Evangelical Community Hospital

Community Health Needs Assessment – Final Report

June 8th, 2012

TrippUmbach
Research • Strategy • Impact

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Introduction

Evangelical Community Hospital, a 127-bed community hospital located in Lewisburg, PA, in response to its community commitment, contracted with Tripp Umbach to facilitate a comprehensive Community Health Needs Assessment (CHNA). The community health needs assessment was conducted between November 2011 and April 2012. As a partnering hospital of ACTION Health, a collaborative partnership in the Central Susquehanna River Valley that includes Geisinger-Shamokin Area Community Hospital (G-SACH), Geisinger Medical Center, Evangelical Community Hospital, Bloomsburg Hospital and Bloomsburg University, Evangelical Community Hospital collaborated with hospitals and outside organizations in the surrounding five-county region (Columbia, Montour, Northumberland, Snyder and Union County) during the community health needs assessment process. The following is a list of organizations that participated in the community health needs assessment process in some way:

- Evangelical Community Hospital
- Geisinger Medical Center
- Bloomsburg Hospital
- Bloomsburg University
- Geisinger-Shamokin Area Community Hospital
- Central PA Healthcare Quality Unit
- Central Susquehanna Community Foundation
- CMSU Behavioral Health Services
- Family Planning Plus of SUN and MJ counties
- Greater Susquehanna Valley United Way
- PA DOH – Montour State Health Center
- Union-Snyder Agency on Aging Inc.
- Sum Child Development Center
- A Community Clinic
- Congrecion Mennonita
- LIFE Geisinger – Kulpmont
- American Cancer Society
- ACTION Health
- Caring Communities
- Degenstein Foundation
- District 107; North'd Ct.
- Susquehanna University
- Bucknell University
- Milton YMCA

This report fulfills the requirements of a new federal statute established within the Patient Protection and Affordable Care Act (PPACA) requiring that non-profit hospitals conduct community health needs assessments every three years. The community health needs assessment process undertaken by Evangelical Community Hospital, with project management and consultation by Tripp Umbach, included extensive input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of public health issues. Tripp Umbach worked closely with leadership from Evangelical Community Hospital and a project oversight committee to accomplish the assessment.

Community Definition

While community can be defined in many ways, for the purposes of this report, the Evangelical Hospital community is defined as 23 zip codes in Northumberland, Snyder and Union counties and one additional zip code area in Juniata County, Pennsylvania containing 80% of the hospital's inpatient discharges (see Figure 1 & Table 1).

Evangelical Community Hospital Community Zip Codes

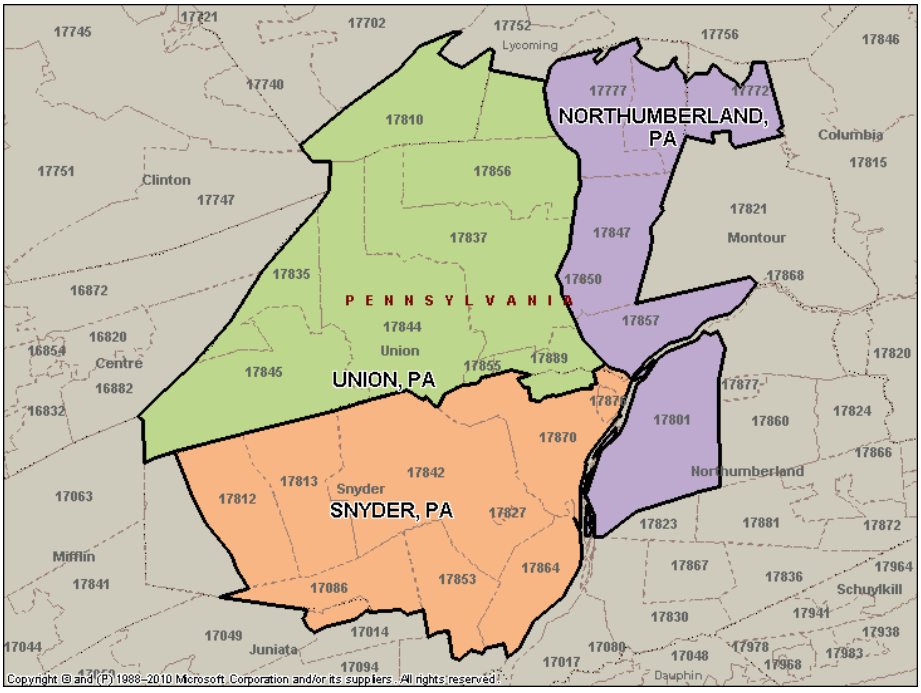
Table 1

Zip	Post Office	County
17086	RICHFIELD	JUNIATA
17772	TURBOTVILLE	NORTHUMBERLAND
17777	WATSONTOWN	NORTHUMBERLAND
17801	SUNBURY	NORTHUMBERLAND
17847	MILTON	NORTHUMBERLAND
17850	MONTANDON	NORTHUMBERLAND
17857	NORTHUMBERLAND	NORTHUMBERLAND
17812	BEAVER SPRINGS	SNYDER
17813	BEAVERTOWN	SNYDER
17827	FREEBURG	SNYDER
17842	MIDDLEBURG	SNYDER
17853	MOUNT PLEASANT MILLS	SNYDER

Zip	Post Office	County
17864	PORT TREVORTON	SNYDER
17870	SELINSGROVE	SNYDER
17876	SHAMOKIN DAM	SNYDER
17810	ALLENWOOD	UNION
17835	LAURELTON	UNION
17837	LEWISBURG	UNION
17844	MIFFLINBURG	UNION
17845	MILLMONT	UNION
17855	NEW BERLIN	UNION
17856	NEW COLUMBIA	UNION
17886	WEST MILTON	UNION
17889	WINFIELD	UNION

Evangelical Community Hospital Community Map

Figure 1



Consultant Qualifications

Evangelical Community Hospital contracted with Tripp Umbach, a private healthcare consulting firm headquartered in Pittsburgh, Pennsylvania to complete the community health needs assessment. Tripp Umbach is a recognized national leader in completing community health needs assessments, having conducted more than 200 community health needs assessments over the past 20 years. Today, more than one in five Americans lives in a community where Tripp Umbach has completed a community health needs assessment.

Paul Umbach, founder and president of Tripp Umbach, is among the most experienced community health planners in the United States, having directed projects in every state and internationally. Tripp Umbach has written two national guide books[1] on the topic of community health and has presented at more than 50 state and national community health conferences.

[1] A Guide for Assessing and Improving Health Status Apple Book: http://www.haponline.org/downloads/HAP_A_Guide_for_Assessing_and_Improving_Health_Status_Apple_Book_1993.pdf and

A Guide for Implementing Community Health Improvement Programs: http://www.haponline.org/downloads/HAP_A_Guide_for_Implementing_Community_Health_Improvement_Programs_Apple_2_Book_1997.pdf

Project Mission & Objectives

The mission of the Evangelical Community Hospital CHNA is to understand and plan for the current and future health needs of residents in its community. The goal of the process is to identify the health needs of the communities served by the hospital, while developing a deeper understanding of community needs and identifying community health priorities. Important to the success of the community needs assessment process is meaningful engagement and input from a broad cross-section of community-based organizations, who were partners in the community health needs assessment.

The objective of this assessment is to analyze traditional health-related indicators, as well as social, demographic, economic and environmental factors. Although the consulting team brings experience from similar communities, it is clearly understood that each community is unique. This project was developed and implemented to meet the individual project goals as defined by the project sponsors and included:

- Assuring that community members, including under-represented residents and those with a broad-based racial/ethnic/cultural and linguistic background are included in the needs assessment process. In addition, educators, health-related professionals, media representatives, local government, human service organizations, institutes of higher learning, religious institutions and the private sector will be engaged at some level in the process.

- Obtaining statistically valid information on the health status and socio-economic/environmental factors related to the health of residents in the community and supplement general population survey data that is currently available.

- Developing accurate comparisons to baseline health measures utilizing the most current validated data.

- Utilizing data obtained from the assessment to address the identified health needs of the service area.

- Providing recommendations for strategic decision-making regionally and locally to address the identified health needs within the region to use as a baseline tool for future assessments.

- Developing a CHNA document as required by the Patient Protection and Affordable Care Act (PPACA).

Methodology

Tripp Umbach facilitated and managed a comprehensive community health needs assessment on behalf of Evangelical Community Hospital — resulting in the identification of community health needs. The assessment process included input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge and expertise of public health issues.

Key data sources in the community health needs assessment included:

- **Community Health Assessment Planning:** A series of meetings were facilitated by the consultants and the CHNA oversight committee consisting of leadership from Evangelical Community Hospital and other participating hospitals and organizations (i.e., Geisinger Medical Center, Evangelical Community Hospital, Bloomsburg Hospital and Bloomsburg University).

- **Secondary Data:** The health of a community is largely related to the characteristics of its residents. An individual's age, race, gender, education and ethnicity often directly or indirectly impact health status and access to care. Tripp Umbach completed comprehensive analysis of health status and socio-economic environmental factors related to the health of residents of the Evangelical Community Hospital community from existing data sources such as state and county public health agencies, the Centers for Disease Control and Prevention, County Health Rankings, Thompson Reuters, CNI, The Center for Rural PA, PennDOT and other additional data sources.

- **Use of previous CHNA:** In 2009, ACTION Health contracted with Geisinger Center for Health Research to complete a CHNA for the same five-county region (Columbia, Montour, Northumberland, Snyder and Union Counties). While it was not possible to complete trend analyses of the 2009 CHNA raw data due to a departure in methodologies, there are references throughout this document to the 2009 CHNA Rural Pennsylvania Counts: A Community Needs Assessment of Five Counties. Tripp Umbach did not complete any independent analysis of the data collected in 2009, but chose to rely on the analysis completed by Geisinger Center for Health Research.

- **Interviews with Key Community Stakeholders:** Tripp Umbach worked closely with the CHNA oversight committee to identify leaders from organizations that have special knowledge and/or expertise in public health (i.e., Evangelical Community Hospital, Union-Snyder Agency on Aging Inc., PA Health Department and American Cancer Society). Such persons were interviewed as part of the needs assessment planning process. A series of 15 interviews were completed with key stakeholders in the Evangelical Community Hospital community. A complete list of organizations represented in the stakeholder interviews can be found in the "Key Stakeholder Interviews" section on page 31 of this report.

- **Focus Groups with Community Residents:** Tripp Umbach worked closely with the CHNA oversight committee to assure that community members, including under-represented residents, were included in the needs assessment planning process via three focus groups conducted by Tripp Umbach in the Evangelical Community Hospital community. Focus group audiences were defined by the CHNA oversight committee utilizing secondary data to identify health needs and deficits in targeted populations. Focus group audiences included: Healthcare Providers, Latino Residents and Under/Uninsured Residents.

- **Identification of top community health needs:** Top community health needs were identified and prioritized by community leaders during a regional community health needs identification forum held on April 5th 2012. Consultants presented to community leaders the CHNA findings from analyzing secondary data, key stakeholder interviews and focus group input. Community leaders discussed the data presented, shared their visions and plans for community health improvement in their communities, and identified the top community health needs in the Evangelical Community Hospital community.

- **Final Community Health Needs Assessment Report:** A final report was developed that summarizes key findings from the assessment process and prioritizes top community health needs.

Key Community Health Needs

Tripp Umbach's independent review of existing data, in-depth interviews with community stakeholders representing a cross-section of agencies, and detailed input provided by three community focus groups resulted in the prioritization of three key community health needs in the Evangelical Community Hospital community. Community leaders identified the following top community health needs that are supported by secondary and/or primary data: 1) Improving access to affordable healthcare, 2) Improving healthy behavior, and 3) Transportation, specifically to health service providers. Many of the same needs were identified in the 2009 CHNA, Rural Pennsylvania Counts. A summary of the top three needs in the Evangelical Community Hospital community follows:

- ✓ **IMPROVING ACCESS TO HEALTHCARE FOR UNDER/UNINSURED RESIDENTS**

  Underlying factors identified by secondary data and primary input from community stakeholders and focus groups with residents: Need for increased access to affordable health insurance and increased number of healthcare providers in general and specifically, healthcare providers that will accept state-funded medical insurance.

  Community leaders, key stakeholders and focus group participants agree that while there are ample medical resources and healthcare facilities in the five-county region; access to healthcare resources can be limited by health insurance coverage (i.e., provider acceptance of state-funded health insurance and affordable health insurance options) and the availability of providers, particularly those that reside in the more rural areas and/or those that are under/uninsured.

  Health Insurance Issues:

  - ✓ Thirteen percent (13%) of Pennsylvania adults ages 18-64 did not have healthcare coverage in 2009. Significantly more young adults reported having no health insurance (23% of those ages 18-29) compared to older adults (13% for ages 30-44 and 9% for ages 45-64). [2]

    - Eleven percent (11%) of Pennsylvania adults responded in 2009 that there was an instance in which they needed to see a doctor in the past year but could not because of cost. Adults under 45 years of age had significantly higher percentages for being unable to see a doctor due to cost compared to older adults.

[2] Centers for Disease Control and Prevention: www.cdc.gov/brfss

- Sunbury, Lewisburg and Shamokin Dam recorded the highest rates of uninsured individuals within the Evangelical Community Hospital study area, with 12% of their populations being uninsured.

✓ Community leaders, key stakeholders and focus group participants were under the impression that state-funded health insurance is not readily accepted in the area among medical and dental providers, causing residents to travel lengthy distances to receive health services. Community leaders, key stakeholders and focus group participants all discussed the gap between the income qualifications for state-funded health insurance and the ability of residents to afford private-pay health insurance premiums. Community leaders, key stakeholders and focus group participants all believed that the limitations of state-funded health insurance can reduce the access residents have to healthcare.

"45,000 deaths annually linked to lack of health coverage. Uninsured working-aged Americans have a 40% higher death risk than privately insured counterparts."
Harvard University; Harvard Gazette 2009

✓ Community leaders, key stakeholders and focus group participants believed that health insurance can be unaffordable for some residents, leading residents to be underinsured with limited coverage and high deductibles and/or uninsured with no coverage at all. Community leaders and focus group participants gave the impression that some employers are not able to offer comprehensive health insurance benefits to their employees due to the high cost of premiums, causing employees to opt out of healthcare plans offered by employers or employers to hire part-time employees only. While key stakeholders and some focus group participants felt that there are medical facilities in the area that provide medical care; the medical care provided may be unaffordable for some residents if they are under/uninsured.

✓ The CHNA completed in 2009 identified a lack of healthcare coverage as one of the six key themes found during the needs assessment. The household survey administered found that 18.2% (one in every five) adults in the region did not have health insurance and unemployed individuals were the least likely to have health insurance.

Availability of healthcare providers:

✓ In 2010, Union county had similar rates of primary care physicians (PCP) (115 PCPs per 100,000 population) as compared with Pennsylvania's rate (119 PCPs per 100,000 population). At the same time, Juniata, Northumberland and Snyder

counties had low PCP rates (Juniata = 56 PCPs; Northumberland = 52 PCPs and Snyder = 65 PCPs per 100,000 population).

- ✓ Community leaders, key stakeholders and focus group participants also discussed the accessibility of providers. Community leaders were under the impression that there is a shortage of dentists in the area to provide both routine and specialty dental care. Similarly, community leaders, key stakeholders and focus group participants believed that there are not enough healthcare providers in the area to meet resident demand for under/uninsured and mental health care. Participants were under the impression that there are limited medical and mental health providers available after-hours, which limits the access residents have to crisis and urgent care services after normal business hours.

- ✓ Community leaders, key stakeholders and focus group participants gave the impression that the limited access some residents have to medical, mental and dental health care may cause: an increase in the utilization of emergency medical care for non-emergent issues; waiting times for healthcare services; an increase in travel distance and time for under/uninsured residents; as well as resistance to seek health services; patients presenting in a worse state of health than they may have with greater access to services and a general decline in the health of residents.

- ✓ The CHNA completed in 2009 identified a lack of healthcare coverage, difficulty locating healthcare providers and paying for services – particularly dental care; and lack of behavioral healthcare services as two of the six key themes found during the needs assessment. Behavioral health was identified as a significant need in every community. The household survey indicated that 5.5% of the residents of the region needed mental health care, but were not able to obtain care and 74% did not obtain this care as the result of not being able to afford the cost of care. Dental care was also frequently mentioned – particularly for Medicaid recipients. In fact, the household survey found that nearly 26,000 individuals in the region are unable to afford recommended dental care and as many as 10,000 were often or very often unable to afford prescription medication.

❑ IMPROVING HEALTHY BEHAVIOR

Underlying factors identified by secondary data and primary input from community stakeholders and focus groups with residents: Need for increased awareness and education, motivation and/or incentives for resident that practice healthy behavior and increased access to healthy options in the region.

The health of a community largely depends on the health status of its residents. Community leaders, key stakeholders and focus group participants believed that the lifestyles of some

residents may have an impact on their individual health status, and consequently, cause an increase in the consumption of healthcare resources. Specifically, community leaders and stakeholders discussed lifestyle choices (i.e., poor nutrition, inactivity, smoking, substance abuse, including alcohol and other drugs, etc.) that can lead to chronic illnesses (i.e., obesity, diabetes, pulmonary diseases, etc). An increase in the number of chronic illness diagnoses in a community can lead to a greater consumption of healthcare resources due to the need to monitor and manage such diagnoses. Community leaders believed that residents making lifestyle choices that negatively impact their individual health status may lack the awareness, motivation and/or access to healthier options to implement healthy behaviors. Key stakeholders perceived the health status of many residents to be poor due to the perceived prevalence of chronic lifestyle-related illnesses.

Awareness and education about healthy behaviors:

- ✓ Northumberland, Snyder and Union counties all show poor county health rankings when compared with the rest of the state of Pennsylvania for Employment, Education and Diet, and Exercise. We know that these three factors are highly correlated with health; i.e., poor employment can lead to lower income which can then lead to fewer options for good educational opportunities, and therefore, poorer health decisions in terms of diet and exercise.

- ✓ Community leaders, key stakeholders and focus group participants were under the impression that residents may not always be aware of healthy choices due to cultural norms, limited access to preventive healthcare, limited prevention education and community outreach in some areas. Community leaders, key stakeholders and focus group participants believed that the health and wellness of residents may be negatively impacted by a lack of education and awareness about healthy behaviors.

- ✓ In 2009, Rural Pennsylvania Counts household survey found that there are significant differences in sources of health information by education. Individuals at the lowest end of the educational spectrum are less likely to use the internet or print materials from home in comparison to individuals with higher levels of education including some college or Bachelor's degree. However, most respondents indicated that they would obtain health information directly from their healthcare provider.

Motivation to implement healthy behaviors:

- ✓ Snyder County shows six categories with a county health rank above the median of 34 indicating poor healthcare access (Social and Economic Factors, Diet and Exercise, Access to Care, Education, Employment and Community Safety). Many of the measures in which Snyder County ranks poorly are social factors that could be improved by increasing community healthcare access.

- ✓ Community leaders recognized that any change in behavior requires individual motivation, which area residents may not always have. Community leaders and focus group participants were under the impression that while some residents may be aware of healthy behaviors; those same residents may not be motivated to make healthy choices. Often it can require more effort and energy to live a healthy lifestyle than to make unhealthy choices.

Implementation and access to healthy options:

- ✓ Snyder and Union counties show poor access to healthy options. Union County contains eight zip code areas of which only two have healthy food options. Also, Union County only has two recreational facilities for more than 43,000 residents.[3]

- ✓ Community leaders, key stakeholders and focus group participants believed that some residents may be aware of and motivated to make healthy choices; however, healthy options may not be available in some communities or affordable for some residents. Specifically, community leaders, key stakeholders and focus group participants were under the impression that healthy options, such as fresh produce, healthy food and physical activities may be unaffordable and/or inaccessible for residents in some communities in the region.

- ✓ In 2009, Rural Pennsylvania Counts household survey found that household size was not significantly associated with an inability to afford healthy food. However, those in the lower income bracket (household income equal to or less than $40,000 per year) were significantly more likely to report that they could not afford fresh fruits and vegetables (10.9% compared to higher income 3.0%). Additionally, there were significant differences in exercise habits by income status. More than one in four lower income residents report no exercise.

✓ COMMUNITY DEVELOPMENT, SPECIFICALLY TRANSPORTATION

Underlying factors identified by secondary data and primary input from community stakeholders and focus groups with residents: Need for community development, specifically transportation.

