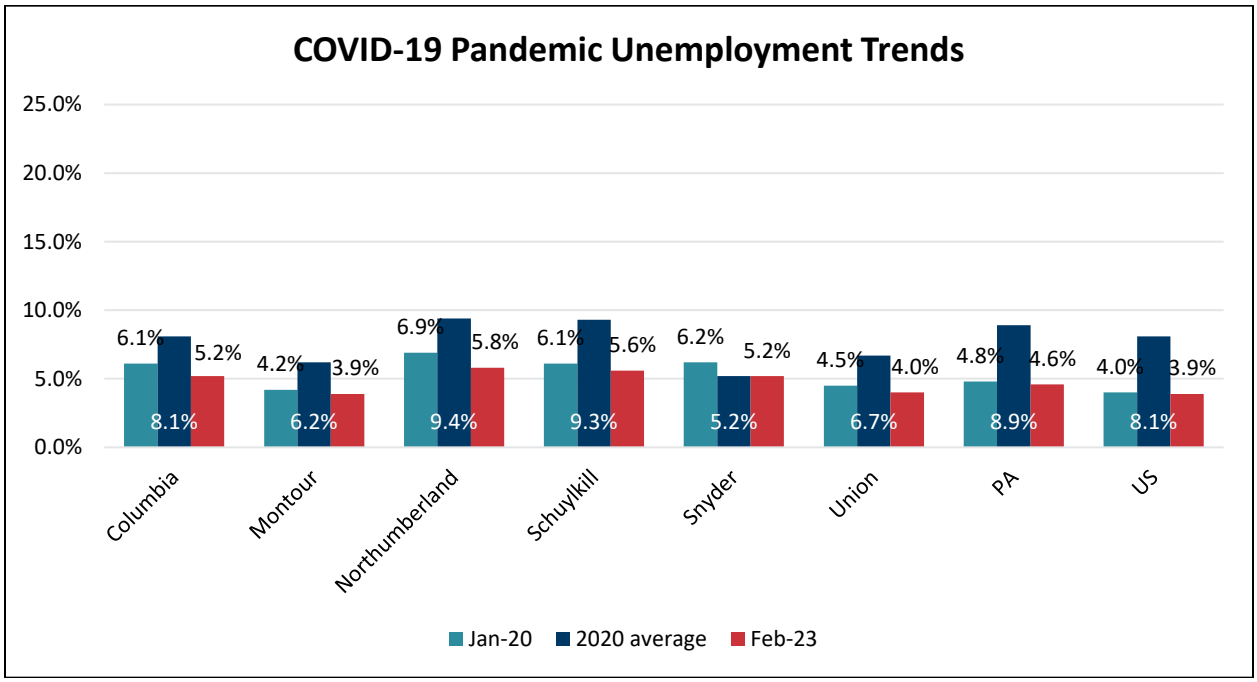


Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

Overall, despite a dramatic uptick in unemployment rates at the height of the COVID-19 pandemic, unemployment rates are down, lower even than pre-pandemic levels in most places. **However, reports of financial hardship remain. ALICE and poverty data demonstrate that although people are working, many still do not have enough money to meet their basic needs, or to do so without the fear of an unexpected expense.** The percentage of people in the region experiencing poverty continued a slow, downward trend, but ALICE households have increased, as depicted in earlier report sections.

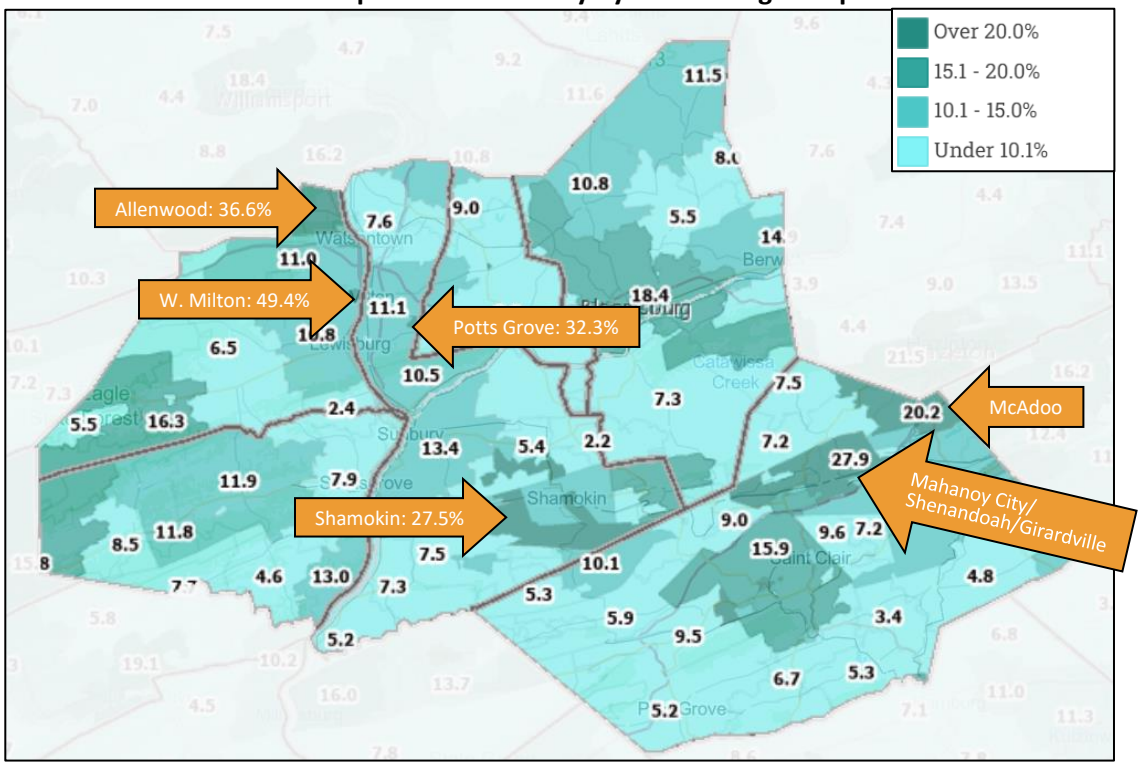


Source: US Bureau of Labor Statistics

When analyzed by zip code, pockets of high poverty are largely seen within Northumberland and Schuylkill counties. **Children are historically disproportionately affected by poverty, and within communities including Shamokin, Mount Carmel, Mahanoy City, Minersville, Shenandoah, and Girardville, approximately one-third to nearly half of children live in poverty. In Washingtonville and West Milton, three-quarters of children live in poverty.**

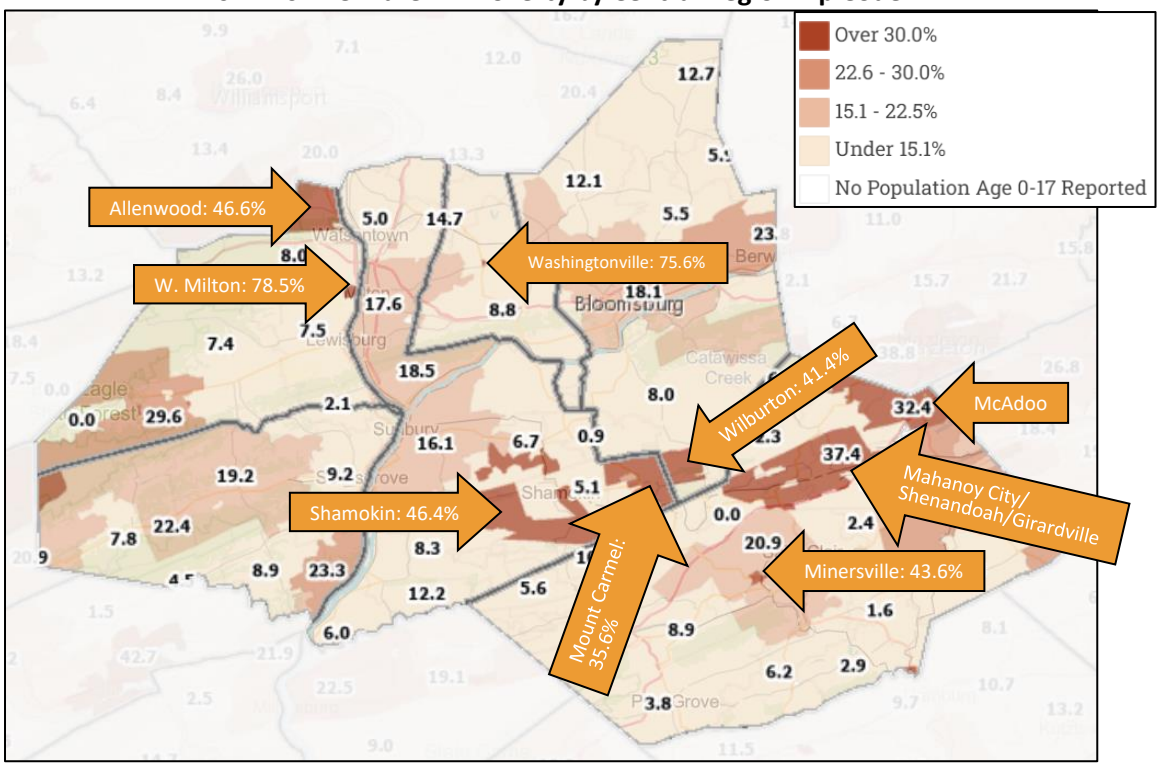
Poverty is not experienced by every community equally and contributes to further inequalities such as access to safe living and working conditions, health services, and basic needs, among other things. Union County has the most significant socioeconomic disparities between racial groups; only 10% of white residents live in poverty compared to 42% of Black residents and a staggering 78% of Latinx residents. This disparity reflects, in part, the inmate population at the Lewisburg Penitentiary.

2017-2021 Population in Poverty by Central Region Zip Code



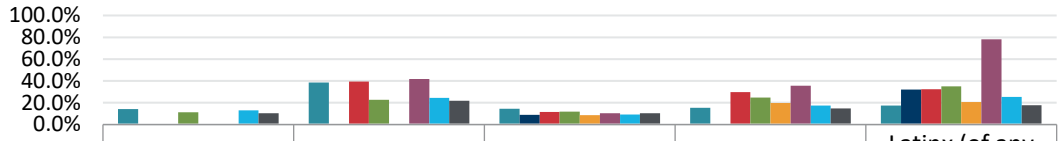
Source: US Census Bureau, American Community Survey & Center for Applied Research and Engagement System

2017-2021 Children in Poverty by Central Region Zip Code



Source: US Census Bureau, American Community Survey & Center for Applied Research and Engagement Systems

2017-2021 Proportion of People within Select Racial and Ethnic Groups Who Live in Poverty

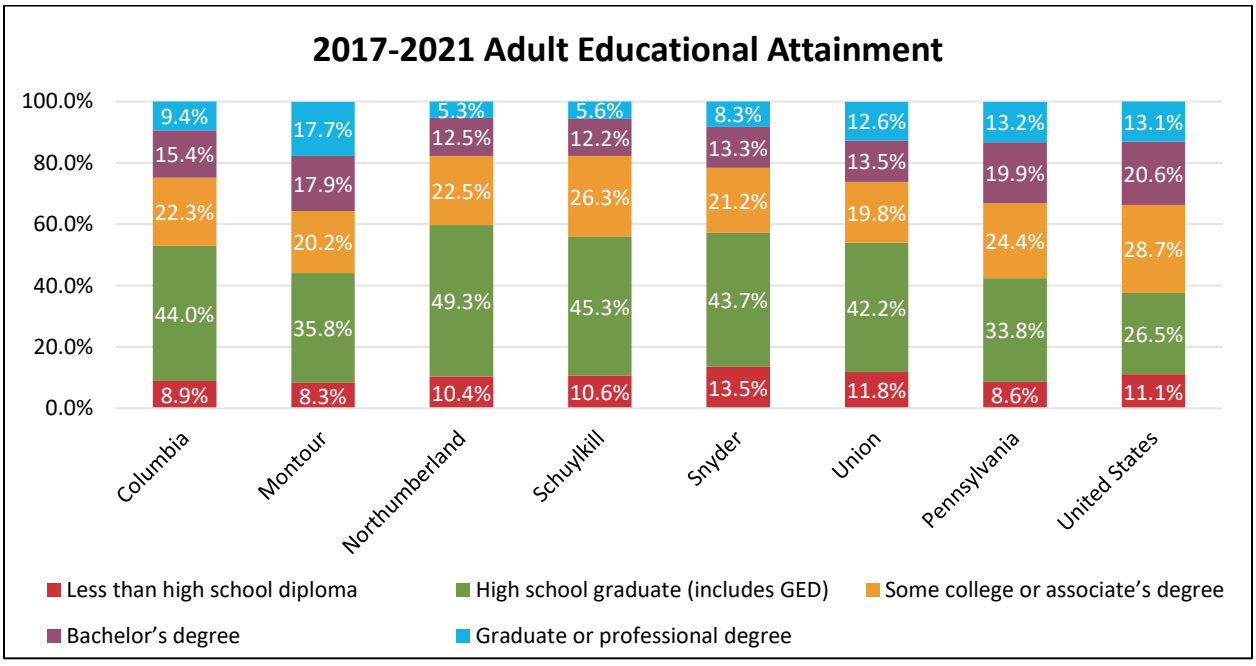


	Asian	Black	White	Multiracial	Latinx (of any race)
Columbia	14.1%	38.6%	14.6%	15.3%	17.3%
Montour			9.0%		32.1%
Northumberland		39.4%	11.5%	29.7%	32.3%
Schuylkill	11.2%	22.7%	11.8%	24.7%	35.0%
Snyder			8.7%	19.7%	20.7%
Union		41.8%	10.4%	35.5%	78.2%
PA	13.1%	24.6%	9.1%	17.4%	25.3%
US	10.3%	21.7%	10.3%	14.9%	17.7%

Source: US Census Bureau, American Community Survey
Note: Data for Central Region counties are shown as available. Percentages are masked for counts less than 50.

Education

High school graduation is one of the strongest predictors of longevity and economic stability. Within Central Region communities, approximately 89% of adults graduated high school, a slightly lower proportion than the state overall. Outside of Montour County, adults are generally less likely to pursue or attain higher education, such as a bachelor's or graduate degree.



Source: US Census Bureau, American Community Survey

Our Homes and Where We Live

Where you live impacts the choices available to you. These choices impact your income, wellness, and ultimately how long you live. When considered with lived experiences such as access to quality services like education and transportation, place-based choices may also inform perception of opportunities.

For neighborhoods, a higher proportion of homeownership means greater neighborhood stability. Greater neighborhood stability means more opportunities for investment in infrastructure, such as schools, roads, public transportation, and green spaces, key elements for healthy living. For families, homeownership is typically their largest asset. The security of knowing one has a home can also reduce chronic stress, a significant factor in developing chronic disease.

In general, Central Region residents are more likely to own their home when compared to state and national benchmarks. Homeownership increases in more rural communities.

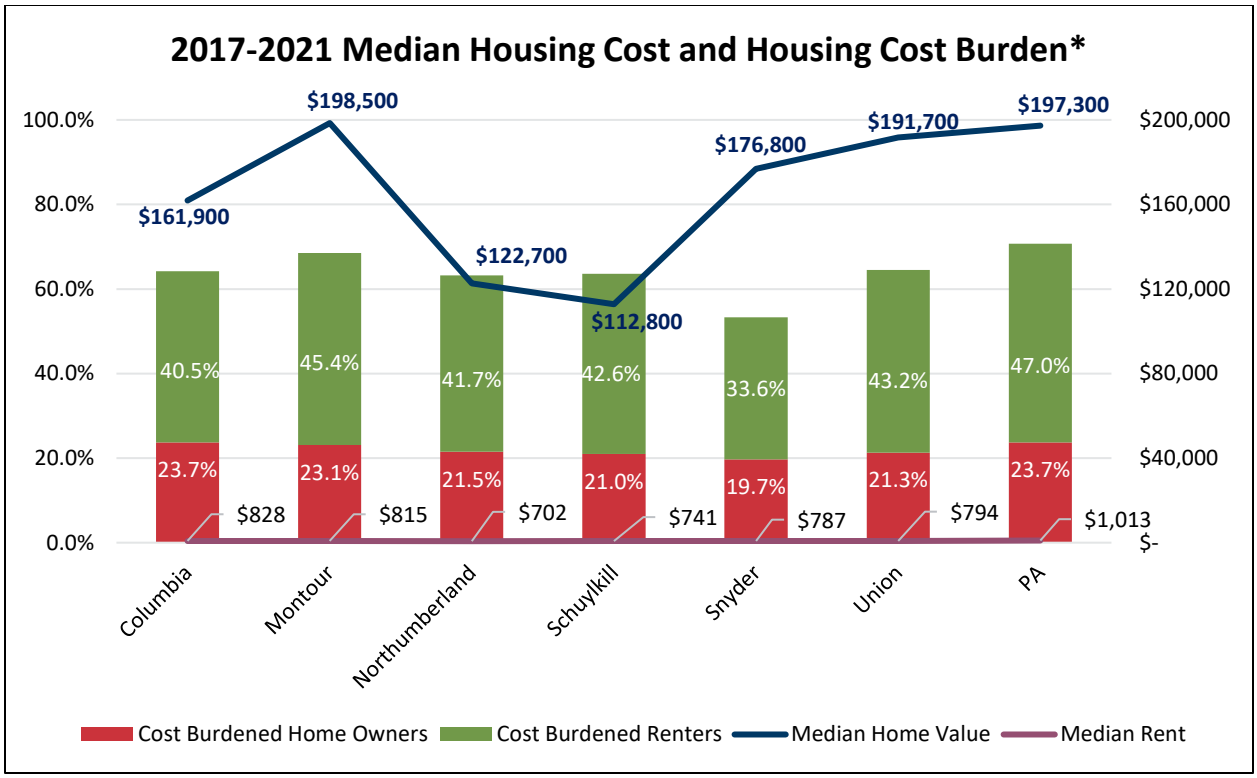
2017-2021 Housing Occupancy

	Owner Occupied Units	Renter Occupied Units
Columbia	70.3%	29.7%
Montour	67.9%	32.1%
Northumberland	72.7%	27.3%
Schuylkill	75.9%	24.1%
Snyder	74.9%	25.1%
Union	71.6%	28.4%
Pennsylvania	69.2%	30.8%
United States	64.6%	35.4%

Source: US Census Bureau, American Community Survey

Housing is often the largest single monthly expense for households and should represent no more than 30% of a household's monthly income. When households spend more than 30% of their income on housing, they are considered housing cost burdened and generally have fewer resources for other necessities like food, transportation, and childcare.

The graph below demonstrates that renters, who may already experience the stresses that accompany less stability as compared to homeowners, are also, on average, more cost-burdened than the homeowners in their communities. **Rental costs have ballooned across the country since COVID-19, leaving many to struggle to continue to afford their current rent, while also having less and less opportunity to save money to make future home ownership possible.** The Central Region is no exception to these trends. Schuylkill and Snyder counties have the highest percentage of homeowners and boast the lowest percentages of cost-burdened homeowners, meaning that housing costs are relatively affordable; however, approximately 20% of homeowners and one-third or more of renters in these counties *still* meet the criteria of being cost-burdened.



Source: US Census Bureau, American Community Survey

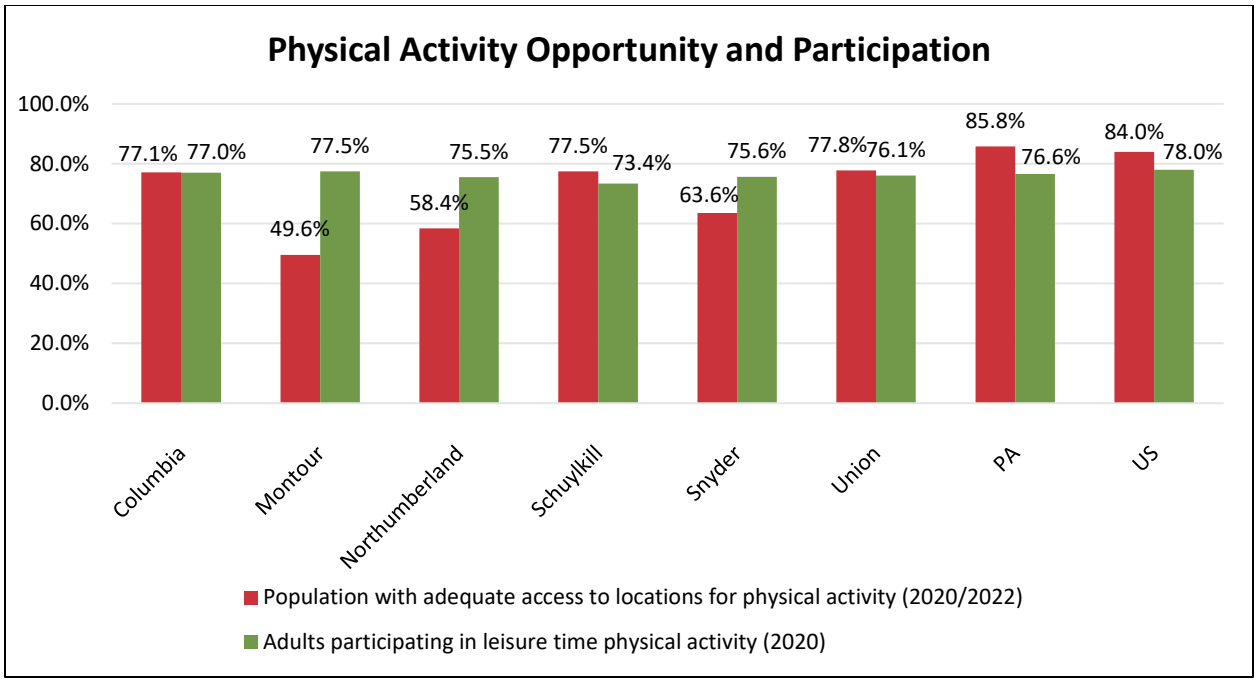
*Defined as spending 30% or more of household income on rent or mortgage expenses.

Neighborhood and Built Environment

In addition to the resources available in communities, the physical environment and infrastructure of neighborhoods impacts health. The availability of well-maintained roads and safe sidewalks, and access to recreation, stores, banks, and other amenities are important components for healthy living.

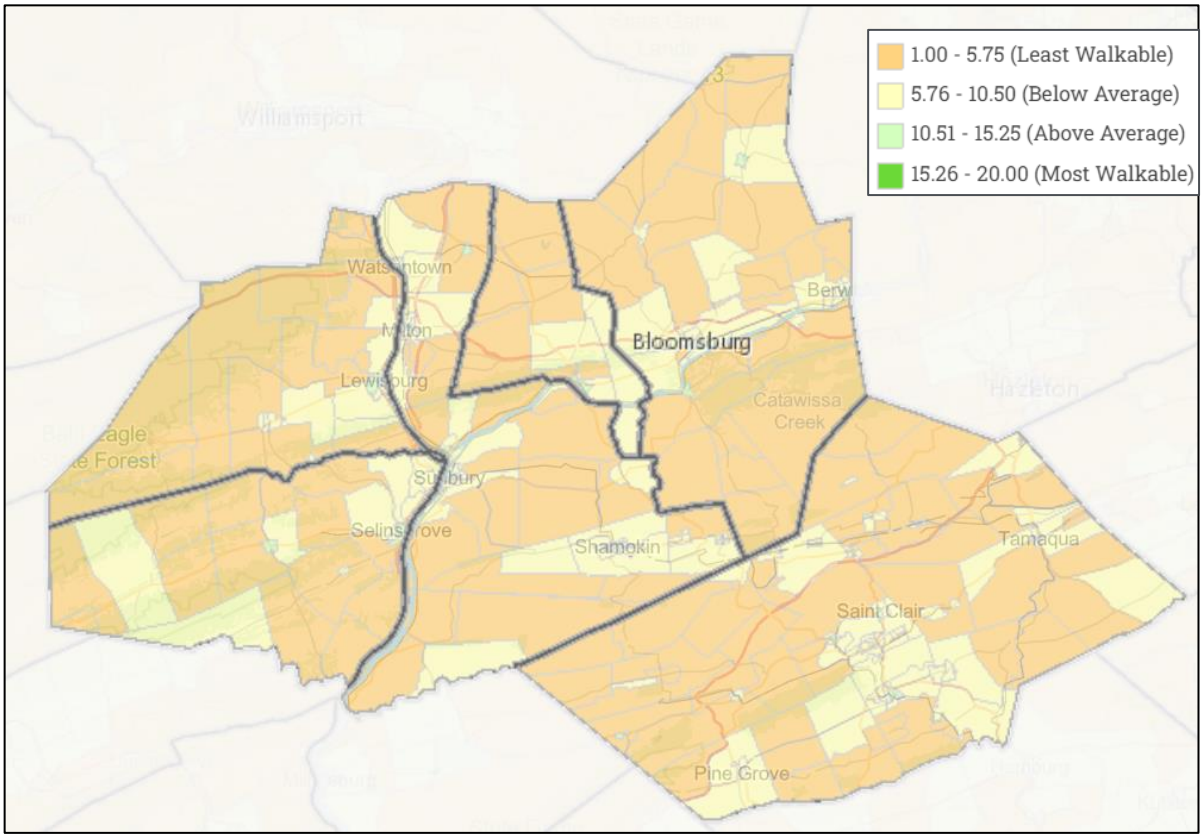
Feedback from Key Stakeholder Survey participants centered around the scarcity of reliable and affordable public transportation options available to residents. Combined with a region that is, on the whole, "below average" in its walkability rating, as well as a rapidly aging population, it can be difficult to access opportunities for physical activity. These factors make afternoon strolls or reaching public parks – activities that might otherwise be free of cost – challenging. Other opportunities to be active may cost money, creating an additional barrier to participation.

Despite these concerns, residents of the Central Region have demonstrated resilience in prioritizing physical activity. Montour, Northumberland, and Snyder counties are far below Columbia and Union counties, as well as the state and nation, in the percentage of the population with adequate access to locations for physical activity. Yet, in all three of these places, the percentage of adults who participate in leisure time physical activity is on par with their counterparts, and far outpaces what would be expected given the reported lack of access.



Source: ArcGIS Business Analyst and Living Atlas of the World; YMCA; US Census Bureau; & Centers for Disease Control and Prevention

2021 National Walkability Index by Central Region Census Block Group



Source: Environmental Protection Agency & Center for Applied Research and Engagement Systems

Food insecurity is defined as not having reliable access to a sufficient amount of nutritious, affordable food. Food insecurity is associated with both disparities in built environment, such as food deserts, and socioeconomic barriers, such as lower household income and poverty. Food insecurity can ultimately affect overall health status, contributing to a higher prevalence of disease and poorer disease outcomes.

In 2020, Feeding America conservatively projected a 36% growth in national food insecurity rates as a result of the pandemic. Similar to poverty and unemployment trends, food insecurity declined post-pandemic, continuing an overall downward trend, but the impact of this experience on long-term health outcomes should continue to be monitored.

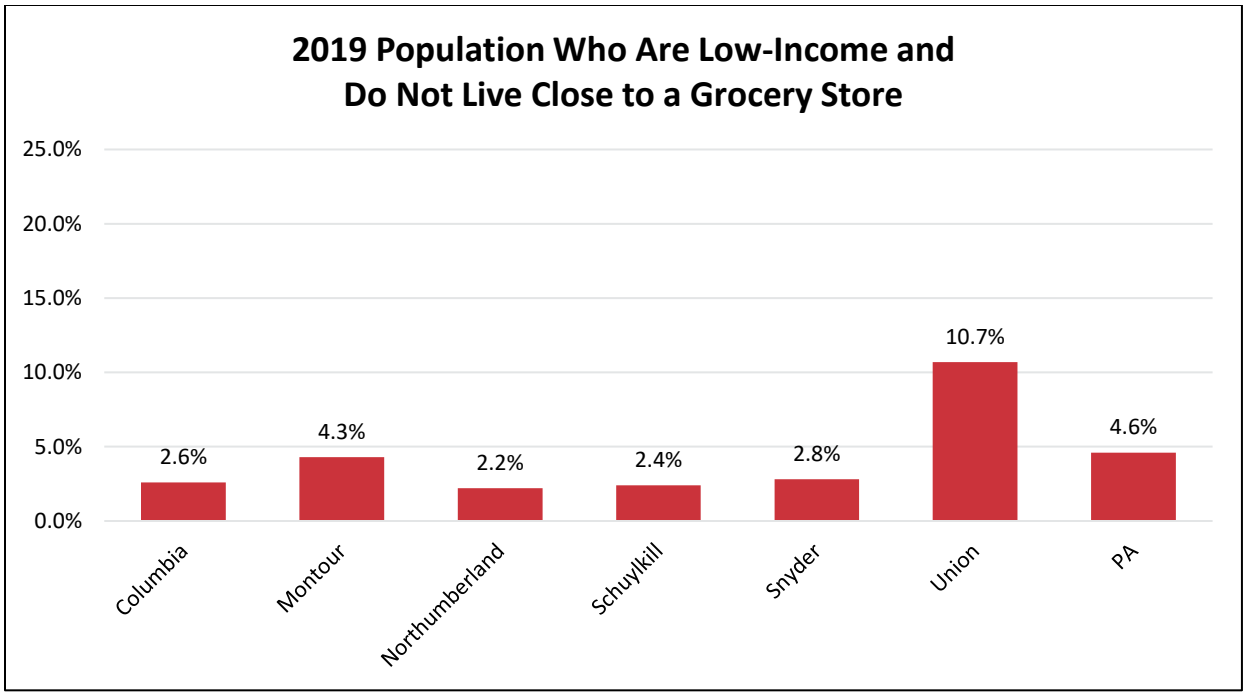
Across the Central Region in 2021, approximately 1 in 10 residents were estimated to be food insecure. **The percentage of children who experience food insecurity outpaces that for adults, but the percentage of children experiencing food insecurity declined *more rapidly* in recent years than the percentage of all residents.** This finding offers the hopeful implication that children are being reached even more with the services they need. Efforts to reach residents may have been helped by the pandemic experience, which increased recognition of people's widespread struggles to meet basic needs and increased availability and awareness of resources to meet those needs.

