Geisinger

2024 Community Health Needs Assessment
Geisinger Lewistown Hospital

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 Huntingdon County Juniata County Mifflin County	Geisinger Lewistown Hospital

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

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2024 CHNA Background

Since 2012, 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
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Mike DiMare, Administrative Director, Geisinger
Kirsten Fordahl, Project Manager, Geisinger
Regina Graham, Program Manager, Geisinger
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Rachel Manotti, Associate Chief Strategy Officer, Geisinger
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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 95 individuals serving the Western Region, who represent healthcare providers, social services professionals, educators, faith-based leaders, and community leaders, among others;
- Regional Community Forum bringing together 23 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.

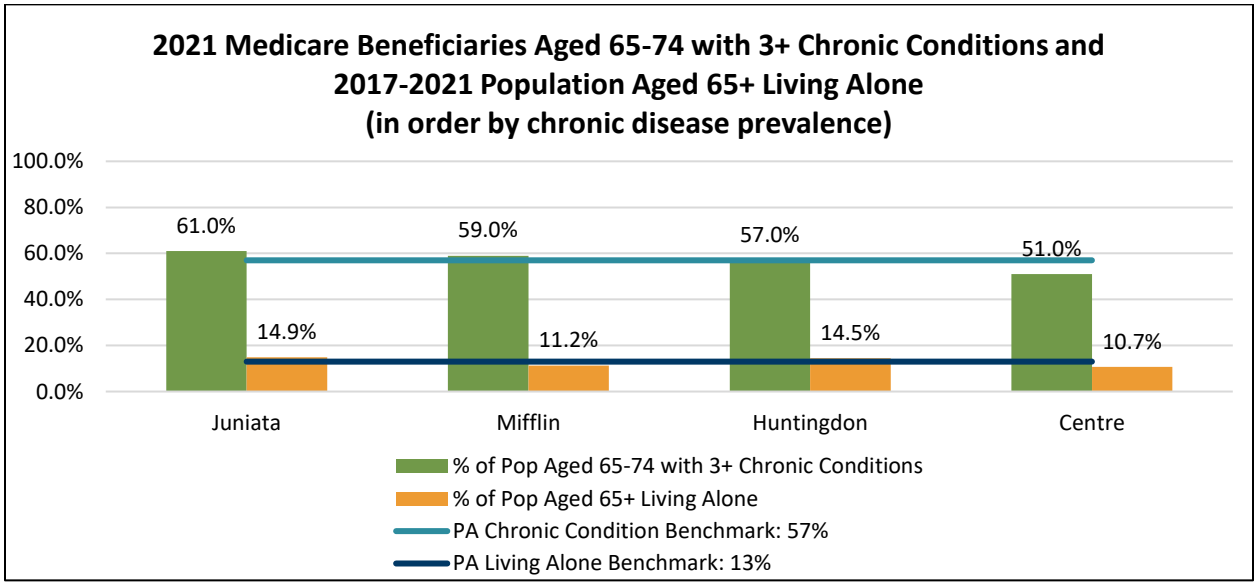
Executive Summary of CHNA Findings

Demographic and Priority Population Trends

The Western Region is comprised of four rural Pennsylvania counties: Centre, Huntingdon, Juniata, and Mifflin. The Center for Rural Pennsylvania defines a county as rural when population density, or the number of people per square mile within the county, is fewer than 291. Within the Western Region, Huntingdon and Juniata counties are the most rural with population density of 52 and 63, respectively.

The total population declined for all counties except Centre over the past decade. Juniata County saw the largest population decline of -3.2% from 2010 to 2021. In contrast, the region saw significant growth in older adults. From 2010 to 2021, the number of adults aged 65 or older grew 17% (Mifflin) to 38% (Centre). Note: Centre County is home to the Pennsylvania State University and other major employers; population statistics for the county differ widely from other Western Region communities.

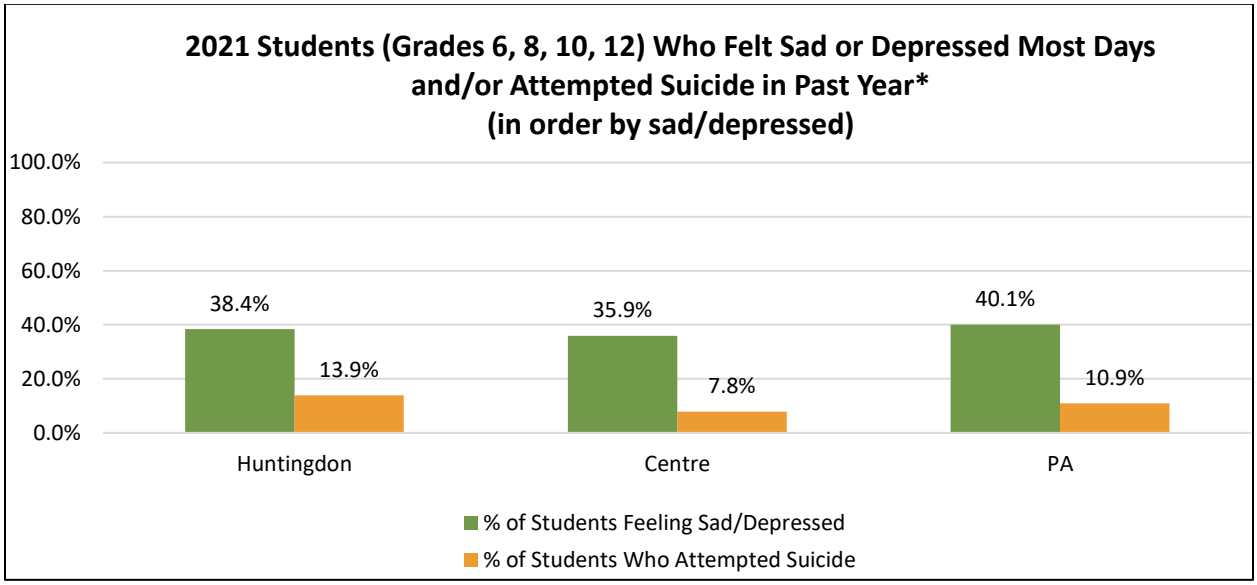
The growth of older adult populations will challenge communities to provide adequate support for aging residents, many of whom live alone and choose to age in place. Consistent with the state overall, approximately 50%-60% of Medicare beneficiaries aged 65-74 residing in the region had three or more chronic conditions in 2021, and disease prevalence increased with older age groups 75+. Juniata County is an area of opportunity for improving older adult health and well-being. Approximately 20% of residents in the county are aged 65 or older, creating demand for services, and 15% of older adults live alone, potentially impeding wellness efforts.



Source: US Census Bureau, American Community Survey & CMS

Western 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, outside of Centre County, 15%-25% of children experience poverty compared to 10%-15% of all residents.

Top health concerns for children in the Western 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 proportion of children who report poor mental health. In Huntingdon County, nearly 2 in 5 students reported feeling consistently sad or depressed in 2021 and more than 1 in 10 students reported an attempted suicide. Note: Data are not publicly available for Juniata and Mifflin counties.

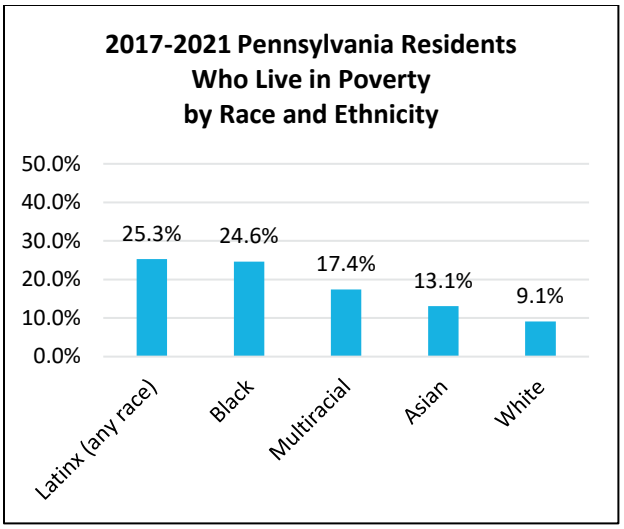


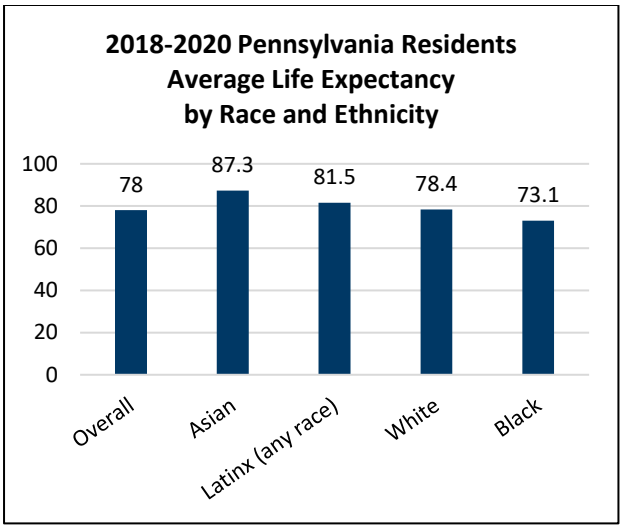
Source: Pennsylvania Youth Survey *Data are reported by county as available.

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 Western Region in 2021, only 39.5% of Huntingdon County students felt school is going to be important for their later life. 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 Western Region is a majority white community, but consistent with state and national trends, people of color are the only growing populations. This demographic shift is slow across counties, accounting for a 2-4 percentage point change over the last decade. Growth among populations of color was most evident for individuals who identify as multiracial and/or Latinx.

While populations of color are growing, they comprise a small proportion of the total population, limiting local-level data and often masking their community experience. Statewide trends demonstrate wide disparities affecting people of color, starting with upstream SDoH like poverty and ultimately downstream outcomes like life expectancy. 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

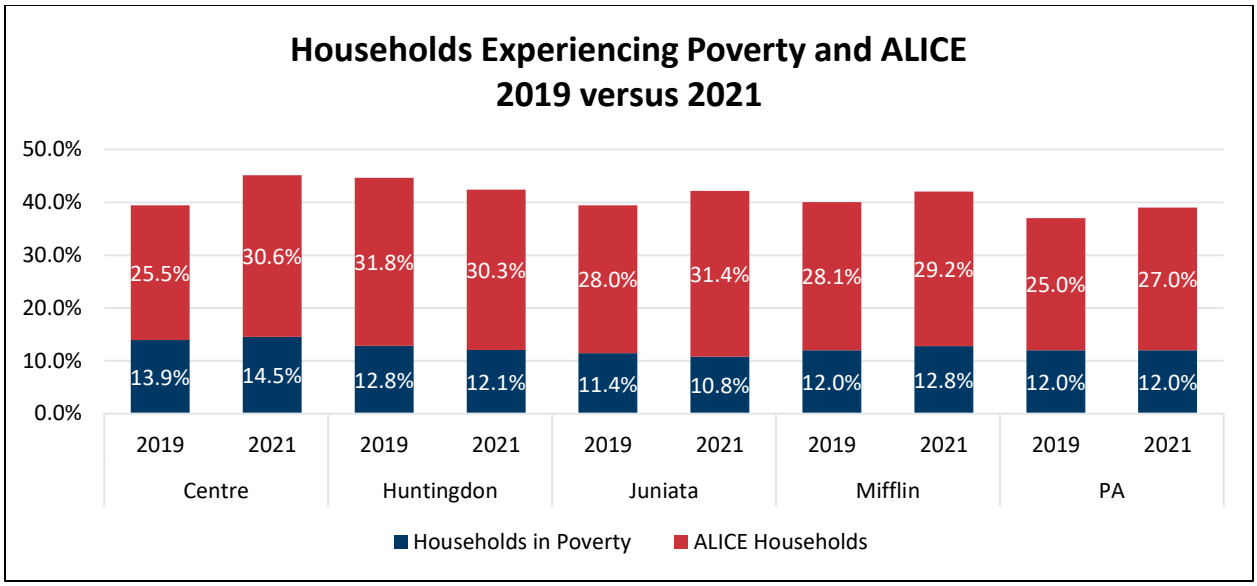
As part of the Key Stakeholder Survey, respondents were asked to share the top five priorities that their community should address to improve health and well-being of the populations they serve. While most respondents selected mental health conditions, the majority of the top five identified priorities were SDoH like economic stability, lack of transportation, and housing.

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	53.4%
Economic stability	45.5%
Lack of transportation	45.5%
Housing (affordable, quality)	42.1%
Substance use disorder	39.8%

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 Western Region counties in 2021, approximately 30% of households were ALICE, and outside of Huntingdon County, the proportion of ALICE households increased from prior years.

The opportunity to address financial hardship for ALICE households is demonstrated in Mifflin County. In 2021, 29% of Mifflin County households were ALICE. Mifflin County households also struggled with basic needs like housing and childcare. Despite having the lowest housing costs in the region, 25% of homeowners and 39% 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 30% of median household income compared to state and national averages of 27%.



Source: United for ALICE

Note: Centre County data are likely skewed by the Pennsylvania State University student population.

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). Western Region counties have similar UNSs of 56-58. When analyzed by zip code, these scores increase to 74-87 in select communities, largely within Juniata and Mifflin counties and depicted in the table below. Note: While findings indicate significant unmet need and disparities in health and well-being, they may also be skewed by Plain Community members.

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. The SVI illuminates significant social disparities within the Western Region that are also associated with significant health disparities. In Lewistown in Mifflin County and Mount Union in Huntingdon County, residents experience more social vulnerabilities, according to the SVI, and have lower average life expectancy of 75 years or less. Average life expectancy in neighboring communities may be as high as 81-84 years.

The maps below display the SVI and average life expectancy by census tract within the GLH primary service area.

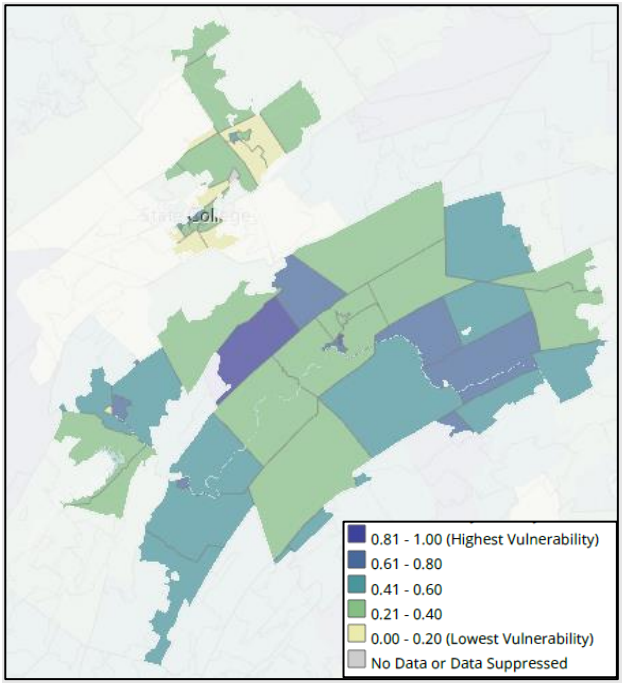
2017-2021 Social Drivers of Health for Western Region Zip Codes with HRSA Unmet Need Score >70 out of 100

Zip Code (County)	Population in Poverty	Children in Poverty	No High School Diploma	No Health Insurance	UNS Score
17004, Belleville (Mifflin)	15.1%	27.3%	25.5%	40.4%	86.8
17002, Allensville (Mifflin)	17.5%	28.9%	41.0%	24.0%	84.8
17084, Reedsville (Mifflin)	10.4%	21.6%	18.2%	25.1%	80.2
17063, Milroy (Mifflin)	11.8%	9.7%	14.1%	20.4%	80.0
17035, Honey Grove (Juniata)	11.3%	19.2%	19.5%	8.8%	76.9
17841, McClure (Mifflin)	17.3%	32.6%	15.9%	9.6%	75.3
16866, Philipsburg (Centre)	19.7%	32.6%	15.4%	3.5%	74.0
Pennsylvania	11.8%	16.4%	8.6%	5.6%	NA

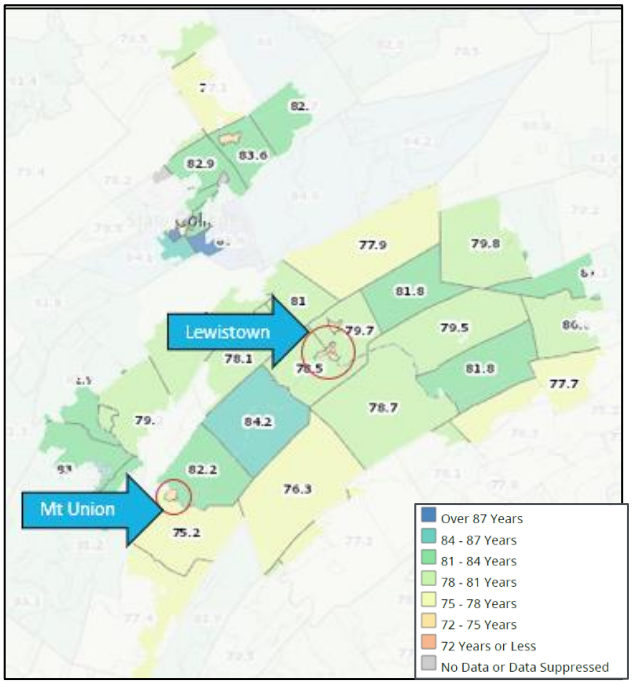
Source: US Census Bureau, American Community Survey; Health Resources and Services Administration

*Note: Findings for zip codes in Mifflin and Juniata counties may be skewed by Plain Community residents.

Social Vulnerability Index by Census Tract within GLH Service Area



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



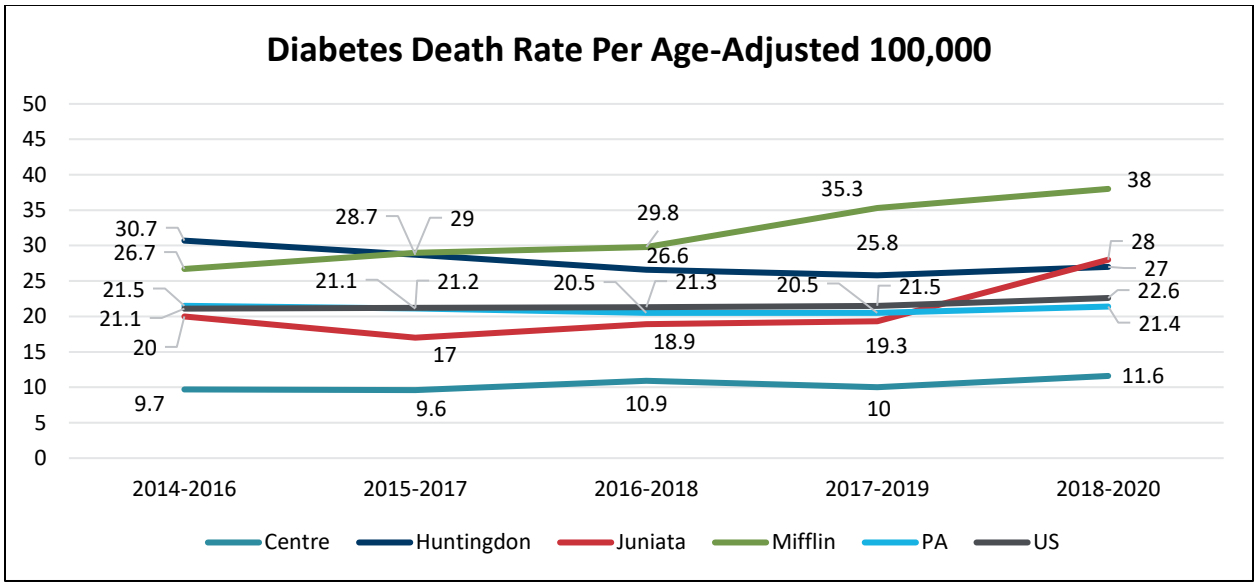
Priority Health Needs

The top health concerns for the Geisinger footprint, including the Western 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. Outside of Centre County, Western Region residents have poorer outcomes from chronic disease than in the rest

of the state, dying at higher rates from conditions like diabetes and chronic lower respiratory disease. It is, however, interesting to note that despite more heart disease risk factors and smokers in the region compared to state and national benchmarks, death rates due to heart disease, diagnoses of asthma and COPD, and incidence and death rates due to lung cancer are comparable.

Western Region adults have a similar prevalence of diabetes as their peers statewide, with approximately 1 in 10 adults affected, but death rates due to diabetes are higher in Huntingdon, Juniata, and Mifflin counties. These findings may indicate access to care and other SDoH barriers that impede diagnosis and/or care management. While the number of residents without health insurance declined and a similarly high percentage of adults report having an annual physical checkup, 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.



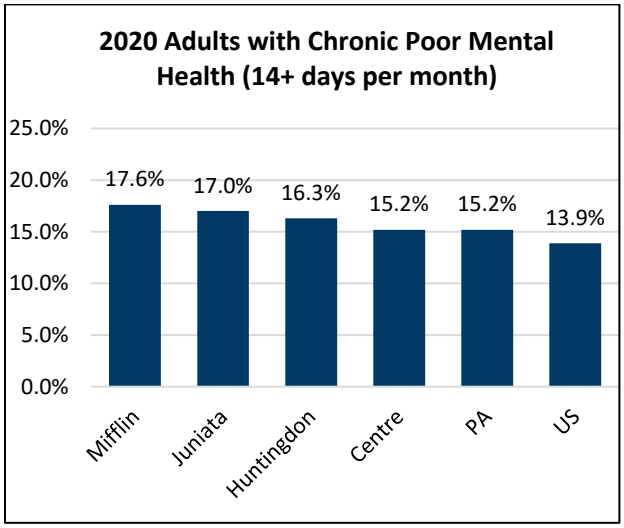
Source: Centers for Disease Control and Prevention

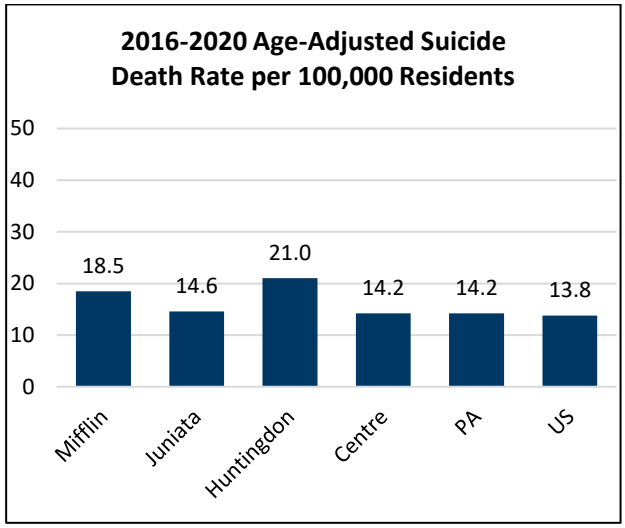
Behavioral health, including mental health and substance use disorder, was a growing concern before the pandemic and was generally exacerbated by the experience. Most recent data for 2020 show that consistent with Pennsylvania residents overall, Western Region adults are more likely to report chronic poor mental health (14 or more poor mental health days per month) than their peers nationwide. Mifflin County has the highest proportion of adults with self-reported chronic poor mental health (17.6%) across the Geisinger footprint. It is worth noting that residents of both Mifflin and Huntingdon counties also exceed state and national suicide death rates.

The region is largely underserved by mental healthcare services. Juniata and Huntingdon counties are Health Professional Shortage Areas (HPSAs) for mental healthcare for all residents. Mifflin County is a HPSA for individuals with low income.

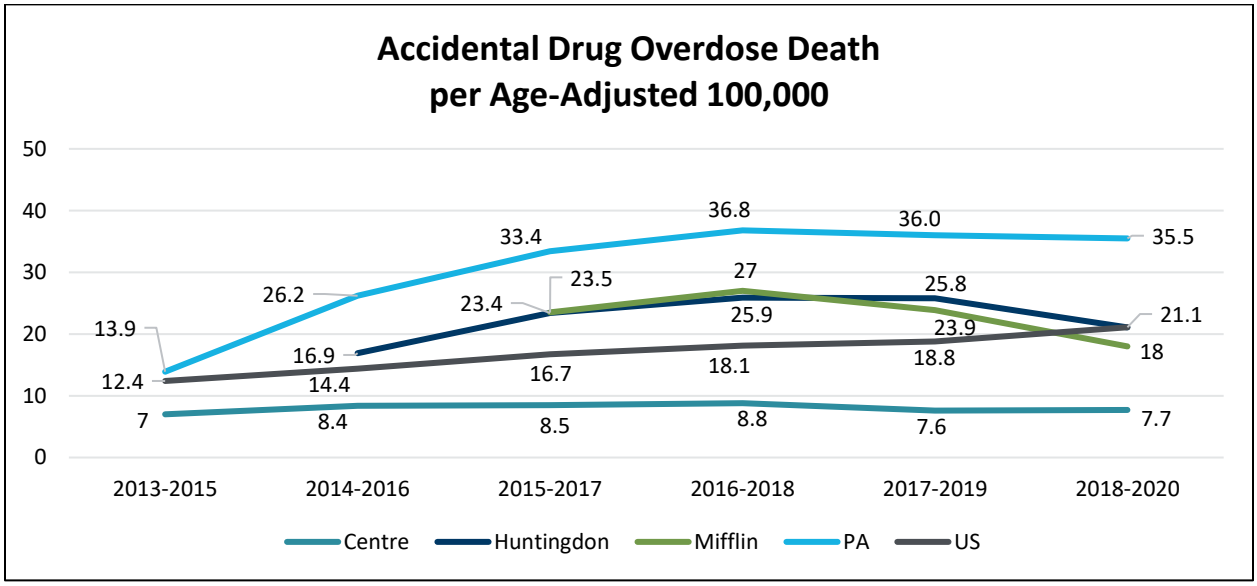
While substance use concerns are still prevalent in the region, counties have historically had fewer hospitalizations or deaths due to drugs like opioids. All counties with reportable data have a lower rate of death due to accidental drug overdose than the state, and death rates declined in Huntingdon and Mifflin counties in recent years.

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





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



Source: Centers for Disease Control and Prevention
Note: Data are not provided by county as available due to low death counts.

Recommendations to Improve Health

Community representatives were engaged throughout the CHNA to reflect on health and social needs for the region and offer recommendations for improvement. These conversations were anchored in building on identified community strengths, including access to healthcare and social services, safe neighborhoods, and good schools. These strengths can be drawn upon to improve the quality of life for all people in the Western 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	*"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."*
Go beyond addressing the immediate need, invest in upstream factors	*"It would be great to see broad community engagement and support to address housing (i.e. bringing together business, developers, Social services, maybe even conservationist groups, funders and private philanthropy to really tackle this issue jointly to create long term viable solutions for affordable and workforce housing."* *"You probably aren't going to be surprised when I say financial support of local social service agencies that address social determinants of health would impact the health of the communities both by strengthening those agencies and by eliminating some of the historical distrust of medical providers by establishing Geisinger/Allies Services/Evan as allies/supporters/partners."* *"Recognize, train and hire individuals in community health worker roles in both healthcare and social service settings. Individuals in these positions can connect and serve individuals and communities to resources and services that promote a healthier lifestyle/setting/community."*

Health Improvement Themes and Supporting Feeback by Community Representatives cont'd

Themes	Verbatim Comments by Community Representatives
Bring services to the community, integrate/co-locate where residents naturally frequent	*"Partnerships like Healthy Kids Day at the Miller Center where families can learn about healthy lifestyles and receive free information about healthy food, bike helmets for kids, be active together, etc. are fantastic! I'd love to see more of that, partnering with the downtown groups/Chambers/Visitors Bureaus in every community."* *"The Fresh Food Farmacy is a wonderful program however the residents of Huntingdon County do not have transportation to this program or access to diabetic education."* *"Many of the resources they need already exist, but it is hard to access – so improved public transportation would be a great benefit."*
Address cultural biases with staff training	*"Providing a personalized experience vs. treating symptoms and moving on in a 10 min appointment. Impersonal surveys at the time of appointment performed by a nurse who is rushing and sometimes making assumptions about a person's situation (or lack of) causes inaccuracies as people are uncomfortable disclosing information if they don't feel as if they are going to be heard and truly listened to."*
Invest in supports for those historically placed at risk (youth, seniors, ALICE, etc.)	*"Educate people about mental health and work with people on ways to de-stress their lives, for example counseling. Invest in the Dream Center Mifflin County to help our community's substance problems. Housing and healthy foods are a concern for the working class. They make too much money for government assistance but yet can't afford decent food and housing for their families."* *"Many of the individuals we care for are below the poverty level that qualify for personal assistant services at home. (Community Health Choices) The need to continue to advocate and educate these individual is very important to keep them living independently."* *"Supporting the local food pantries. The COVID-19 food stamp allocation is about to drop back off and food prices are high."*

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.

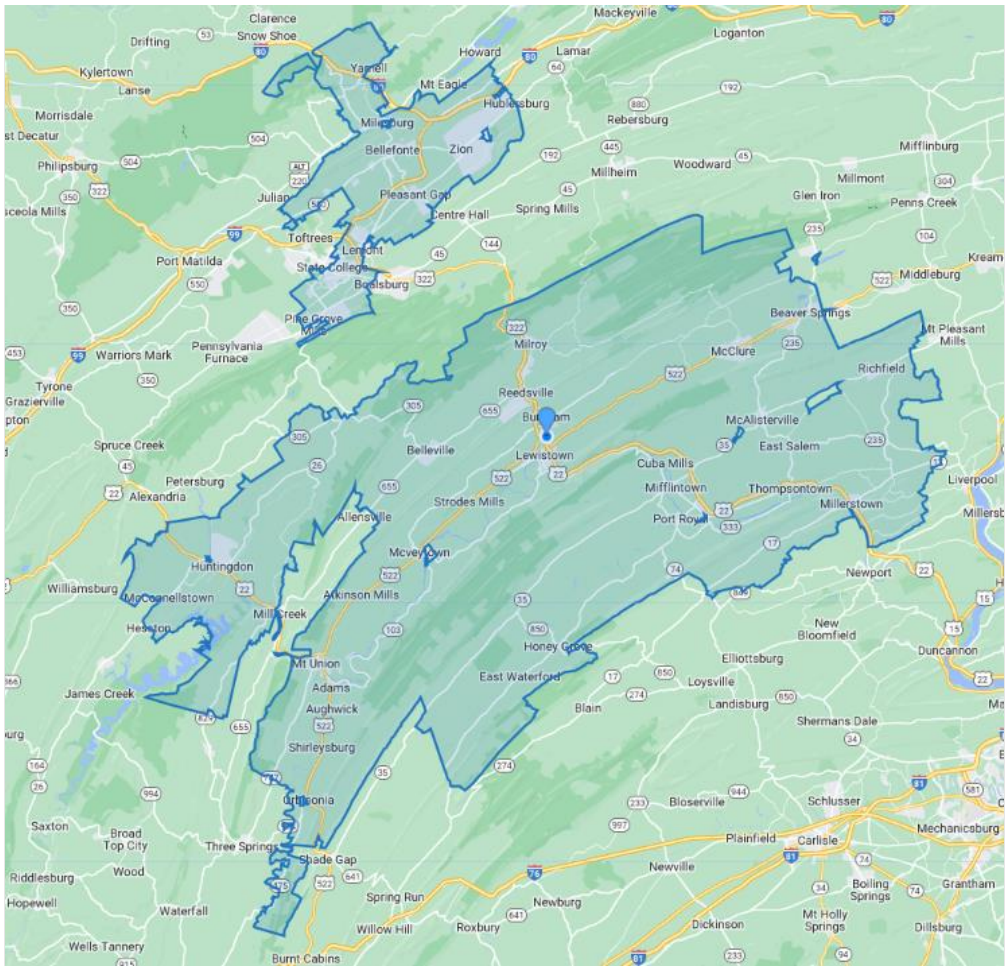
A full summary of CHNA data findings for the Western Region and Geisinger Lewistown Hospital service area, with state and national comparisons, follows.