[3] To measure access to recreational facilities, the *County Health Rankings* replicate the measure used by the USDA Food Environment Atlas, using the most current County Business Patterns data set. The Food Environment Atlas presents a measure of recreational facilities per population, in which recreational facilities are identified by the NAICS code 713940. This industry class includes establishments primarily engaged in operating fitness and recreational sports facilities, featuring exercise and other physical fitness conditioning or recreational sports facilities, such as swimming, skating, or racquet sports. The measure reported by the *County Health Rankings* is recreational facilities per 100,000 population in the county.

Community leaders, key stakeholders and focus group participants gave the impression that the lack of transportation, when coupled with the rural nature of the region, and limited translation services, may cause significant barriers to some residents accessing healthcare. This is because they are not always able to make it to appointments and emergency medical transportation services are not always close by to adequately address medical emergencies.

General public transportation issues:

- ✓ Coordination and Integration of Rural Public Transportation Services in Pennsylvania is a study conducted by Edinboro University that considers the challenges of public transportation in rural Pennsylvania. To identify barriers and opportunities for integration of rural transportation systems, the researcher interviewed administrators and employees from eight of the 21 providers of public transportation that operated in rural PA areas in 2002 and 2003. A summary of the conditions that affect the operation and coordination of public transportation:[4]

    - Rural public transportation systems are funded in part by the Pennsylvania Department of Transportation (PennDOT) and their routes cover at least parts of 27 counties.

    - Tradition and agency preference continue to limit current integration and may limit coordination in the future.

    - The Pennsylvania Constitution prohibits the use of gas tax revenues to fund public transportation, leaving the real estate tax as the primary source for supporting public transportation resulting in severely constrained tax sources. Often, counties lack the revenue resources to better support public transportation.

    - Different policy, budget and funding choices among neighboring counties may present barriers to the formation of transportation alliances and coordination.

    - Transportation agencies lack information about the availability and amounts of transportation funding available from various sources.

    - Increasing numbers of riders are qualifying for subsidized transportation at the same time that states are facing budget shortfalls.

[4] Source: The Center for Rural PA (http://www.rural.palegislature.us/rural_public_transportation.pdf)

- Most private and public interest organizations, primary and secondary schools, and some human services agencies have traditionally provided transportation for their clients separately. After failed integration attempts in the past, transportation providers may be reluctant to coordinate their efforts.

- The difficulties of driving clients to their scheduled appointments on time and of clients having to wait long periods of time for their return rides continue to complicate transportation coordination efforts.

- Behavioral problems among some rider groups prevent some special needs clients from riding in vehicles with some other rider groups.

✓ While community leaders acknowledged that there are transportation systems operating in the region, leaders believed that those systems were limited and disjointed. Specifically, community leaders believed that there are transit systems administered at the county level; however, each county transit system does not carry residents across county lines. Additionally, community leaders were under the impression that where one county transit system ends, another county system does not always pick up, making it difficult to travel across counties. Furthermore, community leaders, key stakeholders and focus group participants gave the impression that the public transportation that is offered is limited in the area that is covered and schedules that are offered. For many residents that do not have access to private transportation, it can be difficult to get around in the region. In particular, key stakeholders and focus group participants believed that the lack of transportation presents residents with barriers to accessing available community services, employment opportunities, healthy nutrition, healthcare, mental health care, etc.

Transportation for medical appointments:

- ✓ According to PennDOT, in FY 09-10, the number one purpose for rural transit services was medical (35%) followed by work (30%) and shopping (23%).[5]

- ✓ Community leaders believed that healthcare providers may not be accepting state-funded health insurance due to recipients having a low attendance rate for scheduled appointments. Community leaders, key stakeholders and focus group participants believed that a lack of transportation due to poor public transportation, inability to maintain a private method of transportation and the cost of gasoline, when coupled with the distance some residents have to travel to get to medical facilities, may reduce the access residents have to medical care. Community leaders believed that transportation may be, in part, responsible for the limited rate of attendance that local medical providers observed from recipients of state-funded health insurance. Additionally, key stakeholders and focus group participants believed that there are clinics in the area that provide medical care to uninsured residents; however, many residents are not able to get to and from these clinics and hospitals, which limits the access residents have to primary, preventive and mental healthcare, as well as employment opportunities, community services and healthy produce.

- ✓ In the 2009 CHNA, Rural Pennsylvania Counts, transportation was one of the six key themes identified in the needs assessment process. One of the greatest needs identified in the household survey was healthcare transportation. Transportation issues were also discussed in focus groups from four of the five counties (Columbia, Northumberland, Snyder and Union Counties).

[5] Source: PennDOT: Public Transportation (ftp://ftp.dot.state.pa.us/public/pdf/TFAC/Toby%20Fauver%20-%20Transit%20Perspective.pdf)

Community Health Needs Identification Forum

The following qualitative data were gathered during a regional community health needs identification forum held on April 5th, 2012 at the Danville Elks Lodge and Banquet Hall. The community forum was conducted with more than 60 community leaders from a five-county region (Columbia, Montour, Northumberland, Snyder and Union Counties). Community leaders were identified by the community health needs assessment oversight committee for Evangelical Community Hospital.

Tripp Umbach presented the results from the secondary data analysis, key stakeholder interviews and community focus groups, and used these findings to engage community leaders in a group discussion. Community leaders were asked to share their vision for the community, discuss a plan for health improvement in their community and prioritize their concerns. Breakout groups were formed and asked to identify issues/problems that were most prevalent in the region, along with ways to resolve the identified problems through innovative solutions that would develop a healthier community.

During the community forum process, community leaders discussed regional health needs that centered around three themes: Access to healthcare for under/uninsured residents, Healthy behaviors: awareness, motivation and implementation and Transportation to health service providers. The following summary represents the most important topic areas discussed at the forum. Community leaders believe the following concerns are the most pressing problems and are identified as the most manageable to address and resolve.

- ✓ **ACCESS TO HEALTHCARE FOR UNDER/UNINSURED RESIDENTS:**
  Access to healthcare was discussed among community leaders at the community forum. Community leaders focused their discussions primarily on the limited number of healthcare providers, and issues surrounding health insurance for the under/uninsured populations in the region.

  - ✓ While community leaders believed there are resources in the area to meet the medical needs of residents, leaders also believed access to those resources can be limited by the limitations of health insurance coverage (i.e., provider acceptance of state-funded health insurance and affordable health insurance options) and the availability of providers.

  - ✓ Community leaders believed that health insurance can be unaffordable for some residents, leading residents to be underinsured with limited coverage and high deductibles and/or uninsured with no coverage at all. Leaders also gave the impression that some employers are not able to offer comprehensive health insurance benefits to their employees due to the high cost of premiums. Additionally, leaders were under the impression that state-funded health insurance is not readily

accepted in the area, causing residents to travel lengthy distances to receive health services.

- ✓ Community leaders also discussed the accessibility of providers, particularly dentists and pediatric mental health services. Community leaders were under the impression that there is a shortage of dentists in the area to provide both routine and specialty dental care. Similarly, leaders believed there is a shortage of pediatric mental health services in the areas of psychiatry, therapy and treatment facilities.

- ✓ **TRANSPORTATION TO HEALTH SERVICE PROVIDERS:**

Community leaders gave the impression that the lack of transportation, when coupled with the rural nature of the region, may cause significant barriers to some residents accessing healthcare because they are not always able to make it to appointments and emergency medical transportation services are not always close by to adequately address medical emergencies.

- ✓ While community leaders acknowledged that there are transportation systems operating in the region, leaders believed that those systems were limited and disjointed. Specifically, community leaders believed that there are transit systems administered at the county level; however, each county transit system does not carry residents across county lines. Additionally, community leaders were under the impression that where one county transit system ends another county system does not always pick up, making it difficult to travel across counties. Furthermore, community leaders gave the impression that the public transportation that is offered is limited in the area that is covered and schedules that are offered. For many residents that do not have access to private transportation, it can be difficult to get around in the region.

- ✓ Community leaders believed that healthcare providers may not be accepting state-funded health insurance due to recipients having a low attendance rate for scheduled appointments. Leaders believed that a lack of transportation due to poor public transportation, limited financial means to maintain a private method of transportation and the cost of gasoline when coupled with the distance some residents have to travel to get to medical facilities may, in part, be responsible for the limited rate of attendance that local medical providers observe from recipients of state-funded health insurance.

- **HEALTHY BEHAVIORS: AWARENESS, MOTIVATION AND IMPLEMENTATION:**

  Community leaders believed that the lifestyles of some residents may have an impact on their individual health status and consequently cause an increase in the consumption of healthcare resources. Specifically, community leaders discussed lifestyle choices (i.e., poor nutrition, inactivity, smoking, substance abuse, including alcohol and other drugs, etc.) that can lead to chronic illnesses (i.e., obesity, diabetes, pulmonary diseases, etc). Community leaders believed that residents making lifestyle choices that negatively impact their individual health status may lack the awareness, motivation and/or access to healthier options to implement healthy behaviors.

  - Community leaders were under the impression that residents may not always be aware of healthy choices due to cultural norms, limited access to preventive healthcare and limited community outreach in some areas. Community leaders believed that the health and wellness of residents may be negatively impacted by a lack of education and awareness about healthy behaviors.

  - Community leaders recognized that any change in behavior requires individual motivation, which area residents may not always have. Community leaders were under the impression that while some residents may be aware of healthy behaviors; those same residents may not be motivated to make healthy choices. Often it can require more effort and energy to live a healthy lifestyle than to make unhealthy choices.

  - Community leaders believed that some residents may be aware of and motivated to make healthy choices; however, healthy options may not be available in some communities or affordable for some residents. Specifically, community leaders were under the impression that healthy options, such as fresh produces, healthy food and physical activities may be unaffordable for residents in some communities in the region.

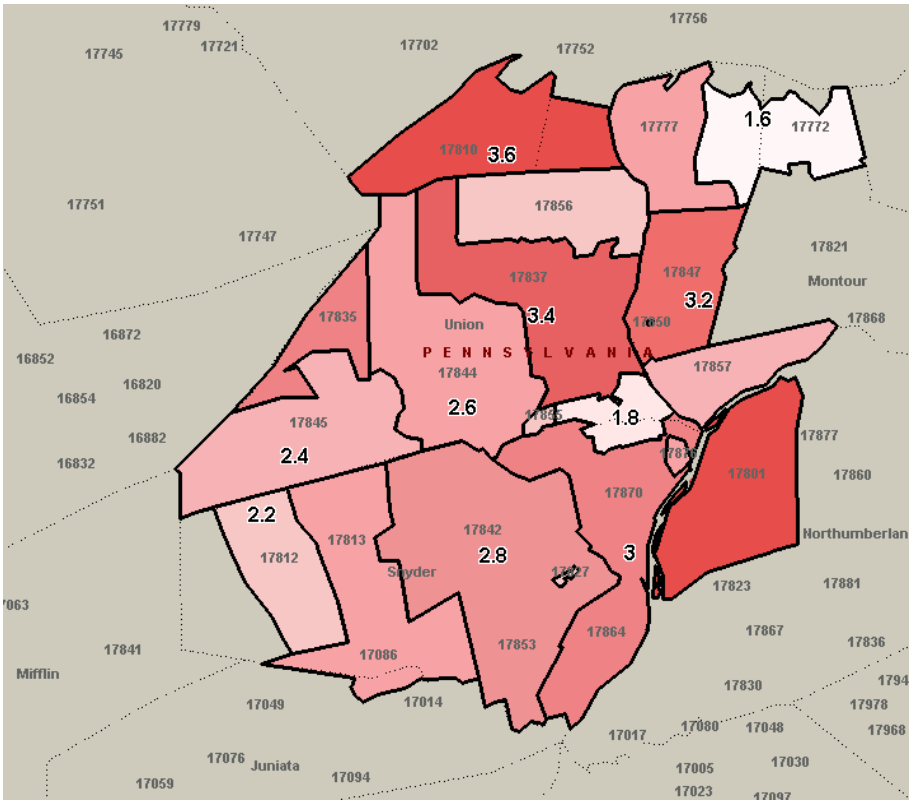
Secondary Data

Tripp Umbach worked collaboratively with the Evangelical Community Hospital community health needs assessment oversight committee to develop a secondary data process focused on three phases: collection, analysis and evaluation. Tripp Umbach obtained information on the demographics, health status and socio-economic and environmental factors related to the health and needs of residents from the multi-community service area of Evangelical Community Hospital. The process developed accurate comparisons to the state baseline of health measures utilizing the most current validated data. In addition to demographic data, specific attention was focused on the development of two key community health index factors: Community Need Index (CNI) and Prevention Quality Indicators Index (PQI).

Demographic Profile

The Evangelical Community Hospital study area encompasses Juniata, Northumberland, Snyder and Union counties, and is defined as a zip code geographic area based on 80% of the hospital's inpatient volumes. The Evangelical Community Hospital community consists of 23 zip code areas (see Figure 2).

Figure 2: Evangelical Community Hospital Community Geographic Definition



** Darker shading indicates greater barriers to healthcare access*

Demographic Profile – Key Findings:

- ✓ Evangelical Community Hospital shows a very slight decline in population over the next five years at a rate of -0.09%. This trend differs from that of Pennsylvania as a whole. Pennsylvania is projected to see a 0.70% rise in population between 2011 and 2016. Therefore, people are coming into Pennsylvania but not to counties in the ACTION Health study area with the exception of Snyder and Union counties.

- ✓ Union County shows a much higher rate of men as opposed to women (56.6% men, 43.4% women). This is important to note when assessing morbidity and mortality data.

- ✓ Northumberland County shows the largest percentage of individuals aged 65 and older (19.5%); much more than state (15.9%) and national levels (13.3%).

- ✓ The Evangelical Community Hospital study area shows an average annual household income of $53,064.
  - The lowest average income is found in Northumberland County ($45,871). Income levels are highly correlated to healthcare access and health activities.
  - It is interesting to see that all of the average household income levels for the study area fall below the averages for Pennsylvania ($64,000) and for the United States ($67,529). Generally, rural areas show lower income levels as compared with more urban areas.

- ✓ Evangelical Community Hospital shows 16.6% of the population who have not received a high school diploma, the lowest in the area, but still much more than the state rate (12.6%) and U.S. rate (15.1%) which are somewhat lower. Educational level is highly related to occupation and therefore income.

- ✓ The Evangelical Community Hospital study area shows very little diversity as compared with Pennsylvania and the United States. Only 5.1% of the population in the Evangelical study area identify as a race/ethnicity other than White, Non-Hispanic, whereas 19.6% in PA and 35.8% in the U.S. identify as a race other than White, Non-Hispanic.

Community Need Index (CNI)

In 2005 Catholic Healthcare West, in partnership with Thomson Reuters, pioneered the nation's first standardized Community Need Index (CNI).[6] CNI was applied to quantify the severity of health disparity for every zip code in Pennsylvania based on specific barriers to healthcare access. Because the CNI considers multiple factors that are known to limit healthcare access, the tool may

[6] "Community Need Index." Catholic Healthcare West Home. Web. 16 May 2011. <http://www.chwhealth.org/Who_We_Are/Community_Health/STGSS044508>.

be more accurate and useful than other existing assessment methods in identifying and addressing the disproportionate unmet health-related needs of neighborhoods.

The five prominent socio-economic barriers to community health quantified in CNI include: Income, Insurance, Education, Culture/Language and Housing. CNI quantifies the five socio-economic barriers to community health utilizing a five-point index scale where a score of 5 indicates the greatest need and 1, the lowest need.

Overall, the Evangelical Community Hospital zip code areas have a CNI score of 2.9, indicating a higher than average level of community health need in the hospital community. The CNI analysis lets us dig deeper into the traditional socio-economic barriers to community health and identify area where the need may be greater than the overall service area.

Table 2: CNI Scores for the Evangelical Community Hospital Service Area by Zip Code

Zip	Post Office	County	Income Rank	Insurance Rank	Education Rank	Culture Rank	Housing Rank	**CNI Score**
17801	SUNBURY	NORTHUMBERLAND	4	3	4	2	5	3.6
17810	ALLENWOOD	UNION	3	3	5	5	2	3.6
17837	LEWISBURG	UNION	3	3	3	3	5	3.4
17847	MILTON	NORTHUMBERLAND	4	2	3	2	5	3.2
17864	PORT TREVORTON	SNYDER	4	2	5	1	3	3.0
17870	SELINSGROVE	SNYDER	3	2	3	3	4	3.0
17835	LAURELTON	UNION	5	2	5	1	2	3.0
17842	MIDDLEBURG	SNYDER	3	2	4	1	4	2.8
17853	MOUNT PLEASANT MILLS	SNYDER	3	2	5	1	3	2.8
17777	WATSONTOWN	NORTHUMBERLAND	3	2	3	1	4	2.6
17813	BEAVERTOWN	SNYDER	2	2	4	1	4	2.6
17876	SHAMOKIN DAM	SNYDER	3	3	2	1	4	2.6
17844	MIFFLINBURG	UNION	3	2	4	1	3	2.6
17086	RICHFIELD	JUNIATA	4	1	4	1	3	2.6
17850	MONTANDON	NORTHUMBERLAND	2	2	4	1	3	2.4
17845	MILLMONT	UNION	3	2	4	1	2	2.4
17857	NORTHUMBERLAND	NORTHUMBERLAND	3	2	3	1	3	2.4
17812	BEAVER SPRINGS	SNYDER	2	2	3	1	3	2.2
17827	FREEBURG	SNYDER	1	2	4	1	3	2.2
17855	NEW BERLIN	UNION	2	2	3	1	3	2.2
17856	NEW COLUMBIA	UNION	2	2	4	2	1	2.2
17889	WINFIELD	UNION	3	1	2	2	1	1.8
17772	TURBOTVILLE	NORTHUMBERLAND	1	1	3	1	2	1.6
Evangelical Community Hospital Summary			**3**	**2**	**4**	**2**	**4**	**2.9**

- ✓ Higher CNI scores indicate greater number of socio-economic barriers to community health.
- ✓ The highest CNI score for the Evangelical Community Hospital study area is 3.6 in the zip code areas of Sunbury and Allenwood in Northumberland County. The highest CNI score indicates the most barriers to community healthcare access.

- ✓ The rates at which individuals are living (either single or married) with children in poverty are concerning. Sunbury=50% single and 17% married living in poverty; Laurleton=75% single and 13% married; and Milton=43% single and 13% married living in poverty.

- ✓ Sunbury in particular shows very high rates of various individuals living in poverty; 65 and older (11%), families with married individuals with children (17%) and families with single individuals with children (50%).

- ✓ Sunbury has the highest percentage of individuals who rent (40%). The renting population is generally comprised of students or individuals with lower incomes who cannot afford to buy a home.

- ✓ Allenwood is a unique population; approximately 78% of the Allenwood population is incarcerated individuals at one of the three, all-male federal correctional facilities (low, medium and high security). The CNI data for Allenwood includes these individuals.

    - With that being said, Allenwood shows the highest unemployment rate (17%), minority (60%), limited English (3%), and individuals with no high school diploma (30%) across the entire ACTION Health study area.

- ✓ Looking beyond Allenwood, we see that all of the other zip code areas have unemployment rates below state and national levels (both approximately 8.2%).

- ✓ Turbotville, on the other hand, shows very low rates for many of the measures used in the CNI score.

    - With only 4% unemployment, Turbotville has a much lower unemployment rate than the state and national rate.

    - Turbotville also shows a very low rate of various individuals living in poverty; 9% 65 and older, 5% married with children living in poverty and 8% single living with children in poverty.

- ✓ The median for the CNI scale is 2.5. The Evangelical Community Hospital study area shows 14 zip code areas above the median, while at the same time shows nine below the median. This helps us to see that the Geisinger study area contains more zip code areas with CNI scores above the median indicating more barriers to community healthcare access.

- ✓ The average CNI scores for Evangelical Community Hospital and the counties included in the service area are all above the median for the scale (2.5); however, none of the scores are substantially high, most are in the mid-range for the number of barriers to community need access.

- ✓ All of the average CNI scores for the study area are very similar. However, Union county shows the highest CNI score (3.0). Evangelical Community Hospital has an average CNI score of 2.9 indicating higher than average need for an area but not the worst (which would be 5.0).

County Health Rankings

The County Health Rankings show that where we live impacts our health status. The health of a community depends on many different factors – from individual health behaviors, education and jobs, to quality of healthcare and the environment. The rankings help community leaders see that where we live, learn, work and play influences how healthy we are and how long we live.