It is worth noting disparities among individuals with low income living in Union County. **Union County overall has a similar proportion of residents living in poverty and/or experiencing food insecurity as neighboring communities, but approximately 11% of residents with low income do not live close to a grocery store, the highest proportion in the region.** Union County's rural status likely contributes to residents' – including low-income residents' – distance from grocery stores, compounding health and financial hardships. Note: Data for this indicator is provided by the US Department of Agriculture and identifies individuals who have both low income and live more than 1 mile (urban areas) or more than 10 miles (rural areas) from the nearest supermarket, supercenter, or large grocery store.

Food Insecurity

	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Food Insecure Residents								
2021	10.6%	8.3%	10.9%	11.0%	8.6%	8.9%	9.4%	10.4%
2020	11.3%	9.6%	12.4%	12.3%	9.9%	9.4%	8.9%	11.8%
2019	11.7%	10.5%	12.7%	12.0%	10.9%	10.1%	10.6%	10.9%
Food Insecure Children								
2021	11.4%	8.6%	13.4%	13.5%	9.3%	8.9%	12.2%	12.8%
2020	14.2%	12.5%	17.8%	17.4%	13.6%	11.4%	13.1%	16.1%
2019	15.6%	13.4%	17.7%	16.6%	15.4%	12.7%	14.7%	14.6%

Source: Feeding America & USDA Food Environment Atlas



Source: Health Resources and Services Administration

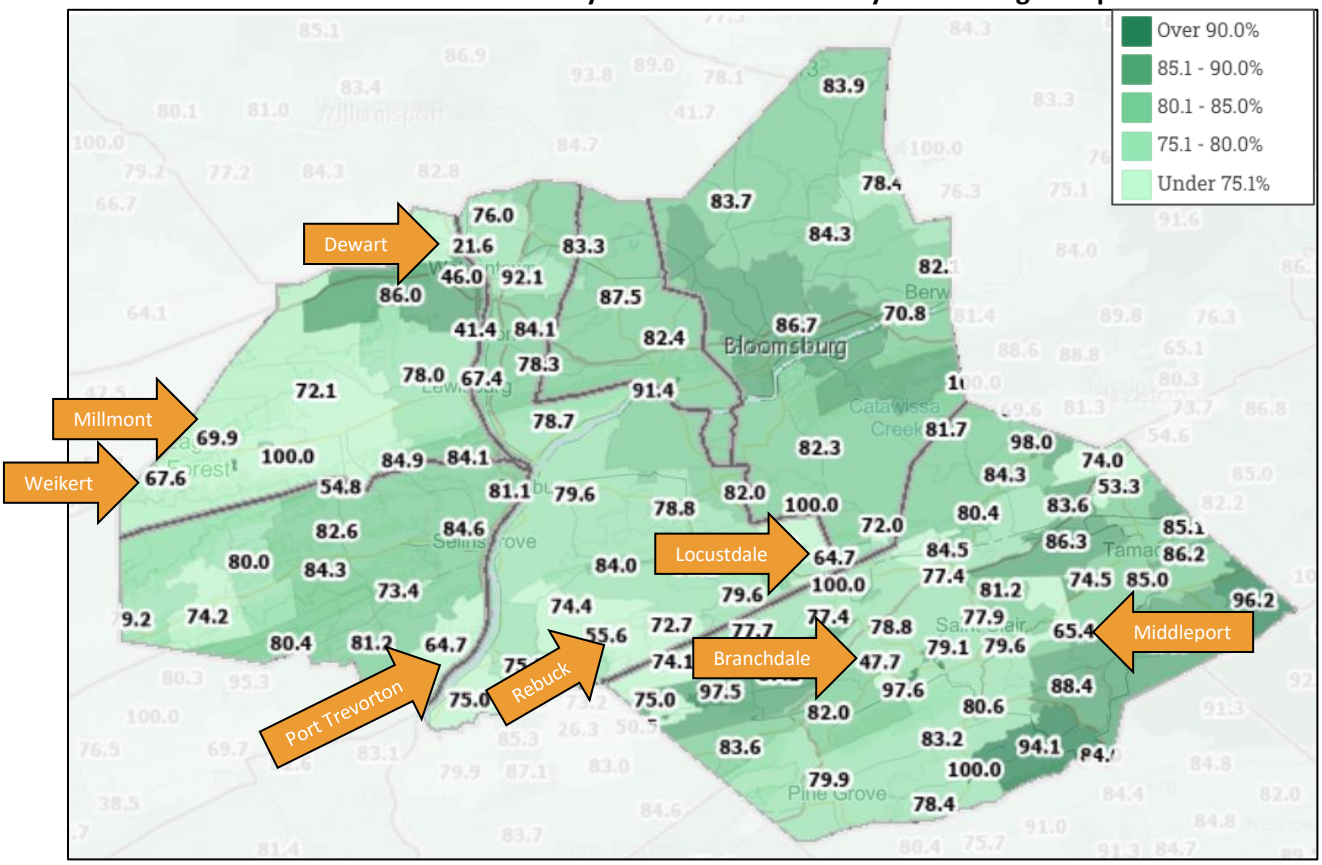
During the COVID-19 pandemic, we were able to use technology to bring services to people in their homes, but not uniformly. We need to bridge the wide digital divide within our communities to effectively reach all residents. Residents of the Central Region generally have slightly lower digital access as compared to state and national benchmarks. **However, deeper analysis reveals that in some smaller communities, highlighted on the map below, fewer than 65% of residents have reliable internet access.** In Dewart in Delaware Township, Northumberland County, *only 22%* of residents have reliable internet access.

2017-2021 Households by Digital Access

	With Computer Access			With Internet Access	
	Computer Device	Desktop / Laptop	Smartphone	Internet Subscription	Broadband Internet
Columbia	89.3%	73.2%	78.5%	84.1%	83.6%
Montour	86.3%	73.2%	77.6%	82.7%	82.3%
Northumberland	85.0%	68.0%	72.9%	80.1%	79.4%
Schuylkill	87.9%	72.3%	76.5%	82.2%	81.7%
Snyder	85.5%	73.6%	75.6%	81.3%	80.7%
Union	84.7%	72.9%	69.8%	76.9%	75.9%
Pennsylvania	90.9%	77.3%	82.0%	86.1%	85.8%
United States	93.1%	78.9%	86.5%	87.2%	87.0%

Source: US Census Bureau, American Community Survey

2017-2021 Households with any Broadband Internet by Central Region Zip Code



Source: US Census Bureau, American Community Survey & Center for Applied Research and Engagement Systems

The pandemic contributed to a nationwide shortage of childcare workers. A New York Times article published in October 2022 reported, "There are 100,000 fewer child-care workers than there were before the coronavirus pandemic, according to the Bureau of Labor Statistics." The shortage of workers has resulted in both fewer childcare options and higher costs for care.

Central to concerns around economic recovery for residents is the lack of *any* childcare options for children who are younger than school-aged (3.7 per 1,000 children under age 5 in Snyder County), as well as the prohibitive cost. **In Columbia County, residents with small children may spend one-third of their income on just childcare.**

Childcare Availability and Affordability

	Number of Childcare Centers per 1,000 Population Under 5 Years Old	Childcare Costs for a Household with Two Children as a Percent of Median Household Income
Columbia	6.0	33.7%
Montour	6.0	26.8%
Northumberland	4.1	26.8%
Schuylkill	5.2	27.0%
Snyder	3.7	22.2%
Union	4.1	20.7%
Pennsylvania	5.2	27.2%
United States	7.0	27.0%

Source: Homeland Infrastructure Foundation-Level Data, 2010-2022 & The Living Wage Calculator, Small Area Income and Poverty Estimates, 2022 & 2021

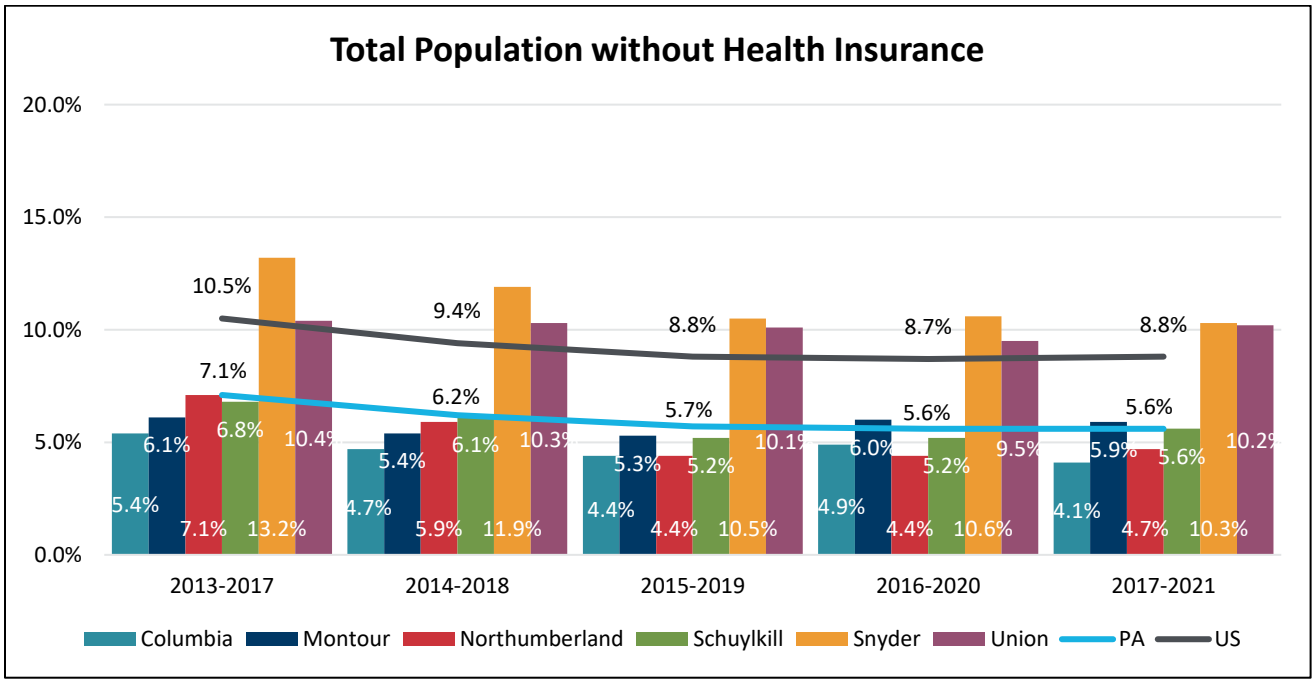
Our Health Status as a Community

Access to Care

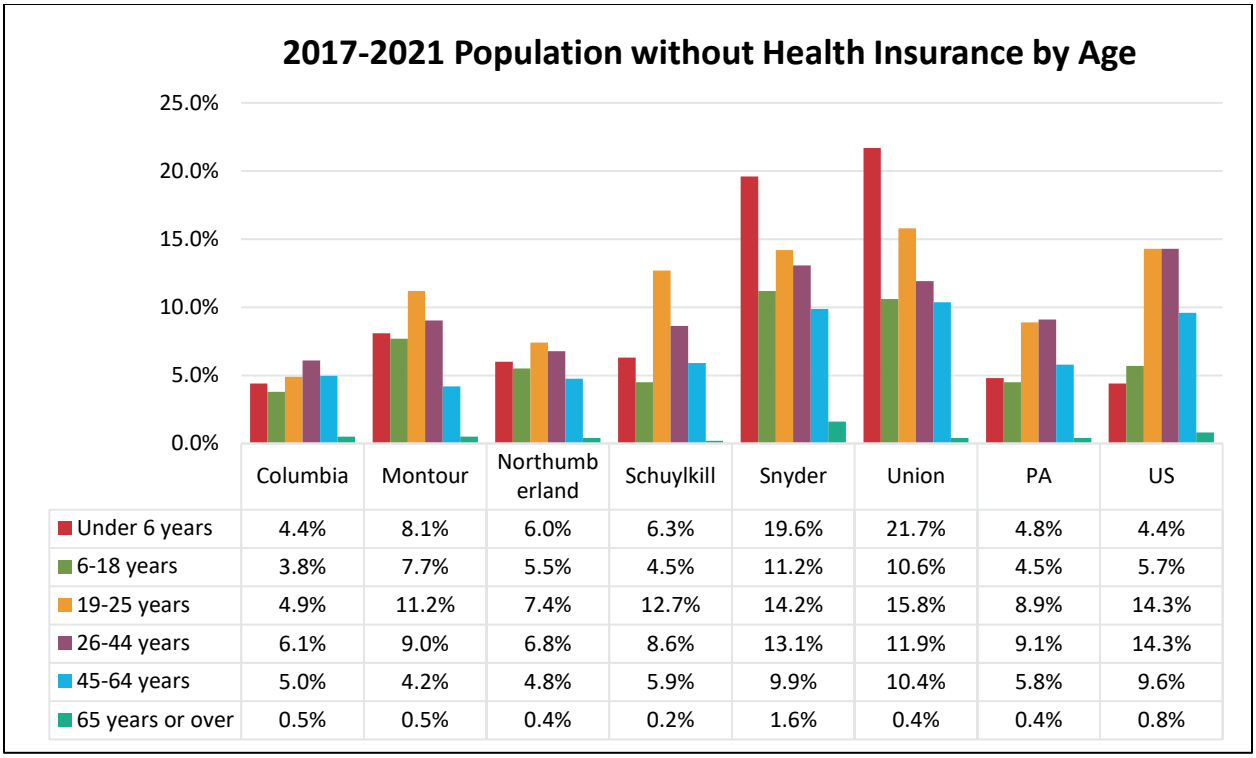
Lack of health insurance is a barrier to accessing healthcare. Without health insurance, residents face high costs for care when they need it, and they are less likely to receive preventive care. Preventive care, such as well visits and screenings, can detect small problems that can be treated more easily and effectively than if treatment is delayed.

While many Central Region residents *have* health insurance, there is a relatively high percentage of young adults (ages 19-25) who are uninsured across all counties. This population may be eligible to remain insured through their guardians under the Affordable Care Act, presenting an opportunity for community awareness and education.

Snyder and Union counties have a high percentage of children ages six and under who are without health insurance, estimated at approximately 20%. This proportion far outpaces the percentage of children living in poverty and the percentage of children who experience food insecurity. This finding may reflect several factors including Plain Community members who are less likely to participate in health insurance programs, or a gap in eligibility awareness for PA Children's Health Insurance Program (CHIP). **No family makes too much for CHIP, presenting an opportunity to increase community awareness and education around what options *are* available for the region's children.**

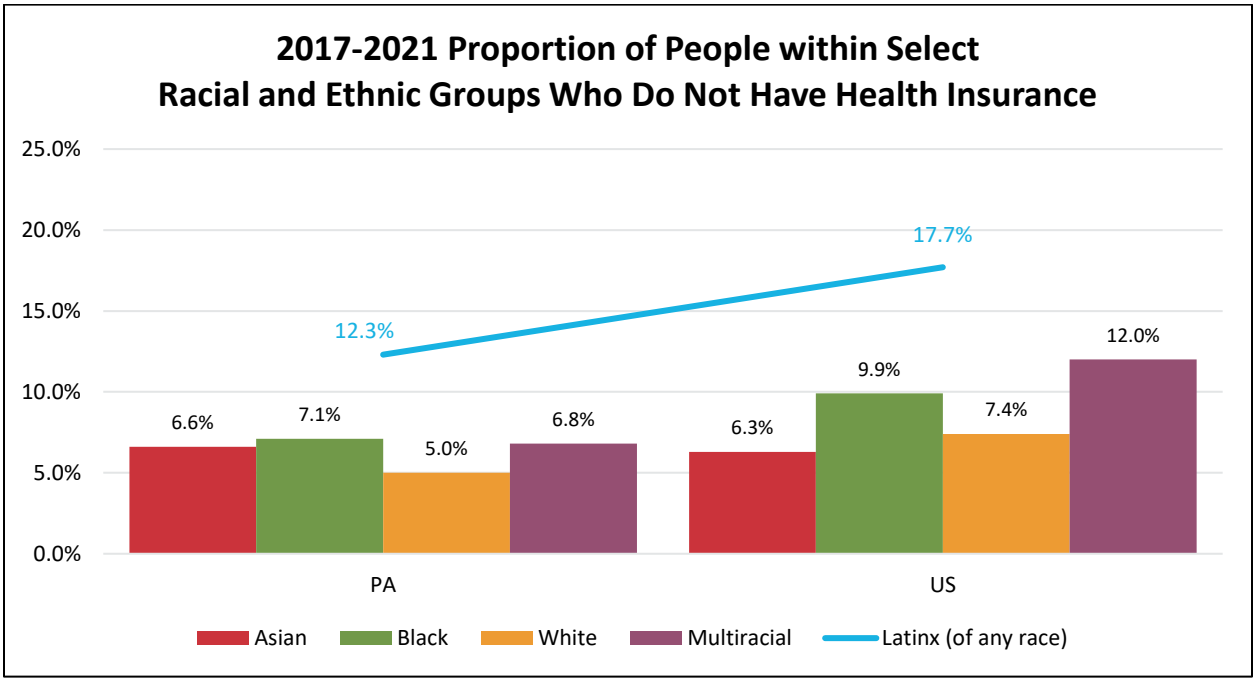


Source: US Census Bureau, American Community Survey

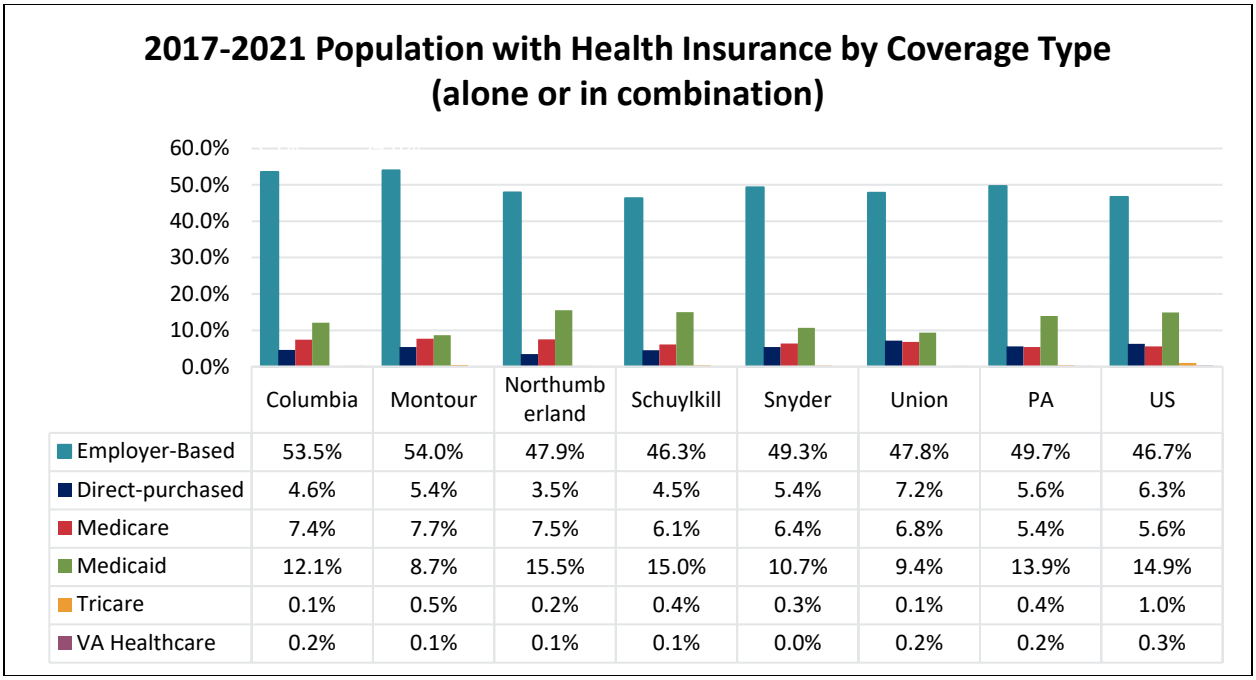


	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Under 6 years	4.4%	8.1%	6.0%	6.3%	19.6%	21.7%	4.8%	4.4%
6-18 years	3.8%	7.7%	5.5%	4.5%	11.2%	10.6%	4.5%	5.7%
19-25 years	4.9%	11.2%	7.4%	12.7%	14.2%	15.8%	8.9%	14.3%
26-44 years	6.1%	9.0%	6.8%	8.6%	13.1%	11.9%	9.1%	14.3%
45-64 years	5.0%	4.2%	4.8%	5.9%	9.9%	10.4%	5.8%	9.6%
65 years or over	0.5%	0.5%	0.4%	0.2%	1.6%	0.4%	0.4%	0.8%

Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey



	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Employer-Based	53.5%	54.0%	47.9%	46.3%	49.3%	47.8%	49.7%	46.7%
Direct-purchased	4.6%	5.4%	3.5%	4.5%	5.4%	7.2%	5.6%	6.3%
Medicare	7.4%	7.7%	7.5%	6.1%	6.4%	6.8%	5.4%	5.6%
Medicaid	12.1%	8.7%	15.5%	15.0%	10.7%	9.4%	13.9%	14.9%
Tricare	0.1%	0.5%	0.2%	0.4%	0.3%	0.1%	0.4%	1.0%
VA Healthcare	0.2%	0.1%	0.1%	0.1%	0.0%	0.2%	0.2%	0.3%

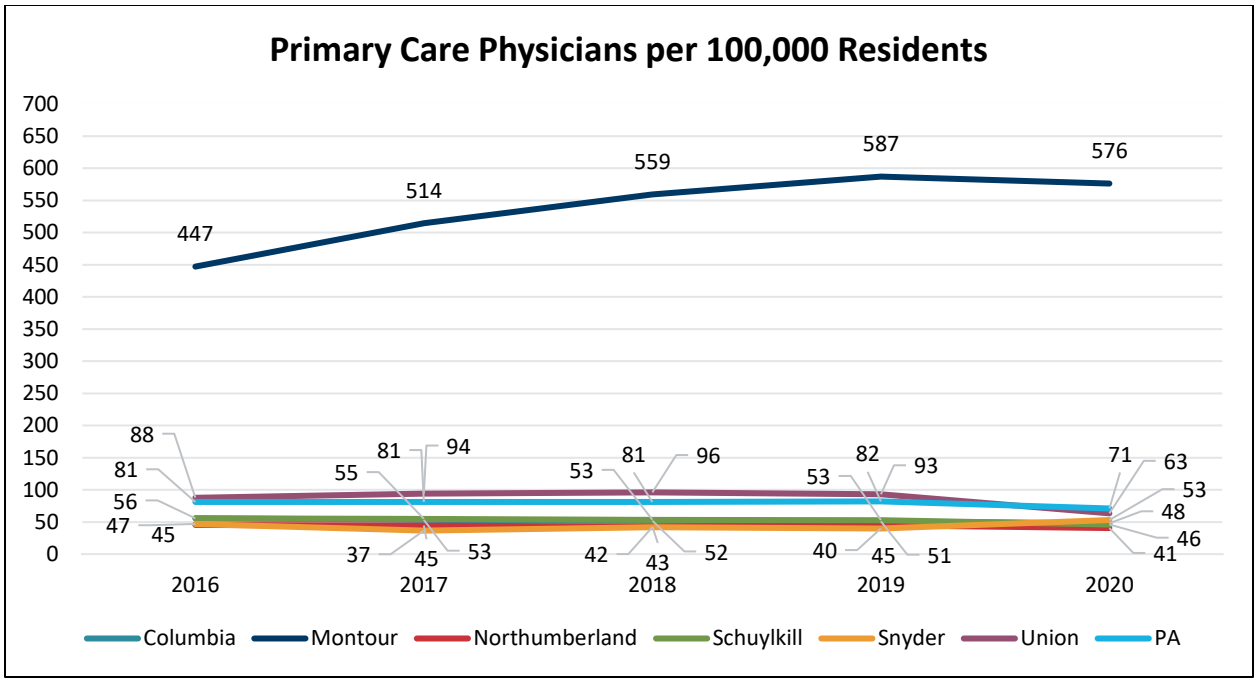
Source: US Census Bureau, American Community Survey

Having health insurance does not ensure access to healthcare when it is needed. Many other factors—like affordability, transportation, language, provider availability, and trust—keep people from receiving the care they need. It is important to continue to seek feedback on residents' experiences of these factors and their impact on people's ability to receive high quality and timely care.

There is an opportunity to grow primary and preventive care services within the Central Region, outside of Montour County. All other counties have fewer physicians and dentists than the state average, and **the entire region, excluding the southeastern portion of Union County, is a Health Professional Shortage Area (HPSA) for dental care for individuals with low income.**

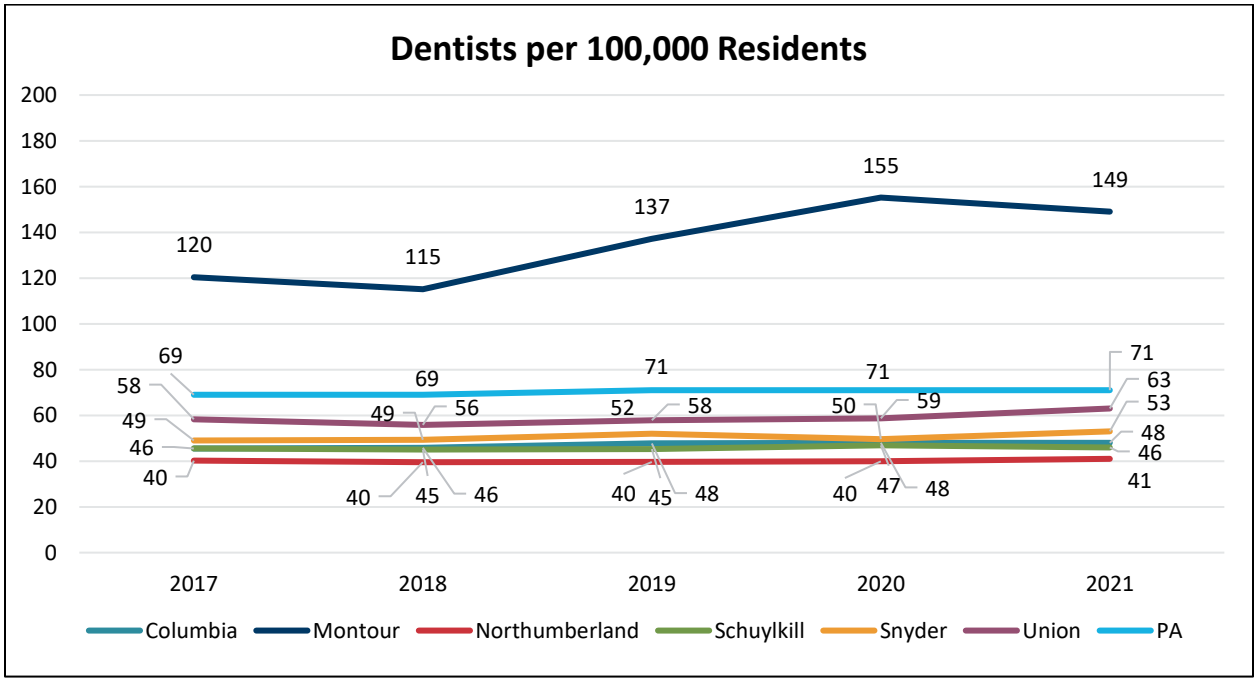
Despite a lack of doctors, adult residents of the Central Region report preventive visits within the last year on par with state and national benchmarks – about three-quarters of adults. They report regular dental checkups with slightly less frequency, 59%-64% of adults, compared to 68% across Pennsylvania.

When analyzed by zip code, the proportion of adults receiving preventive visits is generally consistent across the region, but receipt of regular dental care is more varied. In Northumberland and Schuylkill counties, the proportion of adults with regular dental care falls to approximately 53% in Shamokin, Coal Township, and Mahanoy City.



Source: Health Resources & Services Administration

Note: Montour County is the home county for Geisinger Medical Center in Danville, contributing to higher reported provider rates.



