Geisinger

2024 Community Health Needs Assessment
Geisinger Community Medical Center

About Geisinger

Founded over a century ago as a single hospital in Danville, Pennsylvania, Geisinger now provides the highest quality healthcare services to communities throughout central and northeastern Pennsylvania. Our nonprofit mission is to not only meet the immediate healthcare needs of the people in the communities we serve, but to anticipate, identify, and address future health issues and trends.

The Community Health Needs Assessment (CHNA) helps us do that. Every three years, we conduct a thorough, formal process to identify the specific needs of the communities and regions we serve and then develop meaningful, measurable responses.

Geisinger's integrated healthcare system has become a nationally recognized model of care delivery. Our goal is to help people stay well, not just through clinical treatment and positive patient experiences, but also through education and programs that can help them prevent or manage disease and live healthier lives. Funding and supporting activities, programs, and services that benefit those who live in our service area is a big part of what we do.

By providing support to our local communities, identifying much-needed services, and establishing partnerships with community-based organizations, we can improve the physical, social, and mental well-being of those we serve.

Our goals:

- Creating partnerships with local, community-based organizations
- Providing grassroots support in the communities we serve by establishing relationships and building trust
- Promoting community health and advocacy through engagement
- Providing patient education and information about preventive services
- Increasing access to care in both clinical and community settings
- Identifying services needed to reduce health disparities and promote health equity

We have taken major steps toward improvement and responsiveness to community needs at each of our hospital campuses and invite your partnership to meet the needs of our community, together. We know we cannot do this work alone and that sustained, meaningful health improvement requires collaboration to bring the best that each community organization has to offer.

2024 CHNA Collaborative

The 2024 CHNA was conducted collaboratively by Geisinger, Allied Services, and Evangelical Community Hospital. The three health systems have partnered since 2012 to create a collective CHNA for their overlapping service areas spanning central and northeast Pennsylvania. Collaboration 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 implementation 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 Huntington 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.

Table of Contents

2024 CHNA Background

Since 2012, Geisinger, Allied Services, and Evangelical Community Hospital 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 Geisinger, Evangelical Community Hospital, 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

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

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
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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

Geisinger, Evangelical Community Hospital, 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.

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 169 individuals serving the Northeast Region, who represent healthcare providers, social services professionals, educators, faith-based leaders, and community leaders, among others;
- Regional Community Forum bringing together 32 residents and diverse community representatives to review CHNA findings and collectively define challenges and co-develop meaningful strategies for health 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 Community Health Improvement Plans, Geisinger 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.

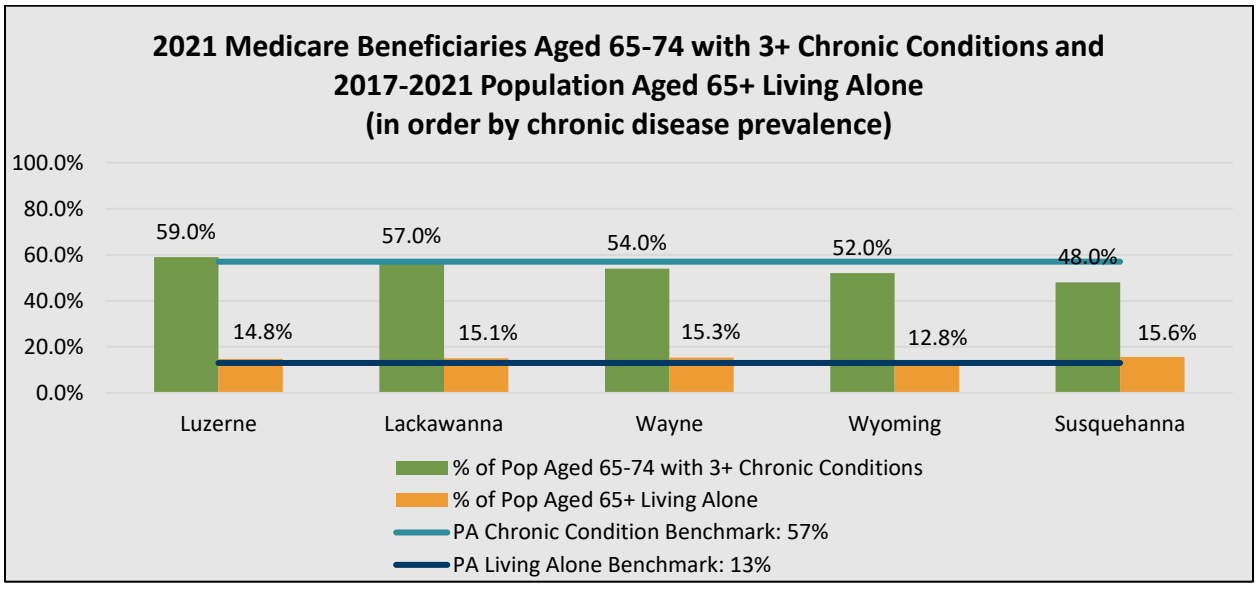
Executive Summary of CHNA Findings

Demographic Trends

The Northeast Region is comprised of five Pennsylvania counties: Lackawanna, Luzerne, Susquehanna, Wayne, and Wyoming. Lackawanna and Luzerne counties are population centers for the region, and home to cities including Scranton, Wilkes-Barre, and Hazleton. Susquehanna, Wayne, and Wyoming counties are largely rural communities with total populations of approximately 25,000 to 50,000 people.

Population growth over the past decade was stagnant in Lackawanna and Luzerne counties and declined in rural counties. Susquehanna County saw the largest population decline of -10.3% from 2010 to 2021. In contrast, the region saw significant growth in older adults, particularly in rural counties. From 2010 to 2021, Susquehanna, Wayne, and Wyoming counties saw 21%-29.5% growth in adults aged 65 or older.

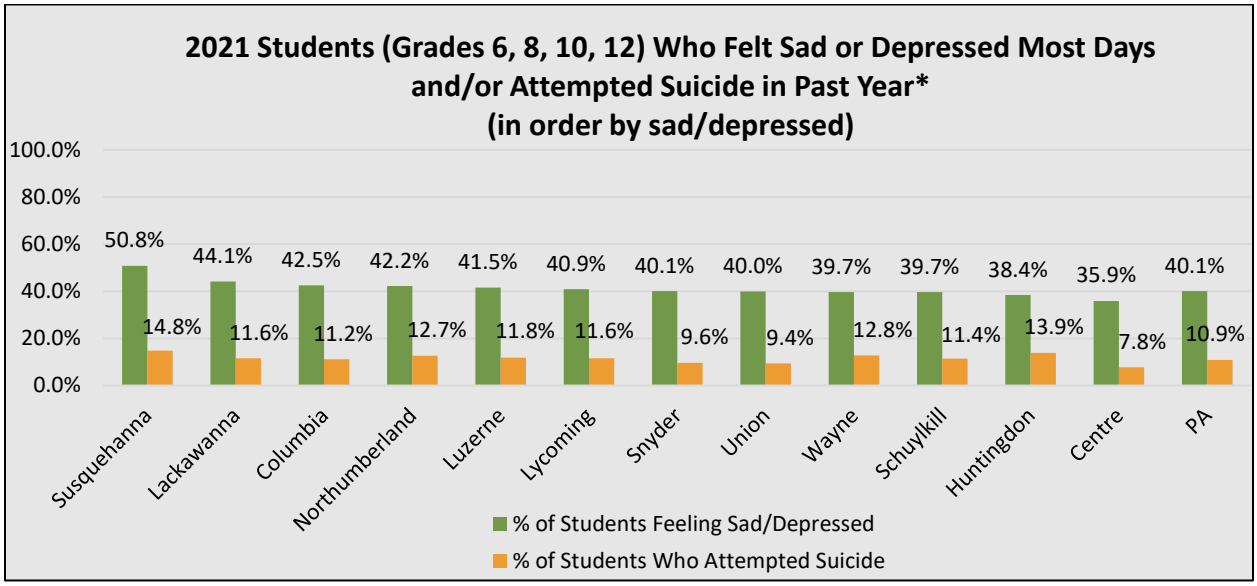
The growth of older adult populations will challenge communities to provide adequate support for aging residents, many of whom live alone and choose to age in place. Consistent with the state overall, 50%-60% of Medicare beneficiaries aged 65-74 residing in the Northeast Region had three or more chronic conditions in 2021, and disease prevalence increased with older age groups 75+. Within the region, Susquehanna and Wayne counties are areas of opportunity for improving older adult health and well-being. Nearly 25% of residents in these counties are aged 65 or older, creating demand for services, and approximately 15% of older adults live alone, potentially impeding wellness efforts.



Source: US Census Bureau, American Community Survey & CMS

Northeast 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 20% of children in Lackawanna County and 25% in Luzerne County experience poverty compared to 14% of all residents.

Top health concerns for children in the Northeast Region, and statewide, include mental health issues. Child mental health was a growing concern before the pandemic, and the region continues to see a high, and often increasing, proportion of children who report poor mental health. Among all Geisinger service area counties with reportable data, the Northeast Region counties of Susquehanna and Lackawanna had among the highest proportion of students who reported feeling consistently sad or depressed in 2021; Susquehanna County also had the highest proportion of students reporting an attempted suicide.

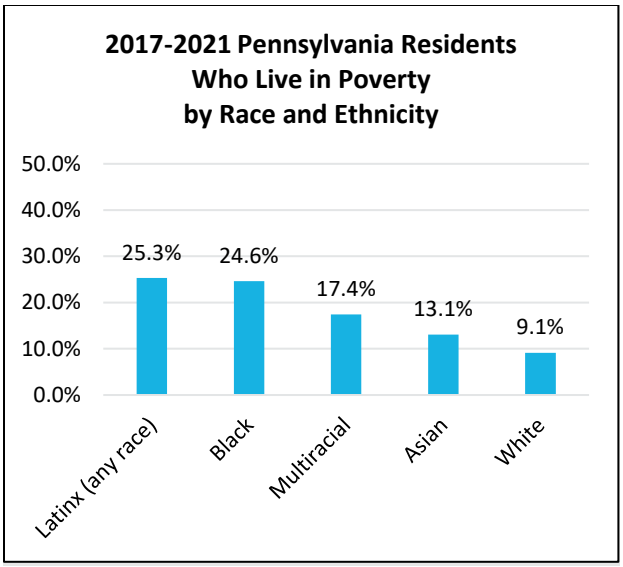


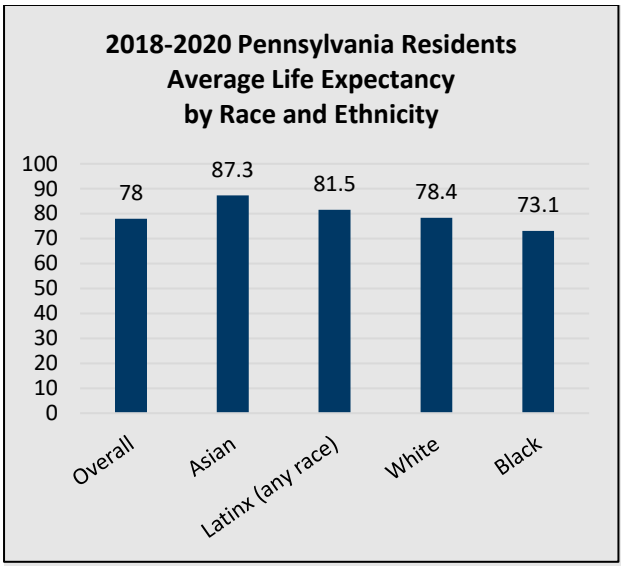
Source: Pennsylvania Youth Survey *Data are reported by county as available.

Commitment to school can be a protective factor for youth, reducing the likeliness of health concerns. School commitment indicators, like how important students feel school is to later life or how much they enjoy the experience, were declining even before the pandemic. Statewide, the percentage of youth who "feel school is going to be important for their later life" declined from 57.5% in 2017 to 41.8% in 2021. In the Northeast Region, Susquehanna County students reported poorer mental health than their peers across the Geisinger footprint and were the least likely to feel school is going to be important for their later life (37.6%). Creating opportunities for youth engagement in schools and other settings and fostering future orientation is essential to improving their overall health and well-being.

The Northeast 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 for rural counties, accounting for a 1-3 percentage point change over the last decade, and more evident in urban counties. Latinx populations grew 5-9 percentage points in Lackawanna and Luzerne counties from 2010 to 2021.

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. Black people have historically experienced more adverse health and social outcomes, largely due to social inequities like racism. Statewide, 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

As part of the Key Stakeholder 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 ability to afford healthcare, housing, and economic stability.

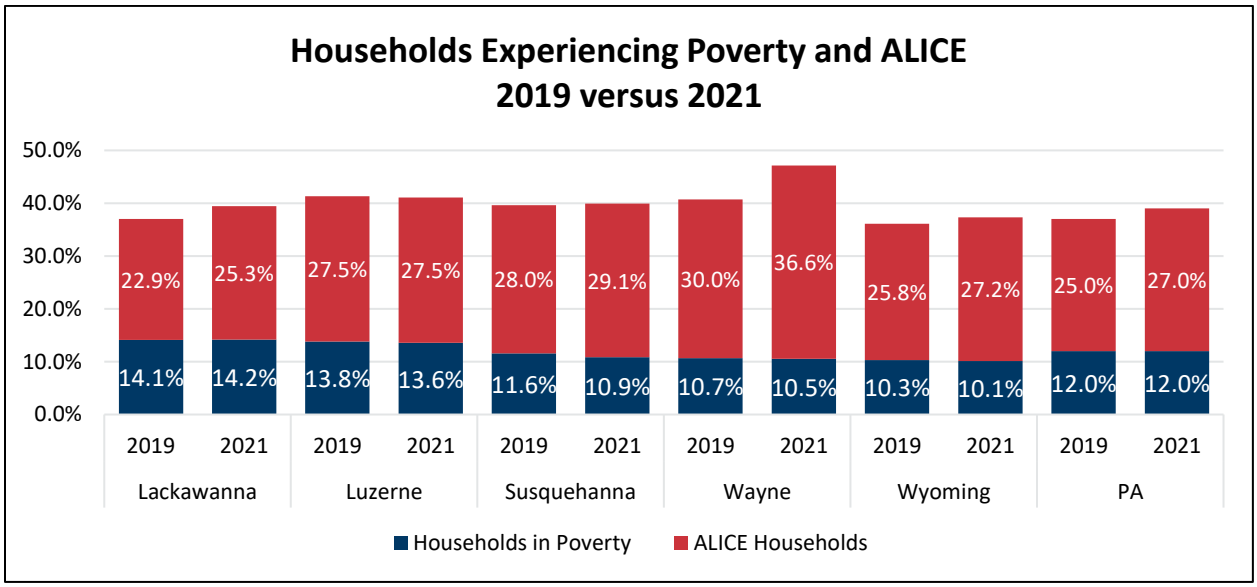
Key Stakeholder Survey: In your experience, what top five priorities should our community address in order to improve health and well-being of the populations your organization serves?

Top Five Priority Responses	Percent of Responses
Mental health conditions	60.3%
Substance use disorder	48.1%
Ability to afford healthcare	45.5%
Housing (affordable, quality)	42.3%
Economic stability	35.3%

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 Northeast Region counties in 2021, at least one-quarter 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 Wayne County. In 2021, more than one-third of Wayne County households were ALICE, a nearly 7-point increase from 2019. Wayne County households also struggled with basic needs like housing and childcare. Nearly 34% of homeowners and 47% 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 35% of median household income, compared to state and national averages of 27%.



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 and Centers for Disease Control and Prevention Social Vulnerability Index.

The Unmet Need Score (UNS) is a measure of access to primary and preventive healthcare services based on disparities in health status and SDoH. Scores range from 0 (least unmet need) to 100 (most unmet need). Within the Northeast Region, more unmet need is seen in Lackawanna and Luzerne. When analyzed by zip code, areas with an UNS of 70 or higher are exclusively in these counties.

The Social Vulnerability Index (SVI) provides a deeper analysis, scoring census tracts on a scale from 0.0 (lowest vulnerability) to 1.0 (highest vulnerability) based on SDoH factors. Consistent with UNS findings, areas of high social vulnerability are concentrated in Lackawanna and Luzerne counties, but areas throughout the region are affected. Areas with high social vulnerability are associated with significant health disparities including lower life expectancy.

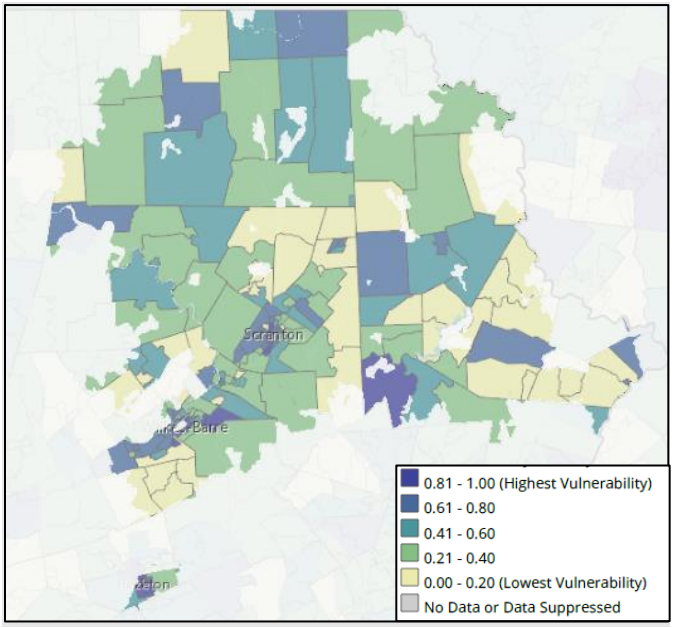
The maps below display the SVI and average life expectancy by census tract within the GCMC primary service area. In the following census tracts, residents experience disproportionately high social vulnerability and may live an average of 72 years, a 10- to 13-year difference from surrounding communities: census tracts 2172 and 2175 in Hazleton; 1002, 1004, 1009, and 1023 in Scranton; and 2005, 2009, 2010, and 2130 in Wilkes-Barre. Residents of Carbondale, Nanticoke, Susquehanna, and Tunkhannock experience similar disparities and may live an average of 75 years or less.

2017-2021 Social Drivers of Health for Northeast Region Zip Codes with HRSA Unmet Need Score >70 out of 100

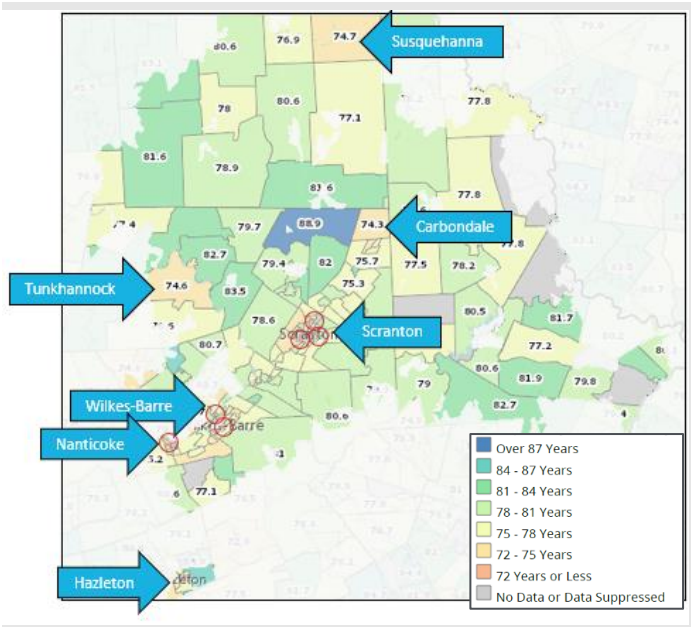
Zip Code (County)	Population in Poverty	Children in Poverty	No High School Diploma	No Health Insurance	UNS Score
18201, Hazleton (Luzerne)	23.0%	35.3%	24.3%	13.4%	84.2
18634, Nanticoke (Luzerne)	18.6%	33.9%	14.0%	4.6%	73.9
18508, Scranton (Lackawanna)	20.6%	33.9%	12.7%	3.8%	73.2
18202, Hazleton (Luzerne)	21.5%	38.8%	14.6%	11.0%	73.1
18702, Wilkes-Barre (Luzerne)	19.1%	32.7%	9.6%	7.6%	72.4
18709, Luzerne (Luzerne)	19.1%	54.3%	11.3%	1.5%	72.3
18505, Scranton (Lackawanna)	19.3%	29.2%	7.9%	8.0%	70.3
18224, Freeland (Luzerne)	13.5%	21.7%	10.6%	6.6%	70.1
Pennsylvania	11.8%	16.4%	8.6%	5.6%	NA

Source: US Census Bureau, American Community Survey; Health Resources and Services Administration

Social Vulnerability Index by Census Tract within GCMC Service Area



2010-2015 Life Expectancy by Census Tract within GCMC Service Area



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

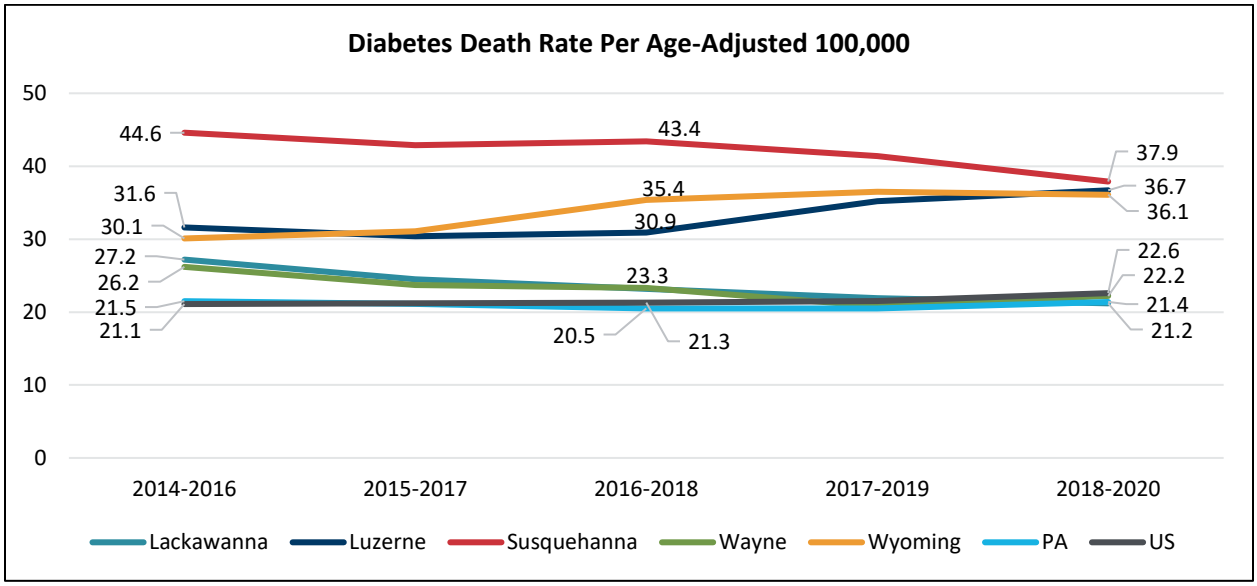
Priority Health Needs

The top health concerns for the Geisinger footprint, including the Northeast Region, 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, and across the Northeast Region, residents overall have poorer outcomes from these conditions, dying at higher rates from diabetes, heart disease, and lower respiratory diseases.

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 Northeast Region adults have been diagnosed with diabetes, and prevalence has increased.

Residents of Luzerne, Susquehanna, and Wyoming counties also experience high death rates due to diabetes, demonstrating access to care and other SDoH 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.

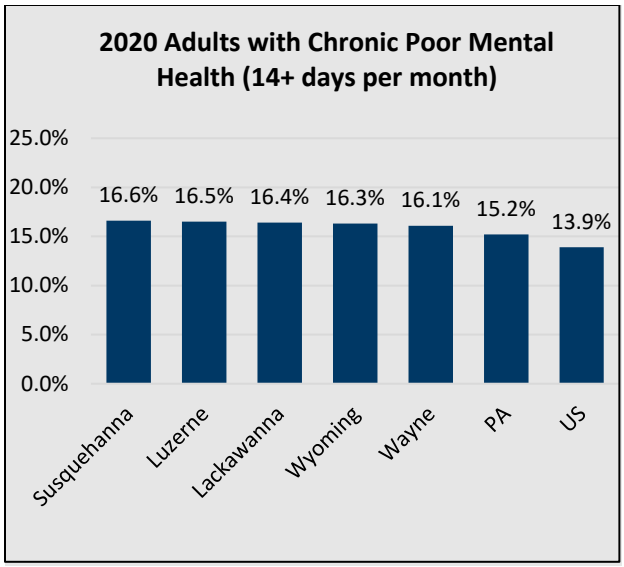


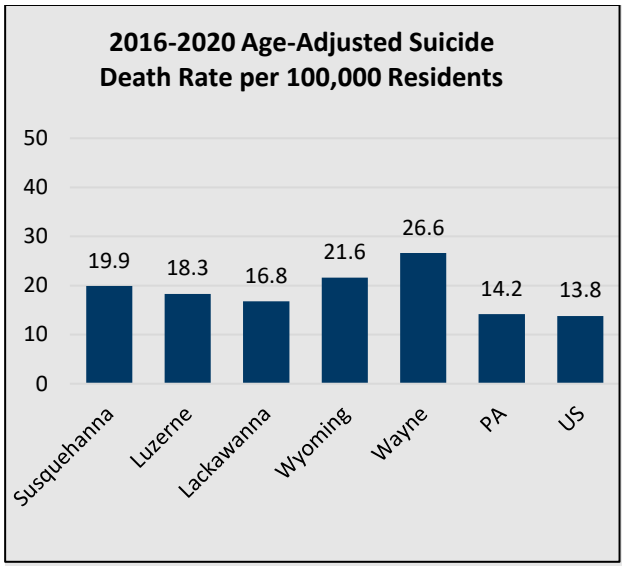
Source: Centers for Disease Control and Prevention

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 Pennsylvania residents had poorer behavioral health outcomes than their peers nationally, and Northeast Region residents had poorer outcomes than the state overall. Notably, from 2016-2020, all counties reported a higher suicide death rate than the state and nation; the Wayne County rate of death was nearly twice as high as the state overall.

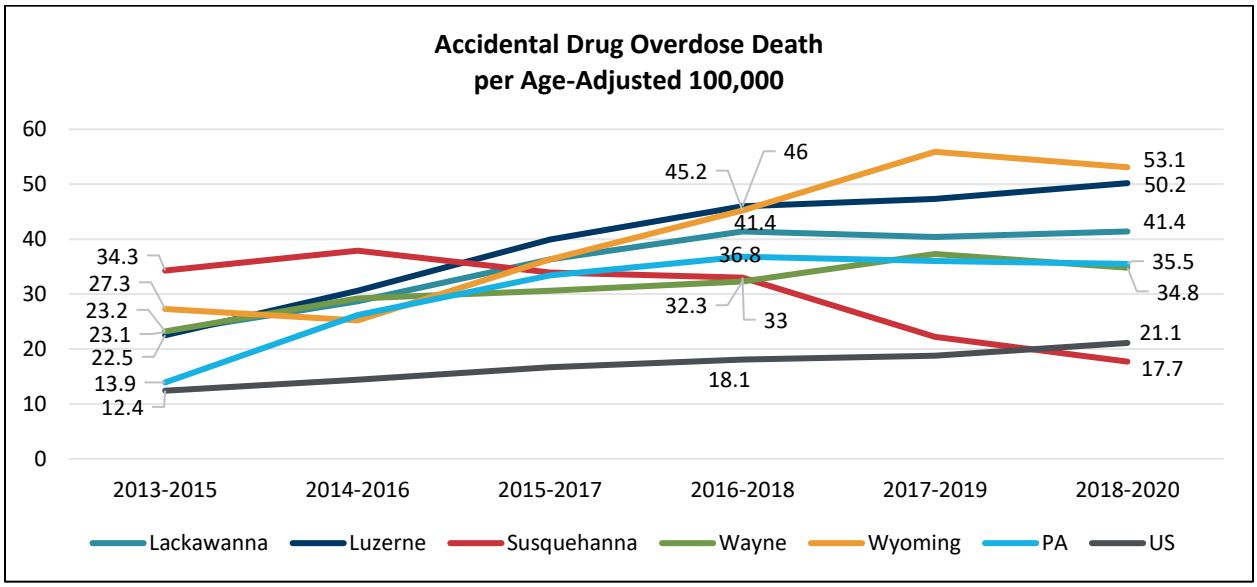
Opioid overdose hospitalizations generally declined despite an uptick in recent years likely related to pandemic difficulties. However, accidental overdose deaths remain high in nearly all Northeast Region counties. Death rates in Wyoming, Luzerne, and Lackawanna are nearly double the national rate.

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





Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention

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 and social services, crisis support services to better meet SDoH and urgent health needs, and overall community connectedness. These strengths can be drawn upon to improve the quality of life for all people in the Northeast 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 Feeback 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	*"Instead of making Geisinger the 'do all' for everything, establish more cross-referral programs with existing organizations."* *"Better data sharing and seeing the big picture/connectedness of all resources."*
Go beyond addressing the immediate need, invest in upstream factors	*"Support for those who are working but one paycheck away from a crisis. ALICE (Asset Limited, Income Constrained, Employed). Connecting people with existing employment opportunities."*
Bring services to the community, integrate/co-locate where residents naturally frequent	*"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."*
Address cultural biases with staff training	*"I think that in today's world the one thing that is truly need is a level of compassion and understanding. It is difficult to walk into any of these locations as it is and then have to come in contact with someone is either rude, upset, having a bad day or in some cases don't respond appropriately because of the color of your skin or the sound of your name."*
Invest in supports for those historically placed at risk (youth, seniors, ALICE, etc.)	*"Students need to be supported more than ever. We are working with school districts that have seen significant declines in academic performance, poor behavior in school, and increased truancy rates. Anything that your organizations can do to help students connect school with a future in healthcare or another field could help. Job shadows, mentorships, internships, and apprenticeships are wonderful tools that can help expose students to the vast amount of healthcare careers in Northeastern Pennsylvania."* *"1. Enhance resources to expand in-home health/social supports for the community-dwelling older adults. 2. Create high quality, affordable residential personal care options for middle-income and lower-income adults. 3. Expand qualified, independent health care advocacy/navigation services. 4. Correct dangerous understaffing in area hospitals, nursing homes via increased reimbursements, wage incentives."*

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 Geisinger and engage local partners to collectively address identified health needs.

Geisinger 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 November 2023.

Following the Board's approval, the CHNA report was made available to the public via Geisinger's website at https://www.geisinger.org/about-geisinger/community-engagement/chna.

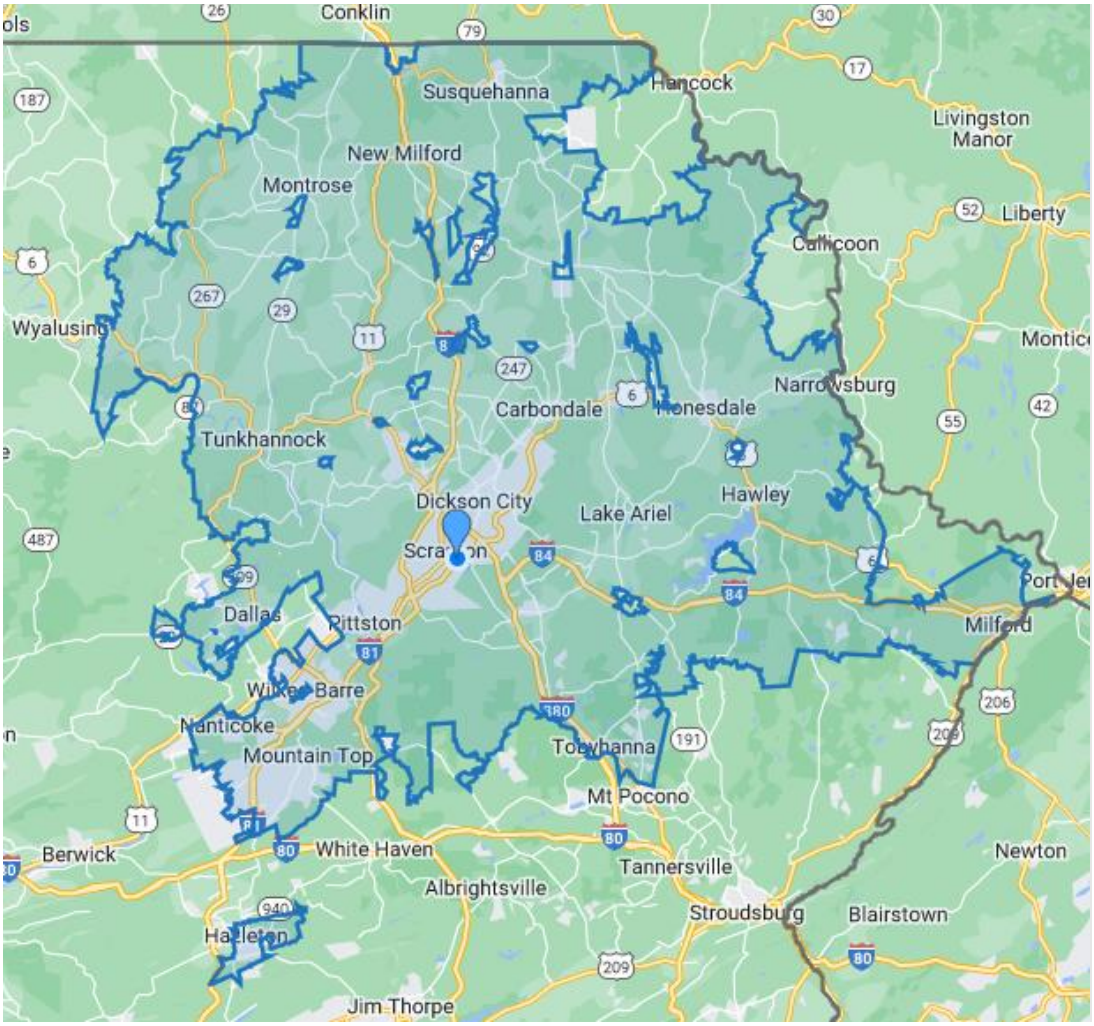
A full summary of CHNA data findings for the Northeast Region and Geisinger Community Medical Center service area, with state and national comparisons, follows.