The County Health Rankings are a key component of the Mobilizing Action Toward Community Health (MATCH) project. MATCH is the collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The rankings identify the multiple health factors that determine a county's health status. Each county receives a summary rank for its health outcomes and health factors – the four different types of health factors include: health behaviors, clinical care, social and economic factors, and the physical environment. The Rankings are a real "Call-to-Action" for state and local health departments to develop broad-based solutions with others in their community so all residents can be healthy. But efforts will also be made to mobilize community leaders outside the public health sector to take action and invest in programs and policy changes that address barriers to good health and help residents lead healthier lives. Other community leaders may include: educators; elected and appointed officials, including mayors, governors, health commissioners, city/county councils, legislators, and staff; business owners; and the healthcare sector.

- ✓ Counties in each of the 50 states are ranked according to summaries of the 37 health measures. Those having good rankings, e.g., 1 or 2, are considered to be the "healthiest." Counties are ranked relative to the health of other counties in the same state on the following summary measures:

    - Health Outcomes —Two types of health outcomes are measured to represent the health of each county: how long people live (mortality) and how healthy people feel (morbidity). These outcomes are the result of a collection of health factors and are influenced by existing programs and policies at the local, state and federal levels.

    - Health Factors — A number of different health factors shape a community's health outcomes. The County Health Rankings are based on weighted scores of four types of factors: Health behaviors (six measures), Clinical care (five measures), Social and economic (seven measures), Physical environment (four measures).

Pennsylvania has 67 counties; therefore, the rank scale for Pennsylvania is one to 67 (one being the healthiest county and 67 being the most unhealthy). The median rank is 34.

- ✓ The top three poorest rankings; indicating the most unhealthy measures across the five-county region (Columbia, Montour, Northumberland, Snyder and Union Counties) are:
    - Education, Diet and Exercise, and Community Safety
- ✓ Northumberland, Snyder and Union counties all show very poor county rankings when compared to the rest of the state for Employment, Education and Diet, and Exercise. We know that these three factors are highly correlated with health; i.e., poor employment can lead to lower income which can then lead to fewer educational opportunities, and therefore, poorer health decisions in terms of diet and exercise.
    - Northumberland county has 14 health rank scores above the median for the state (34). Although Northumberland county has the poorest rankings across the region, the majority of the ranked scores are in the 50's range. Other counties such as Montour and Snyder have some of the worst rankings in the state (Montour rank of 65 for community safety and Snyder rank of 65 for education).
    - Snyder county holds six categories with a rank of 5 or better but also holds six categories with a rank above the median of 34 (Social and Economic Factors, Diet and Exercise, Access to Care, Education, Employment and Community Safety). Many of the measures in which Snyder County ranks poorly are social factors that could be aided by increasing community healthcare access.
    - Union County is ranked the best county in Pennsylvaina (1) for health outcomes and quality of care but has a rank of 63 (one of the unhealthiest in the state) for the built environment.[7]

Prevention Quality Indicators Index (PQI)

The Prevention Quality Indicators index (PQI) was developed by the Agency for Healthcare Research and Quality (AHRQ). The AHRQ model was applied to quantify the PQI within the Evangelical Community Hospital market and Pennsylvania. The PQI index identifies potentially avoidable hospitalizations for the benefit of targeting priorities and overall community health.

The quality indicator rates are derived from inpatient discharges by zip code using ICD diagnosis and procedure codes. There are 14 quality indicators. Lower index scores represent fewer admissions for each of the PQIs.

[7] County Health Rankings states that the built environment refers to human-made (versus natural) resources and infrastructure designed to support human activity, such as buildings, roads, parks, restaurants, grocery stores and other amenities. The characteristics of the built environment can affect the health of residents in multiple ways. This focus area seeks to measure the availability of healthy food and recreational facilities in the local built environment.

Table 3: Prevention Quality Indicators – Evangelical Community Hospital Service Area Compared to Pennsylvania

Prevention Quality Indicators (PQI)	Evangelical Hospital	Pennsylvania	Difference
Perforated Appendix Admission Rate (POI 2)	0.31	0.27	+ 0.04
Angina Without Procedure Admission Rate (POI 13)	0.15	0.17	- 0.03
Lower Extremity Amputation Rate Among Diabetic Patients(POI 16)	0.30	0.43	- 0.13
Uncontrolled Diabetes Admission Rate (POI 14)	0.05	0.20	- 0.15
Diabetes Short-Term Complications Admission Rate (POI 1)	0.41	0.63	- 0.23
Hypertension Admission Rate (POI 7)	0.35	0.59	- 0.25
Diabetes Long-Term Complications Admission Rate (POI 3)	1.02	1.27	- 0.25
Dehydration Admission Rate (POI 10)	0.49	0.76	- 0.27
Bacterial Pneumonia Admission Rate (POI 11)	3.00	3.49	- 0.49
Adult Asthma Admission Rate (POI 15)	0.39	1.44	- 1.06
Low Birth Weight Rate (POI 9)	0.00	1.11	- 1.11
Chronic Obstructive Pulmonary Disease Admission Rate (POI 5)	1.89	3.08	- 1.19
Congestive Heart Failure Admission Rate (POI 8)	3.34	4.85	- 1.51
Urinary Tract Infection Admission Rate (POI 12)	0.55	2.30	- 1.74

Source: Calculations by Tripp Umbach

- ✓ The Evangelical Hospital study area shows only one PQI measure that is higher than the state and that is for Perforated Appendix (and it is only a slight rise, Evan=0.31 and Pa=0.27).

- ✓ This is important to note as it indicates that for 15 out of the 16 preventable hospital admission measures used for the PQI analysis, Evangelical has lower rates.

- ✓ The largest difference between Evangelical and PA is for Urinary Tract Infections in which PA shows a rate of preventable hospitalizations due to UTIs at 2.30, whereas Evangelical shows a rate of only 0.55 (less than ¼ the rate).

- ✓ Evangelical Hospital shows a rate of 0.00 for Low Birth Weight. This does not indicate that there were no preventable hospital admissions due to Low Birth Rate, but rather that so few occurred in the Evangelical Hospital study area that the value is not reported. Pennsylvania, on the other hand, shows a rate of 1.11, indicating that there are some preventable hospital admissions due to Low Birth Rate in the state.

- ✓ Northumberland County shows the worst PQI scores for the study area with eight of the 14 measures above the state rate.

Transportation:

Coordination and Integration of Rural Public Transportation Services in Pennsylvania is a study conducted by Edinboro University that considers the challenges of public transportation in rural Pennsylvania. To identify barriers and opportunities for integration of rural transportation systems, the researcher interviewed administrators and employees from eight of the 21 providers of public transportation that operated in rural PA areas in 2002 and 2003. A summary of the conditions that affect the operation and coordination of public transportation:[8]

- ✓ Rural public transportation systems are funded in part by the Pennsylvania Department of Transportation (PennDOT) and their routes cover at least parts of 27 counties.
- ✓ Tradition and agency preference continue to limit current integration and may limit coordination in the future.
- ✓ The Pennsylvania Constitution prohibits the use of gas tax revenues to fund public transportation, leaving the real estate tax as the primary source for supporting public transportation, resulting in severely constrained tax sources. Often, counties lack the revenue resources to better support public transportation.
- ✓ Different policy, budget and funding choices among neighboring counties may present barriers to the formation of transportation alliances and coordination.
- ✓ Transportation agencies lack information about the availability and amounts of transportation funding available from various sources.
- ✓ Increasing numbers of riders are qualifying for subsidized transportation at the same time that states are facing budget shortfalls.
- ✓ Most private and public interest organizations, primary and secondary schools, and some human services agencies have traditionally provided transportation for their clients separately. After failed integration attempts in the past, transportation providers may be reluctant to coordinate their efforts.
- ✓ The difficulties of driving clients to their scheduled appointments on time and of clients having to wait long periods of time for their return rides continues to complicate transportation coordination efforts.
- ✓ Behavioral problems among some rider groups prevent some special needs clients from riding in vehicles with some other rider groups.

[8] Source: The Center for Rural PA (http://www.rural.palegislature.us/rural_public_transportation.pdf)

Accessibility of Healthcare Professionals:

Being able to access primary care physicians (PCPs), dentists, pediatricians, etc. for proper care is a concern for rural areas as hopsitals are more dispersed. The number of PCPs per individual is a very important value when assessing access to care.

- ✓ In 2010, Union county had similar rates of primary care physicians (PCP) (115 PCPs per 100,000 population) as compared with Pennsylvania's rate (119 PCPs per 100,000 population). At the same time, Juniata, Northumberland and Snyder counties had low PCP rates (Juniata = 56 PCPs; Northumberland = 52 PCPs and Snyder = 65 PCPs per 100,000 population).

COUNTY	Juniata	Northumberland	Snyder	Union	PA
Primary Care Physicians per 100,000 pop. (2010)	56	52	65	115	119

Key Stakeholder Interviews

Tripp Umbach worked collaboratively with the Evangelical Community Hospital community health needs assessment oversight committee to develop a comprehensive list of community stakeholders. Stakeholders were selected based on their involvement within the community and their participation in overall community health. The following qualitative data were gathered during individual interviews with 15 stakeholders of the Evangelical Community Hospital community. Each interview was conducted by a Tripp Umbach consultant and lasted approximately 60 minutes. All respondents were asked the same set of questions developed by Tripp Umbach and reviewed by the Evangelical Community Hospital community health needs assessment oversight committee (see Appendix C).

The organizations represented by stakeholders were:

- Milton YMCA
- Mifflinburg school district
- Haven Ministries
- Evangelical Community Hospital
- Union-Snyder Agency on Aging Inc.
- American Cancer Society
- Bucknell University
- PA Health Department
- Daily Item

The 15 stakeholders identified the following problems and/or barriers as preventing the residents of the Evangelical Community Hospital community from achieving their vision of a healthy community. A high-level summary of community health needs identified by community stakeholders include:

- **ACCESS TO PRIMARY AND PREVENTIVE HEALTHCARE**
  - ✓ While stakeholders felt there are ample medical resources and healthcare facilities in some of their communities, they gave the impression that medical care is not always accessible to all residents, particularly those that reside in the more rural areas and/or those that are under/uninsured.

    Stakeholders believed that there are clinics in the area that provide medical care to uninsured residents; however, many residents are not able to get to and from these clinics and hospitals due to the distance one must travel and a lack of transportation. Similarly, stakeholders believed that affordable health insurance options may be limited for both unemployed and senior residents.

    Stakeholders were under the impression that not all residents are able to access under/uninsured and dental health care. Stakeholders believed that there are not enough healthcare providers in the area to meet resident demand for under/uninsured medical and dental health care. Stakeholders believed that demand for these services has increased as a result of an aging baby-boomer population. Stakeholders believed that there are limited dental providers in the region that accept state-funded health insurance. Additionally; stakeholders believed that there is a stigma around mental health diagnosis

and seeking mental health services, which may cause residents to avoid using the mental health services that exists.

The limited access some residents have to primary and preventive medical and dental health care may cause: an increase in the utilization of emergency medical care for non-emergent issues and limited awareness of dental health.

❑ THE HEALTH AND WELLNESS OF RESIDENTS

- ✓ The health of a community largely depends on the health status of its residents. Community stakeholders perceived the health status of many residents to be poor due to the perceived prevalence of chronic lifestyle-related illnesses, limited education on how to maintain health, limited awareness about prevention and limited access to healthy options.

  Stakeholders felt that residents make poor lifestyle choices (i.e., smoking, inactivity, substance abuse and poor nutrition), which contributes to their unhealthy status and often leads to chronic health conditions (i.e., diabetes, obesity and respiratory issues). Stakeholders felt that residents have a limited understanding about preventive choices and healthy options due to the limited access to preventive healthcare and a lack of prevention education and outreach in their communities. Additionally, stakeholders believed that affordable healthy options can be inaccessible for some residents (i.e., healthy nutrition).

  Poor lifestyle choices can lead to chronic illness like obesity, diabetes, heart disease and respiratory issues. An increase in the number of chronic illness diagnoses in a community can lead to a greater consumption of healthcare resources due to the need to monitor and manage such diagnoses.

- **COMMUNITY SERVICES**
  - ✓ While stakeholders feel their communities provide many services to residents, they also perceive services to be limited in the areas of transportation and recreational activities.

    Stakeholders gave the impression that transportation is not always available to residents in their communities due to the limited public transportation system in the area. Stakeholders believed that when coupled with the rural nature of the region, the lack of transportation presents residents with barriers to accessing available community services, employment opportunities, healthy nutrition, healthcare, dental care, mental health care, recreational activities, etc.

    Stakeholders believed that affordable housing has decreased due to the flooding in September 2011 and limited low-income housing. Stakeholders believed that there are many residents that have been displaced due to homes being flooded, homeowner insurance issues and the length of time renovations and cleanup efforts require. Stakeholders believed that the displacement caused by the flood has left many residents homeless and struggling to meet their everyday needs. Additionally, stakeholders were under the impression that landlords do not offer low-income and/or temporary housing.

Additional data and greater detail related to the Evangelical Community Hospital Community Key Stakeholder Interviews is available in Appendix C.

Focus Groups with Community Residents

Tripp Umbach facilitated three focus groups with residents in the Evangelical Community Hospital community service area. Top community concerns include, access to primary, preventive, mental and dental healthcare, healthy behaviors and community infrastructure. Approximately 35 residents from the Evangelical Community Hospital community participated in the focus groups, each providing direct input related to top community health needs of themselves, their families and communities.

The goal of the focus group process is that each participant feels comfortable and speaks openly so that they contribute to the discussion. It was explained to participants that there are no wrong answers, just different experiences and points of view. This process ensures that each participant shares their experiences from their point of view, even if it is different from what others have said. Specifically, focus group participants were asked to identify and discuss what they perceived to be the top health issues and/or concerns in their communities. The focus group process gathers valuable qualitative and anecdotal data regarding the broad health interests of the communities served by the medical facilities within the service area of Evangelical Community Hospital. Focus group input is subject to the limitations of the identified target populations (i.e., vocabulary, perspective, knowledge, etc.), and therefore, is not factual and inherently subjective in nature.

The three focus group audiences were:

- ✓ Healthcare Providers
  - Conducted on March 20th, 2012 at The Community Health Education Center (Lewisburg, PA)
- ✓ Latino Residents
  - Conducted on March 26th, 2012 at Congrecion Mennonita in (New Columbia, PA)
- ✓ Under/Uninsured Residents
  - Conducted on March 21st, 2012 at A Community Clinic (Sunbury, PA)

Key high-level themes from all three focus groups include:

- ❑ **ACCESS TO PRIMARY, PREVENTIVE, MENTAL AND DENTAL HEALTH CARE**

  Focus group participants felt that primary, preventive, mental and dental health care was difficult for some residents to access due to these services being limited in the areas of availability of providers (i.e., mental health inpatient services) and affordability of medical services.

- ***Availability of providers:*** Group participants believed that access to healthcare is limited due to a limited number of mental health and medical providers and facilities in their communities.

  Participants were under the impression that there are limited medical, dental and mental health providers available. Participants believed that there is an outflux of pediatricians due to state laws that increase the risk of malpractice litigation and consequentially, the cost of malpractice insurance. Some focus group participants perceived a shortage of medical providers and/or translators that can speak Spanish well enough to provide healthcare to Spanish-speaking residents. Focus group participants were under the impression that mental health services at local medical facilities may not have the capacity to meet residents demand. Additionally, participants reported that the limited public transportation system can further restrict the access residents have to under/uninsured medical care and dental care due to the distance between providers.

  Participants reported that the lack of available providers causes lengthy travel times and waits for scheduled appointments, a difficulty securing same-day appointments and an increased use/overcrowding of emergency medical services for non-emergent issues, leading to unmet needs, at times during crisis.

- ***Affordability of medical services:*** Group participants reported that healthcare can be difficult for some residents to afford due to health insurance issues (i.e., state-funded health insurance qualifications and a decrease in healthcare benefits being offered by employers).

  Some focus group participants felt that it can be difficult for adult residents to qualify for state-funded health insurance. Participants reported that the limitations of state-funded health insurance can reduce the access residents have to healthcare because adult residents that make more money than the cutoff for income qualifications often are not able to afford private-pay health insurance and are left uninsured or underinsured with higher co-pays and deductibles that may be unaffordable.

  Focus group participants felt that affordable health insurance may not be readily accessible to residents in their communities, including seniors. Specifically, participants reported that many employers, particularly small businesses, are offering health insurance as a benefit of employment less often. Participants believed that the cost of health insurance has become unaffordable for employers and employees. Participants indicated that the

cost of private-pay health insurance has become unaffordable. Additionally, participants were under the impression that restrictive health insurance regulations reduce the access residents have to affordable healthcare.

❑ HEALTHY BEHAVIORS

Focus group participants discussed the need for some residents to increase their practice of healthy behaviors in the areas of lifestyle choices, healthy nutrition and physical activity.

- ✓ ***Lifestyle choices:*** Focus group participants reported that there are residents in their communities that they feel are not always making the healthiest lifestyle choices for themselves (i.e., nutrition, physical activities, etc.) due to limited access and/or motivation to be healthy. Participants believed that the lifestyle choices many residents are making may lead to chronic illness (i.e., obesity, diabetes, respiratory issues, etc.).

- ✓ ***Healthy Nutrition:*** Participants indicated that residents do not always have access to healthy nutrition. Participants believed that residents are often choosing the most convenient meals, which are not always the healthiest options (i.e., fast food). Participants believed that some residents do not have access to affordable healthy foods in their community. Furthermore, participants felt that healthy choices about nutrition may be hampered by the culture of residents in the region.

- ✓ ***Physical activity:*** Participants believed that residents in their communities may not always have access to and/or be motivated to participate in affordable physical activities and as a result are not always as active as they might need to be to remain healthy.

❑ COMMUNITY INFRASTRUCTURE

Often the barriers to accessing healthcare can be traced back to the infrastructure of a community. Focus group participants perceived the infrastructure of their communities to be limited in the areas of transportation, capacity to provide community services, housing and geographical location.

- ✓ ***Limited transportation:*** Focus group participants reported that residents have limited access to transportation in many of their communities. Participants indicated that there is no affordable method of public transportation available to residents. Latino participants felt that language can be an additional barrier to public transportation for residents for whom

English is a second language. Additionally, participants were under the impression that residents can become trapped at local hospital facilities due to the absence of public transportation after-hours. Participants reported that the lack of transportation, when coupled with the rural nature of the region, limits the access residents have to primary, preventive, emergency, mental, dental health care, and unnecessary overnight hospital stays, as well as employment opportunities, community services and healthy produce.

- ✓ ***Unemployment:*** Focus group participants perceive an increase in unemployment in their communities, which often causes an increase in residents who are under/uninsured due to the loss of employment benefits such as health insurance, as well as a decrease in the amount of money they have to spend on goods and services. The reduction of purchasing power shrinks the community's tax revenues causing funding cuts for basic civic and social services; while simultaneously reducing incentives for small businesses that remain in the community to grow. Additionally, focus group participants reported that, at times, it can be additionally difficult for Hispanic residents to secure gainful employment in the region.

Additional data and greater detail related to the Evangelical Community Hospital Community Focus Groups is available in Appendix D.

Conclusions and Recommended Next Steps

The community needs identified through the Evangelical Community Hospital community health needs assessment process are not all related to the provision of traditional medical services provided by medical centers. However, the top needs identified in this assessment do "translate" into a wide variety of health-related issues that may ultimately require hospital services. For example, limited access to affordable health insurance, particularly in a poverty-stricken area, leaves residents underinsured or uninsured, which can cause an increase in the use of emergency medical services for non-emergent issues and residents that resist seeking medical care until their symptoms become emergent due to the inability to pay for routine treatment and/or preventive care.

Evangelical Community Hospital, working closely with community partners, understands that the community health needs assessment document is only a first step in an ongoing process. It is vital that ongoing communication and a strategic process follow the assessment process – with a clear focus on expanding access to healthcare for under/uninsured residents in Northumberland and Juniata Counties. There is a wealth of medical resources in the region with multiple clinics that serve under/uninsured residents. However, Northumberland and Juniata counties are the most underserved counties in a six-county region. Residents of the Evangelical Community Hospital service area have little access to the healthcare resources in the region due to the need for an increase in healthcare providers, affordable health insurance and transportation to healthcare facilities, including free clinics. Collaboration and partnership are strong in the community. It is important to expand existing partnerships and build additional partnerships with multiple community organizations when developing strategies to address the top identified needs. Implementation strategies will need to consider the higher need areas in Northumberland County and address the multiple barriers to healthcare. Tripp Umbach recommends the following actions be taken by the hospital sponsors in close partnership with community organizations over the next six to nine months.