Source: Health Resources & Services Administration

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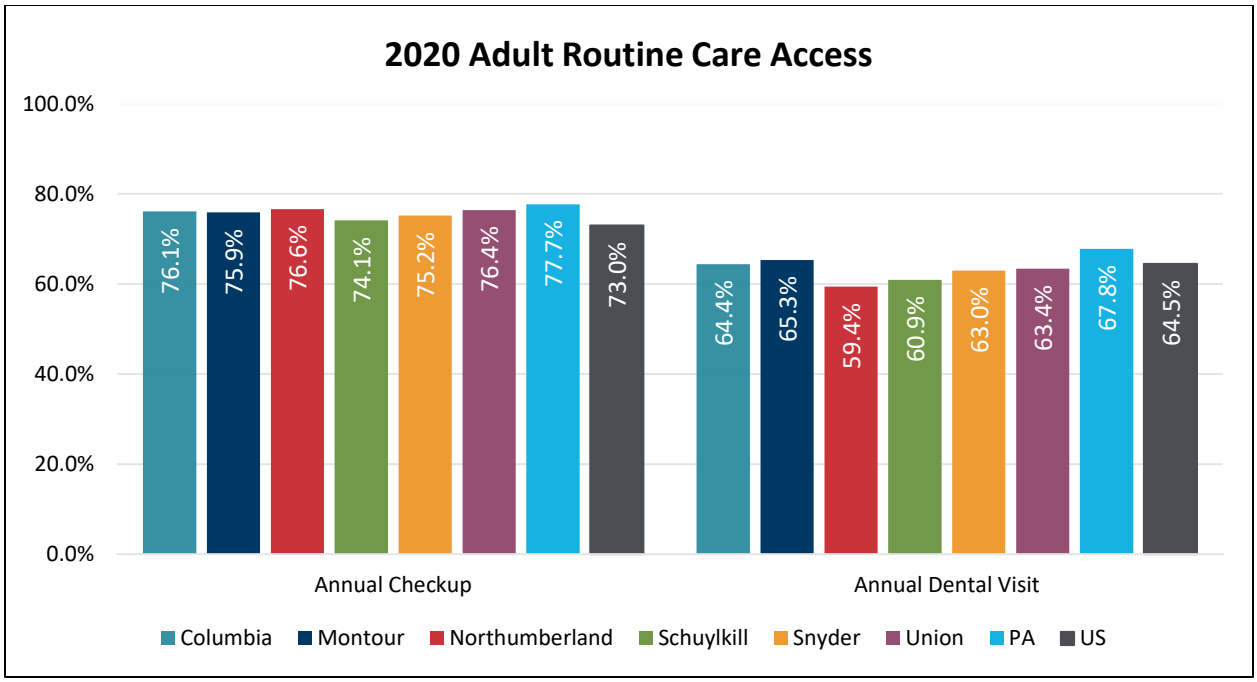
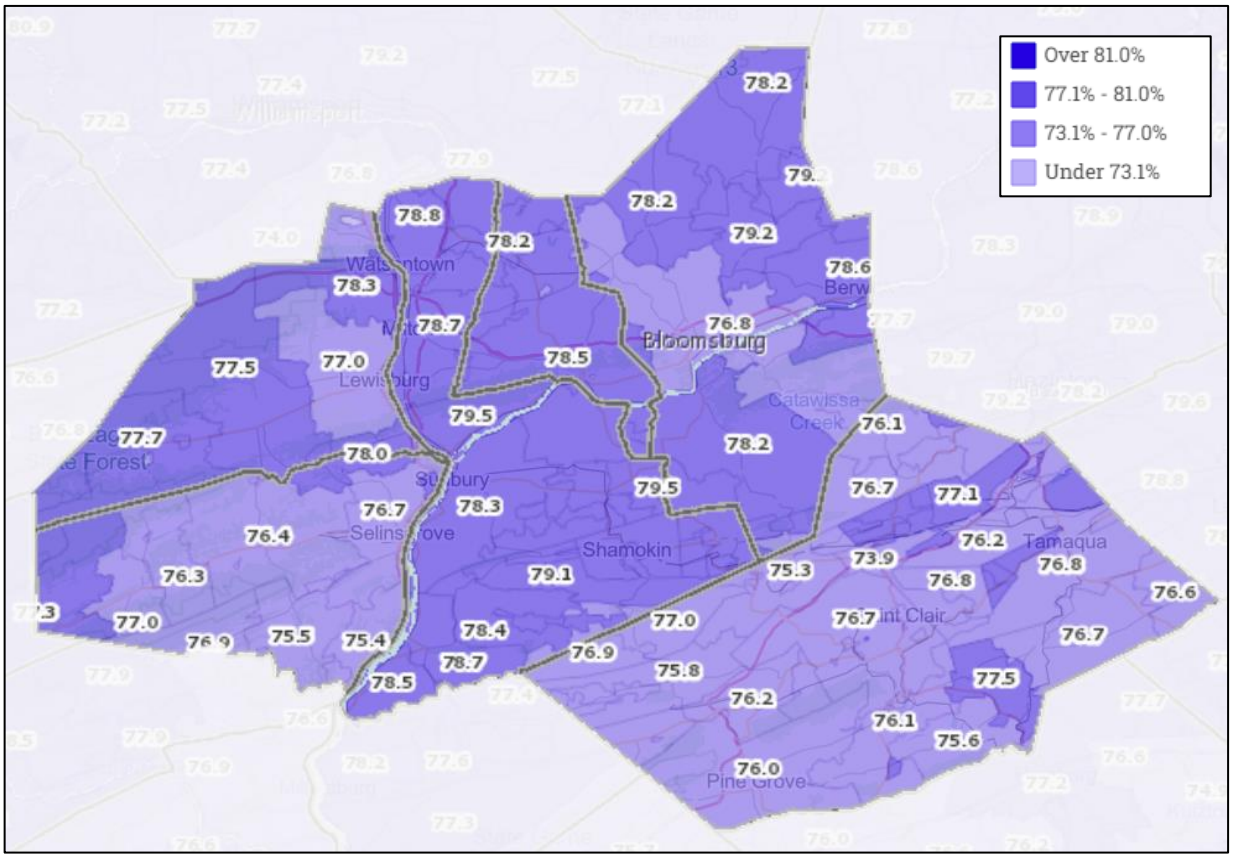


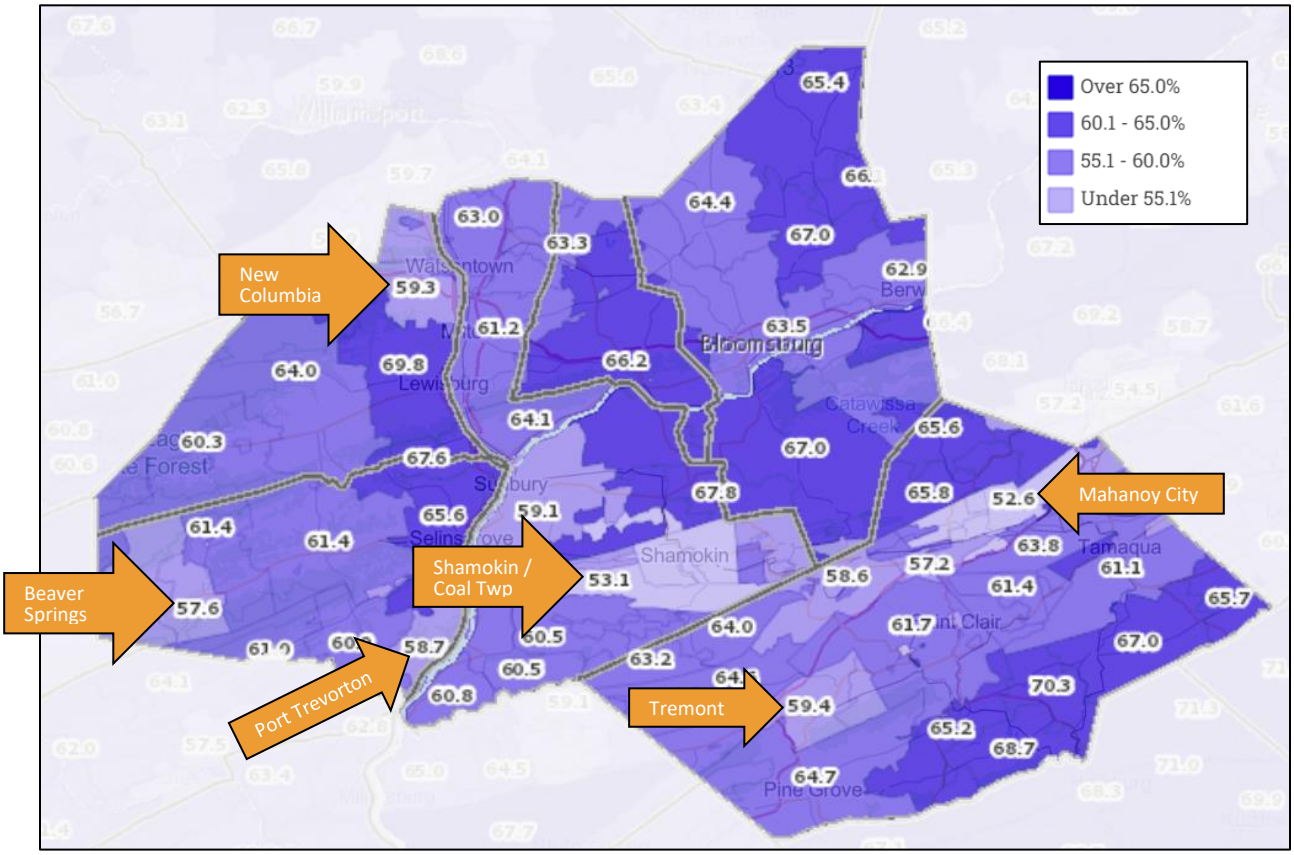
Source: Centers for Disease Control and Prevention

2020 Adults with a Primary Care Visit Within the Past Year by Central Region Zip Code



Source: Centers for Disease Control and Prevention & Center for Applied Research and Engagement Systems

2020 Adults with a Dental Care Visit Within the Past Year by Central Region Zip Code



Source: Centers for Disease Control and Prevention & Center for Applied Research and Engagement Systems

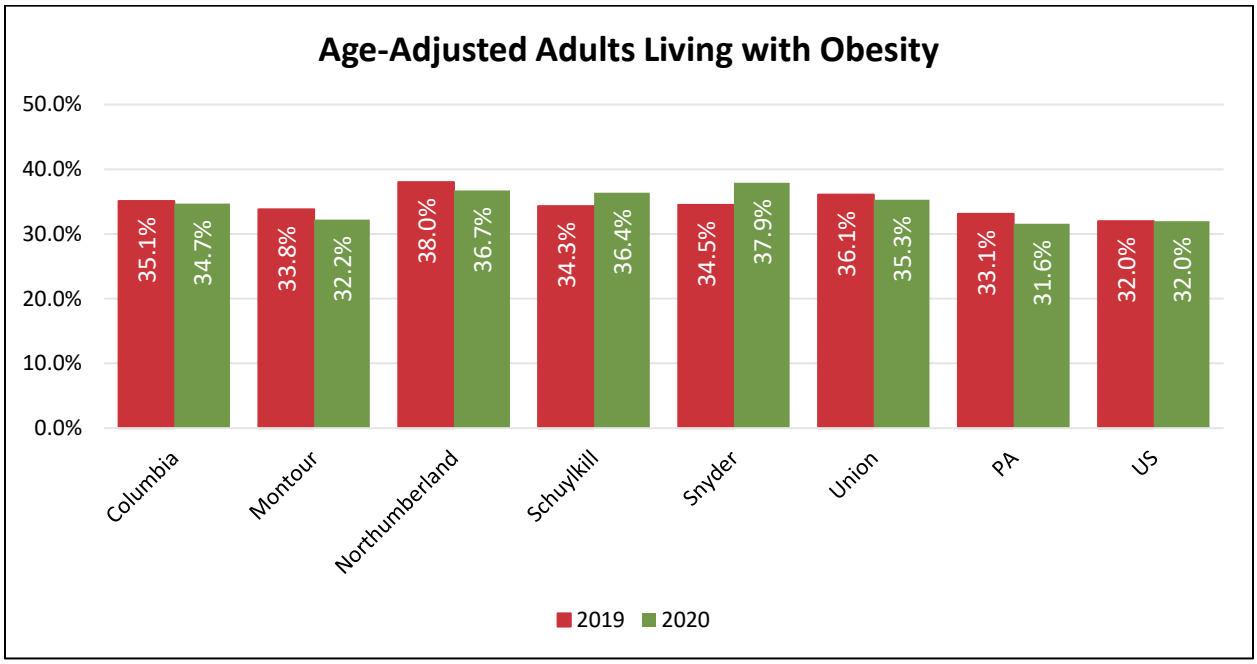
Health Risk Factors and Chronic Disease

Prior to COVID-19, the top leading causes of death for Pennsylvania and US residents were chronic diseases. **Across the Central Region, diabetes and heart disease incidence are comparable to the state and nation, but death rates due to these conditions are higher in Northumberland, Schuylkill, and/or Snyder counties, potentially indicating barriers to diagnosis, treatment, and/or care management.**

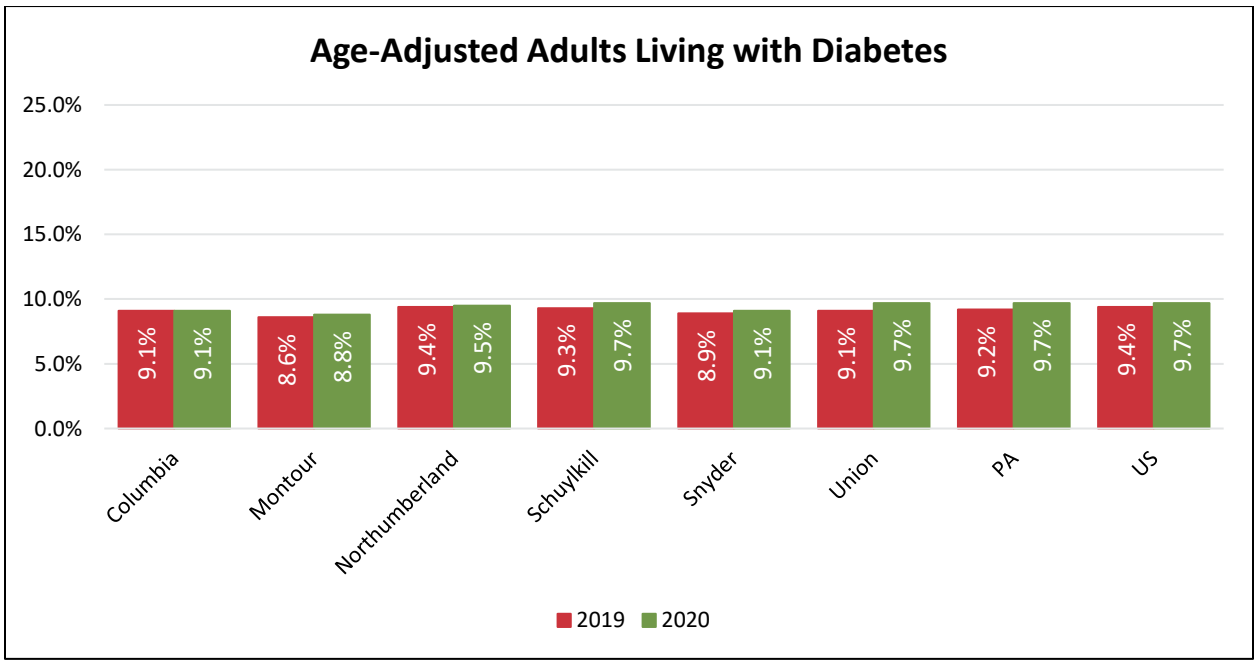
It is interesting to note that despite more smokers and a higher incidence of COPD in the region compared to state and national benchmarks, diagnoses of asthma and incidence and death rates due to lung cancer are comparable. **Snyder and Union counties, despite having a relatively large smoking population, have lung-related death rates at nearly half that of their neighbors, and the state and nation. This finding is worth exploring for other protective factors, such as early and effective screening.**

The region generally has a relatively high overall incidence of cancer; cancer incidence in Montour County is 20% higher than across the state of Pennsylvania. However, excluding Schuylkill County, overall cancer death rates are consistent with state and national benchmarks. This finding may indicate better cancer screening practices and earlier detection and treatment.

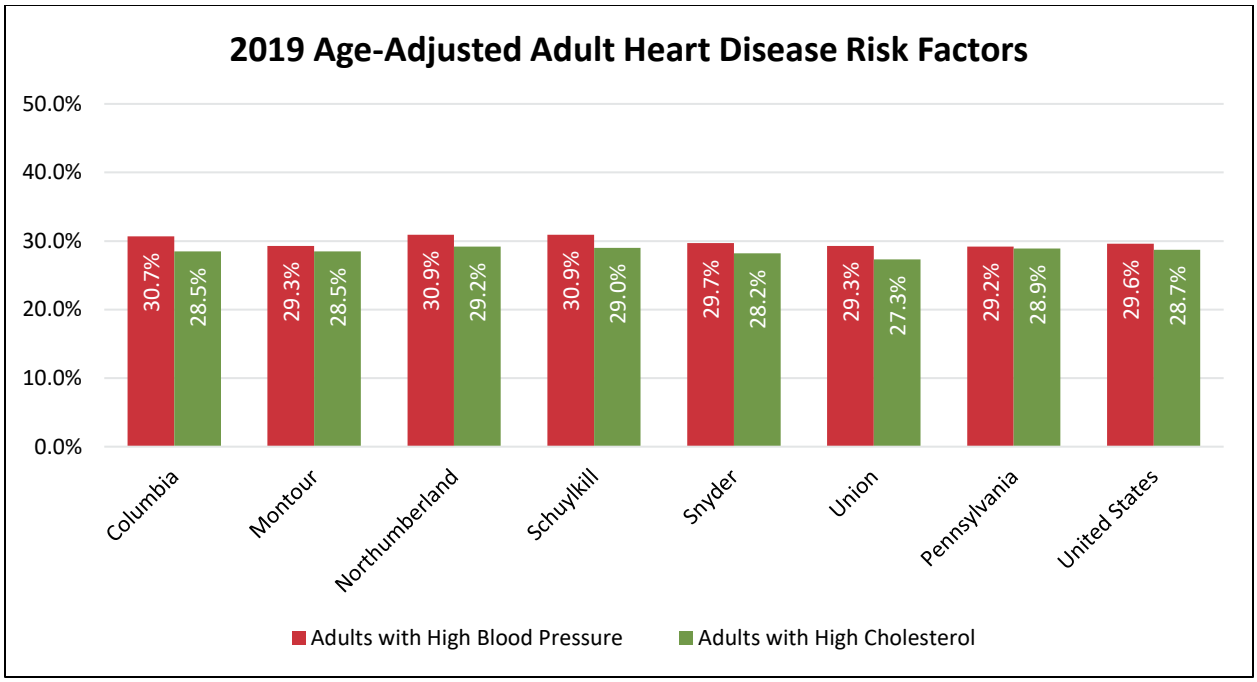
It is clear that social drivers of health directly impact health risk factors and ultimately chronic disease, resulting in inequities in quality of life and life expectancy. Across the state of Pennsylvania, death rates for Black residents attributed to diabetes and heart disease far outpace death rates for those of other races. **The Black population in the Central Region is small and health disparities are not measured, but documented socioeconomic disparities within the region indicate that there are similar disparities in chronic disease outcomes.**



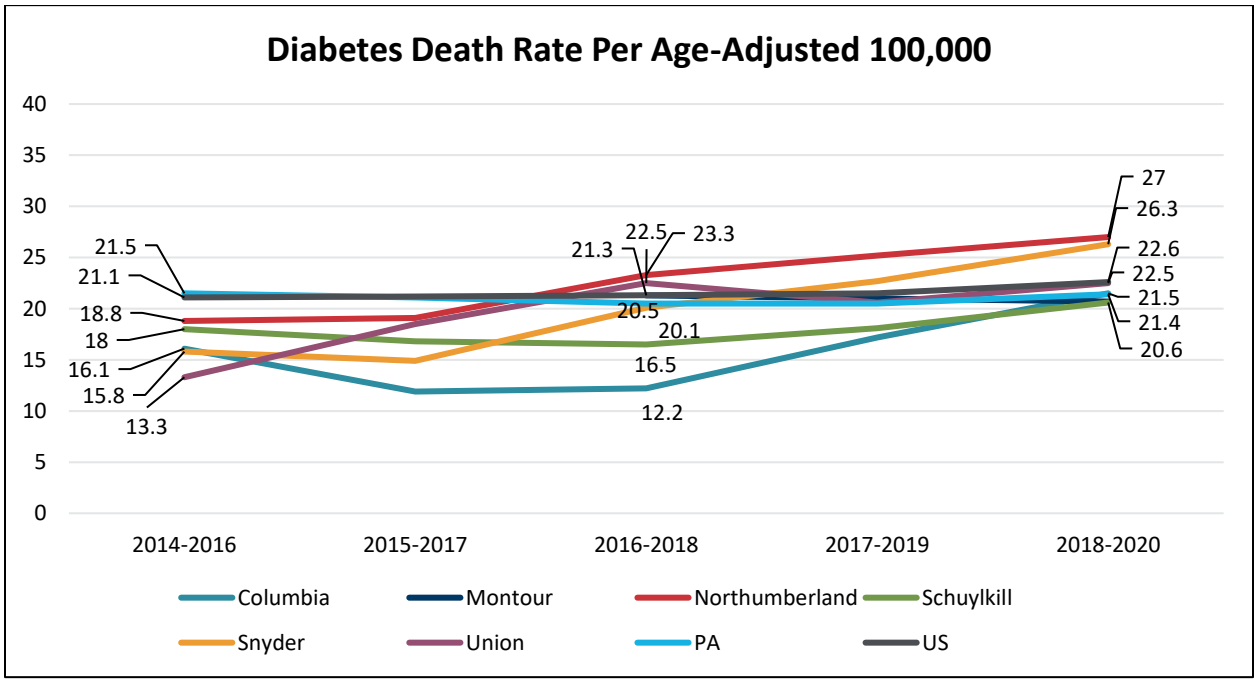
Source: Centers for Disease Control and Prevention



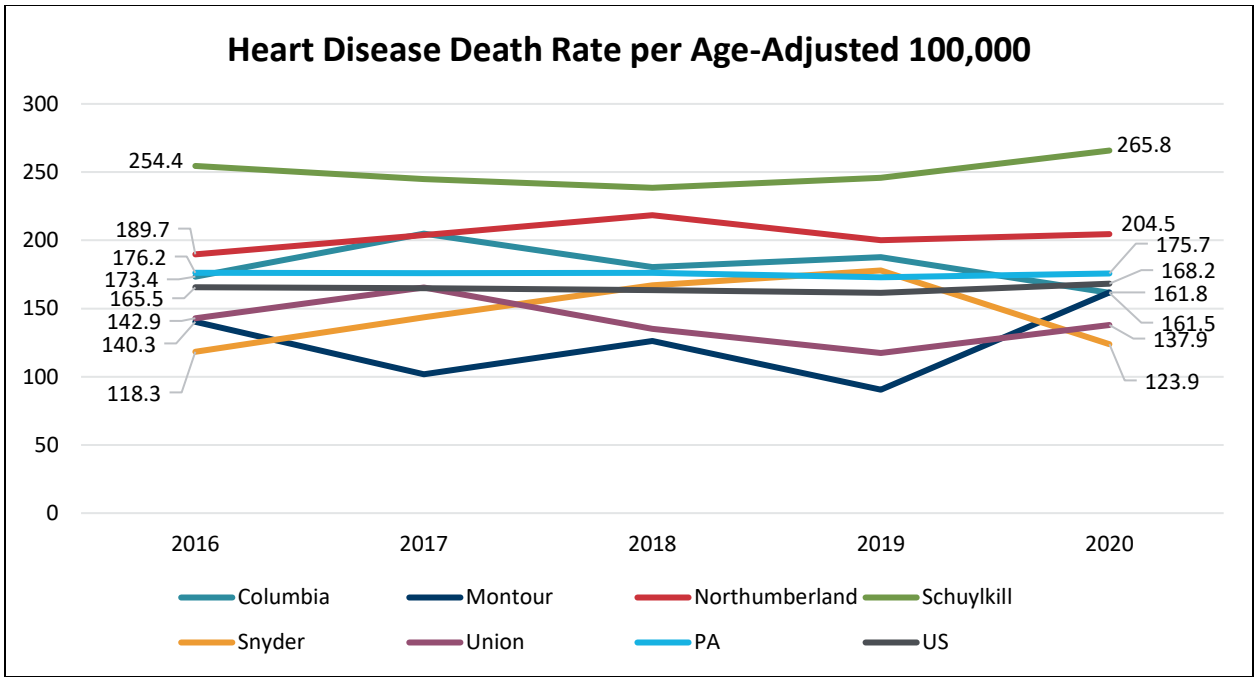
Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention

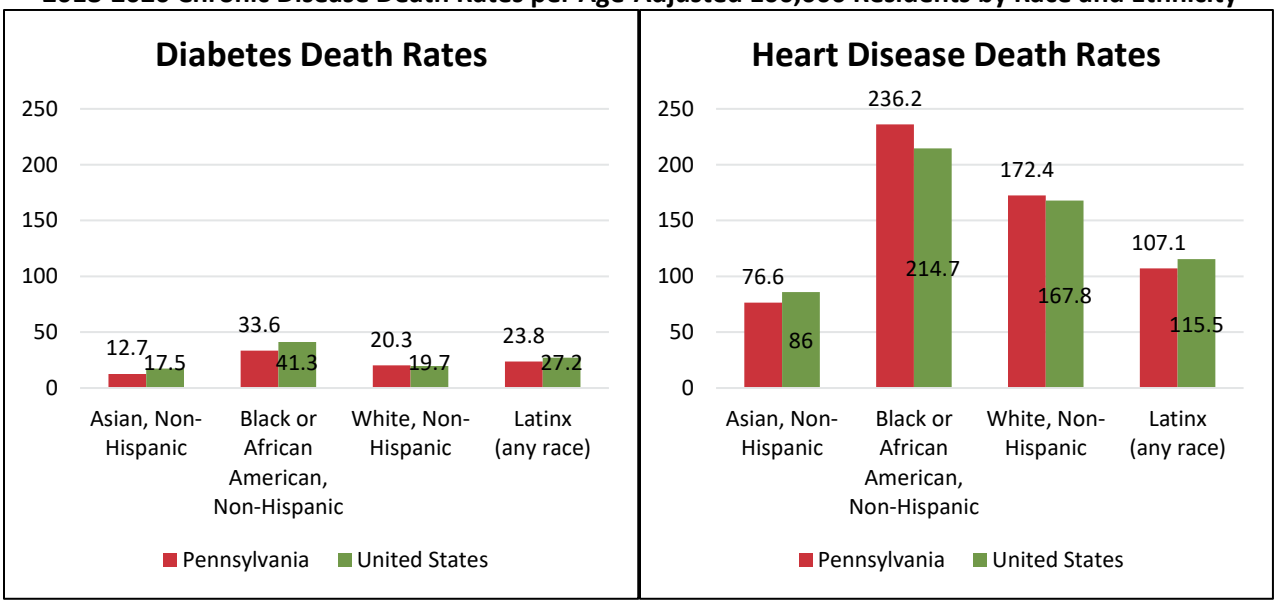


Source: Centers for Disease Control and Prevention
Note: Montour County data are not trended due to missing data. The 2018-2020 diabetes death rate for Montour County was 20.7.