Geisinger Community Medical Center Service Area

Geisinger Community Medical Center (GCMC) is located in Scranton, Lackawanna County. Scranton's history is rooted in its role as one of the nation's leading industrial centers for anthracite coal mining. As oil replaced coal as a popular energy source, Scranton moved from industry to innovation, becoming a geographic and cultural center for northeast Pennsylvania. Scranton is home to a growing downtown business district, several institutions of higher education, leading healthcare institutions, a vibrant arts community, and a diverse population. The mountainous region is known for its lakes, parks, hiking and biking trails, and other outdoor recreation opportunities.

While many GCMC patients are residents of Scranton or the surrounding area, the hospital serves people across northeast Pennsylvania. For the purposes of the 2024 CHNA, GCMC defined its service area as 64 zip codes, primarily within the Northeast Region. The service area was identified based on the patient zip codes of origin comprising 90% or more of hospital discharges in 2021.

Geisinger Community Medical Center Service Area



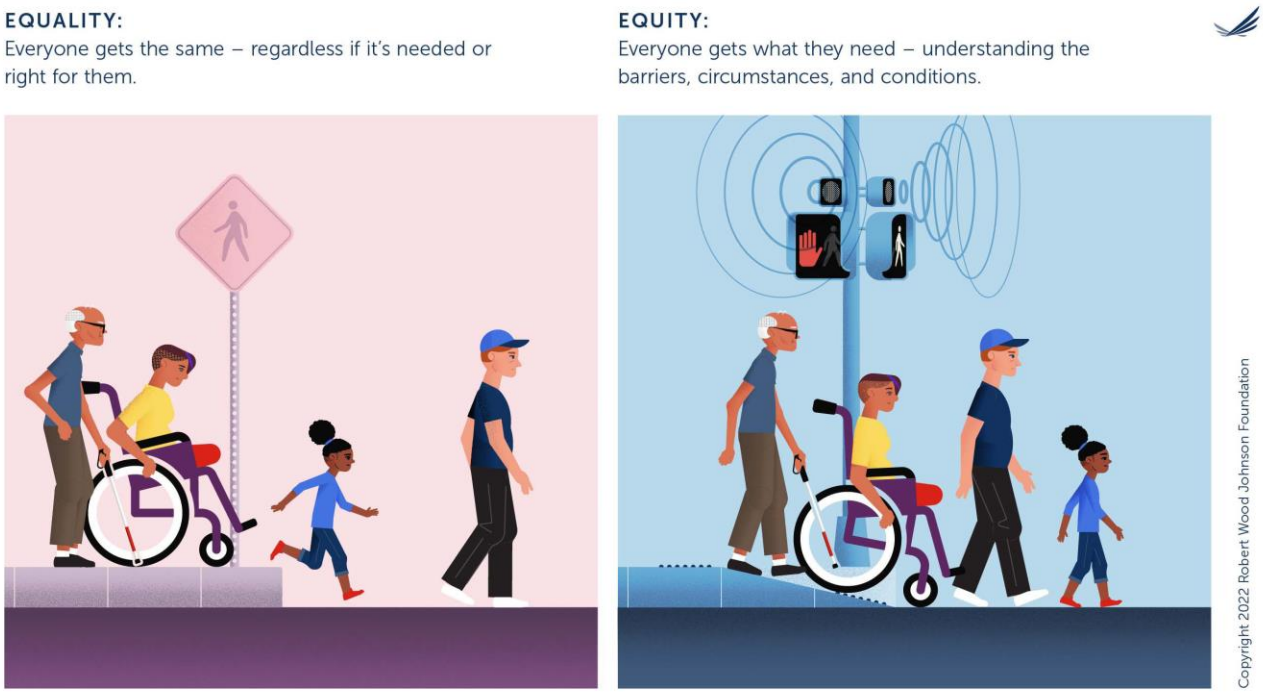
Social Drivers of Health & Health Equity:

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. A description of each index is provided below followed by data visualizations of each tool that show how well the GCMC service area fares compared to state and national benchmarks.

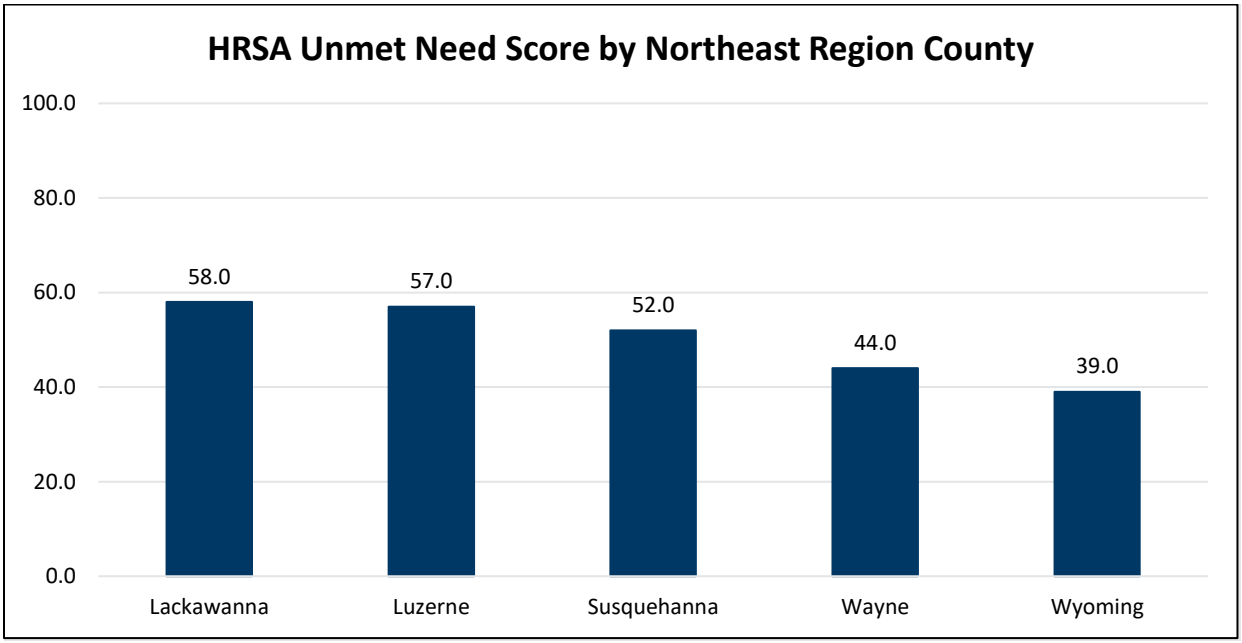
- **Health Resources and Services Administration Unmet Need Score (UNS):** The UNS provides a zip code-based index of unmet need for primary and preventive healthcare services based on disparities in health status and SDoH. UNS scores are displayed on a scale from 0 (least unmet need) to 100 (most unmet need).
- **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).
- **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 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.
- **Geisinger Health Innovations:** Geisinger aims to supplement conventional medical care by incorporating screening solutions to identify unmet social needs and offering recommendations, programming, and services tailored to the individual. As part of this effort, Geisinger launched an urgent social needs screening, largely within its primary care and pediatric clinics and women's health centers, that includes environmental and social drivers of health factors. Based on where the screening is administered, results are captured for either patients or their household to better respond to the multitude of factors affecting health and well-being.

Unmet Need Score and Social Vulnerability Index

The HRSA Unmet Need Score (UNS) is a 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).

Within the Northeast Region, more unmet need is seen in Lackawanna and Luzerne counties. This finding is reflective of both upstream factors like community inequities and social drivers of health like poverty, and downstream health outcomes like lower overall life expectancy.

It is worth noting that while Wyoming County has the lowest UNS in the region, residents have lower average life expectancy than neighboring communities and the state overall. Wyoming County residents have historically experienced a higher prevalence of chronic disease and poor mental health, as well as associated causes of death like diabetes and suicide.



Source: Health Resources and Services Administration

2018-2020 Life Expectancy by Race and Ethnicity

	Overall Life Expectancy	Asian	Black	White	Latinx Origin (any race)
Lackawanna	76.6	88.1	70.0	76.6	80.5
Luzerne	75.7	85.7	70.7	75.4	83.1
Susquehanna	78.5	N/A	N/A	N/A	N/A
Wayne	78.2	N/A	77.5	77.9	83.8
Wyoming	76.1	N/A	N/A	N/A	N/A
Pennsylvania	78.0	87.3	73.1	78.4	81.5

Source: National Vital Statistics System

When analyzed by zip code, areas within the Northeast Region with an UNS of 65 or higher, indicating more unmet need, are almost exclusively in Lackawanna and Luzerne counties, and primarily in metro areas. **Laceyville zip code 18623 in Wyoming County is the only zip code outside of Lackawanna and Luzerne counties to have a high UNS.** While poverty levels in Laceyville are lower than state benchmarks, approximately one-third of residents are considered low-income, having an income below 200% of the federal poverty threshold (defined as $27,180 for a single-person household or $55,500 for a four-person household).

2017-2021 Social Drivers of Health for Northeast Region Zip Codes with Unmet Need Score of >65 out of 100 in Descending Order by Unmet Need Score

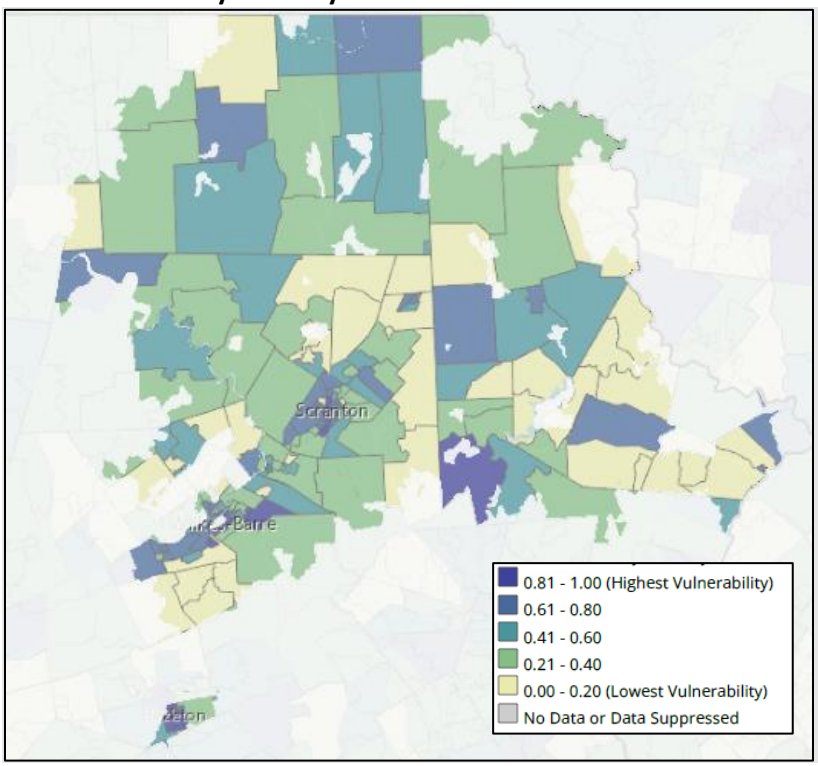
Zip Code (County)	Population in Poverty	Children in Poverty	No High School Diploma	No Health Insurance	UNS Score
18201, Hazleton (Luzerne)	23.0%	35.3%	24.3%	13.4%	84.2
18634, Nanticoke (Luzerne)	18.6%	33.9%	14.0%	4.6%	73.9
18508, Scranton (Lackawanna)	20.6%	33.9%	12.7%	3.8%	73.2
18202, Hazleton (Luzerne)	21.5%	38.8%	14.6%	11.0%	73.1
18702, Wilkes-Barre (Luzerne)	19.1%	32.7%	9.6%	7.6%	72.4
18709, Luzerne (Luzerne)	19.1%	54.3%	11.3%	1.5%	72.3
18505, Scranton (Lackawanna)	19.3%	29.2%	7.9%	8.0%	70.3
18224, Freeland (Luzerne)	13.5%	21.7%	10.6%	6.6%	70.1
18617, Glen Lyon (Luzerne)	17.7%	9.6%	13.2%	10.5%	69.6
18623, Laceyville (Wyoming)	10.6%	12.2%	8.1%	8.1%	69.4
18651, Larksville (Luzerne)	13.4%	18.4%	11.5%	4.7%	68.2
18510, Dunmore (Lackawanna)	21.5%	18.5%	13.3%	6.3%	68.0
18640, Pittston (Luzerne)	16.8%	30.6%	8.8%	2.9%	67.2
Pennsylvania	11.8%	16.4%	8.6%	5.6%	NA

Source: US Census Bureau, American Community Survey; Health Resources and Services Administration

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, and average life expectancy for the GCMC primary service area.

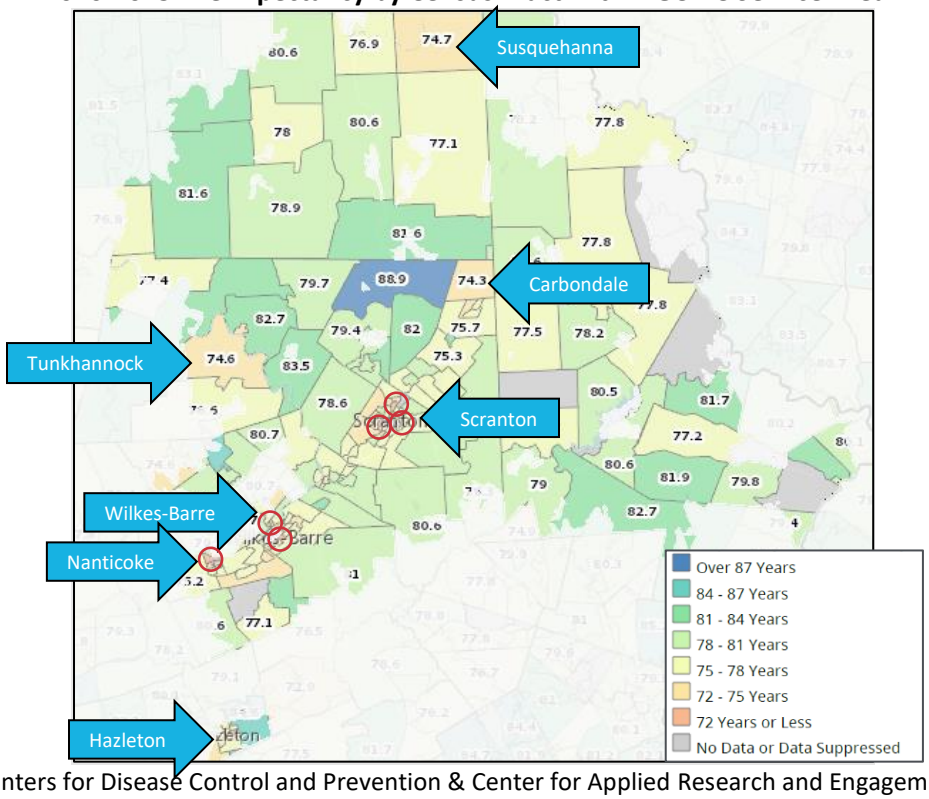
Consistent with UNS findings, areas of social vulnerability within the GCMC primary service area are concentrated in the Hazleton, Scranton, and Wilkes-Barre metro areas, and are associated with significant health disparities. **In census tracts 2172 and 2175 in Hazleton; 1002, 1004, 1009, and 1023 in Scranton; and 2005, 2009, 2010, and 2130 in Wilkes-Barre, residents may live 72 years or less, a 10- to 13-year difference compared to surrounding communities.** Other areas of disparity to note include Carbondale, Nanticoke, Susquehanna, and Tunkhannock, where residents may live fewer than 75 years.

Social Vulnerability Index by Census Tract within GCMC Service Area



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

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



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

*Residents of communities highlighted in red have an average life expectancy of 72 years or less.

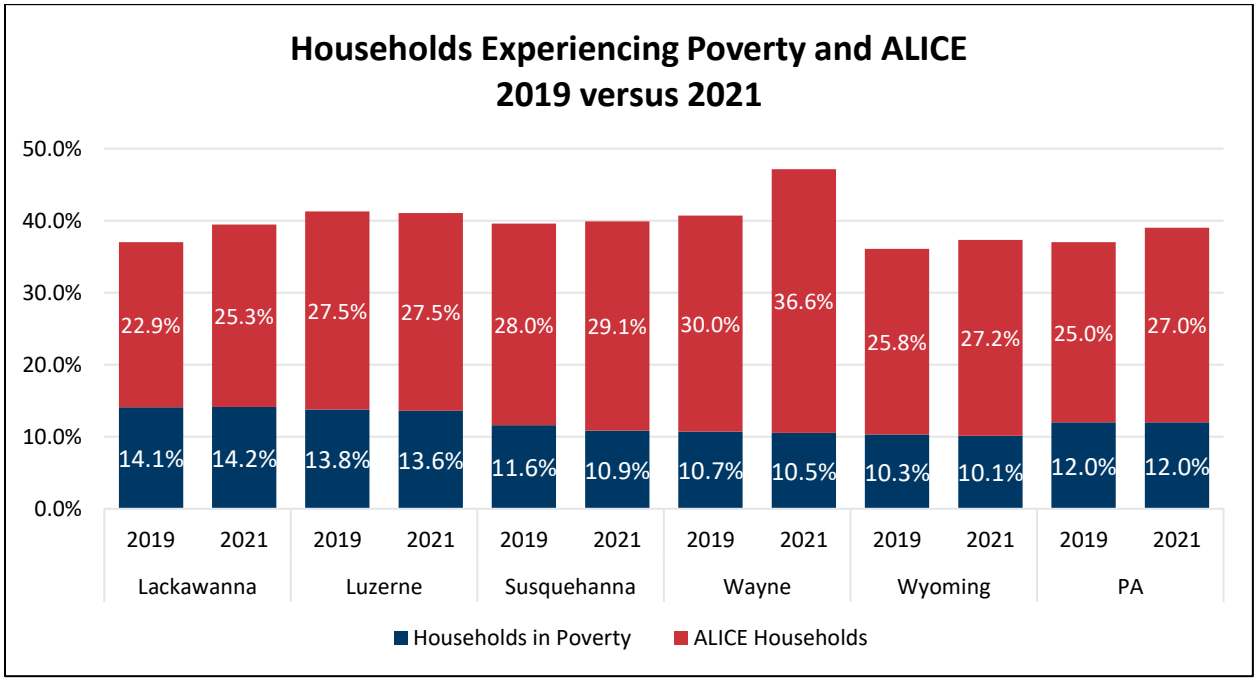
Asset Limited Income Constrained Employed (ALICE)

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 Northeast Region counties in 2021, at least one-quarter of households were ALICE. **In Wayne County, more than one-third of households were ALICE; when combined with households living in poverty, nearly half of all households in Wayne County 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. People's *experience* of financial hardship feels more acute than ever.



Source: United for ALICE

Geisinger Urgent Social Needs Screening

The Geisinger urgent social needs screening assesses environmental and social factors for adult patients or their household to identify and better respond to the multitude of factors affecting health and well-being. The screening is largely conducted within Geisinger primary care and pediatric clinics and women's health centers. The results are used to both assist patients to connect to available community resources in real time and to inform Geisinger community health improvement strategy.

The following table provides a summary of urgent social needs screening results for Geisinger patients residing in the Northeast Region. **It is worth noting consistent employment concerns among adults in nearly every county, and the need for clothing affecting approximately 1 in 10 households with children in all counties.**

Geisinger Universal Health Risk Assessment Northeast Region Patient Results

Top Identified Social Needs	Lackawanna	Luzerne	Susquehanna	Wayne	Wyoming
Top Need (All Adults)	Food Worry (8.9%, n=837)	Employment (7.7%, n=2,501)	Employment (9.4%, n=72)	Employment (7.3%, n=46)	Employment (7.8%, n=132)
Adults aged 18-64	Employment (11.3%, n=788)	Employment (10.2%, n=2,393)	Employment (12.3%, n=71)	Employment (9.8%, n=41)	Employment (10.3%, n=125)
Adults aged 65 or older	Food Worry (3.5%, n=87)	Transportation (3.7%, n=328)	Clothing (4.3%, n=8)	Food Worry (2.8%, n=6)	Clothing (3.7%, n=18)
Top Need (Households with children under age 18)	Clothing (11.6%, n=547)	Clothing (13.5%, n=1,455)	Clothing (9.5%, n=26)	Clothing (8.1%, n=19)	Clothing (9.5%, n=39)

Source: Geisinger Universal Health Risk Assessment, Oct .1, 2022 to Jul. 31, 2023

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

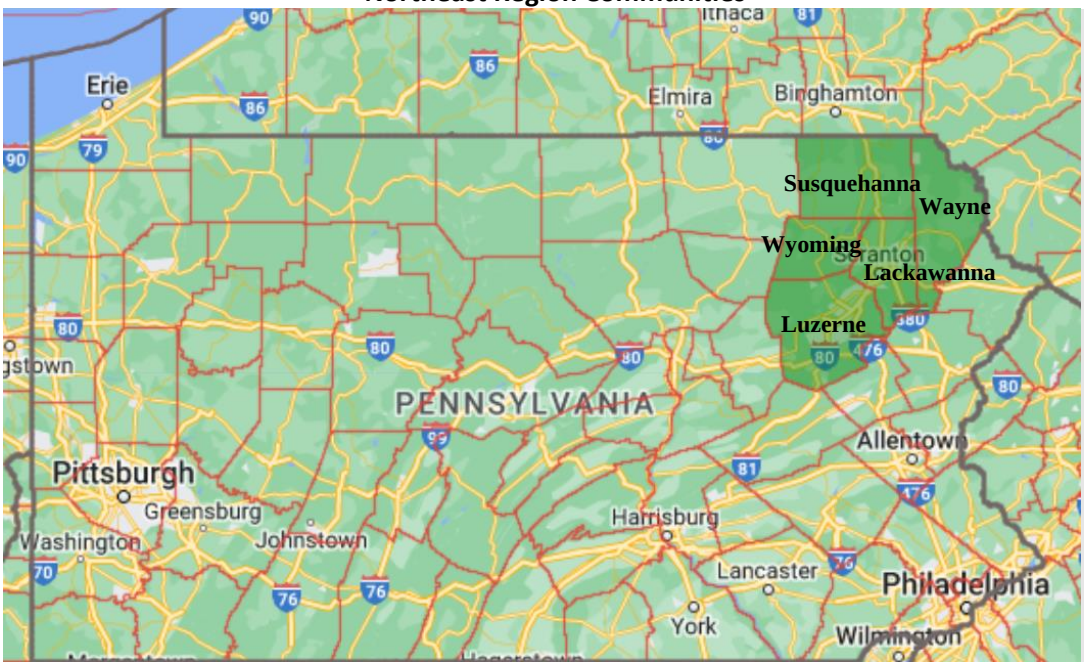
Demographics: Who Lives in the Northeast Region?

Our Community and Residents

Consistent with Pennsylvania overall, the Northeast Region is aging, with a significant increase in the number of older adults from 2010 to 2021 in all counties. Outside of Lackawanna and Luzerne counties, the youth population declined by approximately 20% from 2010 to 2021. **Lackawanna and Luzerne were the only counties to see population growth, although growth was modest at an estimated 1-2%.**

Susquehanna and Wayne are among the oldest counties in the region; approximately one-quarter of residents are aged 65 or older and median ages are nearly eight years older than the state median. In the eastern portion of Wayne County, as many as 40.5% of residents in zip code 18415, Damascus and 55.3% in zip code 18469, Tyler Hill are aged 65 or older. **It is worth noting that outside of the Scranton and Wilkes-Barre metros, 20% or more of residents of nearly all zip codes are aged 65 or older.**

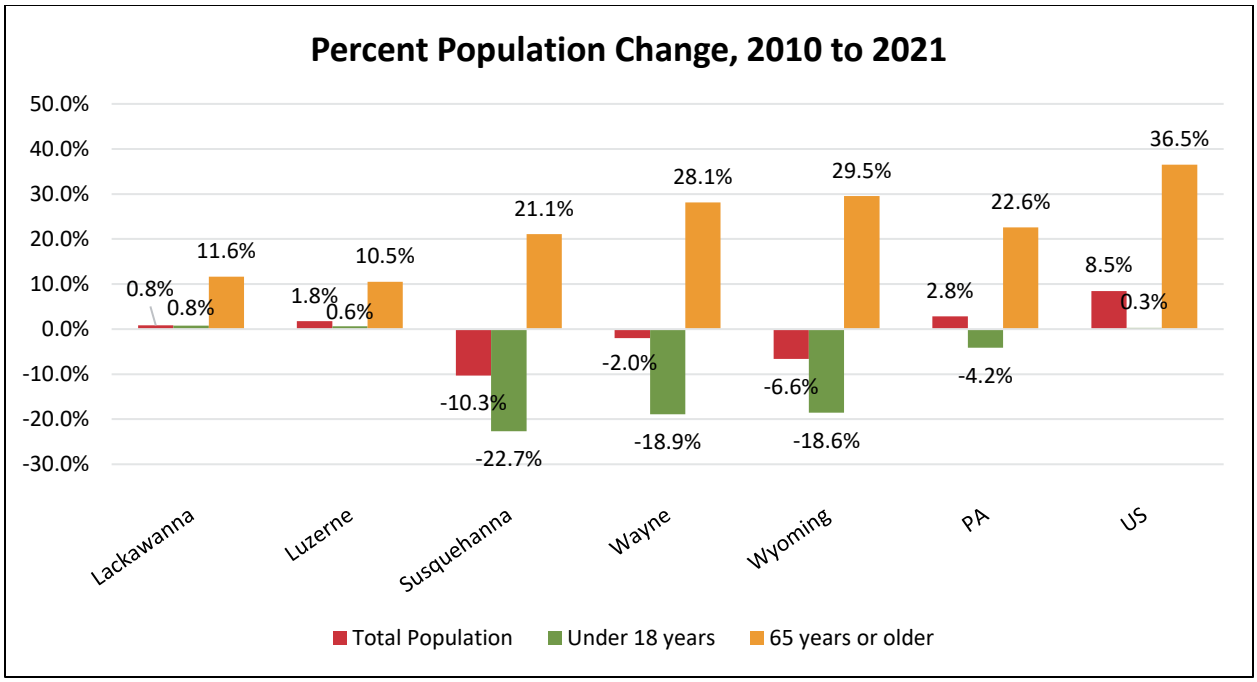
Northeast Region Communities



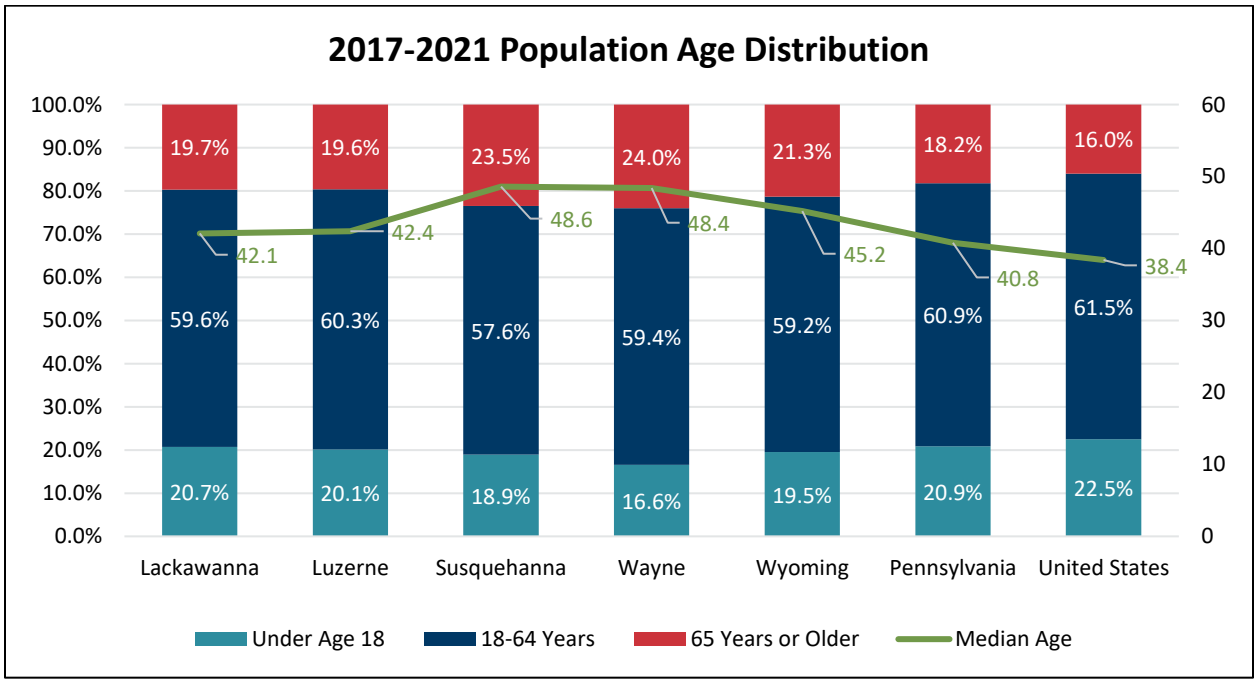
2017-2021 Total Population

	Total Population
Lackawanna	215,529
Luzerne	324,825
Susquehanna	38,892
Wayne	51,244
Wyoming	26,389
Pennsylvania	12,970,650
United States	329,725,481

Source: US Census Bureau, American Community Survey

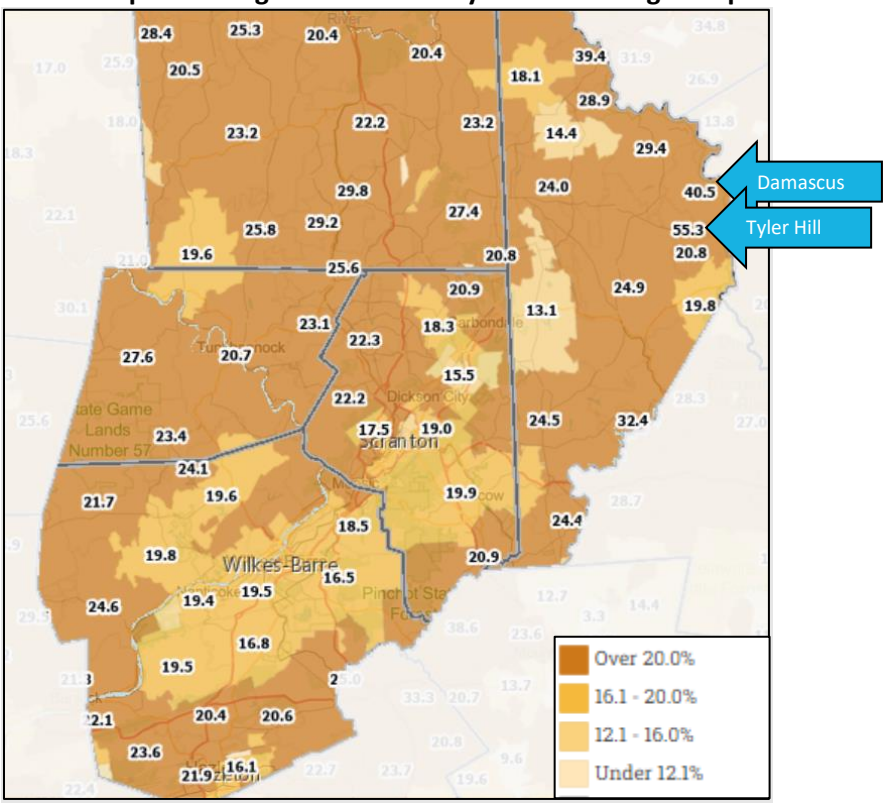


Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

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



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

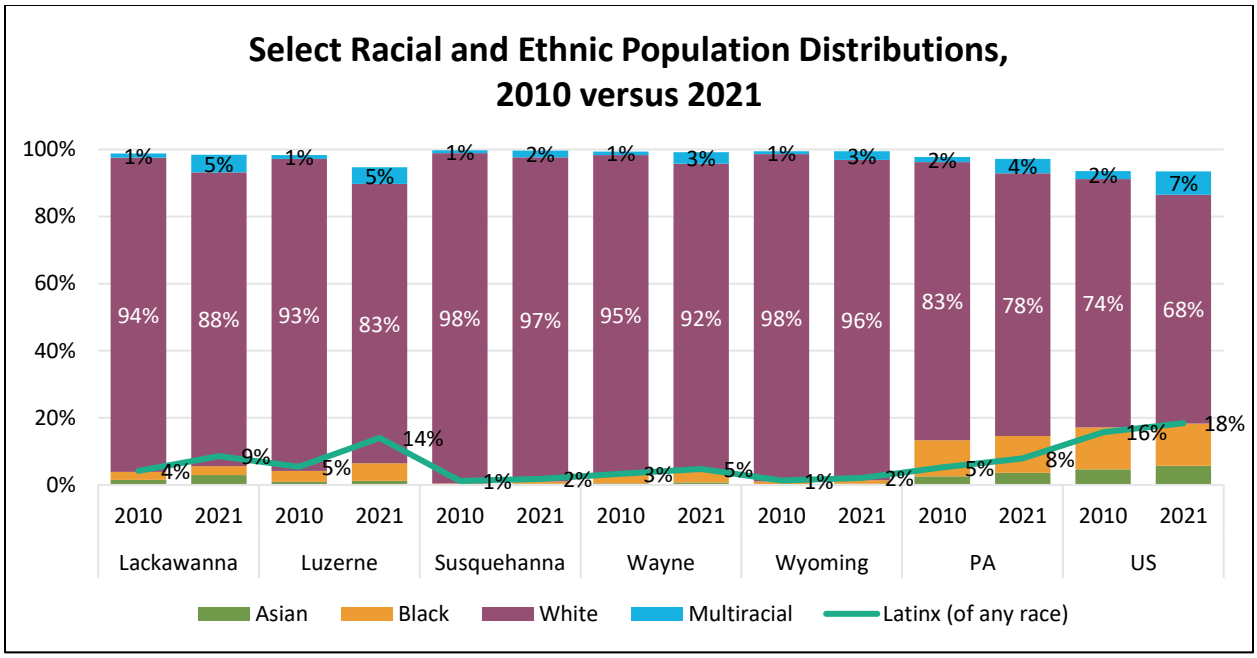
Northeast Region counties are majority white communities with less racial diversity than state and national benchmarks. Luzerne County benefits from the most population diversity with 7% of residents identifying with a race other than white and 14% identifying as Latinx (any race).