Recommended Action Steps:

- ❑ Widely communicate the results of the community health needs assessment document to Evangelical Community Hospital staff, providers, leadership and boards.
- ❑ Conduct an open community forum where the community health needs assessment results are presented widely to community residents, as well as through multiple outlets such as: local media, neighborhood associations, community-based organizations, faith-based organizations, schools, libraries and employers.
- ❑ Take an inventory of available resources in the community that are available to address the top community health needs identified by the community health needs assessment.
- ❑ Implement a comprehensive "grass roots" community engagement strategy in conjunction with ACTION Health to build upon the resources that already exist in the community and

the energy of and commitment of community leaders that have been engaged in the community health needs assessment process.

- Develop three "Working Groups" to focus on specific strategies to address the top three needs identified in the community health needs assessment. The working groups should meet for a period of four to six months to develop action plans and external funding requests.
- Attraction of outside funding and implementation of actions to address the top three community health needs on a regional level.
- Work at the hospital- and regional-level to translate the top identified community health issues into individual hospital- and regional-level strategic planning and community benefits programs.
- Within one year's time, hold a Community Celebration where community leaders present results of the needs assessment and status updates on measurable actions.
- Within three years' time, conduct updated community health needs assessment to evaluate community effectiveness on addressing top needs and to identify new community needs.

APPENDIX A

Community Health Needs Identification Forum Results

EVANGELICAL COMMUNITY HOSPITAL
April 5th, 2012

Community:

Evangelical Community Hospital service area

INTRODUCTION:

The following qualitative data were gathered during a regional community health needs identification forum held on April 5th, 2012 at the Danville Elks Lodge and Banquet Hall (Danville, Pa). The community forum was conducted with more than 60 community leaders from a five-county region (Columbia, Montour, Northumberland, Snyder and Union Counties). Community leaders were identified by the community health needs assessment oversight committee for Evangelical Community Hospital. Evangelical Community Hospital is a 127-bed community hospital. The community forum was conducted by Tripp Umbach consultants and lasted approximately five hours.

Tripp Umbach presented the results from the secondary data analysis, key stakeholder interviews and community focus groups, and used these findings to engage community leaders in a group discussion. Community leaders were asked to share their vision for the community, discuss a plan for health improvement in their community and prioritize their concerns. Breakout groups were formed to pinpoint and identify issues/problems that were most prevalent and widespread in their community. Most importantly, the breakout groups needed to identify ways to resolve the identified problems through innovative solutions in order to bring about a healthier community.

PROBLEM IDENTIFICATION:

During the community forum process, community leaders discussed regional health needs that centered around three themes. These were:

1. **Access to healthcare for under/uninsured residents**
2. **Healthy behaviors: awareness, motivation and implementation**
3. **Transportation to health service providers**

The following summary represents the most important topic areas within the community discussed at the retreat. Community leaders believe the following concerns are the most pressing problems and are identified as the most manageable to address and resolve.

ACCESS TO HEALTHCARE FOR UNDER/UNINSURED RESIDENTS:

Access to healthcare was discussed at the community forum. Community leaders focused their discussions primarily on the limited number of healthcare providers, issues surrounding health insurance for the under/uninsured populations in the region.

Perceived Contributing Factors:

- Community leaders believed that some residents may not be able to afford the rising cost of health insurance premiums, which may lead to residents who are underinsured with limited coverage and/or unaffordable co-pays and deductibles.
- Community leaders believed that providing health insurance to employees may be unaffordable for some employers, which may lead employers to offer only part-time employment so that the business is not required to provide health insurance.
- Community leaders were under the impression that local medical and dental healthcare providers may not always accept state-funded health insurance, leading residents receiving that type of insurance to have to travel lengthy distances to secure medical and dental healthcare.
- Community leaders believed that there are a limited number of pediatric mental health providers in the region.
- Community leaders were under the impression that there are a limited number of dental providers in the region.
- Community leaders were under the impression that some residents may not seek mental health services due to the stigma associated with having a mental health diagnosis.
- Community leaders were under the impression that residents may be seeking emergency medical care for non-emergent issues due to a lack of health insurance and the absence of after-hours medical care, which may lead to poor access to prevention and overall continuity of care.
- Community leaders believed that healthcare providers do not offer under/uninsured healthcare due to many of them getting frustrated with a population that does not show up for their appointments.
- Community leaders were under the impression that providers can become overwhelmed when there are too few of them taking on the needs of under/uninsured residents.
- Community leaders were under the impression that Pennsylvania laws increase the risk of malpractice litigation for physicians, causing physicians to leave the state.

Group Suggestions/Recommendations:

Community leaders offered the following as possible solutions to help improve the access to healthcare for under/uninsured residents in the region.

- *Increase the number of healthcare providers offering under/uninsured services:* Community leaders recommended that local dentists and physicians commit to providing uninsured care to a set number of patients. Leaders believed that providers would be more likely to take on a couple of under/uninsured patients if they knew the limit would not be more than their practices could absorb. Also, leaders believed that medical licensure once required aspiring physicians to spend time providing some form of public health, which leaders recommended be reinstated as a requirement to secure

physician licensure. Additionally, leaders recommended that qualified nurses can provide health services that do not require a physician's license to administer. Leaders also recommended that one community-based organization be identified to organize and manage the newly developed network of providers.

- *Certify caregivers to provide comfort services:* Community leaders recommended that caregivers that provide care to a loved one often learn a great deal during their experience and may be able to become certified to help others in a hospice or other capacity afterward. Leaders believed that a certification would have to be developed.

- *Develop a community-wide electronic record:* Community leaders were under the impression that Google and Yahoo offer electronic medical records that could be used by preventive outreach services to provide screening results to primary care physicians. Developing a community-wide electronic medical record would improve continuity of care for residents.

- *Increase advocacy for legislative change on the state level:* Community leaders believed that advocating for an increase in funding for under/uninsured healthcare could help increase access to under/uninsured health services. Community leaders believed that advocacy for a particular bill (Senate Bill 5) may help to increase funding for under/uninsured healthcare in Pennsylvania.

HEALTHY BEHAVIORS: AWARENESS, MOTIVATION AND IMPLEMENTATION:

Behaviors that impact residents' health were discussed at the community forum. Community leaders focused their discussions primarily on the prevalence of chronic illness and lack of awareness of, motivation to employ and implementation of healthy behaviors among residents in the region.

Perceived Contributing Factors:

- Community leaders believed that residents are not always practicing healthy behaviors and/or modeling how to make healthy lifestyle choices.
- Community leaders were under the impression that healthy foods are not always easily accessible and/or affordable for some residents, which may cause some residents to choose more unhealthy options for their family because they are more accessible and affordable.
- Community leaders believed that there is limited preventive education available in their communities about healthy lifestyle options (i.e., healthy nutrition, smoking cessation, etc.).
- Community leaders were under the impression that many residents may be finding information about healthy choices from sources that may not always be reliable (i.e., the internet).

- Community leaders believed that residents may not always be motivated to implement healthy behaviors, which may cause limited follow-through if there are barriers to accessing healthy options.
- Community leaders were under the impression that chronic disease is prevalent in many communities in their region.

Group Suggestions/Recommendations:

Community leaders offered the following as possible solutions to help improve the practice of healthy behavior in the region:

- ***Increase awareness about healthy behavior:*** Community leaders believed that residents are often unaware of how to implement healthy behaviors. Community leaders recommended that a study of countries that provide health information all the time (i.e., Scandinavian countries) be completed to identify best practices. Leaders suggested that communities place ads about healthy behaviors in locations where unhealthy options are located (i.e., soda machines, McDonalds, warning labels on cigarettes, etc.). Community leaders were under the impression that illiteracy is an issue in the area, and as a result, recommended that any awareness campaigns use pictures and the spokes word. Additionally, leaders believed that residents would be more aware of healthy choices if they were able to see healthy behaviors role modeled.

- ***Increase the incentives for healthy behavior:*** Community leaders believed that residents could be healthier if they had more incentives. Leaders suggested that residents be offered healthcare incentive for healthy behaviors (i.e., a decrease in health insurance premiums for non-smokers).

TRANSPORTATION TO HEALTH SERVICE PROVIDERS:

Transportation was discussed at the community forum. Community leaders focused their discussions primarily on the impact transportation has on access to healthcare in the region.

Perceived Contributing Factors:

- Community leaders gave the impression that the lack of transportation, when coupled with the rural nature of the region, may cause significant barriers to some residents accessing healthcare because they are not always able to make it to appointments and emergency medical transportation services are not always close by.
- Community leaders believed that healthcare providers may not be accepting state-funded health insurance due to recipients having a low attendance rate for scheduled appointments.

- Community leaders were under the impression that some residents (i.e., under/uninsured residents) may not have the financial means to maintain a dependable method of transportation.
- Community leaders believed there were areas of the region that do not have affordable public transportation available.
- Community leaders gave the impression that the public transportation that is available to residents offers limited routes and schedules, leaving lengthy gaps of time during the day when public transportation is not available.
- Community leaders believed that county-wide transportation will not carry residents across county lines. Additionally, community leaders were under the impression that where one county transit system ends the other county system does not always pick up, making it difficult to travel across counties.

Group Suggestions/Recommendations:

Community leaders offered the following as possible solutions to help improve the transportation to health service providers in the region:

- *Increase access to transportation:* Community leaders recommended that healthcare providers offer travel vouchers to residents when an appointment is scheduled. Additionally, leaders recommended that state laws make allowances for single parents traveling with more than one child on medical transportation services. Leaders recommended that county commissioners in the region collaborate to resolve barriers and provide effective transportation from county to county. Community leaders also suggested that efforts to increase transportation increase and build upon and existing support systems between residents in the community to empower the community and promote self-sufficiency.

- *Increase mobile healthcare provided in the community:* Community leaders recommended that mobile healthcare services be offered in public places (i.e., the parking lot of Wal-Mart. Community leaders also recommended that any efforts to increase access to medical care as it relates to transportation for health services be focused on the people that need health services the most.

Appendix B

Community Secondary Data Profile

Evangelical Community Hospital
Completed March 2012

Evangelical Community Hospital Community Health Needs Profile

June 8, 2012

TrippUmbach
Research • Strategy • Impact

Overview

- Evangelical Community Hospital Populated Zip Code Areas
- Key Points
- Demographic Trends
- Community Need Index (CNI)
- County Health Rankings
- Prevention Quality Indicators Index (PQI)

Evangelical Community Hospital Populated Zip Code Areas

The community served by ACTION Health includes Columbia, Montour, Northumberland, Snyder and Union Counties. The Evangelical Community Hospital includes 23 of the 49 populated zip code areas in the ACTION Health System and 1 additional zip code area in Juniata County (excluding zip codes for P.O. boxes and offices).

Zip	County	City
17086	JUNIATA	RICHFIELD
17772	NORTHUMBERLAND	TURBOTVILLE
17777	NORTHUMBERLAND	WATSONTOWN
17801	NORTHUMBERLAND	SUNBURY
17847	NORTHUMBERLAND	MILTON
17850	NORTHUMBERLAND	MONTANDON
17857	NORTHUMBERLAND	NORTHUMBERLAND
17812	SNYDER	BEAVER SPRINGS
17813	SNYDER	BEAVERTOWN
17827	SNYDER	FREEBURG
17842	SNYDER	MIDDLEBURG
17853	SNYDER	MOUNT PLEASANT MILLS

Zip	County	City
17864	SNYDER	PORT TREVORTON
17870	SNYDER	SELINSGROVE
17876	SNYDER	SHAMOKIN DAM
17810	UNION	ALLENWOOD
17835	UNION	LAURELTON
17837	UNION	LEWISBURG
17844	UNION	MIFFLINBURG
17845	UNION	MILLMONT
17855	UNION	NEW BERLIN
17856	UNION	NEW COLUMBIA
17886	UNION	WEST MILTON
17889	UNION	WINFIELD

Key Points – Community Needs for Evangelical Community Hospital

- **The Evangelical Hospital study area includes 23 of the 49 zip code areas used in the 5-County study area with one additional zip code in Juniata County.**
  - Evangelical shows a very slight decline in population over the next 5 years at a rate of -0.09%.
  - This trend differs from that of Pennsylvania as a whole. Pennsylvania is projected to see a 0.70% rise in population between 2011 and 2016. Therefore, people are coming into Pennsylvania but not to counties in the ACTION Health study area with the exception of Snyder and Union counties.

- **The Evangelical Hospital study area shows an average annual household income of $53,064.**
  - The lowest average income is found in Northumberland County ($45,871). Income levels are highly correlated to health care access and health activities.
  - It is interesting to see that all of the average household income levels for the study area fall below the averages for Pennsylvania ($64,000) and for the United States ($67,529). Generally, rural areas show lower income levels as compared with more urban areas.

- **Union County shows a much higher rate of men as opposed to women (56.6% men, 43.4% women).** This is important to note when assessing morbidity and mortality data. Whereas, Evangelical Hospital study area shows (51.6% men, 48.4 women) and PA shows (48.7% men, 51.3% women).

- **Evangelical shows 16.6% of the population who have not received a high school diploma,** the lowest in the area but still much more than the state rate (12.6%) and U.S. rate (15.1%) which are somewhat lower. Educational level is highly related to occupation and therefore income.

Key Points – Community Needs for Evangelical Community Hospital

- **The Community Health Needs Index was applied to the ACTION Health System with the following results for Evangelical:**
  - The highest CNI score for the Evangelical study area is for the towns of Sunbury and Allenwood with scores of 3.6. The highest CNI score indicates the most barriers to community health care access.
  - Sunbury has the highest percentage of individuals who rent (40%). The renting population is generally comprised of students or individuals with lower incomes who cannot afford buying a home.
  - Allenwood is a unique population; approximately 78% of the Allenwood population are incarcerated individuals at one of the three, all-male federal correctional facilities (low, medium and high security). The CNI data for Allenwood includes these individuals. With that being said, Allenwood shows the highest unemployment rate (17%), minority (60%), limited English (3%), and individuals with no high school diploma (30%) across the entire ACTION Health study area.
  - Looking beyond Allenwood, we see that all of the other zip code areas have unemployment rates below state and national levels (both approximately 8.2%).
  - It is important to identify community health needs past those of Allenwood. Therefore, we will be sure to focus on the barriers to community health needs on a zip code level basis.

- **The weighted average CNI score for the entire Evangelical Hospital study area is 2.9.**
  - The median for the CNI scale is 2.5. The Evangelical Hospital study area shows 14 zip code areas above the median while at the same time shows 9 below the median. This helps us to see that the ACTION Health study area contains more zip code areas with CNI scores above the median indicating more barriers to community health care access.

- **All of the average CNI scores for the study area are very similar.** However, Union county shows the highest CNI score (3.0). Evangelical has an average CNI score of 2.9 indicating higher than average need for an area but not the worst possible (which would be 5.0).

Key Points – Community Needs for Evangelical Community Hospital

- **Counties in each of the 50 states are ranked according to summaries of the 37 health measures. Those having good rankings, such as 1 or 2, are considered to be the "healthiest." Counties are ranked relative to the health of other counties in the same state on the following summary measures:**
  - Health Outcomes--We measure two types of health outcomes to represent the health of each county: how long people live (mortality) and how healthy people feel (morbidity). These outcomes are the result of a collection of health factors and are influenced by existing programs and policies at the local, state, and federal levels.
  - Health Factors--A number of different health factors shape a community's health outcomes; Health behaviors (6 measures), Clinical care (5 measures), Social and economic (7 measures), and the Physical environment (4 measures).

- Northumberland, Snyder and Union counties all show very poor rankings for Employment, Education and Diet and Exercise. We know that these three factors are highly correlated; i.e., poor employment can lead to lower income which can then lead to fewer options for good educational opportunities and therefore poorer health decisions in terms of diet and exercise.

- Snyder county holds 6 categories with a rank of 5 or better but also holds 6 categories with a rank above the median for PA of 34 (Social and Economic Factors, Diet and Exercise, Access to Care, Education, Employment, and Community Safety). Many of the measures in which Snyder County ranks poorly are social factors that could be aided with community health care access reform.

Key Points – Community Needs for Evangelical Community Hospital

- **The PQI index identifies potentially avoidable hospitalizations for the benefit of targeting priorities and overall community health. Lower index scores represent less admissions for each of the PQIs. There are 14 quality indicators.**
  - The Evangelical Hospital study area shows only 1 PQI measure that is higher than the state and that is for Perforated Appendix (and it is only a slight rise, Evan=0.31 and Pa=0.27).
  - This is important to note as it indicates that for 15 out of the 16 preventable hospital admission measures used for the PQI analysis; Evangelical has lower rates.
  - The largest difference between Evangelical and PA is for Urinary Tract Infections in which PA shows a rate of preventable hospitalizations due to UTIs at 2.30 whereas Evangelical shows a rate of only 0.55 (less than ¼ the rate).
  - Evangelical Hospital shows a rate of 0.00 for Low Birth Weight. This does not indicate that there were no preventable hospital admissions due to Low Birth Rate, but rather that so few occurred in the Evangelical Hospital study area that the value is not reported. Pennsylvania, on the other hand, shows a rate of 1.11, indicating that there are some preventable hospital admissions due to Low Birth Rate in the state.
  - Northumberland County shows the worst PQI scores for the study area with 8 of the 14 measures above the state rate.

Community Demographic Profile

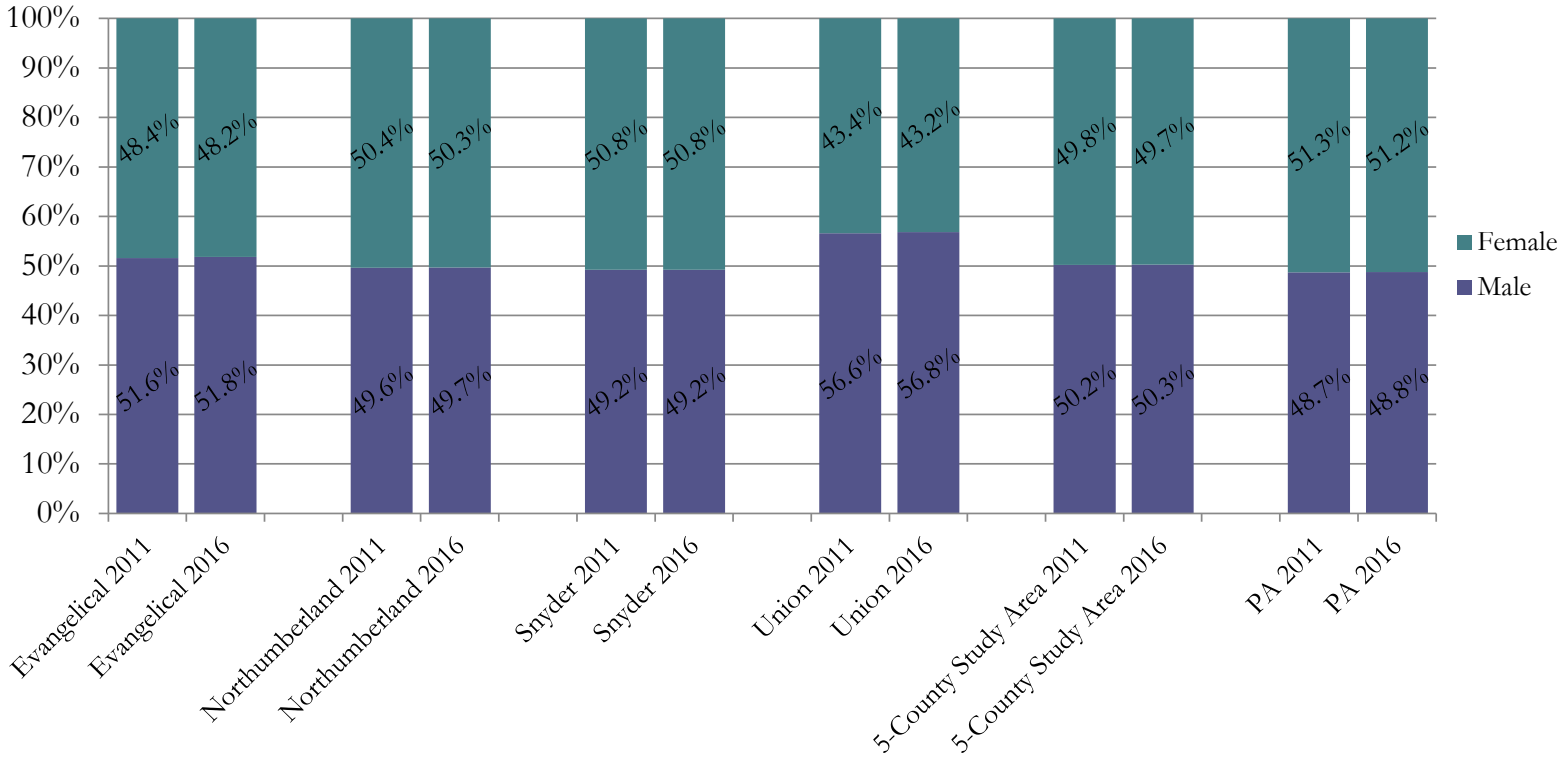
- **The Evangelical Hospital study area** contains 23 of the 49 zip codes in the ACTION Health system service area and 1 additional zip code area (Richfield) in Juniata County.
- **Evangelical shows a very slight decline in population** from 2011 to 2016 (-0.09%). This is not consistent with Pennsylvania which shows a rise in population at a rate of 0.70%.
- **Union County shows a much higher rate of men as opposed to women (56.6% men, 43.4% women).** This is important to note when assessing morbidity and mortality data.
- **Northumberland County shows the largest percentage of individuals aged 65 and older (19.5%);** much more than state (15.9%) and national levels (13.3%).
- **The Evangelical Hospital study area shows an average annual household income of $53,064;** this is above the 5-County average but still lower than PA ($64,000) and the U.S ($67,529). The Evangelical Hospital study area shows the lowest percent of households earning $25K or less annually (25.3%) compared to the counties in the area; however, this rate is still above the rates for PA (24.9%) and the U.S. (23.7%).
- **Evangelical shows 16.6% of the population who have not received a high school diploma, the lowest in the area** but still much more than the state rate (12.6%) and U.S. rate (15.1%) which are somewhat lower. Educational level is highly related to occupation and therefore income.
- **The Evangelical Hospital study area shows very little diversity as compared with Pennsylvania and the United States.** Only 5.1% of the population in the Evangelical study area identify as a race/ethnicity other than White, Non-Hispanic whereas 19.6% in PA and 35.8% in the U.S. identify as a race other than White, Non-Hispanic.