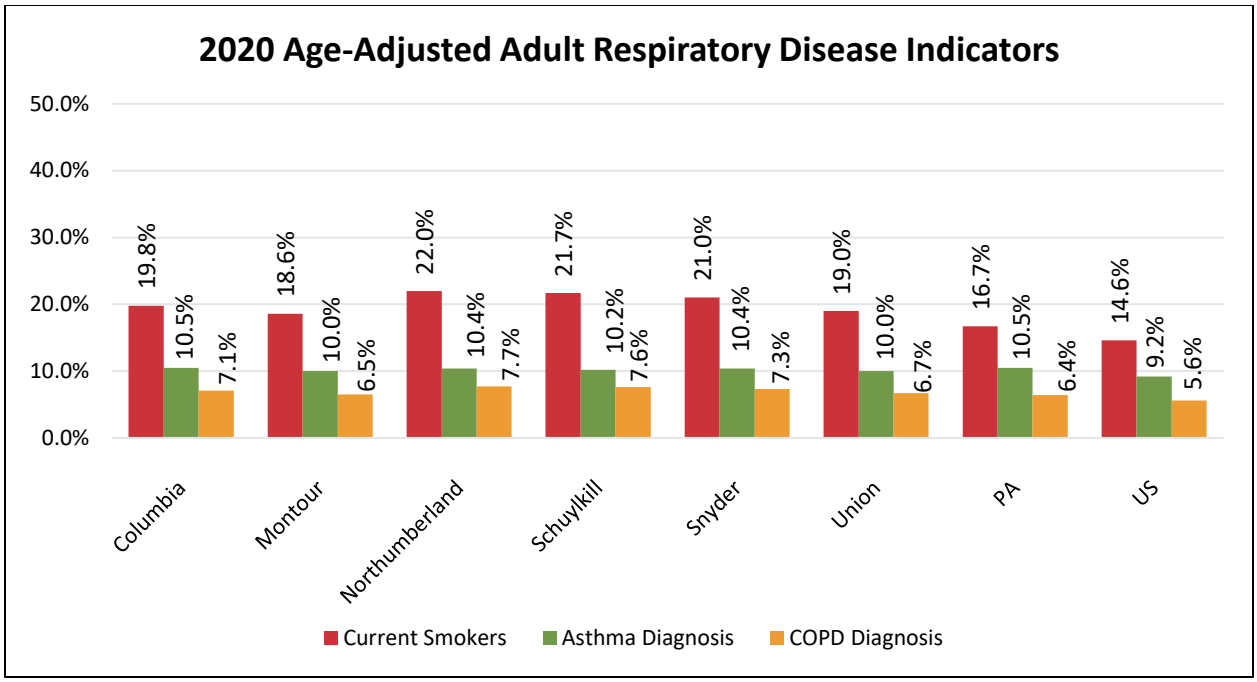


Source: Centers for Disease Control and Prevention

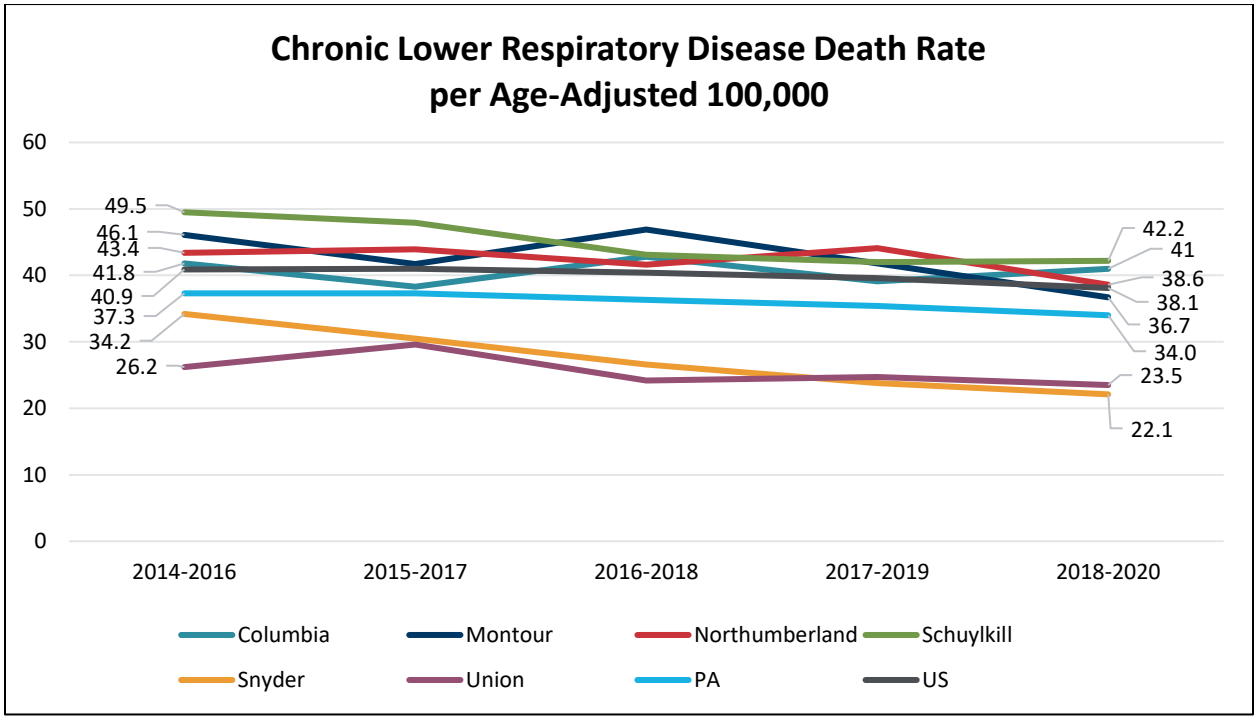
2018-2020 Chronic Disease Death Rates per Age-Adjusted 100,000 Residents by Race and Ethnicity



Source: Centers for Disease Control and Prevention
Note: Data are not provided for Central Region counties due to low population/death counts.



Source: Centers for Disease Control and Prevention



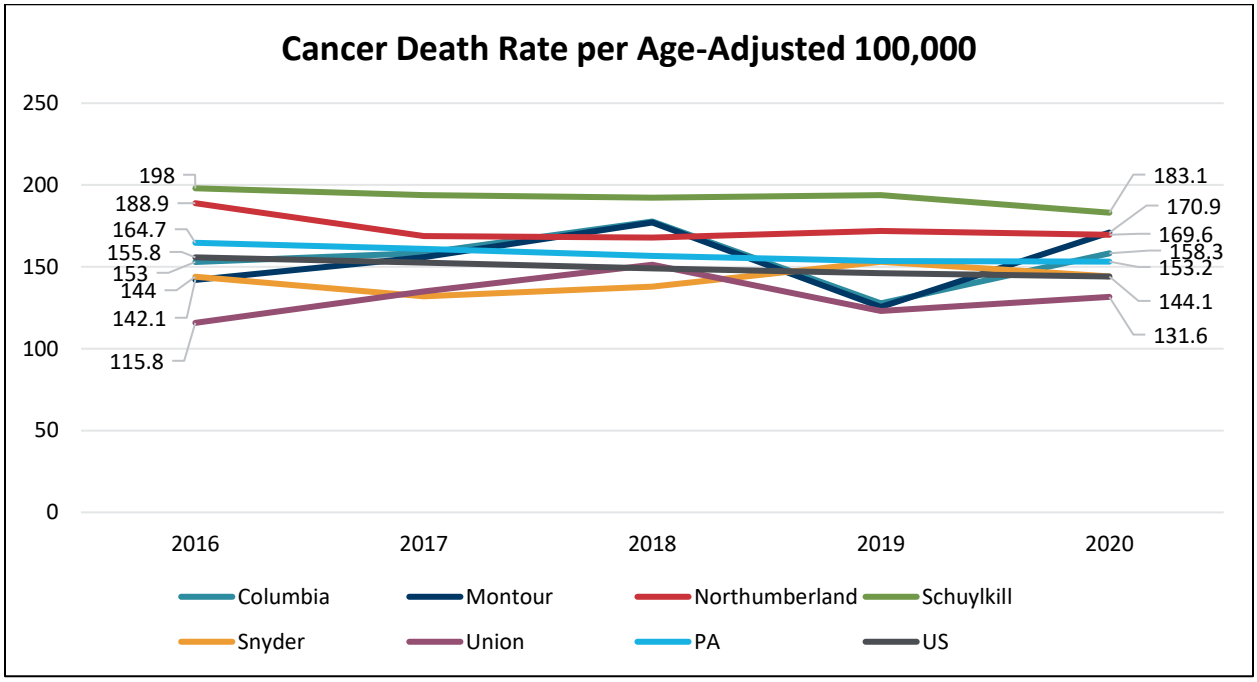
Source: Centers for Disease Control and Prevention

2016-2020 Cancer Incidence (All Types) per Age-Adjusted 100,000

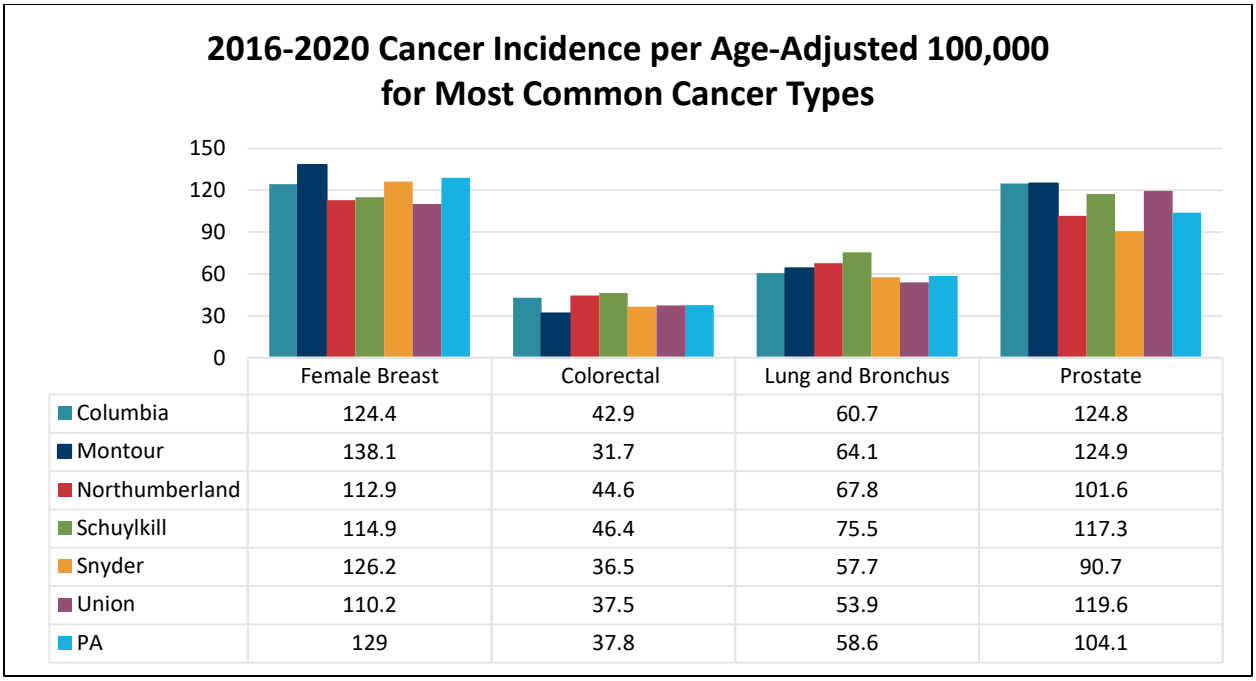
	Cancer Incidence Rate
Columbia	492.9
Montour	534.0
Northumberland	491.6
Schuylkill	506.4
Snyder	451.0
Union	447.7
Pennsylvania	448.4

Source: Pennsylvania Department of Health

Note: Data are not available for the United States for 2016-2020.

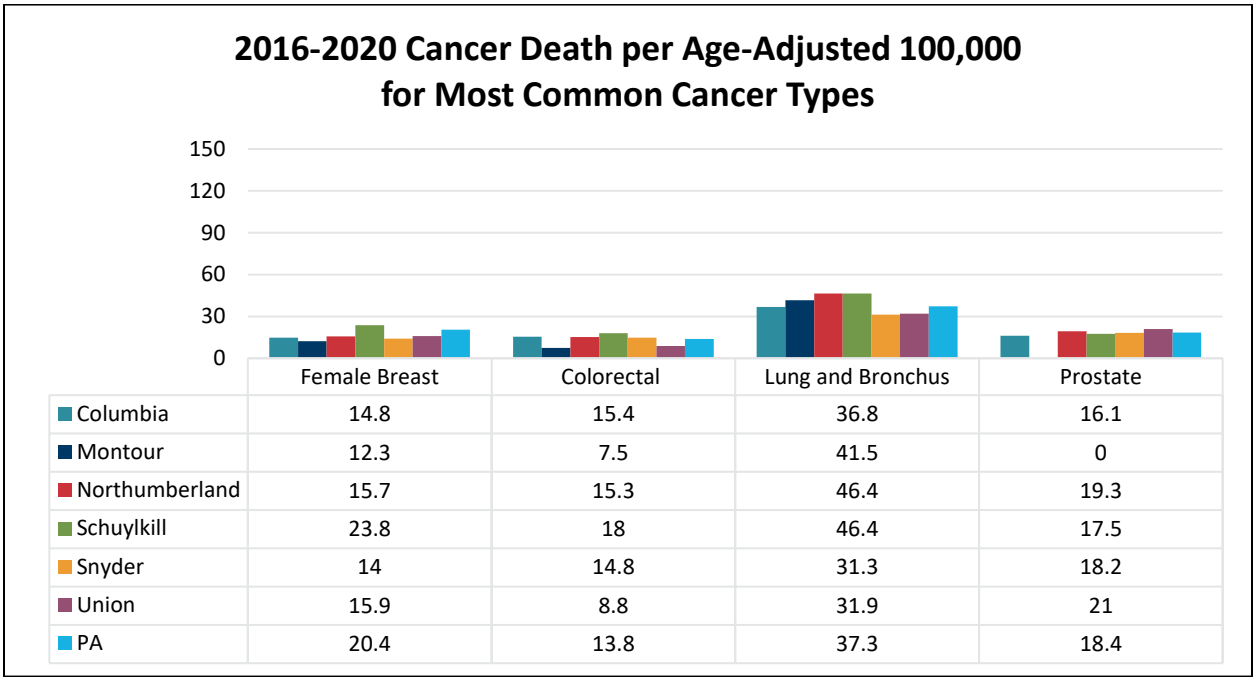


Source: Centers for Disease Control and Prevention



	Female Breast	Colorectal	Lung and Bronchus	Prostate
Columbia	124.4	42.9	60.7	124.8
Montour	138.1	31.7	64.1	124.9
Northumberland	112.9	44.6	67.8	101.6
Schuylkill	114.9	46.4	75.5	117.3
Snyder	126.2	36.5	57.7	90.7
Union	110.2	37.5	53.9	119.6
PA	129	37.8	58.6	104.1

Source: Pennsylvania Department of Health



	Female Breast	Colorectal	Lung and Bronchus	Prostate
Columbia	14.8	15.4	36.8	16.1
Montour	12.3	7.5	41.5	0
Northumberland	15.7	15.3	46.4	19.3
Schuylkill	23.8	18	46.4	17.5
Snyder	14	14.8	31.3	18.2
Union	15.9	8.8	31.9	21
PA	20.4	13.8	37.3	18.4

Source: Pennsylvania Department of Health & Centers for Disease Control and Prevention

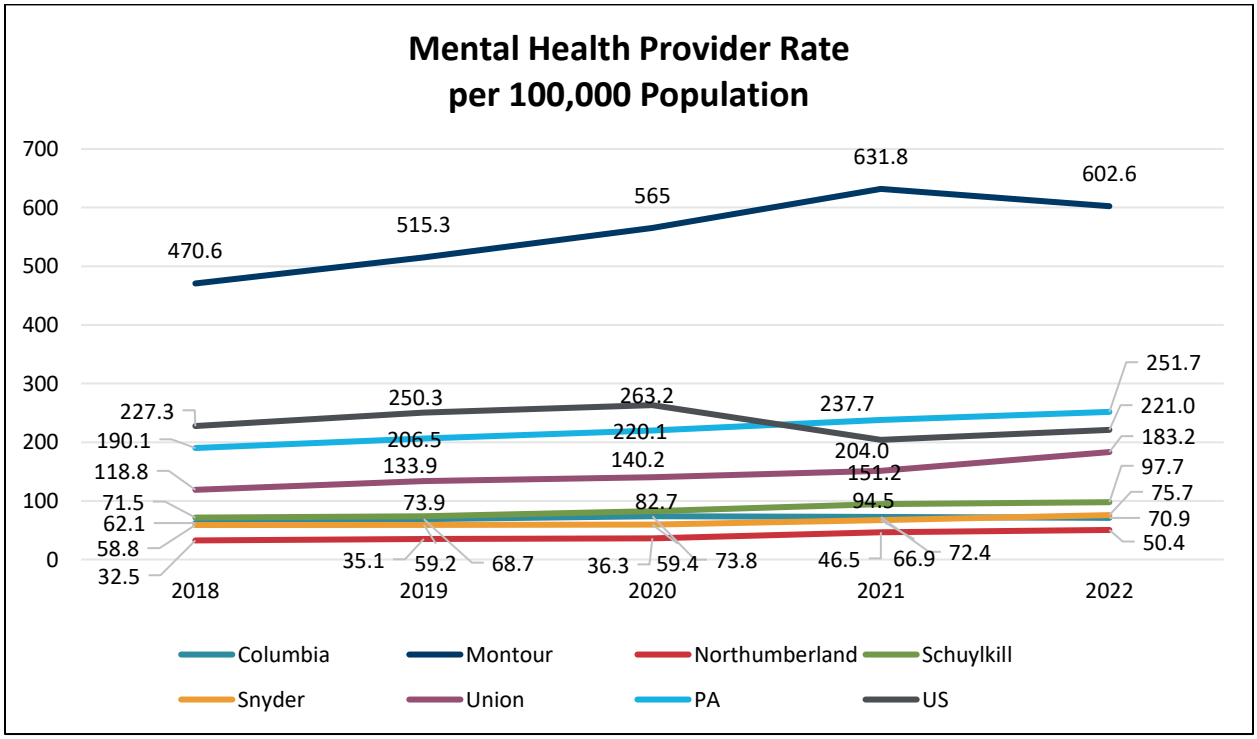
Mental Health and Substance Use Disorder

Mental health concerns like depression and anxiety can be linked to social drivers like income, employment, and environment, and can pose risks of physical health problems by complicating an individual's ability to keep up other aspects of their healthcare and well-being.

Social service and healthcare agencies are consistently reporting difficulty hiring and retaining mental health providers since COVID-19, a problem that is especially exacerbated in more rural communities. Outside of Montour County, Central Region counties have fewer mental health providers than the state or nation overall. Northumberland County has only one-fifth the number of providers per 100,000 residents compared to the rest of Pennsylvania.

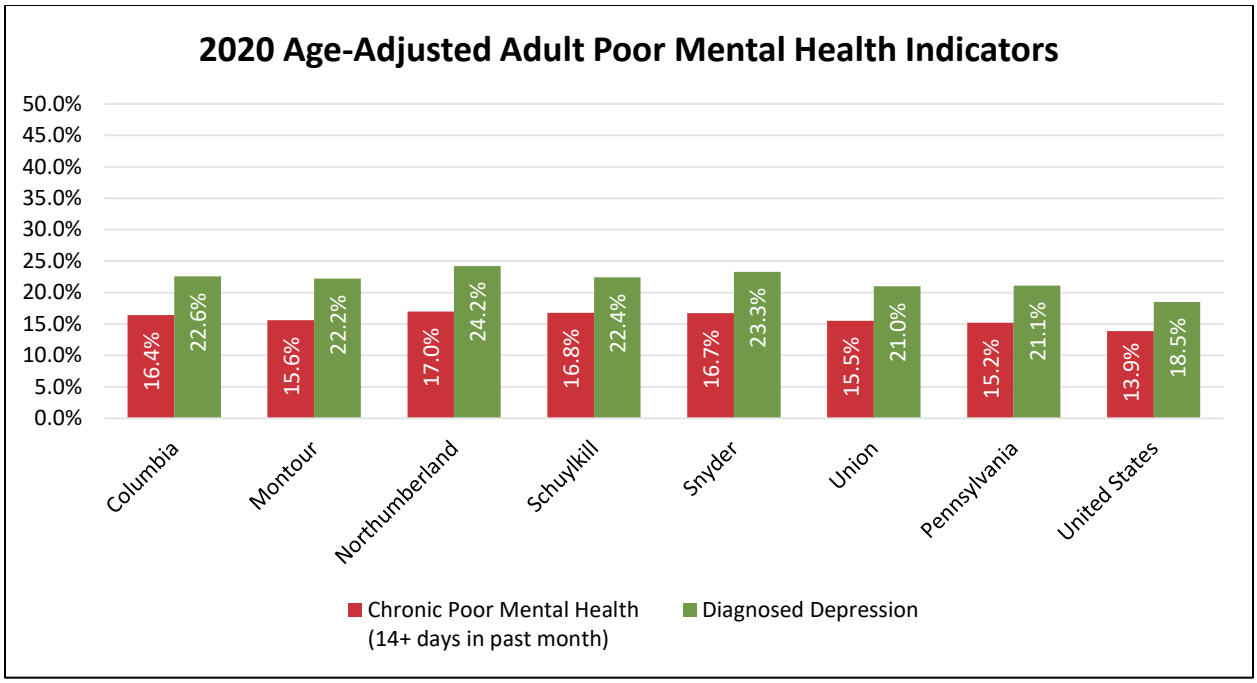
At the other end of the spectrum, community residents suffer disproportionately poor mental health. **In Schuylkill County, the death rate by suicide is 58% higher than state and national rates. Across all counties, more than one in five adults report a diagnosis of depression.** These findings, when considered with underlying social drivers, isolation due to the COVID-19 pandemic and a more rural setting, and limited access to mental healthcare, point to a growing mental health crisis in the region.

When analyzed by zip code, the proportion of adults reporting mental distress is generally consistent across the region, with few areas of notable disparity. Areas of disparity include communities with previously identified health barriers, including poverty and lack of healthcare access (e.g., Shamokin, Mahanoy City, Shenandoah). **Bloomsburg is also an area of disparity, reporting the highest proportion of adults with mental distress in the region at 18.3%.**



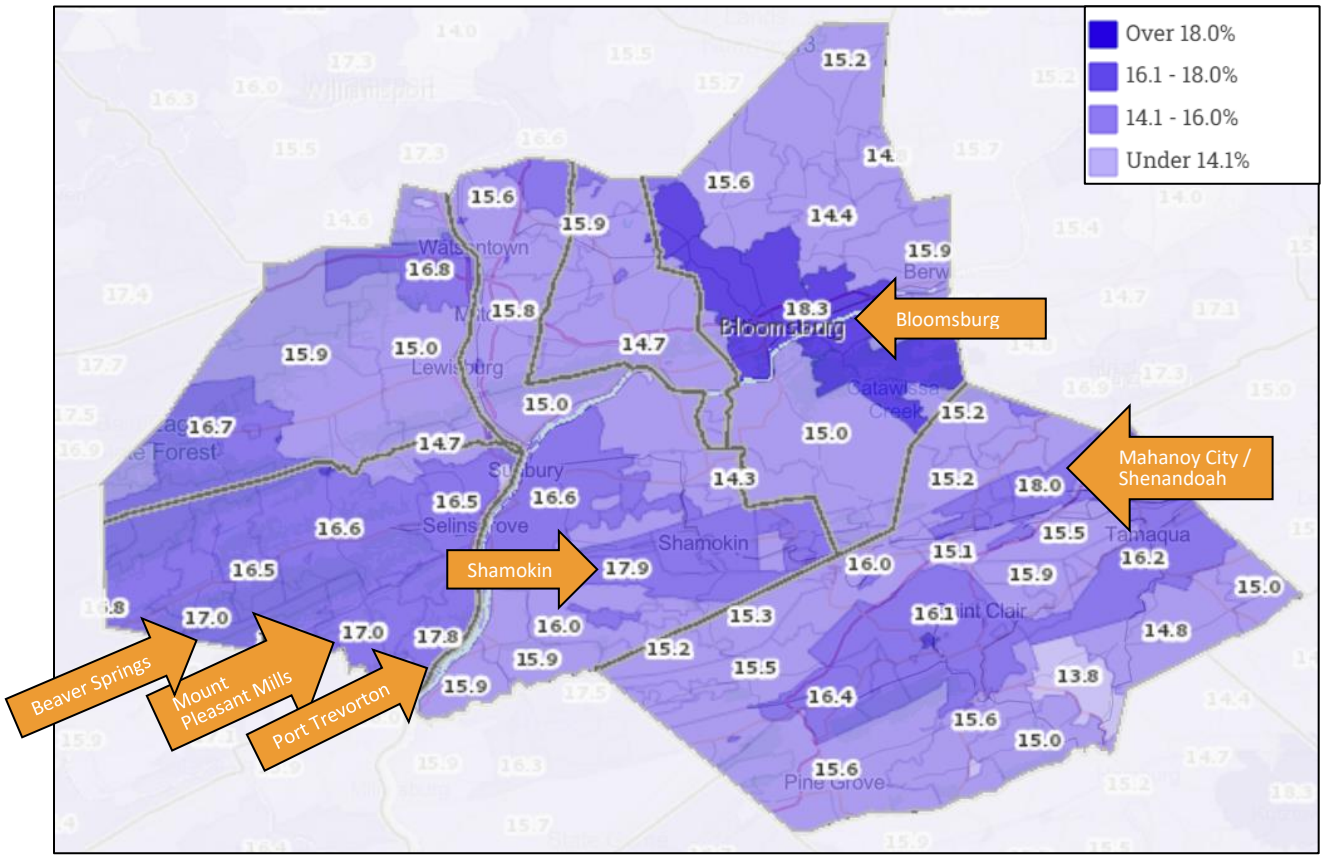
Source: Centers for Medicare and Medicaid Services

Note: Montour County is the home county for Geisinger Medical Center in Danville, contributing to higher reported provider rates.

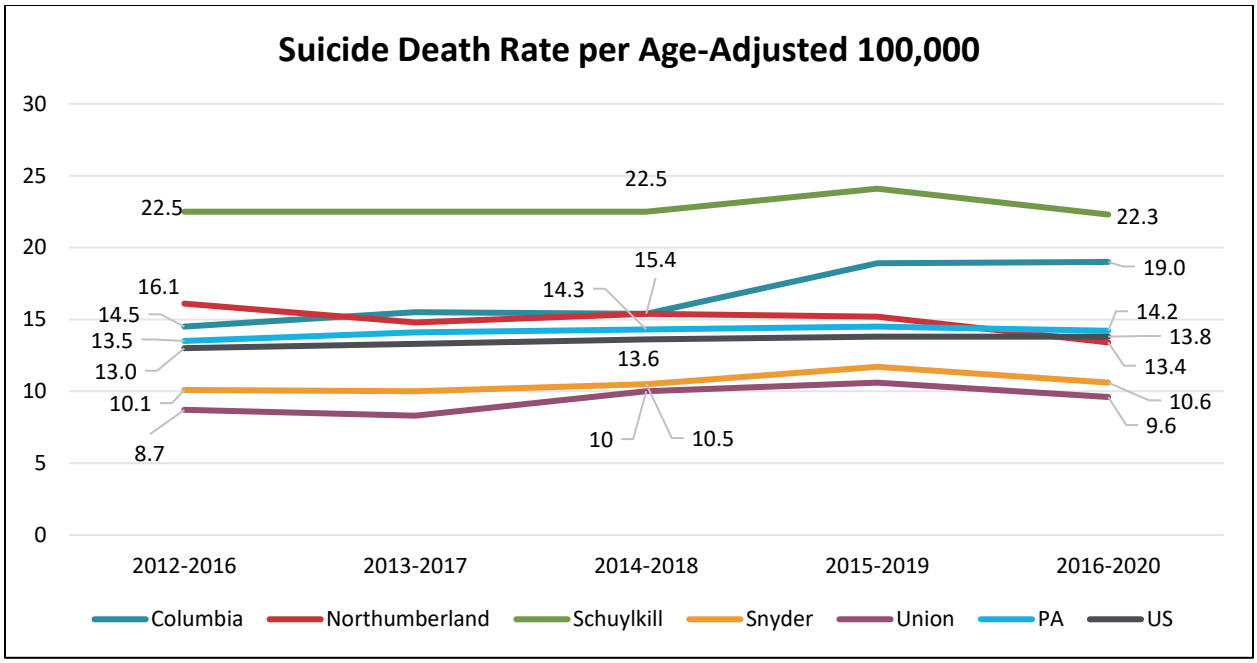


Source: Centers for Disease Control and Prevention

2020 Adults with Chronic Poor Mental Health (14+ days in past month) by Central Region Zip Code



Source: Centers for Disease Control and Prevention & Center for Applied Research and Engagement Systems



Source: Centers for Disease Control and Prevention
Note: Data are not available for Montour County due to low death counts.

Substance use concerns are still prevalent in the region and recent trends indicate the need to evaluate health improvement and treatment efforts. For example, while hospitalizations from the use of drugs such as opioids have generally declined, death rates due to accidental overdose remain high and increased in communities likely Columbia and Northumberland counties.

Surpassing opioids in the Central Region are amphetamines. Across Pennsylvania in 2019, the rate of amphetamine use disorder hospitalizations was *78% lower* than the rate of opioid hospitalizations; however, in Columbia, Montour, and Schuylkill counties, amphetamine hospitalizations *outpaced* those for opioids. It is worth noting a similarly high rate of hospitalizations for both opioids and amphetamines in Northumberland and Schuylkill counties.

Of most pressing concern are rates of alcohol misuse by residents. Approximately 1 in 5 adults in Central Region counties report binge drinking, a slightly higher proportion than the state and nation overall. in all counties, the rate of alcohol-related hospitalizations far outpaces the rate for other reported substances.