Consistent with state and national trends, population diversity is increasing within the region. In Lackawanna and Luzerne counties, from 2010 to 2021, the white population as a proportion of the total population declined 6-10 percentage points.

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)
Lackawanna	0.1%	2.9%	2.7%	0.1%	87.6%	1.5%	5.2%	8.6%
Luzerne	0.1%	1.2%	5.3%	0.1%	83.2%	5.2%	5.0%	14.0%
Susquehanna	0.0%	0.4%	0.6%	0.0%	96.7%	0.3%	2.0%	1.8%
Wayne	0.2%	0.7%	3.3%	0.0%	91.8%	0.6%	3.4%	4.8%
Wyoming	0.1%	0.4%	1.0%	0.0%	95.5%	0.4%	2.6%	2.1%
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%

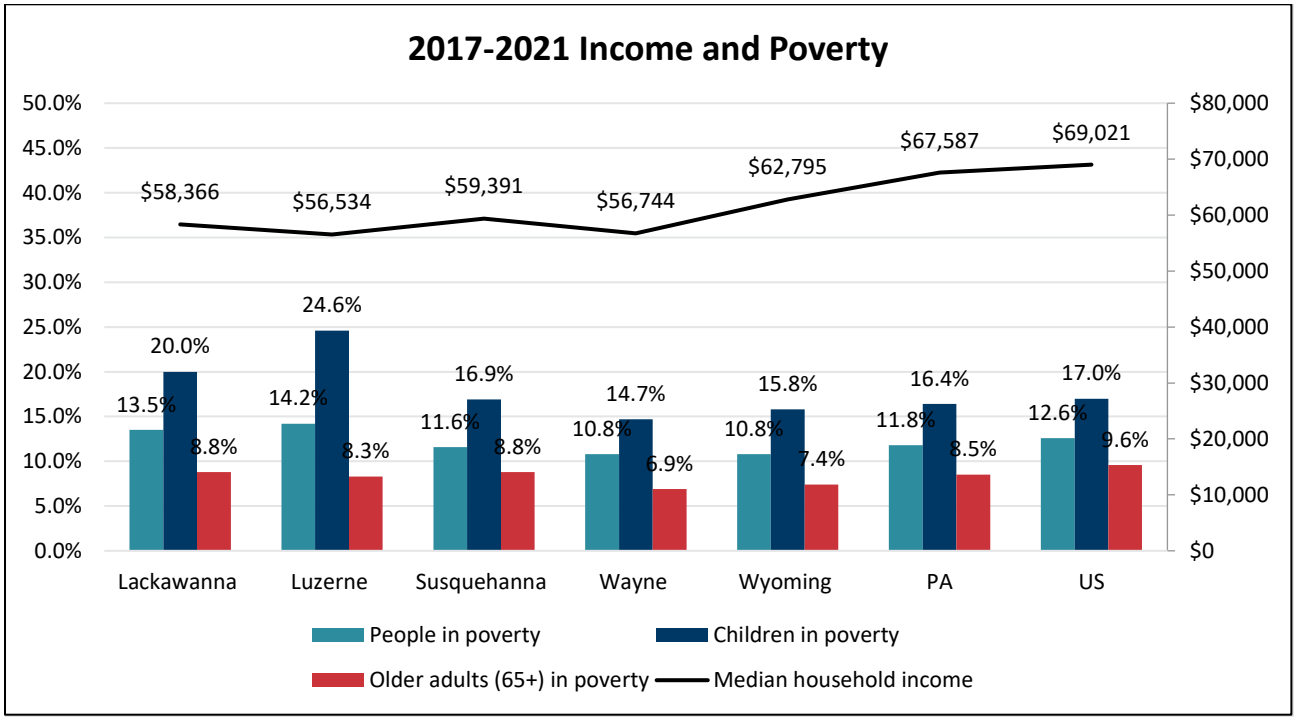
Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

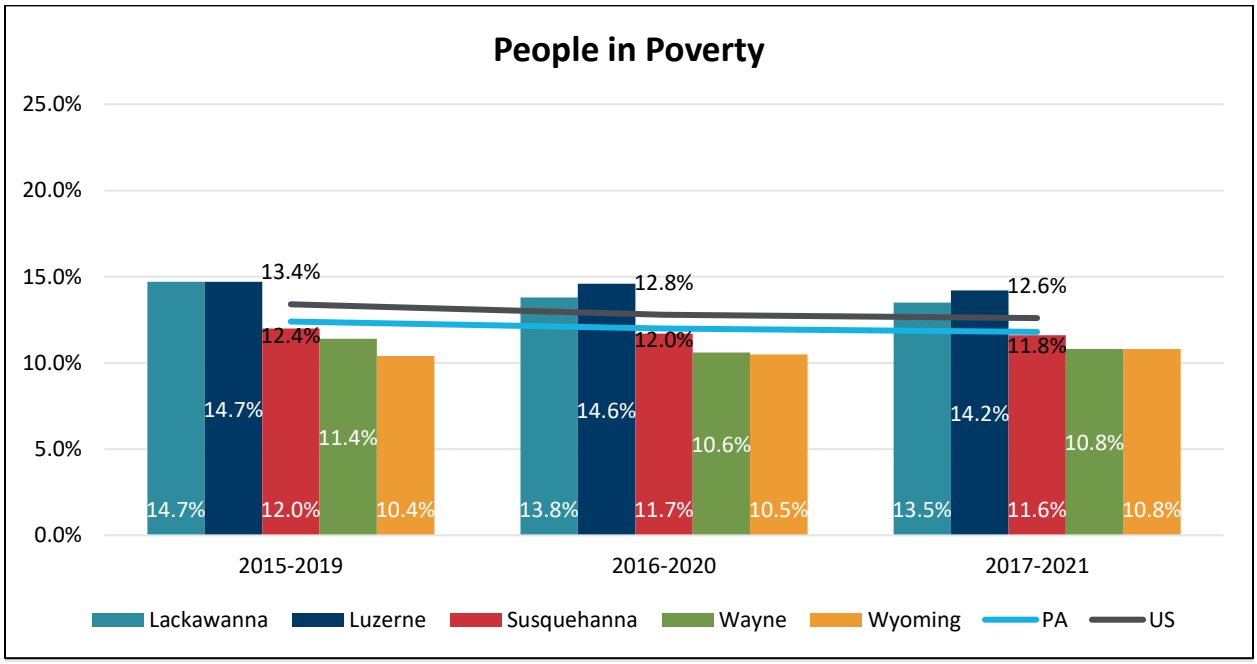
Income and Work

All Northeast Region counties have lower median household incomes than state and national medians, although county-wide poverty levels are only elevated in Lackawanna and Luzerne. **Of note, one-fifth to one-quarter of children in Lackawanna and Luzerne counties live in poverty.**

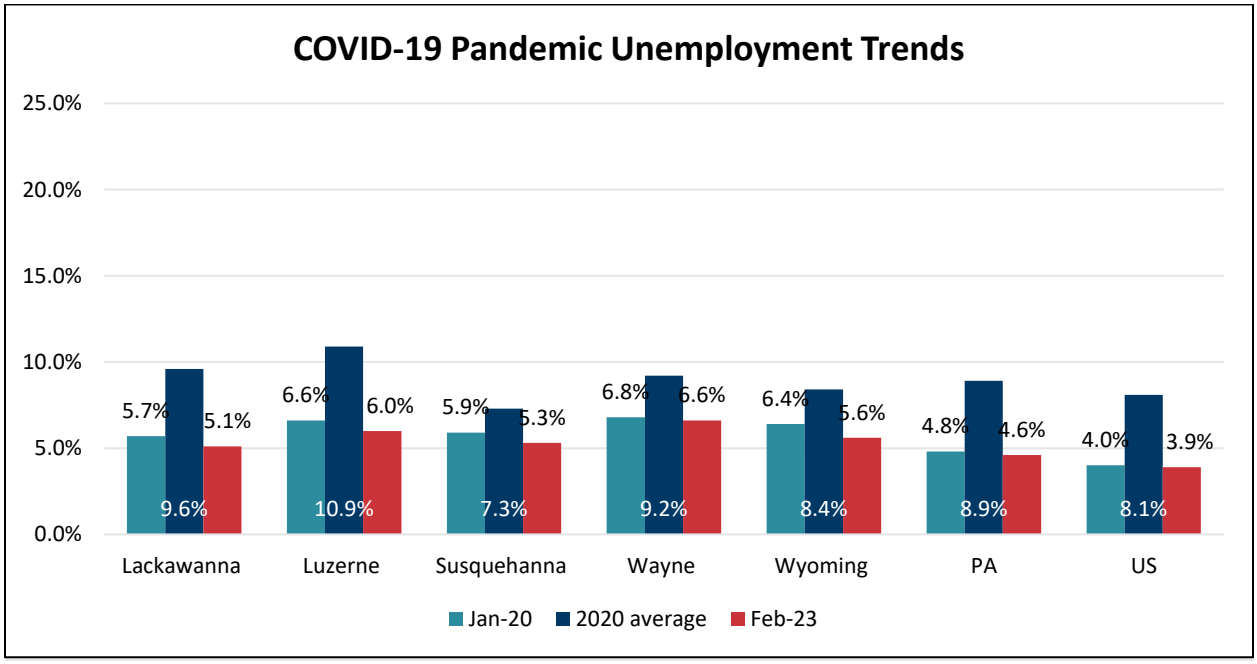


Source: US Census Bureau, American Community Survey

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. **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 Census Bureau, American Community Survey

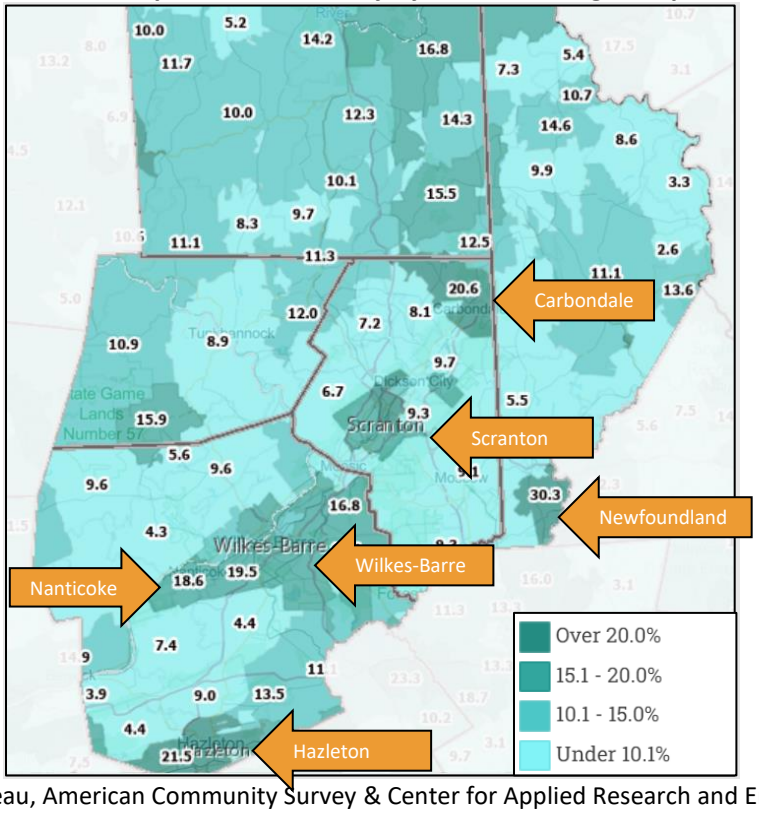


Source: US Bureau of Labor Statistics

When analyzed by zip code, pockets of high poverty are largely seen within the Hazleton, Scranton, and Wilkes-Barre metros. Children are historically disproportionately affected by poverty, and within these same areas, approximately one-third of children live in poverty. **It is also worth noting Newfoundland, where 30.3% of all residents and 45.1% of children live in poverty, and Beach Lake, where 13.6% of all residents live in poverty but 30.8% children live in poverty.**

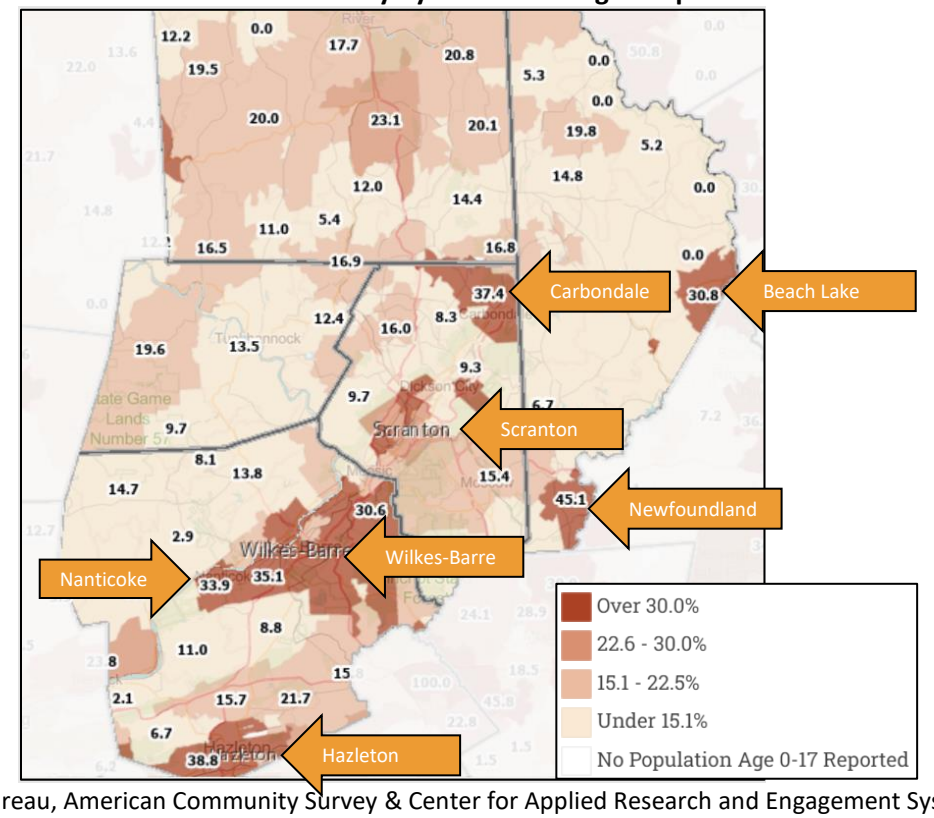
Poverty is not experienced by every community equally and contributes to further inequalities such as access to safe living and working conditions, health services, and basic needs, among other things. In Lackawanna and Luzerne counties, Black and multiracial residents make up 5% or less of the population, each, but one-quarter to one-third of these population groups experience poverty, compared with only 12% of the majority-white population. Similar disparities exist for individuals identifying as Latinx. **While the region has few residents who identify as non-white or non-Hispanic, they do exist, and their lack of visibility may contribute to these disparate experiences.**

2017-2021 Population in Poverty by Northeast Region Zip Code



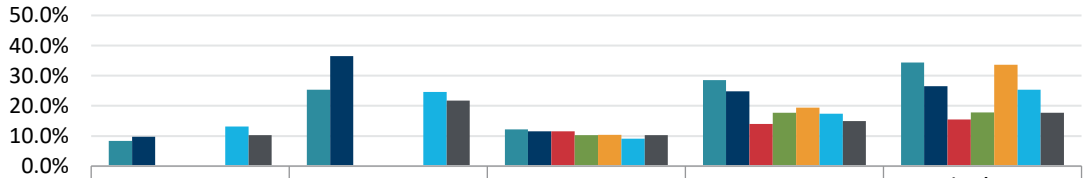
Source: US Census Bureau, American Community Survey & Center for Applied Research and Engagement Systems

2017-2021 Children in Poverty by Northeast 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

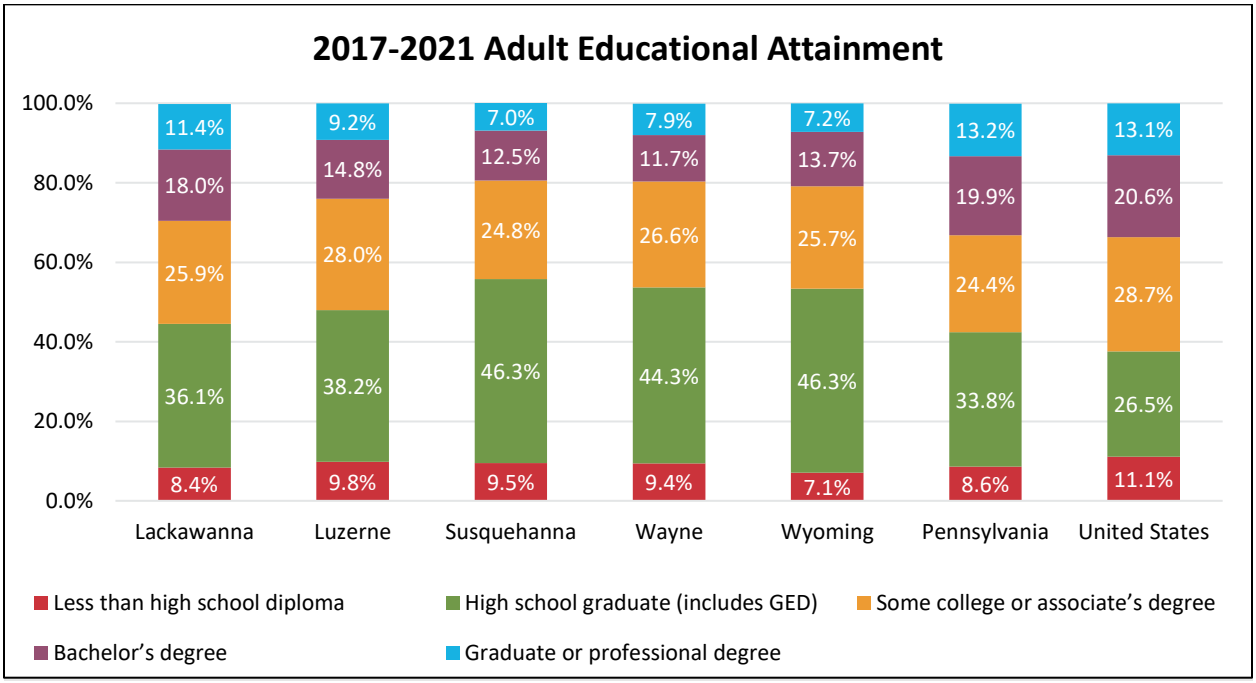


	Asian	Black	White	Multiracial	Latinx (of any race)
Lackawanna	8.4%	25.3%	12.2%	28.5%	34.4%
Luzerne	9.7%	36.5%	11.5%	24.8%	26.5%
Susquehanna			11.5%	14.0%	15.5%
Wayne			10.3%	17.7%	17.8%
Wyoming			10.4%	19.4%	33.6%
PA	13.1%	24.6%	9.1%	17.4%	25.3%
US	10.3%	21.7%	10.3%	14.9%	17.7%

Source: US Census Bureau, American Community Survey
Note: Data for Northeast 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 Northeast Region communities, approximately 90% of adults graduated high school, a similar proportion as the state overall. 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, Northeast Region residents are just as likely or more likely to own their home when compared to state and national benchmarks. Homeownership increases in more rural communities.

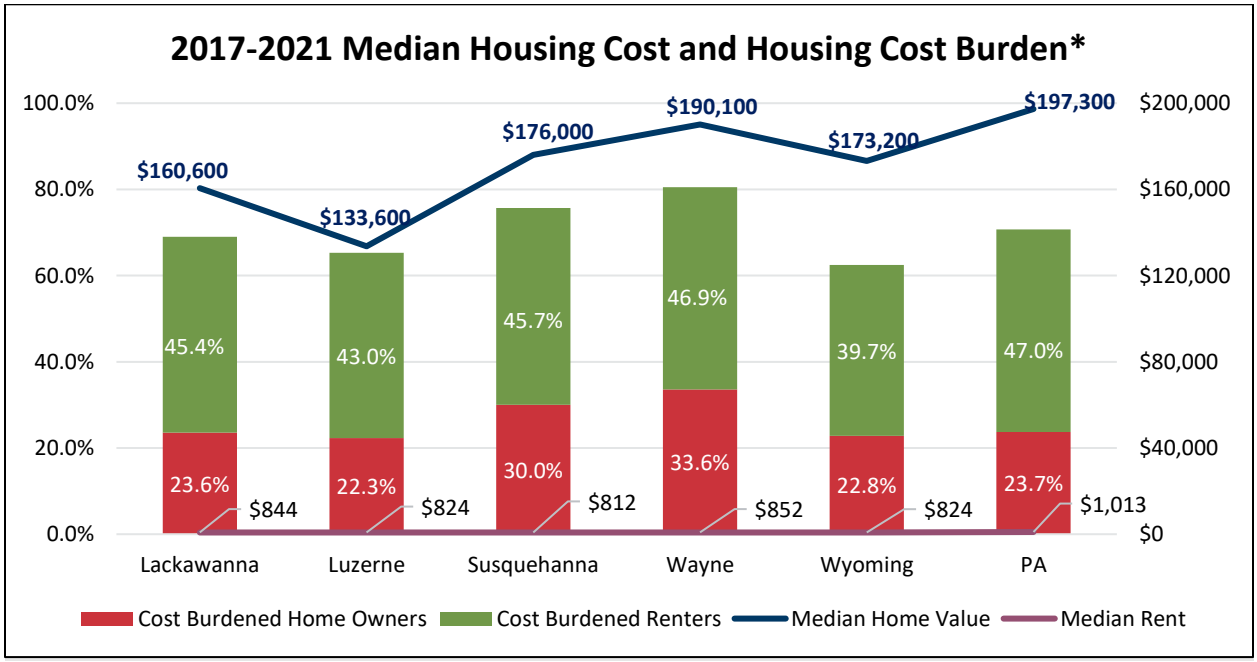
2017-2021 Housing Occupancy

	Owner Occupied Units	Renter Occupied Units
Lackawanna	65.3%	34.7%
Luzerne	67.6%	32.4%
Susquehanna	71.6%	28.4%
Wayne	80.7%	19.3%
Wyoming	77.4%	22.6%
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 homeownership possible.** The Northeast Region is no exception to these trends. Wayne and Wyoming counties have the highest percentage of homeowners, but Wayne County has the most cost-burdened residents, estimated at 47%.



Source: US Census Bureau, American Community Survey

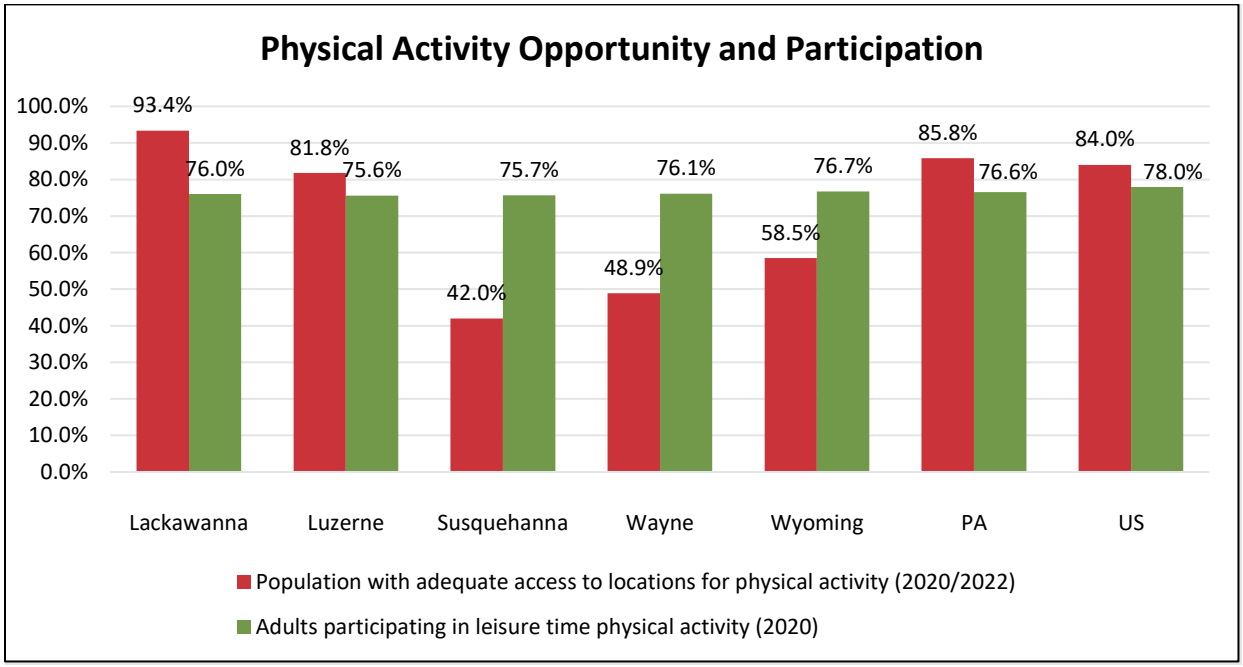
*Defined as spending 30% or more of household income on rent or mortgage expenses.

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.

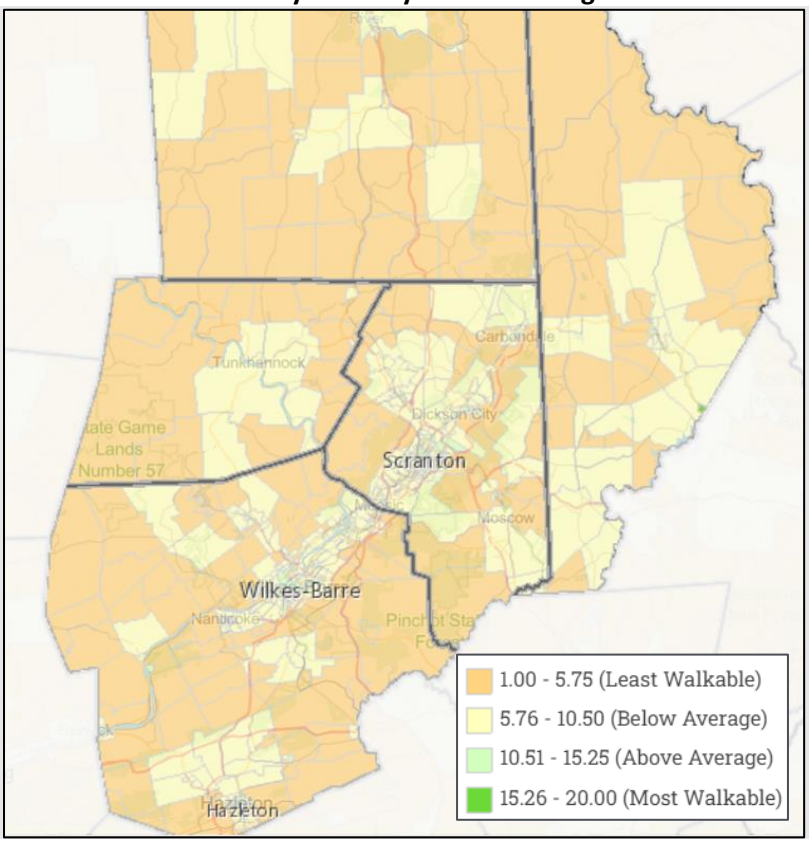
Feedback from Key Stakeholder Survey participants centered around the scarcity of reliable and affordable public transportation options available to residents. Combined with a region that is, on the whole, "below average" in its walkability rating, as well as a rapidly aging population, it can be difficult 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 Northeast Region have demonstrated resilience in prioritizing physical activity. Susquehanna, Wayne, and Wyoming counties are far below Lackawanna and Luzerne 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 Northeast 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.

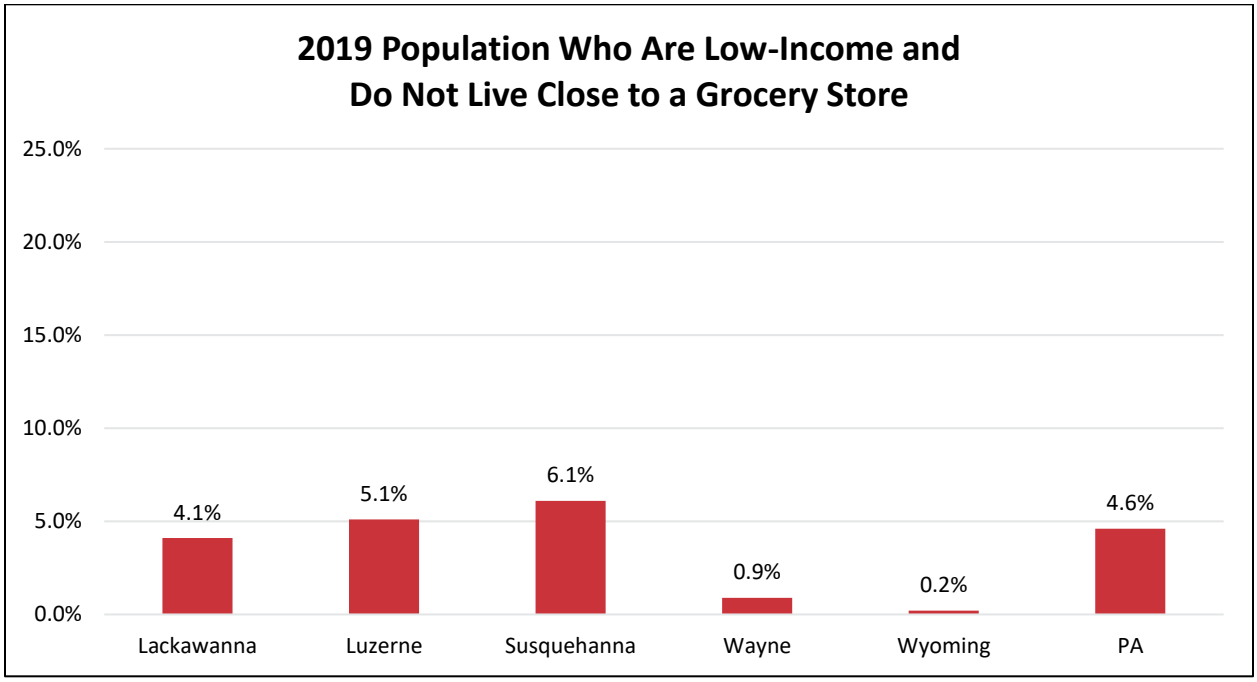
In 2020, Feeding America conservatively projected a 36% growth in national food insecurity rates as a result of the pandemic. Similar to poverty and unemployment trends, food insecurity declined post-pandemic, continuing an overall downward trend, but the impact of this experience on long-term health outcomes should continue to be monitored. Across the Northeast Region in 2021, approximately 1 in 10 residents were estimated to be food insecure. **In Lackawanna and Luzerne counties, where children experience disproportionate poverty, nearly 1 in 5 children were estimated to be food insecure.**

It is also worth noting disparities among individuals with low income living in Susquehanna County. **Susquehanna County overall has fewer residents living in poverty and a similar proportion of food insecure residents as neighboring communities, but approximately 6% of residents with low income do not live close to a grocery store, the highest proportion in the region.** Low-income residents may rely more on smaller neighborhood stores that may not carry healthy foods or may offer them only at higher prices, compounding health and financial hardships.

Food Insecurity

	Lackawanna	Luzerne	Susquehanna	Wayne	Wyoming	PA	US
Food Insecure Residents							
2021	11.5%	11.7%	10.0%	10.0%	9.5%	9.4%	10.4%
2020	12.7%	12.9%	10.7%	11.3%	10.3%	8.9%	11.8%
2019	12.7%	12.5%	11.4%	11.2%	10.6%	10.6%	10.9%
Food Insecure Children							
2021	14.2%	16.8%	12.1%	12.7%	10.8%	12.2%	12.8%
2020	18.4%	21.5%	14.9%	16.1%	13.9%	13.1%	16.1%
2019	16.8%	18.8%	16.3%	15.6%	14.4%	14.7%	14.6%

Source: Feeding America & USDA Food Environment Atlas



Source: Health Resources and Services Administration

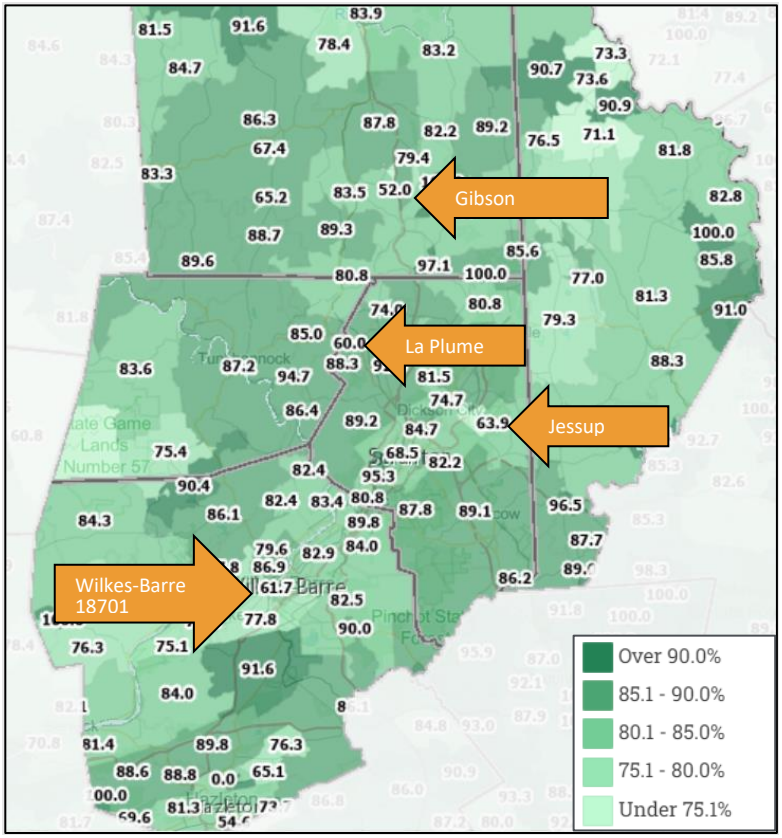
During the COVID pandemic, we were able to use technology to bring services to people in their homes, but not uniformly. We need to bridge the wide digital divide within our communities to effectively reach all residents. The residents of each Northeast Region county generally have digital access comparable to their neighbors and state and national percentages. **However, there are some smaller communities, highlighted on the map below, where fewer than 65% of residents have reliable internet access.** These communities are both urban, such as downtown Wilkes-Barre, as well as more rural.