Population Trends

	Evangelical Hospital	Northumberland County	Snyder County	Union County	5-County Study Area	PA
2011 Total Population	127,410	90,331	39,547	45,824	263,631	12,730,760
2016 Projected Population	127,292	88,631	39,825	46,312	262,370	12,824,937
# Change	-118	-1,700	+278	+488	-1,261	+94,177
% Change	-0.09%	-1.88%	+0.70%	+1.06%	-0.48%	+0.70%

- The Evangelical Hospital study area includes 23 of the 49 zip code areas from the ACTION Health study area as well as one additional zip code area in Juniata County (Richfield).
- Evangelical shows a very slight projected decline in population over the next 5 years at a rate of -0.09%.
- Northumberland County shows a very large decline in population (-1.88%, nearly 1,700 people) whereas Snyder and Union counties show projected rises in population over the next 5 years (+0.70% and +1.06% respectively).
- The trends seen for Evangelical and Northumberland County differs from that of Pennsylvania as a whole; Snyder and Union counties are consistent or are increasing over projections for PA. Pennsylvania is projected to see a 0.70% rise in population between 2011 and 2016. Therefore, people are coming into Pennsylvania but not to counties in the ACTION Health study area with the exception of Snyder and Union counties.

Gender

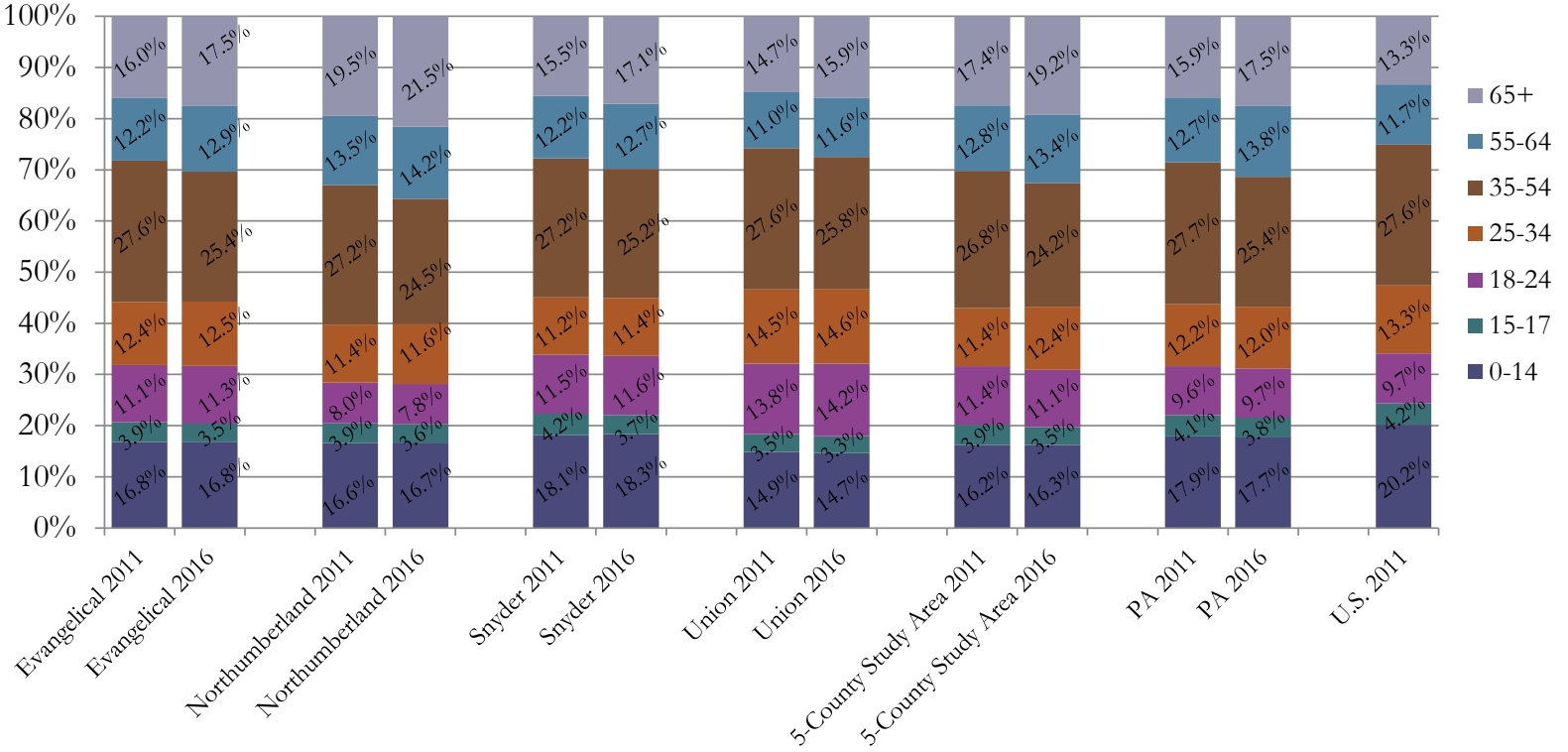


- The Evangelical Hospital study area shows slightly higher percentages of men as opposed to women; this is inconsistent with state and national data.

- Union County shows a much higher rate of men as opposed to women (56.6% men, 43.4% women). This is important to note when assessing morbidity and mortality data.

Source: Thomson Reuters

Age

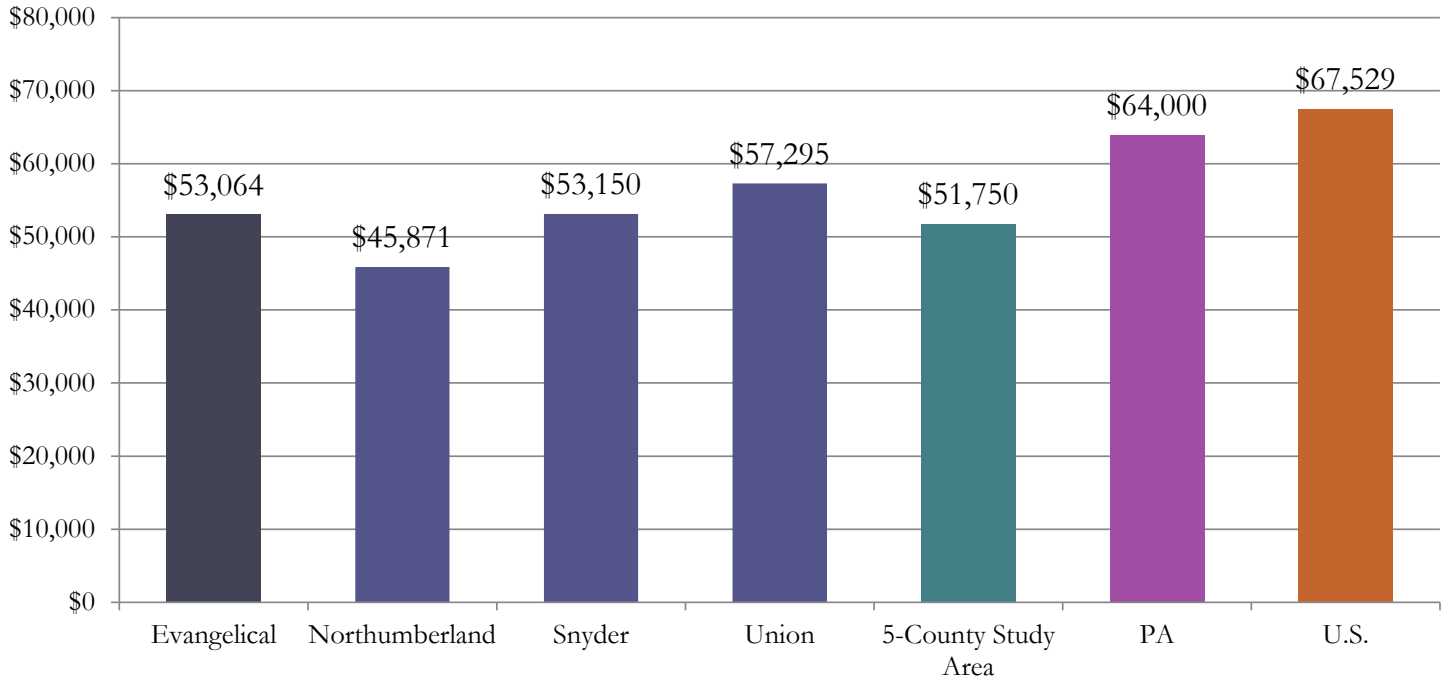


- Northumberland County has a markedly different age break-down than many of the other counties in the area. The Evangelical Hospital study area, however, has age groupings that are consistent with state and national values.

- Northumberland County shows the largest percentage of individuals aged 65 and older (19.5%); much more than state (15.9%) and national levels (13.3%).

Source: Thomson Reuters

Average Household Income (2011)



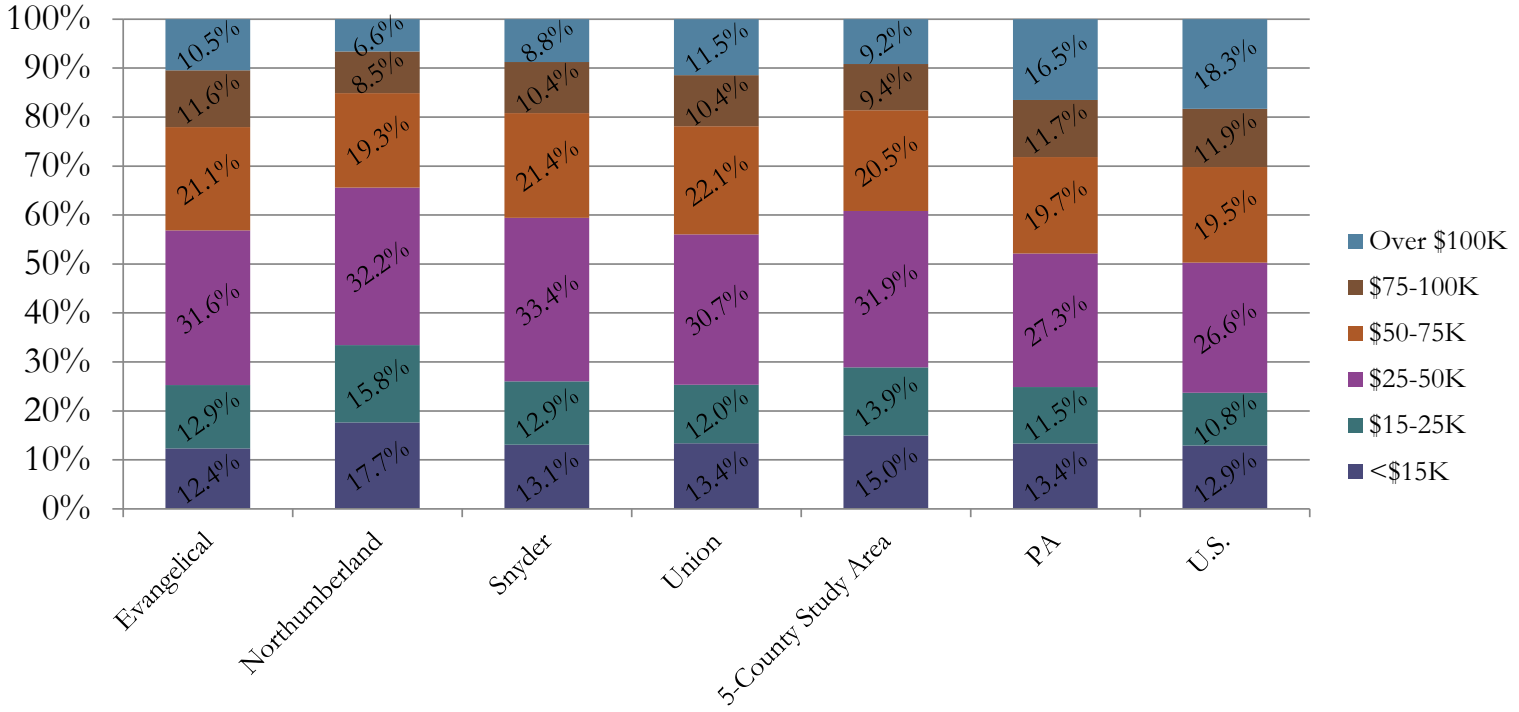
- The Evangelical Hospital study area shows an average annual household income of $53,064; this is above the 5-County average but still lower than PA and the U.S.

- The lowest average annual household income for the study area is found in Northumberland County ($45,871).

- It is interesting to see that all of the average household income levels for the study area fall below the averages for Pennsylvania ($64,000) and for the United States ($67,529). Generally, rural areas show lower income levels as compared with more urban areas.

Source: Thomson Reuters

Household Income Detail (2011)

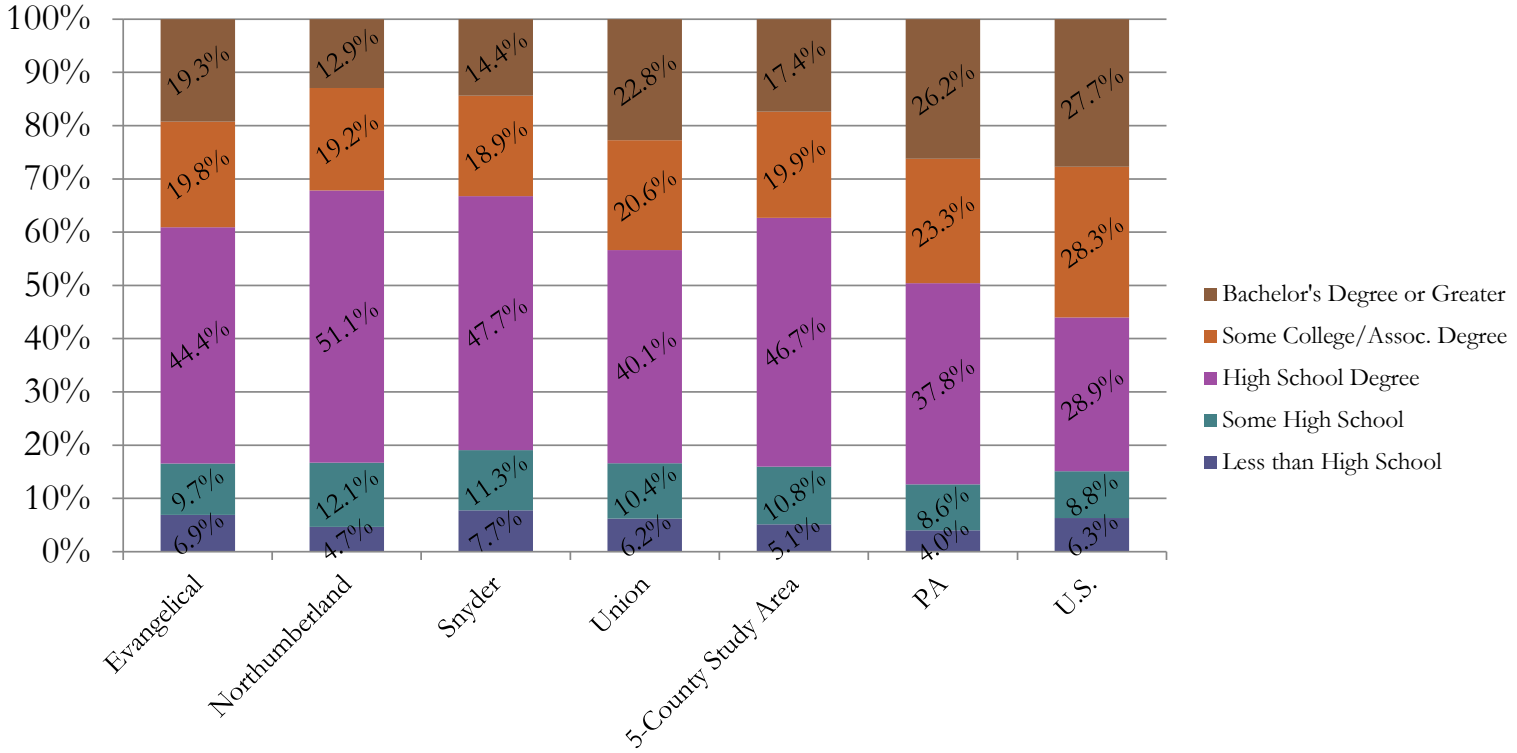


- The Evangelical Hospital study area shows the lowest percent of households earning $25K or less annually (25.3%) compared to the counties in the area; however, this rate is still above the rates for PA (24.9%) and the U.S. (23.7%). Northumberland County shows 33.5% of the households earning $25K or less annually.

- Union County shows a higher rate of households earning more than $100K annually (11.5%) than other counties in the area; however, this is still much less than PA (16.5%) or the U.S. (18.3%).