Alcohol Use Disorder Indicators

	2020 Adults (age-adjusted) Reporting Binge Drinking	2016-2020 Driving Deaths due to Alcohol Impairment
Columbia	20.2%	20.5%
Montour	19.7%	6.2%
Northumberland	20.2%	22.8%
Schuylkill	20.5%	24.7%
Snyder	20.2%	29.1%
Union	19.7%	37.5%
Pennsylvania	18.5%	25.3%
United States	16.7%	27.0%

Source: Centers for Disease Control and Prevention, Fatality Analysis Reporting System

2019 Substance Use Disorder Hospitalizations per 100,000 by Substance

	Alcohol	Opioid	Amphetamine	Cocaine
Columbia	411.5	42.0	129.4	27.0
Montour	507.6	112.1	204.4	NA
Northumberland	477.4	242.7	191.5	44.6
Schuylkill	502.0	285.5	311.6	19.4
Snyder	273.9	62.5	32.7	NA
Union	244.0	64.9	54.5	NA
Pennsylvania	568.4	293.2	63.7	164.1

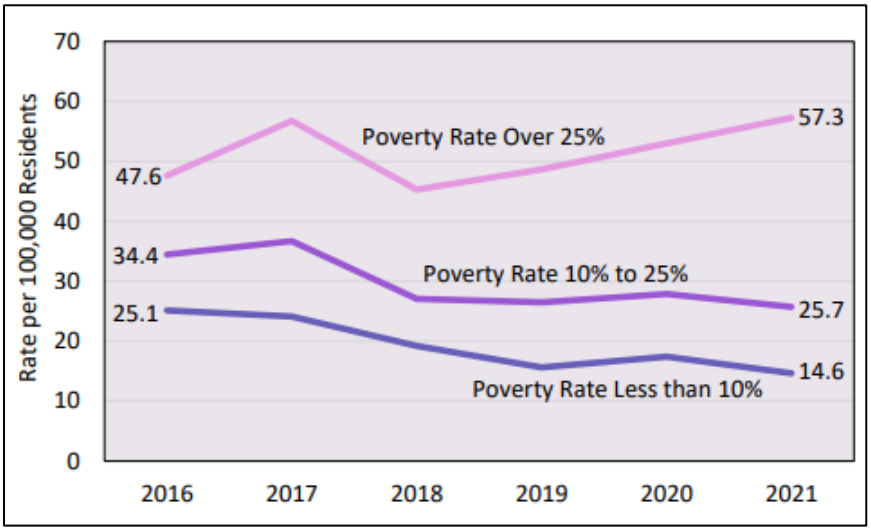
Source: Pennsylvania Health Care Cost Containment Council (PHC4)

Opioid Overdose Hospitalization Rates per 100,000 Central Region Residents

	2016	2017	2018	2019	2020	2021
Columbia	37.2	44.6	NA	28.7	NA	19.8
Montour	NA	NA	NA	NA	NA	NA
Northumberland	36.2	20.8	28.8	22.4	30.3	15.8
Schuylkill	25.0	27.6	22.7	24.5	16.1	18.6
Snyder	NA	NA	NA	NA	NA	NA
Union	NA	NA	NA	NA	NA	NA
Pennsylvania	31.6	33.0	25.1	23.2	24.8	22.9

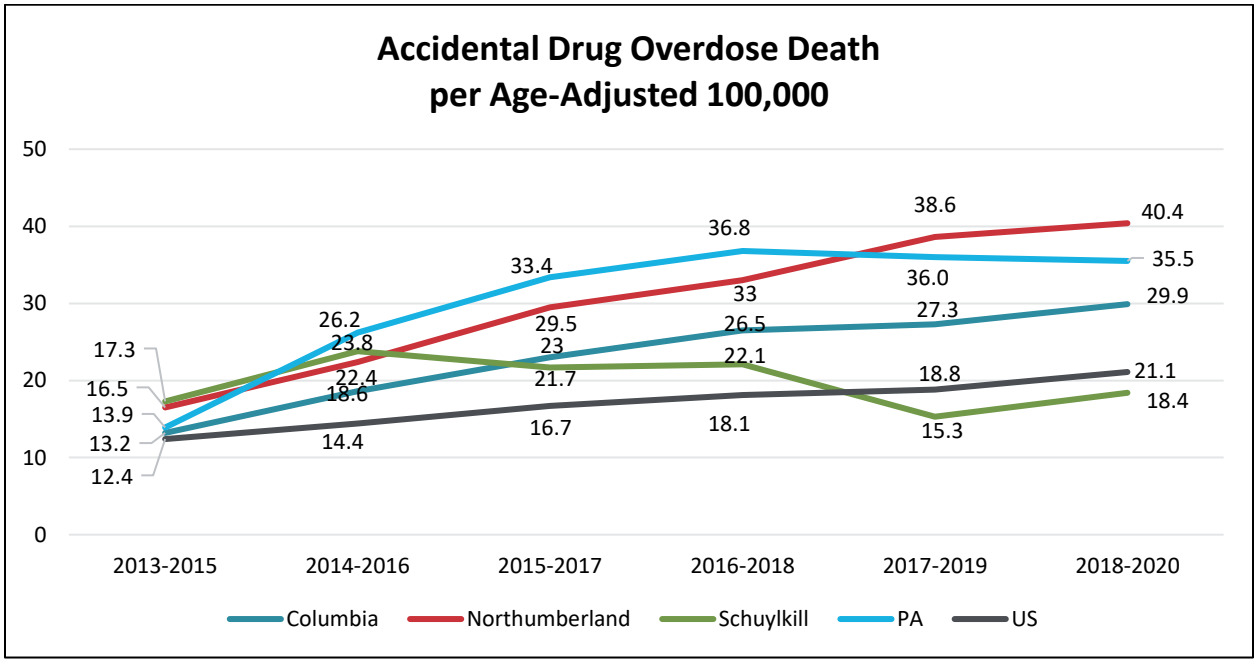
Source: Pennsylvania Health Care Cost Containment Council (PHC4)

Hospitalization Rates* for Opioid Overdose per 100,000 Pennsylvania Residents by Local Poverty Rate



Source: Pennsylvania Health Care Cost Containment Council (PHC4)

*Rates are calculated using PHC4 hospital discharge data and US Census Bureau 2020 population estimates.



Source: Centers for Disease Control and Prevention

Note: Data are not available for Montour, Snyder, and Union counties due to low death counts.

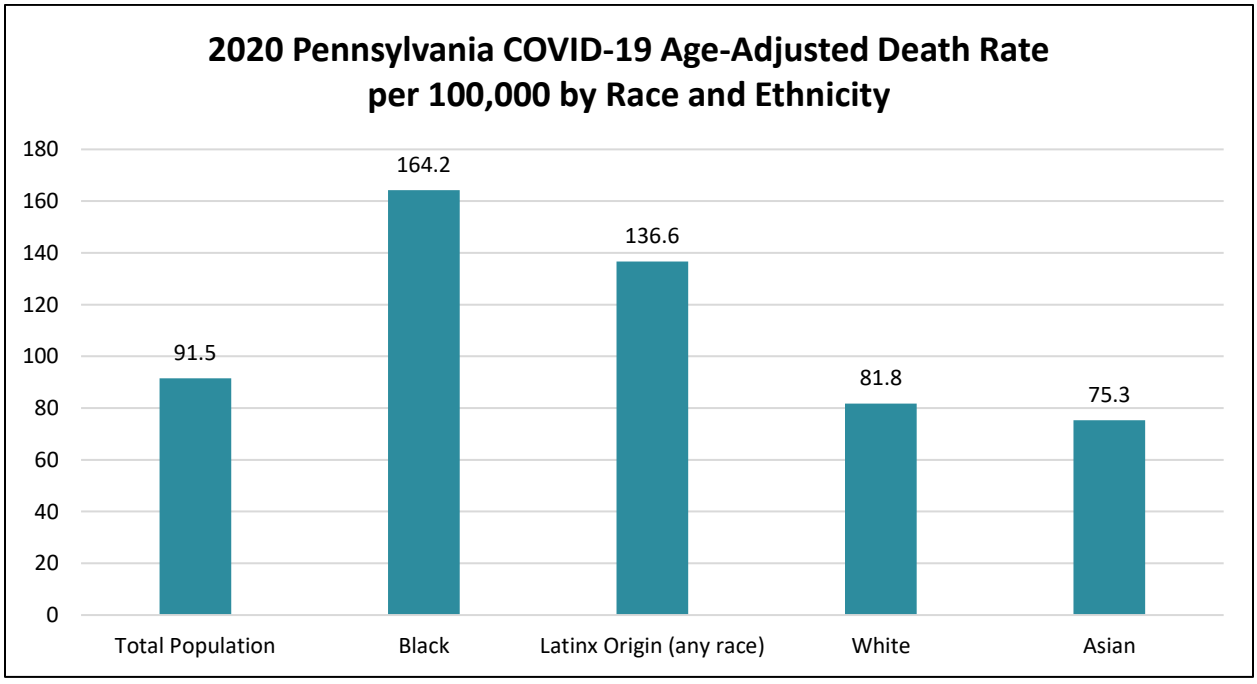
COVID-19

The COVID-19 pandemic both highlighted and deepened socioeconomic and health inequities and exposed disparities within the health and social service systems. The pandemic has not impacted all people equally. Rather, certain structural issues—population density, low income, crowded workplaces, etc.—contribute to higher levels of spread and worse outcomes from COVID-19, and potentially other infectious diseases.

Life expectancy is an overall measure of health and social equity within a community. Structural factors, including housing quality and affordability, environmental conditions, employment, education, transportation, food security, and experience of racism, all play a role in impacting the quality and length of lives.

While localized data on the impacts of COVID-19 on overall life expectancy are not available, local data on chronic disease prevalence suggests an impact on the Central Region communities commensurate to that experienced in the rest of Pennsylvania, as demonstrated in the graphs and charts below.

COVID-19 was the leading cause of death (by death count) for Pennsylvania residents who identified as Latinx and Asian/Pacific Islander in 2020. While COVID-19 was the third leading cause of death for Black residents – who also suffer the highest rates of co-morbid conditions that would exacerbate or be exacerbated by COVID-19 – the death rate for Black residents was the highest of any group, followed by residents who identify as Latinx. **Black and Latinx groups experienced the largest decline (5%) in life expectancy due to COVID-19, but Black people have the lowest overall life expectancy at now 71.5 years, 5.5 years below the average for all citizens, and closer to 6 years below any other single group.**

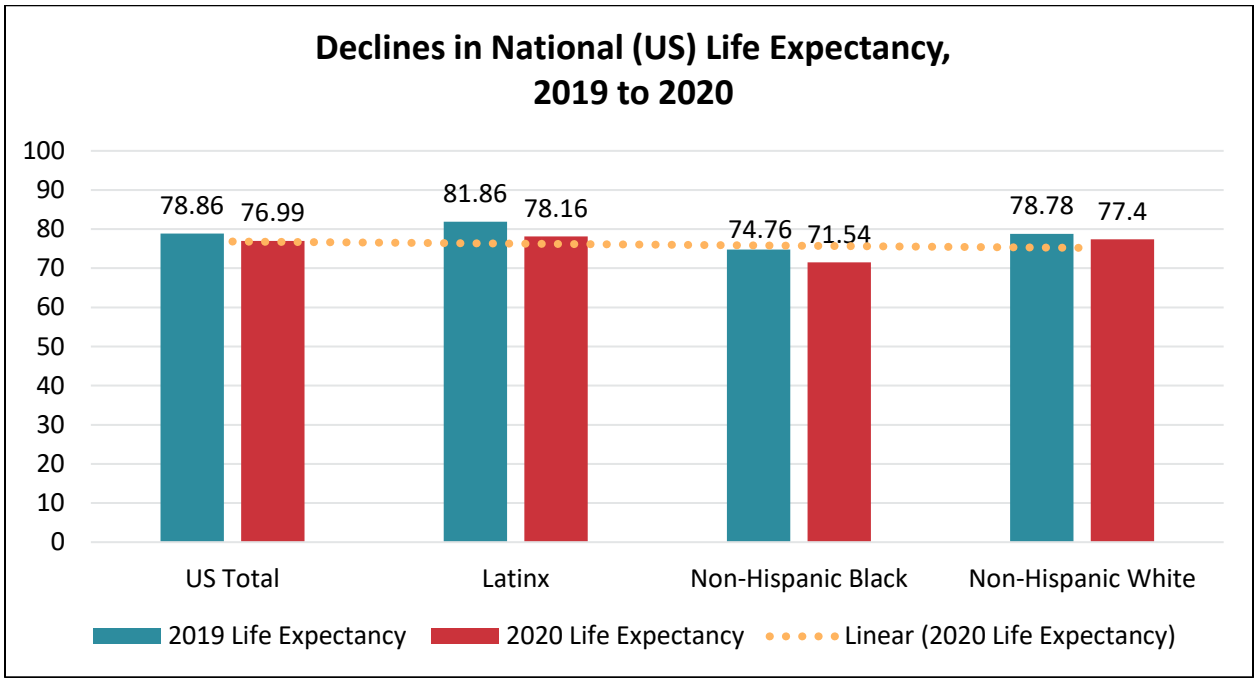


Source: Pennsylvania Department of Health

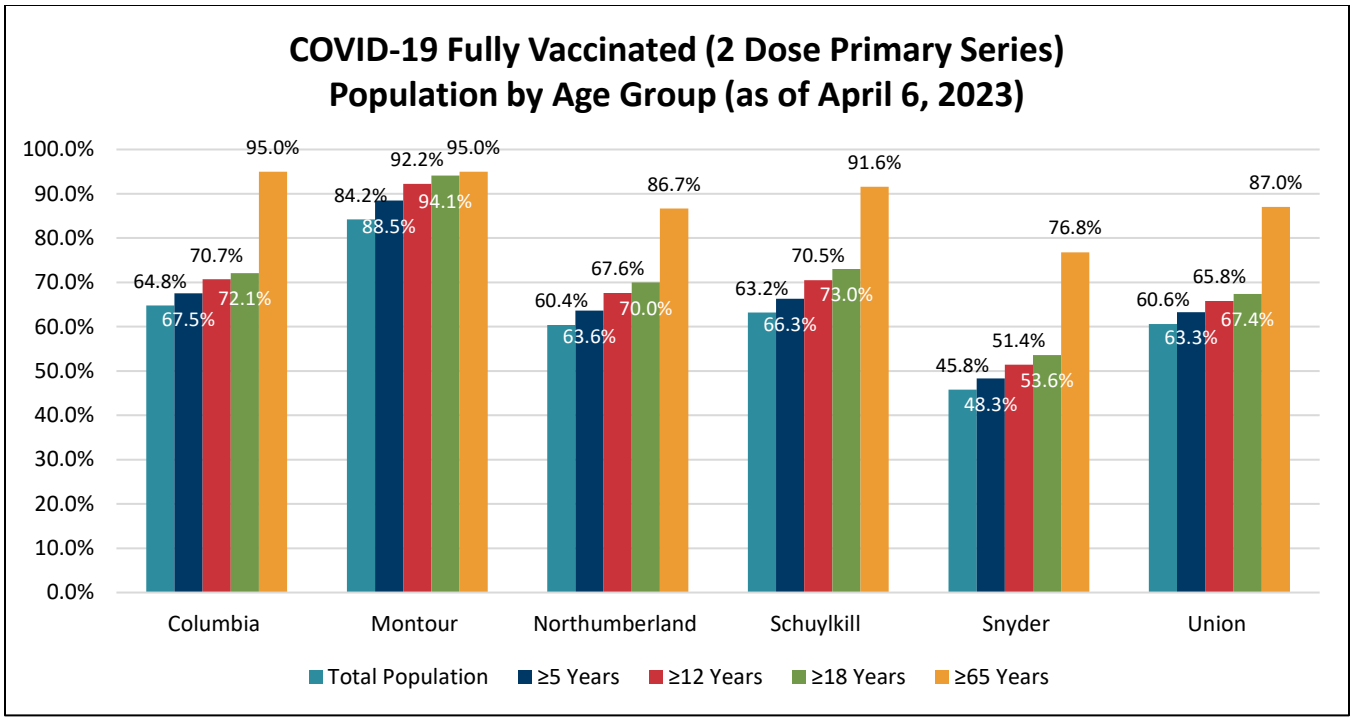
Leading Causes of Death among Pennsylvania Residents by Race and Ethnicity in 2020

Rank	Asian/Pacific Islander		Black		White		Latinx (any race)	
	Cause	Count	Cause	Count	Cause	Count	Cause	Count
1	Cancer	329	Heart disease	3584	Heart disease	28484	COVID-19	722
2	COVID-19	278	Cancer	2701	Cancer	24326	Cancer	621
3	Heart disease	276	COVID-19	2315	COVID-19	13403	Heart disease	585
4	Cerebrovascular diseases	109	Accidents	1351	Accidents	7604	Accidents	583
5	Accidents	62	Drug-induced deaths	955	Cerebrovascular diseases	5948	Drug-induced deaths	405

Source: Pennsylvania Department of Health



Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention

Populations of Special Interest

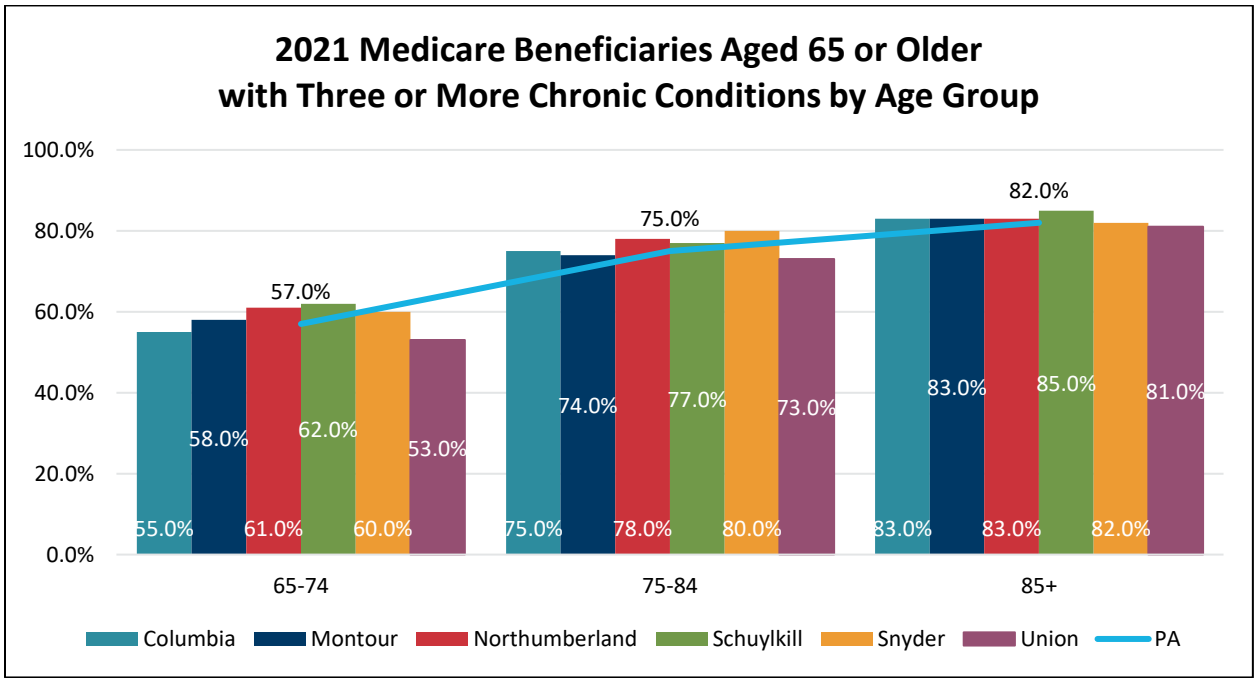
Aging Population

Older adults are generally considered a population placed at risk due to increased chronic disease prevalence, risk of social isolation, and economic instability, among other factors. Adhering to recommended schedules for preventive care can help reduce the burden of disease, limit healthcare utilization and associated costs, and improve quality of life for older adults.

Nationally, among Medicare beneficiaries aged 65 years or older, the most common chronic conditions are hypertension, high cholesterol, and arthritis. Those trends persist in the Central Region, with hypertension and high cholesterol affecting more than half of Medicare Beneficiaries aged 65+, and rheumatoid arthritis affecting more than one-third.

Healthcare utilization and care costs increase significantly with a higher number of reported chronic diseases, due in part to increased emergency department (ED) visits and hospital readmissions. **Across the region in 2021, between 53% (in Union County) and 62% (in Schuylkill County) of Medicare beneficiaries aged 65-74 reported three or more chronic conditions. Disease prevalence increased to between 81% and 85% at age 85+.**

The Central Region is aging with an increasing proportion of residents aged 65 or older. Access to integrated care that bears in mind the complete and complex needs of the aging – especially as individuals increasingly desire to age-in-place – will need to be a top priority. Meeting the needs of the aging population may be challenged in a region with many rural communities, where isolation is more prevalent and access to public transportation and digital access and literacy are more limited.



Source: Centers for Medicare & Medicaid Services

2021 Select Chronic Conditions among Medicare Beneficiaries Aged 65-74 Years

	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Alzheimer's disease, related disorders, senile dementia	2%	2%	2%	2%	2%	2%	2%	2%
Cancer (breast, lung, colorectal, prostate)	10%	10%	10%	10%	10%	9%	10%	9%
Depression	16%	18%	19%	16%	18%	15%	16%	15%
Diabetes	25%	24%	27%	25%	25%	22%	24%	24%
High cholesterol	61%	64%	67%	69%	72%	67%	65%	58%
Hypertension	59%	59%	62%	64%	61%	57%	60%	59%
Obesity	31%	26%	29%	39%	29%	21%	27%	21%
Rheumatoid arthritis	28%	30%	31%	32%	32%	30%	31%	30%

Source: Centers for Medicare & Medicaid Services

2021 Select Chronic Conditions among Medicare Beneficiaries Aged 75-84 Years

	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Alzheimer's disease, related disorders, senile dementia	9%	10%	9%	8%	9%	9%	9%	9%
Cancer (breast, lung, colorectal, prostate)	16%	16%	15%	14%	14%	16%	15%	14%
Depression	17%	19%	21%	18%	20%	19%	18%	17%
Diabetes	29%	29%	34%	31%	34%	28%	30%	29%
High cholesterol	74%	75%	78%	78%	82%	78%	76%	72%
Hypertension	76%	76%	78%	80%	78%	76%	78%	75%
Obesity	31%	26%	26%	32%	33%	23%	25%	19%
Rheumatoid arthritis	38%	38%	41%	41%	42%	40%	41%	39%

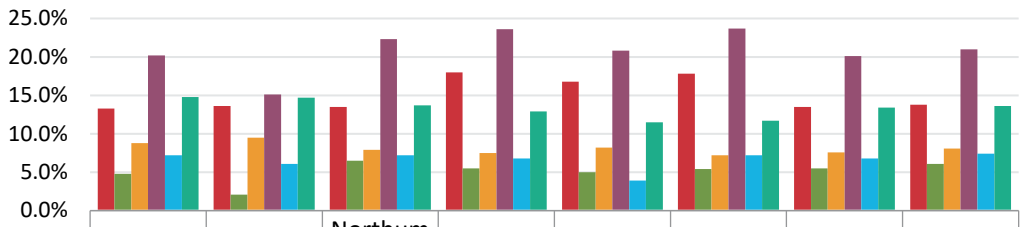
Source: Centers for Medicare & Medicaid Services

2021 Select Chronic Conditions among Medicare Beneficiaries Aged 85 Years or Older

	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Alzheimer's disease, related disorders, senile dementia	26%	27%	27%	26%	25%	25%	26%	25%
Cancer (breast, lung, colorectal, prostate)	16%	14%	14%	15%	15%	15%	15%	14%
Depression	23%	23%	27%	24%	24%	26%	23%	21%
Diabetes	27%	27%	27%	29%	27%	27%	27%	27%
High cholesterol	69%	73%	74%	75%	78%	74%	71%	67%
Hypertension	86%	86%	85%	87%	84%	84%	85%	83%
Obesity	17%	13%	14%	18%	15%	14%	14%	11%
Rheumatoid arthritis	46%	48%	50%	47%	48%	47%	48%	45%

Source: Centers for Medicare & Medicaid Services

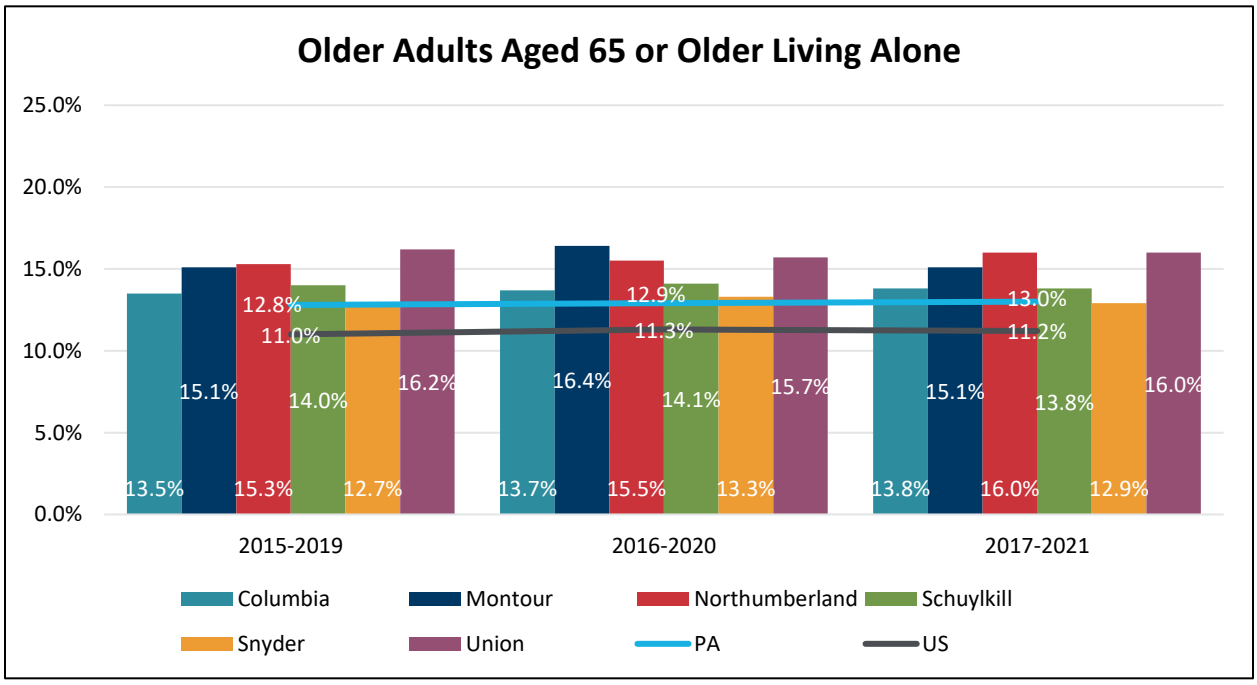
2017-2021 Prevalence of Disabilty Type among Older Adults (65+)



	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Hearing difficulty	13.3%	13.6%	13.5%	18.0%	16.8%	17.8%	13.5%	13.8%
Vision difficulty	4.8%	2.1%	6.5%	5.5%	5.0%	5.4%	5.5%	6.1%
Cognitive difficulty	8.8%	9.5%	7.9%	7.5%	8.2%	7.2%	7.6%	8.1%
Ambulatory difficulty	20.2%	15.1%	22.3%	23.6%	20.8%	23.7%	20.1%	21.0%
Self-care difficulty	7.2%	6.1%	7.2%	6.8%	3.9%	7.2%	6.8%	7.4%
Independent living difficulty	14.8%	14.7%	13.7%	12.9%	11.5%	11.7%	13.4%	13.6%

Source: US Census Bureau, American Community Survey

Older Adults Aged 65 or Older Living Alone



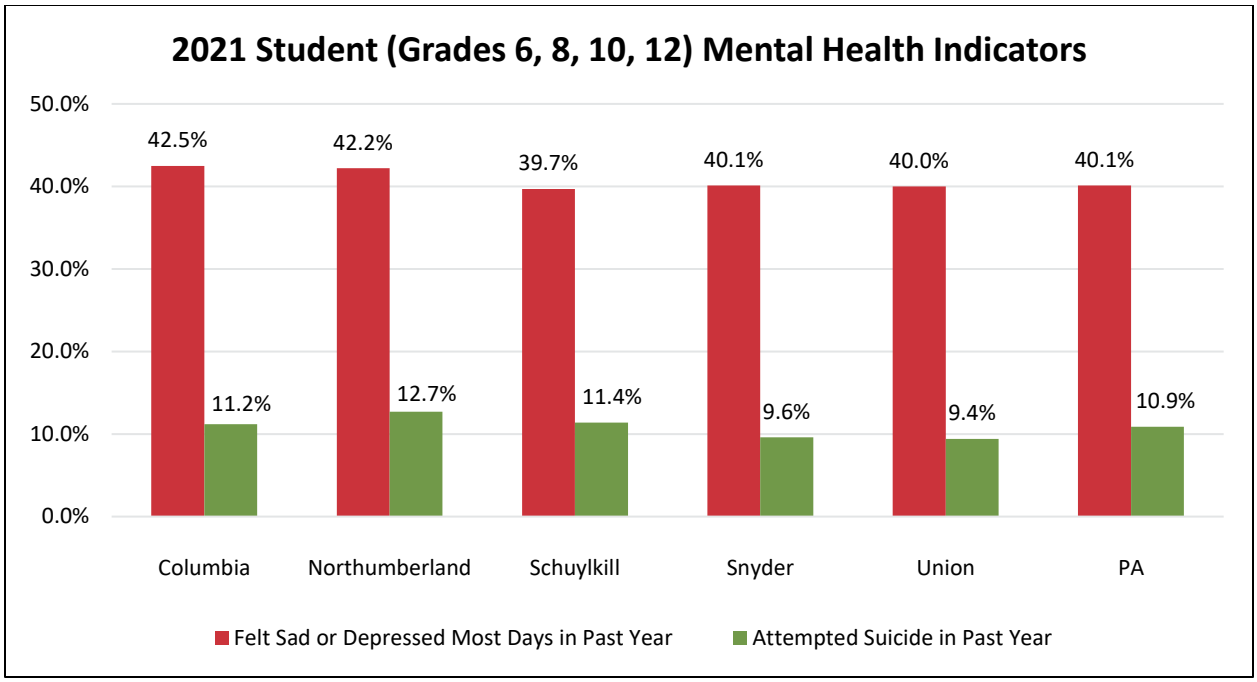
Source: US Census Bureau, American Community Survey

Youth

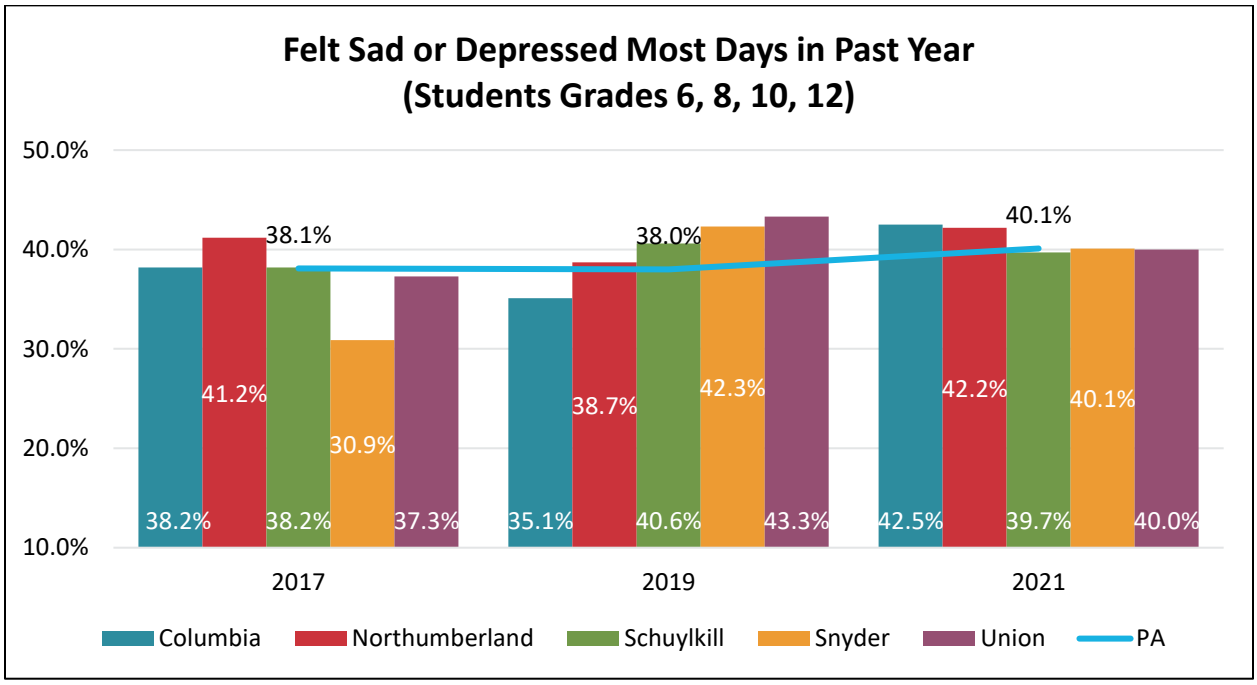
The COVID-19 pandemic has made unprecedented changes to the lives and experiences of young people worldwide. These concerns represent Adverse Childhood Experiences (ACEs), defined as traumatic or stressful events that occur before the age of 18. ACEs can have lifelong impacts on economic, educational, mental, and physical health outcomes for individuals and are associated with decreased life expectancy. While most ACEs are the result of individualized experiences, the graphic below represents how adverse community environments amplify the impact of individual ACEs.