2017-2021 Households by Digital Access

	With Computer Access			With Internet Access	
	Computer Device	Desktop / Laptop	Smartphone	Internet Subscription	Broadband Internet
Lackawanna	89.7%	74.6%	80.7%	84.4%	83.9%
Luzerne	88.4%	71.1%	79.1%	83.5%	83.0%
Susquehanna	89.7%	76.0%	74.5%	86.1%	85.0%
Wayne	88.9%	74.5%	75.1%	84.1%	82.8%
Wyoming	91.3%	76.2%	79.4%	86.1%	85.1%
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 Northeast 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 (2.5 per 1,000 children under age 5 in Wyoming County), as well as the prohibitive cost. **In Wayne County, residents with small children may spend 35% of their income on just childcare. Wayne County residents are also more likely to experience housing cost burden. These combined factors make Wayne County *one of the least affordable places to raise children in the Northeast Region.***

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
Lackawanna	6.3	29.7%
Luzerne	5.8	27.2%
Susquehanna	4.4	27.0%
Wayne	7.2	34.6%
Wyoming	2.5	32.7%
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

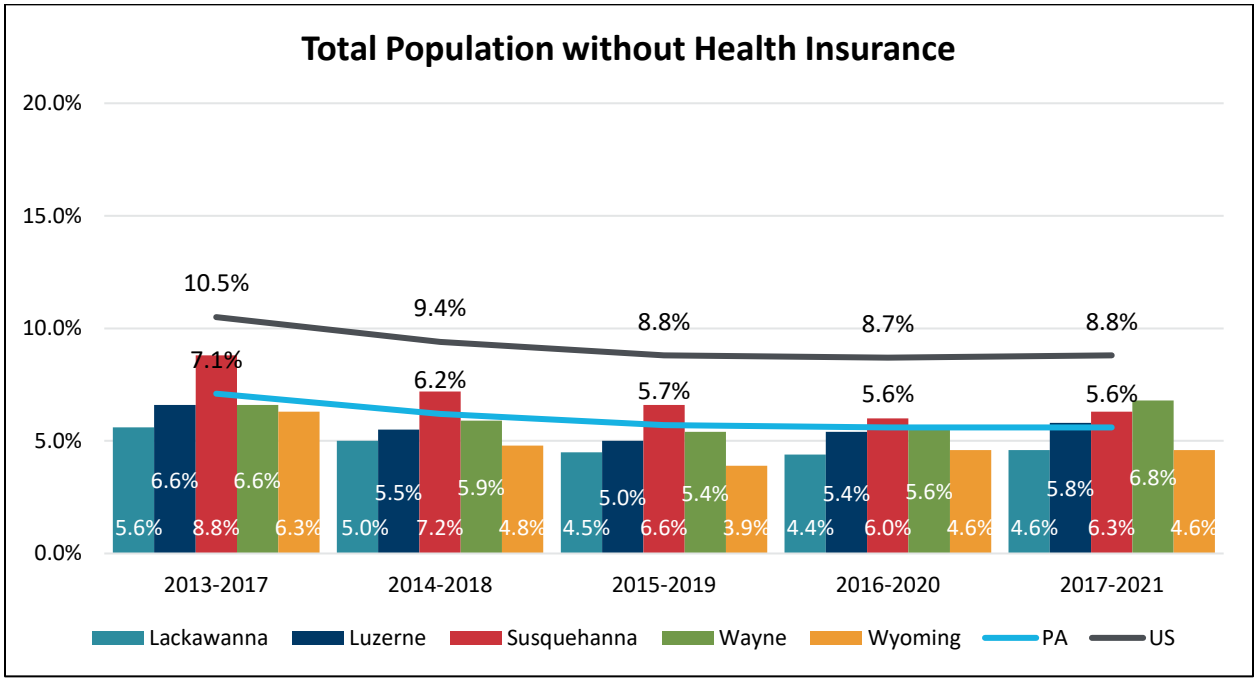
Access to Care

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.

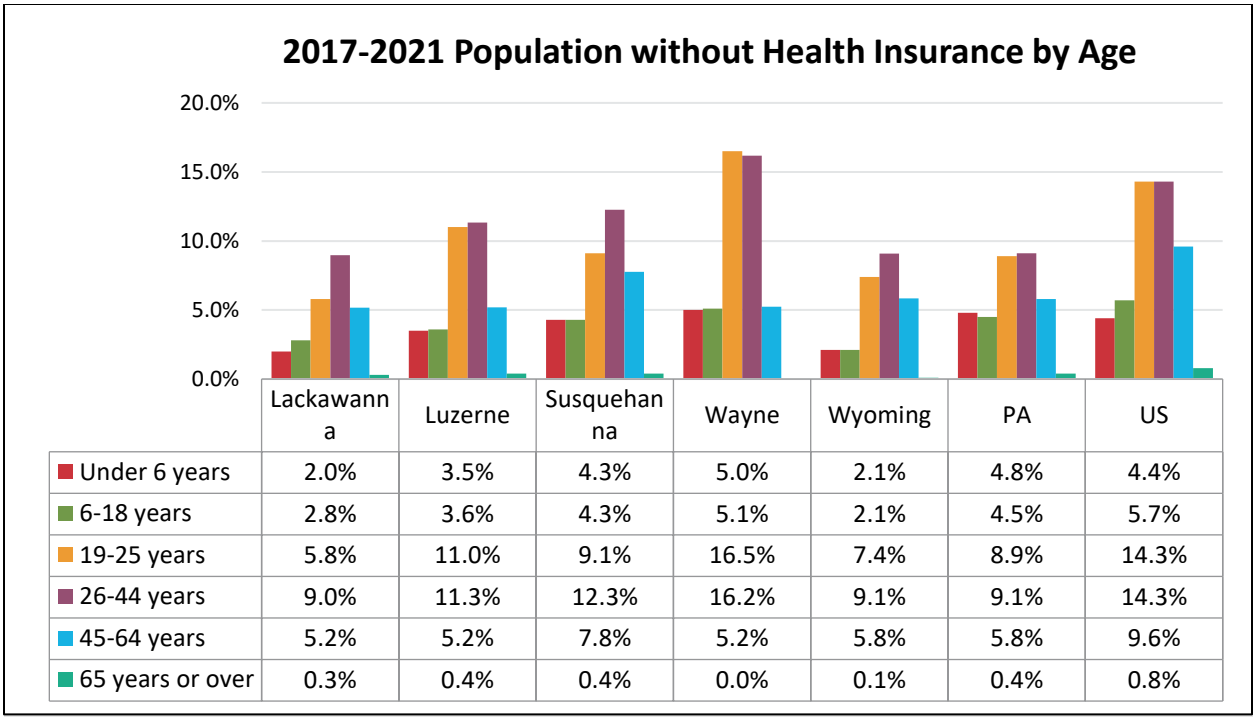
While many Northeast Region residents *have* health insurance, there is a relatively high percentage of young adults (ages 19-25) who are uninsured across all counties. This population may be eligible to remain insured through their guardians under the Affordable Care Act, presenting an opportunity for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

The percentage of uninsured residents increases across most counties for residents aged 26-44, when continued coverage under the ACA is no longer possible, and many would be reliant on employer-sponsored health insurance. Given the increase in ALICE households, these data may represent individuals who do not have employer-sponsored health insurance and are ineligible for Medicaid.

Uninsured data by race and ethnicity are not shown for Northeast Region counties due to low counts. Statewide and nationally, individuals identifying as Latinx have disproportionately higher uninsured rates of 12.3% and 17.7%, respectively.

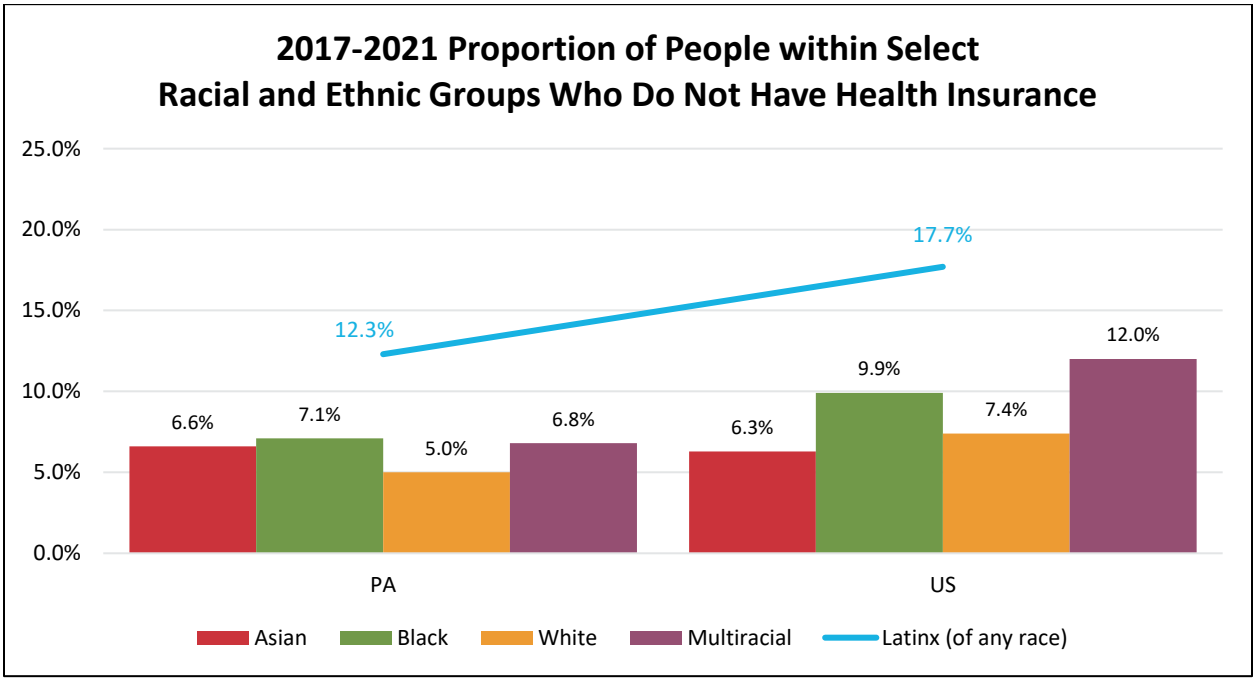


Source: US Census Bureau, American Community Survey

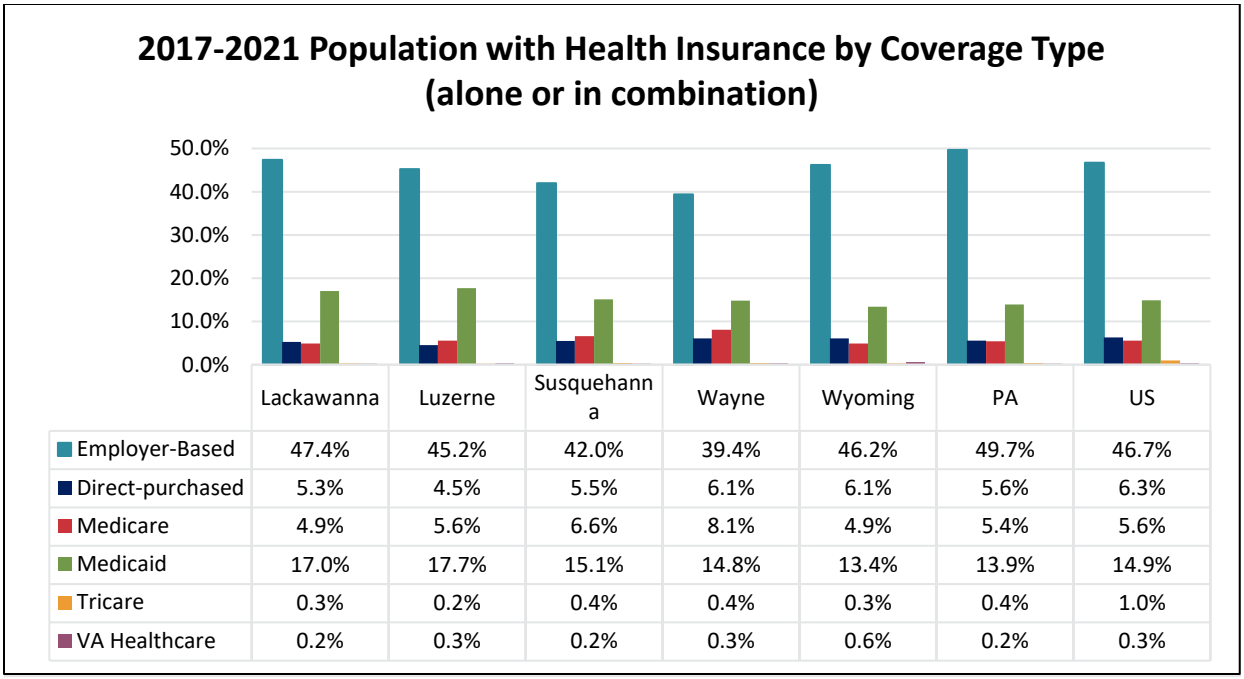


	Lackawanna	Luzerne	Susquehanna	Wayne	Wyoming	PA	US
Under 6 years	2.0%	3.5%	4.3%	5.0%	2.1%	4.8%	4.4%
6-18 years	2.8%	3.6%	4.3%	5.1%	2.1%	4.5%	5.7%
19-25 years	5.8%	11.0%	9.1%	16.5%	7.4%	8.9%	14.3%
26-44 years	9.0%	11.3%	12.3%	16.2%	9.1%	9.1%	14.3%
45-64 years	5.2%	5.2%	7.8%	5.2%	5.8%	5.8%	9.6%
65 years or over	0.3%	0.4%	0.4%	0.0%	0.1%	0.4%	0.8%

Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey



	Lackawanna	Luzerne	Susquehanna	Wayne	Wyoming	PA	US
Employer-Based	47.4%	45.2%	42.0%	39.4%	46.2%	49.7%	46.7%
Direct-purchased	5.3%	4.5%	5.5%	6.1%	6.1%	5.6%	6.3%
Medicare	4.9%	5.6%	6.6%	8.1%	4.9%	5.4%	5.6%
Medicaid	17.0%	17.7%	15.1%	14.8%	13.4%	13.9%	14.9%
Tricare	0.3%	0.2%	0.4%	0.4%	0.3%	0.4%	1.0%
VA Healthcare	0.2%	0.3%	0.2%	0.3%	0.6%	0.2%	0.3%

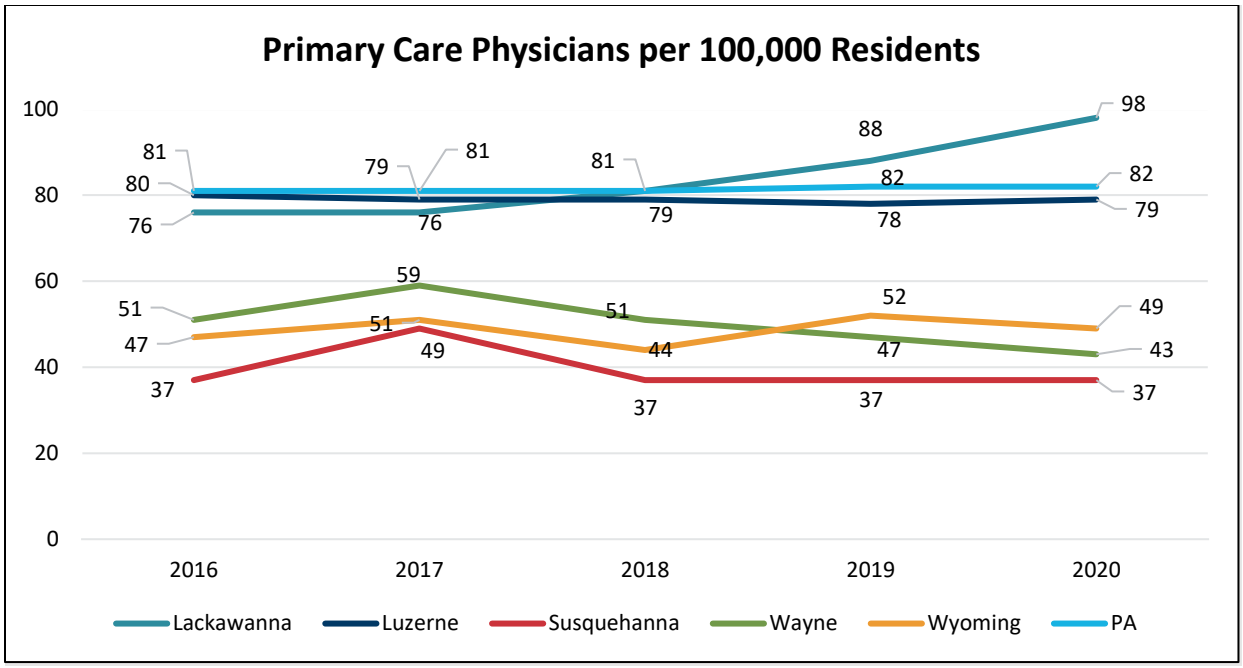
Source: US Census Bureau, American Community Survey

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.

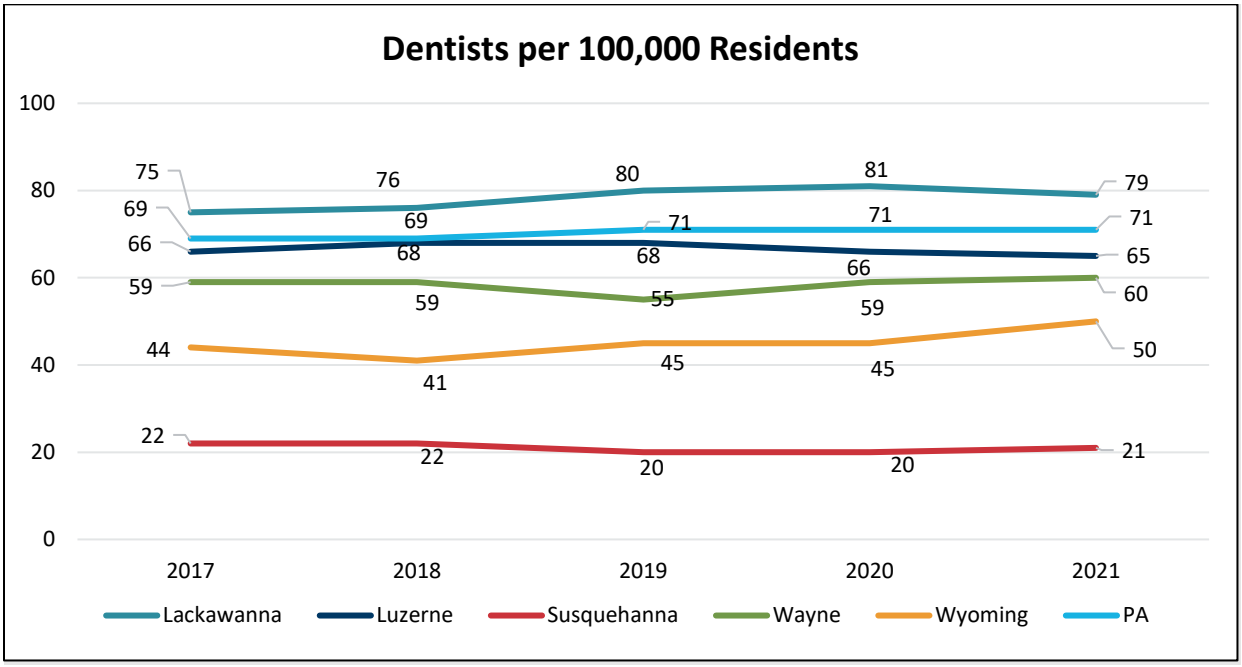
There is an opportunity to grow primary and preventive care services within the Northeast Region. All counties except Lackawanna have fewer physicians and dentists than the state average. **Susquehanna County has the fewest physicians and dentists of any county and is a Health Professional Shortage Area (HPSA) for primary and dental care for individuals with low income, further compounding care access barriers for a population that is historically less likely to receive regular and preventive care.** Despite having the most availability of dentists in the region, Lackawanna and Luzerne counties are also HPSAs for dental care for individuals with low income.

Despite a lack of doctors, adult residents of the Northeast Region report preventive visits within the last year on par with state and national averages – about three-quarters of adults. They report regular dental checkups with slightly less frequency, 60%-65% of adults, compared to 68% across Pennsylvania.

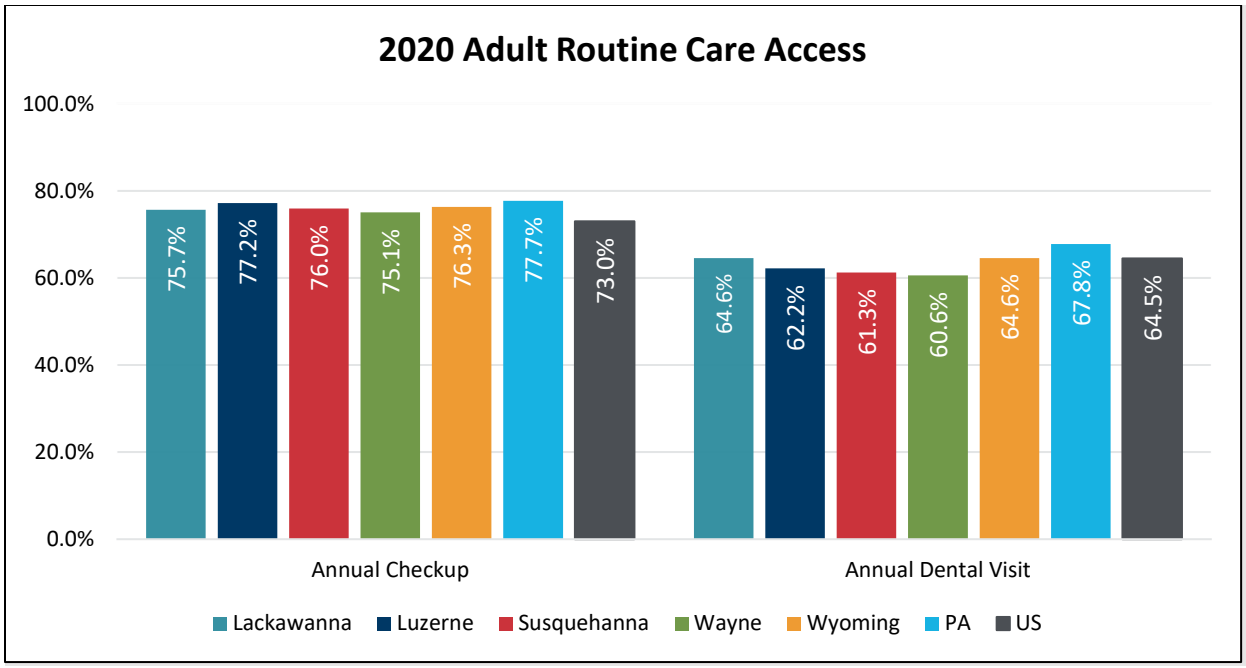
When analyzed by zip code, the proportion of adults receiving preventive visits is generally consistent across the region, while receipt of regular dental care is more varied. In Susquehanna County, the proportion of adults with regular dental care falls to 58-60% in Susquehanna Depot, Great Bend, and Hallstead. Other areas of disparity include downtown Scranton, Wilkes-Barre, and Hazleton. Of note, only 52.8% of adults in Scranton zip code 18503 reported a recent dental checkup. Waymart zip code 18472 in Wayne County is also an area of opportunity, with the lowest proportion of adults receiving preventive care (74.5%) and fewer adults receiving regular dental care (56.2%).



Source: Health Resources & Services Administration

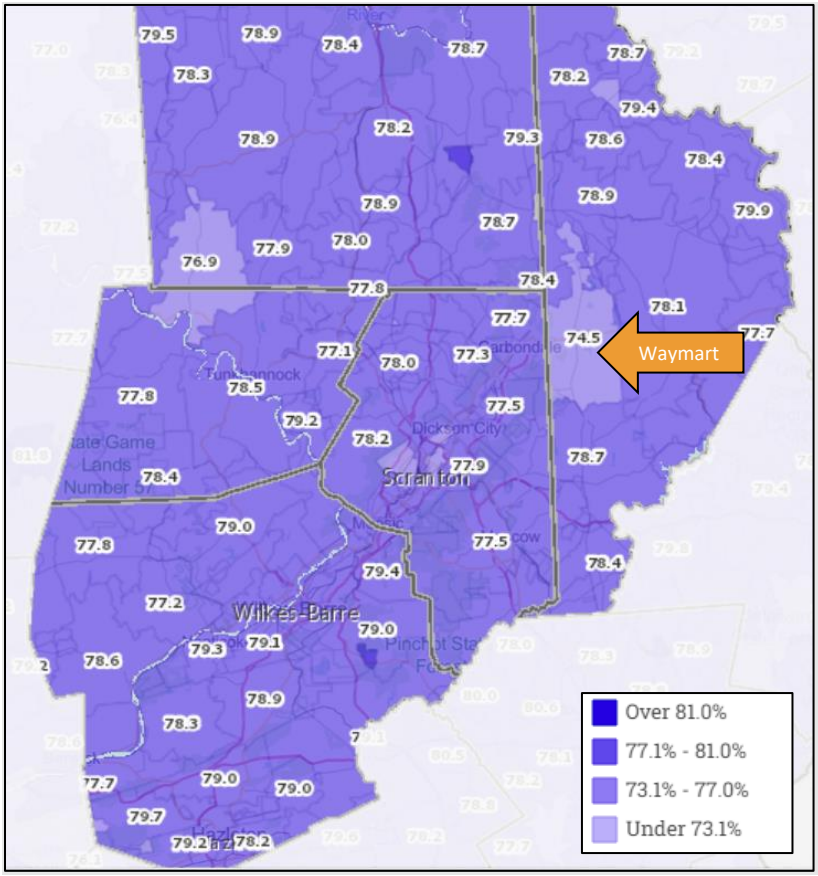


Source: Health Resources & Services Administration



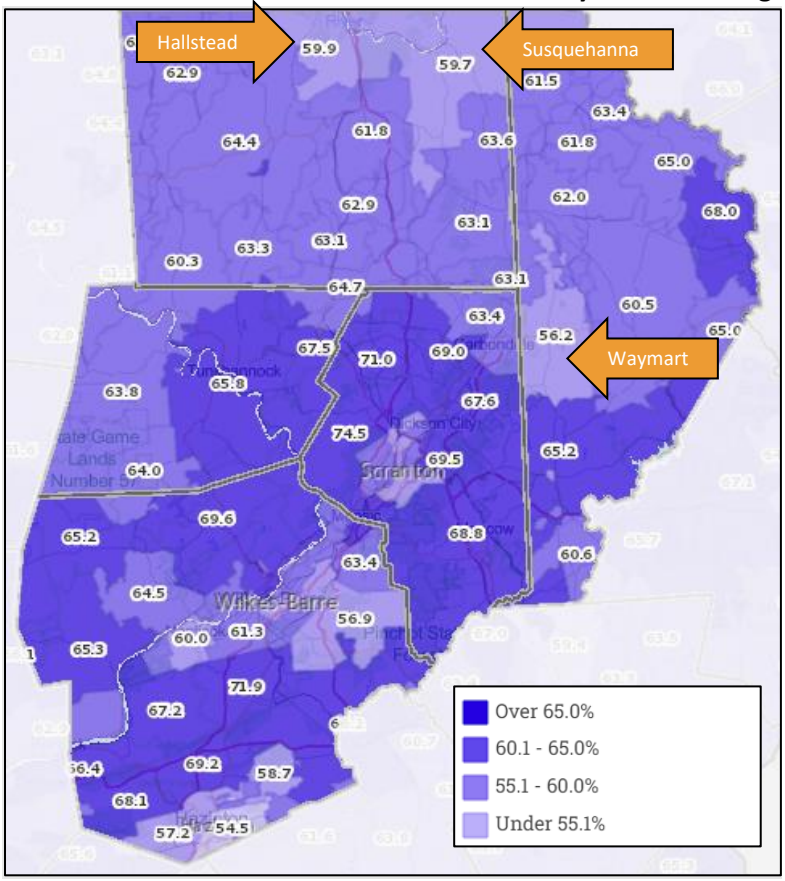
Source: Centers for Disease Control and Prevention

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



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

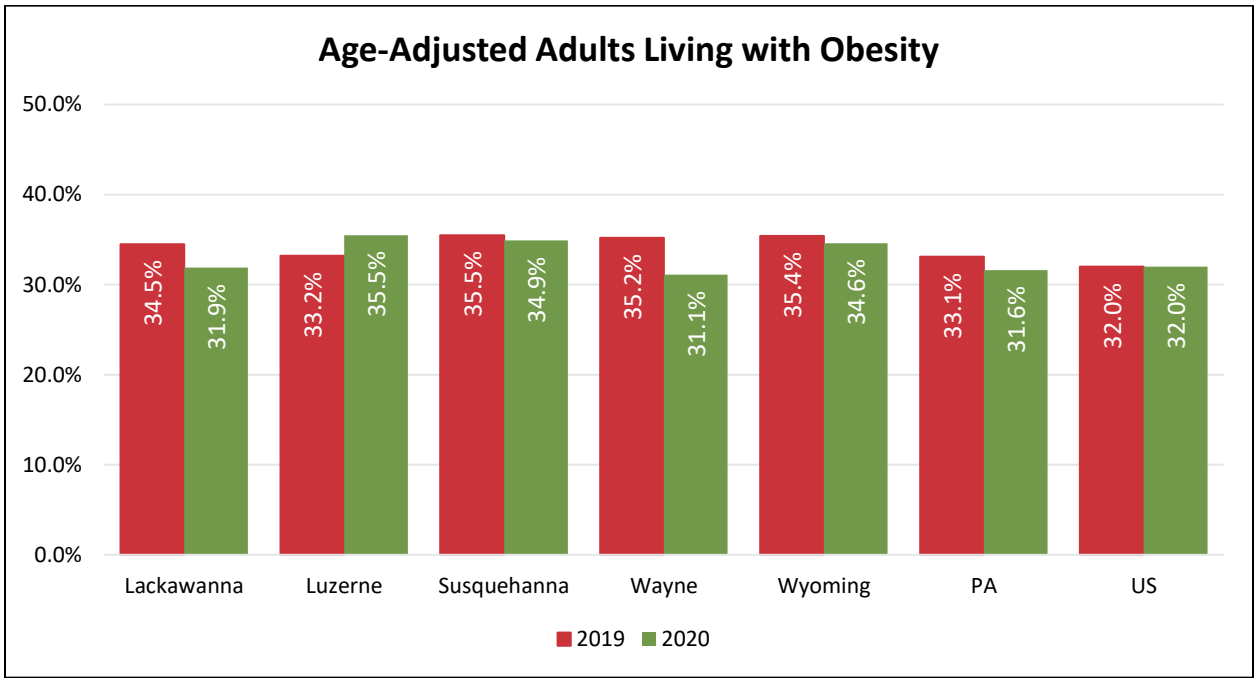
Health Risk Factors and Chronic Disease

Prior to COVID-19, the top leading causes of death for Pennsylvania and US residents were chronic diseases. **Across the Northeast Region, residents overall have poorer outcomes from chronic disease than in the rest of the state, dying at higher rates from diabetes, heart disease, and lower respiratory diseases.** It is, however, interesting to note that despite more smokers in the region compared to state and national benchmarks, diagnoses of asthma and COPD, and incidence and death rates due to lung cancer are comparable.

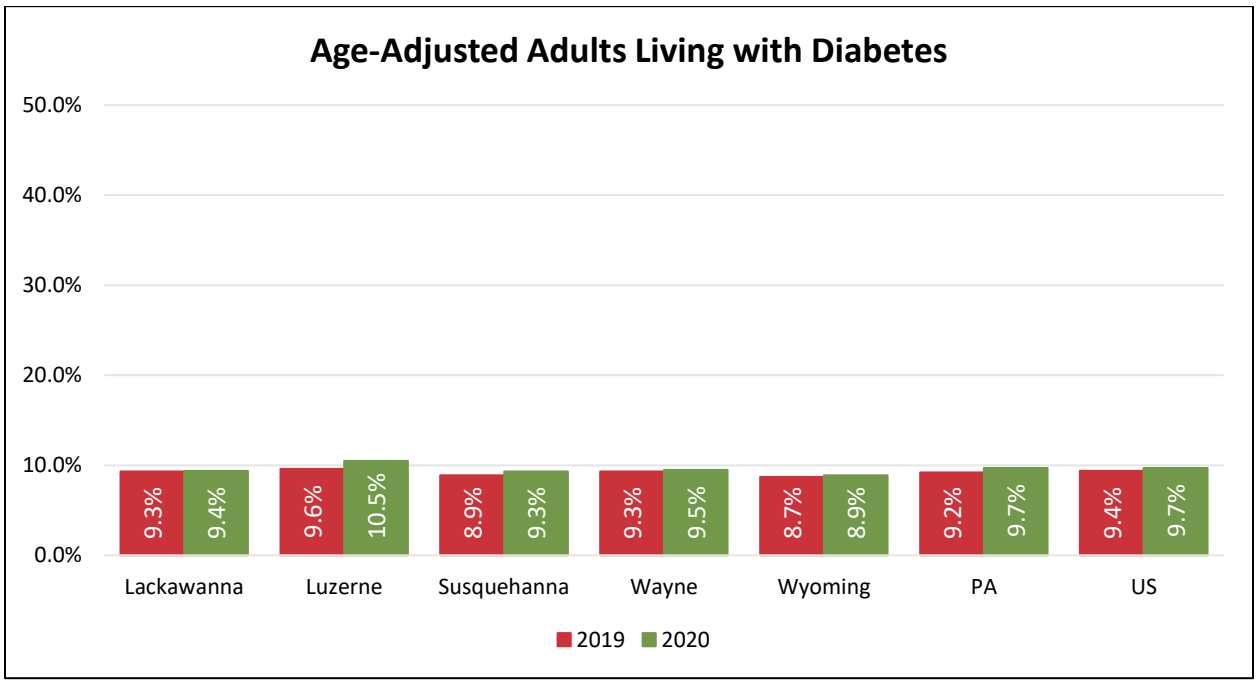
The region generally fares better in its cancer outcomes than the state and nation. Wayne County is an anomaly in the region with the lowest cancer incidence as compared to its neighbors, but the highest cancer death rates. This finding is often reflective of care access barriers, including delayed screening and advanced stage diagnosis.