Geisinger Lewistown Hospital Service Area

Geisinger Lewistown Hospital (GLH) is located in Lewistown, Mifflin County. “Located along the Juniata River, Lewistown is steeped in history and numerous outdoor pursuits. The town is proud of its Civil War heritage as it’s the home of the Logan Guards, one of only five companies to share the honor of being the first U.S. troops to be sent to the capital to answer President Lincoln’s call. Monument Square, situated in the middle of town, serves as a home to the Soldiers and Sailors Monument, a stone from Lincoln’s tomb and a mural, all honoring the Logan Guard. The downtown area is home to many historic structures including the historic courthouse, Embassy Theatre, McCoy House and the Stone Arch Bridge. Its natural setting is great for fishing, hunting, hiking, biking, and walking. Located just of Route 322, Lewistown is situated a short distance from Penn State (visitpa.com, 2023).”

While many GLH patients are residents of Lewistown or the surrounding area, the hospital serves people across central Pennsylvania. For the purposes of the 2024 CHNA, GLH defined its service area as 26 zip codes, primarily within the Western Region. The service area was identified based on the patient zip codes of origin comprising 90% or more of hospital discharges in 2021.

Geisinger Lewistown Hospital Service Area



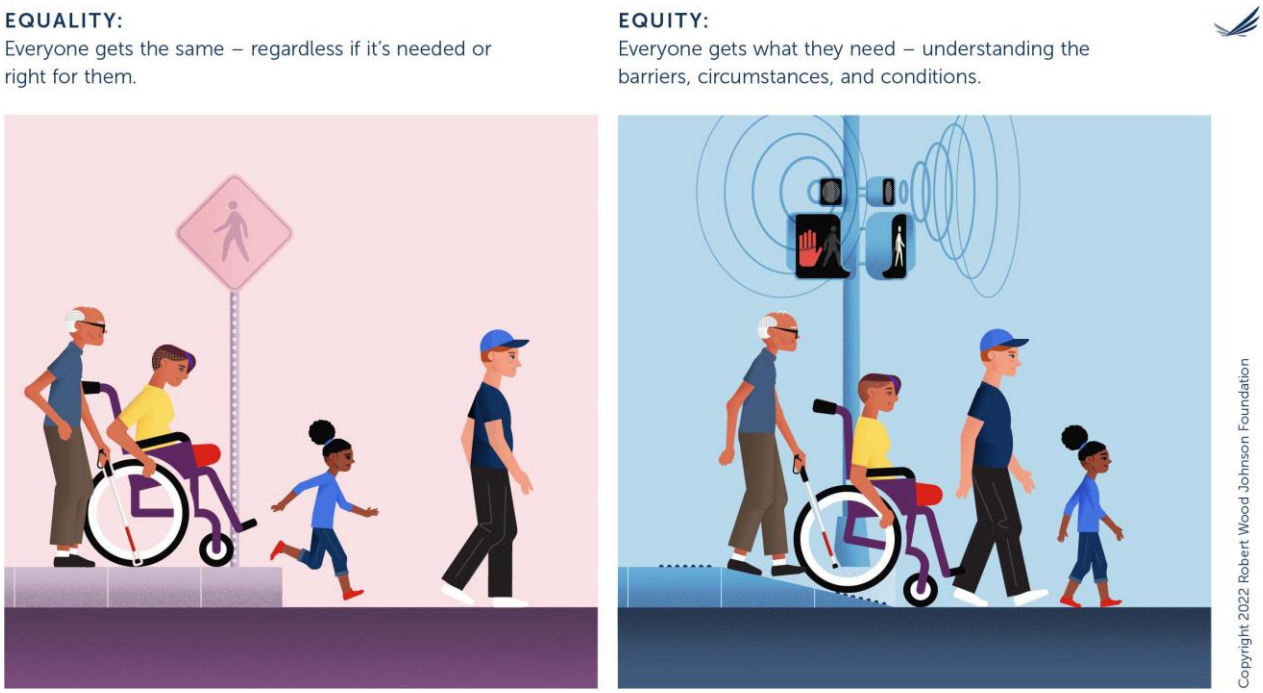
Social Drivers of Health & Health Equity:

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 GLH 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.

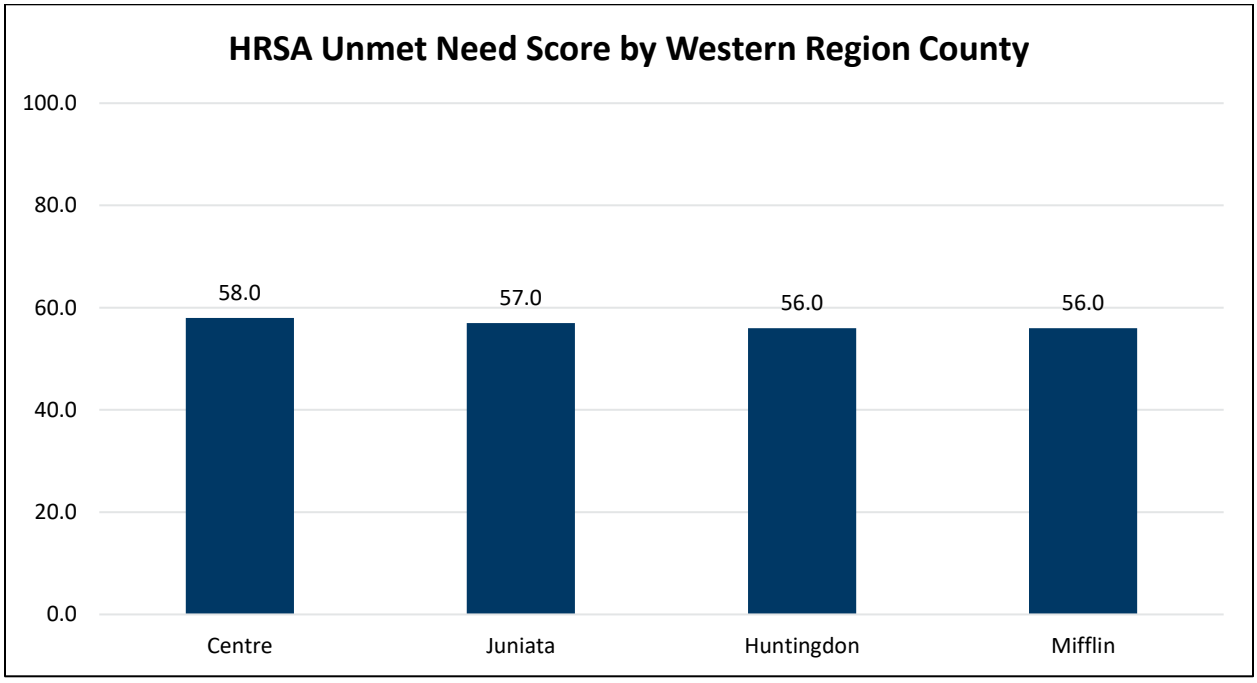
Unmet Need Score and Social Vulnerability Index

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).

Western Region counties have similar UNSs of 56-58, reflecting disparities in upstream social drivers of health like availability of care providers, educational attainment, and transportation, and downstream health outcomes like chronic disease prevalence.

Centre County has the highest UNS in the region, but residents have historically benefited from strong social drivers of health and more positive health outcomes. The data used to calculate the UNS may be skewed by Pennsylvania State University, home to about 46,000 undergraduate students. University students are considered full-time residents of Centre County and may report little to no income. Centre County overall reports the highest average life expectancy in the region of 82.5 years compared to a statewide average of 78 years.

Residents of Juniata and Mifflin counties have historically experienced more negative health outcomes, and when analyzed by zip code, communities with an UNS exceeding 65 are almost exclusively located within these counties. It is worth noting that while no individual community in Huntingdon County reports a high UNS, health disparities experienced by residents are similar to those experienced by Juniata and Mifflin county residents, including limited access to community health resources, health risk factors, and disease prevalence.



Source: Health Resources and Services Administration

2018-2020 Life Expectancy by Race and Ethnicity

	Overall Life Expectancy	Asian	Black	White	Latinx Origin (any race)
Centre	82.5	93.8	83.0	89.8	82.2
Huntingdon	78.3	NA	75.3	78.1	NA
Juniata	78.9	NA	NA	NA	NA
Mifflin	76.9	NA	NA	NA	NA
Pennsylvania	78.0	87.3	73.1	78.4	81.5

Source: National Vital Statistics System

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

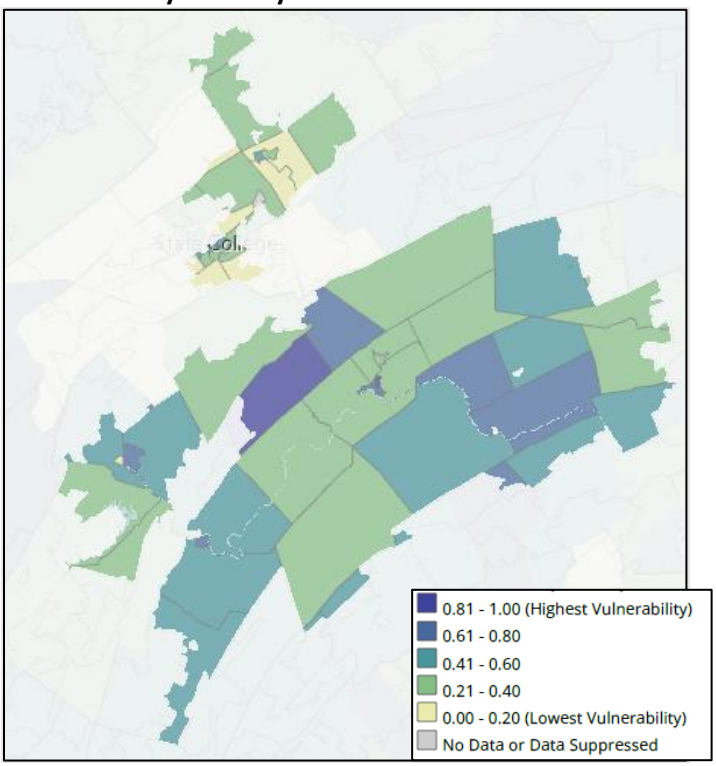
Zip Code (County)	Population in Poverty	Children in Poverty	No High School Diploma	No Health Insurance	UNS Score
17004, Belleville (Mifflin)	15.1%	27.3%	25.5%	40.4%	86.8
17002, Allensville (Mifflin)	17.5%	28.9%	41.0%	24.0%	84.8
17084, Reedsville (Mifflin)	10.4%	21.6%	18.2%	25.1%	80.2
17063, Milroy (Mifflin)	11.8%	9.7%	14.1%	20.4%	80.0
17035, Honey Grove (Juniata)	11.3%	19.2%	19.5%	8.8%	76.9
17841, McClure (Mifflin)	17.3%	32.6%	15.9%	9.6%	75.3
16866, Philipsburg (Centre)	19.7%	32.6%	15.4%	3.5%	74.0
17059, Mifflintown (Juniata)	15.8%	20.9%	17.3%	13.5%	70.0
17058, Mifflin (Juniata)	10.6%	5.1%	15.5%	8.1%	69.1
Pennsylvania	11.8%	16.4%	8.6%	5.6%	NA

Source: US Census Bureau, American Community Survey

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 GLH primary service area.

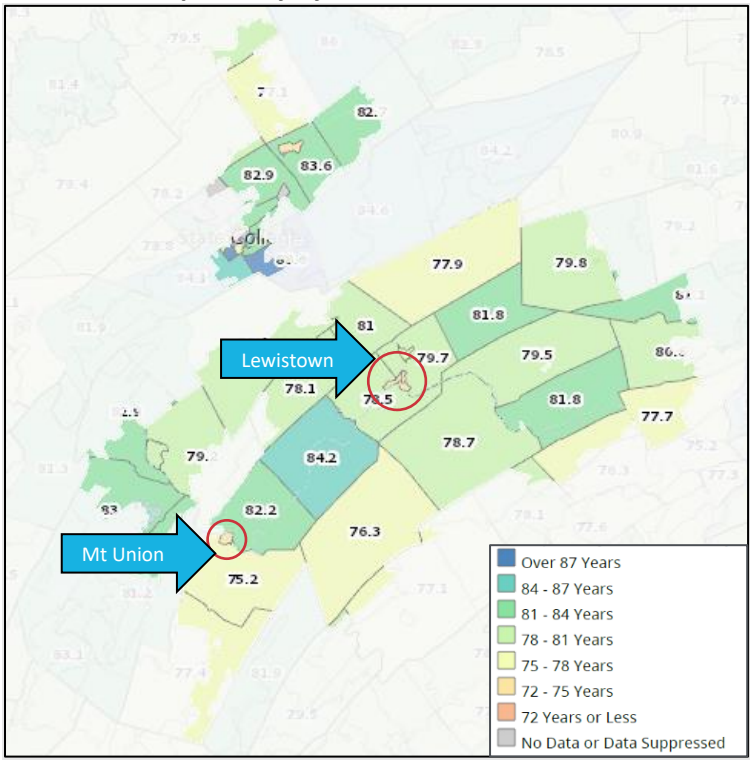
Consistent with UNS findings, areas of social vulnerability within the GLH primary service area are concentrated in Juniata and Mifflin counties and are associated with significant health disparities. **In the outer portions of these counties and Lewistown, the county seat of Mifflin County, social vulnerabilities contribute to as much as a 10-year difference in average life expectancy from neighboring communities.** Lewistown residents have the lowest average life expectancy in the service area of approximately 73-75 years. Similar disparities are seen in Mount Union in Huntingdon County, where residents live an average of 74.6 years.

Social Vulnerability Index by Census Tract within GLH Service Area



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

2010-2015 Life Expectancy by Census Tract within GLH 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 75 years or less.

Asset Limited Income Constrained Employed (ALICE)

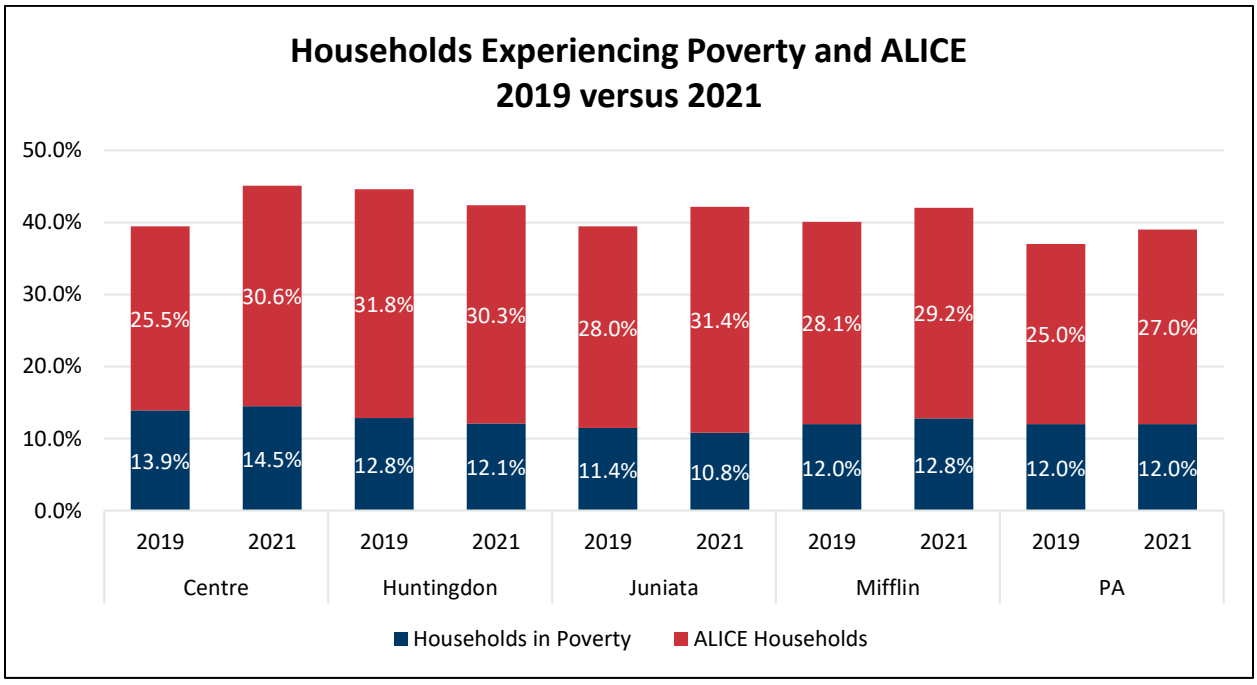
The ALICE index captures the percent of households whose income is above the federal poverty level, but below the threshold necessary to meet all basic needs based on localized cost of living and average household sizes. ALICE measures the proportion of households who struggle to meet basic needs and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

Across Western Region counties in 2021, nearly one-third of households were ALICE compared to one-quarter statewide. When combined with households living in poverty, more than 40% of all households in the region 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.

Statewide, the percentage of people 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.

Juniata County saw a similar trend in ALICE households as the state overall, but Centre, Huntingdon, and Mifflin counties differed in important ways. In Huntingdon County, both households experiencing poverty and ALICE households declined from 2019 to 2021, potentially indicating improving economic well-being. **In Centre and Mifflin counties, both households experiencing poverty and ALICE households increased from 2019 to 2021, potentially indicating growing financial hardship for residents.**



Source: United for ALICE

Note: Centre County data are likely skewed by the Pennsylvania State University student population.

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 Western 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.**

Identified needs for older adults varied by county, but it is worth noting the need for childcare services among older adults in Mifflin County. Mifflin County has some of the lowest availability of childcare services in the region at half the rate of the statewide average. This identified need among screened patients may speak to the use of grandparents and other elders in a caregiver role, beyond their capacity.

Geisinger Universal Health Risk Assessment Western Region Patient Results

Top Identified Social Needs	Centre	Juniata	Mifflin	Huntingdon
Top Need (All Adults)	Employment (4.4%, n=404)	Employment (4.3%, n=243)	Employment (4.0%, n=421)	Connections (4.9%, n=75)
Adults aged 18-64	Employment (5.9%, n=385)	Employment (6.6%, n=229)	Employment (6.0%, n=405)	Connections (6.4%, n=66)
Adults aged 65 or older	Transportation (2.1%, n=56)	Utilities (2.3%, n=51)	Childcare (2.4%, n=92)	Clothing (3.3%, n=16)
Top Need (All Households)	Clothing (8.7%, n=234)	Clothing (7.2%, n=100)	Clothing (9.8%, n=283)	Clothing (10.2%, n=31)
Households with children under 18 years	Clothing (8.7%, n=234)	Clothing (7.2%, n=100)	Clothing (9.8%, n=283)	Clothing (10.2%, n=31)

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

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

Demographics: Who Lives in the Western Region?

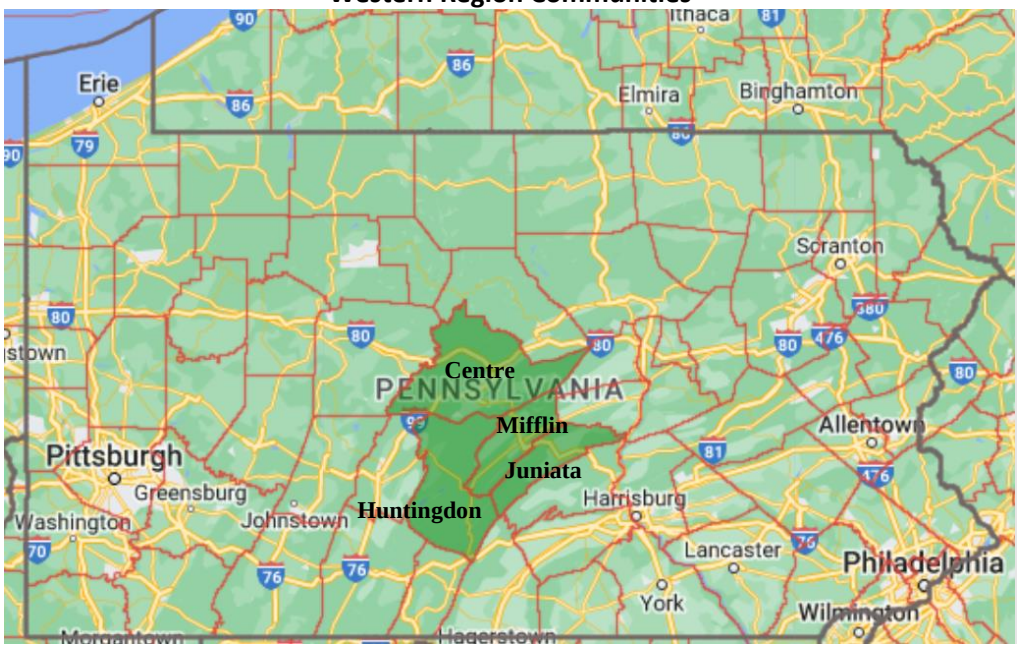
Our Community and Residents

Consistent with Pennsylvania overall, the Western Region is aging, with a significant increase in the number of older adults from 2010 to 2021 in all counties. In contrast, the youth population declined across all counties in the region, and by as much as 10%-13% in Juniata and Huntingdon counties.

Huntingdon, Juniata, and Mifflin counties have a similar age profile that is older than state and national benchmarks. Approximately one-fifth of residents in these counties are aged 65 or older. In select communities in Huntingdon and Juniata counties, mapped in the following pages, as many as one-third of residents are aged 65 or older.

Centre County is an outlier in the region for most demographic, socioeconomic, and health outcomes. It was the only county to see population growth from 2010 to 2021, estimated at 5%. The county is also home to a much younger population, due in large part to the Penn State University student body.

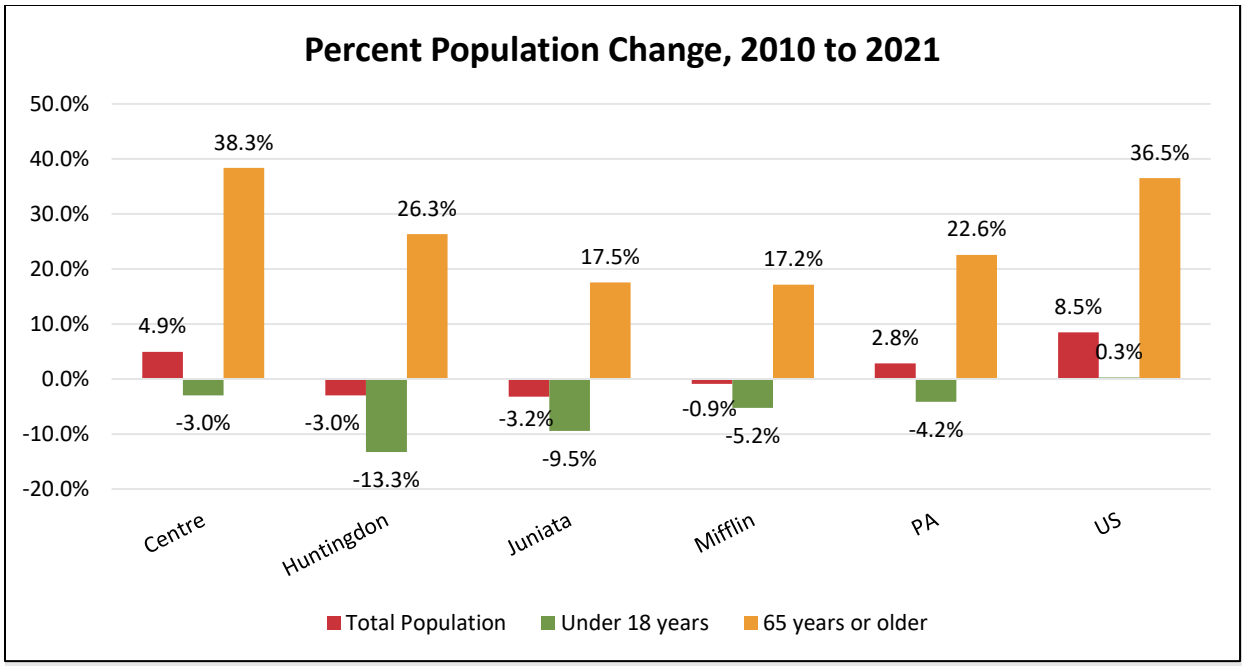
Western Region Communities



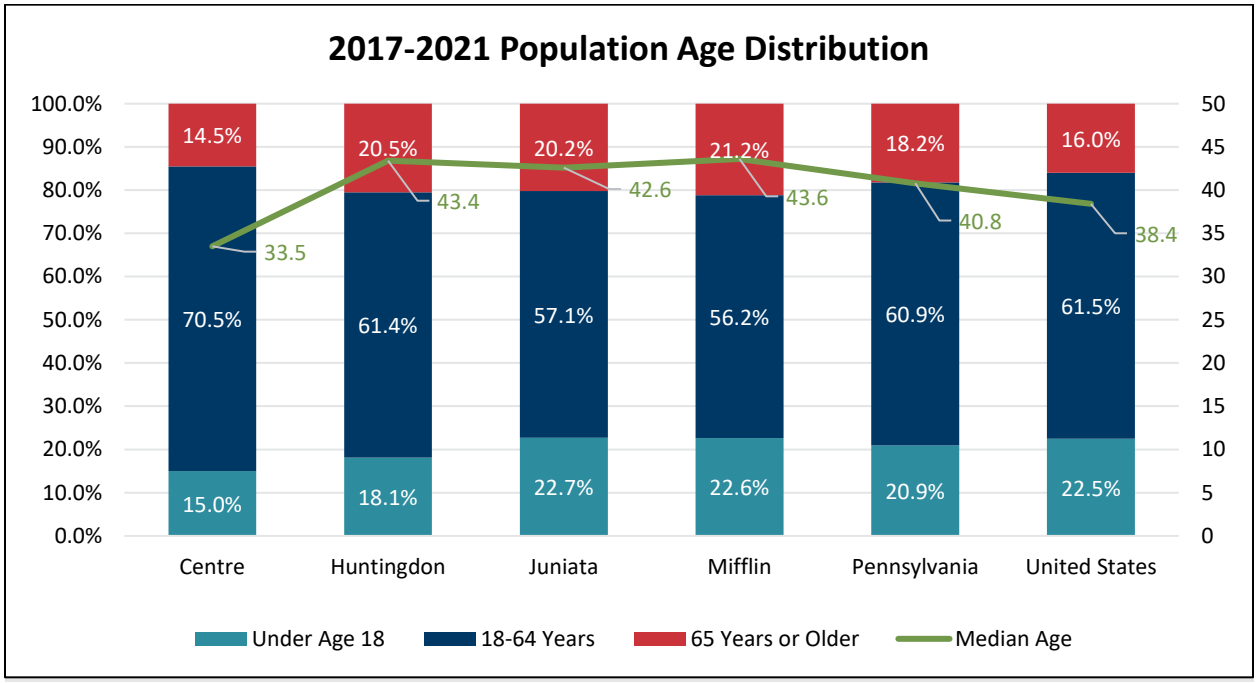
2017-2021 Total Population

	Total Population
Centre	158,879
Huntingdon	44,458
Juniata	23,607
Mifflin	46,156
Pennsylvania	12,970,650
United States	329,725,481

Source: US Census Bureau, American Community Survey

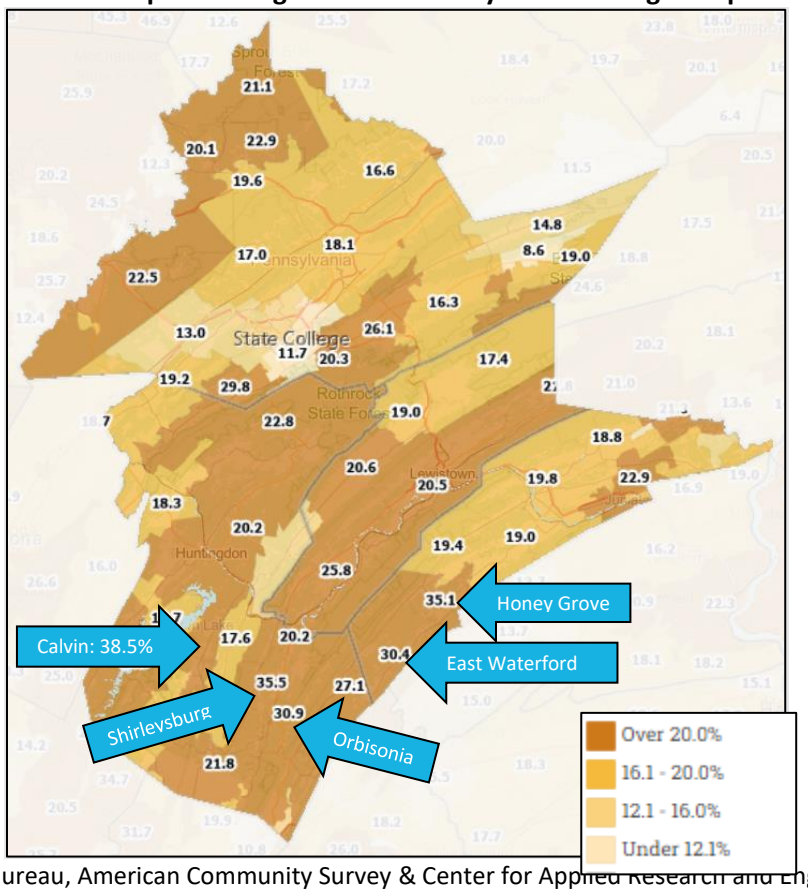


Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

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



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

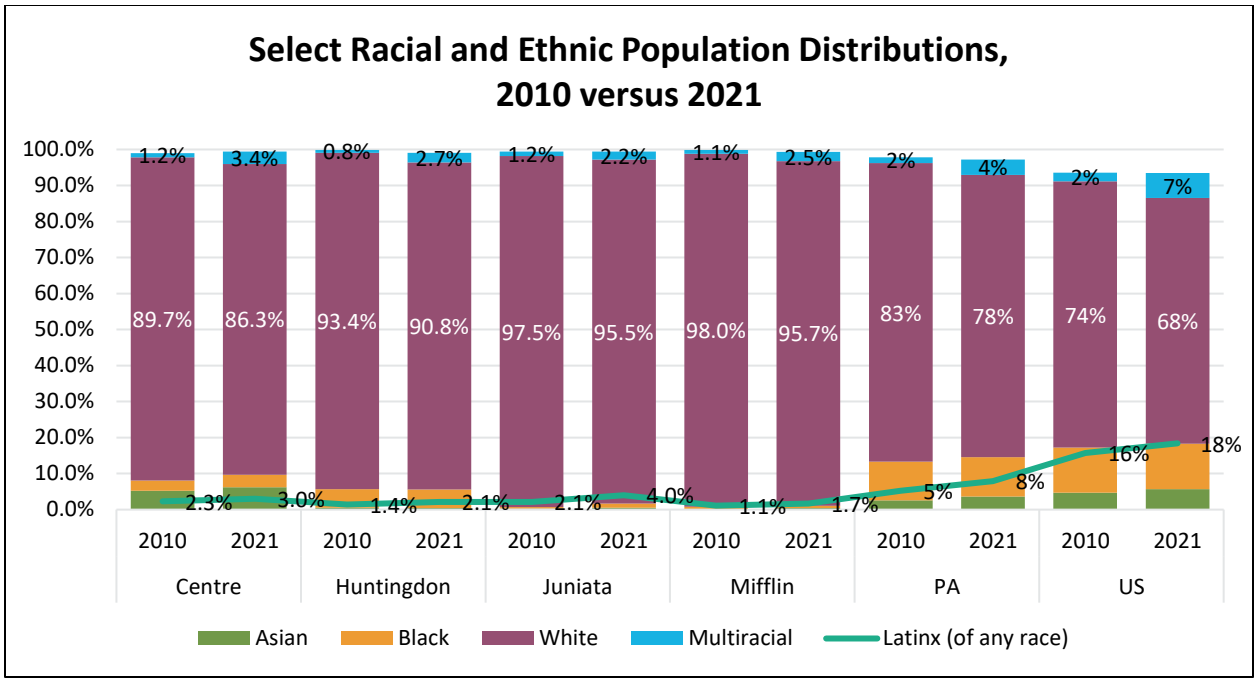
Western Region counties are majority white communities with less racial diversity than state and national benchmarks. Centre County benefits from the most population diversity with 14% of residents identifying with a race other than white and 3% identifying as Latinx (any race).