Mental and behavioral health disorders can be both the result of and the cause of ACEs. Students across Pennsylvania, including the Central Region, are showing a steady decline in substance use of all kinds, and reported use within the region is generally on par with or lower than elsewhere in the state. **The decline in substance use is an especially helpful measure given the ongoing rise in mental health concerns.** Mental health challenges among youth were proportionately high prior to the COVID-19 pandemic and are higher still in recent years.

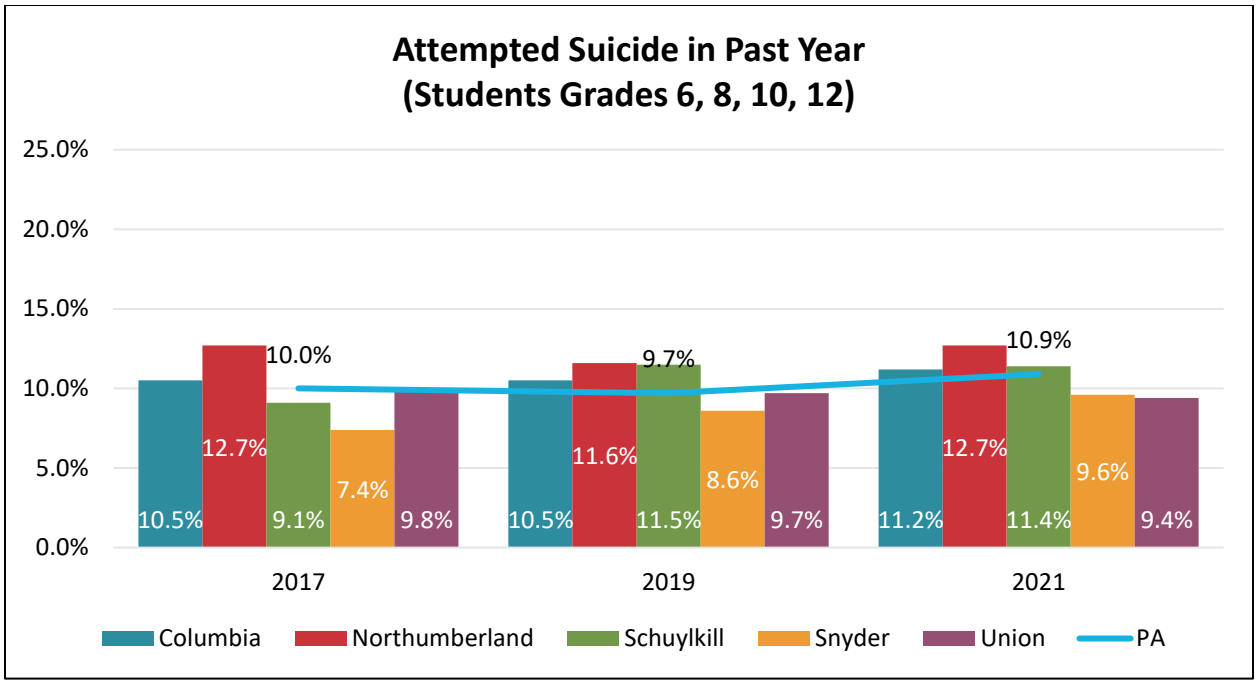
Schools, as they have finally re-opened to "normal" capacity in the last year are feeling the impact of these numbers in tangible ways. **Young people are struggling. In particular, fewer than half of students across the region "feel that school is going to be important for their later life."** Despite this widespread attitude, school outcomes are inextricably linked to all indicators of overall health and well-being later in life. This pandemic within the pandemic requires immediate attention and creative, holistic, and well-funded intervention.



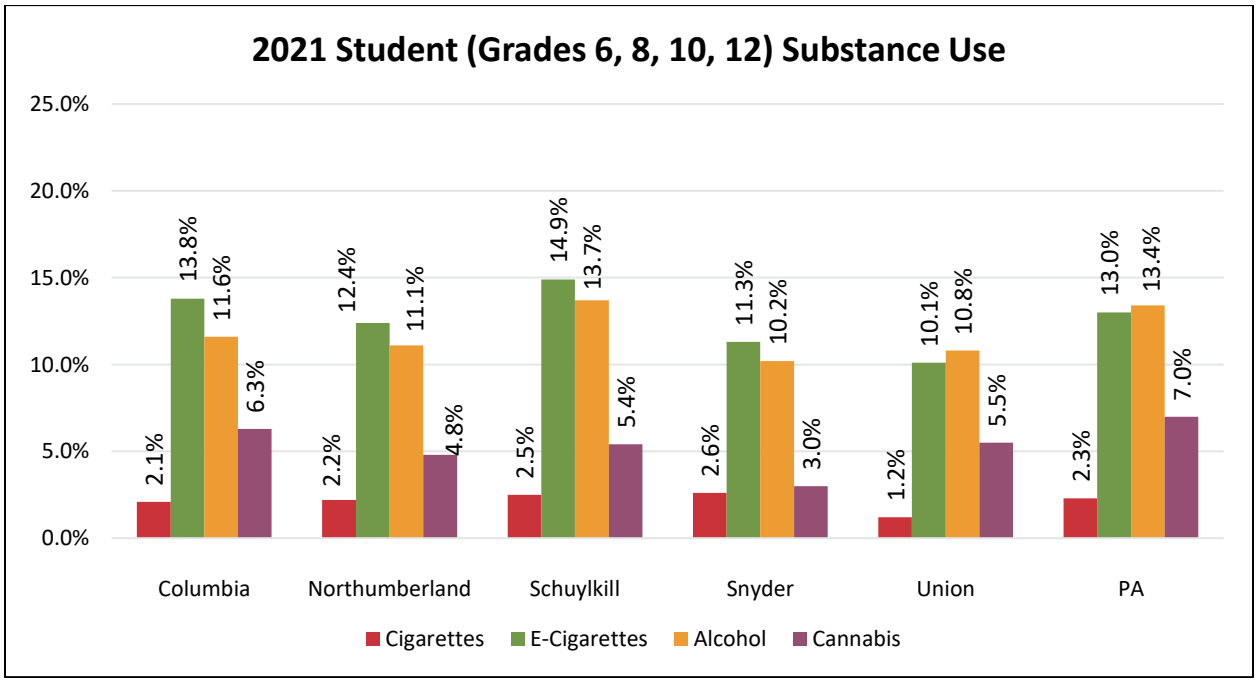
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



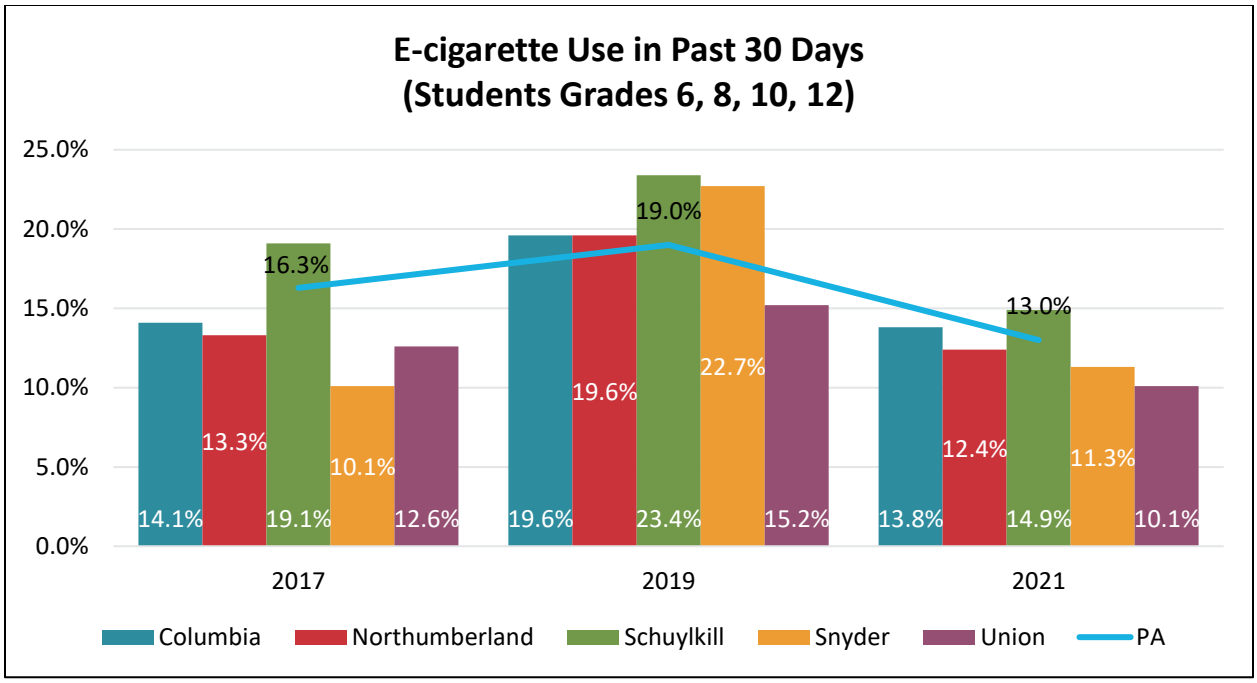
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



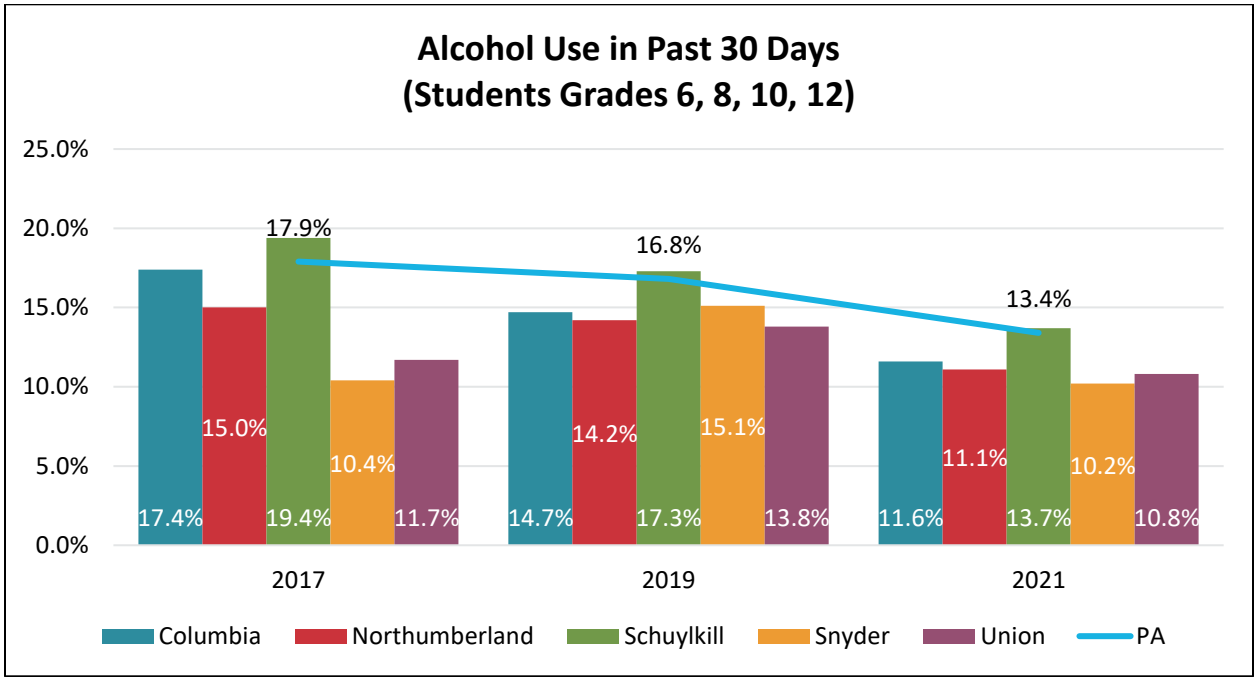
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



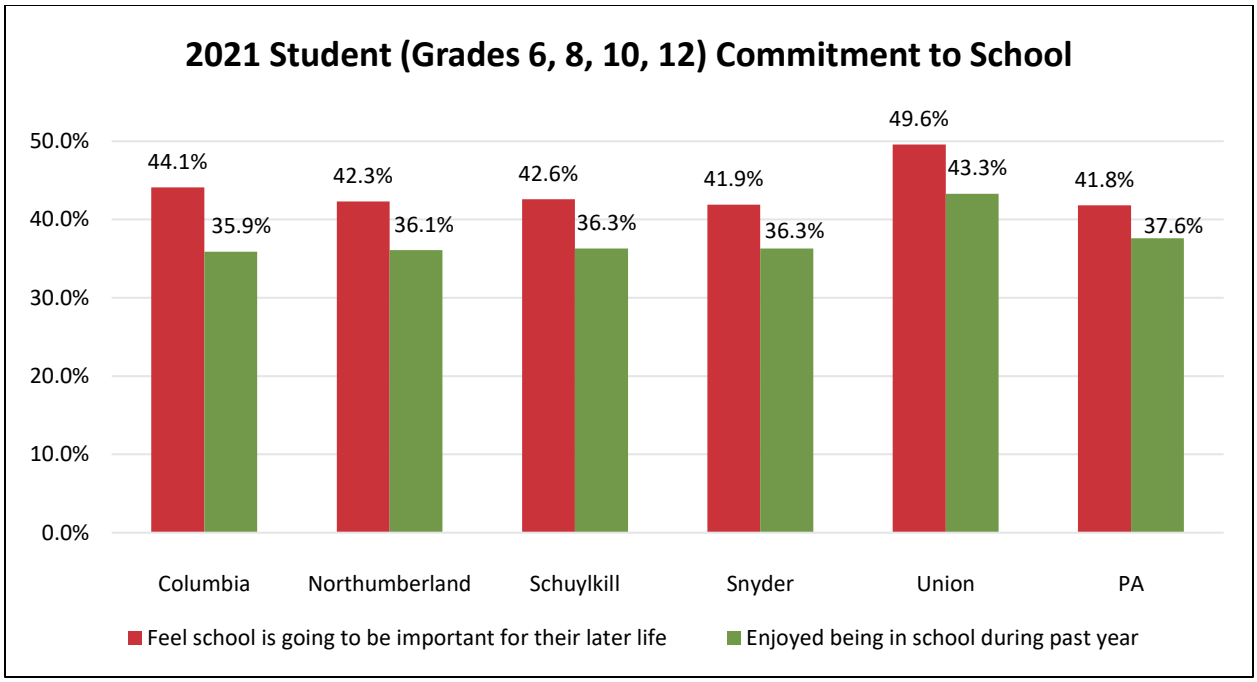
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.

LGBTQIA+

In spring 2022, the Pennsylvania Department of Health, Bradbury-Sullivan LGBT Community Center, and the Research & Evaluation Group at Public Health Management Corporation partnered to administer the 2022 Pennsylvania LGBTQ Health Needs Assessment survey. The survey is conducted biennially to assess the diverse health and wellness needs of LGBTQIA+ individuals. The foundation for the assessment is a recognized historical deficit in representation of LGBTQIA+ individuals in large data systems, limiting widely shared information about this population.

A total of 4,228 LGBTQIA+ Pennsylvanian respondents participated in the online English/Spanish survey. Per the assessment report, "Respondents come from more than 760 different ZIP codes across 66 of Pennsylvania's 67 counties. Respondents identify across LGBTQ communities, including more than 40 percent of respondents who identify as transgender, gender nonconforming, or non-binary (42.4%). Respondents were also able to share other identities, including over 1,000 respondents who identify as neurodivergent, autistic or as a person on the autism spectrum (24.4%). In addition, 123 respondents were born intersex, making this respondent sample the largest known intersex dataset in Pennsylvania."

Mental health and substance use disorders were among the top concerns for LGBTQIA+ community members. When asked to prioritize the top three health issues impacting LGBTQIA+ communities, depression was the most frequently selected priority issue by survey respondents (57.3%). According to the assessment, "Depression was selected as a top priority by more than half of every respondent age group." Other top priorities included loneliness and isolation (37.4%), suicide (35.5%), and alcohol or other substance addictions (34.5%). It is worth noting that after mental health and substance use disorder, access to welcoming care was the next most frequently selected priority issue (33.2%).

The following are other key findings from the survey, taken directly from the 2022 Pennsylvania LGBTQ Health Needs Assessment report and grouped by overarching theme:

General Health

- More than nine in 10 respondents (96.1%) were interested in incorporating healthy living strategies such as healthy eating, active living, and tobacco cessation into their life.
- More than half of respondents ages 18 and older reported having tried cigarettes at some point in their lives (56.3%). The current smoking rate of LGBTQ adult respondents is estimated as 1.6 times higher than that of the general adult population in Pennsylvania. One in every five respondents who reported ever trying any tobacco product used flavored tobacco or vape products, such as menthol (19.8%).

Healthcare

- Within the past year, more than a quarter of respondents had not visited a doctor for a routine check-up (27.4%) and more than two in five had not visited any type of dentist (43.0%).
- Almost half of respondents had not had a flu vaccine in the past year (47.3%).
- More than nine in 10 respondents reported being fully vaccinated for COVID-19 at the time of this survey (92.7%). More than eight in 10 of those fully vaccinated had also received a booster (82.9%) and another one in 10 planned to get a booster (13.9%).
- Over a third of respondents had faced a barrier to receiving care, both physical healthcare (37.6%) and mental healthcare (38.5%).
- Four in 10 respondents preferred to access LGBTQ cancer-related support through an LGBTQ community organization (41.5%).

Discrimination

- In their lifetime, more than six out of 10 respondents (62.4%) had experienced discrimination based on their LGBTQ identity.
- Almost a third of respondents experienced a negative reaction from a healthcare provider when they learned they were LGBTQ (32.1%). Nearly half of respondents feared seeking healthcare services because of past or potential negative reactions from healthcare providers (45.9%).
- Approximately 37.7% of respondents did not believe most of their healthcare providers have the medical expertise (e.g., transgender care, PrEP) related to their health needs as a LGBTQ person.

Basic Needs

- More than two in 10 respondents (21.0%) had experienced homelessness in their lifetime. More Black, Indigenous and people of color (BIPOC) respondents, transgender or non-binary respondents and respondents living with a disability have experienced homelessness in their lifetime compared to respondents overall.
- Three in 10 respondents worried their food would run out before they got money to buy more in the past year (29.7%).

Mental Health & Substance Use Disorder

- In the past year, three in four respondents reported experiencing a mental health challenge (75.0%).
- Nearly half of respondents (48.0%) reported having ever thought of harming themself, with more than three out of four (83.3%), first having thoughts of self-harm at age 19 or younger.
- Depression and other mental health issues were top priorities for respondents, along with alcohol and other substance addiction.

Sexual Health

- Almost one in three respondents (28.1%) reported never being tested for HIV. HIV risk can be prevented with the use of Pre-Exposure Prophylaxis (PrEP), which one in 10 respondents ages 18-64 take (10.5%). Twenty percent (20%) of all gay cisgender men respondents took PrEP (20.8%). Among respondents not taking PrEP, almost one-third experienced at least one primary risk factor for HIV (31.6%).
- Over one-third of respondents had used alcohol or other drugs to help them have sex (34.4%), also known as "chemsex."

Pregnancy, Birth, and Babies

Having a healthy pregnancy is the best way to have a healthy birth. According to the March of Dimes, infants born to mothers who have not received prenatal care have an infant death rate five times the rate of infants born to mothers accessing prenatal care starting in the first trimester of pregnancy.

Across the region, there is an opportunity for improvement in pregnancy outcomes, notably around prenatal care access and smoking during pregnancy. No county meets the national benchmark or Healthy People 2030 (HP2030) goal for first trimester prenatal care access. **Smoking prevalence among adults in the region is higher than across the rest of the state and the nation, a trend that continues among pregnant people in most counties. Outside of Montour and Union counties, between 10% and 18% of people reportedly continued to smoke during pregnancy, compared to 9% across the state and only 5% nationwide.**

However, it doesn't appear that any one factor, whether the timing of the onset of prenatal care or smoking status during pregnancy, has a consistent impact on birth outcomes, such as prematurity or low-birth weight, within the region. All counties, excluding Northumberland, experience these outcomes at a similar rate as the state and nation.

Black birthing people and babies have the worst outcomes across the state and nation compared to any other racial group. While more local data on these outcomes are not available, and the local Black population is small, it would be remiss not to note these trends and learn from efforts in other places to reduce these disparities.

2020 All Births and Births by Race and Ethnicity as Percentage of All Births in the Area

	All Births		White Birth %	Black/African American Birth %	Latinx (any race) Birth %
	Count	Birth Rate per 1,000			
Columbia	544	16.4	91.2%	1.5%	5.0%
Montour	220	23.8	90.0%	1.4%	3.2%
Northumberland	877	19.5	90.9%	2.6%	7.4%
Schuylkill	1,280	18.5	86.3%	2.3%	14.1%
Snyder	377	18.9	96.8%	1.3%	1.6%
Union	406	20.9	91.9%	2.7%	2.2%
Pennsylvania	130,730	19.9	69.4%	14.2%	12.8%
United States	3,613,647	11.0	51.0%	14.7%	24.0%

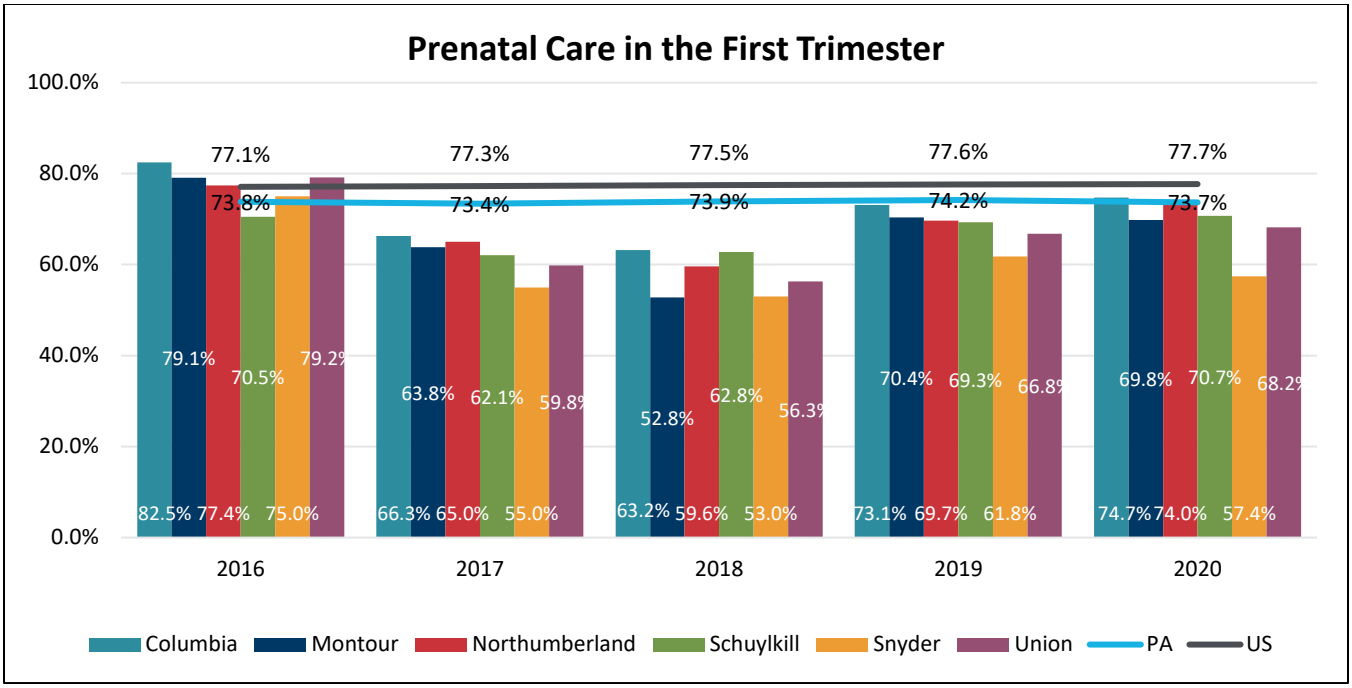
Source: Pennsylvania Department of Health & Centers for Disease Control and Prevention

2020 Maternal and Infant Health Indicators

Opportunities for improvement based on HP2030 goals are highlighted

	Teen (15-19) Births	First Trimester Prenatal Care	Premature Births	Low Birth Weight Births	Non-Smoking during Pregnancy
Columbia	3.3%	74.7%	9.0%	7.2%	86.5%
Montour	NA	69.8%	9.1%	5.0%	94.0%
Northumberland	5.8%	74.0%	10.9%	10.1%	81.5%
Schuylkill	4.8%	70.7%	10.1%	7.3%	81.6%
Snyder	4.0%	57.4%	7.7%	6.1%	89.7%
Union	2.5%	68.2%	4.0%	4.2%	93.3%
Pennsylvania	3.7%	73.7%	9.6%	8.3%	91.3%
Black/African American	6.8%	64.8%	14.0%	14.5%	93.1%
White	2.6%	77.2%	8.6%	6.8%	90.1%
Latinx (any race)	8.5%	65.3%	10.2%	8.5%	95.5%
United States	4.4%	77.7%	10.0%	8.2%	94.5%
Black/African American	6.4%	68.4%	14.3%	14.1%	95.5%
White	3.0%	82.8%	9.1%	6.8%	91.9%
Latinx (any race)	6.8%	72.3%	9.8%	7.4%	98.6%
HP2030 Goal	NA	80.5%	9.4%	NA	95.7%

Source: Pennsylvania Department of Health & Centers for Disease Control and Prevention



Source: Pennsylvania Department of Health & Centers for Disease Control and Prevention

2016-2020 Infant Death per 1,000 Live Births

	Infant Deaths
Columbia	5.1 (n=2,738)
Montour	NA (n=1,087)
Northumberland	6.6 (n=4,565)
Schuylkill	8.5 (n=6,589)
Snyder	NA (n=2,099)
Union	NA (n=2,010)
Pennsylvania	5.9 (n=4,012)
Black/African American	13.0
White	4.6
Latinx (any race)	6.5
HP2030 Goal	5.0

Source: Pennsylvania Department of Health

2018 Pennsylvania Pregnancy-Associated Mortality Ratio per 100,000 Live Births by Race and Ethnicity

All Live Births	Non-Hispanic Black/African American	Non-Hispanic White	Non-Hispanic Other Race	Latinx
82	163	79	29	70

Source: Pennsylvania Department of Health

Key Stakeholder Survey

Background

An online Key Stakeholder Survey was conducted with community representatives of the Central Region to solicit information about local health needs and opportunities for improvement. Community representatives included healthcare and social service providers; public health experts; civic, social, and faith-based organizations; policy makers and elected officials; and others serving diverse community populations.