Source: Thomson Reuters

Education Level (2011)

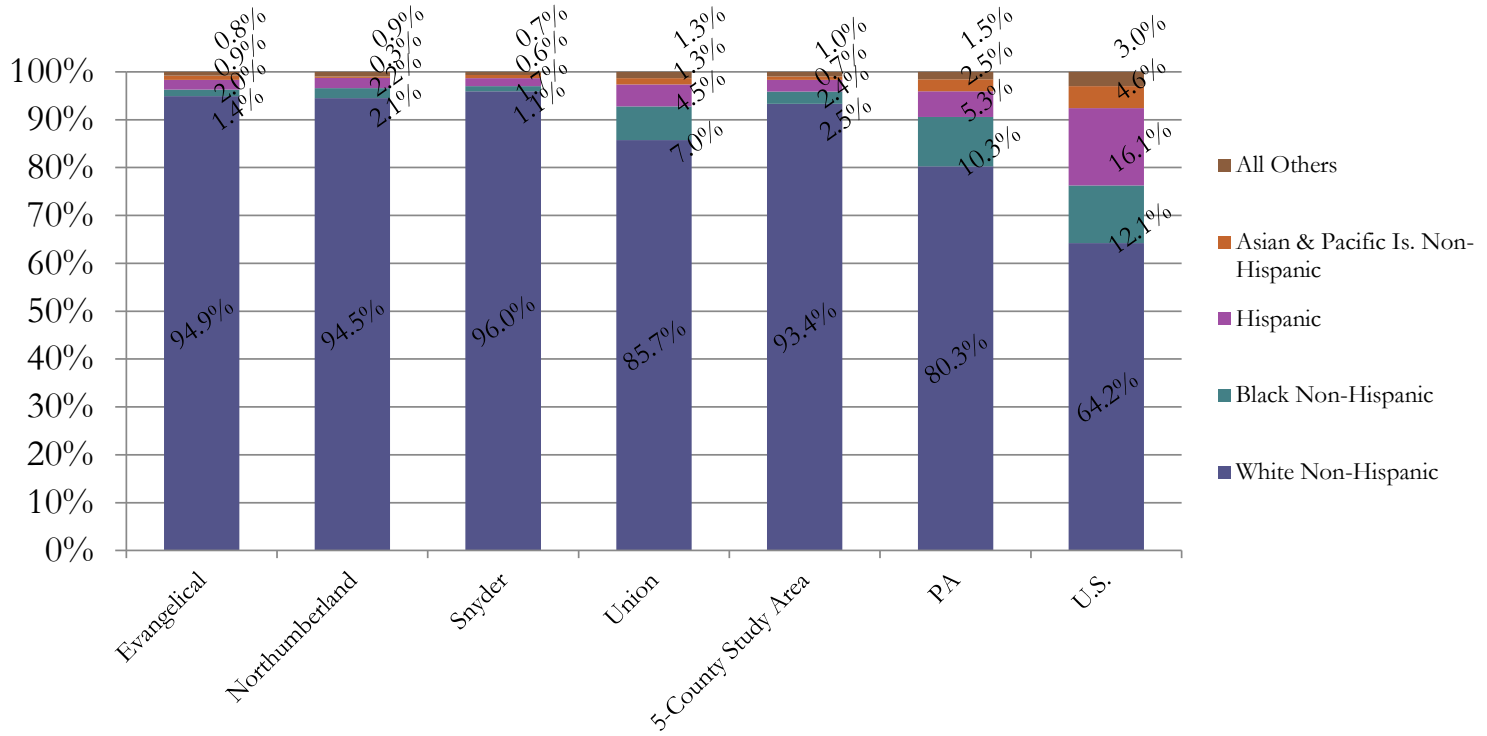


- Evangelical shows 16.6% of the population who have not received a high school diploma, the lowest in the area but still much more than the state rate (12.6%) and U.S. rate (15.1%) which are somewhat lower. Educational level is highly related to occupation and therefore income.

- On the other hand, 39.1% of the Evangelical study area have received some college education or received a college degree.

Source: Thomson Reuters

Race/Ethnicity (2011)



- The Evangelical Hospital study area shows very little diversity as compared with Pennsylvania and the United States. Only 5.1% of the population in the Evangelical study area identify as a race/ethnicity other than White, Non-Hispanic whereas 19.6% in PA and 35.8% in the U.S. identify as a race other than White, Non-Hispanic.

- Union County in the Evangelical Hospital study area shows the most diversity with 14.1% of a race or ethnicity other than White, Non-Hispanic.

Source: Thomson Reuters

CNI Data Methodology

- The data collected to analyze demographic statistics was collected from Thomson Reuters and was from 2011 data.
- The data collected to analyze the CNI statistics was also collected from Thomson Reuters but was from 2010 data.
- Between 2010 and 2011, the town of West Milton (17886) in Union County was assigned a residential zip code and therefore the CNI data does not reflect zip code (17886) yet.
- Please note this discrepancy; that the following slides concerning CNI statistics include 23 towns in the study area, as opposed to the 24 towns in the demographic data.

Community Need Index (CNI)

- **The highest CNI score for the ACTION Health study area is 3.6 in the zip code areas of Sunbury and Allenwood in Northumberland County. The highest CNI score indicates the most barriers to community health care access.**
  - **Sunbury shows very high rates of various individuals living in poverty; 65 and older (11%), families with married individuals with children (17%) and families with single individuals with children (50%). It is striking that 50% of the population in Sunbury is a single parent living with children in poverty.**
  - **Allenwood has an unemployment rate of 17%; this is concerning as unemployment has many far-reaching consequences (i.e. household income, ability to access health care, transportation issues, health coverage issues, etc.). The next highest unemployment rates are for Selinsgrove and Beavertown, but at only 6% their unemployment rates are below both state and national levels (both approximately 8.2%).**

- **The median for the CNI scale is 2.5. The Evangelical Hospital study area shows 14 zip code areas above the median while at the same time shows 9 below the median. This helps us to see that the ACTION Health study area contains more zip code areas with CNI scores above the median indicating more barriers to community health care access.**

- **All of the average CNI scores for the ACTION Health study area are very similar. However, Union county shows the highest CNI score (3.0). Evangelical has an average CNI score of 2.9 indicating higher than average need for an area but not the worst possible (which would be 5.0).**

Community Need Index

Five prominent socio-economic barriers to community health are quantified in the CNI

- **Income Barriers –**
  Percentage of elderly, children, and single parents living in poverty
- **Cultural/Language Barriers –**
  Percentage Caucasian/non-Caucasian and percentage of adults over the age of 25 with limited English proficiency
- **Educational Barriers –**
  Percentage without high school diploma
- **Insurance Barriers –**
  Percentage uninsured and percentage unemployed
- **Housing Barriers –**
  Percentage renting houses

Assigning CNI Scores

To determine the severity of barriers to health care access in a given community, the CNI gathers data about the community's socio-economy. For example, what percentage of the population is elderly and living in poverty; what percentage of the population is uninsured; what percentage of the population is unemployed, etc.

Using this data we assign a score to each barrier condition. A score of 1.0 indicates a zip code area with the lowest socio-economic barriers (low need), while a score of 5.0 represents a zip code area with the most socio-economic barriers (high need). The scores are then aggregated and averaged for a final CNI score (each barrier receives equal weight in the average).

A CNI score above 3.0 will typically indicate a specific socio-economic factor impacting the community's access to care. At the same time, a CNI score of 1.0 does not indicate the community requires no attention at all, which is why a larger community such as the study area community presents a unique challenge to hospital leadership.

CNI Scores (Data)

Zip	City	County	2010 Tot. Pop.	Rental %	Unemp %	Uninsu %	Minor %	Lim Eng	No HS Dip	65+ Pov	M w/ Chil Pov	Sin w/ Chil Pov	Inc Rank	Insur Rank	Educ Rank	Cult Rank	Hous Rank	CNI Score
17801	SUNBURY	NORTHUMBERLAND	15,597	40%	4%	12%	6%	1%	17%	11%	17%	50%	4	3	4	2	5	3.6
17810	ALLENWOOD	UNION	6,686	18%	17%	7%	60%	3%	30%	5%	10%	40%	3	3	5	5	2	3.6
17837	LEWISBURG	UNION	20,089	35%	4%	12%	10%	1%	14%	9%	7%	30%	3	3	3	3	5	3.4
17847	MILTON	NORTHUMBERLAND	10,486	35%	5%	10%	6%	1%	13%	11%	13%	43%	4	2	3	2	5	3.2
17864	PORT TREVORTON	SNYDER	2,958	20%	2%	10%	1%	1%	29%	19%	14%	36%	4	2	5	1	3	3.0
17870	SELINSGROVE	SNYDER	14,102	31%	6%	9%	7%	0%	15%	10%	10%	40%	3	2	3	3	4	3.0
17835	LAURELTON	UNION	306	19%	5%	11%	2%	0%	25%	11%	13%	75%	5	2	5	1	2	3.0
17842	MIDDLEBURG	SNYDER	9,517	25%	5%	9%	2%	0%	20%	11%	10%	33%	3	2	4	1	4	2.8
17853	MOUNT PLEASANT MILLS	SNYDER	2,094	20%	4%	9%	1%	1%	24%	13%	11%	30%	3	2	5	1	3	2.8
17777	WATSONTOWN	NORTHUMBERLAND	6,797	29%	4%	10%	2%	0%	16%	15%	10%	30%	3	2	3	1	4	2.6
17813	BEAVERTOWN	SNYDER	2,151	25%	6%	8%	1%	0%	18%	9%	8%	23%	2	2	4	1	4	2.6
17876	SHAMOKIN DAM	SNYDER	1,472	32%	5%	12%	3%	0%	12%	17%	6%	28%	3	3	2	1	4	2.6
17844	MIFFLINBURG	UNION	9,534	23%	4%	10%	2%	0%	18%	12%	10%	36%	3	2	4	1	3	2.6
17086	RICHFIELD	JUNIATA	1,762	21%	4%	8%	1%	0%	23%	12%	4%	55%	4	1	4	1	3	2.6
17850	MONTANDON	NORTHUMBERLAND	851	22%	4%	9%	2%	0%	20%	7%	14%	21%	2	2	4	1	3	2.4
17845	MILLMONT	UNION	2,295	19%	4%	10%	1%	0%	20%	12%	8%	26%	3	2	4	1	2	2.4
17857	NORTHUMBERLAND	NORTHUMBERLAND	7,393	24%	4%	8%	3%	1%	12%	8%	8%	36%	3	2	3	1	3	2.4
17812	BEAVER SPRINGS	SNYDER	1,547	24%	5%	9%	3%	0%	15%	8%	10%	14%	2	2	3	1	3	2.2
17827	FREEBURG	SNYDER	614	21%	5%	11%	1%	0%	21%	10%	6%	10%	1	2	4	1	3	2.2
17855	NEW BERLIN	UNION	884	23%	3%	11%	2%	1%	14%	2%	5%	25%	2	2	3	1	3	2.2
17856	NEW COLUMBIA	UNION	3,718	15%	3%	9%	5%	1%	17%	5%	6%	29%	2	2	4	2	1	2.2
17889	WINFIELD	UNION	2,197	13%	3%	6%	4%	0%	11%	5%	4%	39%	3	1	2	2	1	1.8
17772	TURBOTVILLE	NORTHUMBERLAND	3,458	16%	4%	5%	1%	1%	15%	9%	5%	8%	1	1	3	1	2	1.6
Evangelical Hospital Community Summary			**126,508**	**28.6%**	**5.0%**	**9.8%**	**7.7%**	**0.7%**	**17.0%**	**10.2%**	**10.0%**	**35.7%**	**3.1**	**2.3**	**3.5**	**2.0**	**3.8**	**2.9**

- The highest CNI score for the Evangelical Hospital study area is 3.6 in the zip code areas of Sunbury and Allenwood in Northumberland County. The highest CNI score indicates the most barriers to community health care access.
- Sunbury and Allenwood have the highest CNI scores but some of the other zip code areas (Lewisburg, Port Trevorton and Laurelton) have high individual rates of measures used to calculate the CNI score.
- We must remember that Allenwood contains the correctional facility, so we must look at barriers found in other zip code areas as well.

Source: Thomson Reuters

CNI Scores (Findings)

- **The rates at which individuals are living (either single or married) with children in poverty are concerning.** Sunbury=50% single and 17% married living in poverty; Laurleton=75% single and 13% married; and Milton=43% single and 13% married living in poverty.

- **Sunbury shows very high rates of various individuals living in poverty;** 65 and older (11%), families with married individuals with children (17%) and families with single individuals with children (50%).
  - It is striking that 50% of the population in Sunbury is a single parent living with children in poverty.

- **Sunbury also shows the highest rate of individuals who rent (40%) as opposed to own their homes.** The renting population is generally comprised of students or individuals with lower incomes who cannot afford buying a home.

- **Allenwood has an unemployment rate of 17%;** this is concerning as unemployment has many far-reaching consequences (i.e. household income, ability to access health care, transportation issues, health coverage issues, etc.). **Allenwood also shows the highest rates of minority individuals (60%)** and individuals who have limited English (3.0%, the average for the area is 0.7%).

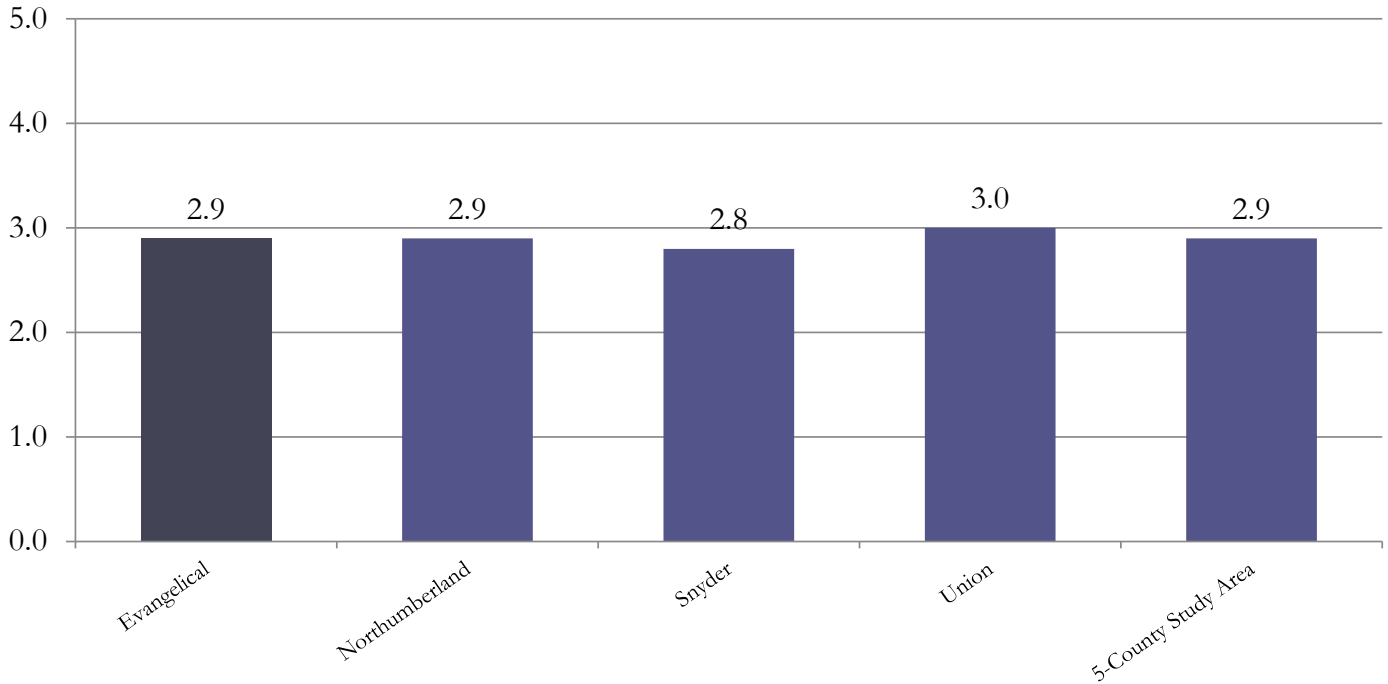
- **After Allenwood, Lewisburg shows some of the highest rates** of minorities (10%) and uninsured (12%) individuals.

- **Turbotville, on the other hand,** shows very low rates for many of the measures used in the CNI score.
  - With only 4% unemployment, Turbotville has a much lower unemployment rate than the state and national rate.
  - Turbotville also shows very low rate of various individuals living in poverty; 9% 65 and older, 5% married with children living in poverty and 8% single living with children in poverty.

- **The median for the CNI scale is 2.5.** The Evangelical Hospital study area shows 14 zip code areas above the median while at the same time shows 9 below the median. This helps us to see that the ACTION Health study area contains more zip code areas with CNI scores above the median indicating more barriers to community health care access.

Source: Thomson Reuters

Community Need Index



- The average CNI scores for Evangelical and the counties in which it includes are all above the median for the scale (2.5); however, none of the scores are substantially high, most are in the mid-range for number of barriers to community need access.

- All of the average CNI scores for the study area are very similar. However, Union county shows the highest CNI score (3.0). Evangelical has an average CNI score of 2.9 indicating higher than average need for an area but not the worst (which would be 5.0).

Source: Thompson Reuters

County Health Rankings Data

- The County Health Rankings show that where we live impacts our health status. The health of a community depends on many different factors – from individual health behaviors, education and jobs, to quality of healthcare and the environment. The rankings help community leaders see that where we live, learn, work, and play influences how healthy we are and how long we live.

- The County Health Rankings are a key component of the Mobilizing Action Toward Community Health (MATCH) project. MATCH is the collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The rankings identify the multiple health factors that determine a county's health status. Each county receives a summary rank for its health outcomes and health factors - the four different types of health factors include: health behaviors, clinical care, social and economic factors, and the physical environment. The Rankings are a real "Call to Action" for state and local health departments to develop broad-based solutions with others in their community so all residents can be healthy. But efforts will also be made to mobilize community leaders outside the public health sector to take action and invest in programs and policy changes that address barriers to good health and help residents lead healthier lives. Other community leaders may include: educators; elected and appointed officials, including mayors, governors, health commissioners, city/county councils, legislators, and staff; business owners; and the healthcare sector.

Source: 2011 County Health Rankings
A collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

County Health Rankings Data

- Data across 37 various health measures is used to calculate the Health Ranking.
  - The measures include:
    - Mortality
    - Morbidity
    - Tobacco Use
    - Diet and Exercise
    - Alcohol Use
    - Sexual Behavior
    - Access to care
    - Quality of care
    - Education
    - Employment
    - Income
    - Family and Social support
    - Community Safety
    - Environmental quality
    - Built environment
    - Population
    - % below 18 years of age
    - % 65 and older
    - % African American
    - % American Indian and Alaskan Native
    - % Asian
    - % Native Hawaiian/Other Pacific Islander
    - % Hispanic
    - % not proficient in English
    - % female
    - % rural
    - % diabetic
    - HIV rate
    - Binge drinking
    - Physical Inactivity
    - Mental health providers
    - Median household income
    - % with high housing costs
    - % of children eligible for free lunch
    - % illiterate
    - Liquor store density
    - % of labor force that drives alone to work

Source: 2011 County Health Rankings
A collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

County Health Rankings Data

- Counties in each of the 50 states are ranked according to summaries of the 37 health measures. Those having good rankings, such as 1 or 2, are considered to be the "healthiest." Counties are ranked relative to the health of other counties in the same state on the following summary measures:
  - Health Outcomes--We measure two types of health outcomes to represent the health of each county: how long people live (mortality) and how healthy people feel (morbidity). These outcomes are the result of a collection of health factors and are influenced by existing programs and policies at the local, state, and federal levels.
  - Health Factors--A number of different health factors shape a community's health outcomes. The County Health Rankings are based on weighted scores of four types of factors:
    - Health behaviors (6 measures)
    - Clinical care (5 measures)
    - Social and economic (7 measures)
    - Physical environment (4 measures)

Source: 2011 County Health Rankings
A collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

County Health Rankings Data

- Pennsylvania has 67 counties; therefore, the rank scale for Pennsylvania is 1 to 67 (1 being the healthiest county and 67 being the most unhealthy). The median rank is 34.
- Data for the County Health Rankings is only defined as far as the county level, zip code level data is not available. Therefore, the county level data has been presented here (no Evangelical Community Hospital service area level data is available).
- The counties included in the Evangelical Community Hospital service area show very poor (unhealthier) rankings for the following measures:
  - Education (Northumberland=58, Snyder=65 and Union=35; all above the median)
  - Employment (Northumberland=52, Snyder=41 and Union=41; all above the median)
  - Diet and Exercise (Snyder=53 and Union=49)
- Northumberland, Snyder and Union counties all show very poor rankings for Employment, Education and Diet and Exercise. We know that these three factors are highly correlated; i.e., poor employment can lead to lower income which can then lead to fewer options for good educational opportunities and therefore poorer health decisions in terms of diet and exercise.

Source: 2011 County Health Rankings

County Health Rankings Data

- Northumberland county has 14 health rank scores above the median for the state (34). Although, Northumberland county has the most poor rankings across the study area, the majority of the rank scores are in the 50's range. Other counties such as Montour and Snyder have some of the highest (unhealthiest) rank scores (Montour rank of 65 for community safety and Snyder rank of 65 for education).

- Snyder county holds 6 categories with a rank of 5 or better but also holds 6 categories with a rank above the median of 34 (Social and Economic Factors, Diet and Exercise, Access to Care, Education, Employment, and Community Safety). Many of the measures in which Snyder County ranks poorly are social factors that could be aided with community health care access reform.

- Union county has a rank of 1 (the healthiest in the state) for health outcomes and quality of care but has a rank of 63 (one of the unhealthiest in the state) for the built environment. The Built Environment is defined by access to recreational facilities, limited access to healthy foods and number of fast food restaurants.