Consistent with state and national trends, population diversity is increasing within the region, though only marginally. In all four counties, from 2010 to 2021, the white population as a proportion of the total population declined 2-3 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)
Centre	0.1%	6.2%	3.5%	0.0%	86.3%	0.4%	3.4%	3.0%
Huntingdon	0.2%	0.4%	5.2%	0.0%	90.8%	0.7%	2.7%	2.1%
Juniata	0.0%	0.5%	1.2%	0.0%	95.5%	0.6%	2.2%	4.0%
Mifflin	0.2%	0.4%	0.7%	0.0%	95.7%	0.6%	2.5%	1.7%
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



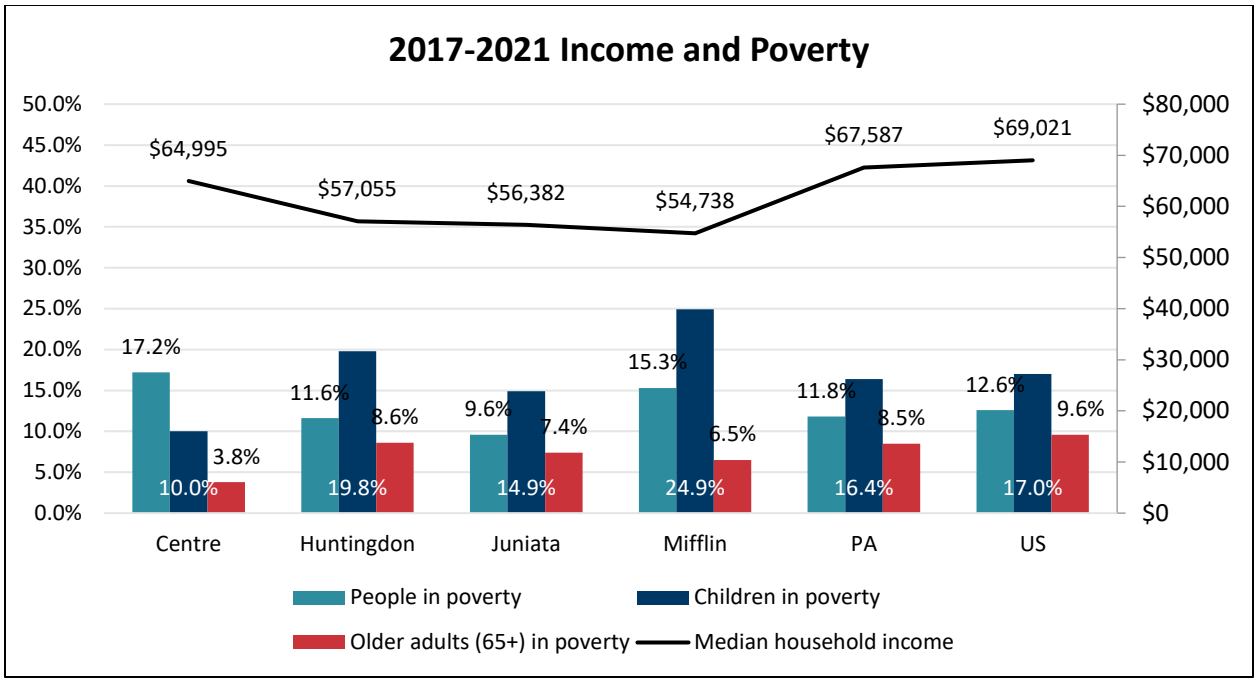
Source: US Census Bureau, American Community Survey

Income and Work

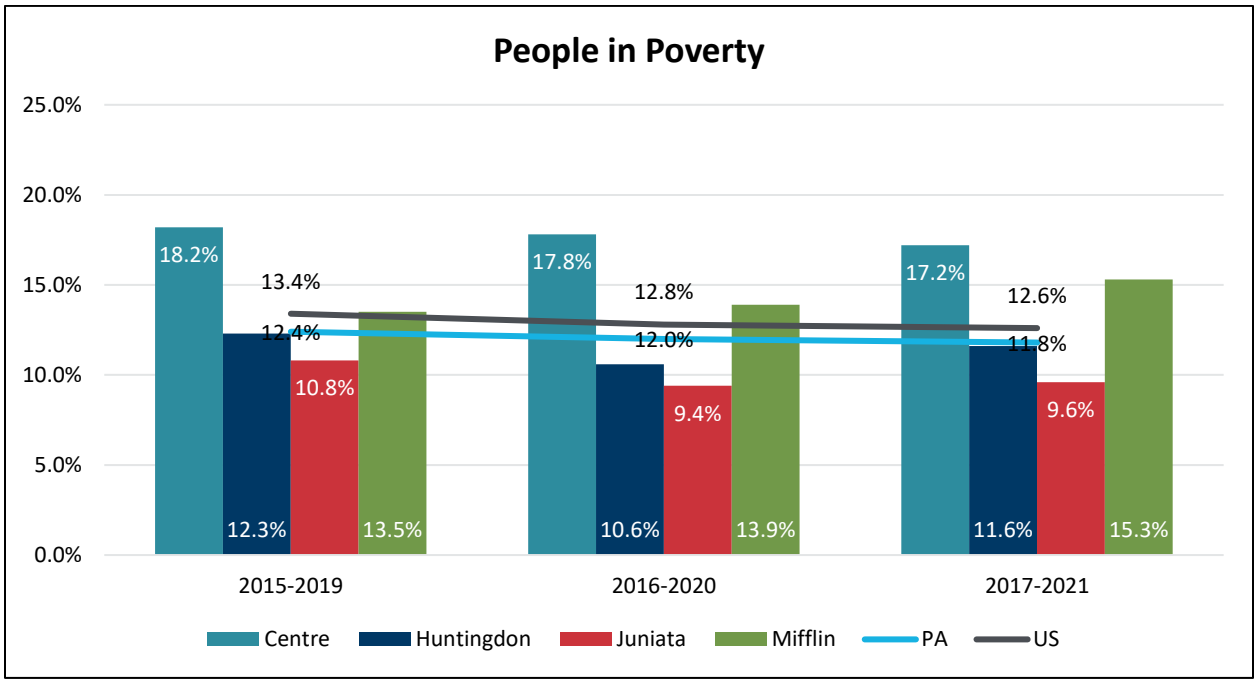
All Western Region counties have lower median household incomes than state and national medians, although county-wide poverty levels are only elevated in Huntingdon and Mifflin. **Of note, 20% of children in Huntingdon County live in poverty.** Mifflin County is home to a large Plain Community, which likely contributes to its high reported percentage of children living in poverty. While Plain People report low income, they are generally highly skilled and specialized in rural life.

A high proportion of Centre County residents are reported to live in poverty, but this indicator is inflated by university students who report little or no income. Child poverty is a more accurate measure of economic stability for Centre County and generally indicates widespread economic strength.

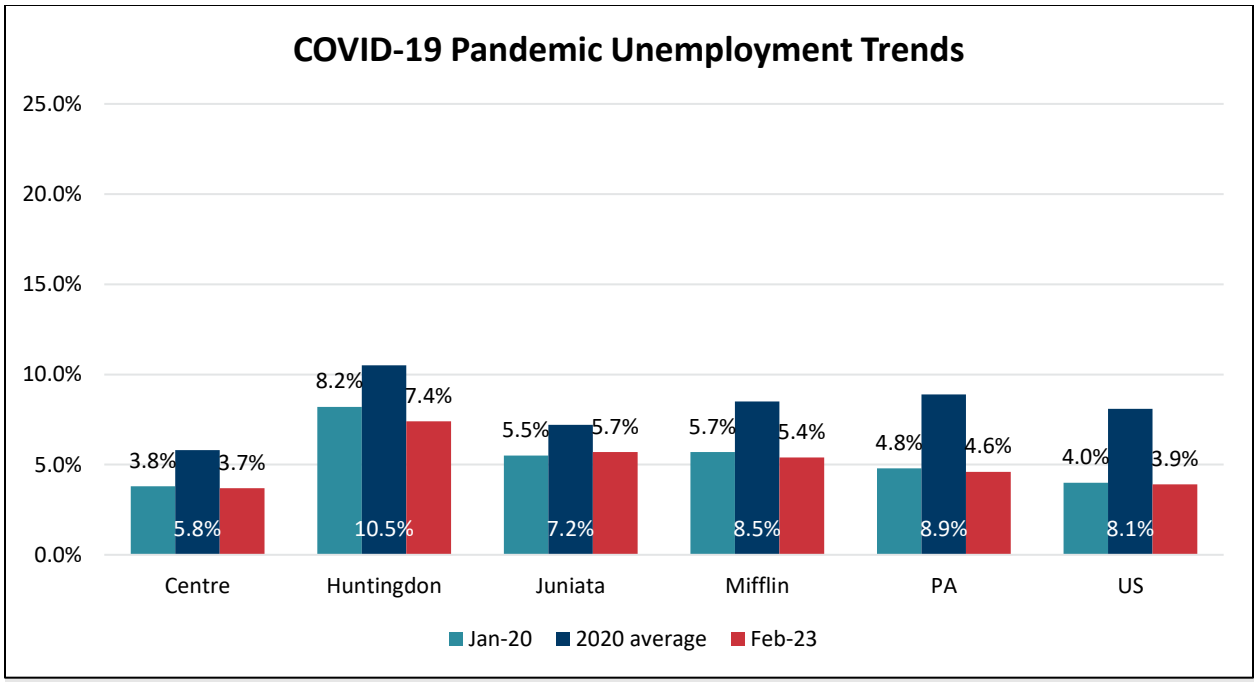
Overall, despite a dramatic uptick in unemployment rates at the height of the COVID-19 pandemic, unemployment rates are down and on par with or lower than pre-pandemic levels. **However, reports of financial hardship remain. ALICE and poverty data demonstrate that although people are working, many still do not have enough money to meet their basic needs, or to do so without the fear of an unexpected expense.** The percentage of ALICE households increased from 2019 to 2021 in all counties except Huntingdon. Notably, individual poverty levels also increased in Mifflin County.



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

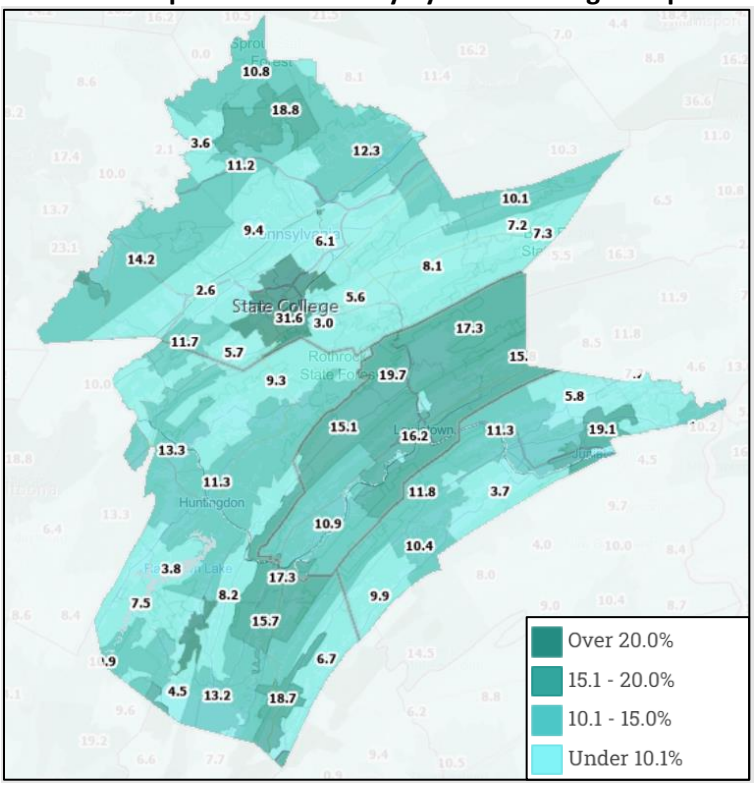


Source: US Bureau of Labor Statistics

When analyzed by zip code, pockets of high poverty exist in all Western Region counties and disproportionately affect children. **In northern Centre County, Milroy and Reedsville in Mifflin County, Thompsontown in Juniata County, and Cassville in Huntingdon County, approximately one-third or more of children live in poverty.**

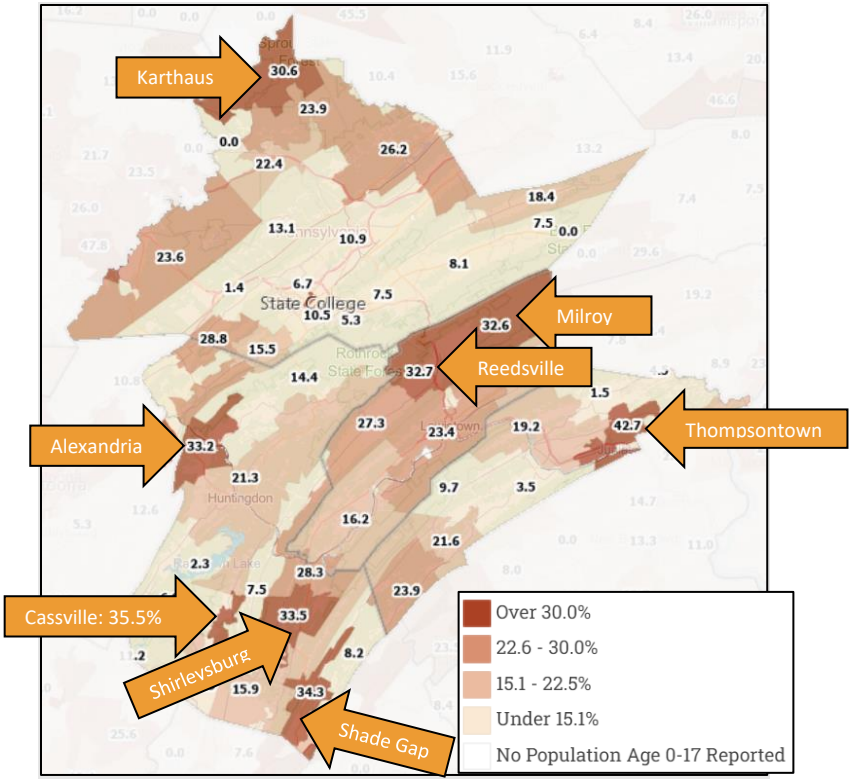
Poverty is not experienced by every community equally and contributes to further inequalities such as access to safe living and working conditions, health services, and basic needs, among other things. While the Western Region overall is less racially and ethnically diverse than other communities, significant socioeconomic disparities affect residents of color. In Centre and Mifflin counties, 20%-40% of Black and Latinx residents live in poverty compared to 15% of white residents living in the same community. In Juniata County, 77% of Asian residents (n=92) are estimated to live in poverty.

2017-2021 Population in Poverty by Western Region Zip Code

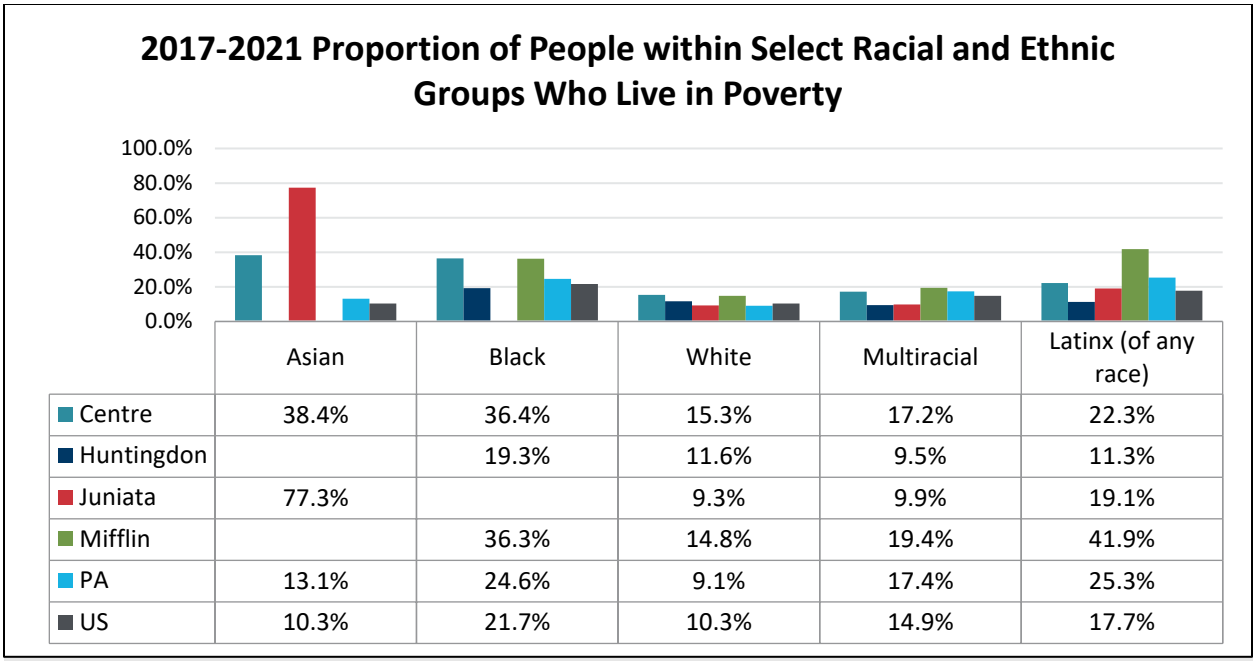


Source: US Census Bureau, American Community Survey & Center for Applied Research and Engagement Systems

2017-2021 Children in Poverty by Western Region Zip Code



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

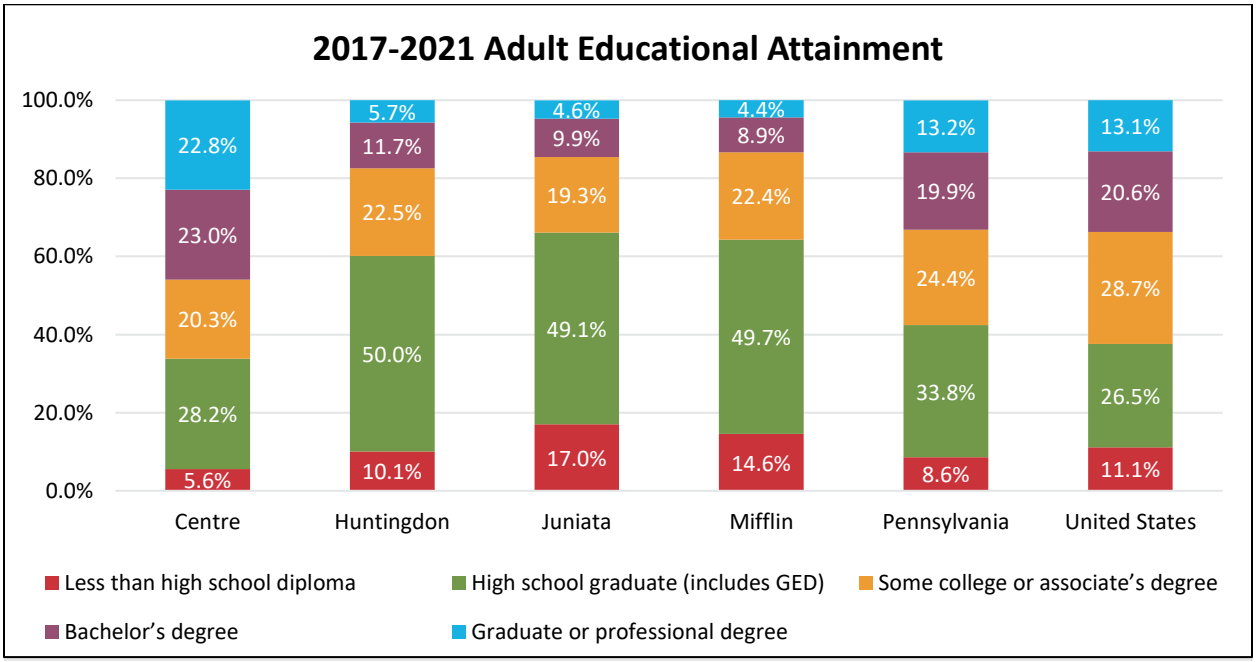


	Asian	Black	White	Multiracial	Latinx (of any race)
Centre	38.4%	36.4%	15.3%	17.2%	22.3%
Huntingdon		19.3%	11.6%	9.5%	11.3%
Juniata	77.3%		9.3%	9.9%	19.1%
Mifflin		36.3%	14.8%	19.4%	41.9%
PA	13.1%	24.6%	9.1%	17.4%	25.3%
US	10.3%	21.7%	10.3%	14.9%	17.7%

Source: US Census Bureau, American Community Survey
Note: Data for Western 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. High school graduation rates vary widely within the Western Region, ranging from 83% in Juniata County to 94% in Centre County. Outside of Centre County, adults are generally less likely to pursue or attain higher education, such as a bachelor's or graduate degree.



Source: US Census Bureau, American Community Survey

Our Homes and Where We Live

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

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

In general, outside of Centre County, Western Region residents are more likely to own their home when compared to state and national benchmarks. Homeownership rates in Centre County are impacted by Penn State University students.

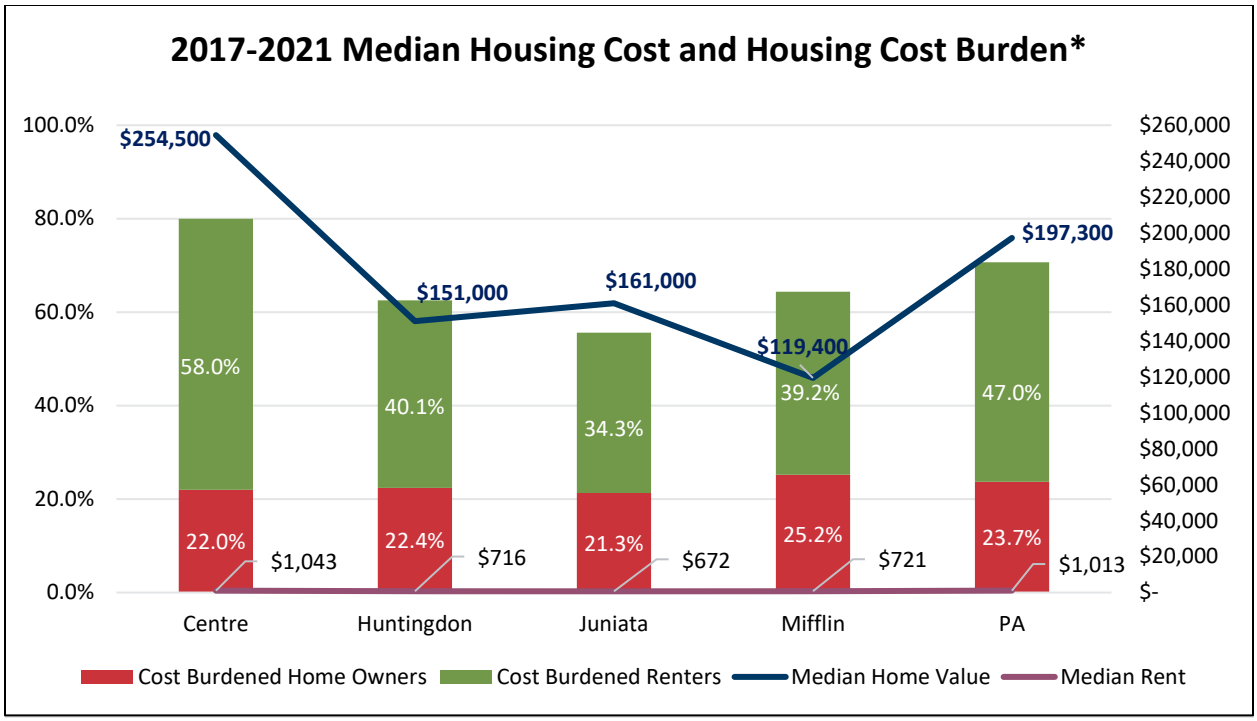
2017-2021 Housing Occupancy

	Owner Occupied Units	Renter Occupied Units
Centre	63.1%	36.9%
Huntingdon	78.0%	22.0%
Juniata	74.0%	26.0%
Mifflin	72.3%	27.7%
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 Western Region is no exception to these trends. Huntingdon, Juniata, and Mifflin counties have the highest percentage of homeowners and boast the lowest percentages of cost-burdened homeowners, meaning that housing costs are relatively affordable; however, more than 20% of homeowners and approximately 40% of renters in these counties *still* meet the criteria of being cost-burdened.



Source: US Census Bureau, American Community Survey

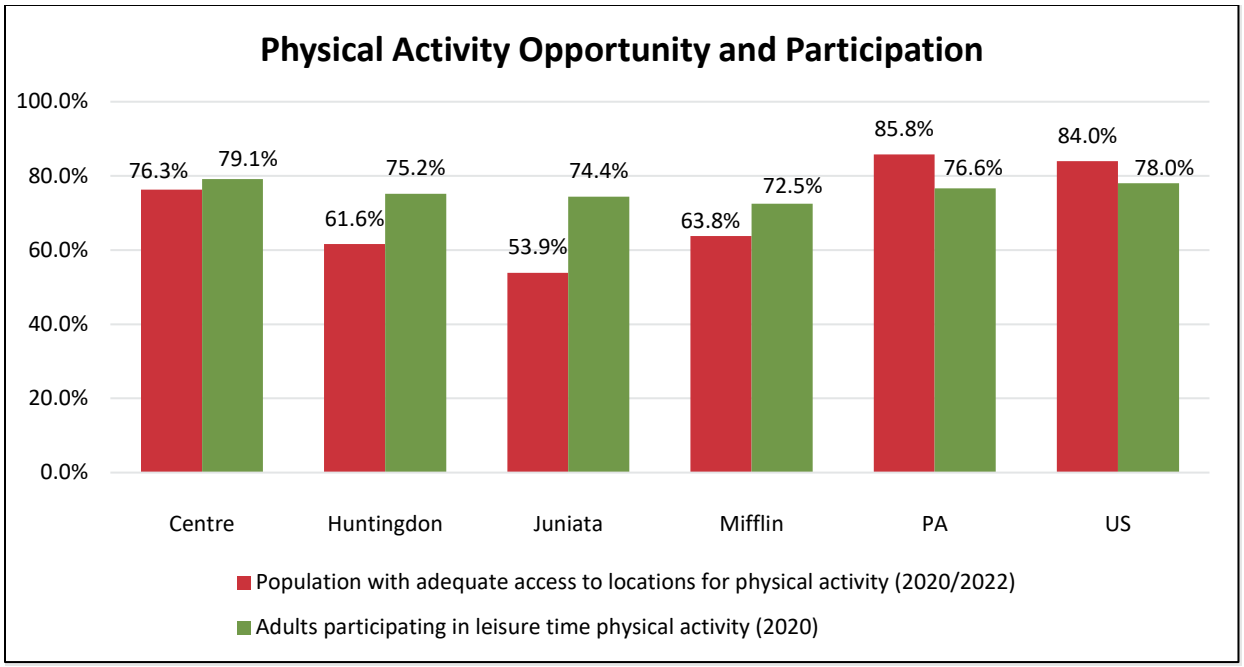
*Defined as spending 30% or more of household income on rent or mortgage expenses.

Neighborhood and Built Environment

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

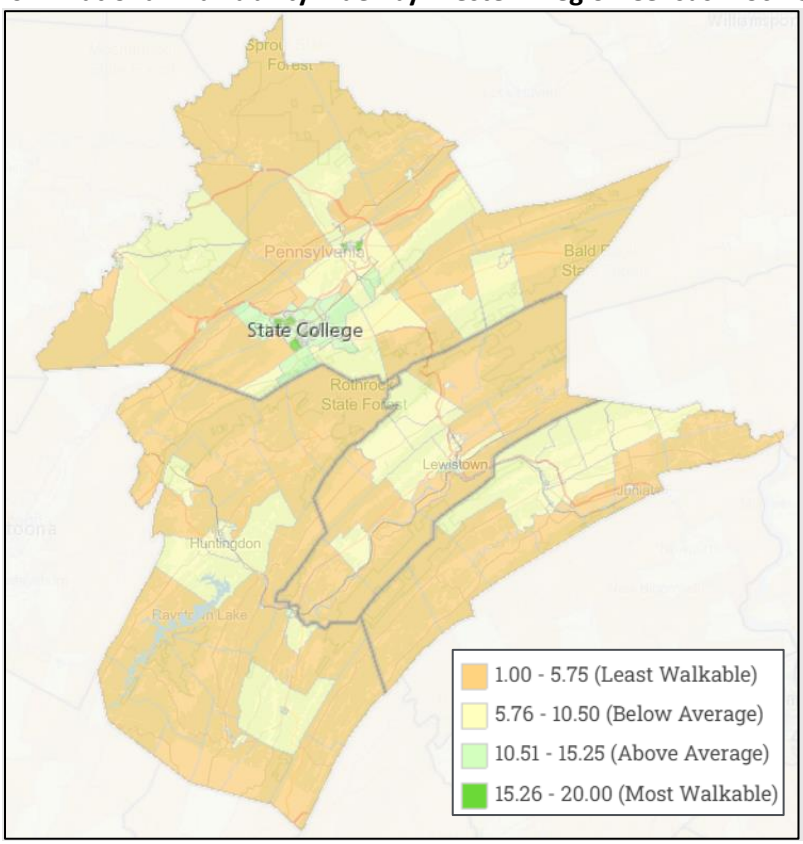
Feedback from Key Stakeholder Survey participants centered around the scarcity of reliable and affordable public transportation options available to residents. Combined with a region that is, on the whole, "below average" in its walkability rating, as well as a rapidly aging population, it can be difficult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

Despite these concerns, residents of the Western Region have demonstrated resilience in prioritizing physical activity. Huntingdon, Juniata, and Mifflin counties are far below Centre County, 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 Western 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.