A total of 180 individuals representing the Central Region responded to the survey. A list of the represented community organizations and the participants' respective titles is included in Appendix B.

Many of the stakeholders' organizations served residents of more than one Pennsylvania county, and a few provided statewide, or even nationwide, services. In total, stakeholder organizations served more than 40 Pennsylvania counties. More than 60% of respondents worked with organizations serving Northumberland, Snyder, and Union counties within the Central Region. Most considered their services to be open to all populations, regardless of age, race, religion, health needs, or income. Beyond that, the populations most served were people or families with low incomes or in poverty, children (age 0-11 years), and older adults/seniors.

Populations Served by Key Stakeholder Survey Participants

	Number of Participants	Percent of Total
No specific focus-serve all populations	111	61.7%
People or families with low incomes or in poverty	38	21.1%
Children (age 0-11)	36	20.0%
Older adults/Seniors	31	17.2%
Adolescents (age 12-18)	28	15.6%
Young adults (age 19-24)	28	15.6%
People with behavioral health concerns	23	12.8%
Other	23	12.8%
People or families experiencing homelessness	22	12.2%
People or families without health insurance or who are underinsured	20	11.1%
People with disabilities (physical, intellectual, developmental, etc.)	18	10.0%
LGBTQ+ community	13	7.2%
Veterans	12	6.7%
African American/Black	8	4.4%
Pregnant or postpartum people	8	4.4%
Asian/South Asian	5	2.8%
Hispanic/Latinx	5	2.8%
American Indian/Alaska Native	4	2.2%
People with memory care (Alzheimer's disease, dementia) concerns	4	2.2%
Faith-based community	3	1.7%
Pacific Islander/Native Hawaiian	3	1.7%
New Americans/Immigrants/Refugees	2	1.1%
Undocumented citizens	2	1.1%

Survey Findings

Health and Quality of Life

While the goal of the CHNA is to address gaps in care and opportunities for improvement, it is imperative to recognize the strengths that people and communities *already* possess, and to leverage and build from those in future strategic planning. This approach helps to foster buy-in and boost morale.

While most stakeholders described the overall quality of life of the people they serve as average (54%), about one in seven respondents described the quality of life as "above average" or "excellent," and all stakeholders identified numerous strengths within the community. These strengths, listed below, can be drawn upon to improve the quality of life for all people in the Central Region.

What are the top strengths in the community(ies) you serve?
Top Key Stakeholder Selections.

	Number of Participants	Percent of Total
Access to healthcare services	64	38.3%
Good schools	61	36.5%
Safe neighborhoods	51	30.5%
Available social services	32	19.1%
Community connectedness	31	18.6%
Access to crisis support services (e.g., Neighborly, United Way 211, 988 National Suicide Hotline)	24	14.4%
Clean environment	23	13.8%
Employment opportunities	23	13.8%
Strong family life	21	12.6%
Resources for seniors	19	11.4%

Stakeholders saw "access to healthcare services," as their communities' top strength, while "ability to afford healthcare," "health literacy," and "limited healthcare capacity" were among the most pressing concerns noted from the same group. Other feedback collected and shared indicated that the expansion of telehealth options during the COVID-19 pandemic improved perceptions of healthcare access. In light of these different perspectives, it would be helpful to gain additional insight into what stakeholders would consider "good access" to healthcare services.

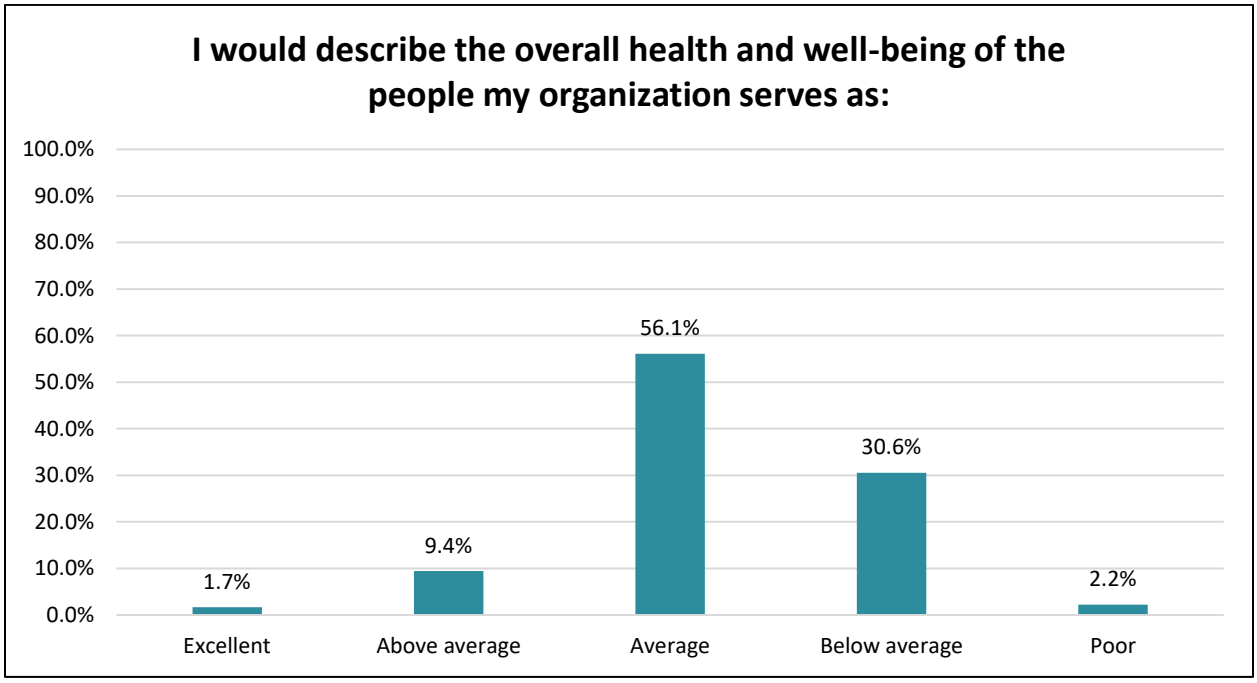
Additionally, stakeholders identified feelings of safety within the community, both from violence and within interpersonal relationships, as well as *some* opportunities for social mobility such as good schools, employment opportunities, and available stop-gap resources for those who fall on hard times, among the top strengths.

Thinking about the people their organization serves, key stakeholders were asked to describe the overall health and well-being of individuals and the most pressing concerns affecting them. Approximately 56% of stakeholders described overall health and well-being as "average" and 31% described it as "below average" or "poor," indicating opportunity for health improvement.

When asked to identify the top five most pressing concerns affecting the people their organization serves, an overwhelming 61% of respondents selected mental health conditions, and almost half (46%) identified lack of transportation. Childcare (affordable, quality), housing (affordable, quality), and substance use disorder were all selected by more than one-third of respondents as top five concerns among constituents.

The top concerns highlight the interrelatedness and interdependence of health and well-being with the conditions and concerns of everyday life. Substance use disorder and poor mental health outcomes can be both precipitated by and exacerbated by stressors such as unsafe and unaffordable housing and limited childcare and transportation options that make it difficult to participate in the community. These environmental concerns also hinder individuals' ability to receive adequate care for ongoing behavioral health needs.

It is notable that, while COVID-19 is not, and may never be "over," not one key stakeholder named the pandemic (the disease and/or its immediate effects) as a top five concern. However, it would be remiss to ignore its lingering impact on many of the issues affirmed by respondents as high priority.



What are the most pressing concerns among people that your organization serves? Top Key Stakeholder Selections.

	Number of Participants	Percent of Total
Mental health conditions	101	60.5%
Lack of transportation	77	46.1%
Housing (affordable, quality)	60	35.9%
Substance use disorder (dependence/ misuse of opiates, heroin, etc.)	59	35.3%
Childcare (affordable, quality)	58	34.7%
Ability to afford healthcare	55	32.9%
Economic stability (employment, poverty, cost of living)	54	32.3%
Ability to afford health foods	44	26.4%
Overweight/Obesity	31	18.6%
Stress (work, family, school, etc.)	25	15.0%
Older adult health concerns	23	13.8%
Health literacy (ability to understand health information)	21	12.6%
Limited healthcare capacity (appointments, convenient time/location, etc.)	18	10.8%
Child/Adolescent health concerns	16	9.6%
Limited healthcare providers	15	9.0%

In a follow-up question, key stakeholders were asked to provide open-ended feedback on what the community needs to do differently to address the most pressing concerns they identified. Consistent themes addressed access to care barriers that focus on improving social drivers of health, efforts to increase the capacity and quality of healthcare and social service providers, and improved partnerships between organizations as well as between organizations and the communities they serve. Verbatim comments by stakeholders are included below.

- *"Continue to focus on social determinants; people can't focus on health issues if basic housing/food/job needs are not met."*
- *"I believe investment in building out community resources for behavioral health resources, housing and transportation specifically for members who are transitioning from one level of care to another needs to be priority. We often struggle to transition a member safely from an acute or post-acute facility back into the community because they do not have appropriate housing or transportation for their follow up appts."*
- *"Offer childcare for their employee's families."*
- *"…the cost of nutritious foods is too exorbitant. Individuals with lower incomes cannot afford healthy choices and therefore choose prepackaged, economical foods. It would benefit the community at large to find a way to provide some sort of local transportation for those who cannot afford vehicles to make appointments, go grocery shopping, etc. Many of the local universities have a 'communal' bus that takes students to stores for shopping purposes and it seems the community should be able to provide something like that for its members."*

- *"Provide health literacy (physical, chronic, and above all, mental wellness) workshops out in the community. In general, more people need to understand that mental health needs to be regarded on par with physical health. With stigma reduction, there will be more community support for the intersection of mental health, substance abuse, and poverty. Here at the Bloomsburg Public Library we provide a stopping place for vulnerable, 'unseen' individuals. On the other hand, we have other patrons who are stuck in a mindset that people who live with addiction, poverty, or mental illness should continue to be criminalized or pushed to the margins."*
- *"Incentivize caregivers with better pay, benefits to encourage applicants and as well as to retain employed caregivers, provide housing for those who don't qualify for skilled care."*
- *"Training and technical assistance to ensure providers are educated and comfortable addressing intimate partner violence, sexual assault, human trafficking and other traumas and improve partnership with local victim service organization."*
- *"Educational programs/partnerships to build the healthcare workforce pipeline while elevating educational attainment."*
- *"Work more collaboratively with nonprofits and agencies whose missions align with solving these challenges. Move beyond ownership to a greater good model. Too much competition over limited resources and with the excuse of we are doing it for the greater good."*
- *"Continuum of care and referrals to partnering organizations. Collaborative funding applications to address systemic issues."*
- *"Bring health and wellness programs into the communities via church groups, schools and community centers to offer help in a neutral space – not clinic/doctor office."*
- *"Connect with nontraditional service providers like community centers, senior centers. Advocate at the state and federal level for funding for sex education, and family resources as health care."*
- *"Be more visible and accessible in the community. Make health care less complicated. Talk to people in lay terms."*
- *"More mobile clinics. Preventative clinics, irrespective of insurance availability. Insurance is a big problem."*

Social Drivers of Health

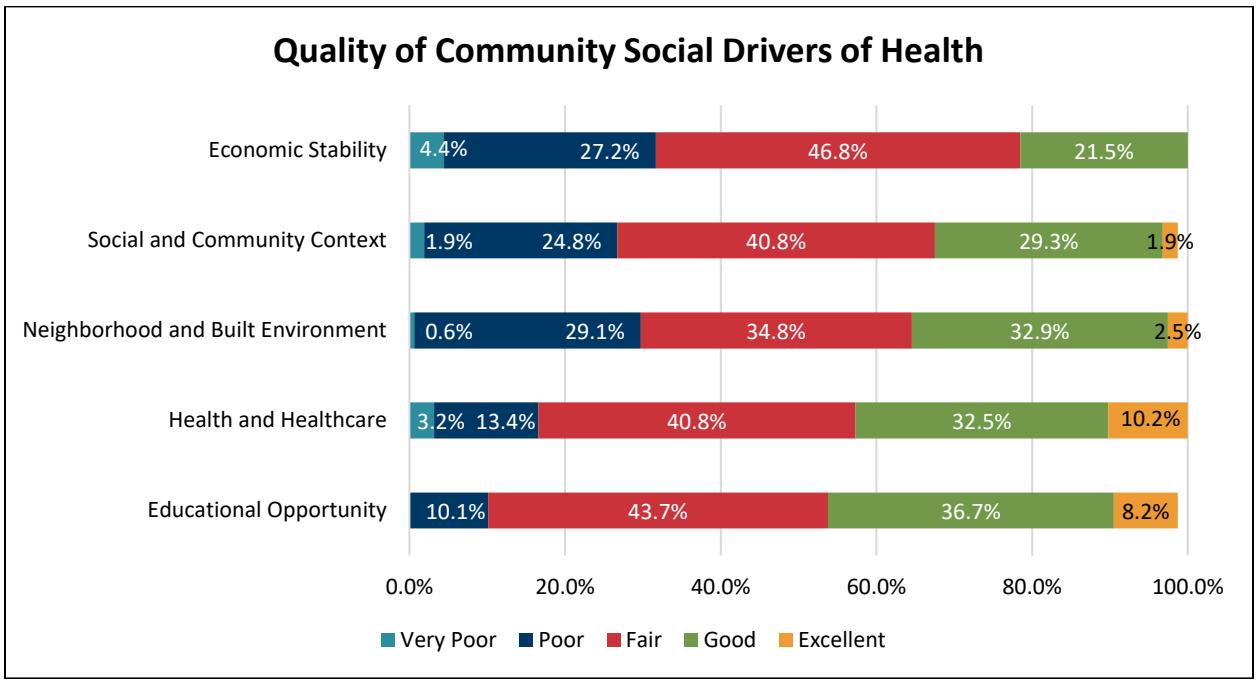
Key stakeholders were asked to rate the quality of the social drivers of health (SDoH) within the community(ies) their organization serves, focusing on the five key domains identified by Healthy People 2030: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context. Ratings were provided using a scale of (1) "very poor" to (5) "excellent."

The mean score for each SDoH domain is listed in the table below in rank order, followed by a graph showing the scoring frequency. Educational opportunity was seen as the strongest community SDoH with 45% of stakeholders rating it as "good" or "excellent." Economic stability was seen as the weakest SDoH with 47% rating it as "fair" and 32% rating it as "poor" or "very poor." There was greater variability in stakeholders' perceptions of health and healthcare, with the highest percentage of "excellent" ratings, but also the second highest percentage of "very poor" ratings.

Approximately 56% (n= 89) of stakeholders stated that their organization currently screens the people their organization serves for needs related to SDoH.

Ranking of Social Drivers of Health in Descending Order by Mean Score

	Mean Score
Educational Opportunity (Consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)	3.44
Health and Healthcare (Consider access to healthcare, access to primary care, health literacy)	3.33
Neighborhood and Built Environment (Consider access to healthy foods, quality of housing, crime and violence, environmental conditions, transportation)	3.08
Social and Community Context (Consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	3.05
Economic Stability (Consider poverty, employment, food security, housing stability)	2.85



Key stakeholders were invited to provide open-ended feedback on SDoH within the community and examples of how they impact resident health. Verbatim comments are included below.

- *"Hard to retain workforce and pay living wage. Limited healthcare workforce pipeline. Many rural areas face critical issues with transportation, health care access, healthy food, childcare, etc."*
- *"Economic Stability: food security is a real concern in our communities. Local organizations are being leveraged more than ever…Social and Community Context: There is a major cultural divide in our communities. There are negative perceptions of minoritized populations as well as a sense that these populations should leave the area. Perceptions of cultural diversity is that it is a threat to the area versus enrichment…Neighborhood: crime is truly out of control. There has been an uptick in violence against women."*

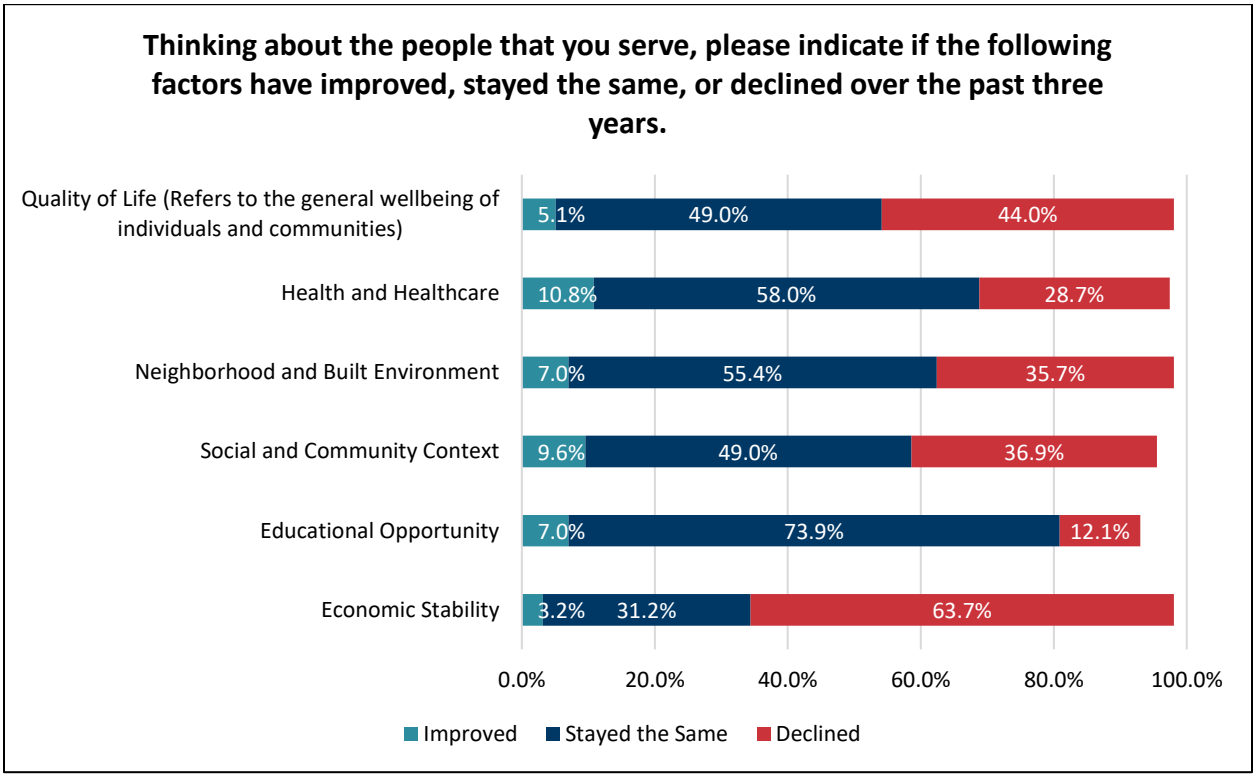
- *"Poor – urgent referrals often take months to be seen. A lot of homelessness as well as drug addiction and overdose in the area although I see a community that fights any movement with homeless shelters or treatment facilities."*
- *"There are no medical or mental health facilities in the towns within our school district. There is also no public transportation in the area."*
- *"Schools, most houses of worship and social institutions not LGBTQ+ supportive in general and some are hostile. Same for families. No LGBTQ Center in the immediate area. Very few GSA clubs or LGBTQ+ youth groups."*
- *"Working in social services for over 30 years and in multiple different fields, I recognize that we live in a very poor county with families that have had multigenerational trauma which affects all areas of their lives as noted above. It takes a lot of time and energy to build trusting relationships to help people move out of the intergenerational problems they have experienced. People who work in human services are not compensated enough to do the hard work that is required to build healthy communities. They too are often living in poverty unable to meet their own basic needs."*
- *"Poverty is a cycle. Many of the young people I work with come from poverty and are desperately trying to get out. The odds are usually against them. Many lack family stability and support at home, especially when it comes to education. Without proper education, participants are left working entry-level jobs, struggling to make ends meet, and relying on assistance programs in order to survive; therefore, making it extremely difficult to end the cycle of poverty."*
- *"The justice involved population are often limited in access to self-sustaining employment. They have issues making enough money to meet their basic needs. Transportation is consistently a barrier due to loss of license. This limits their ability to participate in community activities that give them a sense of belonging. Crime and criminal behavior also limit their ability to reintegrate into society successfully. There is a lack of cognitive behavior interventions, mental health treatment and substance abuse treatment that could help overcome some of the barriers noted that greatly limit the quality of life available to justice involved individuals."*
- *"People with disabilities live in poverty due to the structure of the Medicaid SSI system. Our community offers no further education opportunities after High School to our population. Societal stigmas are a major community barrier for people with disabilities. Transportation continues to be a HUGE barrier for this population that most do not or are not able to drive. Distance to healthcare, options for specialists, medical community stigmas about the quality of life for people with disabilities and offering care based on that stigma."*

COVID-19 Insights and Perspectives

COVID-19 had a significant impact on key stakeholder organizations and communities. While most key stakeholders indicated they have moved on to addressing needs that are, on the surface, distinct from the COVID-19 pandemic, the pandemic continues to have a lingering impact.

Key stakeholders were also asked how SDoH have fared over the last three years, compared to before the pandemic. On four of six SDoH measures, most respondents perceived conditions to be the same as, if not improved, from the start of the pandemic. However, stakeholders cited a perceived precipitous decline in overall economic stability, including poverty, employment, food security, and housing.

Conversely, more stakeholders perceived improvement in health and healthcare than in any other measure (11%), influenced by lessons learned and skills acquired throughout the pandemic, such as telehealth. Feedback to this effect includes stakeholder reflections such as, *"Online support works and is very important and should continue even now that we can also meet physically."*



Additional reflections on continued opportunities for improvement in light of the COVID-19 pandemic and other national events, such as the social justice movements, are highlighted below.

- *"Relate to a variety of ethnic and cultural differences; provide public health screenings targeted to minorities, immigrants and refugees; help people navigate difficult and confusing public systems to qualify for assistance and healthcare; get out into the community – community health workers."*
- *"Work together to efficiently and effectively deploy resources. Reduce duplication of efforts."*
- *"Make an individual's 'total health' the top priority – building systems that incent outcomes based on performance and leverage/coordinate the full suite of community programs and services needed to attain better health."*
- *"Our families do not always know how to advocate for their children. When they cannot get into appointments for illness or injury, they make use of urgent care and become reliant on urgent care, even sometimes for physicals. A primary pediatrician would more likely be able to guide ongoing healthcare of the child and pick up on things that the parents are not."*
- *"Less stigma, offer harm reduction strategies (needle exchanges, methadone clinics, etc.)"*
- *Support and employ more support staff positions – health navigators, CHWs, etc. who can bridge the gaps between those in need and the healthcare and social services providers."*

- *"Routine screenings (colorectal, mammograms, pap), childhood immunizations, and depression screening took a back seat during the COVID-19 pandemic. Organizations need to take stronger initiatives to get back on track."*
- *"By continuing to ride the wave of technology used to increase and improve connectivity with members."*
- *"Transportation is a huge issue in our area. There are many elderly that do not drive and a lot of people that cannot afford cars or gas and cannot get to their appointments because we do not have bus transportation and taxis/Ubers are too expensive."*
- *"Fight for lower insurance rates, focus on hiring and retaining staff and making them happy. Focus a lot less on the bottom line and acquiring more and more and more and more property."*

In closing, key stakeholders were asked to leave any parting or summary thoughts regarding the COVID-19 pandemic. A total of 102 stakeholders responded, and their responses are grouped thematically below.

COVID-19 Pandemic Feedback Themes	Number of Responses
Necessity of teamwork and partnerships (between community-based organizations, among healthcare providers, and between and amongst members of the community in "big" and "small" ways)	24
Mental health (the ongoing impact on people's mental health and the need for increased services, especially for youth)	22
Health education (the necessity of providing consistent, accurate, and accessible health information to members of the community to promote health)	18
Importance of prevention and preparedness, and implementing lessons learned	17
Necessity of addressing mistrust (in the government, in the healthcare system, between diverse community members)	13
Current economic crisis (disparate impact of all factors on the poor, need to address SDoH)	9
More support solutions for vulnerable populations (elderly, people with disabilities)	6
Address ongoing barriers to accessing healthcare (transportation, insurance concerns, etc.)	4
Strengthening capacity of healthcare and social services organization (hiring and retention, training, availability)	3

Next Steps and Future Collaboration

Key stakeholder feedback suggested a strong understanding and respect for the necessity of effective collaboration as a powerful tool toward reaching shared goals on behalf of the community. Key stakeholders were asked to provide recommendations for improvement toward more efficient and effective partnerships, as well as examples of past or current partnerships that they have deemed successful, and perhaps instructive for future endeavors. Verbatim comments are included below.

- *"Better data sharing and seeing the big picture/connectedness of all resources."*
- *"Childcare options for all income levels and additional opportunities for low-to-moderate income families."*
- *"Ensure vulnerable populations are connected with a healthcare based social worker or medical advocate."*
- *"Use 211/Help Line and Warm Line as a resource more to reduce crisis and access to services."*
- *"By financially supporting organizations in their quest to build stronger communities of mutual interest."*
- *"Come out into the community and provide free workshops, talks, screenings in the locations where people already come for information – for example, the Bloomsburg Public Library."*
- *"Keep resource lists for LGBTQ+ people of all ages, and their families and keep them updated. Make it easy for people to search and find gender affirmative care. Work with LGBTQ+ groups, family groups such as PFLAG and Trans Central PA. Make medical record gender affirming."*
- *"Reach out to county BH/ID/ Aging offices for transitioning impaired individuals to supportive communities to reduce revolving door of admission/discharge and to ensure least restrictive housing opportunities with necessary services."*
- *"Perhaps a community collaboration committee that consists of Geisinger leadership and community-based organizations. This would allow for better conversations, collaboration, and ensure that everyone is working toward the same health outcomes."*
- *"If a foster child is a 'no show,' make repeated calls to C&Y caseworkers, CASA volunteers, foster parents, bio parents, and other family members until the child is evaluated."*
- *"More mobile health services would be beneficial."*
- *"The COVID vaccine delivery to vulnerable citizens Task Force was excellent."*
- *"The partnership at the Miller Center is a prime example of successful efforts to address Social Drivers of Health by collaborating on healthy food initiatives to ensure no one goes hungry."*
- *"Partnerships like Healthy Kids Day at the Miller Center where families can learn about healthy lifestyles and receive free information about healthy food, bike helmets for kids, be active together, etc. are fantastic! I'd love to see more of that, partnering with the downtown groups/Chambers/Visitors Bureaus in every community."*
- *"Continue to offer subject matter experts to other organizations."*

Central Region Community Forum

Background

Geisinger, Allied Services, and Evangelical Community Hospital hosted a Community Forum on September 13, 2023, at the Pine Barn Inn in Danville. The forum convened 39 representatives of health and social service agencies, education sectors, senior services, local government, and civic organizations, among others. The objective of the forum was to share data from the CHNA and garner feedback on community health priorities and opportunities for collaboration among partner agencies.

Research from the CHNA was presented at the session. Small group dialogue, focused on identified priority areas, was facilitated to discuss research findings, existing resources and initiatives to address priority areas, underserved populations, and new opportunities for cross-sector collaboration.

A summary of the forum discussion follows, grouped by priority area and common themes. A list of participants and their respective organization is included in Appendix C.

Common Themes

- The region benefits from robust health and social services to improve access to care, behavioral health, and chronic disease. Participants identified a number of services, many addressing SDoH barriers (e.g., transportation, cost assistance, care for uninsured/underinsured), bringing care directly to the community (e.g., mobile or in-home), and/or facilitating inter-agency referrals.

Identified Community Assets

Access to Care	Behavioral Health	Chronic Disease
▪ Aging Office ▪ Berwick Urgent Care ▪ Central Susquehanna Sight Services ▪ Community Action Agencies ▪ Family Health - WIC/SNAP ▪ Geisinger at Home, Life Geisinger, 65 Forward ▪ Head Start ▪ Mobile health units (Evangelical/Geisinger) ▪ Penn College/Luzerne County Community College ▪ Penn State Extension (educational programs) ▪ Rabbit Transit ▪ SEDA-COG (broadband and transportation planning) ▪ Susquehanna Valley United Way ▪ Transitions of PA	▪ Gaudenzia ▪ Geisinger: EMRLink, Free2BMom, Medication Assisted Treatment (MAT), Outpatient Pharmacy Program ▪ School-based health education programs ▪ LPN Career Center ▪ Mental health telehealth services for patients with low income ▪ SEARCH Academy	▪ Geisinger 65 Forward ▪ Berwick Teen Center ▪ Danville Area Community College ▪ School-based health education programs ▪ Question Persuade Refer (QPR) Training ▪ SEARCH Academy ▪ YMCAs

- Sustained, collective impact will require broad-based and multi-sector collaboration. Success factors for collaboration include:
    - Consistent inter-agency communication to share available resources and conduct joint outreach efforts;
    - Non-competitive forums to foster collaboration and address duplication of services;
    - Government and elected official involvement to impact policy and funding; and
    - Collective investment for community revitalization and efforts to retain and attract young families and working age residents.
- Community childcare options are limited and increasingly expensive, affecting family work-life balance and financial security, as well as community economic potential.
    - The region (and nation) is experiencing a childcare staffing crisis with fewer people entering the workforce due to low wages.
    - Childcare related call-offs by employees are hindering employer operations.
    - Employers are exploring creative solutions to childcare challenges. Examples include Evangelical Community Hospital's pilot onsite childcare center for employees with emergency care needs. The center is available on a sliding scale based on income and in partnership with Patch Caregiving.
- Individuals with special needs, non-English speakers, transient families, and the unhoused individuals are often missing from community conversations, and therefore the opportunity to share their lived experience and address service delivery gaps.