Overall, the counties' death rates from cancer are lower than, or nearly on par with, the rest of Pennsylvania. It is notable that Luzerne County has a particularly high incidence of prostate cancer, 22% higher than the next highest county in the region, but a death rate only 10% higher than the next highest. These factors suggest that residents are receiving early and effective cancer care in the region.

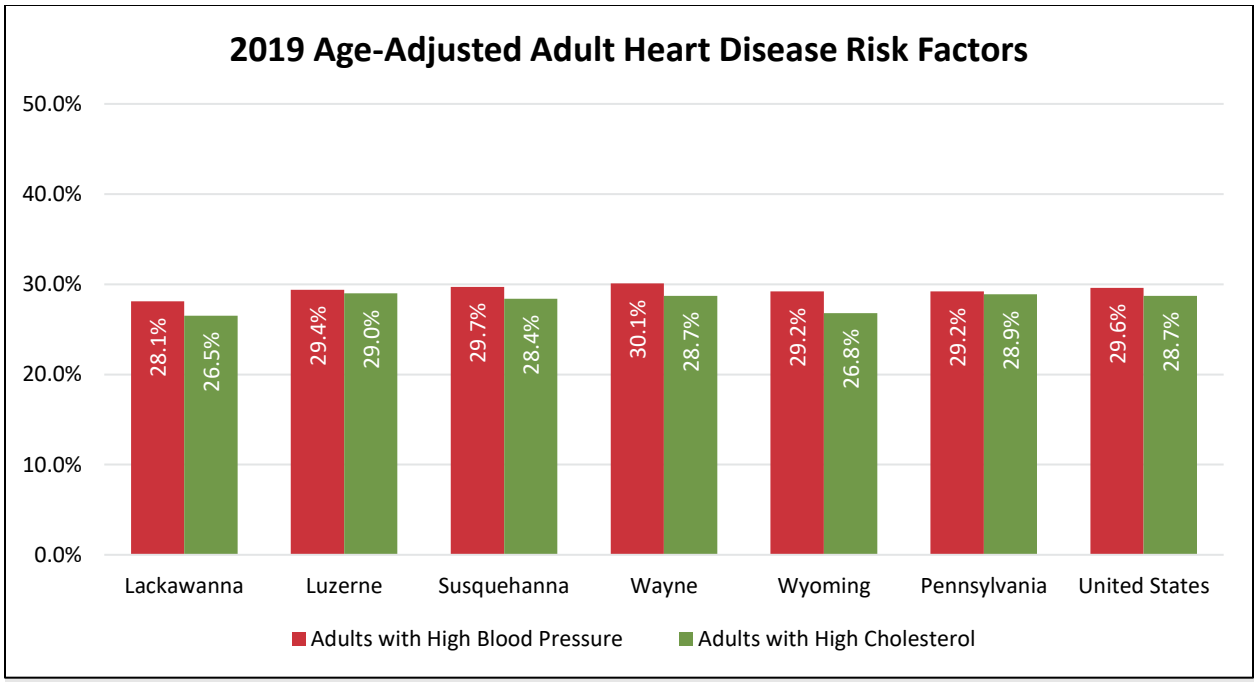
It is clear that social drivers of health directly impact health risk factors and ultimately chronic disease, resulting in inequities in quality of life and life expectancy. Across the state of Pennsylvania, death rates for Black residents attributed to diabetes and heart disease far outpace death rates for those of other races. **The Black population in the Northeast 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.**



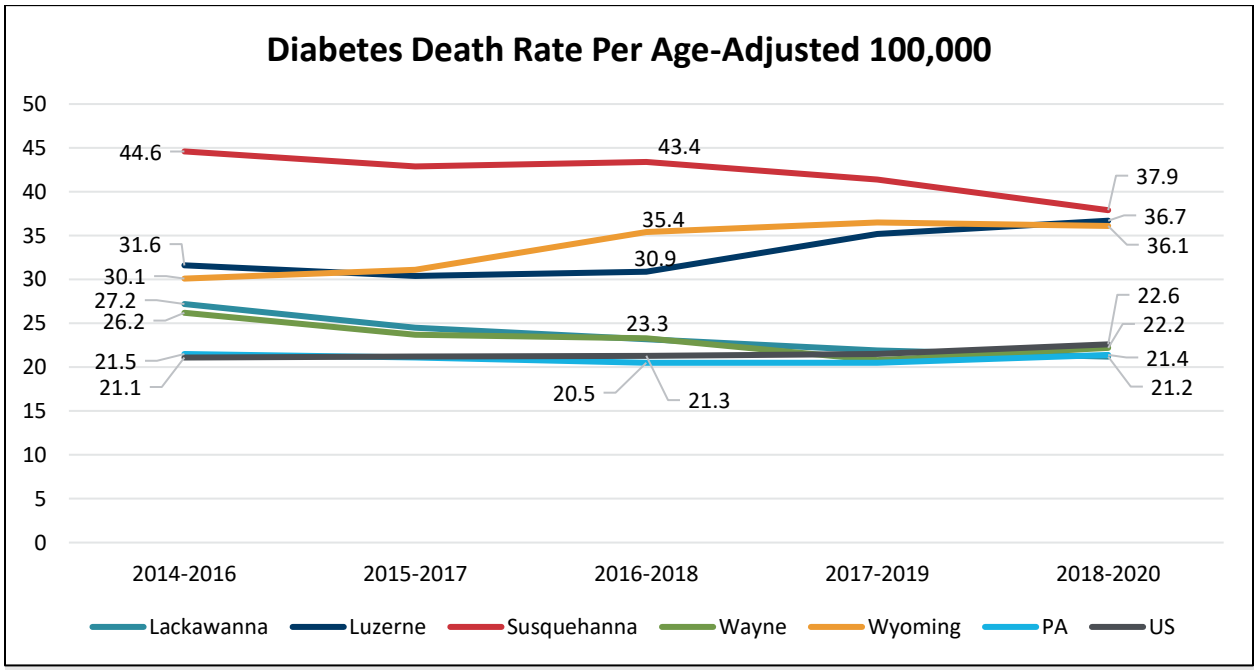
Source: Centers for Disease Control and Prevention



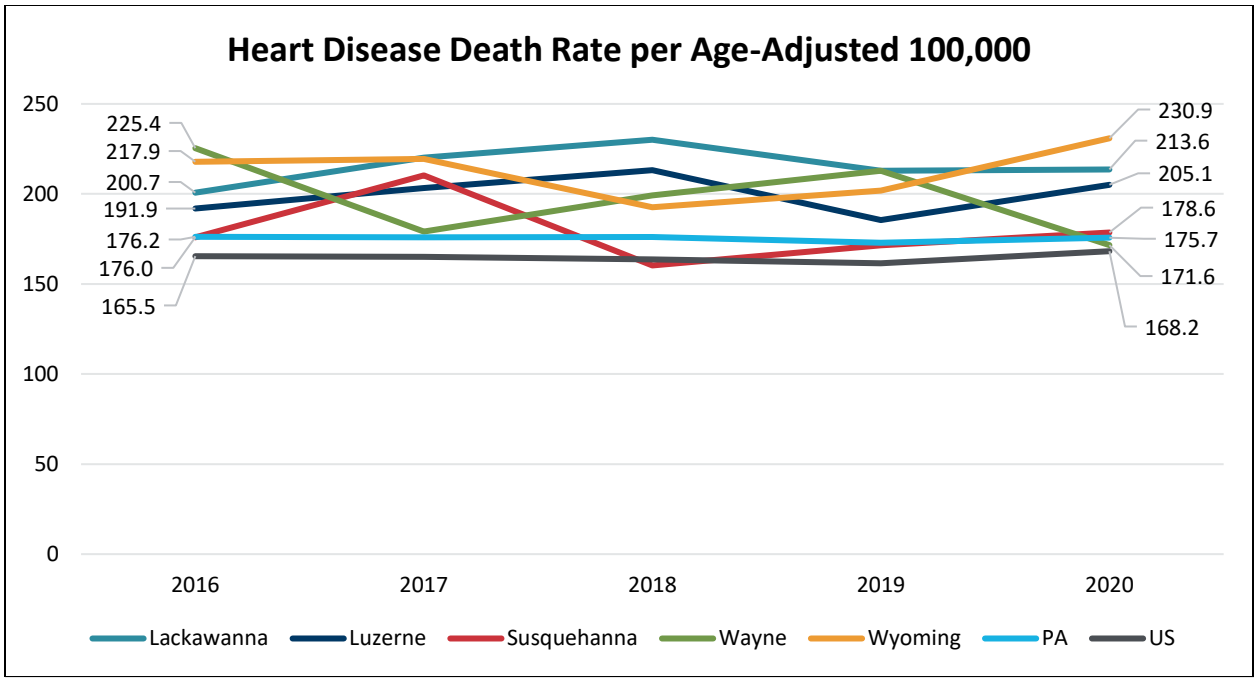
Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention

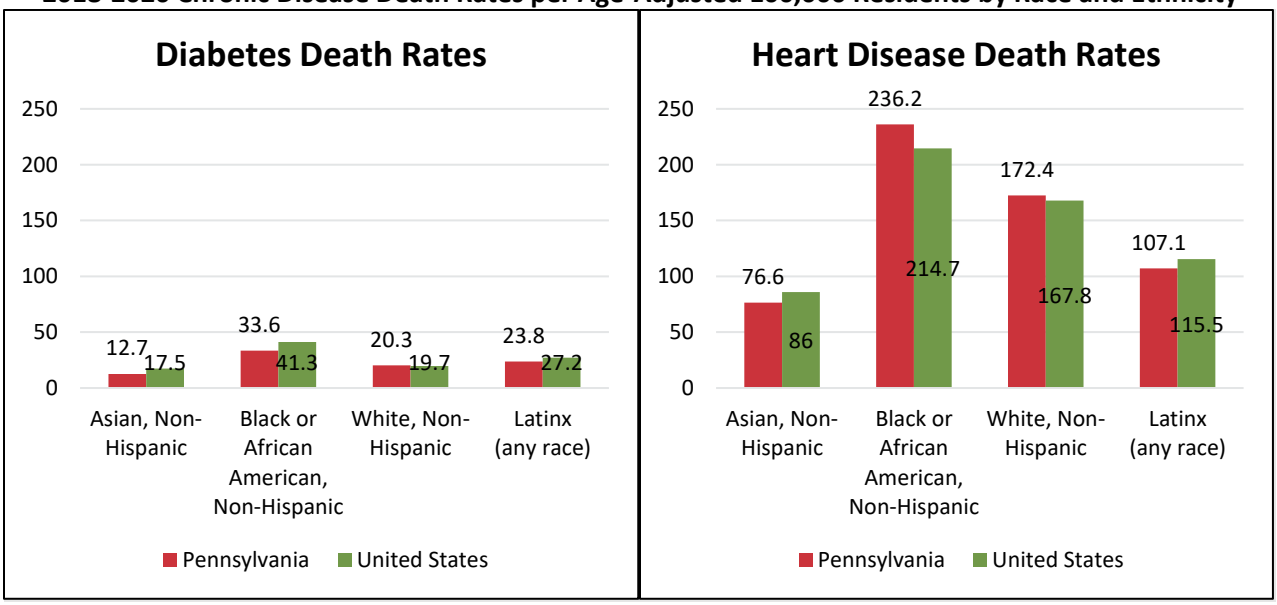


Source: Centers for Disease Control and Prevention

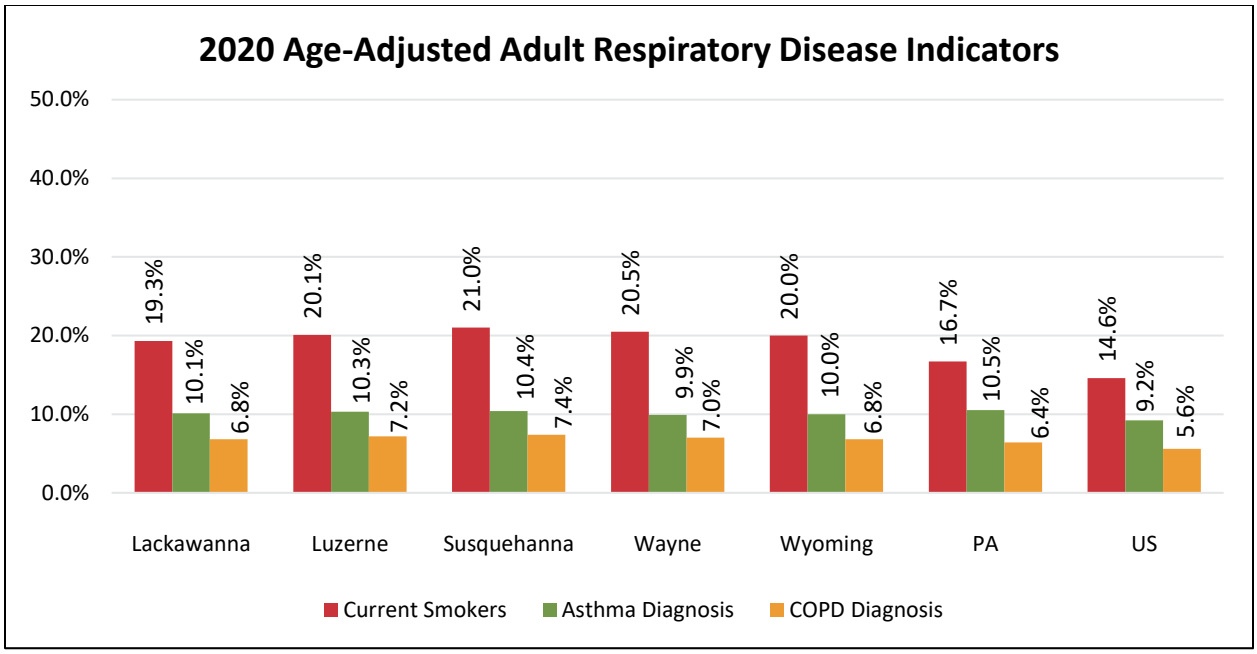


Source: Centers for Disease Control and Prevention

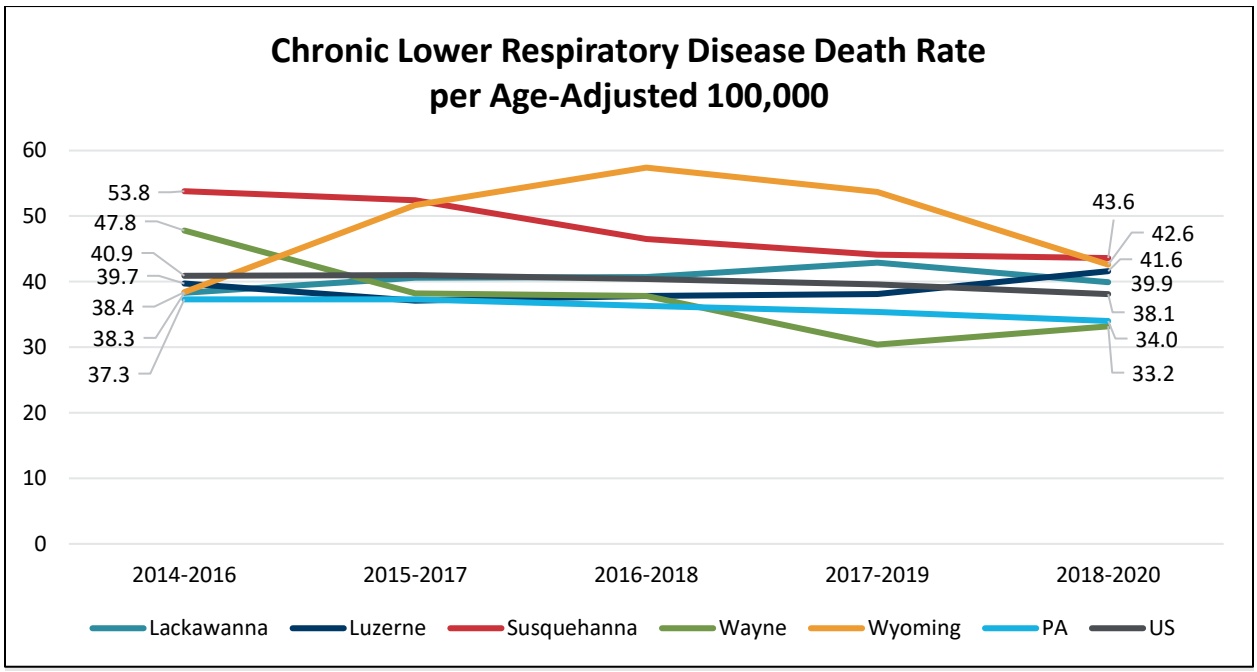
2018-2020 Chronic Disease Death Rates per Age-Adjusted 100,000 Residents by Race and Ethnicity



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



Source: Centers for Disease Control and Prevention



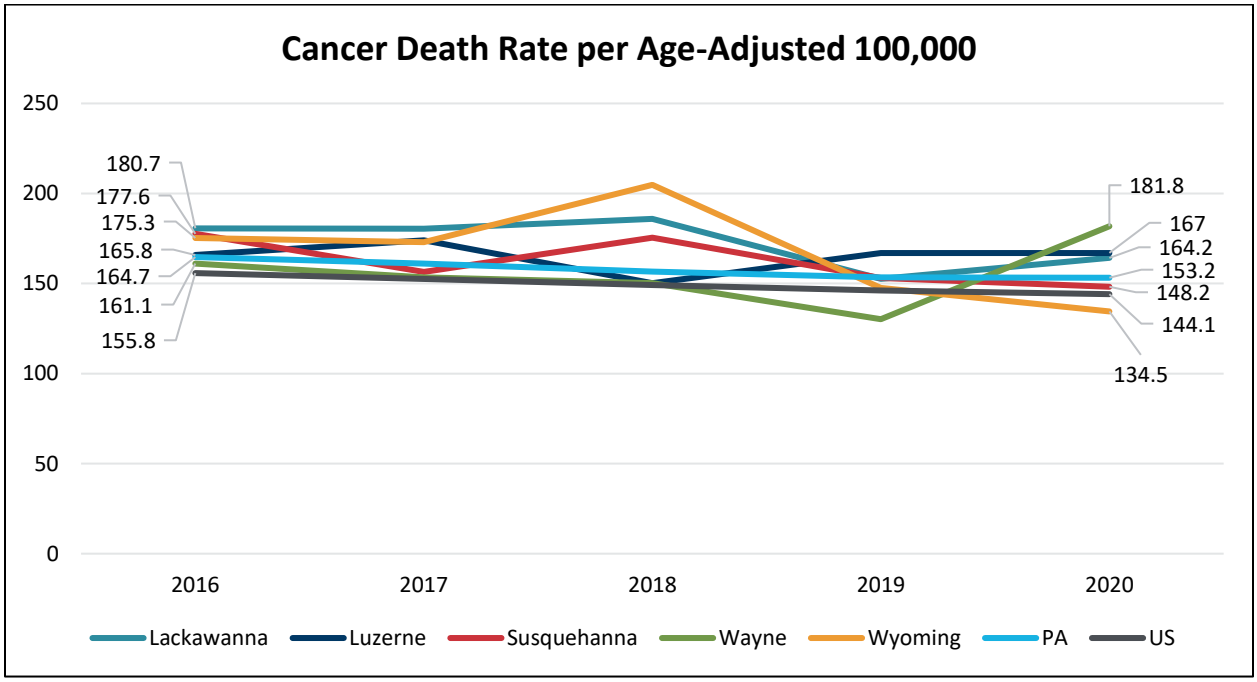
Source: Centers for Disease Control and Prevention

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

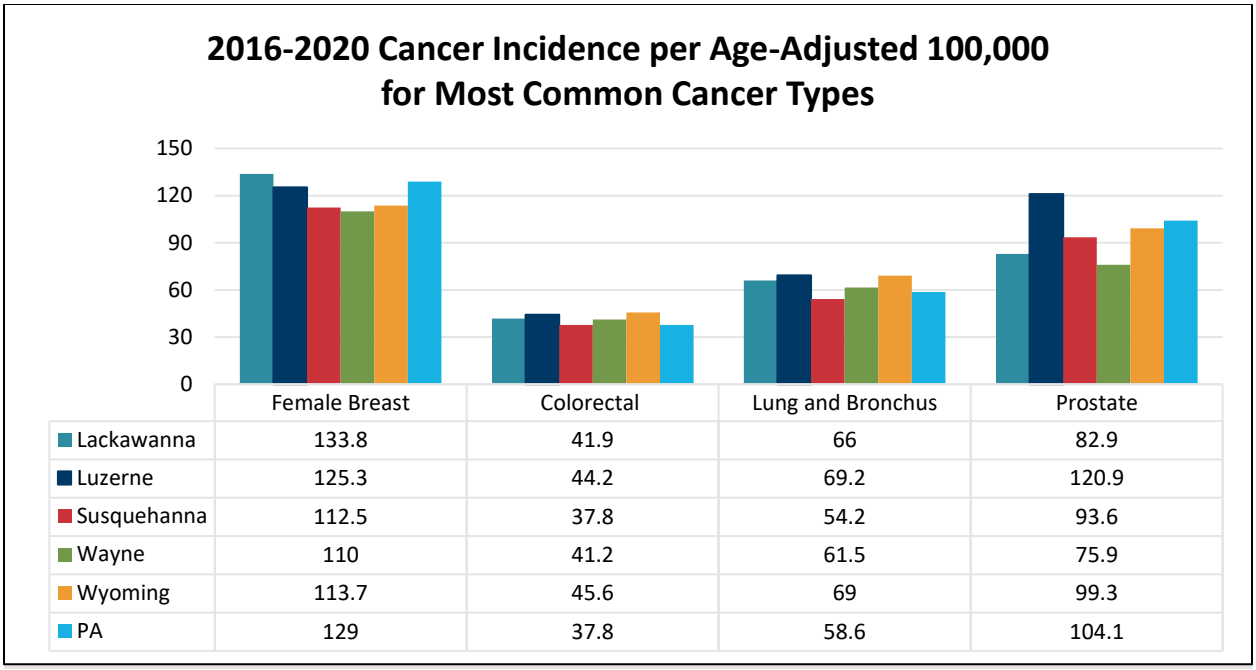
	Cancer Incidence Rate
Lackawanna	473.8
Luzerne	491.6
Susquehanna	437.6
Wayne	410.6
Wyoming	473.1
Pennsylvania	448.4

Source: Pennsylvania Department of Health

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

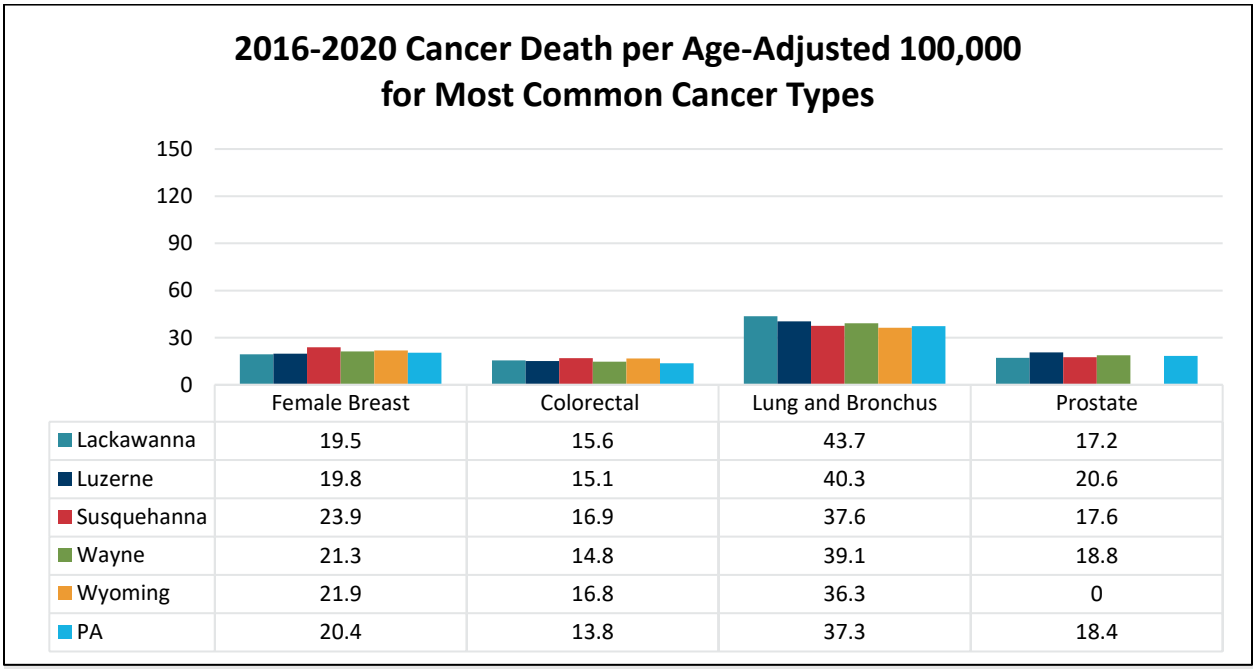


Source: Centers for Disease Control and Prevention



	Female Breast	Colorectal	Lung and Bronchus	Prostate
Lackawanna	133.8	41.9	66	82.9
Luzerne	125.3	44.2	69.2	120.9
Susquehanna	112.5	37.8	54.2	93.6
Wayne	110	41.2	61.5	75.9
Wyoming	113.7	45.6	69	99.3
PA	129	37.8	58.6	104.1

Source: Pennsylvania Department of Health



	Female Breast	Colorectal	Lung and Bronchus	Prostate
Lackawanna	19.5	15.6	43.7	17.2
Luzerne	19.8	15.1	40.3	20.6
Susquehanna	23.9	16.9	37.6	17.6
Wayne	21.3	14.8	39.1	18.8
Wyoming	21.9	16.8	36.3	0
PA	20.4	13.8	37.3	18.4

Source: Pennsylvania Department of Health

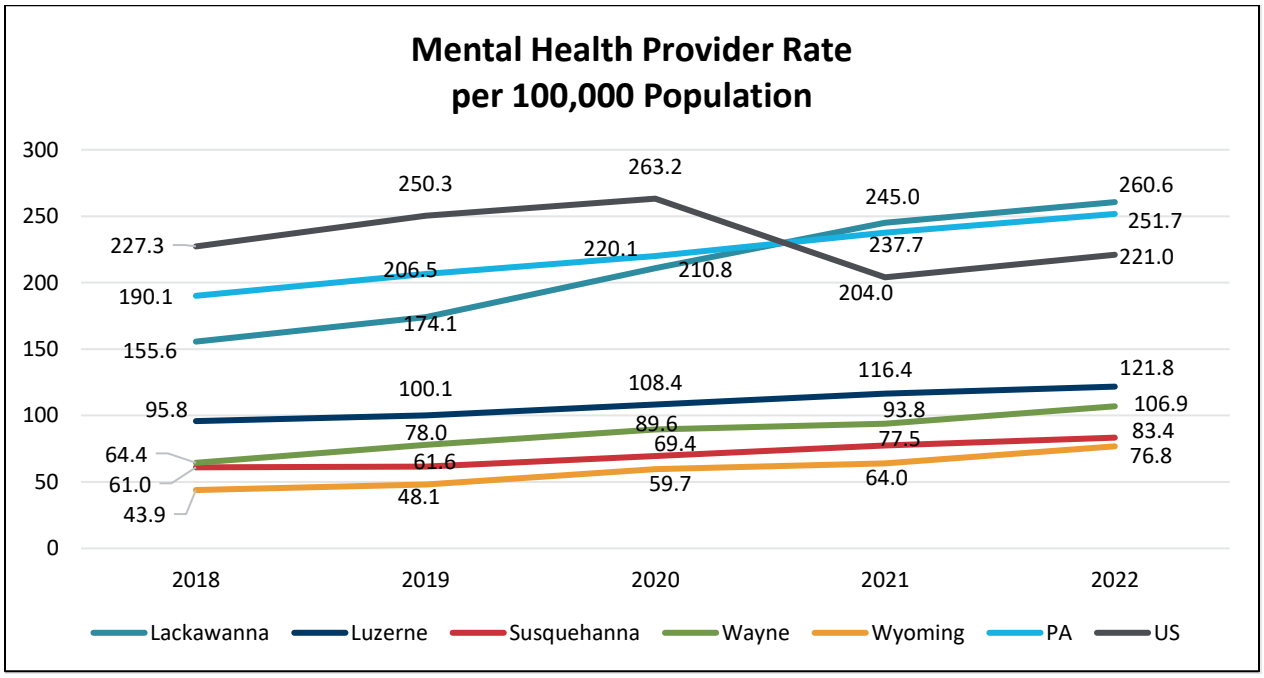
Mental Health and Substance Use Disorder

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.

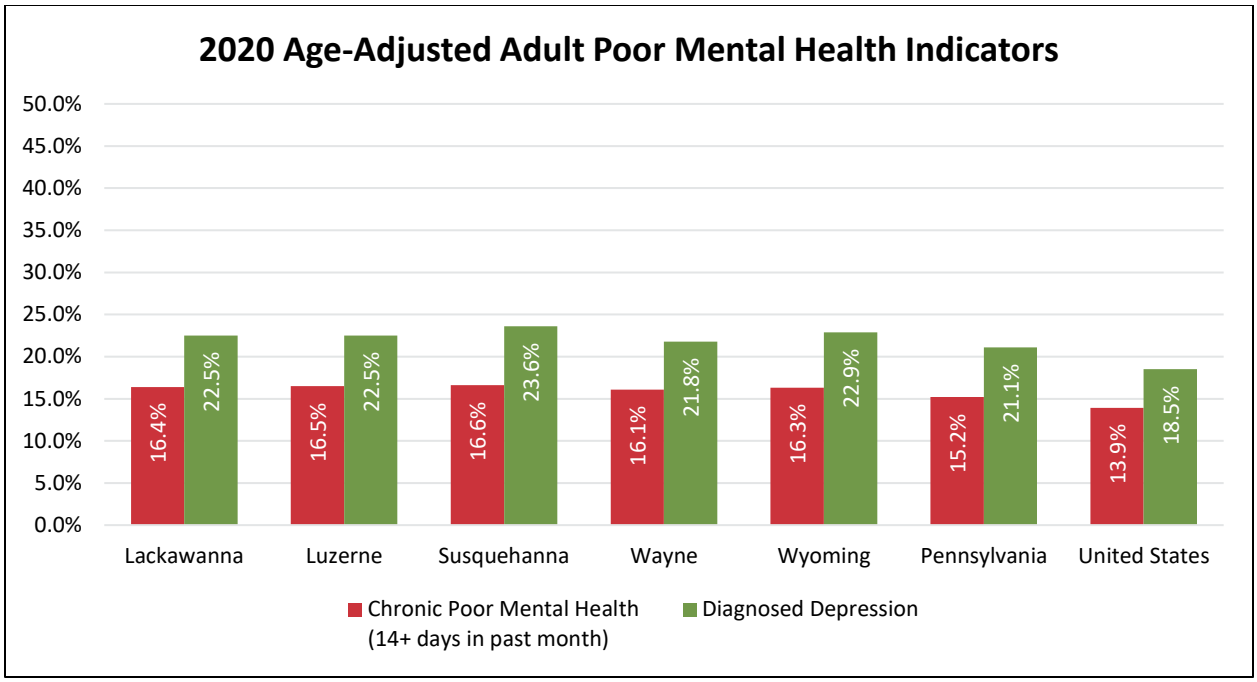
Social service and healthcare agencies are consistently reporting difficulty hiring and retaining mental health providers since COVID-19, a pandemic within a pandemic that is especially exacerbated in more rural communities. Outside of Lackawanna County, the Northeast Region has fewer mental health providers than the rest of the state or nation, at only one-third to one-half the number of providers per 100,000 residents.

At the other end of the spectrum, **the region suffers disproportionately high rates of death by suicide, with Wayne County experiencing twice the rate of suicide deaths compared to state and national rates. Across all counties, nearly one-quarter of 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, areas with more mental distress among residents generally align with previously identified health barriers, including poverty and healthcare access. For example, a higher proportion of adults report frequent mental distress in communities like Carbondale, Susquehanna, Hallstead, Scranton, Wilkes-Barre, and Hazleton.