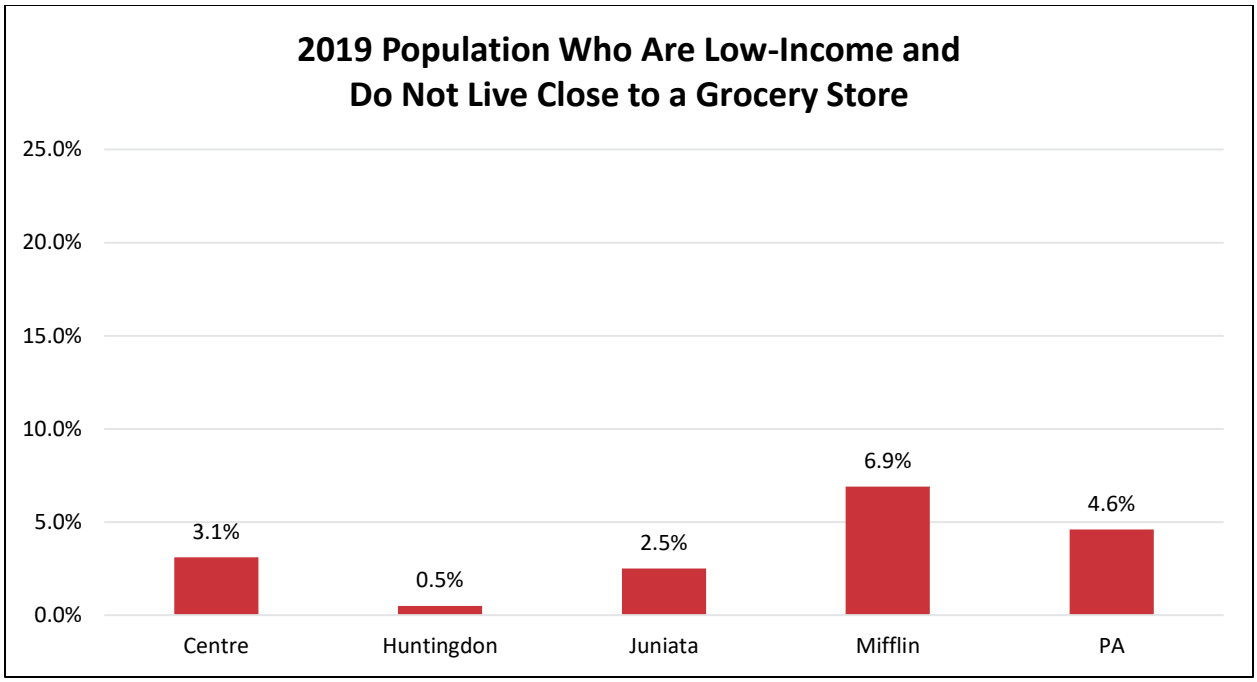
Across the Western Region in 2021, approximately 1 in 10 residents were estimated to be food insecure. **Outside of Centre County, children are more likely to experience food insecurity than the general population; however, the percentage of children experiencing food insecurity declined *more rapidly*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

It is worth noting disparities among individuals with low income living in Mifflin County. **Mifflin County overall has a higher proportion of residents living in poverty and/or experiencing food insecurity as neighboring communities, and approximately 7% of residents with low income do not live close to a grocery store, the highest proportion in the region.** Mifflin County's rural status likely contributes to residents' – including low-income residents' – distance from grocery stores, compounding health and financial hardships.

Food Insecurity

	Centre	Huntingdon	Juniata	Mifflin	PA	US
Food Insecure Residents						
2021	7.9%	10.4%	8.7%	11.5%	9.4%	10.4%
2020	8.4%	11.6%	9.5%	12.1%	8.9%	11.8%
2019	9.3%	12.2%	10.7%	12.4%	10.6%	10.9%
Food Insecure Children						
2021	5.7%	14.0%	9.5%	14.1%	12.2%	12.8%
2020	7.5%	16.8%	12.8%	16.8%	13.1%	16.1%
2019	9.6%	18.2%	14.5%	17.7%	14.7%	14.6%

Source: Feeding America & USDA Food Environment Atlas



Source: Health Resources and Services Administration

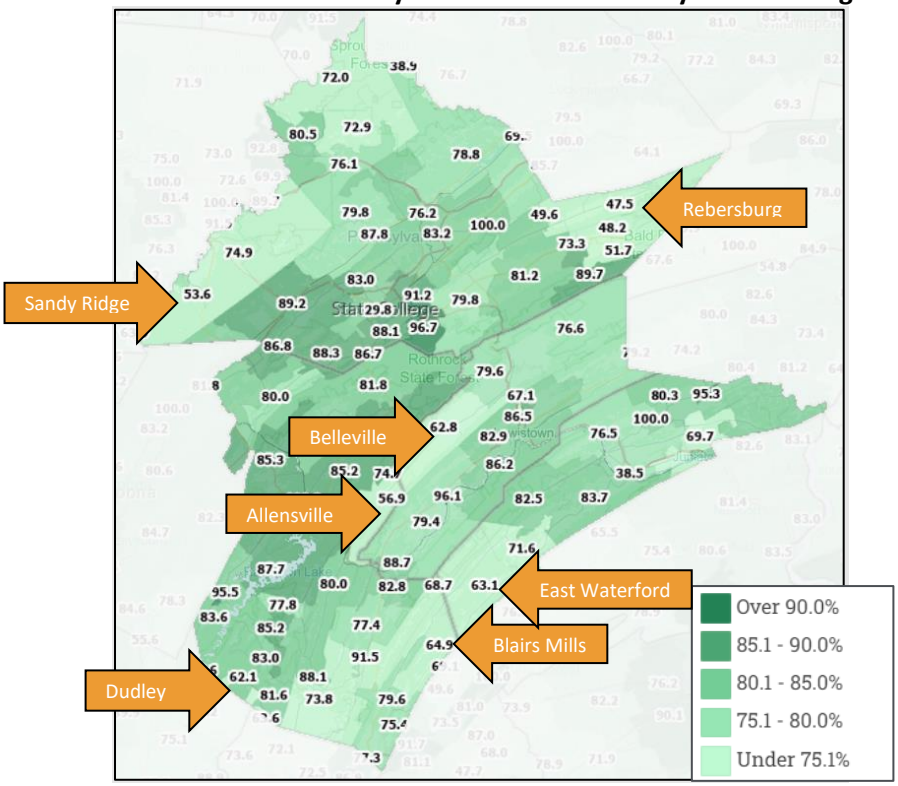
During the COVID pandemic, we were able to use technology to bring services to people in their homes, but not uniformly. We need to bridge the wide digital divide within our communities to effectively reach all residents. Outside of Centre County, residents of Western Region counties generally have lower digital access as compared to state and national benchmarks, particularly broadband internet access. **Broadband internet access varies widely across the region with fewer than 65% of residents of select communities having access, as highlighted on the map below.**

2017-2021 Households by Digital Access

	With Computer Access			With Internet Access	
	Computer Device	Desktop / Laptop	Smartphone	Internet Subscription	Broadband Internet
Centre	92.4%	83.9%	84.0%	84.0%	83.6%
Huntingdon	87.7%	71.7%	72.6%	82.7%	81.9%
Juniata	81.9%	64.9%	69.7%	78.8%	77.7%
Mifflin	84.4%	66.4%	73.2%	80.4%	79.7%
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 Western 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 (0.7 per 1,000 children under age 5 in Juniata County), as well as the prohibitive cost. **Residents with small children may spend approximately 25% of their income on just childcare.**

Childcare Availability and Affordability

	Number of Childcare Centers per 1,000 Population Under 5 Years Old	Childcare Costs for a Household with Two Children as a Percent of Median Household Income
Centre	8.8	23.4%
Huntingdon	3.6	27.8%
Juniata	0.7	22.5%
Mifflin	2.7	29.5%
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

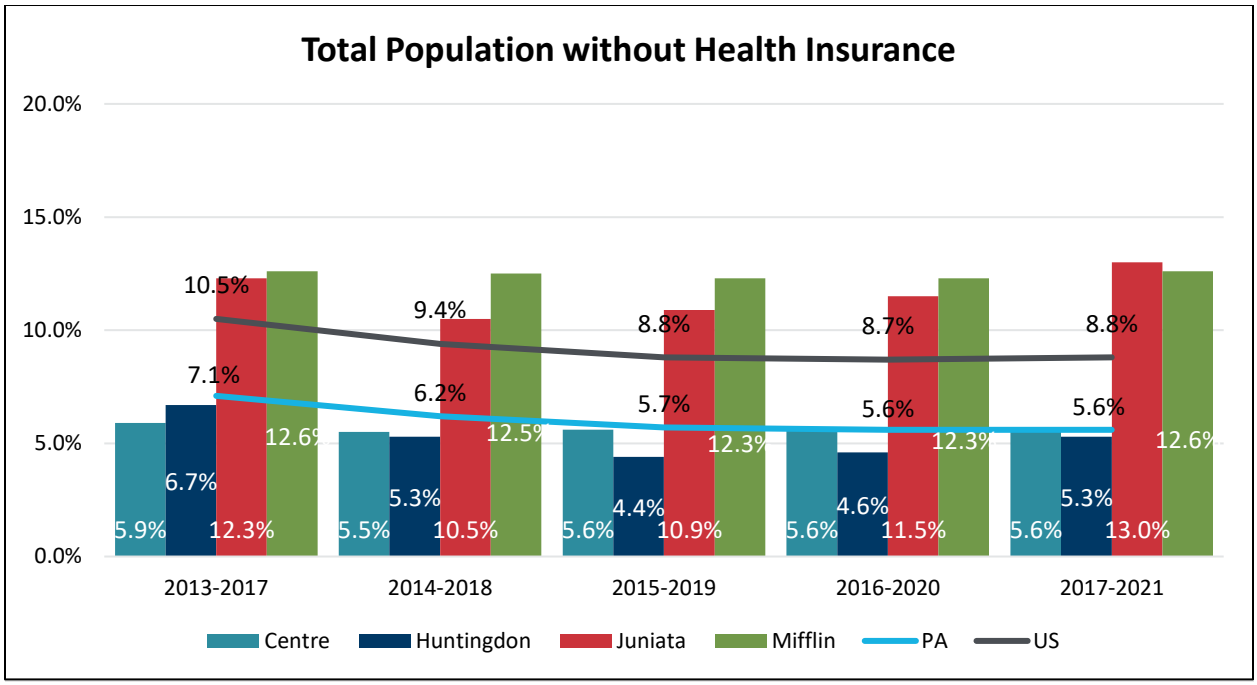
Access to Care

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.

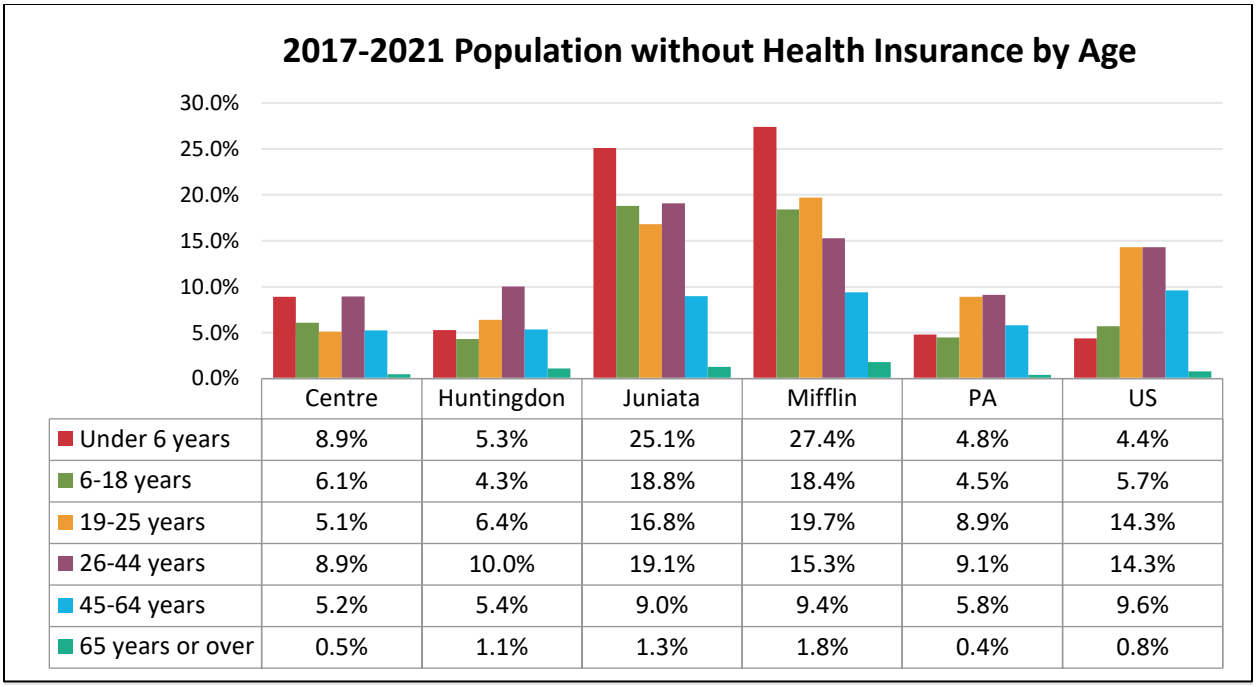
While many Western Region residents *have* health insurance, there is a relatively high percentage of individuals who are uninsured in Juniata and Mifflin counties. This finding may reflect, in part, Plain Community members who do not participate in health insurance programs. It may also present an opportunity for community awareness and education around the PA Children's Health Insurance Program (CHIP) and eligibility for young adults under their guardian as part of the Affordable Care Act.

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 Western 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.

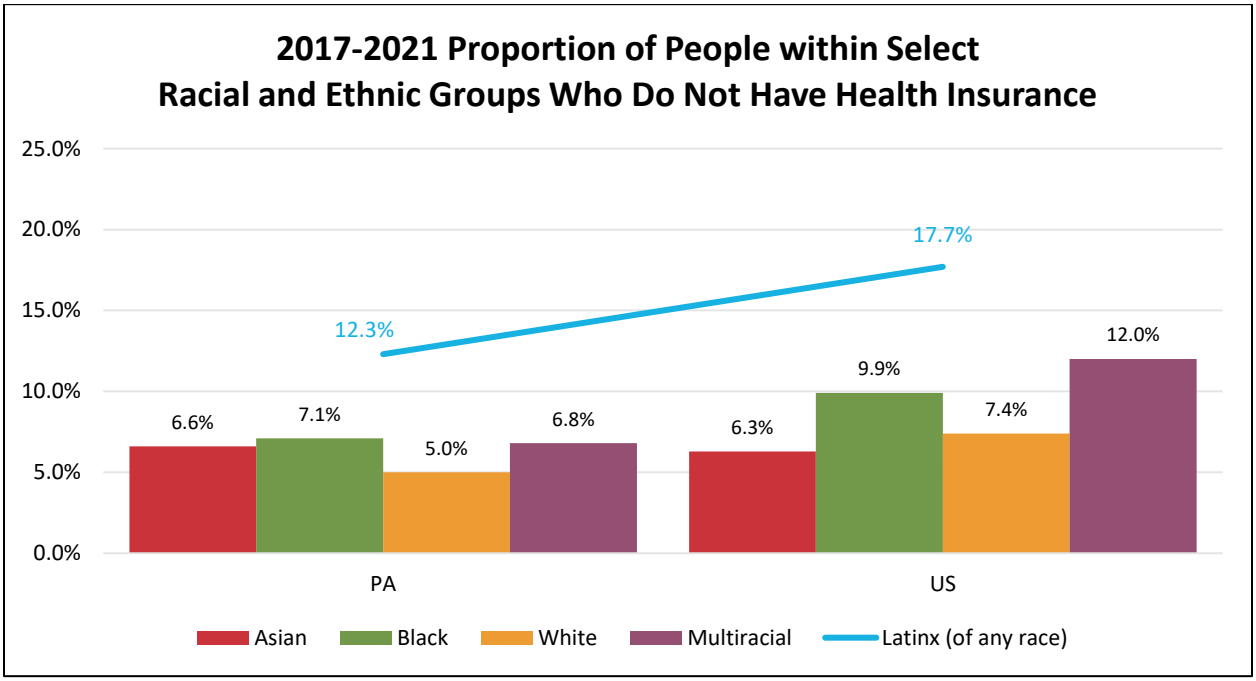


Source: US Census Bureau, American Community Survey

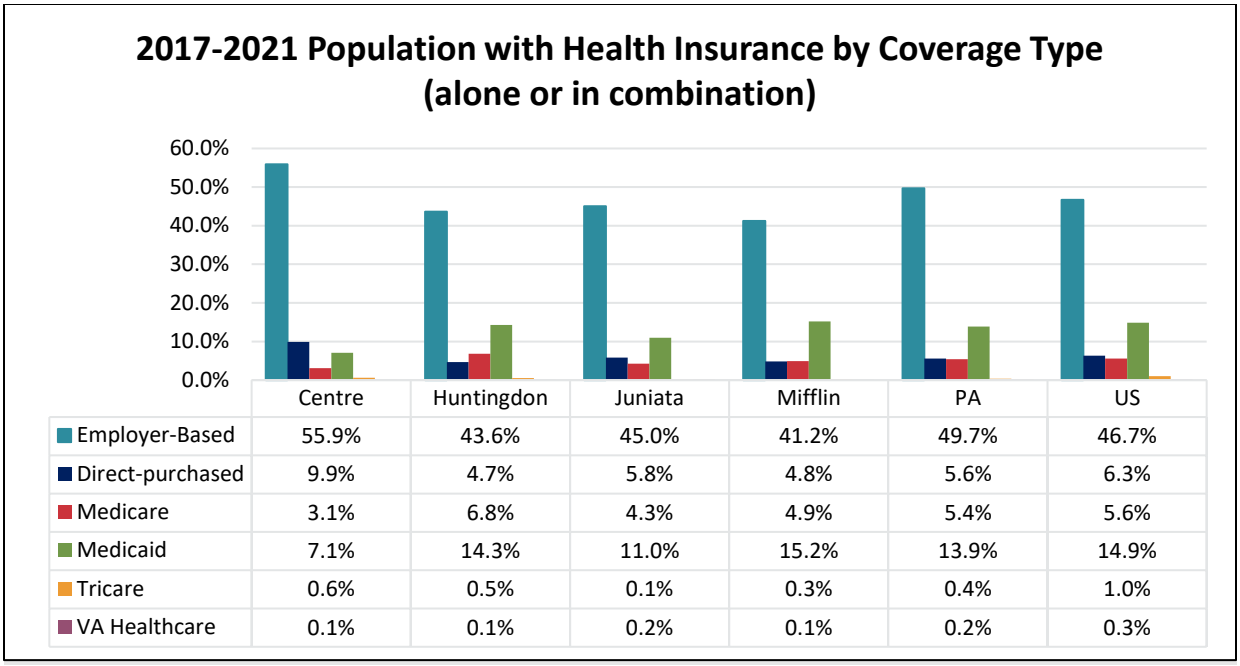


	Centre	Huntingdon	Juniata	Mifflin	PA	US
Under 6 years	8.9%	5.3%	25.1%	27.4%	4.8%	4.4%
6-18 years	6.1%	4.3%	18.8%	18.4%	4.5%	5.7%
19-25 years	5.1%	6.4%	16.8%	19.7%	8.9%	14.3%
26-44 years	8.9%	10.0%	19.1%	15.3%	9.1%	14.3%
45-64 years	5.2%	5.4%	9.0%	9.4%	5.8%	9.6%
65 years or over	0.5%	1.1%	1.3%	1.8%	0.4%	0.8%

Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey



	Centre	Huntingdon	Juniata	Mifflin	PA	US
Employer-Based	55.9%	43.6%	45.0%	41.2%	49.7%	46.7%
Direct-purchased	9.9%	4.7%	5.8%	4.8%	5.6%	6.3%
Medicare	3.1%	6.8%	4.3%	4.9%	5.4%	5.6%
Medicaid	7.1%	14.3%	11.0%	15.2%	13.9%	14.9%
Tricare	0.6%	0.5%	0.1%	0.3%	0.4%	1.0%
VA Healthcare	0.1%	0.1%	0.2%	0.1%	0.2%	0.3%

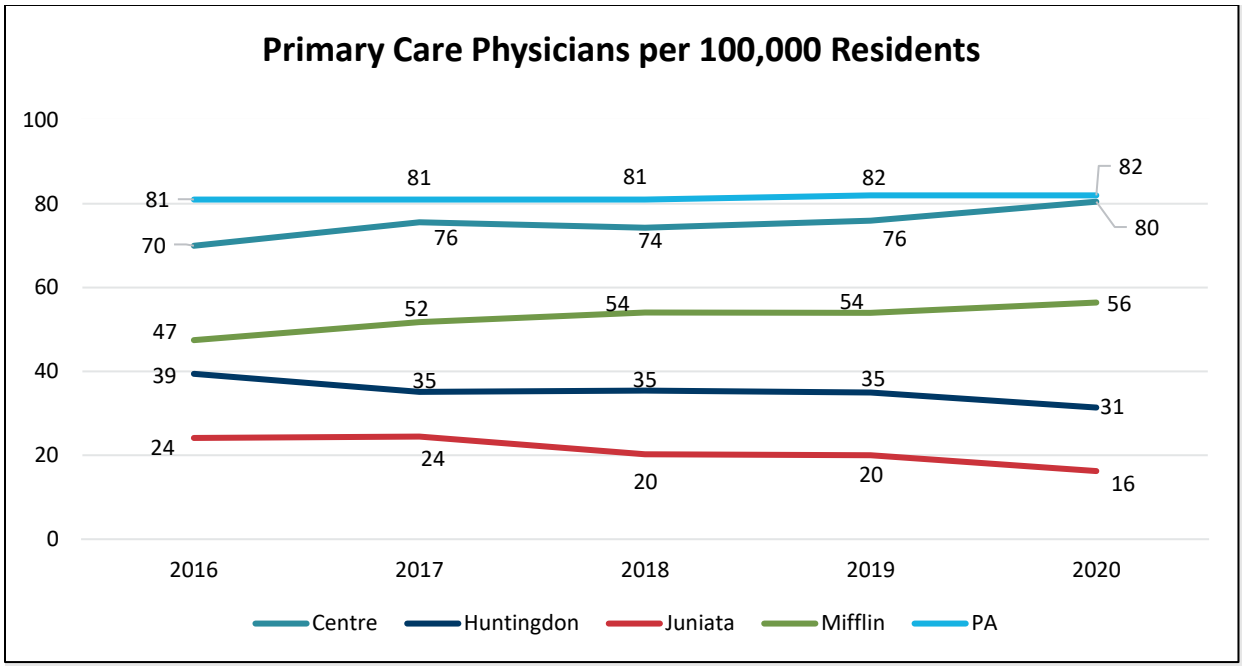
Source: US Census Bureau, American Community Survey

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.

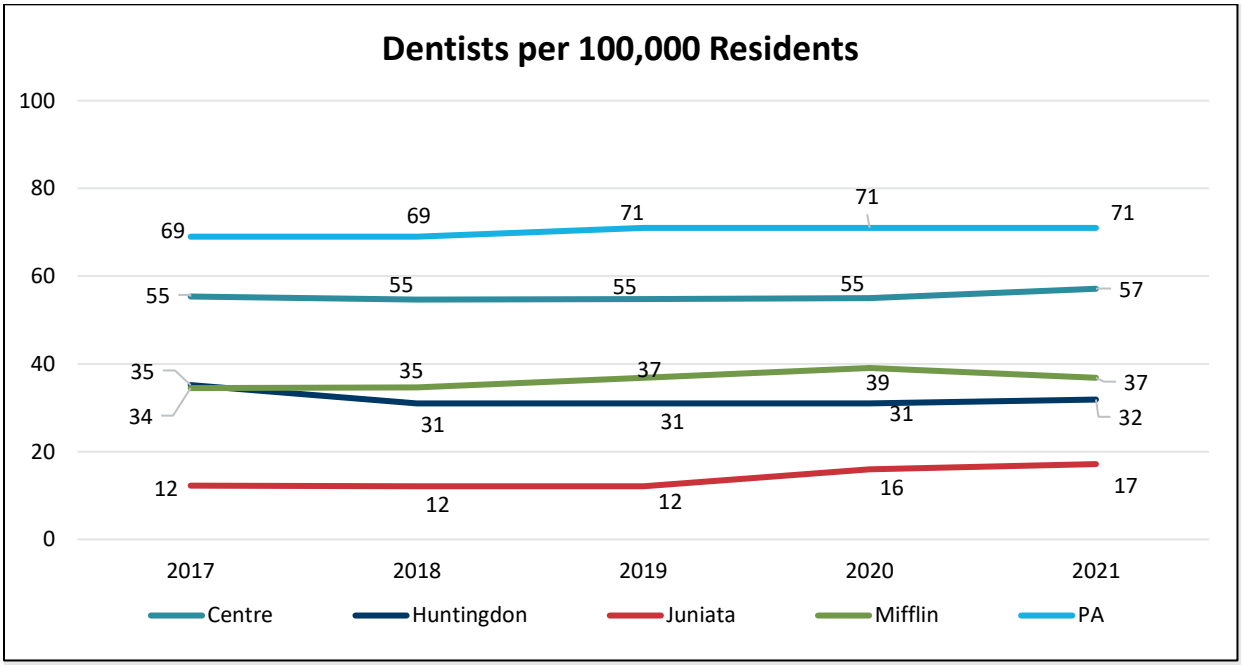
There is an opportunity to grow primary and preventive care services within the Western Region. All counties have fewer physicians than the state average, and **the entire region is a dental Health Professional Shortage Area (HPSA) for individuals with low income. The southern portion of Huntingdon County (Broad Top/Hopewell) and the western portion of Centre County (Philipsburg) are also primary care HPSAs for individuals with low income.** While not a primary care HPSA, Juniata County has the fewest physicians and dentists in the region.

Despite a lack of doctors, adult residents of the Western 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%-67% of adults, compared to 68% across Pennsylvania.

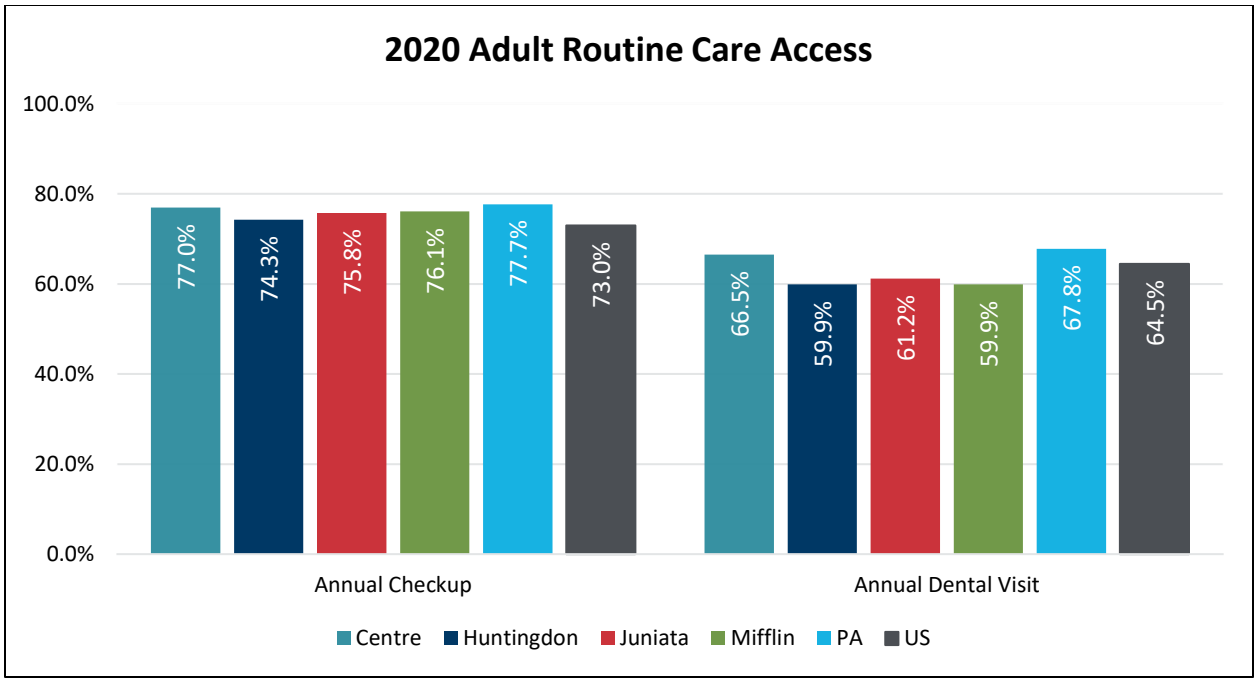
When analyzed by zip code, the proportion of adults receiving preventive visits is generally consistent across the region. Receipt of regular dental care is more varied with wide disparities between communities. **In communities like Karthaus and Philipsburg in Centre County, McClure and Belleville in Mifflin County, Thompsontown and East Waterford in Juniata County, and Huntingdon and Mount Union in Huntingdon County, the proportion of adults with regular dental care falls to 56-59%.**