Source: 2011 County Health Rankings

County Health Rankings Data

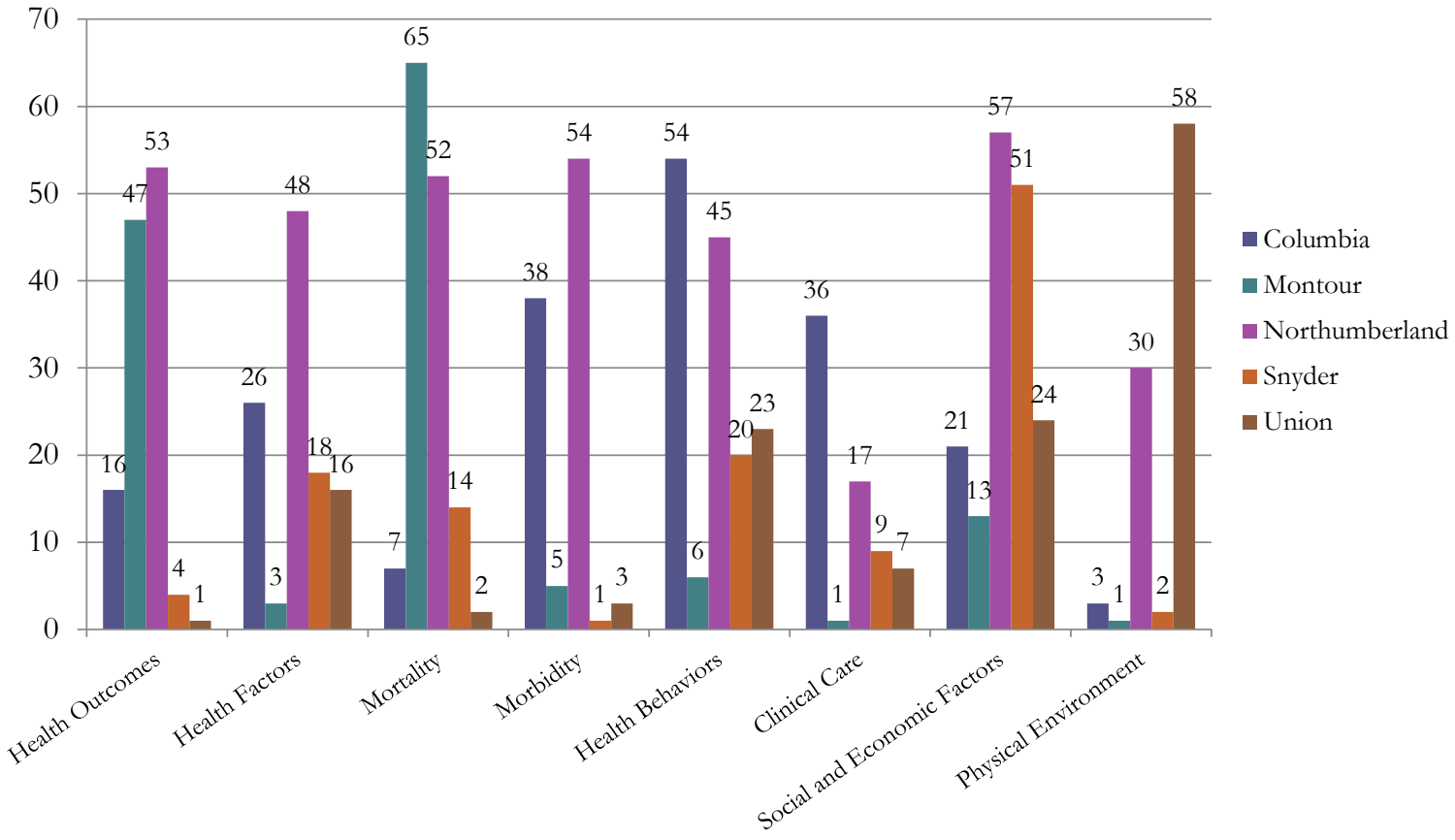
County	Health Outcomes	Health Factors	Mortality	Morbidity	Health Behaviors	Clinical Care	Social and Economic Factors	Physical Environment
Columbia	16	26	7	38	54	36	21	3
Montour	47	3	65	5	6	1	13	1
Northumberland	53	48	52	54	45	17	57	30
Snyder	4	18	14	1	20	9	51	2
Union	1	16	2	3	23	7	24	58

Blue text indicates a rank in the top 5 (good ranking).

Red text indicates a rank above the state median (poor ranking).

Source: 2011 County Health Rankings

County Health Rankings Data



Source: 2011 County Health Rankings

County Health Rankings Data

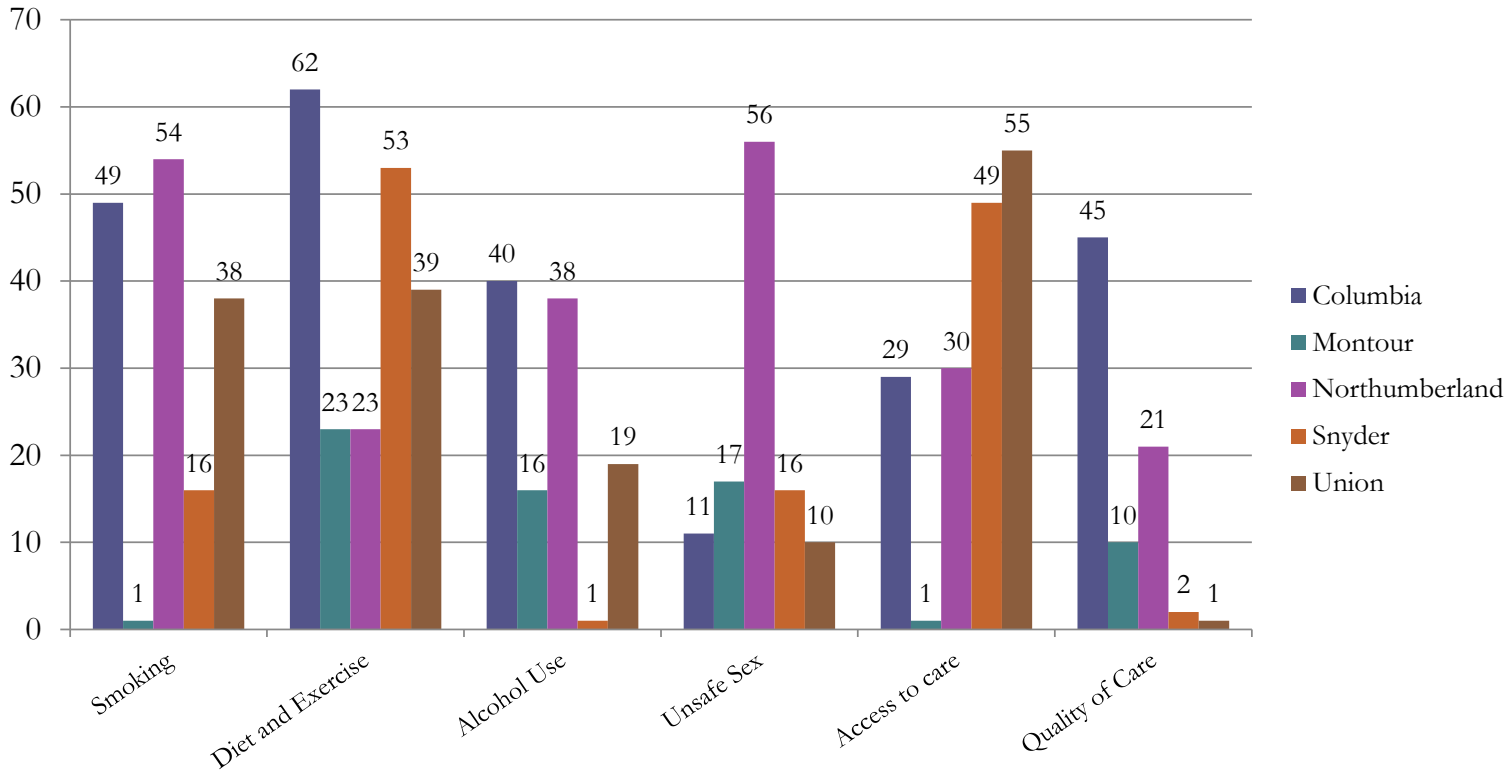
County	Smoking	Diet and Exercise	Alcohol Use	Unsafe Sex	Access to care	Quality of Care
Columbia	49	62	40	11	29	45
Montour	1	23	16	17	1	10
Northumberland	54	23	38	56	30	21
Snyder	16	53	1	16	49	2
Union	38	39	19	10	55	1

Blue text indicates a rank in the top 5 (good ranking).

Red text indicates a rank above the state median (poor ranking).

Source: 2011 County Health Rankings

County Health Rankings Data



Source: 2011 County Health Rankings

County Health Rankings Data

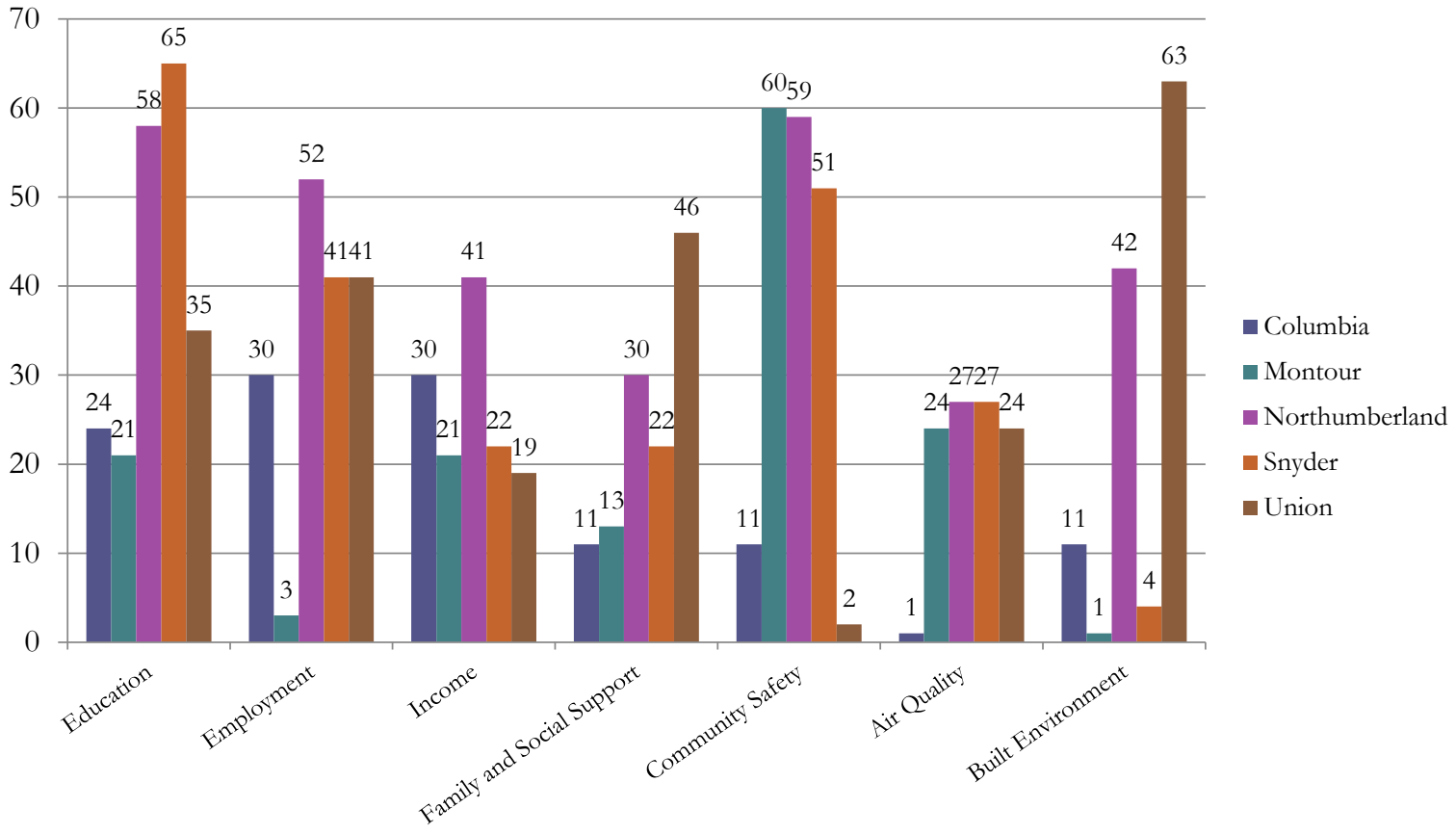
County	Education	Employment	Income	Family and Social Support	Community Safety	Air Quality	Built Environment
Columbia	24	30	30	11	11	1	11
Montour	21	3	21	13	60	24	1
Northumberland	58	52	41	30	59	27	42
Snyder	65	41	22	22	51	27	4
Union	35	41	19	46	2	24	63

Blue text indicates a rank in the top 5 (good ranking).

Red text indicates a rank above the state median (poor ranking).

Source: 2011 County Health Rankings

County Health Rankings Data



Source: 2011 County Health Rankings

Prevention Quality Indicators Index (PQI)

The Prevention Quality Indicators index (PQI) was developed by the Agency for Healthcare Research and Quality (AHRQ). PQI is similarly referred to as Ambulatory Care Sensitive Hospitalizations. The quality indicator rates are derived from inpatient discharges by zip code using ICD diagnosis and procedure codes. There are 14 quality indicators.

The PQI index identifies potentially avoidable hospitalizations for the benefit of targeting priorities and overall community health. Lower index scores represent less admissions for each of the PQIs.

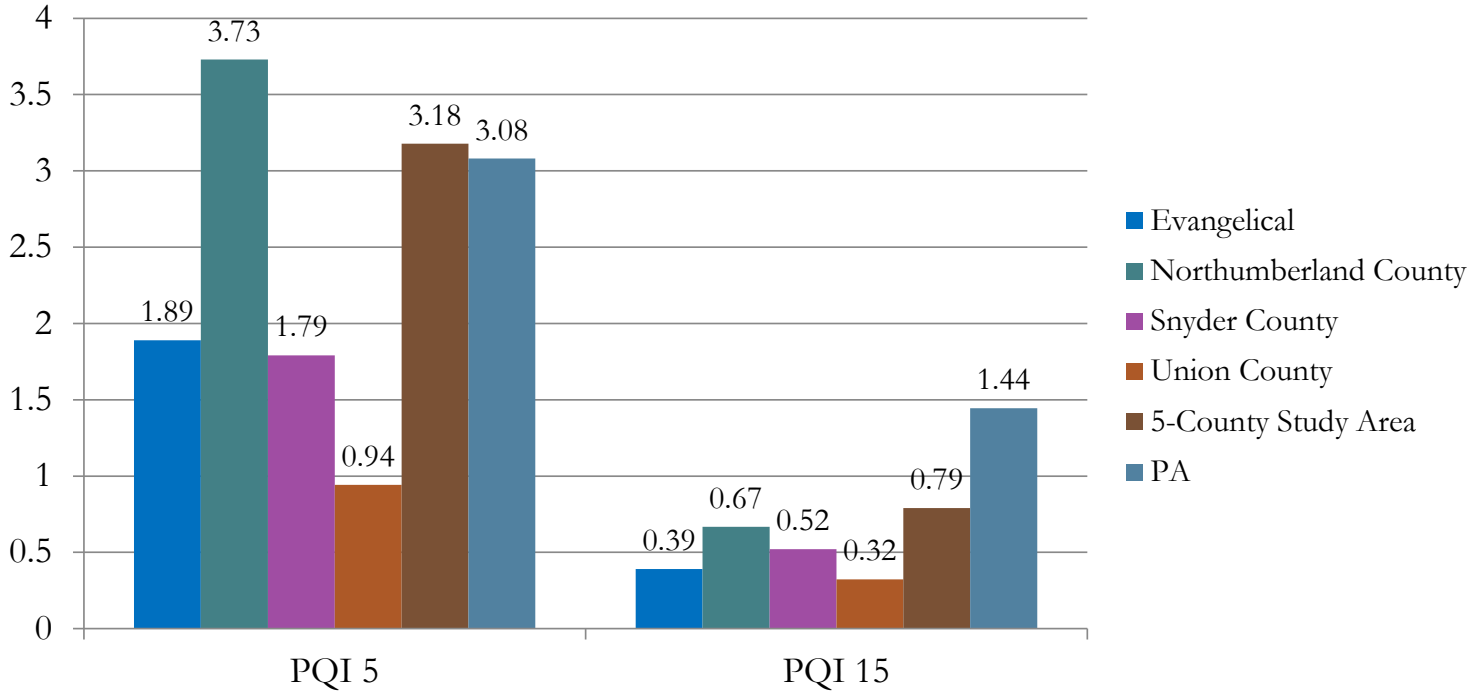
- The Evangelical Hospital study area shows only 1 PQI measure that is higher than the state and that is for Perforated Appendix (and it is only a slight rise, Evan=0.31 and Pa=0.27).
- This is important to note as it indicates that for 15 out of the 16 preventable hospital admission measures used for the PQI analysis; Evangelical has lower rates.
- The largest difference between Evangelical and PA is for Urinary Tract Infections in which PA shows a rate of preventable hospitalizations due to UTIs at 2.30 whereas Evangelical shows a rate of only 0.55 (less than ¼ the rate).
- Evangelical Hospital shows a rate of 0.00 for Low Birth Weight. This does not indicate that there were no preventable hospital admissions due to Low Birth Rate, but rather that so few occurred in the Evangelical Hospital study area that the value is not reported. Pennsylvania, on the other hand, shows a rate of 1.11, indicating that there are some preventable hospital admissions due to Low Birth Rate in the state.
- Northumberland County shows the worst PQI scores for the study area with 8 of the 14 measures above the state rate.