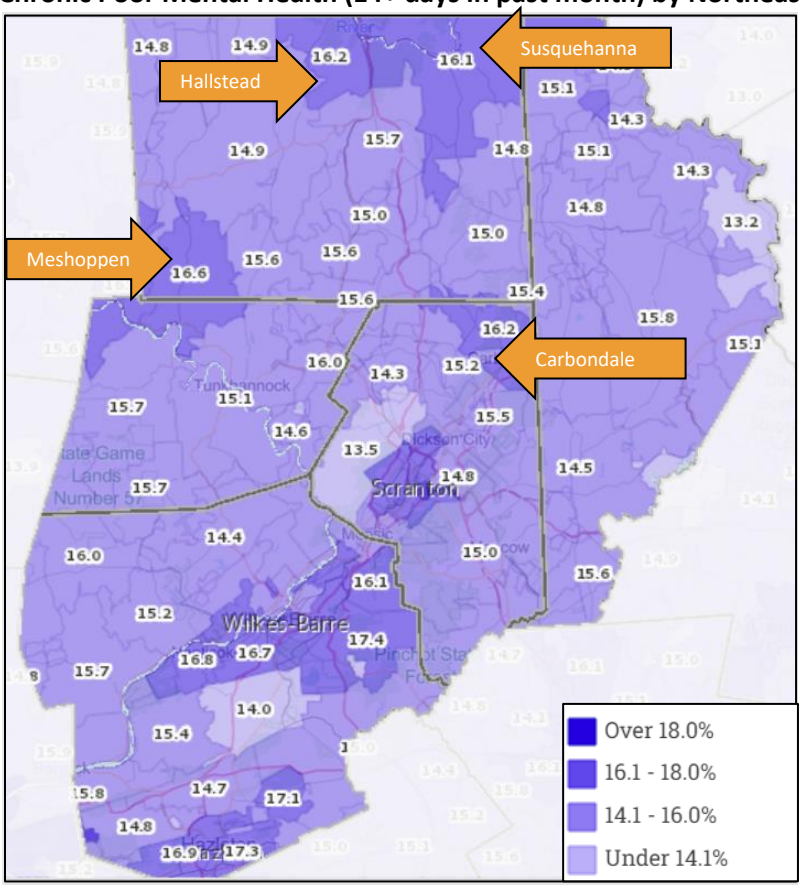


Source: Centers for Medicare and Medicaid Services

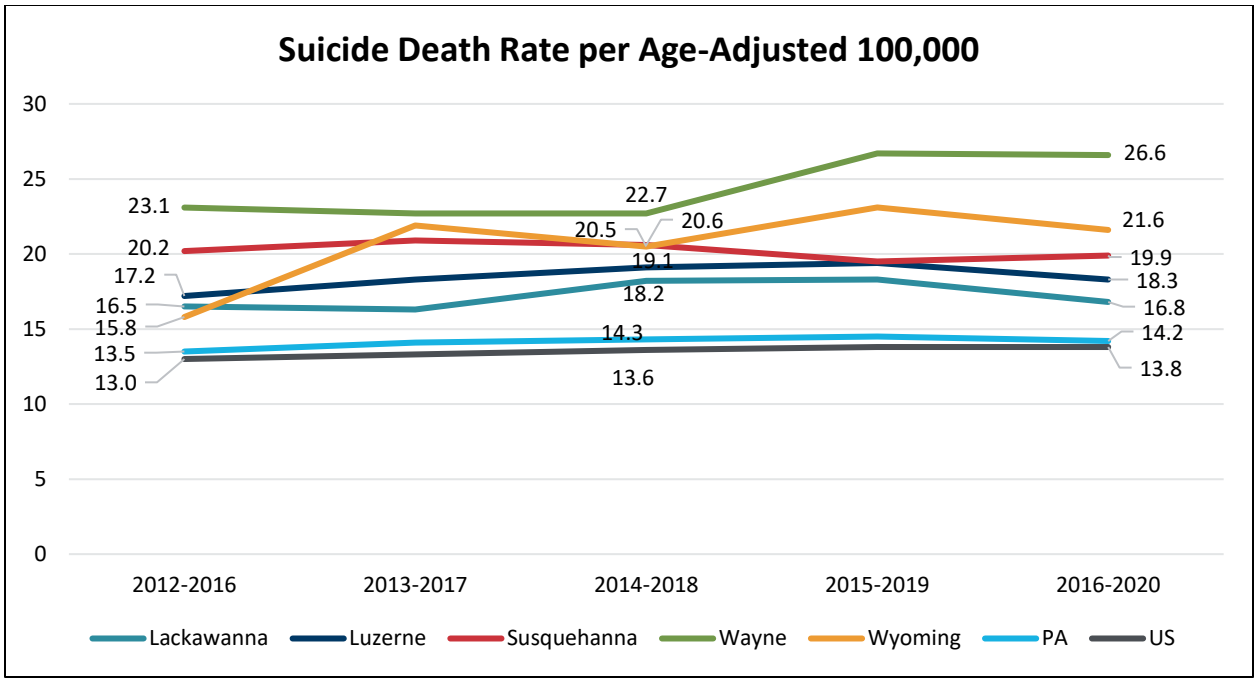


Source: Centers for Disease Control and Prevention

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



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



Source: Centers for Disease Control and Prevention

Opioid overdose hospitalizations generally declined despite an uptick in recent years likely related to pandemic difficulties. However, **accidental overdose deaths remain high in the region, with Susquehanna County as the exception.** Wyoming, Luzerne, and Lackawanna counties have overdose death rates above 40 per 100,000, more than double the national rate.

More research is needed to understand the disparately high fatality rates associated with opioid use in the region. Factors could include higher incidence of additional substances such as fentanyl in the supply, socioeconomic factors, or isolation making it more difficult for people to be reached and helped in time to administer Narcan or reach a hospital.

Of most pressing concern are rates of alcohol misuse, although there are some seeming inconsistencies among different factors surrounding alcohol use by residents. **Adults in Lackawanna and Luzerne counties report less binge drinking than adults in the other counties, and there are fewer alcohol-related driving deaths in these communities, but residents experience twice the rate of alcohol-related hospitalizations as compared to the other counties.** It is worth noting that 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
Lackawanna	18.4%	23.5%
Luzerne	20.1%	23.2%
Susquehanna	20.4%	41.1%
Wayne	21.1%	29.5%
Wyoming	20.6%	31.5%
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 Hospitalization Rate	Opioid Hospitalization Rate	Amphetamine Hospitalization Rate	Cocaine Hospitalization Rate
Lackawanna	559.7	231.9	40.2	49.4
Luzerne	534.1	210.1	49.6	56.4
Susquehanna	207.3	96.4	55.5	NA
Wayne	275.6	121.0	57.6	NA
Wyoming	266.0	141.9	NA	NA
Pennsylvania	568.4	293.2	63.7	164.1

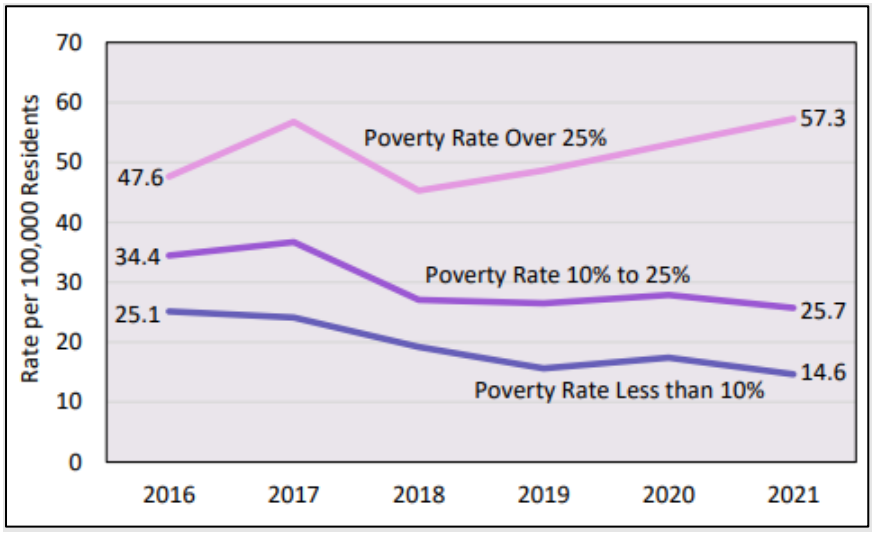
Source: Pennsylvania Health Care Cost Containment Council (PHC4)

Opioid Overdose Hospitalization Rates per 100,000 Residents

	2016	2017	2018	2019	2020	2021
Lackawanna	42.1	27.4	21.2	14.3	21.3	28.7
Luzerne	27.4	27.0	25.1	20.3	26.4	21.9
Susquehanna	NA	NA	NA	NA	NA	NA
Wayne	NA	NA	NA	NA	27.0	24.8
Wyoming	NA	NA	NA	NA	NA	NA
Pennsylvania	31.6	33.0	25.1	23.2	24.8	22.9

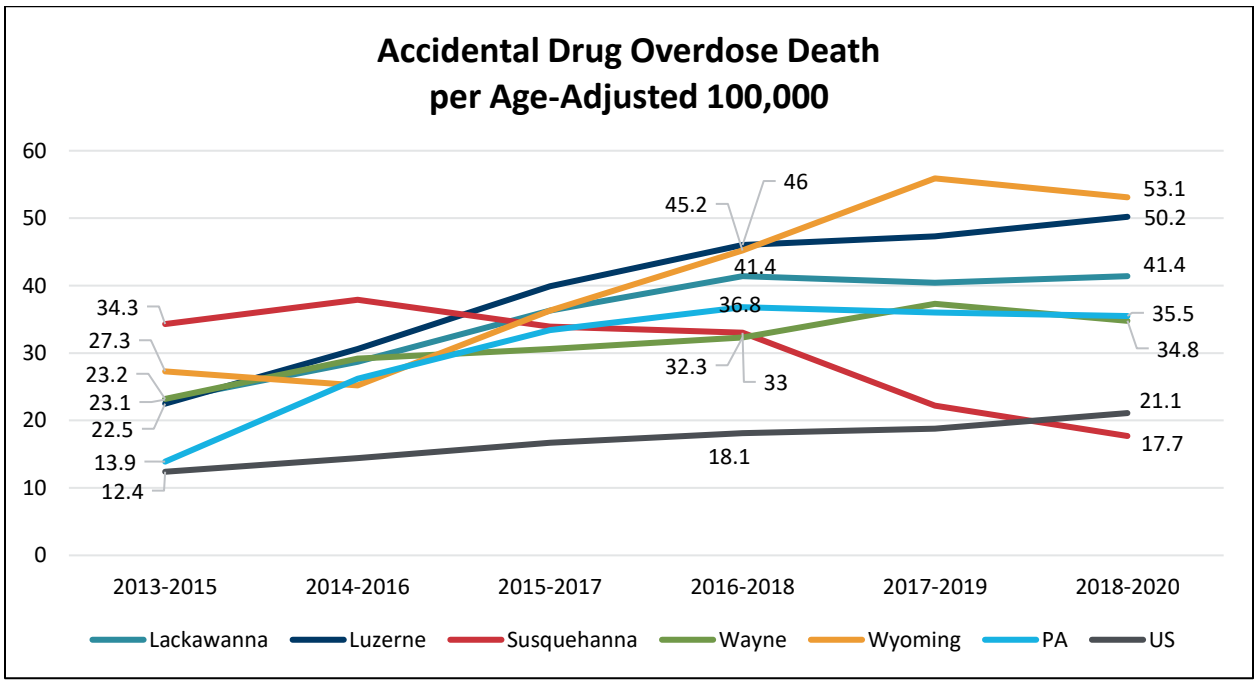
Source: Pennsylvania Health Care Cost Containment Council (PHC4)

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

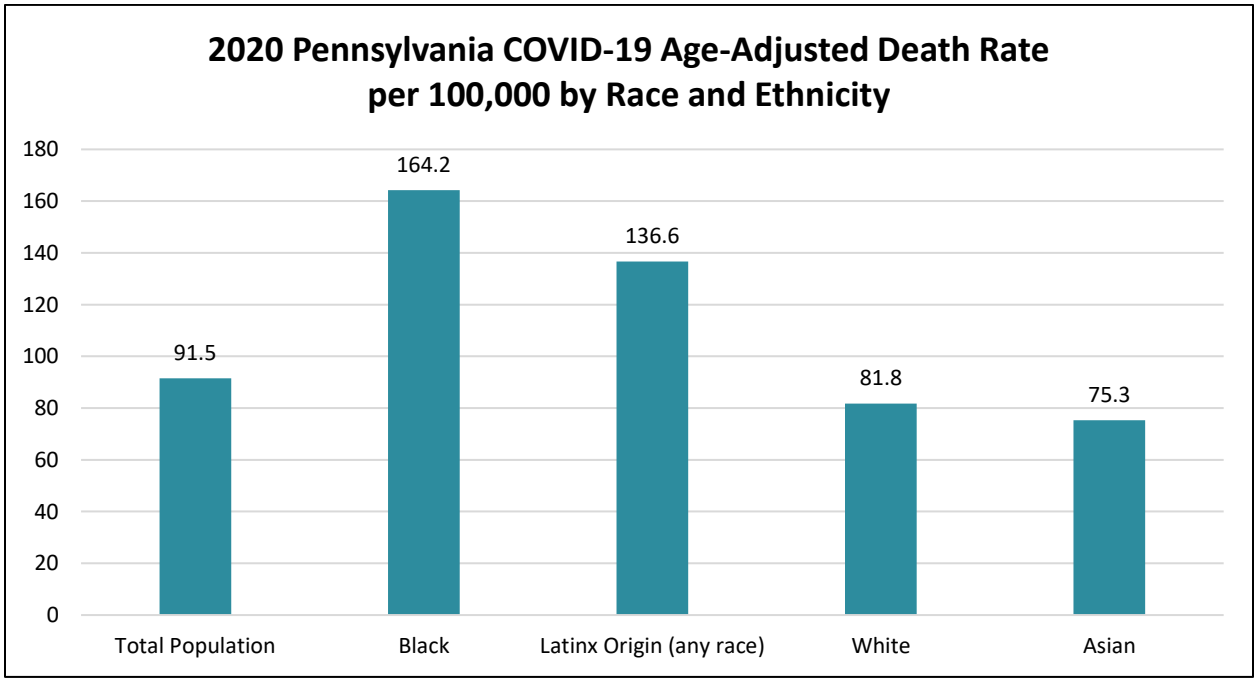
COVID-19

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 Northeast 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.**

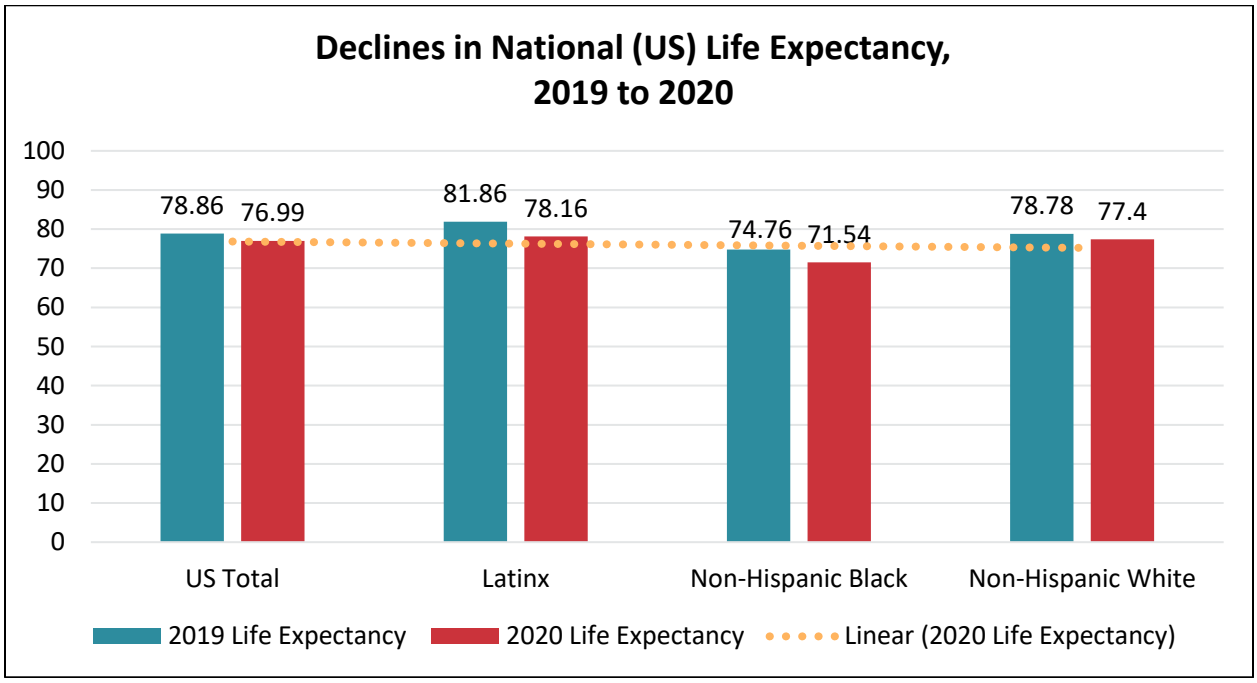


Source: Pennsylvania Department of Health

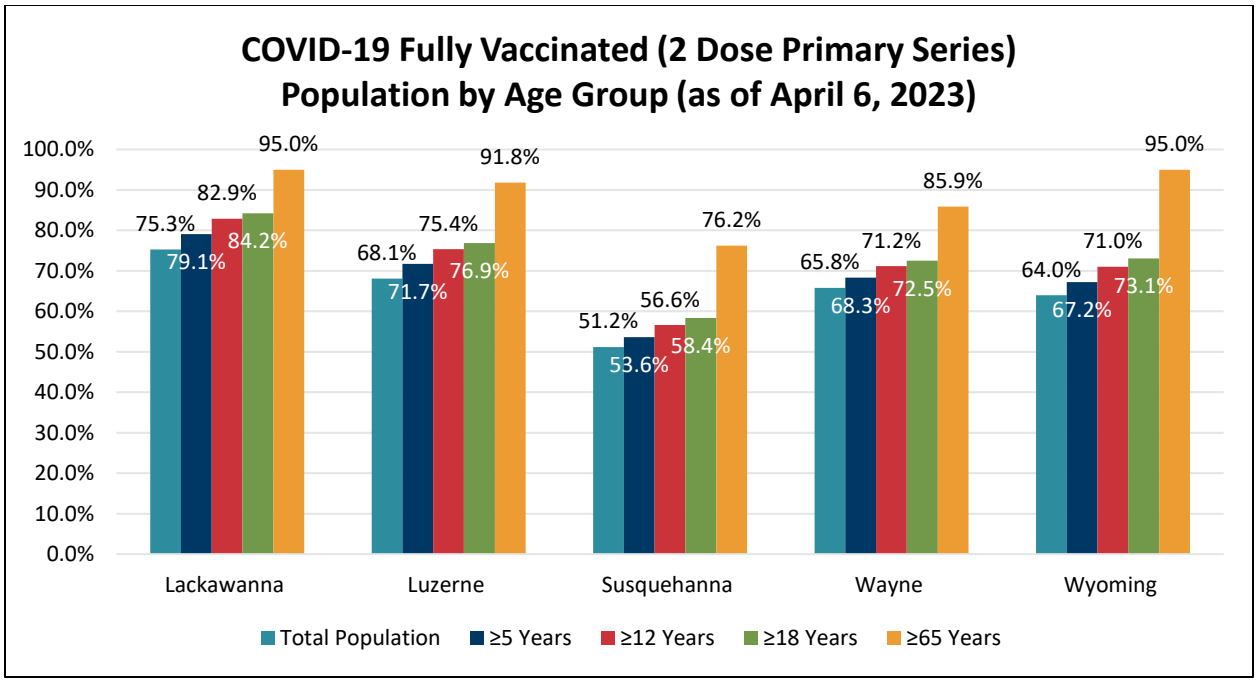
Leading Causes of Death among Pennsylvania Residents by Race and Ethnicity in 2020

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

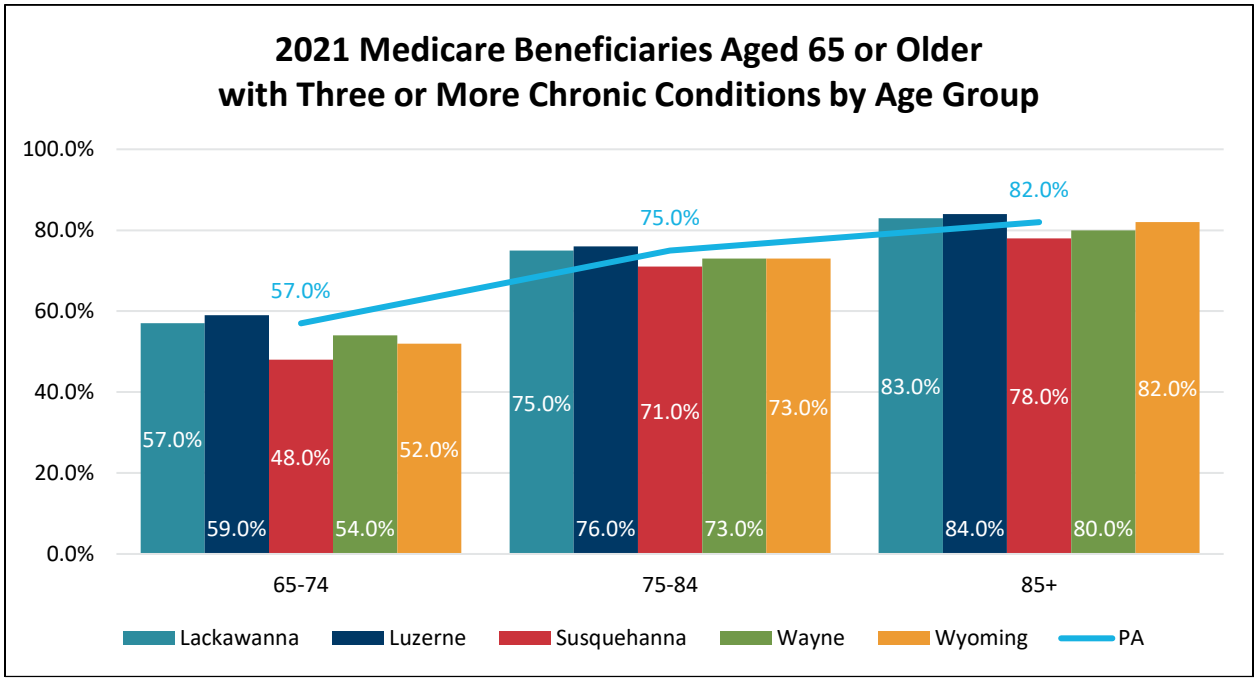
Aging Population

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 Northeast 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 48% (in Susquehanna County) and 59% (in Luzerne County) of Medicare beneficiaries aged 65-74 reported three or more chronic conditions. Disease prevalence increased to between 78% and 84% at age 85+.**

In the Northeast Region, the population of adults aged 65+ is between 20% and 25% higher than both the rest of Pennsylvania and the nation as a whole. The local population is aging rapidly, and 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

	Lackawanna	Luzerne	Susquehanna	Wayne	Wyoming	PA	US
Alzheimer's disease, related disorders, senile dementia	2%	2%	2%	2%	2%	2%	2%
Cancer (breast, lung, colorectal, prostate)	10%	10%	9%	9%	10%	10%	9%
Depression	15%	13%	9%	12%	12%	16%	15%
Diabetes	24%	25%	22%	22%	23%	24%	24%
High cholesterol	66%	67%	58%	63%	60%	65%	58%
Hypertension	63%	65%	58%	59%	60%	60%	59%
Obesity	22%	26%	17%	26%	20%	27%	21%
Rheumatoid arthritis	33%	32%	29%	29%	30%	31%	30%

Source: Centers for Medicare & Medicaid Services

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

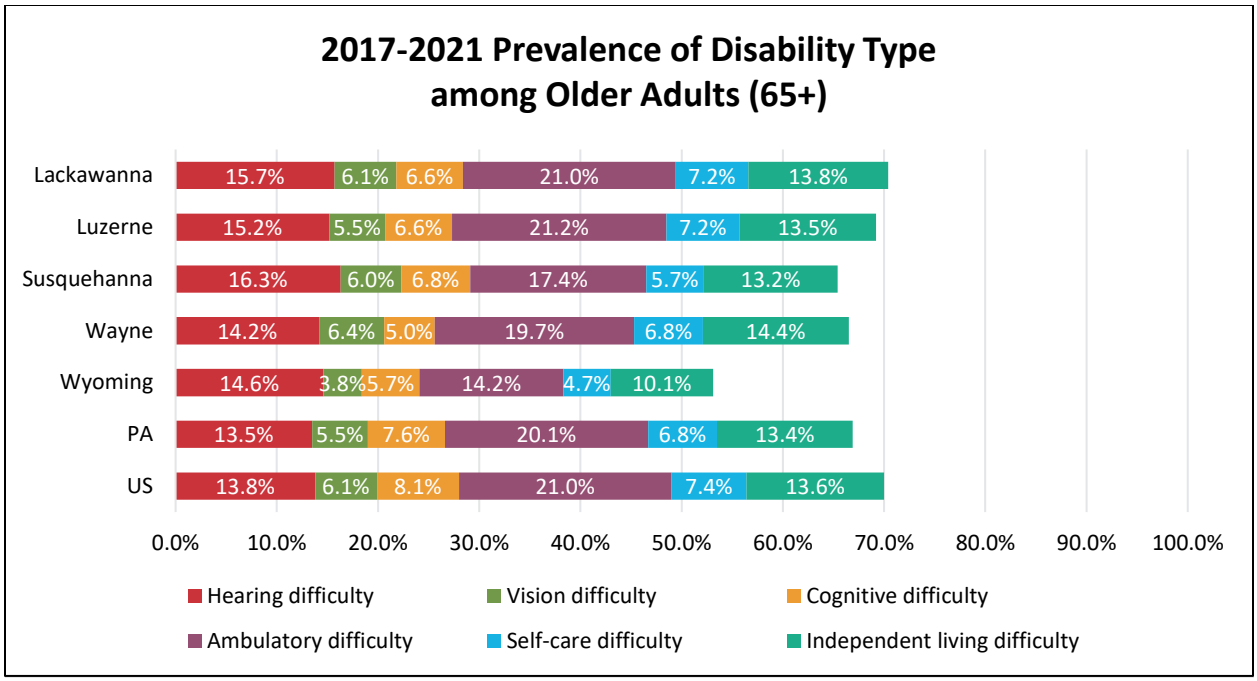
	Lackawanna	Luzerne	Susquehanna	Wayne	Wyoming	PA	US
Alzheimer's disease, related disorders, senile dementia	9%	8%	7%	7%	9%	9%	9%
Cancer (breast, lung, colorectal, prostate)	15%	15%	15%	14%	16%	15%	14%
Depression	16%	15%	13%	13%	16%	18%	17%
Diabetes	30%	31%	30%	30%	32%	30%	29%
High cholesterol	77%	79%	71%	74%	73%	76%	72%
Hypertension	80%	81%	78%	77%	77%	78%	75%
Obesity	18%	21%	16%	11%	22%	25%	19%
Rheumatoid arthritis	44%	44%	38%	39%	39%	41%	39%

Source: Centers for Medicare & Medicaid Services

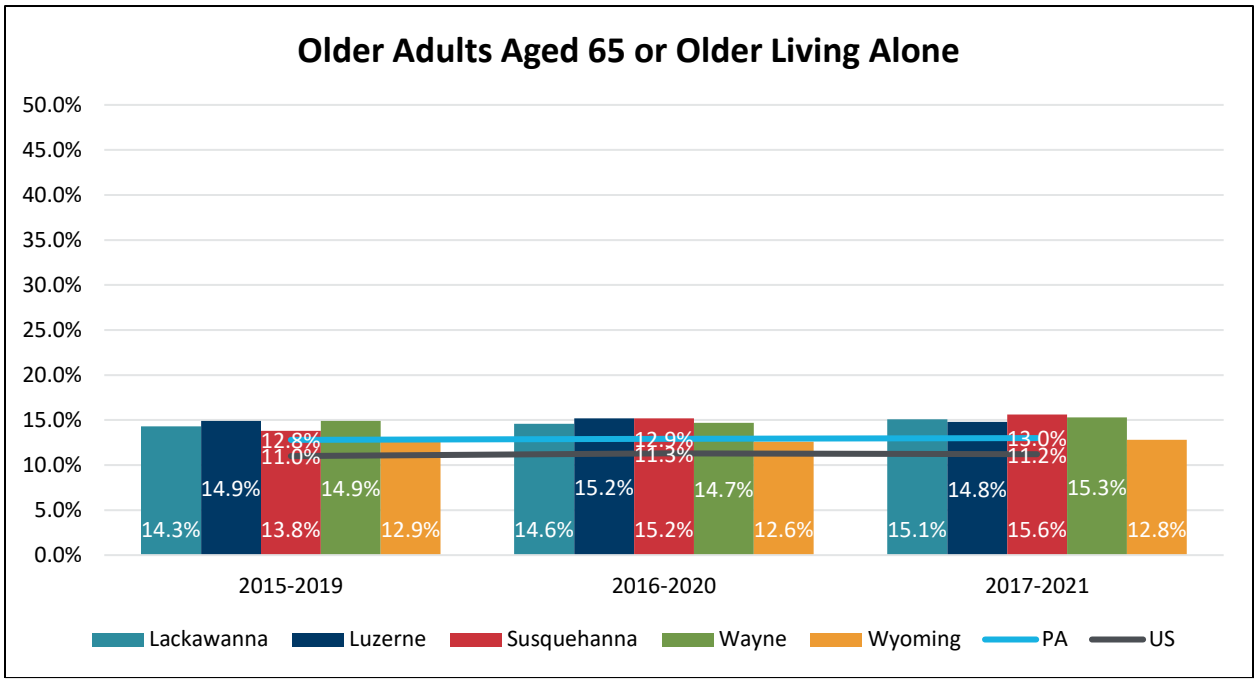
2021 Select Chronic Conditions among Medicare Beneficiaries Aged 85 Years or Older

	Lackawanna	Luzerne	Susquehanna	Wayne	Wyoming	PA	US
Alzheimer's disease, related disorders, senile dementia	26%	26%	22%	22%	25%	26%	25%
Cancer (breast, lung, colorectal, prostate)	16%	14%	13%	15%	15%	15%	14%
Depression	21%	20%	14%	19%	23%	23%	21%
Diabetes	27%	28%	27%	27%	26%	27%	27%
High cholesterol	72%	74%	65%	70%	71%	71%	67%
Hypertension	86%	86%	82%	83%	85%	85%	83%
Obesity	9%	10%	8%	13%	15%	14%	11%
Rheumatoid arthritis	55%	56%	46%	44%	45%	48%	45%

Source: Centers for Medicare & Medicaid Services



Source: US Census Bureau, American Community Survey



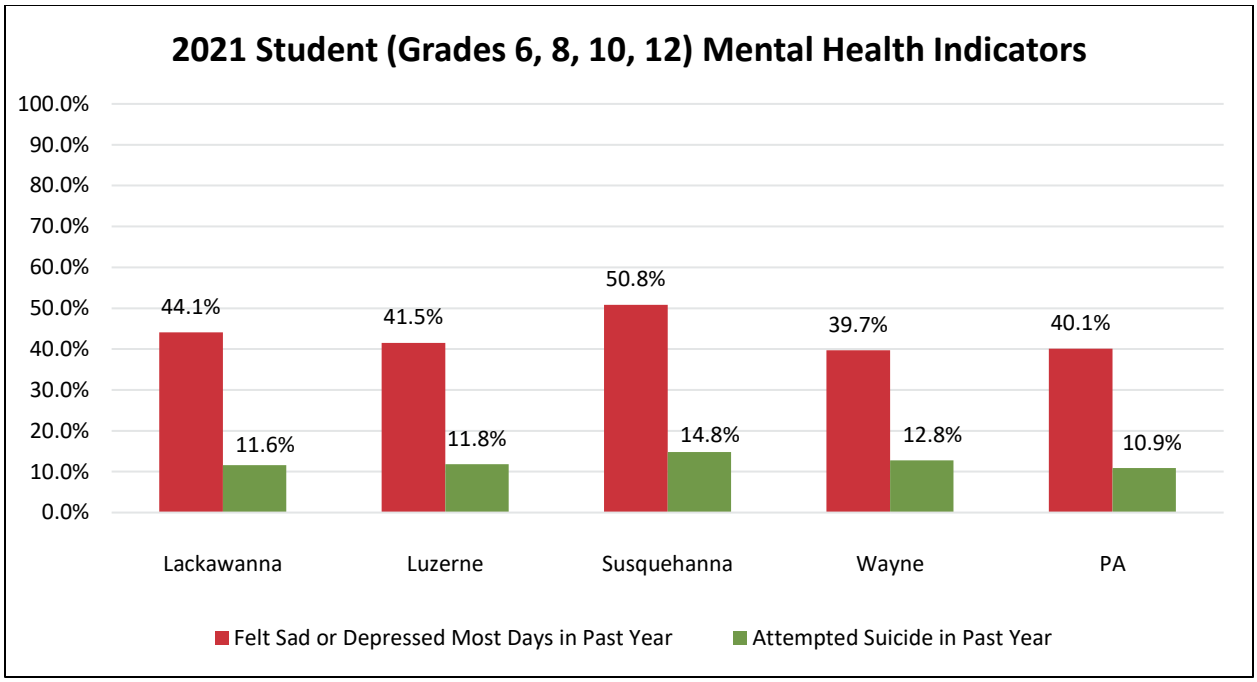
Source: US Census Bureau, American Community Survey

Youth

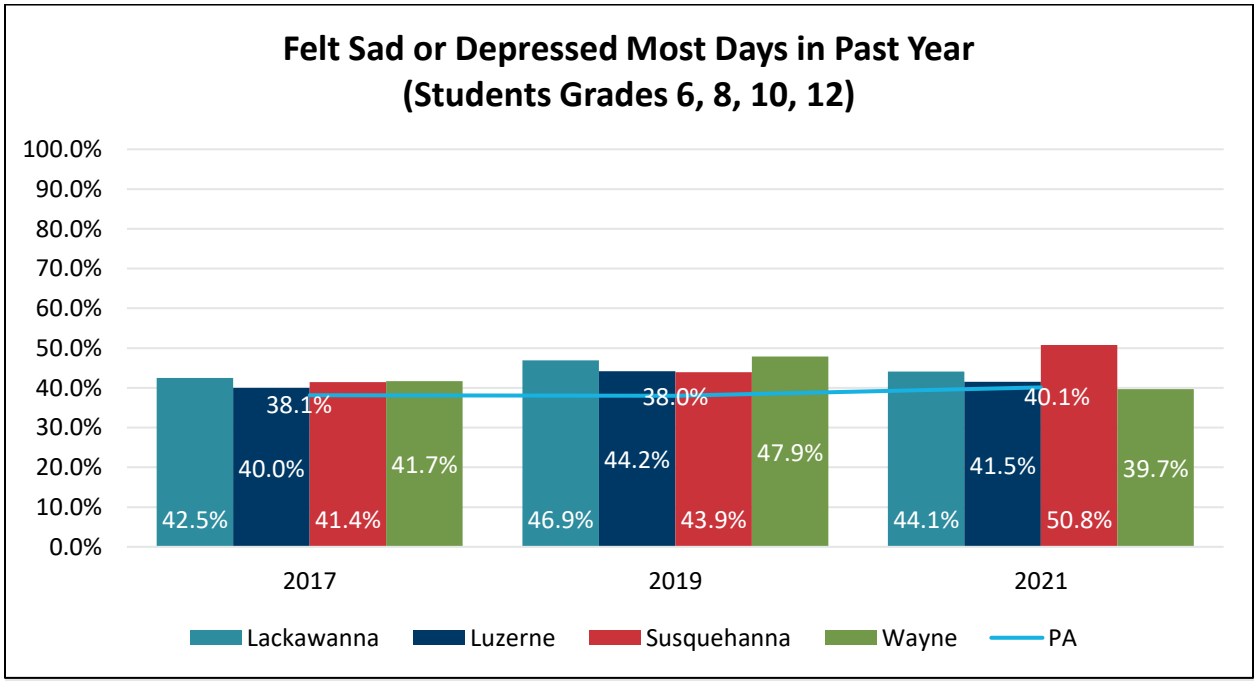
The COVID-19 pandemic has made unprecedented changes to the lives and experiences of young people worldwide. These concerns represent Adverse Childhood Experiences (ACEs), defined as traumatic or stressful events that occur before the age of 18. ACEs can have lifelong impacts on economic, educational, 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 Northeast Region, are showing a steady decline in substance use of all kinds; however, prevalence of substance use is marginally higher in the region than elsewhere. **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.