Source: Health Resources & Services Administration

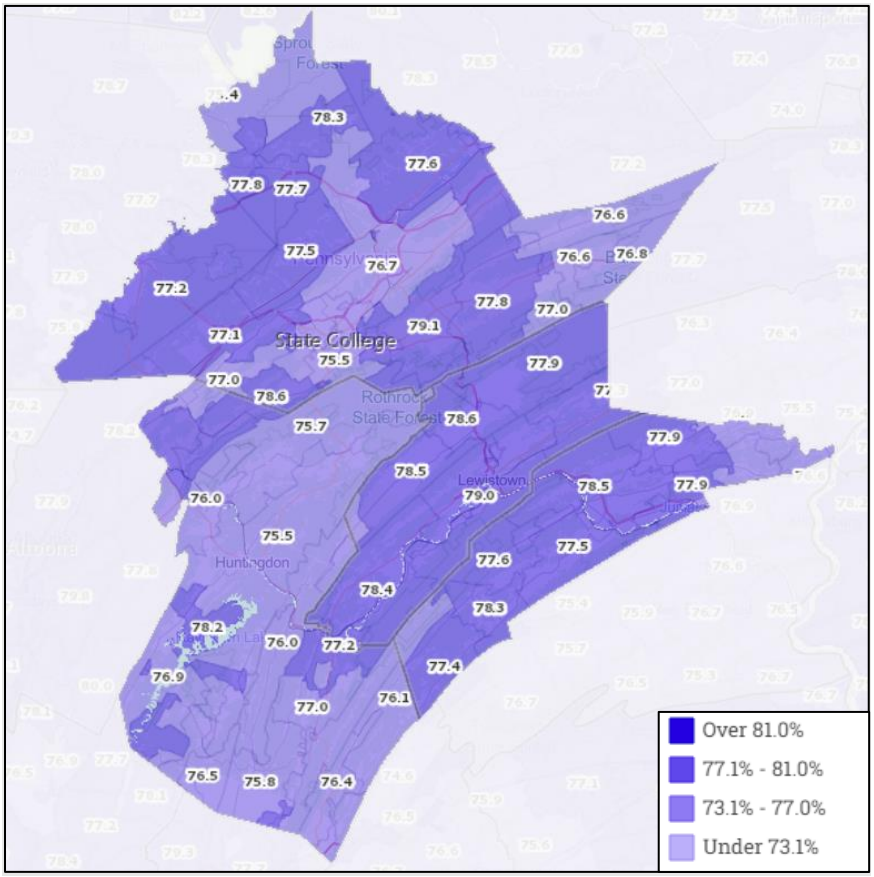


Source: Health Resources & Services Administration



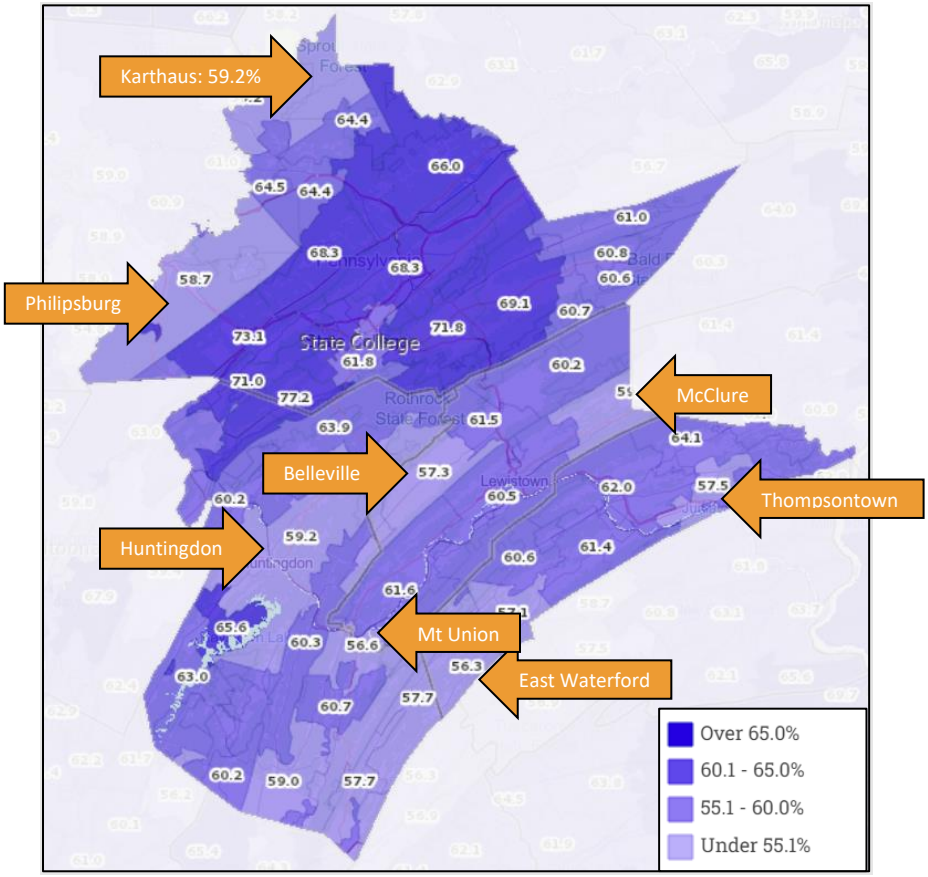
Source: Centers for Disease Control and Prevention

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

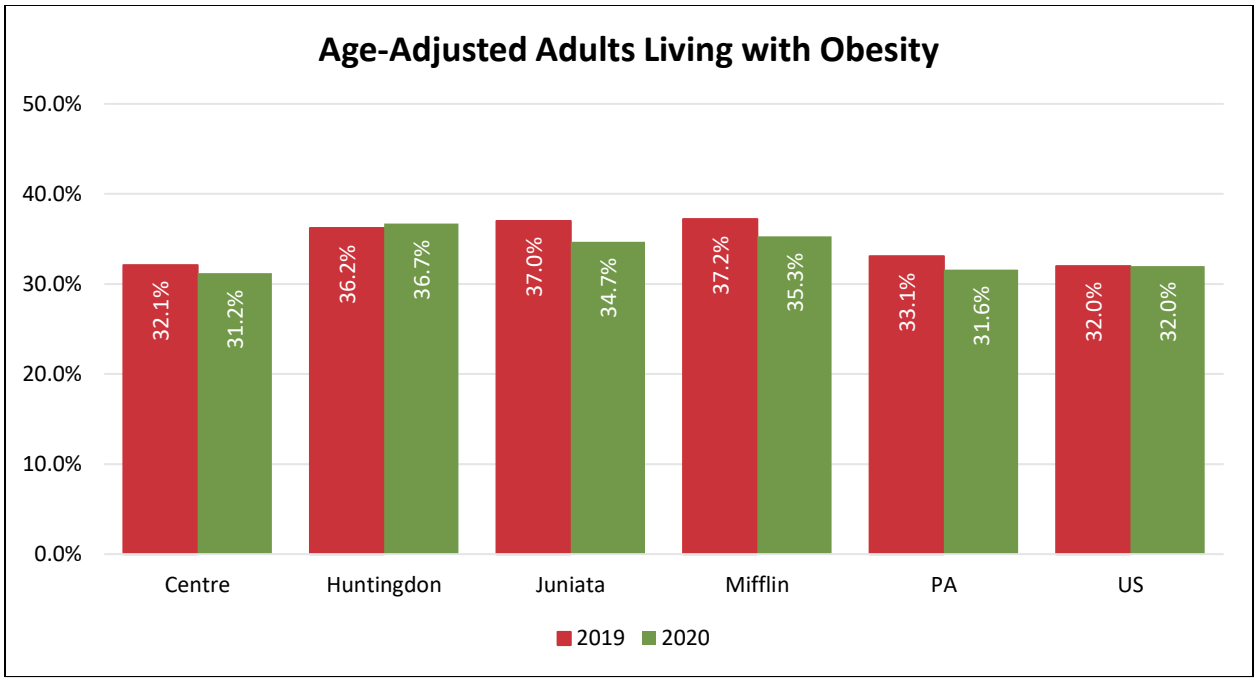


Source: Centers for Disease Control and Prevention & Center for Applied Research and Engagement Systems

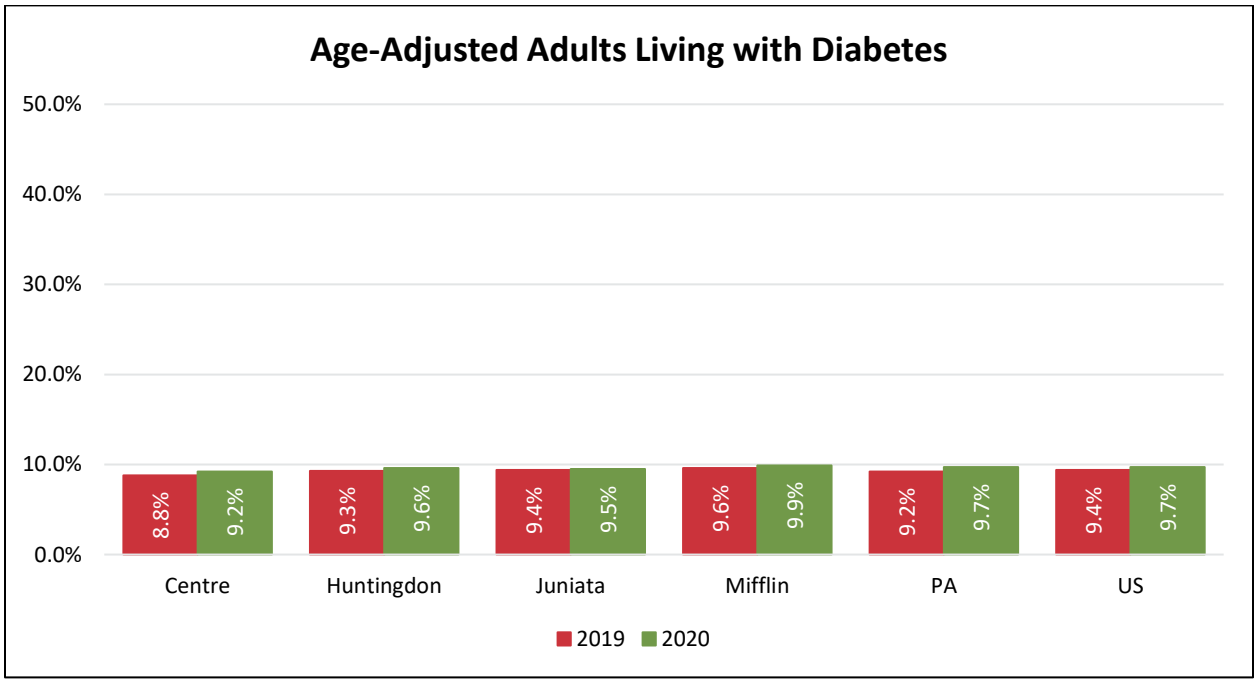
Health Risk Factors and Chronic Disease

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

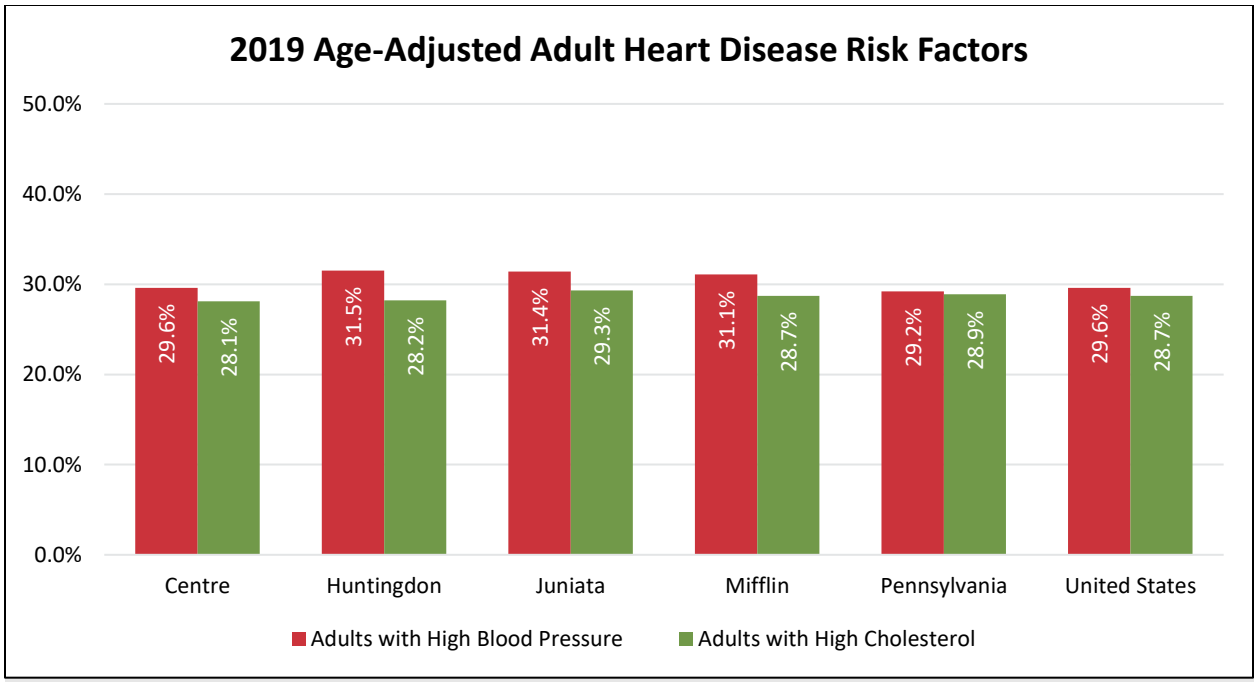
It is clear that social drivers of health directly impact health risk factors and ultimately chronic disease, resulting in inequities in quality of life and life expectancy. Across the state of Pennsylvania, death rates for Black residents attributed to diabetes and heart disease far outpace death rates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



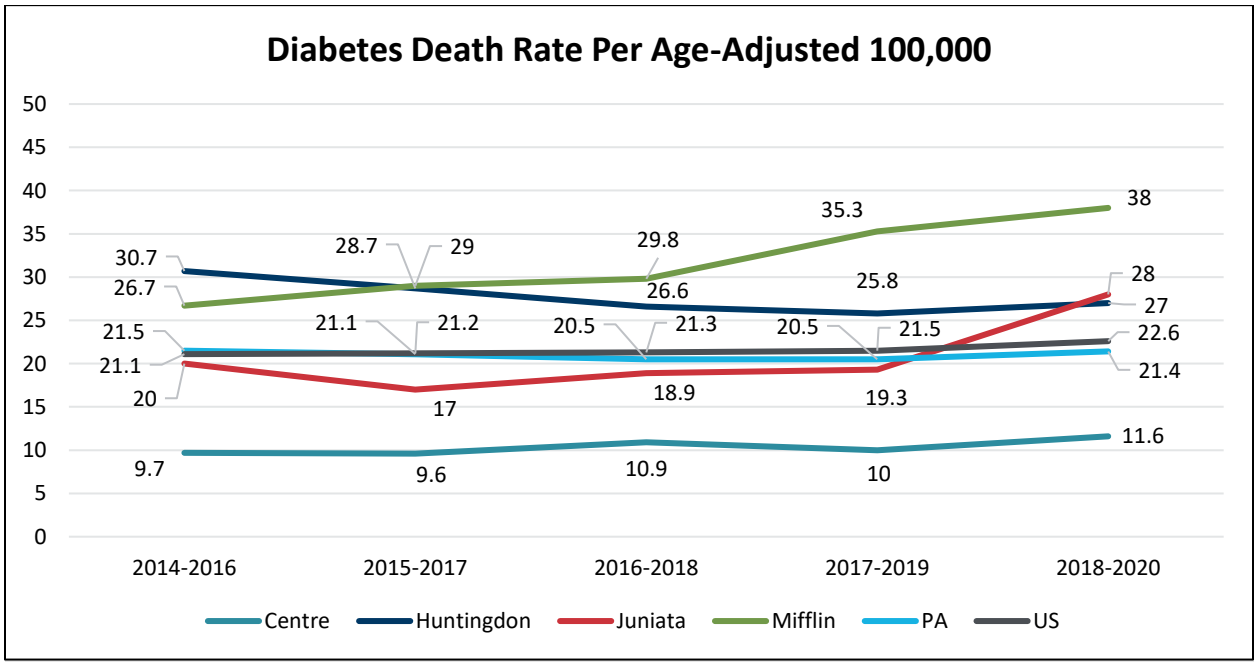
Source: Centers for Disease Control and Prevention



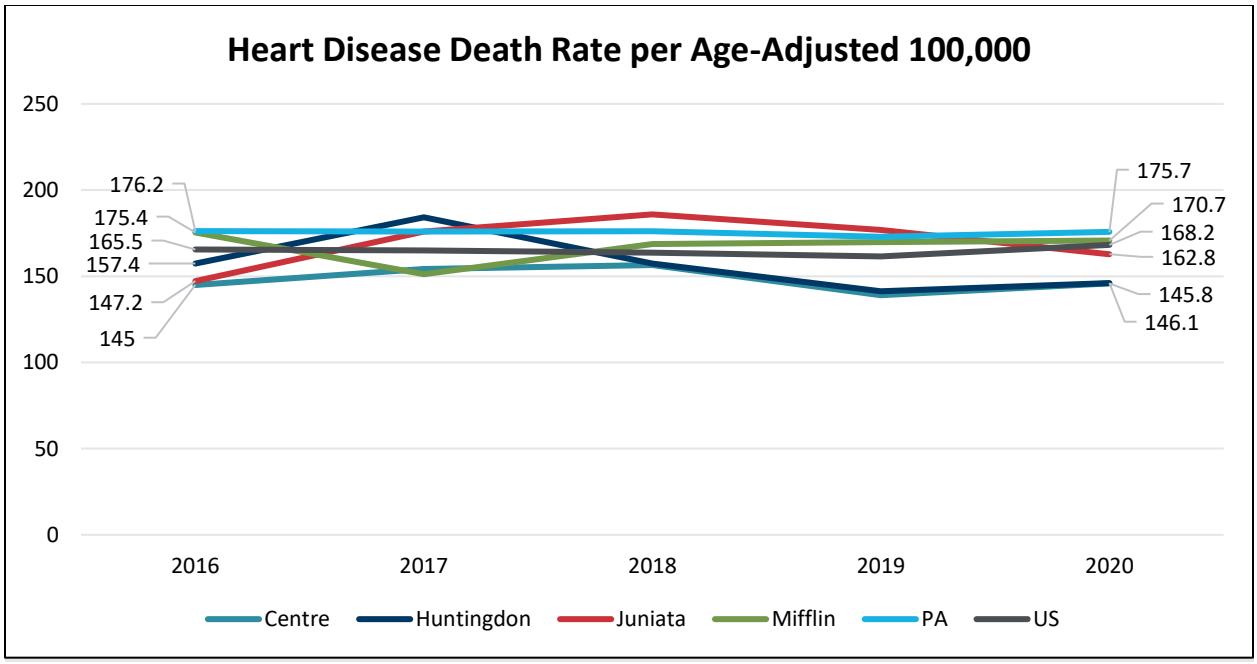
Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention

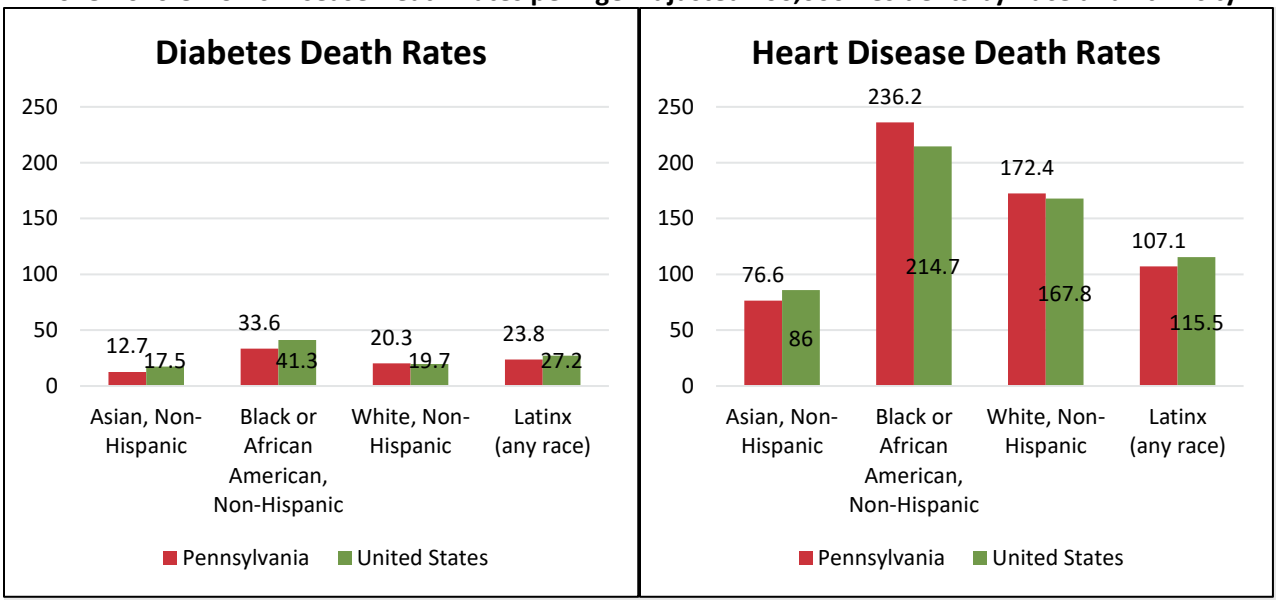


Source: Centers for Disease Control and Prevention

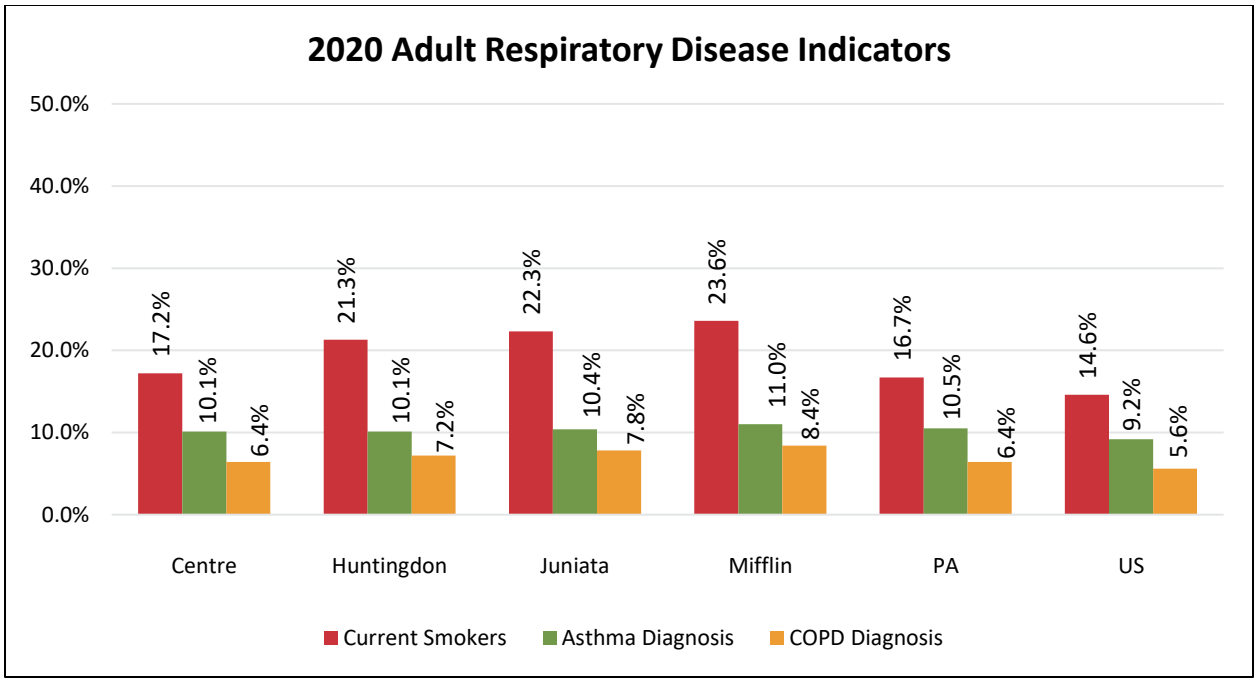


Source: Centers for Disease Control and Prevention

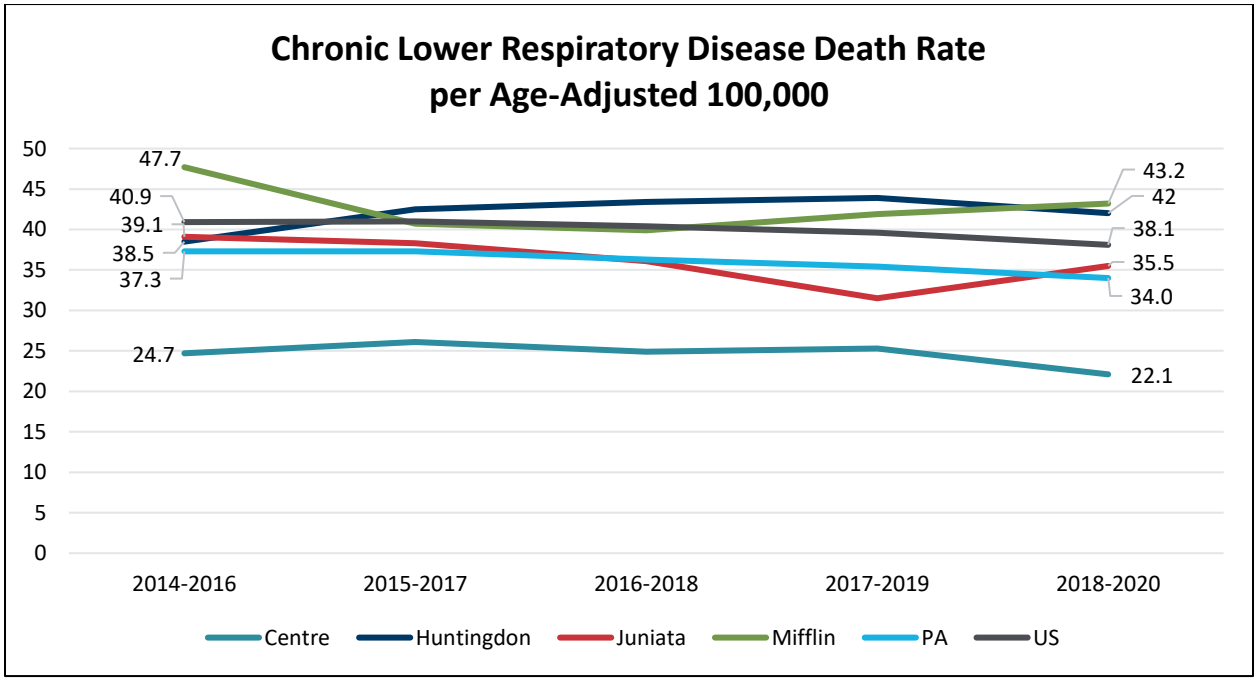
2018-2020 Chronic Disease Death Rates per Age-Adjusted 100,000 Residents by Race and Ethnicity



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



Source: Centers for Disease Control and Prevention



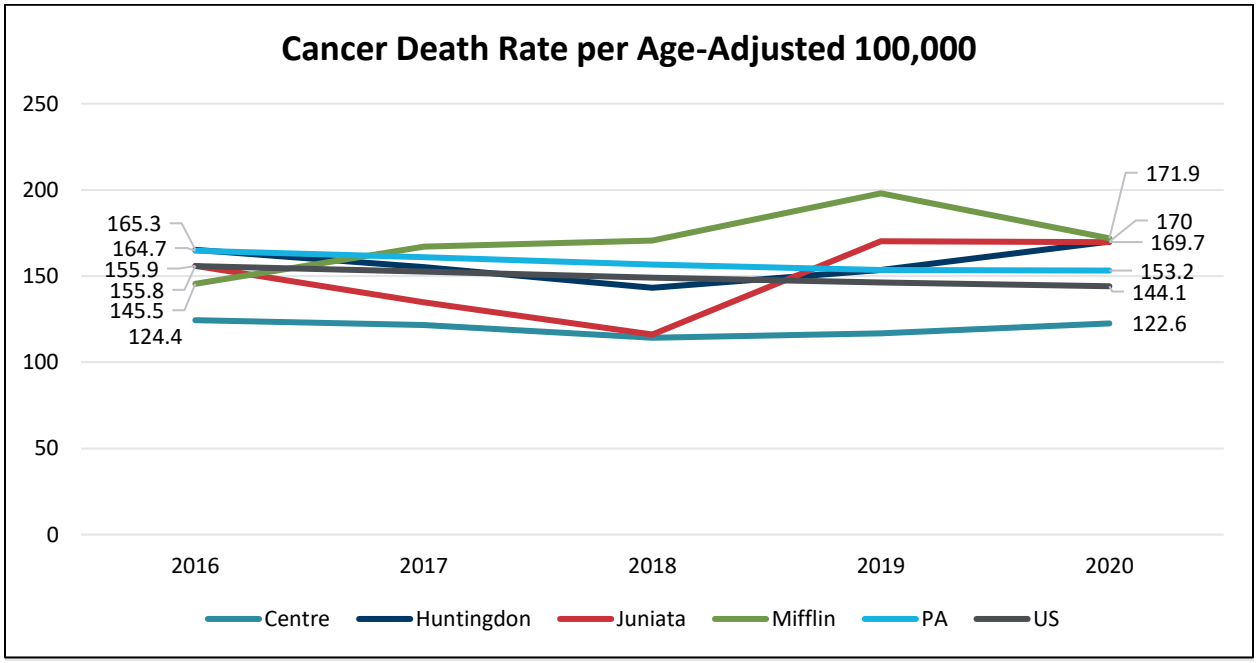
Source: Centers for Disease Control and Prevention

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

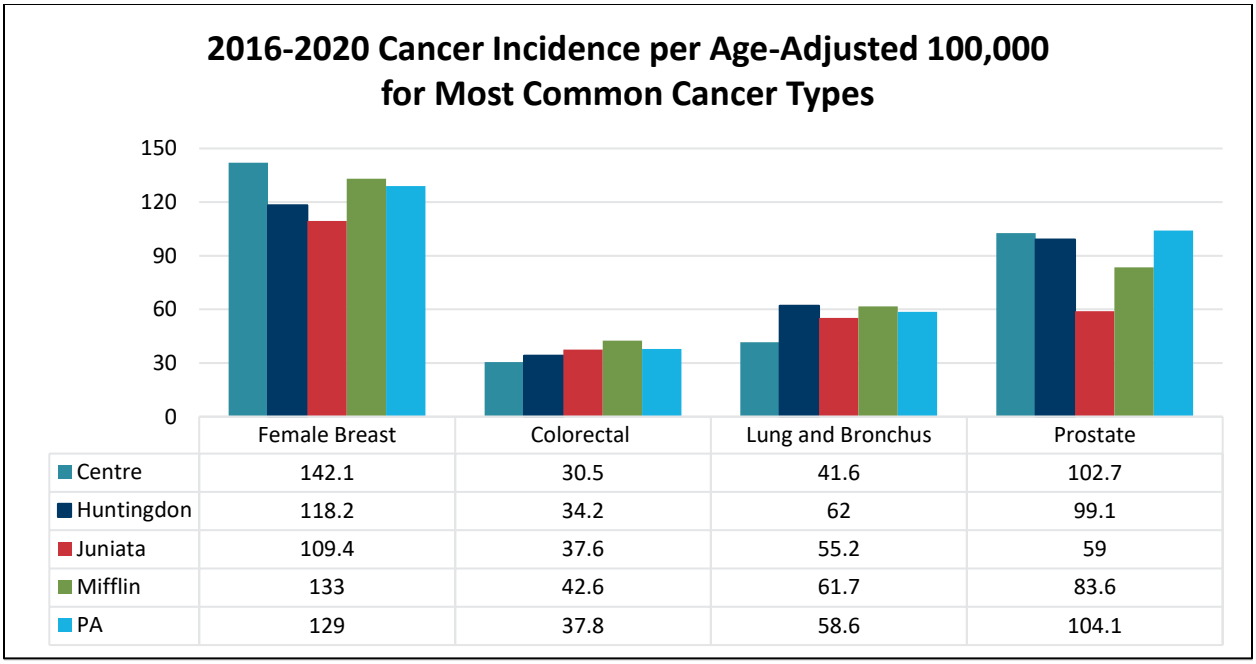
	Cancer Incidence Rate
Centre	407.6
Huntingdon	418.0
Juniata	463.3
Mifflin	433.0
Pennsylvania	448.4