Access to Care and Chronic Disease

- Rural communities are underserved by healthcare services and would benefit from mobile services, better public transportation, and support for rural clinics.
    - Urgent care centers are partners in meeting care gaps, but services are often limited and wait times can be long.
    - The region may benefit from community member training and education to assist in medical emergencies while waiting for medical services.
- Affordable healthcare and childcare are needed to support financially burdened populations, like ALICE households, and make available the opportunity to prioritize their health. Advocacy for policies like universal health coverage (Healthcare for All) is needed.
- Populations living in isolation and/or experiencing socioeconomic barriers (e.g., unhoused, older adults, individuals with low-income or low technology access, and caregivers) are consistently not benefiting from available community resources. Primary barriers continue to be access issues like transportation, lack of awareness of services, and lack of knowledge of eligibility.
    - Community action agencies, faith-based organizations, and human services agencies can better collaborate to reach these populations and identify strategic partnerships to provide holistic service.

- Communities that have lost their local hospital and/or have limited access to care providers are at risk for worse health outcomes due to unmanaged chronic diseases. The region can learn from other organizations and collaboratives working to address health disparities, including:
    - Jewish Healthcare Foundation (Pittsburgh), an activist and grantmaking foundation working to test new models of care, new public health initiatives, and new collaboratives to improve coordination and manage population health.
    - Pennsylvania Perinatal Quality Collaborative, a partnership of birth sites, NICUs, and health plans to review processes and adopt strategies to improve maternal outcomes.
- The community would benefit from integrated, more inclusive injury prevention initiatives. Injury or trauma is a disease process, and the only disease process that is 100% preventable. At Geisinger Medical Center, the leading mechanism of injury is falls, across all age groups, but especially in older adults. Older adults in rural communities are particularly vulnerable as many of those who sustain injuries do not return to their homes. The second cause of injury is motor vehicle crashes, affecting both young and mature drivers.

Behavioral Health

- Access to behavioral healthcare has improved, but certain populations (listed below) continue to be underserved for a variety of reasons like stigma and poverty. Essential community champions or connectors to underserved populations must be identified to better serve these individuals.
    - Individuals who are unhoused
    - Individuals with co-occurring mental health disorders
    - LGBTQIA+
    - Single mothers living in poverty
    - Youth
- The region can learn from best practice behavioral healthcare models in other communities, including screening for mental health at client encounters and individualized treatment plans that keep patients at home and meet them where they are at. Example models include:
    - Behavioral Health Rehabilitation Services (BHRS), providing individualized care and treatment primarily in community settings
    - Lifestyle medicine options for coordinated, team-based care that prioritizes preventive healthcare and self-care
    - UPMC's Health Access Initiative for Recovery (HAIR) training Allegheny County-based Black barbers and stylists on how to talk to their clientele about substance use, anxiety, depression, suicide prevention, and how to properly refer them to resources and help
    - Walk-in mobile crisis centers

Community Forum findings were considered in conjunction with secondary data and Key Stakeholder Survey findings to inform priority health needs and community health improvement strategies. Community partner feedback is valuable in informing strengths and gaps in services, as well as wider community context for data findings.

Evaluation of Health Impact

At Evangelical Community Hospital, a key word is right in the name—COMMUNITY. Improving the health of the communities it serves is a commitment rooted deeply in the culture at Evangelical. In FY2022 and FY2023, the Hospital invested more than $90 million in the health of the community. These funds supported the care of individuals who could not afford to pay for some or all of the costs associated with their treatment, addressed government funding shortfalls, provided for donations to community outreach organizations for them to fulfill their own visions of community support, and delivered free of charge community health education programs to promote healthier living.

In 2023, Evangelical re-introduced programs sidelined by the global pandemic and rolled out new programs designed to encourage employee and provider engagement, promote wellbeing, ensure a safe work environment, and nurture a culture of diversity, equity, and inclusion. As we inch ever closer to our centennial anniversary in 2026, we will be looking to you—our patients and supportive community—to share how this Hospital has impacted your lives.

Knowing where to focus Evangelical's resources starts with a CHNA and a comprehensive understanding of the community's needs, assets, and opportunities. Evangelical completed its last CHNA in 2021 and developed a supporting three-year Community Health Improvement Plan (CHIP) outlining targeted action items to address the identified CHNA health priorities of Access to Care, Behavioral Health, and Chronic Disease Prevention and Management. The following sections outline our work to impact the priority health needs in our communities.

Priority – Access to Care

Action Item 1: Provide free or reduced-fee health screenings and preventive programs at various locations and times throughout the community.

Evangelical Health Screening Participants in FY2022 and FY2023

Community Health and Wellness Screenings	FY2022	FY2023
Comprehensive blood screenings	1,473	1,408
Community health screenings (Men's, Women's, Heart)	150	130
Skin screenings	237	346
Blood pressure/blood sugar screens	777	901
Heel scan/bone density clinics	67	113
Hearing screenings	27	76
Vein screenings	Started FY2023	66

Action Item 2: Continue screening patients for food insecurity and providing free food boxes to patients with identified need.

- During FY2022-2023, Evangelical Community Hospital distributed 37 food boxes to patients identified as food insecure. The program is provided in partnership with case management, Hospital to Home, and the Union County Food Hub at The Miller Center.

Action Item 3: Work with the Nurse-Family Partnership Program for at-risk, young, and expectant women to improve pregnancy outcomes, child health and development, and economic self-sufficiency for the family.

- Evangelical made 133 referrals in FY2022-2023 to the Nurse Family Partnership. Of those referred, 78 were enrolled in the program, and to date, 15 have graduated from the program. This collaborative program provides nurse home visits over 30 months, starting before birth and through age two. More than 30 years of randomized, controlled trials show that families who participate in the Nurse-family Partnership model fare better than those not in the program.

Action Item 4: Continue leveraging and building on collaborations and partnerships through the Miller Center Joint Venture to increase awareness and access to lifestyle-based resources.

- As of October 31, 2023, the Lewisburg YMCA at The Miller Center had a total of 3,558 members. Prior to the joint venture formation, membership at the facility was 1,620, increasing memberships by 1,938.
- Since the formation of the Joint Venture in December 2019, 83 members were granted financial assistance to join the facility and access programming.
- Evangelical and Geisinger completed their first ever lifestyle medicine-based research study through the Joint Venture, The Complete Health Improvement Program (CHIP) to Improve Glycemic Control and Reduce Cost of Care for Geisinger Health Plan Members with Type 2 Diabetes. The study identified the following outcomes:
    - 25 patients with a diagnosis of Type 2 Diabetes participated in the study.
    - Study findings showed an overall decrease in waist circumference of 5.1 inches in the intervention group vs. 2.2 inches in the control group at 3 months. After 6 months, the intervention group maintained a decrease in waist circumference of 4.2 inches vs. an increase of 0.6 inches in the control group.
    - HbA1c dropped by 0.9% at 3 months in the intervention group vs. 0.6% in the control group. At 6 months the difference was 0.8% vs. 0.6%, respectively.
- In FY2022, Community Health of Evangelical moved its offices and primary site for programming to The Miller Center.
- A Phase 3 Cardiac Rehabilitation Program was established through the joint venture. In FY2022, 11 patients were referred from the Evangelical Cardiac Rehabilitation clinic and enrolled in the program. In FY2023, enrollment increased to 14 patients.
- A Parkinson's Exercise class was established and had a total of 7 participants in FY2022. In FY2023, enrollment increased to 14 participants.

- The YMCA at the Miller Center offers a summer day-camp, providing childcare and programming to school-age children. In FY2022, 97 children participated in the program. In FY2023, participation grew to 111 children.

Action Item 5: Evangelical Regional Mobile Medical Services (ERMMS) will maintain access to quality emergency medical services throughout the ECH service area.

- ERMMS continues its commitment to EMS services for the ECH service area with a fleet of six Mobile Intensive Care Units, four Basic Life Support Units, and one Medic Unit. Additional collaboration with local fire departments and Quick Response Services allows for faster medical response outside local population centers. ERMMS responds to an average of 1,061 calls each month.
- The ERMMS wheelchair van also continues operation to ensure that patients have transportation to appointments, procedures, and home following hospitalization. This service meets a critical need for transportation and ensuring access to medical care, averaging 52 transports each month.

Action Item 6: Utilize Mobile Health of Evangelical to reach populations that are in areas lacking primary care and health screening options locally.

- Funded entirely through business and community donations, Mobile Health of Evangelical seeks to improve access to healthcare by overcoming the barriers of transportation, distance, and cost of care. The 38-foot unit features a welcome/registration area, blood draw area, and two exam rooms. During the pandemic, the Unit was primarily deployed for COVID-19 testing. From March 2020 to February 2022, more than 55,000 COVID-19 tests were administered out of the Mobile Medical Unit. ***Through these efforts, the Hospital was recognized as a top 10 finisher for the Hospital Association of Pennsylvania (HAP) COVID-19 Response Innovation Award.***
- Following COVID-19 testing deployment, the Unit was back on the road focused primarily on preventive primary care services. These services were all provided at no cost to the patient. The following free or reduced-fee services were offered in FY2022-FY2023:

Mobile health of Evangelical Patients in FY2022 and FY2023

Mobile Health of Evangelical Services	FY2022	FY2023
Lipid Point of Care	N/A	117
Blood pressure/blood sugar screenings	24	302
Heel scan/bone density clinics	N/A	46
Oral health screenings	N/A	41

Action Item 7: Evangelical aims to improve access to lifestyle focused chronic disease prevention programs and education by making health coaching services more accessible in the ECH service area.

- In FY2023, workflows were established in EPIC to allow providers to make direct referrals to health coaching services. Provider education regarding the services was offered to primary care, internal medicine, and bariatric medicine as key areas for referrals. Referral opportunities were also expanded to outside primary care practice providers.

Action Item 8: Evangelical seeks to develop partnerships with education institutions in an effort to cultivate interest in healthcare jobs.

- In FY2022, Mobile Health of Evangelical forged a partnership with the Pennsylvania State University College of Medicine (PSU COM). Through this partnership, Evangelical's Mobile Medical Unit is utilized three days per month by PSU COM residents and medical students to serve rural areas of Centre County and give medical students an opportunity to gain clinical experiences in a mobile health clinic setting.
- In FY2023, Evangelical Community Health started a Public Health Nursing Student Clinical Rotation in collaboration with Bloomsburg University. In the Spring of 2023, two nursing students completed the inaugural rotation.

Priority – Behavioral Health

Action Item 1: Serve as the County/Regional Centralized Coordinating Entity (CCE) for Snyder, Union, and Northumberland Counties to provide free Naloxone to all First Responders.

- The Hospital offered 14 Narcan training courses, educating 616 individuals, and distributed over 1600 opioid reversal kits to various First Responders, agencies acting as First Responders, and individuals who may need to act as a First Responder.

Action Item 2: Evaluate the usage and effectiveness of the Evangelical tele-psychiatric program.

- Evangelical continues to provide tele-psych services for inpatient and Emergency Department (ED) patients. During FY2022, a total of 389 ED and 188 In-Patient Visits were completed. During FY2023, a total of 564 ED and 162 In-Patient Visits were completed. Average response times were 5 hours for inpatient and 3 hours for ED patients.

Action Item 3: Continue offering community based educational programming on the topics of stress management, resiliency, and burnout.

- Evangelical Community Health and Wellness educated over 3,700 youth on understanding what stress looks and feels like, triggers, and how to deal with stress in healthy ways.

Priority – Chronic Disease Prevention and Management

Action Item 1: Develop programs and events focused on Diabetes education and prevention

- Evangelical offers a free Diabetes Resource program accredited through the Diabetes Education Accreditation Program of the American Association of Diabetes Educators. Program classes are taught by a Registered Nurse/Certified Diabetes Educator. Covered topics include introduction to diabetes; dietary management; complication prevention; home blood glucose monitoring; and medication options. In FY2022 and FY2023, 210 patients participated in this program.

Action Item 2: Continue to promote and educate the community about a variety of health screenings.

- Through various screening events and grant funds, Evangelical offered 478 low dose CT scans, 393 mammograms, and 169 iFob screening kits in FY2022 and FY2023.

Action Item 3: Offer a variety of adult and school aged wellness programs to promote a healthy lifestyle and reduce the risk for chronic health conditions.

- Evangelical's health and wellness programs reached nearly 15,500 youth and adults in the community in FY2022 and over 28,000 youth and adults in FY2023.

Evangelical Health and Wellness Program Participants in FY2022 and FY2023

Health and Wellness Programs	FY2022	FY2023
Youth educational programs	13,657	25,329
Adult/community educational programs	1,392	2,195
Worksite Site Wellness health promotion programs	406	558

- Evangelical knows that staying fit, disease prevention, and related interventions are essential tools in helping individuals achieve their health and wellness goals. The Hospital offered a wide range of programs in FY2022 and FY2023, including the following:
    - Freedom From Smoking®: A seven-week, eight session program to learn to overcome tobacco addiction with the help of a certified educator.
    - Safe Sitter: A one-day comprehensive babysitting course for children ages 11 and older.
    - Safe at Home: A 90-minute program for students in grades 4-6 that encourages the first steps to independence by teaching safe habits and prevention of unsafe situations.
    - Educational Programs for Children: Free programs on diverse topics, including nutrition, healthy lifestyles, Hands Only CPR, the dangers of tobacco products, summer safety, stress management, personal hygiene, bike helmet safety, and online safety.
    - Wellness 360: Designed to help individuals aged 55 or older live an active, healthy lifestyle, the program includes health screenings, exercise classes, lectures on a variety of health topics, brown bag medicine checks, and other special events and courses designed especially for seniors.

- Childbirth Education Classes: Free or reduced-fee programs on topics including prepared childbirth, newborn care, prenatal breastfeeding, and child safety seat inspections.
- Talk With the Doc and Speakers Bureau: Provider-led seminars on a variety of health topics.

Action Item 4: Evangelical aims to improve access to fresh, local produce and education around healthy sustainable food options with the goal of improving youth obesity in the ECH service area.

- In FY2022, Evangelical implemented the "Farm to School" program for middle-school students. Participants receive hands on learning experiences that help them better understand where their food comes from, differences between organic and conventional farming, what grows on a farm, growth cycles of vegetables, healthy foods vs. "sometimes" foods, and whole foods vs. processed foods.
- During the FY2022 pilot year, the program reached 250 Shikellamy Area School District fifth graders. In FY2023, the program continued, serving 205 Shikellamy Area School District fifth graders. The program will expand in FY2024 to serve the Milton Areas School District.

Next Steps

Evangelical Community Hospital welcomes your partnership to meet the health and medical needs of our community. We know we cannot do this work alone and that sustained, meaningful health improvement will require collaboration to bring the best that each of community organizations has to offer.

To learn more about our community health improvement work or to discuss partnership opportunities, please visit our website: https://www.evanhospital.com/HealthNeedsAssessment/ or contact Ryan McNally at Ryan.McNally@evanhospital.com.

Appendix A: Public Health Secondary Data References

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Appendix B: Key Stakeholder Survey Participants

AIDS Resource, Executive Director
Allied In-Home Services, AVP
Allied Services-Behavioral Health Division, Director, Behavioral Health Division
American Rescue Workers, Director of Development and Community Engagement
B.I.D.A., Executive Director
BARRASSE LAW, owner
Berwick Teen Center, Director
Bloomsburg Food Cupboard, Coordinator
Bloomsburg Public Library, Library Director
Bloomsburg Public Library, Board Member
Busy Little Beavers, CEO
Center for Breast Health, RN
Center for Community Resources, Case Management Program Manager
Central Susquehanna Intermediate Unit, Adult Education Program Manager
Central Susquehanna Intermediate Unit, SYNCH Project and Data Collection Manager, CSIU Nurse Aide Training Program Coordinator
Central Susquehanna Intermediate Unit, Career Coach
Central Susquehanna Opportunities, Inc., Project Coordinator
Central Susquehanna Sight Services, Life Skills Director
Central Susquehanna Sight Services, Prevention of Blindness Specialist
Central Susquehanna Sight Services, President/CEO
Child & Family Support Services, Clinical Director of our Pottsville Office
Columbia Child Development Program, Coordinator
Columbia Child Development Program, Executive Director
Columbia County Family Center, Director
Columbia County Volunteers in Medicine, Executive Director
Commonwealth of Pennsylvania, Commonwealth of Pennsylvania
Community Giving Foundation, Program Officer
Concerned Citizens for Child Care, Inc., Executive Director
County of Snyder, Commissioner
CSIU, Career Counselor
CSIU Early Childhood, Director of Early Childhood
DACC, Director of Operations
Danville Head Start, Family and Health Services Manager
Degenstein Community Library, Director
Donald L. Heiter Community Center, Inc., Executive Director
Evangelical Community Hospital, HR
Evangelical Community Hospital, EVP/COO
Evangelical Community Hospital, AVP Revenue Cycle
Evangelical Community Hospital, Manager
Evangelical Community Hospital, Vice President
Evangelical Community Hospital, VPMA
Evangelical Community Hospital, Vice President Patient Care/CNO
Evangelical Community Hospital, Associate Vice President

Evangelical Community Hospital, Operations Manager - EVS
Evangelical Community Hospital, HIPAA Compliance Coordinator
Evangelical Community Hospital, Director Cardiopulmonary Services
Evangelical Community Hospital, Director of Imaging Services
Evangelical Community Hospital, Director, Project Management
Evangelical Community Hospital, President & CEO
Evangelical Community Hospital, Controller
Evangelical Community Hospital, Director
Evangelical Community Hospital, Vascular Access Coordinator
Evangelical Community Hospital, Associate Vice President, Medicine Practices
Evangelical Community Hospital, Chief of EMS Services
Evangelical Community Hospital, Director Care Coordination
Evangelical Community Hospital, Director, Women's Health and Cancer Services
Evangelical Community Hospital, Director/RN
Evangelical Community Hospital, Office Supervisor
Evangelical Community Hospital, Vice President, Clinical Operations
Evangelical Community Hospital, RN Practice Manager
Evangelical Community Hospital, AVP of Surgical Services
Evangelical Community Hospital, OB Nurse Manager
Evangelical Community Hospital, Real Estate Manager
Evangelical Community Hospital, Employee & Public Safety Supervisor
Evangelical Community Hospital, IT Training Manager
Evangelical Community Hospital, Manager
Evangelical Community Hospital, Director, Miller Center and Community Health Initiatives
Evangelical Community Hospital, Director Quality, Patient Safety & Risk Management
Evangelical Medical Services Organization, Office Manager
Family Service Association of Northeastern Pennsylvania, CEO
First Order Painting, Owner
Foster Grandparent Program of Central PA, Program Coordinator
Foster Grandparent Program of Central PA, Director
Geisinger, Inpatient Social Work Care Manager
Geisinger, Community Engagement Strategist, Senior
Geisinger, VP, Strategy & Market Advancement
Geisinger, CAO
Geisinger, Community Benefit Coordinator
Geisinger, Director
Geisinger, Director
Geisinger, Director
Geisinger, Nursing Director
Geisinger, CMO
Geisinger Bloomsburg Hospital, Operations Manager
Geisinger Encompass Health Rehabilitation Hospital, Business Development Director
Geisinger Health Plan, Chief Administrative Officer, Geisinger Clinic
Geisinger Health Plan, Director
Geisinger Health System, Program Director, DEI
Geisinger Henry Cancer Center, Social worker
Geisinger Home Infusion, Director

Geisinger Hospice, Chaplain/Bereavement Coordinator
Geisinger Medical Center, Breast and Cervical Cancer Early Detection Program Navigator
Geisinger Medical Center, Outreach/Injury Prevention Coordinator for Adult Trauma
Girls on the Run Mid State PA, Executive Director
Greater Susquehanna Valley Chamber of Commerce, Membership & Workforce Development Director
Greater Susquehanna Valley YMCA, CEO
Greater Susquehanna Valley YMCA, Mifflinburg Branch, Director
Hospice of Evangelical, Director
Innovative Manufacturers Center (IMC), Manager, Outreach & Special Projects
L&I BWPO, L&I BWPO
Lewisburg Borough - Lewisburg, PA, Mayor
Lewisburg Children's Museum, Executive Director
Lewisburg YMCA, Associate Executive Director
LIFE Geisinger, LIFE Geisinger
Luzerne County Community College- Berwick Center, Director
Middlecreek Area Community Center, Executive Director
Mifflinburg YMCA, Youth Coordinator
Montgomery House Library, Library Director
Montour Area Recreation Commission, Director
Montour County Children and Youth, Executive Director
Montour County PA Board of Commissioners, Chairman Montour County PA Board of Commissioners
Moses Taylor Foundation, President and CEO
Mount Carmel Area Public Library, Librarian
N4CS, Executive Director
Northern Montour Recreation Association (Exchange Pool), Board Secretary
Northumberland County Aging Office, Center Supervisor
Northumberland County BHIDS, Program Specialist/Outpatient Clinic Director
Northumberland County CYS, Administrator
Office of PA Senator Lynda Schlegel Culver, Constituent Relationship Specialist
PA Department of Health, PA Department of Health
PA Education for Children & Youth Experiencing Homelessness, Consultant
PA State Police- Selinsgrove, Station Commander- Sergeant
Pennsylvania Department of Health, Community Health Nurse Snyder County
Pennsylvania State Police, Trooper - Community Service Officer
PFLAG Danville / Central Susquehanna Valley, President
Regional Engagement Center, President
Schuylkill Intermediate Unit 29, School Social Worker/Interagency Coordinator
Schuylkill MH/DS, Deputy Administrator
Selinsgrove Area Meals on Wheels, President - Board of Directors
Shamokin Area School District, Curriculum Coordinator
Shikellamy School District, Superintendent
Shikellamy School District, School Psychologist
Shiloh United Church of Christ, Senior Pastor
Snyder County Children and Youth Services, CYS Administrator
Snyder County DA's Office, District Attorney
Sunbury's Revitalization, Inc., Executive Director
Susquehanna Council, BSA, Seven Bridges District Executive

Susquehanna University, Chief of Staff
Susquehanna Valley CASA - Voices for Children, Board Vice President and CASA Volunteer
Susquehanna Valley CASA, Susquehanna Valley Mediation, Board Member and Volunteer
Susquehanna Valley Ethical Society, Founder/Board President
Susquehanna Valley Mediation, Executive Director
Susquehanna Valley Mediation Center, Crisis/Rapid Response Coordinator
Susquehanna Valley Sight Services, Board Member
Susquehanna Valley United Way, President/CEO
Susquehanna Valley United Way, Northumberland County Safe Care Manager
Susquehanna Valley United Way, Recovery Engagement Project Coordinator
Tapestry of Health, Director
THACC The Gate House, Program Director
The Arc Susquehanna Valley, Executive Director
The Bloomsburg Children's Museum, Director
The Foundation of the Columbia Montour Chamber of Commerce, Director
The Good Samaritan Mission, Executive Director
The Miller Center, Marketing & Communications
The Ronald McDonald House of Scranton, Executive Director
The Wright Center for Community Health, Assistant Director of Clinical Compliance & Reporting
The Wright Center for Community Health, Project Manager
TIME – The Improved Milton Experience, Executive Director
Town of Bloomsburg, Mayor
Town of Bloomsburg Human Relations Commission, Chair
Transitions of PA, CEO
Trinity Reformed United Church of Christ-Bloomsburg, Pastor
Union County Government, County Commissioner
Union County Housing Authority, Executive Director
Union County Prison, Deputy Warden
Union County Probation Department, Chief Probation Officer
Union Snyder Agency on Aging, Inc., Long Term Care Manager
Union-Snyder Agency on Aging, Inc., Retired Health & Wellness Coordinator; member of Advisory Council
Union-Snyder Agency on Aging, Inc., Community Services Manager
Union-Snyder Community Action Agency, Executive Director
Union-Snyder Community Action Agency, Food Security Director
Union-Snyder Community Action Agency, Community Impact Director
Union-Snyder Community Action Agency, Administrator
Veterans Multi-Service Center, Homeless Veterans Reintegration Program- Case Manager
VNA Health System, Community Liaison, Events Coordinator
Weis Center Bucknell University, Artist Liaison
Weis Center for the Performing Arts, Marketing Director
Williams Valley Schools, Social Worker

Appendix C: Central Region Community Forum Participants

Sue Auman, Union-Snyder Community Action Agency
Matt Beagle, First Columbia Bank & Trust Co.
Chris Berleth, Columbia Montour Chamber of Commerce
Ashlee Bower, Central Susquehanna Intermediate Unit
Kelly Braun, Pennsylvania Office of Rural Health
Taryn Crayton, Columbia Montour Chamber of Commerce
Darcy Decker, PFLAG
Tyler Dombroski, SEDA-Council of Governments
Cathy Esworthy, Trinity Learning Center
Kelly Everitt, Evangelical Community Hospital
Jada Fasold, Geisinger Health Plan
Regina Graham, Geisinger
Ashley Hackenberg, Danville Head Start
Angela Haines, Greater Susquehanna Valley YMCA
Steve Herman, SEDA-Council of Governments
Dana Hotra, Family Health Council of Central PA
Ethan Howard, Penn State Extension
Denika Keefer, Geisinger Health Plan
Dave Kovach, Columbia County Commissioner
Betsy Kramer, SEDA-Council of Governments
Adrienne Mael, United Way
Linda Marshall, Danville Area School District
Bonita McDowell, Greater Susquehanna Valley YMCA
Ryan McNally, Evangelical Community Hospital
Alyssa Meyers-Sanonu, Community Giving Foundation
Tessa Moore, The Arc Susquehanna Valley
Kim Olszewski, Commonwealth University
Sheila Packer, Evangelical Community Hospital
Jessica Probst, Central Susquehanna Intermediate Unit
Stacy Richards, Union County Commissioner
Kara Seesholtz, Community Giving Foundation
Heather Shnyder, Transitions of PA
Amy Shortlidge, Berwick Industrial Development Association
Ayrin Shortlidge, Berwick Area United Way
Jen Sullivan, Evangelical Community Hospital
Lacy Temple, Columbia-Montour Aging Office
Katherine Vastine, Central Susquehanna Intermediate Unit
Danielle Velkoff, Susquehanna Valley United Way
Amy Wright, Geisinger

Appendix D: Glossary of Terms

Age-Adjusted Rates Age-adjusted rates depict a comparable burden of disease across years and geographic areas. Age-adjusted rates adjust for differences in age distributions in communities so that data can be compared as if the communities reflect the same age distribution.

Asset Limited Income Constrained Employed (ALICE) The ALICE index measures the minimum income level required for survival for an average-sized household, based on localized cost of living and average household sizes. The index captures the percent of households whose income is above the federal poverty level, but below the threshold necessary to meet all basic needs. The ALICE project is led by United Way of Northern New Jersey and has spread to half of U.S. states.

Cisgender Denoting or relating to a person whose gender identity corresponds with the sex registered for them at birth; not transgender

Disability The American Community Survey identifies and collects prevalence data for individuals experiencing serious difficulty within the following areas:

- Ambulation: Having serious difficulty walking or climbing stairs
- Cognition: Having difficulty remembering, concentrating, or making decisions
- Hearing Difficulty: Deaf or having serious difficulty hearing
- Independent Living: Having difficulty doing errands alone such as visiting a doctor's office or shopping
- Self-Care: Having difficulty bathing or dressing
- Vision Difficulty: Blind or having serious difficulty seeing, even when wearing glasses

Health Equity Simply defined as a fair and just opportunity for every person to be as healthy as possible. Health equity strategies seek to dismantle systematic inequities that affect access to power and wealth distribution, education attainment, job opportunities, housing, and safe environments, to build a healthier community for all people now and in the future.

Low-Income and Low-Access to Grocery Stores A US Department of Agriculture indicator that identifies individuals who have both low income and live more than 1 mile (urban areas) or more than 10 miles (rural areas) from the nearest supermarket, supercenter, or large grocery store. Low income is defined as annual family income at or below 200 percent of the Federal poverty threshold for family size.

Social Drivers of Health (SDOH) The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health risks and outcomes. The five key areas of SDoH include economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context. Public health agencies, including the CDC, widely hold that at least 50% of a person's health profile is influenced by SDoH.

Social Vulnerability Index (SVI) The CDC's SVI has historically been used to help public health officials and local planners better prepare for and respond to emergency events like hurricanes, disease outbreaks, or exposure to dangerous chemicals. The SVI identifies census tract-level community vulnerability to these events based on social factors, such as poverty, lack of access to transportation, and overcrowded housing. Each census tract receives a ranking from 0.0 (lowest vulnerability) to 1.0 (highest vulnerability).

Unmet Need Score (UNS) The UNS is a Health Resources and Services Administration (HRSA) measure providing a zip code-based index of unmet need for primary and preventive healthcare services based on disparities in health status and SDoH. UNS scores are displayed on a scale from 0 (least unmet need) to 100 (most unmet need). The UNS is calculated by leveraging publicly available data that depict a community's social, economic, and health status. The tool is helpful in allocating resources across areas of highest unmet need.