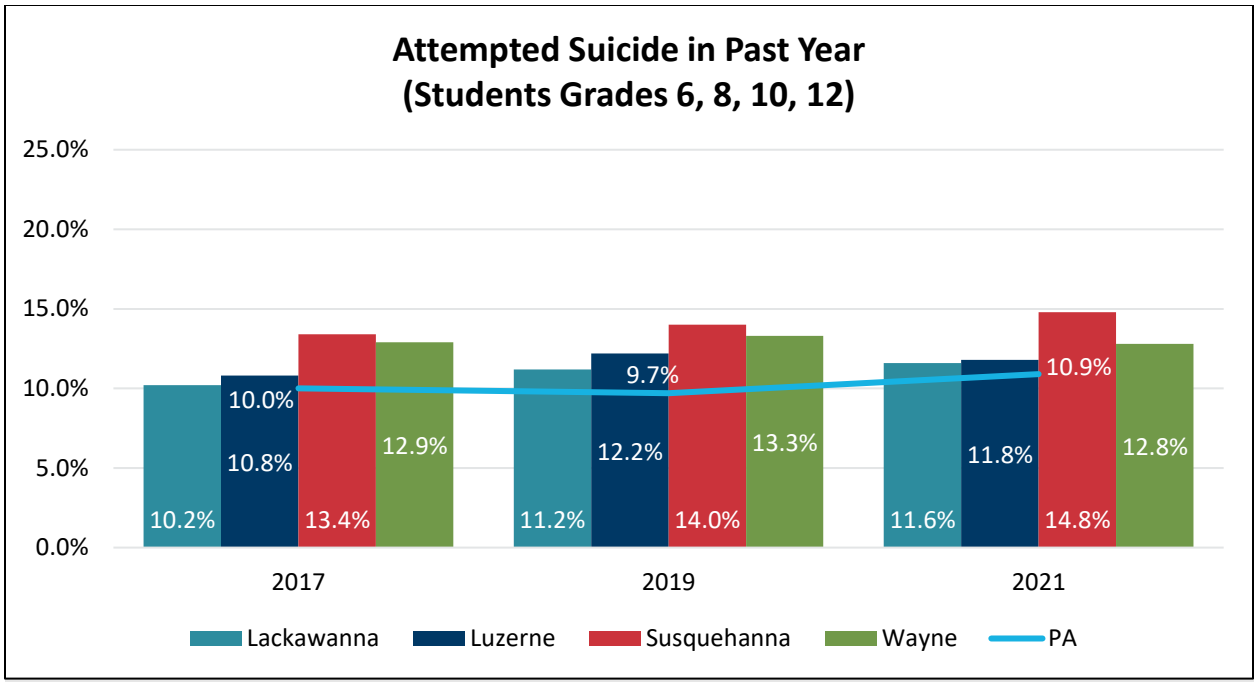
Schools, as they have finally re-opened to "normal" capacity in the last year are feeling the impact of these numbers in tangible ways. **Young people are struggling. In particular, fewer than half of students across the region "feel that school is going to be important for their later life."** Despite 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.



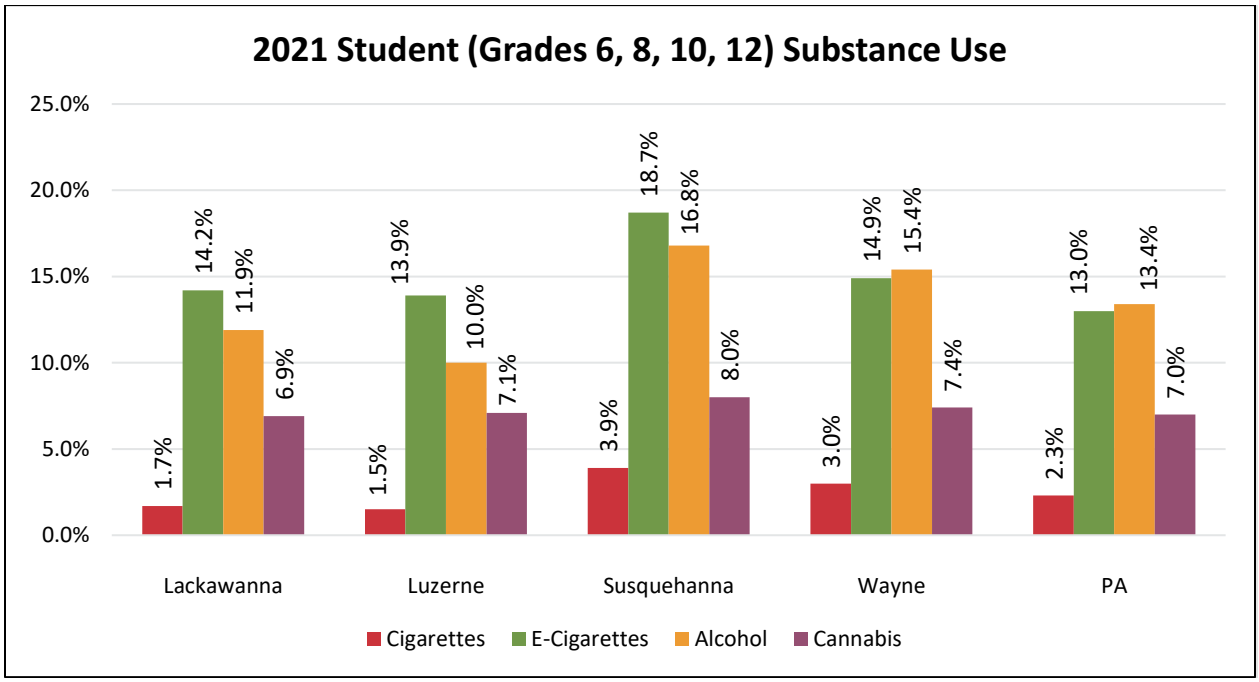
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Wyoming County.



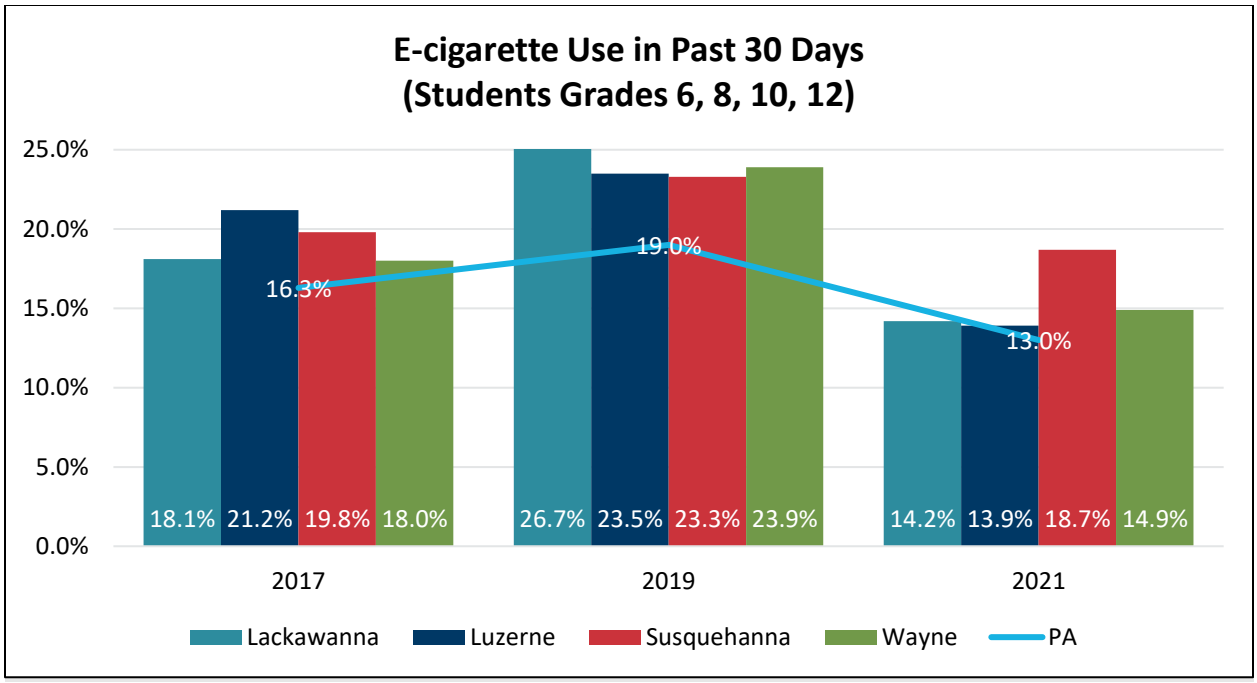
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Wyoming County.



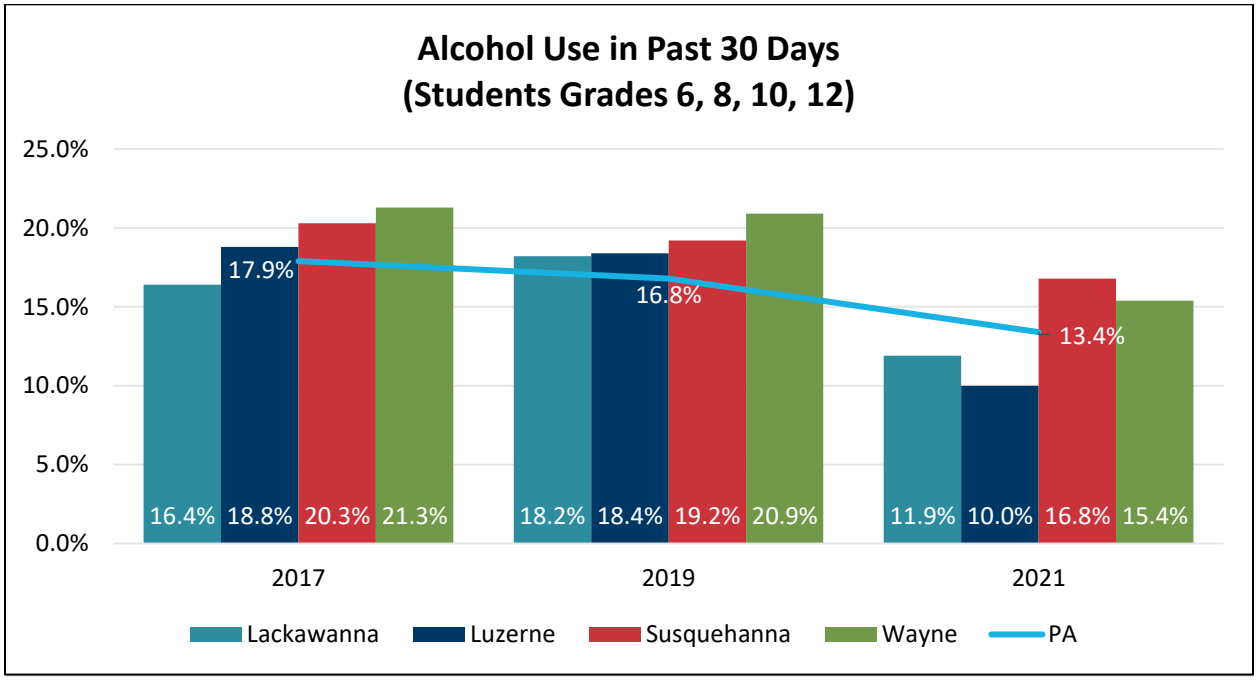
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Wyoming County.



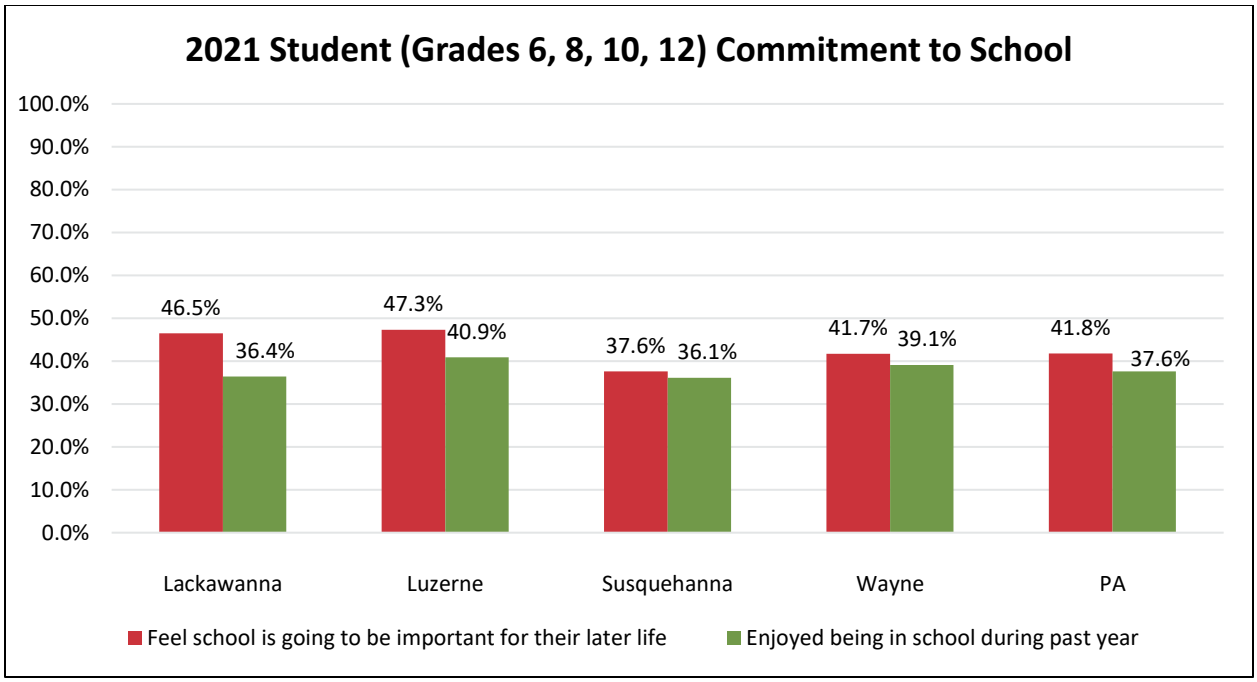
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Wyoming County.



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



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



Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Wyoming 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%).
- More than one in three respondents did not believe most of their healthcare providers have the medical expertise related to their health needs as an LGBTQ person (37.7%).

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. Within the region, between 14% 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 Wayne, 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			
Lackawanna	2,044	18.6	77.2%	6.6%	16.2%
Luzerne	3,181	19.5	66.3%	9.2%	28.7%
Susquehanna	340	17.9	96.5%	0.0%	2.6%
Wayne	435	18.3	92.6%	1.1%	5.3%
Wyoming	207	16.1	93.2%	0.5%	2.9%
Pennsylvania	130,730	19.9	69.4%	14.2%	12.8%
United States	3,613,647	11.0	51.0%	14.7%	24.0%

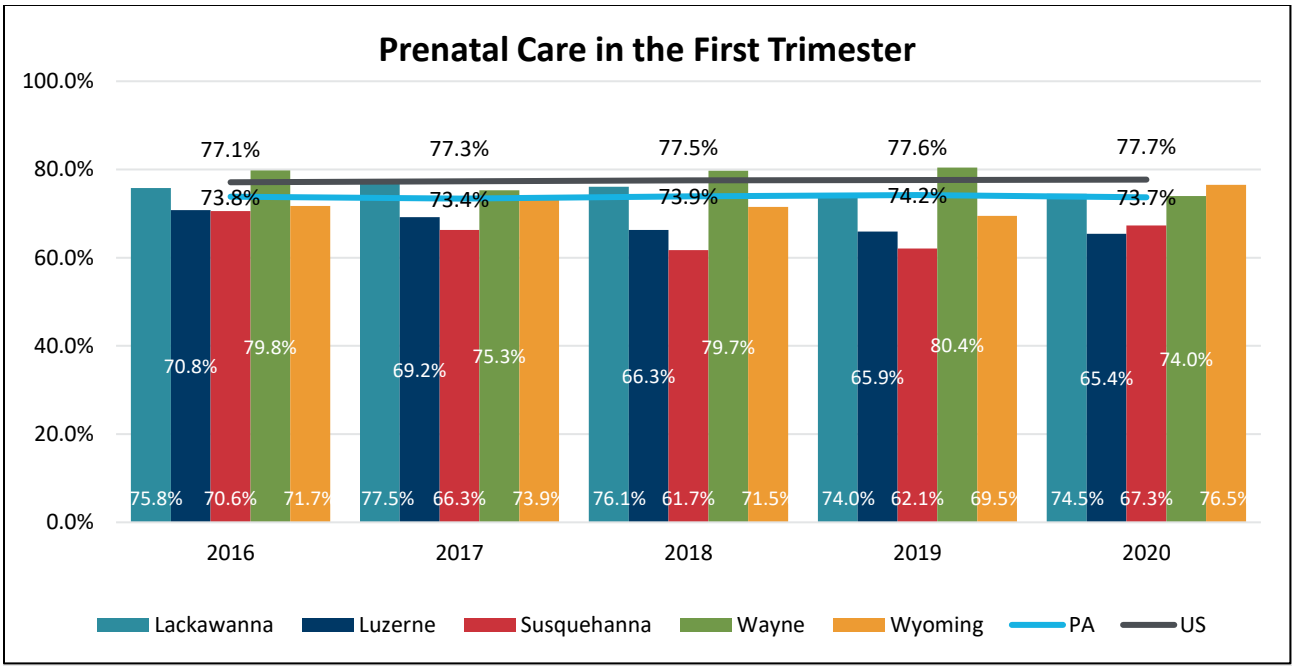
Source: Pennsylvania Department of Health & Centers for Disease Control and Prevention

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
Lackawanna	4.0%	**74.5%**	9.5%	8.7%	83.8%
Luzerne	5.6%	**65.4%**	9.5%	8.7%	85.6%
Susquehanna	3.2%	**67.3%**	7.4%	6.5%	82.2%
Wayne	3.0%	**74.0%**	11.0%	10.6%	85.9%
Wyoming	5.3%	**76.5%**	7.2%	4.9%	81.6%
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
Lackawanna	5.9 (n=62)
Luzerne	6.3 (n=96)
Susquehanna	5.5 (n=11)
Wayne	NA (n=12)
Wyoming	NA (n=7)
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 Northeast 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 organizations; policy makers and elected officials; and others serving diverse community populations.

A total of 169 individuals representing the Northeast 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 organizations provided statewide, or even nationwide, services. In total, stakeholder organizations served more than 30 Pennsylvania counties. More than 80% of respondents worked with organizations serving Lackawanna County. 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 income or in poverty, those without health insurance or who are underinsured, as well as people with behavioral health concerns.

Populations Served by Key Stakeholder Survey Participants

	Number of Participants	Percent of Total
No specific focus-serve all populations	127	75.2%
People or families with low income or in poverty	35	20.7%
People with behavioral health concerns	33	19.5%
People or families without health insurance or underinsured	33	19.5%
Children (age 0-11)	23	13.6%
Older adults/Seniors	23	13.6%
People or families experiencing homelessness	23	13.6%
Adolescents (age 12-18)	22	13.0%
People with disabilities (physical, intellectual, developmental, etc.)	21	12.4%
Young adults (age 19-24)	21	12.4%
LGBTQ+ community	19	11.2%
Undocumented citizens	14	8.3%
African American/Black	13	7.7%
Hispanic/Latinx	13	7.7%
Pregnant or postpartum people	13	7.7%
People with memory care (Alzheimer's disease, dementia) concerns	12	7.1%
Veterans	11	6.5%
New Americans/Immigrants/Refugees	10	5.9%
Other	8	4.7%
American Indian/Alaska Native	6	3.6%
Asian/South Asian	6	3.6%
Faith-based community	6	3.6%
Pacific Islander/Native Hawaiian	4	2.4%

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 six 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 Northeast 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	58	37.1%
Access to crisis support services (e.g., Neighborly, United Way 211, 988 National Suicide Hotline)	36	23.1%
Available social services	36	23.1%
Community connectedness	35	22.4%
Safe neighborhoods	29	18.6%
Available public transportation	27	17.3%
Employment opportunities	25	16.0%
Strong family life	23	14.7%
Good schools	17	10.9%
Walkable, bike friendly communities	17	10.9%

Stakeholders saw "access to healthcare services," as their communities' top strength, while "lack of transportation," "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.

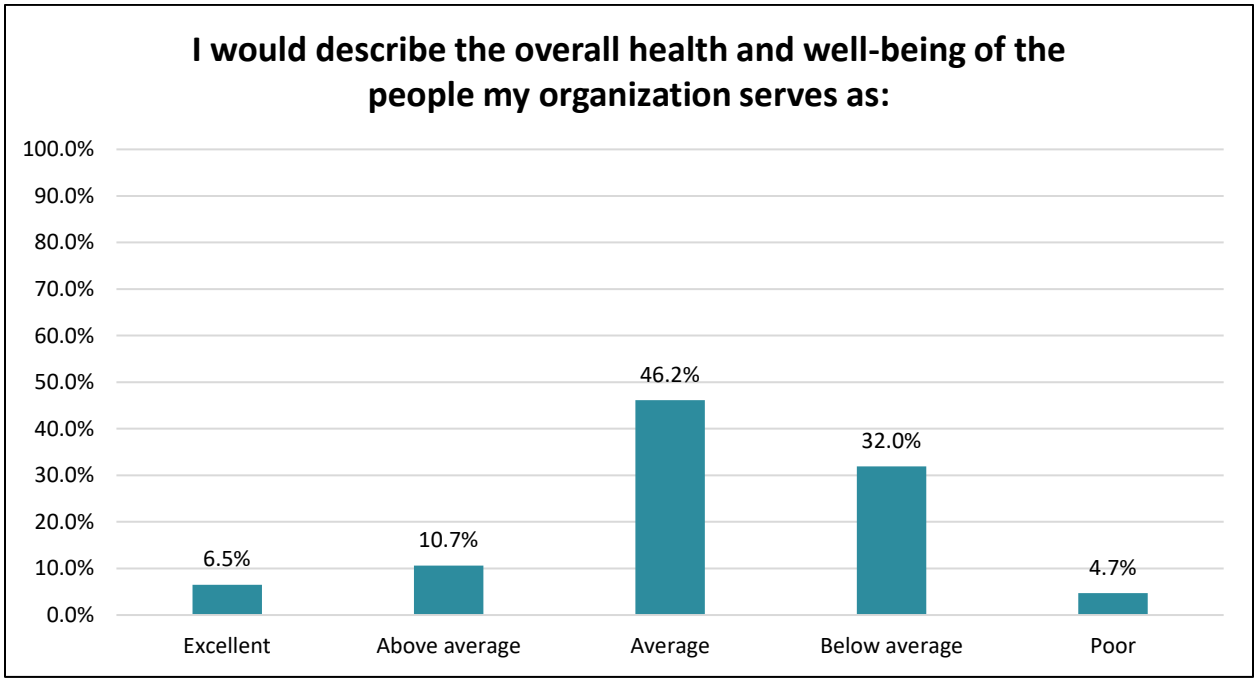
Additionally, stakeholders identified feelings of safety within the community, both from violence and within interpersonal relationships, community connectedness, and access to social services and crisis support services designed to help members of the community in times of need, as top strengths.

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 46% of stakeholders described overall health and well-being as "average" and 37% 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 60% of respondents selected mental health conditions. One-third or more of respondents identified ability to afford healthcare, economic stability (employment, poverty, cost of living), housing (affordable, quality), and substance use disorder 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, the general but pervasive impacts of poverty, and the inability to afford routine care services. 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," only 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	94	60.3%
Substance use disorder (dependence/misuse of alcohol, opiates, heroin, etc.)	75	48.1%
Ability to afford healthcare	71	45.5%
Housing (affordable, quality)	66	42.3%
Economic stability (employment, poverty, cost of living)	55	35.3%
Ability to afford health foods	48	30.1%
Lack of transportation	39	25.0%
Childcare (affordable, quality)	33	21.2%
Health literacy (ability to understand health information)	28	18.0%
Stress (work, family, school, etc.)	25	16.0%
Overweight/Obesity	21	13.5%
Limited healthcare capacity (appointments, convenient time/location, etc.)	20	12.8%
Limited healthcare providers	17	10.9%
Older adult health concerns	16	10.3%
Child/Adolescent health concerns	14	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.

- *"The greater Hazleton area is undergoing a major population expansion. Unfortunately, the infrastructure is aging and affordable housing is scarce. Most of our newcomers are economically underserved and many are newly arriving immigrants from Latinx countries. The HASD is overcrowded and severely underfunded. Neither the school board nor the administration even begins to address the changing demographics. Food insecurity issues are rampant and continue to grow despite responses from many social service agencies. School-based responses to mental health issues are woefully inadequate, and there is a dire shortage of mental health professionals within the overall community as well."*
- *"COVID pandemic disruptions in education has significantly set our youth back. Exposing them to opportunities in the healthcare field could help connect what they are learning in school with a successful future which has been proven to influence behavior and help them make good choices if they have hope for what their lives may look like after high school."*
- *"To me work stress is at an all time high, that paired with unaffordability to live (housing, car, and healthcare prices) make this time incredibly difficult to work through."*
- *"We have health care facilities, but we need more mental health facilities. Since COVID there is such a rise in mental issues. It would also be nice to have a kidney dialysis treatment facility here as people have to travel to Scranton for this."*

- *"Partnerships. Increase outpatient psychiatric options for those in needs even if it is peer support groups in a community location, spend funds on providing additional transportation for those in need. Do fundraisers for things like transportation and OP psych providers and create a partnership."*
- *"1. Enhance resources to expand in-home health/social supports for the community-dwelling older adults. 2. Create high quality, affordable residential personal care options for middle-income and lower-income adults. 3. Expand qualified, independent health care advocacy/navigation services. 4. Correct dangerous understaffing in area hospitals, nursing homes via increased reimbursements, wage incentives."*
- *"Better collaboration between healthcare/public health entities and community-based organizations. Geisinger cannot be expected to address community concerns in isolation; but rather, in collaboration with area partners who are providing services to the community. To highlight an example: the need for increased healthcare capacity. This is a need that Geisinger can tackle through innovative service models, recruitment efforts, and continuing health education. Collaborative partners can promote health literacy by offering health education, medical advocates, etc."*
- *"Would like to see more doctors that look like me and can relate to me (black and/or Hispanic doctors)."*
- *"We provide free healthcare to low income working uninsured families. Over 40% are non-English speaking so we experience health literacy issues and cost of living challenges. We treat patients with severe dental issues and many aren't educated on good oral hygiene. Patients that get private insurance or Medicaid, explain to us that they can't get in to see a primary care doctor in an appropriate amount of time."*
- *"mobile clinics? community health nursing?"*

Social Drivers of Health

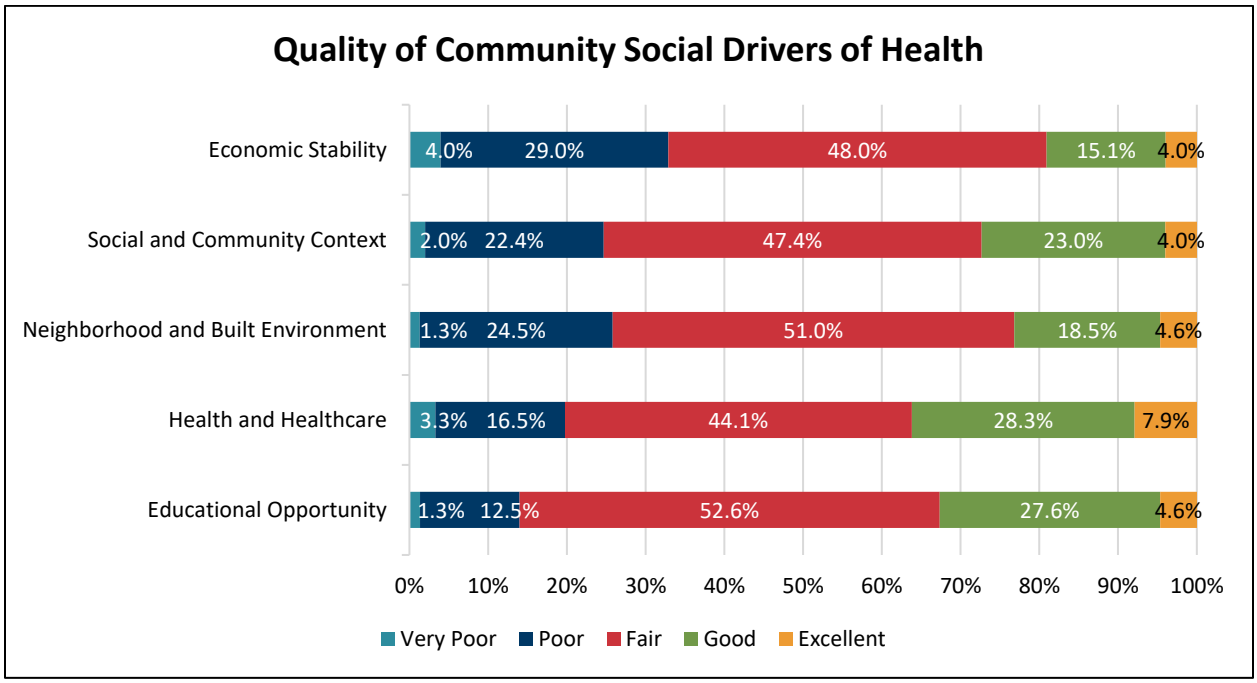
Key stakeholders were asked to rate the quality of the social drivers of health (SDoH) within the community(ies) their organization serves, focusing on the five key domains identified by Healthy People 2030: economic stability, education access and quality, healthcare access and quality, neighborhood 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 32% of stakeholders rating it as "good" or "excellent." Economic stability was seen as the weakest SDoH, with 48% rating it as "fair" and 33% rating it as "poor" or "very poor."

Approximately 76% (n= 116) 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)	3.22
Health and Healthcare (Consider access to healthcare, access to primary care, health literacy)	3.21
Social and Community Context (Consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	3.05
Neighborhood and Built Environment (Consider access to healthy foods, quality of housing, crime and violence, environmental conditions, transportation)	3.01
Economic Stability (Consider poverty, employment, food security, housing stability)	2.86



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.