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

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

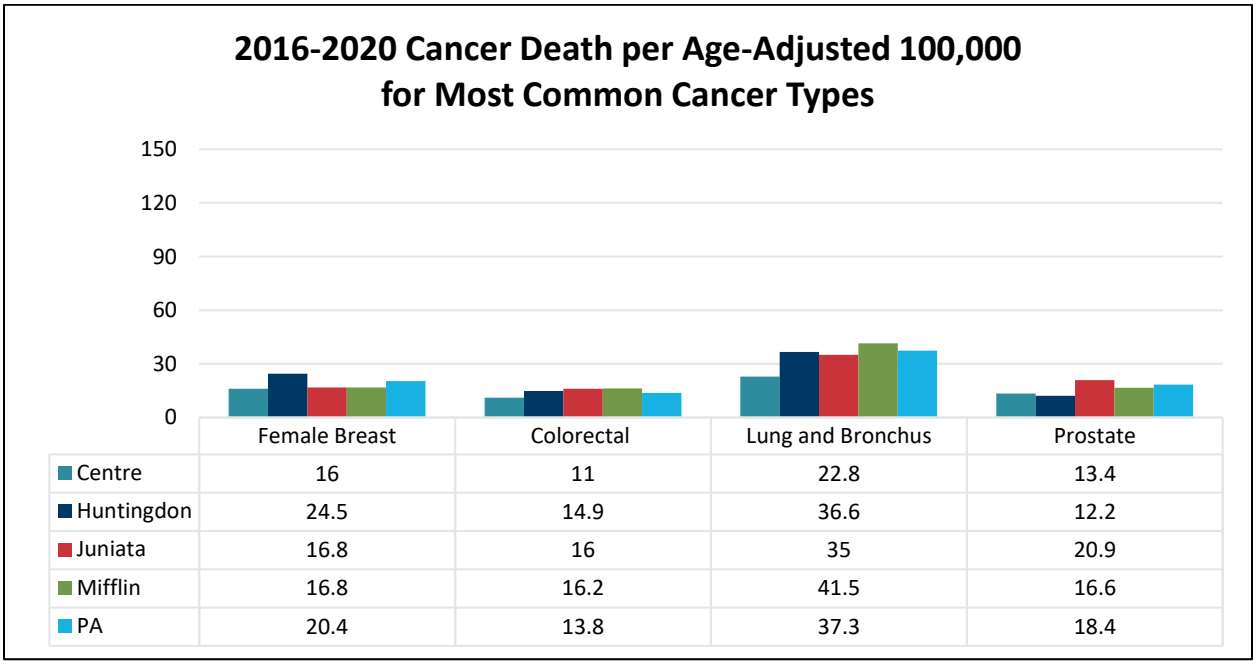


Source: Centers for Disease Control and Prevention



	Female Breast	Colorectal	Lung and Bronchus	Prostate
Centre	142.1	30.5	41.6	102.7
Huntingdon	118.2	34.2	62	99.1
Juniata	109.4	37.6	55.2	59
Mifflin	133	42.6	61.7	83.6
PA	129	37.8	58.6	104.1

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



	Female Breast	Colorectal	Lung and Bronchus	Prostate
Centre	16	11	22.8	13.4
Huntingdon	24.5	14.9	36.6	12.2
Juniata	16.8	16	35	20.9
Mifflin	16.8	16.2	41.5	16.6
PA	20.4	13.8	37.3	18.4

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

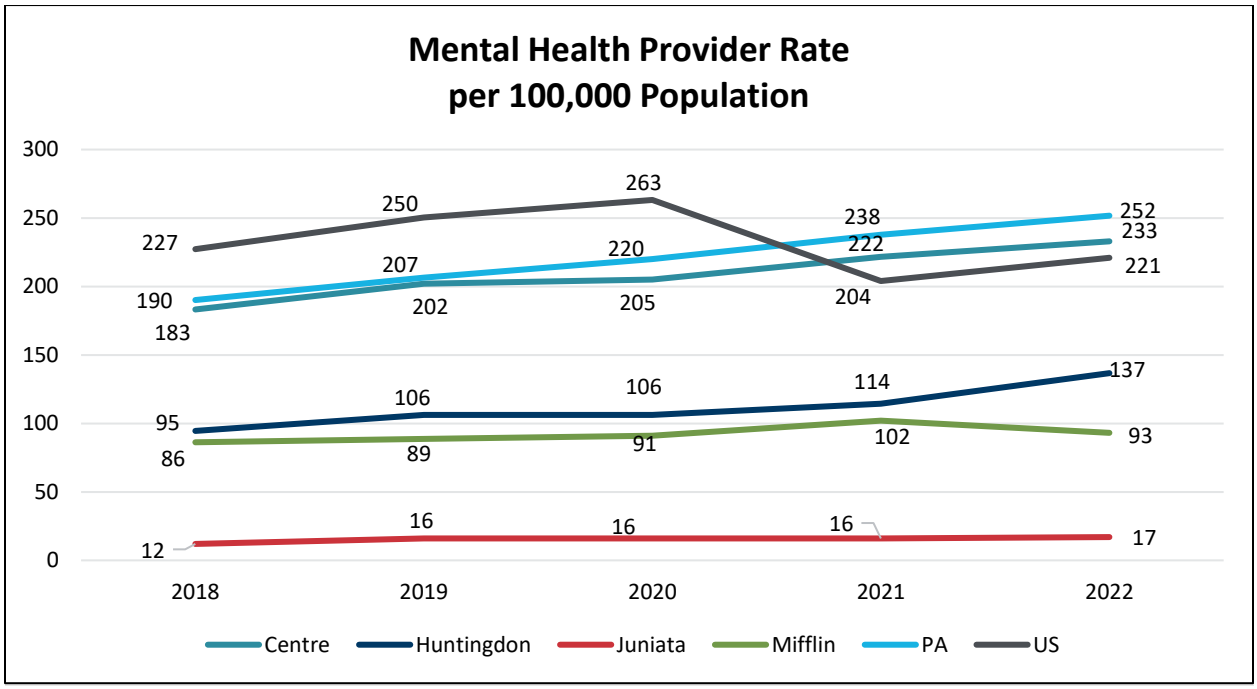
Mental Health and Substance Use Disorder

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

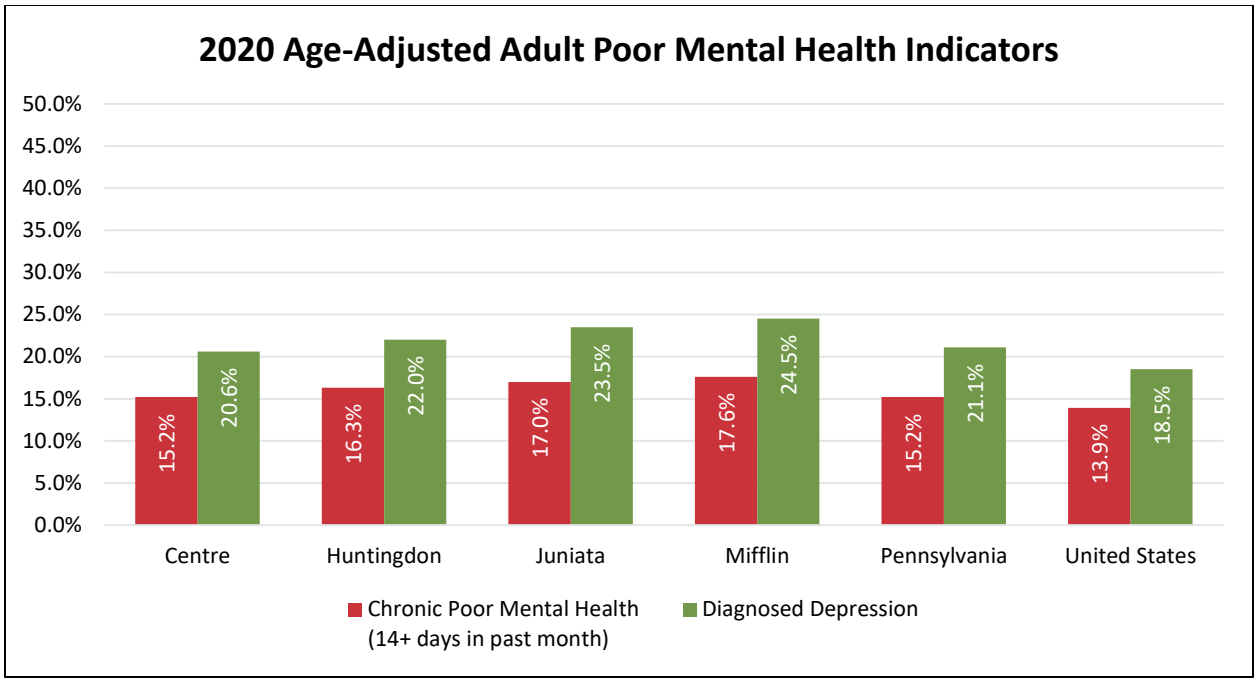
Social service and healthcare agencies are consistently reporting difficulty hiring and retaining mental health providers since COVID-19, a pandemic within a pandemic that is especially exacerbated in more rural communities. The Western Region, excluding Centre County, has fewer mental health providers than the rest of the state or nation. The mental health provider rate for Juniata County is approximately 15 times lower than the statewide rate. Both Juniata and Huntingdon counties are mental healthcare HPSAs for all residents; Mifflin County is a HPSA for individuals with low income.

At the other end of the spectrum, **the region suffers disproportionately high rates of death by suicide, with Huntingdon County experiencing nearly twice the rate of suicide deaths compared to neighboring Centre County. Across all counties, approximately one-fifth to 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 largely 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 East Waterford, Mount Union, and Thompsontown.

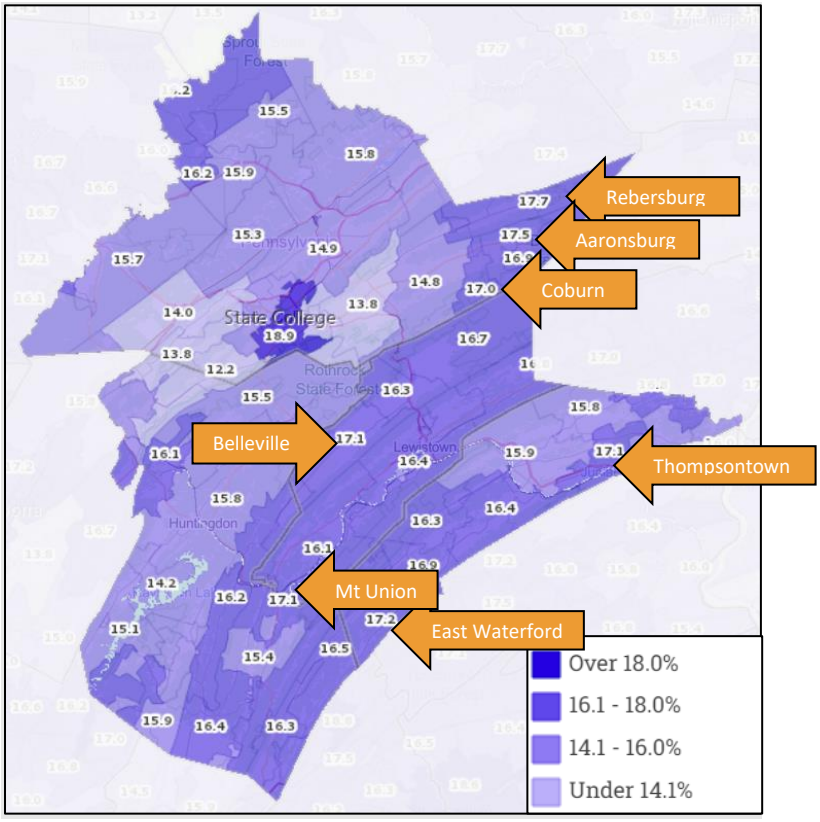


Source: Centers for Medicare and Medicaid Services

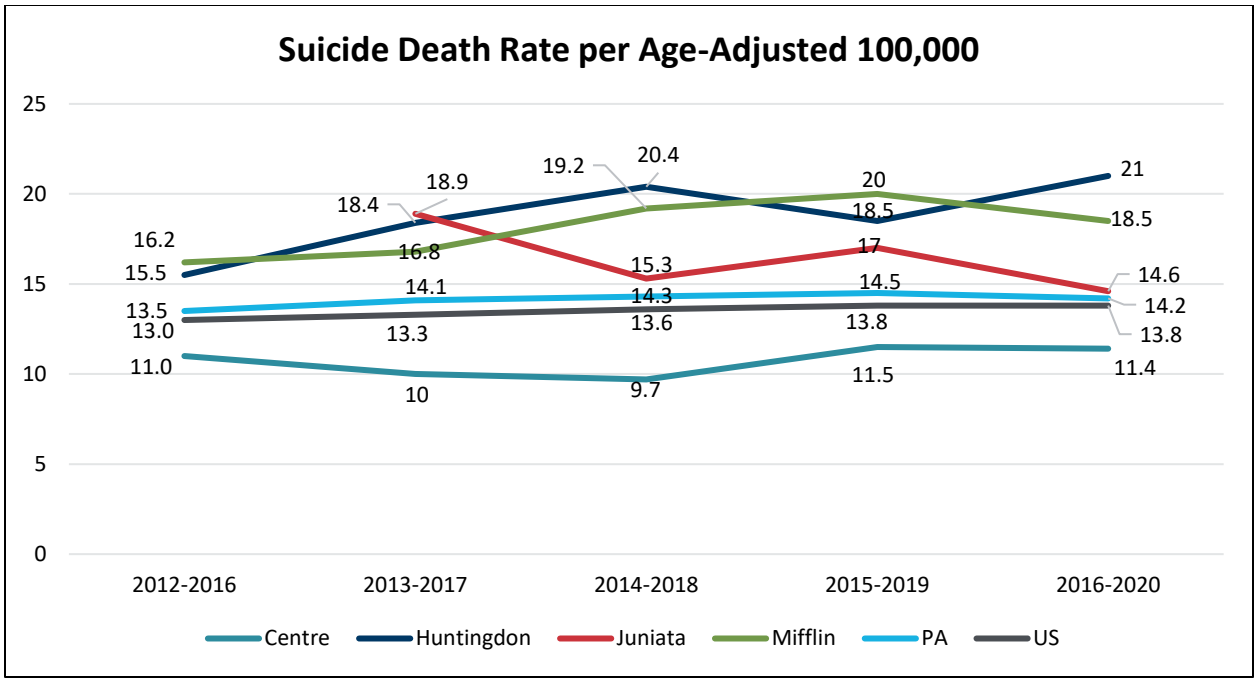


Source: Centers for Disease Control and Prevention

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



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



Source: Centers for Disease Control and Prevention
Note: Data for Juniata County are not reported prior to 2013-2017 due to low death counts.

While substance use concerns are still prevalent in the region, counties have historically had fewer hospitalizations or deaths due to drugs like opioids. **All counties with reportable data have a lower rate of death due to accidental drug overdose than the state, and death rates declined in Huntingdon and Mifflin counties in recent years.**

Of most pressing concern are rates of alcohol misuse by residents. Approximately 1 in 5 adults in Western Region counties report binge drinking, a slightly higher proportion than the state and nation overall. **In Juniata County, nearly half of all driving deaths were due to alcohol impairment. In Mifflin County, the rate of alcohol-related hospitalizations was approximately double the rate for neighboring 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
Centre	19.6%	26.5%
Huntingdon	20.3%	26.9%
Juniata	20.0%	46.6%
Mifflin	20.2%	26.6%
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
Centre	316.0	69.4	39.2	11.9
Huntingdon	455.0	124.1	77.6	NA
Juniata	300.9	98.7	NA	NA
Mifflin	614.3	210.1	87.8	95.7
Pennsylvania	568.4	293.2	63.7	164.1

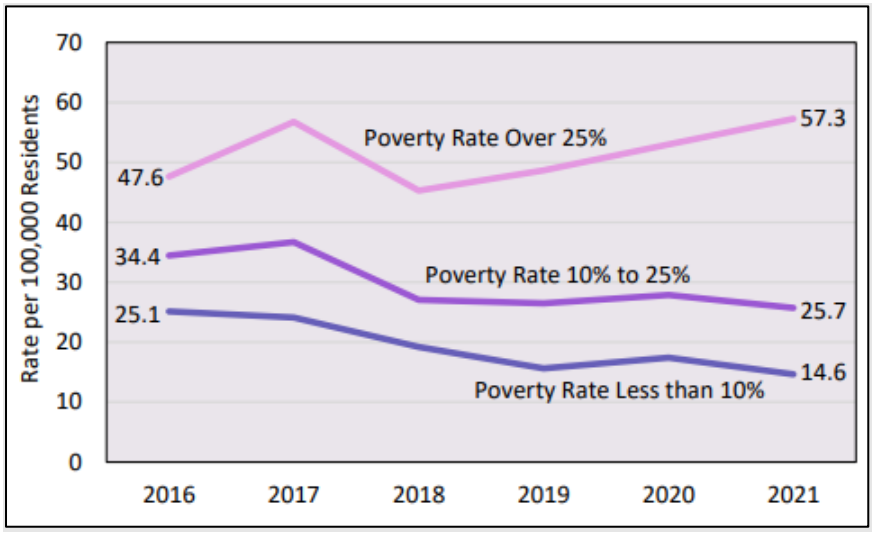
Source: Pennsylvania Health Care Cost Containment Council (PHC4)

Opioid Overdose Hospitalization Rates per 100,000 Residents

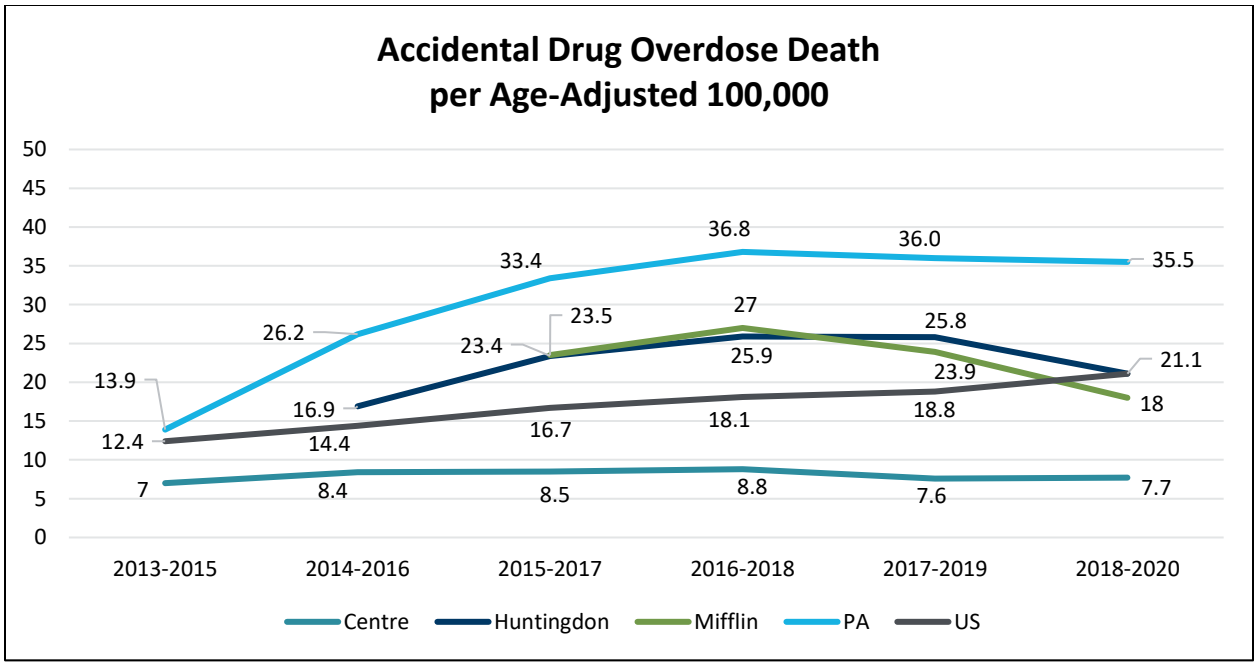
	2016	2017	2018	2019	2020	2021
Centre	15.5	7.7	NA	NA	8.5	7.7
Pennsylvania	31.6	33.0	25.1	23.2	24.8	22.9

Source: Pennsylvania Health Care Cost Containment Council (PHC4)
Note: Data are provided for Western Region counties as available.

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



Source: Pennsylvania Health Care Cost Containment Council (PHC4)
*Rates are calculated using PHC4 hospital discharge data and US Census Bureau 2020 population estimates.



Source: Centers for Disease Control and Prevention
Note: Data for Juniata County are not reported, and data for Huntingdon and Mifflin counties are limited due to low death counts.

COVID-19

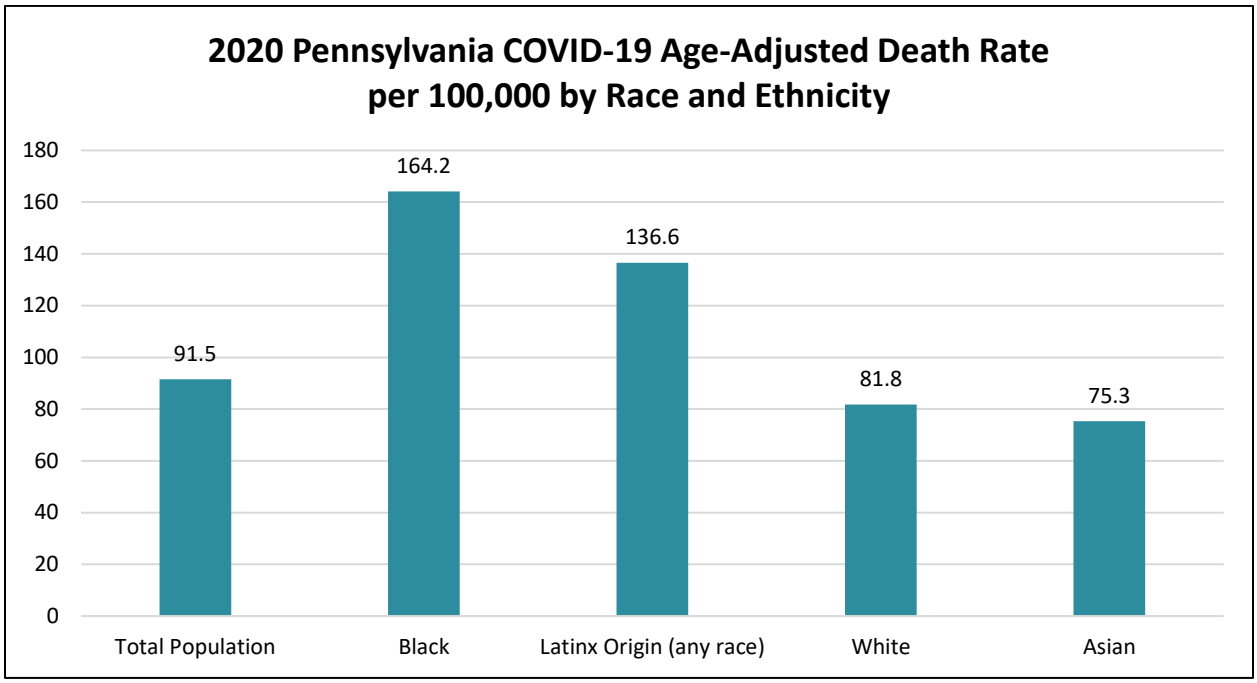
The COVID-19 pandemic both highlighted and deepened socioeconomic and health inequities and exposed disparities within the health and social service systems. The pandemic has not impacted all people equally. Rather, certain structural issues—population density, low income, crowded workplaces, etc.—contribute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

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

While localized data on the impacts of COVID-19 on overall life expectancy are not available, local data on chronic disease prevalence suggests an impact on the Western 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.

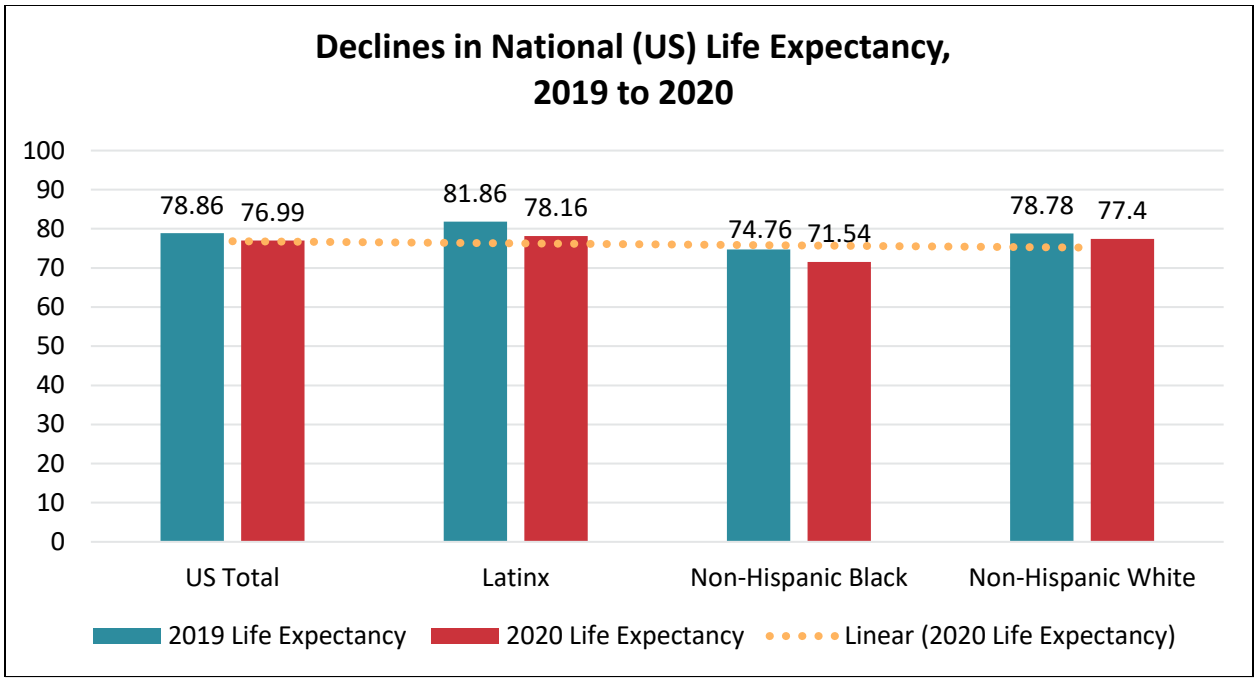


Source: Pennsylvania Department of Health

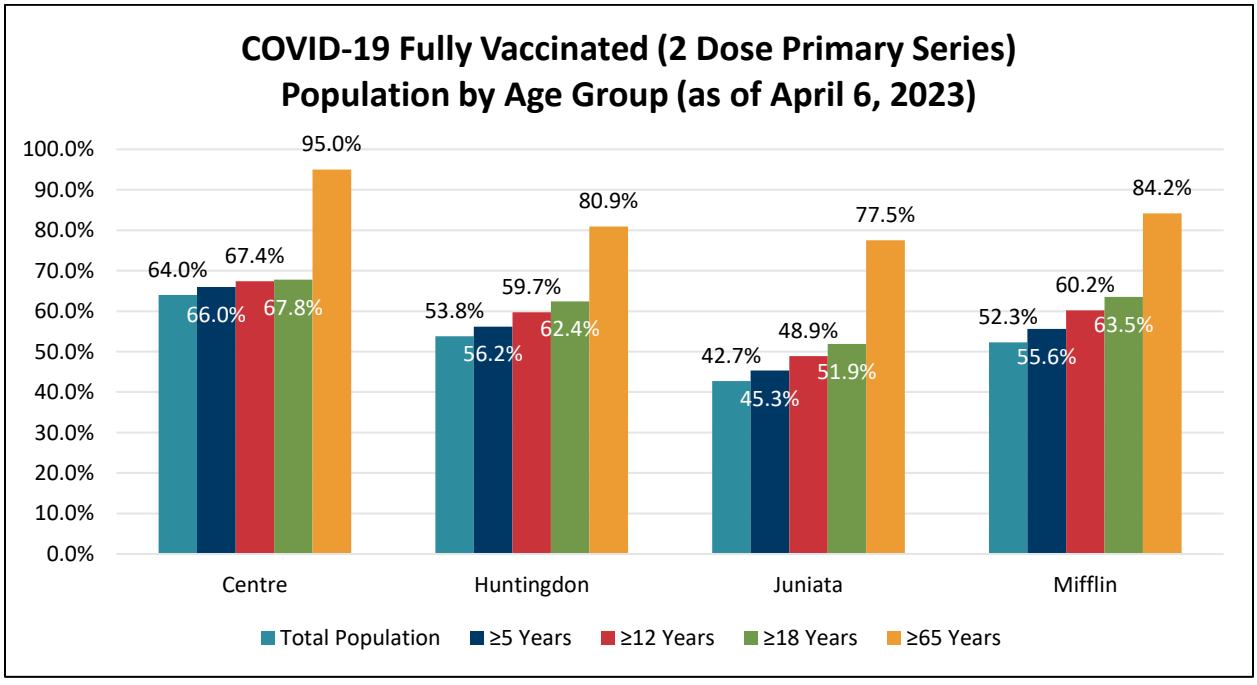
Leading Causes of Death among Pennsylvania Residents by Race and Ethnicity in 2020

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

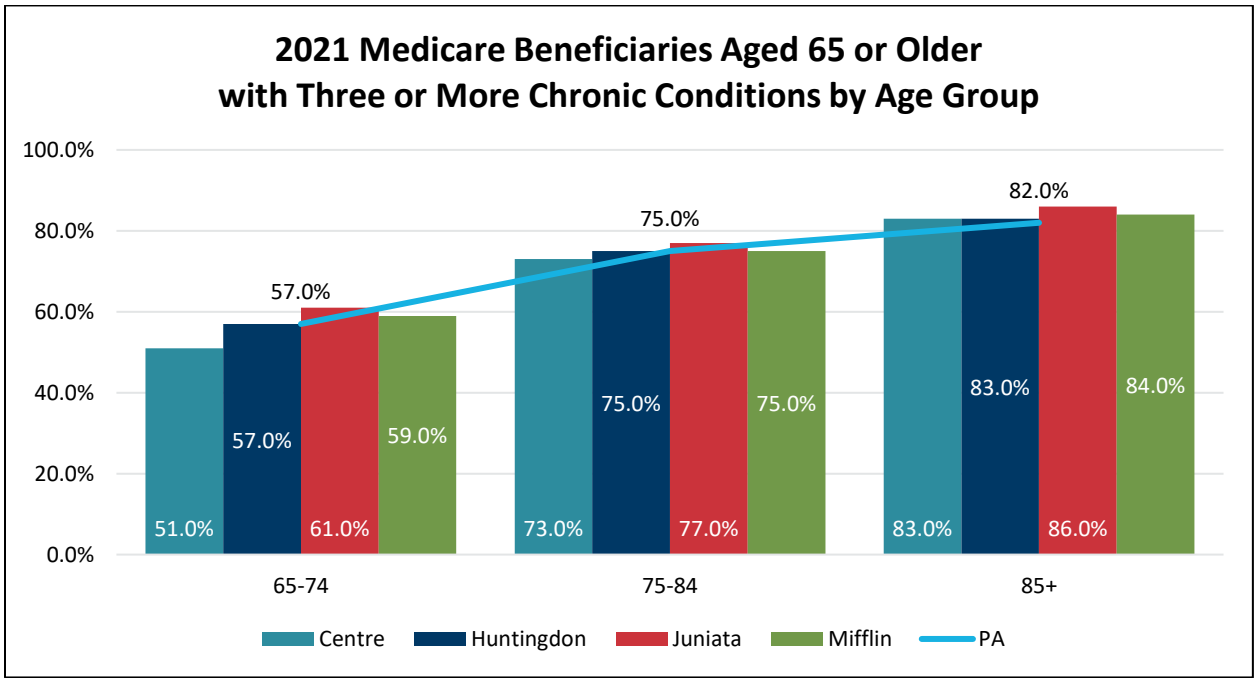
Aging Population

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 Western 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 51% (in Centre County) and 61% (in Juniata County) of Medicare beneficiaries aged 65-74 reported three or more chronic conditions. Disease prevalence increased to between 83% and 86% at age 85+.**

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



Source: Centers for Medicare & Medicaid Services

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

	Centre	Huntingdon	Juniata	Mifflin	PA	US
Alzheimer's disease, related disorders, senile dementia	2%	2%	2%	3%	2%	2%
Cancer (breast, lung, colorectal, prostate)	10%	10%	10%	9%	10%	9%
Depression	16%	15%	18%	19%	16%	15%
Diabetes	21%	25%	27%	25%	24%	24%
High cholesterol	60%	69%	74%	69%	65%	58%
Hypertension	55%	61%	62%	60%	60%	59%
Obesity	17%	25%	28%	23%	27%	21%
Rheumatoid arthritis	27%	31%	26%	28%	31%	30%

Source: Centers for Medicare & Medicaid Services

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

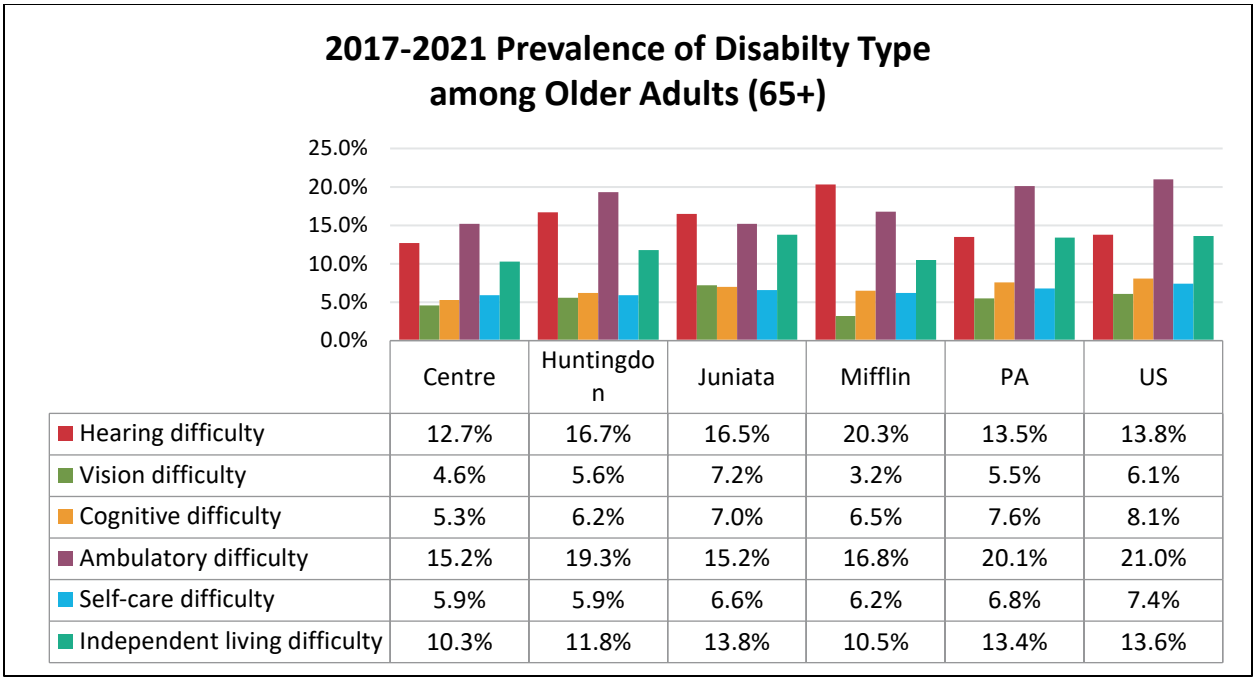
	Centre	Huntingdon	Juniata	Mifflin	PA	US
Alzheimer's disease, related disorders, senile dementia	8%	8%	9%	9%	9%	9%
Cancer (breast, lung, colorectal, prostate)	16%	15%	16%	16%	15%	14%
Depression	19%	18%	19%	19%	18%	17%
Diabetes	26%	30%	34%	31%	30%	29%
High cholesterol	74%	75%	81%	79%	76%	72%
Hypertension	73%	78%	77%	77%	78%	75%
Obesity	16%	20%	26%	21%	25%	19%
Rheumatoid arthritis	39%	40%	41%	39%	41%	39%

Source: Centers for Medicare & Medicaid Services

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

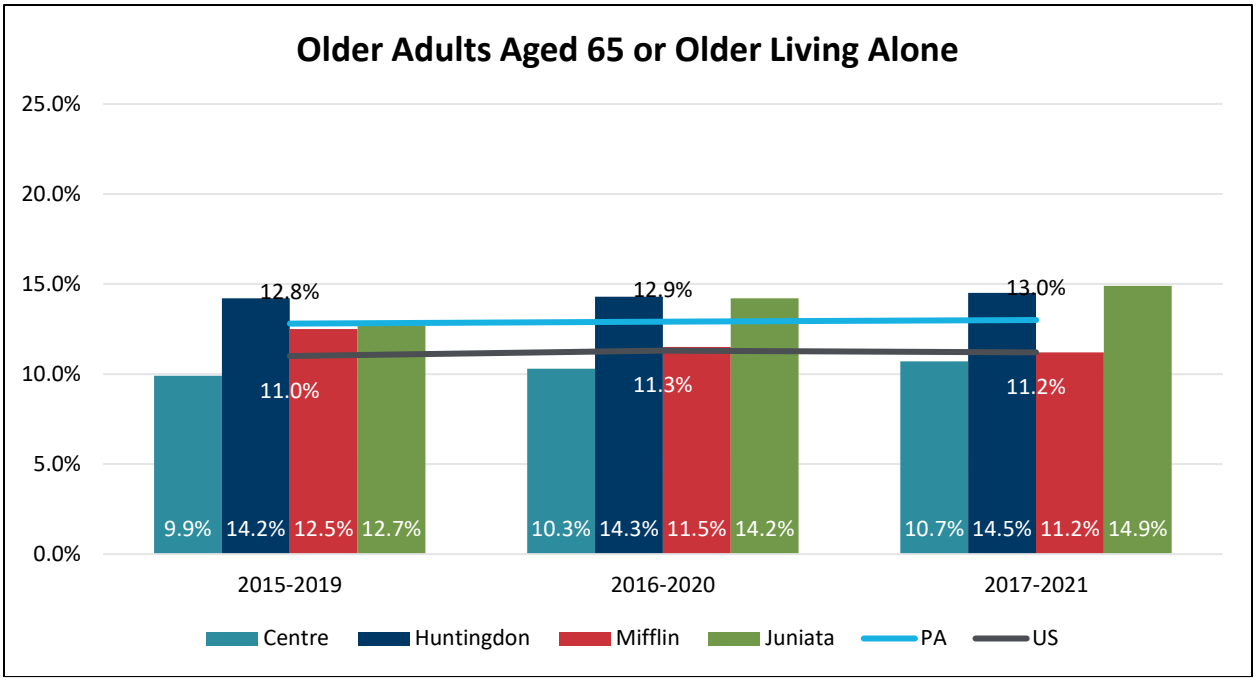
	Centre	Huntingdon	Juniata	Mifflin	PA	US
Alzheimer's disease, related disorders, senile dementia	25%	25%	25%	24%	26%	25%
Cancer (breast, lung, colorectal, prostate)	15%	15%	15%	15%	15%	14%
Depression	22%	23%	24%	23%	23%	21%
Diabetes	25%	27%	27%	28%	27%	27%
High cholesterol	68%	70%	85%	78%	71%	67%
Hypertension	86%	84%	86%	86%	85%	83%
Obesity	7%	12%	14%	10%	14%	11%
Rheumatoid arthritis	43%	46%	51%	48%	48%	45%

Source: Centers for Medicare & Medicaid Services



	Centre	Huntingdon	Juniata	Mifflin	PA	US
Hearing difficulty	12.7%	16.7%	16.5%	20.3%	13.5%	13.8%
Vision difficulty	4.6%	5.6%	7.2%	3.2%	5.5%	6.1%
Cognitive difficulty	5.3%	6.2%	7.0%	6.5%	7.6%	8.1%
Ambulatory difficulty	15.2%	19.3%	15.2%	16.8%	20.1%	21.0%
Self-care difficulty	5.9%	5.9%	6.6%	6.2%	6.8%	7.4%
Independent living difficulty	10.3%	11.8%	13.8%	10.5%	13.4%	13.6%

Source: US Census Bureau, American Community Survey



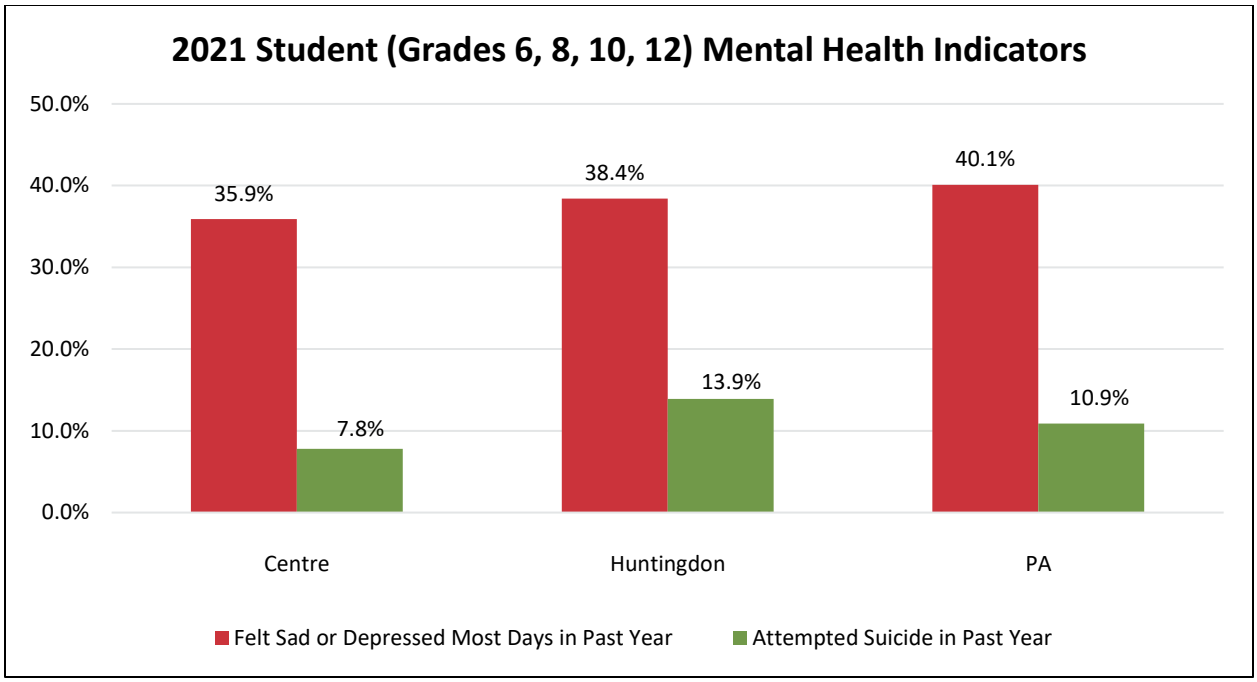
Source: US Census Bureau, American Community Survey

Youth

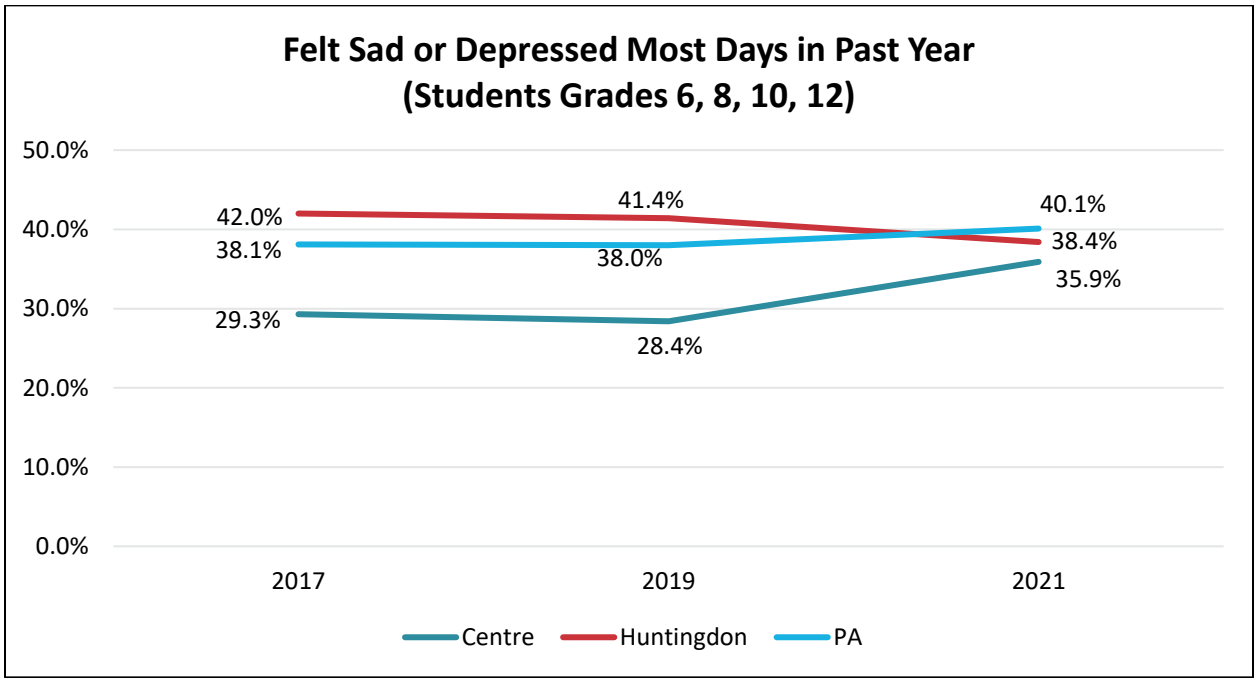
The COVID-19 pandemic has made unprecedented changes to the lives and experiences of young people worldwide. These concerns represent Adverse Childhood Experiences (ACEs), defined as traumatic or stressful events that occur before the age of 18. ACEs can have lifelong impacts on economic, educational, 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. Related student data are limited to Centre and Huntingdon counties in the Western Region. Within these counties, and across Pennsylvania, students are showing a steady decline in substance use of all kinds, although prevalence is higher in Huntingdon County than elsewhere. **The decline in substance use is an especially helpful measure given the ongoing rise in mental health concerns. Nearly 14% of students in Huntingdon County reported an attempted suicide in 2021.** Mental health challenges among youth were proportionately high prior to the COVID-19 pandemic and are higher still in recent years.

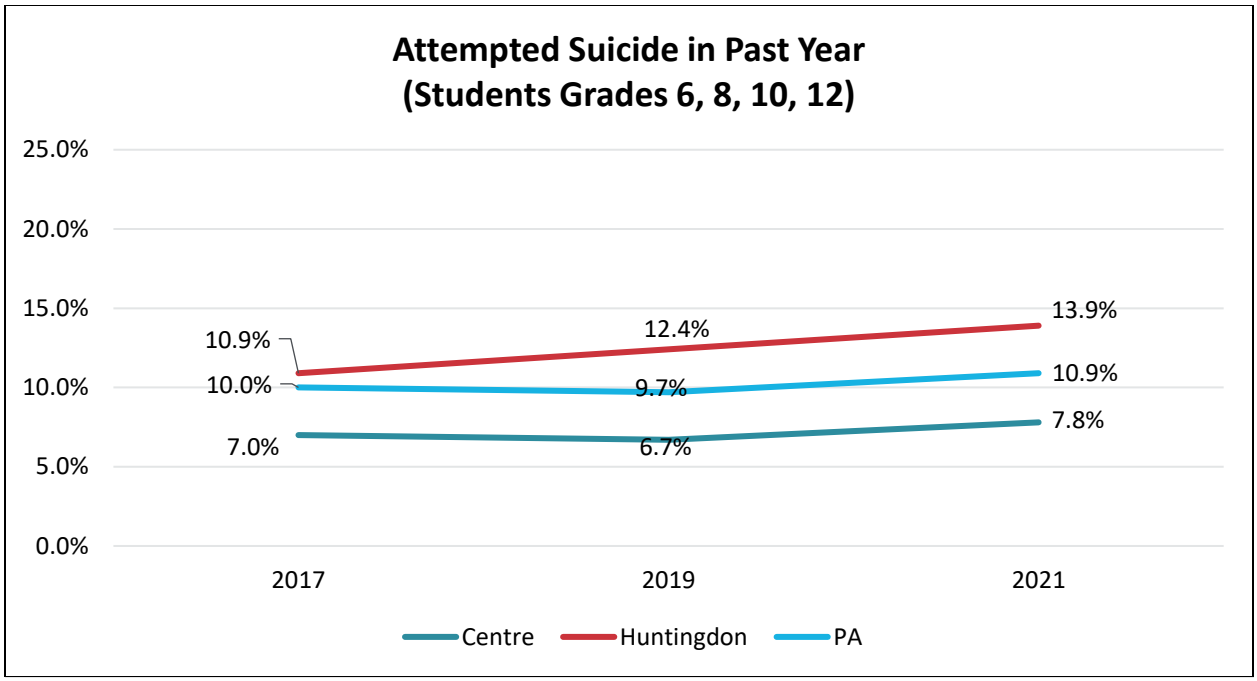
Schools, as they have finally re-opened to "normal" capacity in the last year are feeling the impact of these numbers in tangible ways. **Young people are struggling. In particular, fewer than half of students in Centre County and fewer than 40% of students in Huntingdon County "feel that school is going 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.



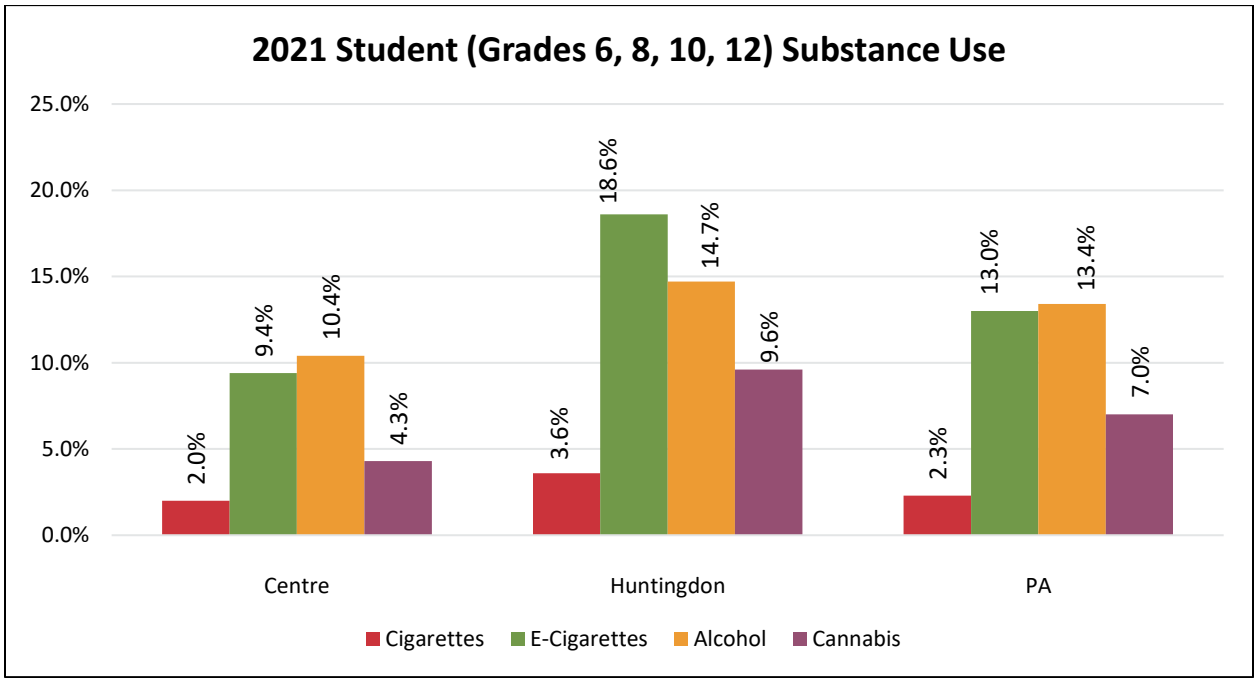
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Juniata and Mifflin counties.



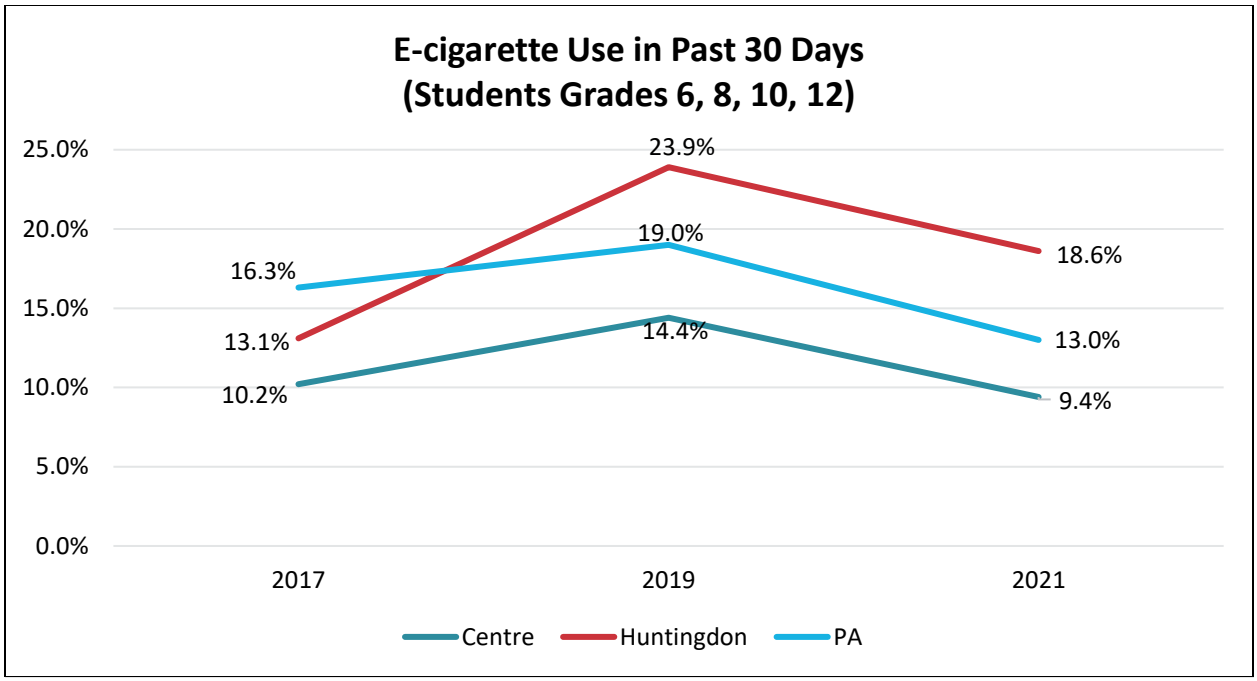
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Juniata and Mifflin counties.



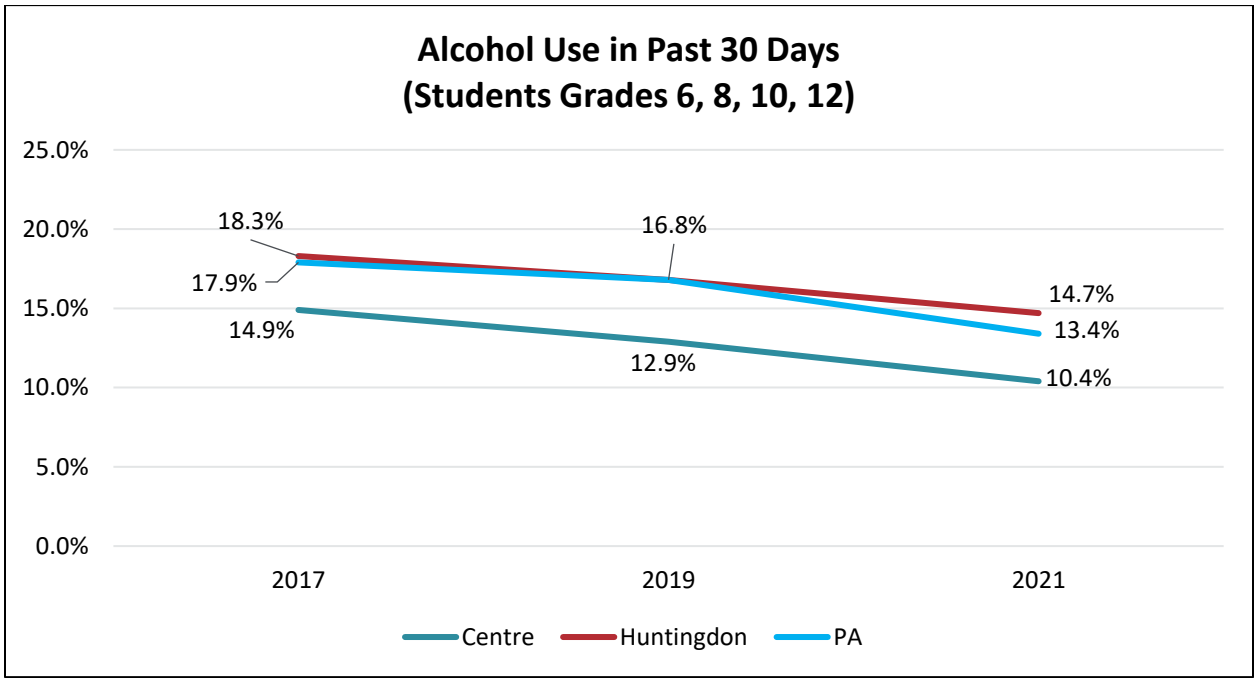
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Juniata and Mifflin counties.



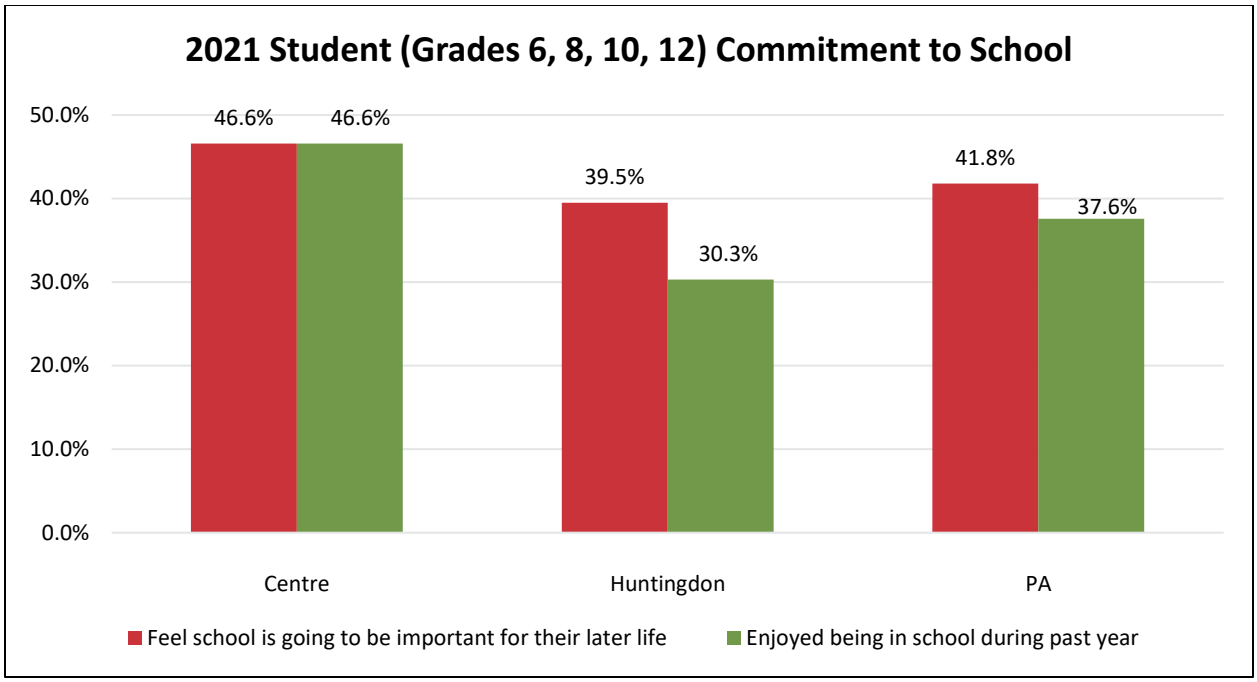
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Juniata and Mifflin counties.



Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Juniata and Mifflin counties.



Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Juniata and Mifflin counties.



Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Juniata and Mifflin counties.

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. In Juniata and Mifflin counties, approximately 60% or fewer birthing people received first trimester prenatal care. **Smoking prevalence among adults in Huntingdon, Juniata, and Mifflin counties is higher than across the rest of the state and the nation, a trend that continues among pregnant people. Within these counties, between 13% and 16% 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 experience these outcomes at a similar or lower 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			
Centre	1,065	14.3	86.7%	2.4%	3.8%
Huntingdon	367	17.9	96.2%	0.5%	0.8%
Juniata	310	26.7	94.5%	0.3%	4.5%
Mifflin	528	22.6	97.9%	0.4%	1.9%
Pennsylvania	130,730	19.9	69.4%	14.2%	12.8%
United States	3,613,647	11.0	51.0%	14.7%	24.0%

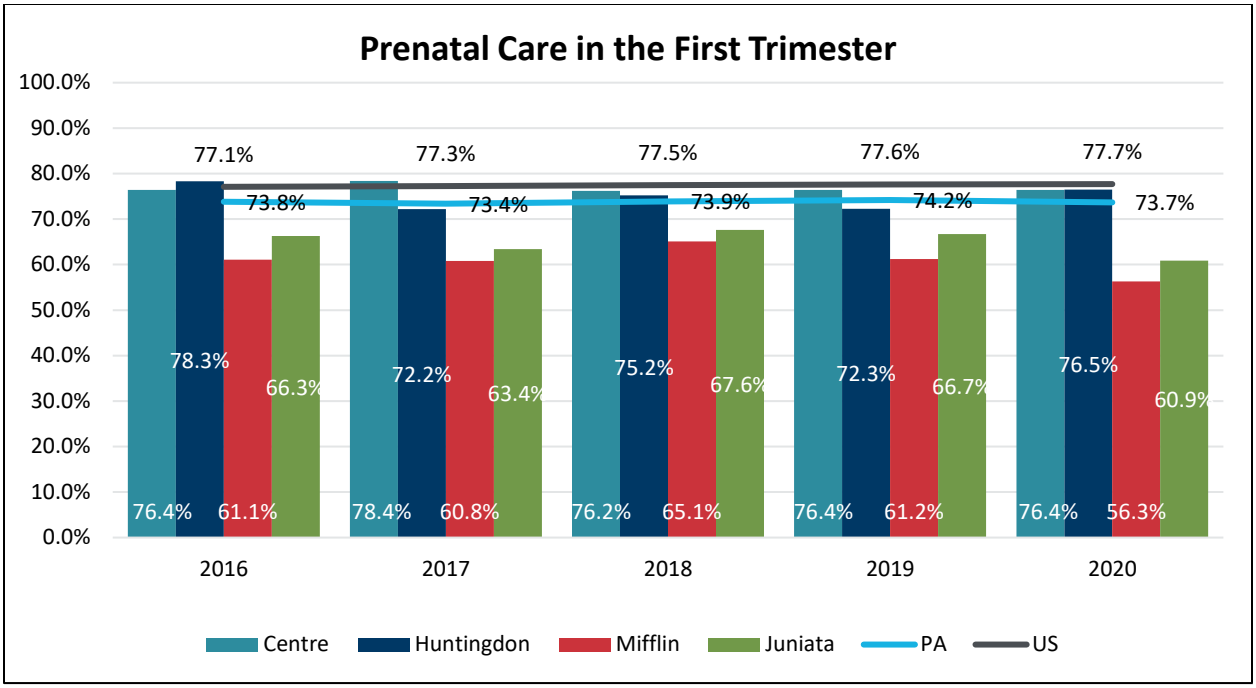
Source: Pennsylvania Department of Health & Centers for Disease Control and Prevention

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
Centre	1.0%	76.4%	6.5%	3.9%	93.9%
Huntingdon	7.9%	76.5%	8.7%	7.9%	84.0%
Juniata	4.2%	60.9%	8.4%	6.5%	87.2%
Mifflin	3.0%	56.3%	6.3%	6.7%	85.6%
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
Centre	4.6 (n=26)
Huntingdon	10.0 (n=19)
Juniata	7.0 (n=10)
Mifflin	9.9 (n=28)
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 Western 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 95 individuals representing the Western 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 40 Pennsylvania counties. More than 80% of respondents worked with organizations serving Mifflin County. Most (63%) 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 and older adults/seniors.