- *"Although employment is readily available, the pay-scale keeps families in the economically underserved class. The educational opportunity is likely the most damaging aspect of our community. Although 65% of the HASD student body is Hispanic, only 5 of the 750 teachers are Hispanic. And there are no Hispanic administrators or school board members, nor are any school police or safety officers. This must change if the area is going to take advantage of the population boom and prosper. Healthy food choices are often more expensive and out of reach for families in the economic underclass. Affordable housing is critical. So many of our newest residents arrive without insurance and until they are established, they suffer from limited health care options. And mental health services must expand to meet a growing local crisis."*
- *"We are experiencing an influx of new patients that are non-English speaking and may be an immigrant so they have difficulties with schooling and employment. Due to the cost of housing,*

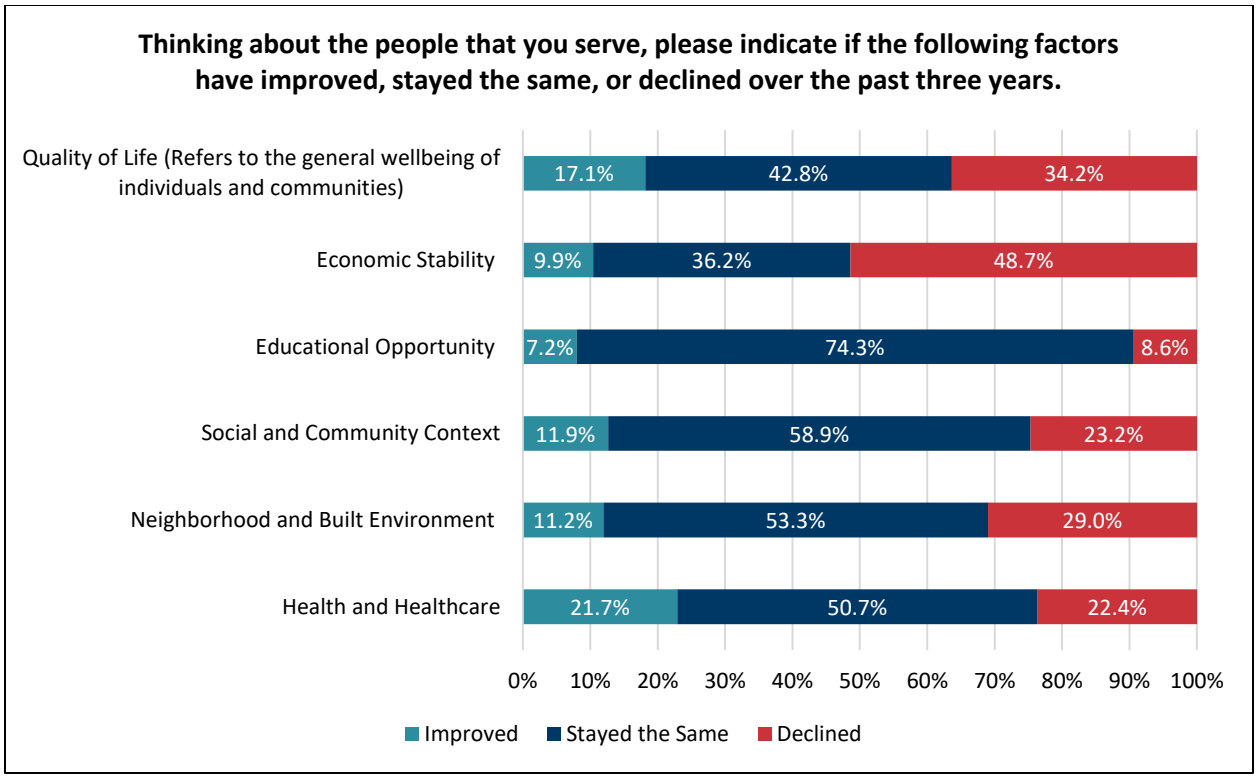
households have multiple family units living together. We provide immediate access to healthcare services to our registered patients as well as food and even transportation resources, therefore the excellent rating."

- *"Support for those who are working but one paycheck away from a crisis. ALICE (Asset Limited, Income Constrained, Employed). Connecting people with existing employment opportunities."*
- *"Local school district is severely underfunded by the state. There are so many organizations that know nothing about each other not knowing they support the same causes. Lack of competent mental health care and lack of minority providers."*
- *"Many people who do not drive themselves or have access to a car struggle with our public transportation systems as there are not enough/not convenient/not timely/not reliable."*
- *"There are waiting list for public housing and the housing available is limited and rent is very high for seniors and people with physical disabilities."*
- *"There are many occasions where the built environment is not very wheelchair/disability friendly and public transportation options are very limited."*
- *"Rampant obesity, cardiac diseases and diabetes, expensive to eat healthy, fresh fruit, veg, proteins. Lack of transportation to meet needs of those without vehicles, gas expensive. Inability to pay for meds prescribed. Lack of care facilities or beds in those that are in community, skilled facilities."*
- *"Participants wait months for medical appointments and weeks for life-sustaining psych med appointments. Wait lists for affordable housing programs are months/years long. Limited beds for mental health residential programs result in participants waiting months (and in 1 case, 1 year) in jail. Wait time for SSI and SSD applications to be appealed and approved is 2-3 years. There is only 1 homeless program in our area that does not immediately require rent but it is a short-term program."*
- *"Deep political / social divide in our communities influenced by the national political landscape. Limits the public discourse on discrimination and equity and the ability to address systems that maintain the status quo."*

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 five SDoH measures, as well as overall Quality of Life, most respondents perceived conditions to be the same as, if not improved, from the start of the pandemic. However, nearly half of key stakeholders cited a perceived decline in overall economic stability, including poverty, employment, food security, and housing stability. Conversely, more stakeholders perceived improvement in health and healthcare than in any other measure (22%), despite ongoing concerns about the accessibility and affordability of healthcare options.



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.

- *"Students need to be supported more than ever. We are working with school districts that have seen significant declines in academic performance, poor behavior in school, and increased truancy rates. Anything that your organizations can do to help students connect school with a future in healthcare or another field could help. Job shadows, mentorships, internships, and apprenticeships are wonderful tools that can help expose students to the vast amount of healthcare careers in Northeastern Pennsylvania."*
- *"Provide appointments more quickly. Provide transportation options (bus fare or cab fare) as needed."*
- *"Expand telehealth access to behavioral health, health education – expand language support resources for patients not fluent in English."*
- *"Follow up to make sure appointments or meds are kept or taken. Community workers can follow up. Stop sending unnecessary correspondences in the mail to facilities and save that money for health care. Send email surveys to get patient feedback."*
- *"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."*
- *"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."*

- *"Focusing on equality. Making sure that people of all races, genders, and educational levels are being treated with same standards of care and respect."*
- *"I think that in today's world the one thing that is truly need is a level of compassion and understanding. It is difficult to walk into any of these locations as it is and then have to come in contact with someone is either rude, upset, having a bad day or in some cases don't respond appropriately because of the color of your skin or the sound of your name."*
- *"As a small nonprofit organization, we triaged 1900 phone calls in the first 3 months of the pandemic. Many were not patients but those in the public that could not get through to other healthcare facilities and private healthcare offices. Many were desperate for their medications. Moving forward…make it easy for a patient to get assistance."*
- *"By continuing to ride the wave of technology used to increase and improve connectivity with members."*

In closing, key stakeholders were asked to leave any parting or summary thoughts regarding the COVID-19 pandemic. A total of 90 stakeholders responded, and their feedback is grouped thematically below.

COVID-19 Pandemic Feedback Themes	Number of Responses
Importance of prevention and preparedness, and implementing lessons learned	25
Health education (the necessity of providing consistent, accurate, and accessible health information to members of the community to promote health)	24
Mental health (the ongoing impact on people's mental health and the need for increased services, especially for youth)	18
Current economic crisis (disparate impact of all factors on the poor, need to address SDoH)	12
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)	12
Strengthening capacity of healthcare and social services organization (hiring and retention, training, availability)	10
Necessity of addressing mistrust (in the government, in the healthcare system, between diverse community members)	9
More support solutions for vulnerable populations (elderly, people with disabilities)	5
Address ongoing barriers to accessing healthcare (transportation, insurance concerns, etc.)	2

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."*
- *"Instead of making Geisinger the 'do all' for everything, establish more cross-referral programs with existing organizations."*
- *"Use 211/Help Line and Warm Line as a resource more to reduce crisis and access to services."*
- *"Improve hospital discharge planning to ensure that medically fragile patients are appropriately placed & have appropriate resources (medical, rehab, skilled nursing, pharmaceutical, personal care) for their safety and continuing recovery. – Improve health advocacy and navigation services to help patients navigate/obtain appropriate care, including specialty services."*
- *"1. Promotion/education of health literacy from HCOs to the community. This can be done by structured education, better communication, and partnering with GHP's Pop Health to promote education. Potential to have incentives for taking an online course in health literacy. 2. Publishing and supporting homeopathic remedies to chronic illnesses. Empowering the population to take healthcare into their own hands by having better quality foods and where to find them, (i.e., CHF patients being given education on diet and where to find good foods rather being told to avoid 'salt')."*
- *"The organizations can collaborate to put together a type of farmer's market that goes year-round. To benefit people in poverty, it would be great to be able to accept access cards or have it be free (with limited quantities per person/household)."*
- *"Give us access to the decision makers to make the connections to outside investors or potential private partners that can make some of the access to health care possible in Berwick."*
- *"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."*
- *"Since you asked! Junior Achievements across the country are effectively partnering with healthcare organizations to address problems like those facing our local youth. Partnerships have produced positive outcomes that connect students directly to healthcare jobs out of high school, internships, jobs that require certificates, etc. Underestimated students have great potential when they are exposed to the right people and interactions that they do not have opportunity to experience in their daily lives."*
- *"Continue to collaborate with community-based organizations such as United Way in addressing needs such as recovery from addiction. Provide a living wage for multi-lingual support staff at public health clinics to improve health outcomes for the underserved."*

Northeast Region Community Forum

Background

Geisinger, Allied Services, and Evangelical Community Hospital hosted a Community Forum on September 19, 2022, at Glenmaura National Golf Club in Moosic. The forum convened 32 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

- Successful community health improvement programs include those that bring services to the community and are integrated or co-located at places residents naturally frequent. Examples of these programs include:
    - United Way See to Succeed, bringing vision care and eyeglasses to school students;
    - Behavioral health crisis interventions in school settings;
    - Mobile medication-assisted treatment (MAT) units; and
    - Home visiting services offered by Geisinger Health Plan, CommunityCare Behavioral Health, and others.
- 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; and
    - Government and elected official involvement to impact policy and funding.

Access to Care

- Rural communities are underserved by healthcare services and would benefit from mobile services and support for rural clinics.
- Individuals with special needs are often missing from community conversations, and therefore the opportunity to share their lived experience and address service delivery gaps (e.g., Autism services, behavioral health, day programs).

- The region is aging rapidly, and older adults have historically been placed at risk due to social isolation, chronic disease prevalence, and economic insecurity, among other factors. Population health management and funding regulators have prioritized shorter stays for older adults in healthcare facilities, including rehab and skilled nursing, as cost savings and quality of life measures, but home environments may not offer adequate supports due to existing risk factors.
    - More advocacy is needed to promote home-based services (e.g., home care, home health) and adequate reimbursement for qualified home-based providers, and to reduce burden on health systems providing home-based care with decreased funding and diminished staff.
- Other advocacy efforts should address misaligned Medicaid reimbursement and cost of providing quality care, particularly given inflation levels and living wage. Current reimbursement levels do not support needed staffing to meet care quality measures.

Behavioral Health

- The region benefits from best practice behavioral health models and treatment solutions including:
    - Community-based trainings like Question Persuade Refer (QPR) suicide prevention, Mental Health First Aid, Thrive (parents and families), and Health Rocks (students);
    - Healthcare services like an inpatient psychiatric facility, dual-diagnosis (mental health and substance use disorder) treatment, hospital crisis centers, and mobile MAT units;
    - Expanded employer benefits to support coverage of mental health services;
    - School-based crisis interventions; and
    - Provider training for culturally competent crisis intervention and stigma reduction.
- While access to behavioral healthcare and resources has improved, certain populations continue to be underserved for a variety of reasons:
    - LGBTQIA+: Lack of culturally appropriate and informed care;
    - Veterans / Aging population: Complexity of navigating health insurance and lack of informed care;
    - Single parents: Socioeconomic challenges including lack of childcare during appointments and benefits cliff (sudden and often unexpected loss of public benefits due to small increase in earnings);
    - First responders: Fear of confidentiality breach or showing weakness, lack of convenient availability;
    - Non-native English speakers / English as second language: Lack of appropriate tools and resources to address health literacy gaps;
    - Pediatrics: Lack of behavioral health services; and

    - Wyoming County residents: Behavioral health services expanded at the Children's Service Center, but the county overall has lost hospital services and has the lowest availability of mental health providers in the region.

- Behavioral health treatment options are needed, but they don't address root causes of issues or prevent future demand for services. Additional support is needed for community efforts that address upstream factors like social drivers of health.
- Medical marijuana presents challenges for employers to manage legal consumption and risk in the workplace. For example, heavy machine operators may have a prescription, but consumption is not safe at work. Additional conversation and guidance are needed.
- Schools are a hub for community services but lack consistent funding to staff long-term positions like behavioral health specialists. External community resources are also limited due to provider shortages.
- Community culture change that addresses stigma and generational substance use is needed to improve behavioral health outcomes and prevent future healthcare demand.

Chronic Disease Prevention and Management

- New, non-judgmental language is needed to define chronic disease prevention and management and change the way providers and communities talk about and treat health and body weight.
    - Examples of this language and approach include "Healthy at any size" and "Body positive services."
- Working poor populations continue to be an underserved group for health and healthcare services. Access issues for this population are varied and include scheduling/appointment times, transportation, and childcare.
    - Successful ways to reach this population include co-located services and "one-stop shop" opportunities, including in person pop-up or piggybacked events. Engaging employers as partners and hosting events at the workplace is an effective strategy.
- Technology access has improved across the region, but it is limited for some populations. Outreach efforts should continue to be broad and include newspaper, mailings, and in-person events.

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 Geisinger, we're committed to improving the health and well-being of those who live in the communities we serve, regardless of race, religion, ethnicity, sexual orientation, gender identity, or ability to pay. Our commitment extends beyond the walls of our hospitals, clinics, and schools to foster positive change for our patients, employees, students, health plan members, and neighbors right here — in the places where they live, work, and play.

By providing support to our local communities, identifying much-needed services, and establishing partnerships with community-based organizations, we can improve the physical, social, and mental well-being of those we serve.

Our goals:

- Creating partnerships with local, community-based organizations
- Providing grassroots support in the communities we serve by establishing relationships and building trust
- Promoting community health and advocacy through engagement
- Providing patient education and information about preventive services
- Increasing access to care in both clinical and community settings
- Identifying services needed to reduce health disparities and promote health equity

In 2020, Geisinger completed a CHNA and developed a supporting three-year Implementation Plan to advance systemwide goals for community health improvement. The Implementation Plan outlined our strategies for measurable impact on identified priority health needs, including 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, as well as our ongoing efforts to respond to COVID-19.

Priority – Access to Care

As part of the 2021-2023 Implementation Plan, Geisinger conducted the following programs and initiatives in response to our overarching goal to *ensure residents have access to quality, comprehensive healthcare close to home*:

- In response to Covid 19, Geisinger set up an informational website for families, as well as organizations, including precautions to help keep everyone safe, how to schedule vaccine appointments, and testing and prevention FAQs.
- Fostered pursuit of health careers and ongoing training of health professionals through ongoing participation in college orientations and health symposiums and providing volunteerism opportunities to encourage high school and college students to enter the healthcare field. Participated in 20 high school Healthcare Career Days and Co-op and career pathways program opportunities; seven university and college job fair events and lunch and learns; and various engagement opportunities with universities and colleges from all over Pennsylvania through Student Nurse Association of Pennsylvania (SNAP).

- Recruited primary care providers to our region and partnered with area healthcare providers to address specialty care delivery gaps.
- Implemented telehealth services to address pandemic-related access to care barriers.
- Implemented the Neighborly social care platform to help connect patients and residents with available social services in their community.
- Provided Geisinger Mobile Mammography unit to bring care to areas throughout the Geisinger footprint on a weekly basis.
- In partnership with Geisinger Health Plan, provided Mobile Dentistry unit to deliver no-cost dental exams and preventive services to children in pre-K through grade 12.
- Worked with Geisinger's Office of Diversity, Equity & Inclusion to identify and sponsor nonprofit community health organizations in support of their programs and activities that engage members around health (e.g., Black Scranton Project, Hazelton Integration Project, NAACP, YWCA).
- Offered free or reduced-cost screenings in partnership with community events and agencies.
- Supported Latino Connection to provide COVID-19 vaccines across the Geisinger footprint.
- Hosted no-cost flu shots available at more than 40 convenient locations across Geisinger's footprint in 2022.

Program and Strategy Highlights:
Geisinger supported the Junior Achievement Inspire Live Career Discovery Event and Virtual Experience to provide students with a better understanding of the possible career pathways that align with their interests and opportunities within our local community. More than 2,000 local students participated.

Junior Achievement Inspire is a virtual career exploration platform with live event opportunities, bringing together the business community and local schools to help launch middle and high school students into their future. Several areas of Geisinger were represented in outreach efforts, including nursing, Geisinger Health Plan, Volunteer Services, Geisinger Commonwealth School of Medicine, MyCode, and more. Each area offered students a hands-on, interactive experience to pique their interest in a career in healthcare.

Surveys conducted by the Junior Achievement event organizers found that:

- 87.6% of the students said JA Inspire helped to determine their future career
- 81.2% of the students said JA Inspire helped them find a new career they wanted to learn more about

Geisinger launched the Neighborly platform in March 2020, and the site has since seen over 170,000 searches for local resources for food, housing assistance, childcare, transportation, utility assistance, healthcare, and other social needs. The platform is an easy-to-use online search tool with links to more than 17,000 free and reduced-cost programs in Pennsylvania. Neighborly is available to both patients and community members. In July 2023, Geisinger launched a new mobile app for Neighborly to increase access to communities.

Priority – Behavioral Health

As part of the 2021-2023 Implementation Plan, Geisinger conducted the following programs and initiatives in response to our overarching goal to *model best practices to address community behavioral healthcare needs and promote collaboration among organizations to meet the health and social needs of residents*:

- Opened a 96-bed facility providing care for adult, pediatric, and adolescent patients who struggle with acute symptoms of behavioral health disorders such as anxiety, depression, bipolar disorder, psychosis, and posttraumatic stress disorder in Moosic, PA. Development plans for a second, 96-bed hospital – Geisinger Behavioral Health Center Danville – are underway, and the facility is expected to open in 2025.
- Continued to provide Narcan overdose reversal kits in the community and partnered with community agencies to increase distribution.
- Offered Free2BMom program specifically designed to treat pregnant women addicted to opioids or with a history of opioid use disorder.
- Provided medication disposal boxes at GCMC and area retailers as part of the Medication Take Back Program to prevent misuse and/or harm to the environment.
- Implemented standard postpartum depression screenings for new mothers.

Program and Strategy Highlights:

Geisinger Behavioral Health Center Northeast opened in July of 2023 as a joint venture between Geisinger and Acadia Healthcare. The 96-bed facility provides care for adult, pediatric, and adolescent patients who struggle with acute symptoms of behavioral health disorders such as anxiety, depression, bipolar disorder, psychosis, and posttraumatic stress disorder. This array of acute behavioral health services provides a level of care unparalleled in northeastern Pennsylvania, especially for children and adolescents. The hospital will admit patients at the beginning of August 2023.

The new behavioral health center, located at 60 Glenmaura Blvd., Moosic, is the first of two hospitals to be constructed under the joint venture between Geisinger and Acadia. A second, 96-bed hospital – Geisinger Behavioral Health Center Danville – is currently in development in Danville and is expected to open in 2025. These two new centers will allow Geisinger to consolidate inpatient behavioral health programs from Geisinger Medical Center, Geisinger Bloomsburg Hospital, and Geisinger Community Medical Center, providing additional capacity to expand medical care availability at those hospitals. Together, the new facilities are expected to create approximately 400 new jobs.

The Free2BMom program provides healthcare and social services for new mothers or pregnant people who struggle with opioid use or substance use disorder (or SUD, a dependence on alcohol, amphetamines, methamphetamines, benzodiazepines, marijuana, cocaine and other substances). Participation in Free2BMom begins during pregnancy and supports pregnant people and their baby for two years after childbirth. Individuals can also be enrolled after the birth of their baby.

Free2BMom participants receive: Help finding outpatient counseling; weekly or monthly appointments with the medication-assisted treatment healthcare team (as appropriate); social services and

community-based assistance; family members' involvement in treatment; help finding therapy and 12-step meetings to provide the tools necessary to succeed while avoiding relapse. Participants also receive medication-assisted treatment for six weeks postpartum to help ease cravings and are then assisted to connect with other providers to continue recovery. The program is available for residents of Columbia, Luzerne, Montour, Union, Snyder, or Northumberland counties.

Priority – Chronic Disease Prevention and Management

As part of the 2021-2023 Implementation Plan, Geisinger conducted the following programs and initiatives in response to our overarching goal to *reduce risk factors and premature death attributed to chronic diseases*:

- Conducted screening and referral practices to identify and respond to social drivers of health needs for patients.
- Provided Geisinger Mobile Care Gap bus to reach individuals with diabetes who have a care gap in their preventive health and require critical screenings and services.
- Provided Geisinger Fresh Food Farmacy in Scranton, offering diabetes education and management resources as well as nutritious foods for individuals identified as having A1C levels greater than 8.0 and food insecurity.
- Implemented the ZING543210 online website and program for community-based healthy lifestyle education.
- Supported and sponsored community-based programs, trainings, and events to promote community wellness and prevention.
- Implemented Walk with a Doc, pairing discussions on timely health topics and wellness walks.
- Dr. Ruiz, Chair of Cardiology, attended 28 community events in 2023 to educate the community on topics such as stress in the workplace, heart health and prevention, and heart disease.
- Implemented best practices in cancer detection, including low-dose CT scans for lung cancer and machine-learning algorithm to identify and conduct outreach for patients with high-risk for colorectal cancer.
- Relocated all Lackawanna County women's health services to Geisinger Women's Health Scranton, 3 W. Olive Street, creating a "one-stop shop" for women's healthcare.
- Began construction on a new state-of-the art cancer center in Lackawanna County.

Program and Strategy Highlights:

Geisinger's Mobile Care Gap bus offers care to individuals with diabetes who have a care gap in their preventive health. It offers critical services and screenings to help patients with diabetes manage their health. The bus stops every Monday, Wednesday, and Friday at different locations in the Geisinger footprint. Patients with care gap misses are contacted and scheduled for appointments on the bus — no walk-ins are taken. Staff members also assist in scheduling mammography and colorectal screening services. Three nurses on the bus each see up to 20 patients. Services provided include height, weight and blood pressure checks, foot exams, diabetic retinopathy eye exams, nephropathy screening (urine collection) and any overdue lab work including phlebotomy services (A1C). Patients can also be vaccinated against pneumonia and flu, when needed.

The Mobile Care Gap bus was established in response to the COVID-19 pandemic and resulting care gaps for diabetic patients. Patients were missing critical yearly eye exams, kidney checks, and blood tests used to monitor how well people are managing blood sugar levels. The bus continues to operate and during the fall and winter months, when the bus may not be appropriate, the mobile nurses will go into clinics to continue closing diabetic care gaps.

In partnership with community philanthropists, the Fresh Food Farmacy was launched in July 2016 at GSACH and has since expanded to serve three locations: Shamokin, Scranton, and Lewistown. The program is available for patients with diagnosed diabetes and facing food insecurity. Patients receive more than 20 hours of diabetes education with clinical staff and access to the Fresh Food Farmacy app, which includes healthy recipes and nutrition information. Patients receive enough food to prepare healthy, nutritious meals for their whole family, twice a day for five days (10 meals per week). Patients attend an evidence-based weekly diabetes or chronic disease self-management program and have access to other no-cost classroom education offered by dietitians and team members. The program now serves more than 200 patients and their families.

Geisinger Women's Health moved all its services in Lackawanna County under one roof at Geisinger Women's Health Scranton, 3 W. Olive Street. Services offered at the location include obstetrics and gynecology, urogynecology, and maternal-fetal medicine. Radiology services will also be available. Pregnant people can receive all needed care at the facility, including prenatal visits, scans and imaging, and high-risk appointments.

In June 2022, Geisinger broke ground on a state-of-the art cancer center, expanding services in Lackawanna County. The center will offer more appointments in the community while keeping world-class cancer care closer to home. The need for cancer care continues to grow in Lackawanna County and is expected to increase over the next four years. Currently, one-in-five patients leave the county to receive care. The planned 55,000-square-foot facility will provide a broader spectrum of services for patients.

Geisinger's COVD-19 Response

To meet the challenge of the pandemic, Geisinger flexed its operations to assist the communities we serve in the following manner:

Vaccine Distribution

- More than 320,000 vaccines were distributed to date.
- Converted empty office space to vaccine centers to vaccinate employees and the community-at-large.
- Walk-in Care locations doubled as testing facilities as well as serving as a resource for schools and employers requiring testing and return to work/school documentation.
- Coordinated 2,300 deployment/interventions with statewide skilled nursing facilities. Assisted with rapid response, PPE, testing, infection prevention, and vaccines.

Contact Tracing

- Typically a public health responsibility, Geisinger worked to get upstream of the virus' spread as prevention.

- Redeployed dozens of employees for contact tracing.
- Completed more than 3,000 notifications in the spring and summer of 2020.

Community

- Webinars, town halls, and digital resources provided for schools, community groups, Chambers, and employers throughout the pandemic to keep everyone up to date on the pandemic.
- Fresh Food Farmacy provided 42,000 meals per month for participants.
- 65 Forward locations offered outside exercise classes and delivered care packages of personal care items for individuals confined to home.

Next Steps

Geisinger 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.geisinger.org/about-geisinger/community-engagement/chna/contact-us or contact GeisingerCommunity@geisinger.edu.

Appendix A: Public Health Secondary Data References

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Appendix B: Key Stakeholder Survey Participants

Allied In-Home Services, AVP

Allied Services Foundation, Director, Corporate & Foundation Relations

Allied Services-Behavioral Health Division, Director, Behavioral Health Division

B.I.D.A., Executive Director

BARRASSE LAW, owner

Berwick Teen Center, Director

Busy Little Beavers, CEO

Center for Community Resources, Case Management Program Manager

Central Susquehanna Intermediate Unit, SYNCH Project and Data Collection Manager, CSIU Nurse Aide Training Program Coordinator

Central Susquehanna Intermediate Unit, Career Coach

Columbia County Family Center, Director

Columbia County Volunteers in Medicine, Executive Director

Community Giving Foundation, Program Officer

Evangelical Community Hospital, Director, Women's Health and Cancer Services

Evangelical Community Hospital, Director Quality, Patient Safety & Risk Management

Family Service Association of Northeastern Pennsylvania, CEO

First Order Painting, Owner

Geisinger, AVP operations

Geisinger, Inpatient Social Work Care Manager

Geisinger, Community Engagement Strategist, Senior

Geisinger, VP, Strategy & Market Advancement

Geisinger, Community Benefit Coordinator

Geisinger, Director

Geisinger, Director

Geisinger, Administrative Director

Geisinger, Operations Manage

Geisinger, Director

Geisinger, CMO

Geisinger, Medical Assistant

Geisinger Bloomsburg Hospital, Operations Manager

Geisinger CMC, RN

Geisinger Community Medical Center, Injury Prevention Outreach Coordinator

Geisinger Health Plan, Chief Administrative Officer, Geisinger Clinic

Geisinger Health Plan, VP
Geisinger Health Plan, Director
Geisinger Health System, Program Director, DEI
Geisinger Health System, Administrative Fellow I
Geisinger Henry Cancer Center, Social worker
Geisinger Home Infusion, Director
Geisinger Medical Center, Breast and Cervical Cancer Early Detection Program Navigator
Geisinger Medical Center, Outreach/Injury Prevention Coordinator for Adult Trauma
Geisinger Wyoming Valley, Geisinger Wyoming Valley
Geisinger Wyoming Valley Medical Center Trauma, Trauma Outreach/Prevention Coordinator
Greater Pittston Chamber of Commerce, President
Greater Scranton Chamber of Commerce, President/CEO
Greater Wyoming Valley Chamber of Commerce, Greater Wyoming Valley Chamber of Commerce
Hanover Area School District, Director of Pupil Services
Hazleton Integration Project, Founding President
Individual Abilities in Motion, President
Jessup Borough, Assistant Borough Manager
Jessup Borough, Jessup Borough
Jewish Family Service of Northeastern Pennsylvania, Executive Director
Junior Achievement, President
Lackawanna and Luzerne County Medical Society, Executive Director
Lackawanna County Area Agency on Aging, Acting Director
Lackawanna County Mental Health Court, Coordinator
Luzerne County Community College- Berwick Center, Director
Moses Taylor Foundation, President and CEO
NAACP Lackawanna County Branch 26AD-B, President
NEPA Pride Coalition, Founder & Executive Director
Office of PA Senator Lynda Schlegel Culver, Constituent Relationship Specialist
Old Forge School District, Superintendent
PA ECYEH, Consultant
Penn State Extension, Registered dietitian/ extension educator
Saint Joseph's Center, President/CEO
Scranton Primary Health Care Center, Inc., CEO
Susquehanna County, Susquehanna County Commissioner
Susquehanna University, Chief of Staff
TELESPOND SENIOR SERVICES INC, President/CEO

The Bloomsburg Children's Museum, Director
The City of Scranton, The City of Scranton
The Ronald McDonald House of Scranton, Executive Director
The Wright Center, CNA
The Wright Center, Patient Service Assistant
The Wright Center, Controller
The Wright Center, Billing specialist
The Wright Center, Public Health Dental Hygiene Practitioner
The Wright Center, Certified Medical Assistant
The Wright Center, HIM Scanning Clerk
The Wright Center, CCMA
The Wright Center, Practice Manager
The Wright Center, Community Health Worker
The Wright Center, Community Education
The Wright Center, Physician
The Wright Center, Dental Receptionist
The Wright Center, Accounting Clerk
The Wright Center, Applications and Solutions Developer
The Wright Center, Medical Assistant
The Wright Center, EHR Specialist and Trainer
The Wright Center, Dental Claims Processor/Prior Auth Specialist
The Wright Center, Certified Recovery Specialist/Certified Community Health Worker
The Wright Center, CRNP
The Wright Center, CHW
The Wright center, Director of the 340B program
The Wright Center, Medical Assistant
The Wright Center, GME Admin
The Wright Center, AR Medical Payment Specialist
The Wright Center, BH Therapist
The Wright Center, Medical Assistant
The Wright Center, Executive Assistant
The Wright Center, Program Coordinator
The Wright Center, EHR Specialist
The Wright Center, Clerkships Coordinating Assistant
The Wright Center, BH
The Wright Center, HIV Asst.

The Wright Center, Executive Assistant

The Wright Center, EHR Application Specialist & Trainer

The Wright Center, CMA

The Wright Center, Accounting Clerk

The Wright Center, The Wright Center

The Wright Center, CMA

The Wright Center, Documentation and Date Department

The Wright Center, Dental Hygienist

The Wright Center, AVP Value Based Performance Program

The Wright Center, Team Lead/AR Specialist

The Wright Center for Community Care, Certified Recovery Specialist

The Wright Center for Community Health, Outreach and Enrollment Coordinator

The Wright Center for Community Health, AR Payment Poster Lead

The Wright Center for Community Health, Director of Government Relations

The Wright Center for Community Health, Co Practice Manager

The Wright Center for Community Health, Registered Dietitian

The Wright Center for Community Health, Executive Administrative Assistant

The Wright Center for Community Health, Executive Administrative Assistant

The Wright Center for Community Health, Executive Director of Public Affairs

The Wright Center for Community Health, Credentialing Manager

The Wright Center for Community Health, Director of Development and Relations for Community Outreach

The Wright Center for Community Health, CCMA

The Wright Center for Community Health, Project Manager

The Wright Center for Community Health, Collections

The wright center for community health, Controller Revenue Cycle

The Wright Center for Community Health, Spiritual Aide

The Wright Center for Community Health, Senior Financial Reporting & Special Projects Analyst

The Wright Center for Community Health, Co Manger of Medical Assistants

The Wright Center for Community Health, AVP Primary Care and Recovery Services Integration

The Wright Center for Community Health, Dental Receptionist

The Wright Center for Community Health, Assistant Director of Clinical Compliance & Reporting

The Wright Center for Community Health, Employee Health

The Wright Center for Community Health, Director of Dental

The Wright Center for Community Health, Project Manager

The Wright Center for Community Health, CCHW

The Wright Center for Community Health, Medical Records

The Wright Center for Community Health, Social Worker

The Wright Center for Community Health, Quality and Safety

The Wright Center for Community Health, Licensed Professional Counselor

The Wright Center for Community Health, In-House Counsel

The Wright Center for Community Health, LPN

The Wright Center for Community Health, LPN

The Wright Center for Community Health, Governance Officer

The Wright Center for Community Health, Center of Excellence for Opioid Use Disorder Case Manager

The Wright Center for Community Health, Grants Specialist

The Wright Center for Community Health, RN-AVP Integrated Primary Health Services

The Wright Center for Community Health, CAA Supervisor

The Wright Center for Graduate Medical Education, Director of Scholarly Activity

The Wright Center for Graduate Medical Education, Senior Financial Analyst

The Wright Center Medical Group, PC, Director of Graduate & Undergraduate Medical Experience

The Wright Center Oral Health Clinic, EFDA

The Wright Center, Senior Financial Analyst

The Wright Center for Community Health and Graduate Medical Education, Executive Director, Marketing and Communications

The Wright Center, Billing specialist

The Wright Center HAP, CCMA

Volunteers in Medicine, Executive Director

Wilkes-Barre City Health Department, Director

Wilkes-Barre Health Department, Educator, maternal health

Wright Center, MD, medical director

WVADS, Inc., CEO

Wyoming County Courthouse, Wyoming County Courthouse

Appendix C: Northeast Region Community Forum Participants

Sarah Bodnar, United Neighborhood Centers of Northeast Pennsylvania
Chris Boland, Geisinger
Danielle Breslin, Moses Taylor Foundation
Jim Brogna, Allied Services
Kathy Bufalino, Brighter Journeys
Sherry Dean, Geisinger
Cathy Fitzpatrick, Scranton Area Community Foundation
Kristen Follert, NEPA Community Health Care
Kirsten Fordahl, Geisinger
Dylan Fredricey, NEPA Pride Coalition
Christopher Gatto, Old Forge School District
Regina Graham, Geisinger
Mallory Hammer, Geisinger Health Plan
Amber Hughes, Penn State Extension
Andy Hurchick, St. Joseph's Center
Karen Kearney, Wild Hope Therapy
Sara McDonald, Lackawanna County Government
Shanie Mohamed, Greater Wyoming Valley Chamber of Commerce
Rebecca Montross, Allied Services
Barbara Norton, Allied Services
Judy Oprisko, Allied Services
Evan Perry, Allied Services
Lauren Pluskey Mclain, Geisinger
Christina Pulman, Penn State Extension
Tori Reinard, Geisinger
Donna Sedor, Telespond Senior Services
Karen Stroney, Allied Services
Charles Suppon, Tunkhannock Area School District
Gina Suydam, Wyoming County Chamber of Commerce
Lisa Urbanski, Brighter Journeys
Carl Witkowski, Berkshire Hathaway GUARD Insurance Companies
David Yonki, Wilkes-Barre City