Populations Served by Key Stakeholder Survey Participants

	Number of Participants	Percent of Total
No specific focus-serve all populations	60	63.2%
Older adults/Seniors	21	22.1%
People or families with low income or in poverty	19	20.0%
People with behavioral health (mental health, substance use disorder) concerns	15	15.8%
Children (age 0-11)	14	14.7%
Young adults (age 19-24)	14	14.7%
Adolescents (age 12-18)	13	13.7%
People with disabilities (physical, intellectual, developmental, etc.)	13	13.7%
Other	9	9.5%
People or families experiencing homelessness	9	9.5%
People or families without health insurance or underinsured	9	9.5%
Veterans	9	9.5%
Pregnant or postpartum people	7	7.4%
Faith-based community	5	5.3%
LGBTQ+ community	5	5.3%
New Americans/Immigrants/Refugees	3	3.2%
African American/Black	2	2.1%
People with memory care (Alzheimer's disease, dementia) concerns	2	2.1%
Undocumented citizens	2	2.1%
American Indian/Alaska Native	1	1.1%
Asian/South Asian	1	1.1%
Hispanic/Latinx	1	1.1%
Pacific Islander/Native Hawaiian	1	1.1%

Survey Findings

Health and Quality of Life

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

While many stakeholders described the overall quality of life of the people they serve as average (47%), about one in five 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 Western 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	38	43.2%
Available social services	26	29.6%
Safe neighborhoods	24	27.3%
Good schools	22	25.0%
Strong family life	17	19.3%
Community connectedness	16	18.2%
Clean environment	15	17.1%
Employment opportunities	14	15.9%
Access to crisis support services (e.g., Neighborly, United Way 211, 988 National Suicide Hotline)	11	12.5%
Affordable housing	10	11.4%

Stakeholders saw "access to healthcare services," as their communities' top strength, while "lack of transportation," "ability to afford healthcare," and "limited healthcare capacity and providers" 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.

Stakeholders from the Western region were the only respondents to identify "affordable housing," among the top 10 community strengths. However, affordable, quality housing, or the lack thereof, was also ranked as the fourth most pressing concern among stakeholders in a later question, suggesting varied experiences within the region. Additionally, stakeholders identified feelings of safety within the community, both from violence and within interpersonal relationships, community connectedness, and access to social services as top strengths.

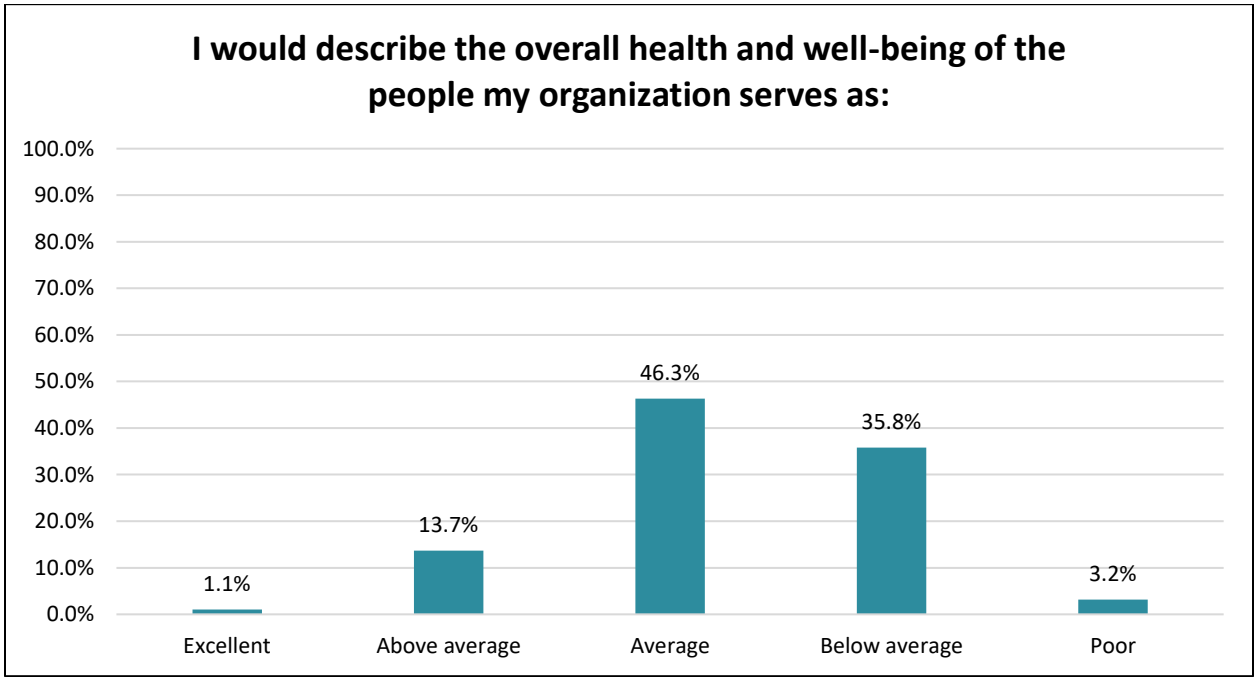
Thinking about the people their organization serves, key stakeholders were asked to describe the overall health and well-being of individuals and the most pressing concerns affecting them. Approximately 46%

of stakeholders described overall health and well-being as “average” and 39% 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 53% of respondents selected mental health conditions. One-third or more of respondents identified economic stability (employment, poverty, cost of living), housing (affordable, quality), lack of transportation, 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, unreliable or non-existent public transportation, and the general but pervasive impacts of poverty. These environmental concerns also hinder individuals’ ability to receive adequate care for ongoing behavioral health needs.

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



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

	Number of Participants	Percent of Total
Mental health conditions	47	53.4%
Economic stability (employment, poverty, cost of living)	40	45.5%
Lack of transportation	40	45.5%
Housing (affordable, quality)	37	42.1%
Substance use disorder (dependence/misuse of alcohol, opiates, heroin, etc.)	35	39.8%
Childcare (affordable, quality)	28	31.8%
Ability to afford health foods	26	29.6%
Ability to afford healthcare	25	28.4%
Overweight/Obesity	19	21.6%
Limited healthcare providers	12	13.6%
Stress (work, family, school, etc.)	12	13.6%
Dental problems	11	12.5%
Limited healthcare capacity (appointments, convenient time/location, etc.)	11	12.5%
Older adult health concerns	10	11.4%
Cancers	7	8.0%

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.

- *"There is no public transportation in any area we serve. The CARSCART program requires long wait periods which is difficult for many older people and persons with diabetes."*
- *"Dental and vision insurance/access seem to be lacking in our region, as they are generally not included in healthcare plans. Mobile clinics, which Geisinger and Evan already have, would be helpful in rural communities especially for Seniors. Childcare services can always be improved – within employers and healthcare systems."*
- *"Many of the resources they need already exist but it is hard to access – so improved public transportation would be a great benefit."*
- *"With vacant buildings/houses around, it would be a good thing to get HUD funding to repair, update, build, housing that is safe and affordable. There are so many of my clients living in homes where landlords are not keeping properties safe and habitable. Not to mention, these same landlords are hiking rents and not making necessary repairs to their properties."*
- *"Educate people about mental health and work with people on ways to de-stress their lives, for example counseling. Invest in the Dream Center Mifflin County to help our community's substance problems. Housing and healthy foods are a concern for the working class. They make too much money for government assistance but yet can't afford decent food and housing for their families."*

- *"Strive to offer additional resources at affordable rates paired with strong marketing and advertisement with minimizing of stigma."*
- *"Providing a personalized experience vs. treating symptoms and moving on in a 10 min appointment. Impersonal surveys at the time of appointment performed by a nurse who is rushing and sometimes making assumptions about a person's situation (or lack of) causes inaccuracies as people are uncomfortable disclosing information if they don't feel as if they are going to be heard and truly listened to."*
- *"Provide more in school Mental Health counseling to Children and young adults."*
- *"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."*
- *"Work better together. The Council on area Agencies is doing a great job of trying to share information between organizations but how can the information get out to the community?"*
- *"Incentivize caregivers with better pay, benefits to encourage applicants and as well as to retain employed caregivers, provide housing for those who don't qualify for skilled care."*
- *"Recognize, train and hire individuals in community health worker roles in both healthcare and social service settings. Individuals in these positions can connect and serve individuals and communities to resources and services that promote a healthier lifestyle/setting/community."*
- *"Offer childcare for their employee's families."*

Social Drivers of Health

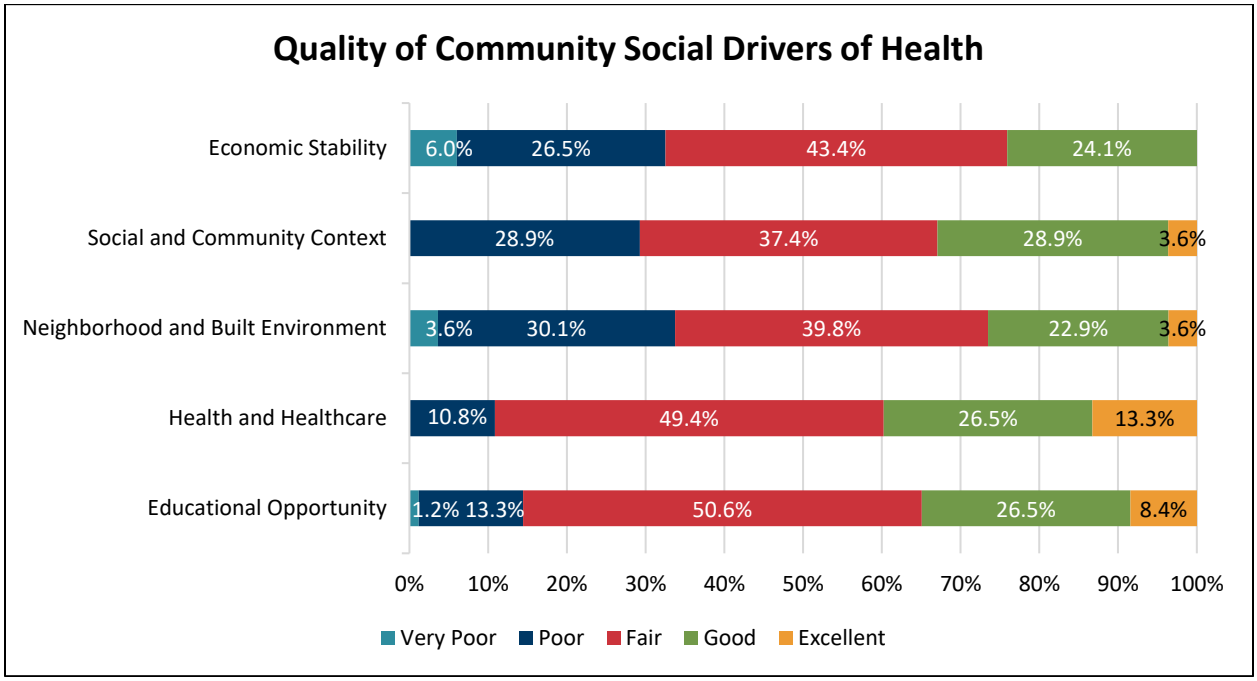
Key stakeholders were asked to rate the quality of the social drivers of health (SDoH) within the community(ies) their organization serves, focusing on the five key domains identified by Healthy People 2030: economic stability, education access and quality, healthcare access and quality, neighborhood 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. Health and healthcare was seen as the strongest community SDoH with 40% of stakeholders rating it as "good" or "excellent," and *none* rating it "very poor." Economic stability was seen as the weakest SDoH, with 43% rating it as "fair" and 33% rating it as "poor" or "very poor," and *none* rating it as "excellent."

Approximately 51% (n= 48) 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
Health and Healthcare (Consider access to healthcare, access to primary care, health literacy)	3.42
Educational Opportunity (Consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)	3.28
Social and Community Context (Consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	3.07
Neighborhood and Built Environment (Consider access to healthy foods, quality of housing, crime and violence, environmental conditions, transportation)	2.93
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.

- *"We have very little to no community transportation. Many of our clients due to their addiction get looked down upon, kind of discrimination."*
- *"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 customers that are unaware of Pennie, CHIP and medical assistance through the county office."*
- *"Cyclical poverty is extremely prevalent. Many depend on SSI/SSD alone to provide. Rental properties and the basic utilities needed to keep household habitable are no longer able to be funded by this income alone, especially an individual who resides alone. Subsidized rent is only*

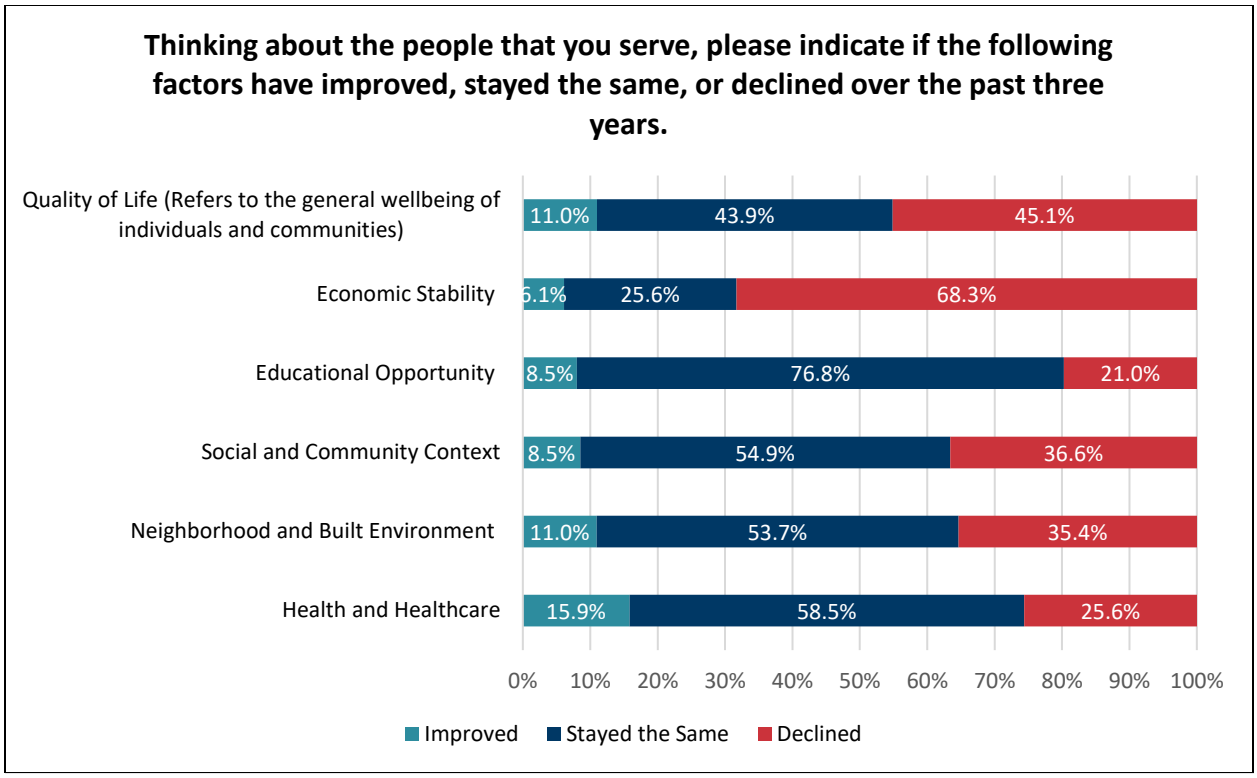
available to certain populations and/or many individuals are ineligible for public housing due to criminal history, poor credit, etc. Many households are doubled and tripled up just to make ends meet. Housing stock in the area is very poor with landlords charging more than a tenant can afford for a home that has electrical issues, structural damage and mold. There is no public transportation available with the exception of 1 taxi service which is not affordable to many. Therefore, they use money they could otherwise use for food or utilities in order to get to a doctor appointment."

- *"The homeless do not have stable housing … when they leave the shelter they often can only afford the most deplorable conditions. This causes them to also be in the most violent, high crime areas of our community."*
- *"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."*
- *"Many of the community members we care for have difficulty paying bills particularly in the window of illness. Many of those we serve look to churches to help with payments."*
- *"Lack of access and affordability of childcare is in crisis mode."*
- *"I work with low-income individuals who are receiving Medical Assistance. Most are unemployed, unmarried, and do not have family or social support. Many have SUD and are lucky if they have a high school diploma. They cannot find childcare to go to doctor appointments and therapy, and cannot afford to pay the fees for taking their children with them to their appointments."*
- *"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."*
- *"There is clear division in our schools, among school administrators, and school boards. There is misinformation, culture wars, politicization of beneficial student programs like SEL (Social Emotional Learning) and a lack of understanding or willingness to engage with DEI."*
- *"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, more than 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 (16%), consistent with their rankings of the SDoH and listing of community strengths.



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.

- *"First, receive training from each social service agency and fully understand all they can or cannot do in their agency. Then, connect and/or refer community members to appropriate, eligible service agencies for assistance."*
- *"Set up clinics for people to get the care they need in Mifflin or Mifflintown Boroughs. Just get a B/P check or get help if they are sick, and have no one to call, but an ambulance to take them to the ER. With medics and EMTs in short supply, we need more help. Maybe give our medics and EMTs more training. And don't make it so expensive. All EMTs and paramedics are now paid, and now no one volunteers anymore."*
- *"Create community outreach teams; Better collaboration with all stakeholders."*
- *"Many of the individuals we care for are below the poverty level that qualify for personal assistant services at home. (Community Health Choices) The need to continue to advocate and educate these individual is very important to keep them living independently."*
- *"More interaction and interventions through the schools."*
- *"Transportation to and from facilities and delivery of pharmacies from their pharmacies."*
- *"Ensuring access – meet communities where they are (mobile services) education to address misinformation, restore trust. Amplify programs supporting the holistic health outcomes of community members – or providing prevention programs."*

- *"Supporting the local food pantries. The COVID-19 food stamp allocation is about to drop back off and food prices are high."*
- *"The Fresh Food Farmacy is a wonderful program however the residents of Huntingdon County do not have transportation to this program or access to diabetic education."*
- *"Pay people for following good practices. People respond to incentives and not marketing. For example, pay a small stipend for colonoscopy, since there is a high incidence of colon cancer. Support good food through the food pantries."*
- *"Continue to educate to bias and DEI issues."*
- *"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. More than in any other region, stakeholders from the Western Region shared disparate views on the *validity* of the pandemic, as well as measures taken in light of COVID-19, and perceived outcomes. A total of 62 stakeholders responded, and their feedback is grouped thematically below.

COVID-19 Pandemic Feedback Themes	Number of Responses
Necessity of addressing mistrust (in the government, in the healthcare system, between diverse community members)	17
Importance of prevention and preparedness, and implementing lessons learned	13
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
Health education (the necessity of providing consistent, accurate, and accessible health information to members of the community to promote health)	11
Mental health (the ongoing impact on people's mental health and the need for increased services, especially for youth)	11
Current economic crisis (disparate impact of all factors on the poor, need to address SDoH)	10
Address ongoing barriers to accessing healthcare (transportation, insurance concerns, etc.)	6
More support solutions for vulnerable populations (elderly, people with disabilities)	3
Strengthening capacity of healthcare and social services organization (hiring and retention, training, availability)	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.

- *"Some kind of Health Care computer system that all hospitals have the same information. If I go to GMC one time and another time Mt Nittany Hospital, they should all be able to pull up the information immediately."*
- *"Receive training from each social service agency and fully understand all they are/aren't funded to do within their agency. Listen to responses when you contact an agency to ascertain if what they're saying, outside of 'they're a conflict,' that may give you assistance or an answer without breaking confidentiality."*
- *"You probably aren't going to be surprised when I say financial support of local social service agencies that address social determinants of health would impact the health of the communities both by strengthening those agencies and by eliminating some of the historical distrust of medical providers by establishing Geisinger/Allies Services/Evan as allies/supporters/partners."*
- *"Instead of starting new initiatives and trying to bring folks to your table – try sending some of your folks to tables that are already meeting and support those efforts."*
- *"Pay for transportation for individuals to bring their children with them to appointments and have on-site short-term childcare at the facilities."*
- *"It would be great to see broad community engagement and support to address housing (i.e. bringing together business, developers, Social services, maybe even conservationist groups, funders and private philanthropy to really tackle this issue jointly to create long term viable solutions for affordable and workforce housing."*
- *"Well-being screenings in the schools."*
- *"Have information at hospitals and medical offices of programs you support (eg: Girls on the Run)"*
- *"I'm impressed the Geisinger has been present at a menu of the community meetings that I attend."*
- *"Partnerships like Healthy Kids Day at the Miller Center where families can learn about healthy lifestyles and receive free information about healthy food, bike helmets for kids, be active together, etc. are fantastic! I'd love to see more of that, partnering with the downtown groups/Chambers/Visitors Bureaus in every community."*
- *"I have seen strong connections and benefit among family physicians as well as urgent care supports. I believe there have been communication and teaming improvements over the last few years in this area of streamlining and refining care."*
- *"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."*

Western Region Community Forum

Background

Geisinger, Allied Services, and Evangelical Community Hospital hosted a Community Forum on September 14, 2022, at the Birch Hill Events in Lewistown. The forum convened 23 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. A list of participants and their respective organization is included in Appendix C.

Community Needs and Disparities

- Inflation and resulting higher costs for basic needs (food, shelter) have strained individuals and households, limiting their ability to prioritize healthy activities (nutrition, routine care). Housing expenses, including rent and utilities, are among the top needs for individuals seeking assistance. The region would benefit from supportive housing programs and collaboration with schools to identify and assist unhoused families.
- Many rural Western Region towns struggle to maintain a sense of community and community pride, largely due to depressed economic conditions. These factors contribute to challenges in recruiting healthcare professionals and attracting new residents.
- Additional outreach is needed to identify and better serve individuals historically isolated and/or disproportionately affected by health and social disparities. These populations include but are not limited to the following:
    - Young mothers living in poverty and not receiving prenatal care
    - Older adults living alone with neuro-cognitive disorders
    - Plain Community members
    - ALICE households
    - Individuals experiencing domestic violence
- The region lacks access to low-income dental care, as well as primary care within rural areas. Mobile health units and satellite clinics are needed to help bridge the care gap.

Community Solutions and Opportunities

- Sustained, collective impact will require broad-based and multi-sector collaboration. Success factors for collaboration include:
    - Engagement of trusted organizations, influencers, and first responders (e.g., Faith-based organizations, schools/teachers, EMS);
    - Partnership between existing agencies to expand services (e.g., YMCA and Geisinger 65 Forward);
    - Use of diverse communication channels to engage residents and stakeholders; and
    - Shared community health improvement goals by collaborating organizations, and forums and tracking tools to convene partners and measure progress.
- National lawsuit settlements related to the opioid and addiction crisis will create new funding opportunities for treatment and recovery services. Organizations should collaborate to help funnel these funds to local communities and create holistic programs.
- The region may benefit from efforts to promote a community culture of health and revitalization of shared spaces. A community engagement initiative may help keep and attract families and advance a more sustainable economy.
- Veteran services are seen as models for holistically and comprehensively caring for individuals. These services should be explored to better serve other community populations.
- Geisinger's Fresh Food Farmacy program is also seen as a community health model, making an impact on individuals who require food assistance and manage a chronic condition.
- Successful community health improvement programs include those that bring services to the community and are integrated into a social service or co-located at places residents naturally frequent. Examples of these programs include:
    - Co-responder programs that embed a mental health worker in police departments.
    - Girls on the Run, a school-based program for combating ACES and promoting health through social activities and mentorship.
    - Geisinger Home Team, offering assisted telehealth visits and home health inspections based on social drivers of health.
    - NuVisions Center, offering visually impaired assistance at home and group programming to foster socialization and shared learning.
- Faith-based groups continue to be an important partner for health and social service agencies, helping to reach residents more effectively and foster collaboration.

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.
- Collaborated with the Plain Community to assess healthcare needs and establish treatment plans consistent with cultural norms and values.
- Began development plans for a new clinic in Bellefonte. The new 23,900-square-foot facility will host 34 exam rooms offering primary care, lab, and radiology services. Geisinger Bellefonte Community Medicine and ConvenientCare Bellefonte will both move to this new location to provide all services under one roof — with more space for a better patient experience.
- Relocated the State College hematology and oncology clinic to an expanded location. The clinic remains at 200 Scenery Drive, State College, but is now on the second floor, entrance 1, and offers more than triple the space of its previous location and includes a more welcoming environment, larger lobby, seven spacious exams rooms, and 12 infusion treatment chairs.

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.
- Continued to partner with Juniata Valley Behavioral and Developmental Services to better serve individuals with serious mental illness, people with intellectual disabilities, and early interventions for children.
- Provided medication disposal boxes at 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.

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 at GLH, 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.
- Expanded palliative medicine program into Centre 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's palliative medicine program expanded into Centre County through the work of Nicki Vithalani, M.D. Palliative medicine is essential to the care of patients with serious and/or progressive illness affecting quality of life. Palliative care allows for symptom management, coordination of healthcare services, and clarification of the patient's goals and priorities. Palliative care helps the entire family be on the same page in planning treatment. Conditions that may warrant a referral to palliative medicine include metastatic cancer, dementia, amyotrophic lateral sclerosis, stroke, and end-stage heart, liver, kidney, or lung disease.

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.

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Appendix B: Key Stakeholder Survey Participants

AIDS Resource, Executive Director

Allied In-Home Services, AVP

American Rescue Workers, Director of Development and Community Engagement

BARRASSE LAW, owner

Belleville Mennonite School, Superintendent

Broad Top Health and Wellness, Nurse Administrator

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

Centre County Government, Human Services Administrator

Chamber of Business & Industry Centre County, VP, Membership Engagement

Clear Concepts Counseling, Clinical Director

Community Care Behavior Health, Director

Compass Community Connections, Program Manager

Compass Community Connections, Executive Director

CSIU, Career Counselor

Evangelical Community Hospital, President & CEO

Evangelical Community Hospital, Director

Evangelical Community Hospital, Chief of EMS Services

Evangelical Community Hospital, Director Care Coordination

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

Evangelical Community Hospital, Director/RN

Evangelical Community Hospital, RN Practice Manager

Evangelical Community Hospital, OB Nurse Manager

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

First Area Federal Credit Union, Manager

Foster Grandparent Program of Central PA, Program Coordinator

Foster Grandparent Program of Central PA, Director

Geisinger, Inpatient Social Work Care Manager

Geisinger, Community Engagement Strategist, Senior

Geisinger, VP, Strategy & Market Advancement

Geisinger, CAO

Geisinger, Community Benefit Coordinator

Geisinger, Director
Geisinger, Director
Geisinger, Director
Geisinger, CMO
Geisinger Health Plan, Chief Administrative Officer, Geisinger Clinic
Geisinger Health Plan, Director
Geisinger Health System, Program Director, DEI
Geisinger Home Infusion, Director
Geisinger Hospice, Chaplain/Bereavement Coordinator
Geisinger Lewistown Hospital, Nursing Operations Manager
Geisinger Lewistown Hospital, Director of Operations
Geisinger Medical Center, Breast and Cervical Cancer Early Detection Program Navigator
Geisinger Medical Center, Outreach/Injury Prevention Coordinator for Adult Trauma
Girls on the Run Mid State PA, Executive Director
Grace United Methodist Church/Susquehanna Conference UMC, Pastor
GREATER LEWISTOWN CORP, PRESIDENT
Hand of Grace, Director/Administrator
Hospice of Evangelical, Director
Innovative Manufacturers Center (IMC), Manager, Outreach & Special Projects
Juniata County Food Pantry, Inc, Director
Juniata River Valley Chamber of Commerce, Executive Director
Juniata Valley Behavioral and Developmental Services, Administrative Officer
Juniata Watershed Alliance, VP
JVBDS, Administrator
Kish Valley Grace Brethren Church, Director
Kiwanis, Secretary
KNA Enterprises, LP, Owner
LIFE Geisinger, LIFE Geisinger
Mifflin CAO, Income Maintenance Casework Supervisor
Mifflin County, Commissioner
Mifflin County CareerLink, Customer Service Specialist
Mifflin County Industrial Development Corporation, President/CEO
Mifflin County Probation, Supervisor
Mifflin Juniata Human Services, Mifflin Juniata Human Services
Mifflin Juniata Human Services, Services Coordinator
Mifflin Juniata Human Services, Housing Stability Coordinator

Mifflin Juniata Human Services, Housing Programs Coordinator

Mifflin Juniata Human Services, Director

Mifflin Juniata Regional Services Corp, PA MEDI Local Coordinator

Mifflin-Juniata Area Agency on Aging, Licensed Professional Care Manager - Pre and Post Natal Care Manager

NuVisions Center, Director of Community Services

Pa CareerLink, Workforce Specialist

PA Department of Health, PA Department of Health

Rupert Insurance, Rupert Insurance

Shelter Service, Executive Director

Spring Run Church of the Brethren, Pastor

St. Mark's Episcopal Church, Pastor

Susquehanna University, Chief of Staff

Tapestry of Health, Director

The Abuse Network, Inc., Executive Director

The Bloomsburg Children's Museum, Director

The Salvation Army, Corps Officer/Pastor

Trinity United Methodist Church, Administrative Secretary

United Methodist Church, Pastor

United Way of Mifflin-Juniata, Executive Director

Veterans Multi-Service Center, Homeless Veterans Reintegration Program- Case Manager

VNA Health System, Community Liaison, Events coordinator

Weis Center for the Performing Arts, Marketing Director

Wellspring Counseling, Owner

Appendix C: Western Region Community Forum Participants

Daniel Auker, District Legislative Aide to State Rep. David Rowe
Brandi Bradrick, Geisinger
Karen Burke, PA Office of Rural Health
Gillian Byerly, Girls on the Run - Mid State PA
Nick Felice, MCIDC - Mifflin County Industrial Development
Allison Fisher, Mifflin/Juniata Human Services
Kendra Haas, United Way Mifflin-Juniata - Impact Coordinator
AJ Hartsock, Gesinger
Colette Hartzler, United Way
Kristy Hine, Gesinger
Frankie Hockenbrocht, SEDA-COG
Kira Jerzerick, Geisinger Lewistown Hospital
Rhonda Kelley, Chamber of Commerce
Wendy Knouse, Geisinger Health Plan
Becky Lock, Juniata Sentinel
Kate Long, NuVisions Center
Stacey Osborne, Geisinger
Crystal Paige, The Abuse Network
Robert Postal, Mifflin County Commissioner
Valerie Reed, Geisinger
Steven Small Jr., Lewistown UMC Parish
Karen Snook, Geisinger
Jim Zubler, Downtown Lewistown, Inc.