Prevention Quality Indicators Index (PQI)

PQI Subgroups

- Chronic Lung Conditions
  - PQI 5 Chronic Obstructive Pulmonary Disease Admission Rate
  - PQI 15 Adult Asthma Admission Rate
- Diabetes
  - PQI 1 Diabetes Short-Term Complications Admission Rate
  - PQI 3 Diabetes Long-Term Complications Admission Rate
  - PQI 14 Uncontrolled Diabetes Admission Rate
  - PQI 16 Lower Extremity Amputation Rate Among Diabetic Patients
- Heart Conditions
  - PQI 7 Hypertension Admission Rate
  - PQI 8 Congestive Heart Failure Admission Rate
  - PQI 13 Angina Without Procedure Admission Rate
- Other Conditions
  - PQI 2 Perforated Appendix Admission Rate
  - PQI 9 Low Birth Weight Rate
  - PQI 10 Dehydration Admission Rate
  - PQI 11 Bacterial Pneumonia Admission Rate
  - PQI 12 Urinary Tract Infection Admission Rate

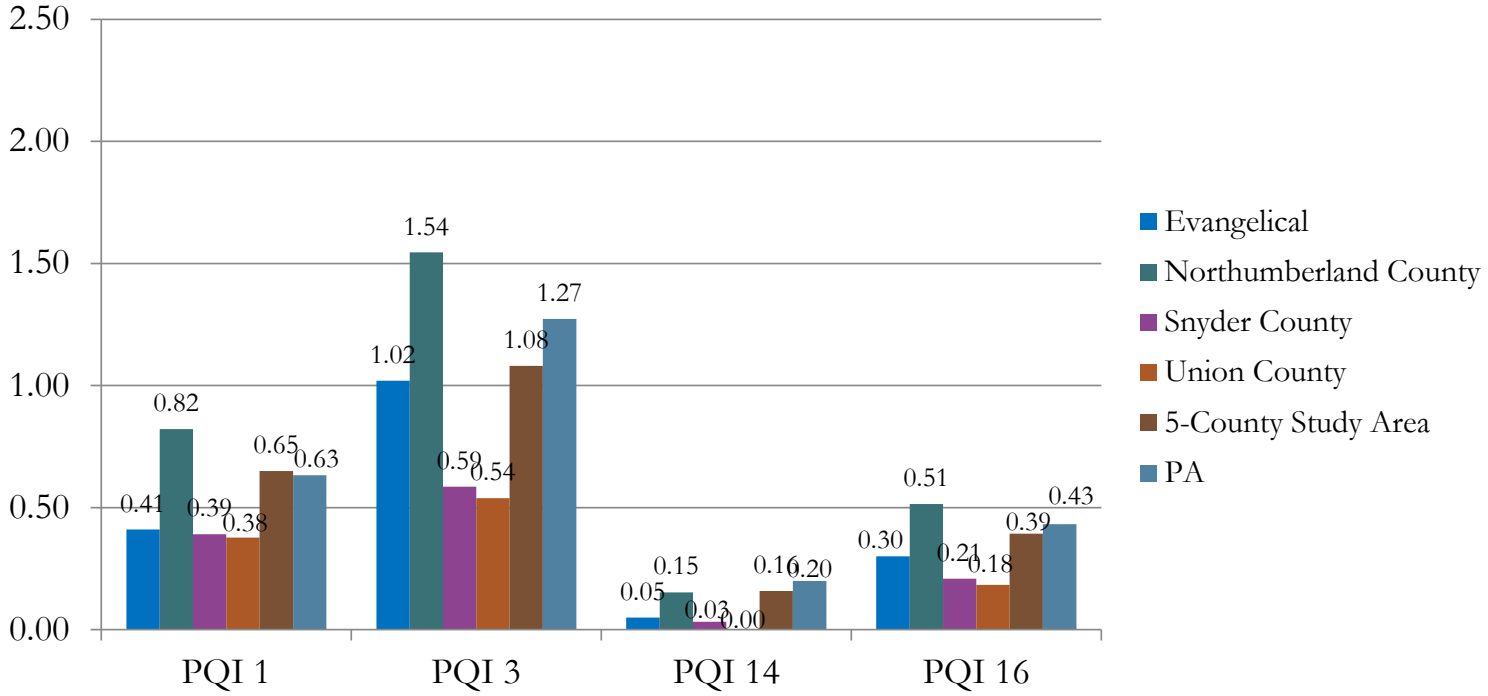
Chronic Lung Conditions



PQI 5 Chronic Obstructive Pulmonary Disease Admission Rate
PQI 15 Adult Asthma Admission Rate

Source: Ohio Hospital Association

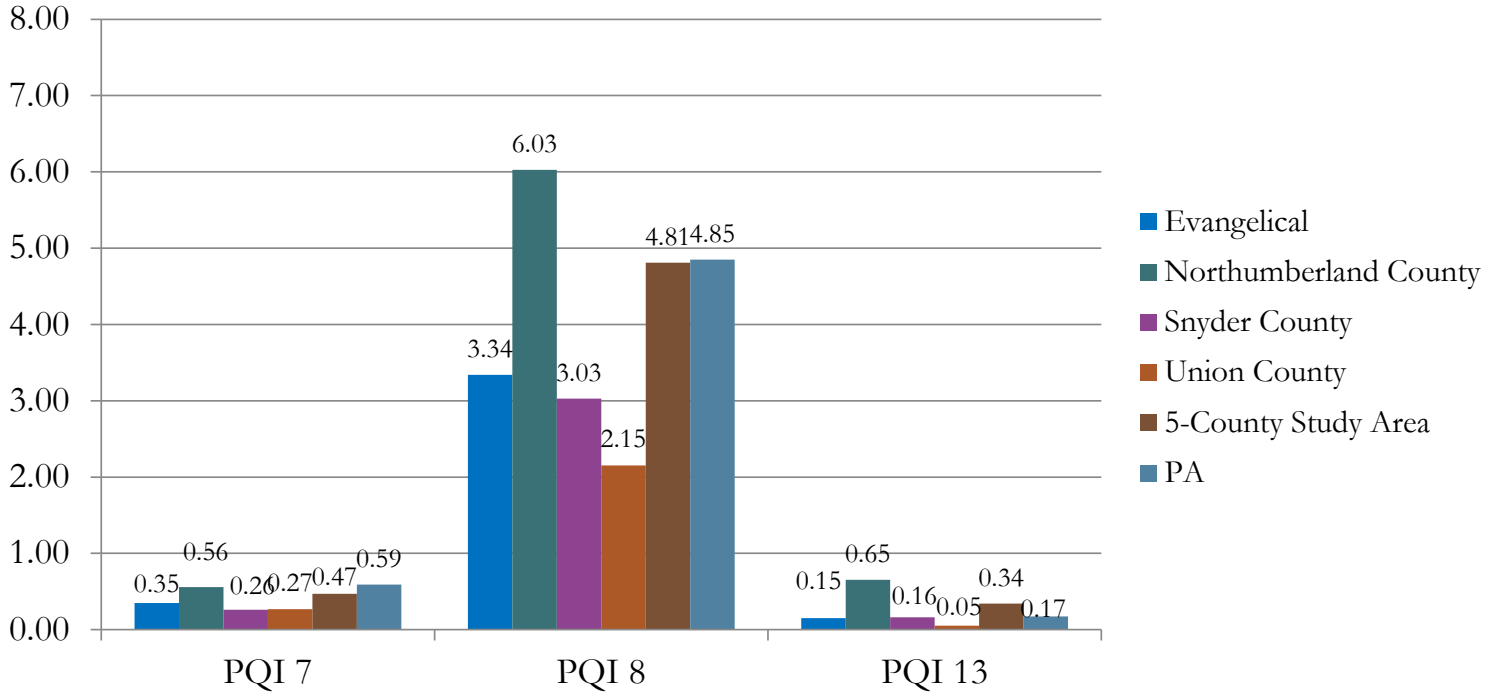
Diabetes



PQI 1 Diabetes Short-Term Complications Admission Rate
PQI 3 Diabetes Long-Term Complications Admission Rate
PQI 14 Uncontrolled Diabetes Admission Rate
PQI 16 Lower Extremity Amputation Rate Among Diabetic Patients

Source: Ohio Hospital Association

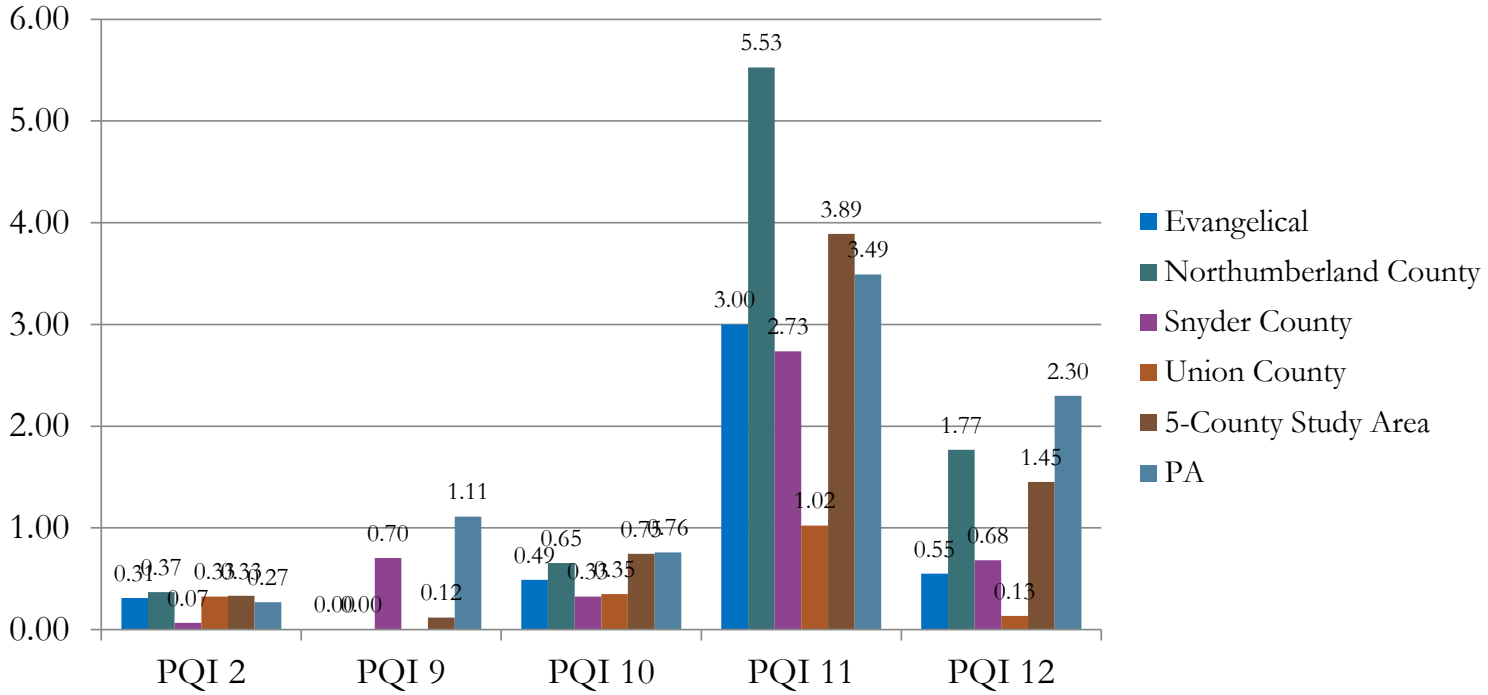
Heart Conditions



PQI 7 Hypertension Admission Rate
PQI 8 Congestive Heart Failure Admission Rate
PQI 13 Angina Without Procedure Admission Rate

Source: Ohio Hospital Association

Other Conditions



PQI 2 Perforated Appendix Admission Rate
PQI 9 Low Birth Weight Rate
PQI 10 Dehydration Admission Rate
PQI 11 Bacterial Pneumonia Admission Rate
PQI 12 Urinary Tract Infection Admission Rate

Source: Ohio Hospital Association

Evangelical Hospital – Initial Reactions to Secondary Data

- The consultant team has identified the following data trends and their potential impact:
  - Evangelical shows a very slight decline in population over the next 5 years at a rate of -0.09%. This trend differs from that of Pennsylvania as a whole. Pennsylvania is projected to see a 0.70% rise in population between 2011 and 2016. Therefore, people are coming into Pennsylvania but not to counties in the ACTION Health study area with the exception of Snyder and Union counties (2 of the 3 counties that make up the service area for Evangelical Community Hospital).
  - The Evangelical Hospital study area shows an average annual household income of $53,064. It is interesting to see that all of the average household income levels for the study area fall below the averages for Pennsylvania and for the United States. Generally, rural areas show lower income levels as compared with more urban areas.
  - With the exception of Allenwood (unemployment rate of 17%, linked to the fact that Allenwood contains a correctional facility), the unemployment rates for the Evangelical study area are lower than state and national levels (8.3% for both).
  - The rates at which individuals are living (either single or married) with children in poverty are concerning. Sunbury=50% single and 17% married living in poverty; Laurleton=75% single and 13% married; and Milton=43% single and 13% married living in poverty.
  - Snyder county holds 6 categories with a county health rank of 5 or better but also holds 6 categories with a rank above the median of 34 (Social and Economic Factors, Diet and Exercise, Access to Care, Education, Employment, and Community Safety). Many of the measures in which Snyder County ranks poorly are social factors that could be aided with community health care access reform.
  - The Evangelical Hospital study area shows only 1 PQI measure that is higher than the state and that is for Perforated Appendix (and it is only a slight rise, Evan=0.31 and Pa=0.27). This is important to note as it indicates that for 15 out of the 16 preventable hospital admission measures used for the PQI analysis; Evangelical has lower rates.

APPENDIX C

Community Stakeholder Interview Results

EVANGELICAL COMMUNITY HOSPITAL
Conducted December 2011 – January 2012

Community:

Evangelical Hospital service area

INTRODUCTION:

Tripp Umbach conducted interviews with community leaders in the Evangelical Community Hospital service area. Leaders whom were targeted for interviews encompassed a wide variety of professional backgrounds including education, healthcare, media, local government, human service organizations, institutes of higher learning, religious institutions, and the private sector (See Appendix 1 for a list of participating organizations). The interviews offered community leaders an opportunity to provide feedback on the needs of the community, input on the focus group audiences, secondary data resources, and other information relevant to the study.
This report represents a section of the overall community health needs assessment project completed by Tripp Umbach.

DATA COLLECTION:

The following qualitative data were gathered during individual interviews with 15 stakeholders of the Evangelical Community Hospital service area as identified by an advisory committee of Evangelical Community Hospital. Evangelical Community Hospital is a 127-bed community hospital. Each interview was conducted by a Tripp Umbach consultant and lasted approximately 60 minutes. All respondents were asked the same set of questions developed by Tripp Umbach and previously reviewed by the Evangelical Community Hospital advisory committee. The purpose of these interviews was for stakeholders to identify health issues and concerns affecting residents in the Evangelical Community Hospital service area, as well as ways to address those concerns.

Of the 15 respondents, the 12 places mentioned by stakeholders when asked what community they were speaking on behalf of were: Union County, Snyder County, Northumberland County, Montour County, Central Susquehanna Valley, Columbia County, Borough of Danville, Riverside, Bloomsburg, Central Pa, Bloomsburg University, and Lewisburg, Pa (in order of most mentioned). Additionally, there was a diverse representation of positions held in the community. Those positions represented included local media, educator, educational leader, non-profit leader, county employee, religious leader, medical specialist and university faculty.

EFFECTIVE COMMUNICATION IN THE COMMUNITY:

Many stakeholders felt there was not one method of communication that is most effective. More often, stakeholders identified the need to utilize multiple communication methods over a period of time to effectively communicate with residents. That being said, stakeholders identified the following as effective methods of information dissemination to residents in the community and their own clients and consumers (listed in order of most mentioned):

Communicating with Residents in the Community:

- Newspaper
- Radio
- Television
- Send flyers home from school
- Announcements to audiences (i.e., Town hall meetings)
- Hand-delivering information
- Electronically (i.e., Internet, email, etc.) though many stakeholders felt this was not effective
- Face-to-face contact
- Positing information at local agencies/organizations residents use (i.e., medical facilities)
- Word of mouth
- Newsletters
- Health fairs (i.e., mall)
- Church bulletins or announcements

Stakeholder Communication with Clients and Consumers:

- Face-to-face contact (i.e., community education and outreach, on-site patient education)
- Email/constant contact
- Newspaper
- Direct mailing
- Website
- Social media outlets
- Bulletin boards
- Send things home with children
- Calling system for school closure (i.e., recorded message goes out to 3,000 people)
- Educational session/workshops
- Talk with the doc night
- Publications (i.e., white papers, proposals, reports, etc.)
- Fax
- Television

PROBLEM IDENTIFICATION:

During the interview process, the stakeholders stated three overall health issues and concerns in their community. In random order these were:

1. Access to primary and preventive medical services
2. Resident wellness
3. Access to community services

PRIMARY AND PREVENTIVE HEALTH SERVICES:

While many stakeholders felt that quality primary medical care is available in the area; they also perceived primary and preventive health services provided by medical facilities (i.e., hospitals, private practitioners, etc.) in their communities to be limited in the areas of access to affordable healthcare, limited number of providers, transportation, availability of insurance coverage, use of emergency room services, medical resources for seniors.

Contributing Factors:

- Limited access to affordable health insurance for the under/unemployed and senior populations.
- There are not enough clinics in the community to meet resident demand for under/uninsured medical care.
- Clinics are many times located a far distance from the patient and the lack of public transportation makes it difficult to obtain services.
- Access to dental care is limited due to the limited number of local providers that accept medical assistance and restricted health insurance coverage of dental care costs.
- Access to affordable preventive medical care is limited due to health insurance coverage restrictions, cost of preventive care, limited prevention services for under/uninsured and limited resident participation/demand.
- Emergency room services are being over utilized for non-emergent health issues due to the lack of walk-in medical services and limited under/uninsured medical care being offered in the area.
- An aging baby boomer population is placing a strain on medical care resources.

Mitigating Resources:

Stakeholders identified the following existing resources in their community that they felt could help improve their access to primary and preventive health services:

- There are many local medical facilities that offer primary/secondary/tertiary medical care (five hospitals in five counties),
- Senior services are offered in many communities,
- Community Clinic offers affordable and/or free under/uninsured medical care,
- Area Agency on Aging offers limited direct elder care,
- Evangelical Community Education Program,
- There are caring compassionate healthcare workers striving to meet the needs of residents and
- Geisinger offers an independent health plan.

Group Suggestions/Recommendations:

Stakeholders offered the following as possible solutions to improve their access to primary and preventive health services in their communities:

- *Increase access to primary and preventive care:* Stakeholders felt that access to primary and preventive medical care as well as dental care should be increased. Stakeholders also felt that physicians should be educating patients about affordable healthy alternatives. Additionally, Medicare/Medicaid reimbursements would need to be increased; however in the meantime, physicians could more readily accept and provide under/uninsured healthcare services. Stakeholders felt that residents need to be better informed about their individual status and how best to interact with the healthcare industry. Finally, stakeholders recommended that there be an increase in the number of campus-based healthcare clinics that provide services to students as well as residents in the community.

RESIDENT WELLNESS:

Stakeholders felt that the wellness of residents was lacking in the areas lifestyle choices, awareness, available services and the prevalence of chronic illness.

Contributing Factors:

- Affordable prevention education and outreach programs are needed in many communities.
- Many residents make lifestyle choices that can lead to poor health statuses (i.e., smoking, inactivity, substance abuse and poor nutrition).
- Many residents are not aware of how to lead healthier lifestyles.
- Chronic illness is prevalent (i.e., diabetes, obesity, respiratory issues, etc.).
- The rise in childhood obesity will lead to increased chronic illness and health costs.
- There are limited exercise opportunities (i.e., community centers, gyms, etc.).
- Due to the economy, residents are primarily focused on meeting their basic needs instead of wellness.
- There is limited access to healthy food.
- Under/uninsured residents often do not have access to wellness information and/or programs.

Mitigating Resources:

Stakeholders identified the following existing resources in their community that they felt could help improve resident wellness:

- There are institutions that offer services to improve resident wellness (i.e., Penn State Cooperative Extension, YMCA, local hospitals community education departments, etc.),

- There are outreach programs offered in the community,
- There are prevention programs offered in the community,
- Supportive services are available to improve resident wellness (i.e., smoking cessation, diabetes, etc.),
- There are community centers that offer a variety of wellness services and
- Natural resources are available locally for outdoor wellness activities.

Group Suggestions/Recommendations:

Stakeholders offered the following as possible solutions to improve the wellness of residents in their communities:

- ***Improve the wellness of residents:*** Stakeholders felt that residents need to be accountable for their own lifestyle choice. However, they also indicated that residents could be healthier if there were more preventive education and wellness programs available. Also, stakeholders felt that local primary care physicians should be referring residents to community services that were relevant to the wellness of each individual.

ACCESS TO COMMUNITY SERVICES:

While stakeholders believed that there are some services available in their communities; they perceived community services to be limited in the areas of transportation, behavioral health services, recreational activities and housing.

Contributing Factors:

- Access to community services can be limited due to the lack of public transportation and the distance residents must travel due to the rural nature of the area.
- Access to mental health services can be limited due to a lack of providers, the stigma around mental illness and a fear of being seen seeking mental health services.
- Access to recreational activities can be limited by resident's motivation to participate in the activities that are available, the lack of recreational activities and costly fees associated with participation in such activities.
- Access to affordable stable housing is limited in some areas due to recent flooding and the unwillingness of landlords to offer low-income housing.

Mitigating Resources:

Stakeholders identified the following existing resources in their community that they felt could help improve access to community services:

- Churches have a strong presence and provide many services to the community,
- There are institutions and organization in the area that provide recreational activities (i.e., community centers, YMCA, etc.),
- There are a number of soup kitchens/food pantries and shelters in the area,
- Community members (residents and institutions) were generous and collaborative in meeting the needs of flood victims and

- There are some behavioral health providers in the area.

Group Suggestions/Recommendations:

Stakeholders offered the following as possible solutions to improve access to community services in their communities:

- ***Increase the access residents have to community services:*** Resident awareness of available services could be increased by a community liaison that residents could interact with and ask questions. Also, stakeholders recommended making a community resource guide available to residents. Additionally, stakeholders recommended increasing the number of services available to at-risk populations. Stakeholders also recommended developing a regional transportation service. Finally, stakeholders recommended consolidating available services and reducing any duplication of services to maximize the use of available funding.

APPENDIX D

Community Focus Group Results

EVANGELICAL COMMUNITY HOSPITAL
Conducted March 2012

Community:

Evangelical Community Hospital service area

INTRODUCTION:

The following qualitative data were gathered during three separate discussion groups conducted with target populations that were defined by the advisory committee for Evangelical Community Hospital. Evangelical Community Hospital is a 127-bed community hospital. Each group was conducted by Tripp Umbach consultants, and participants were provided an incentive of $20 for participating. The discussion groups were conducted using a discussion guide previously created by Tripp Umbach and reviewed by the Evangelical Community Hospital advisory committee (Appendix 1).

The goal of the focus group process is that each participant feels comfortable and speaks openly so that they contribute to the discussion. It was explained to participants that there are no wrong answers, just different experiences and points of view. This process ensures that each participant shares their experiences from their point of view, even if it is different from what others have said. Specifically, focus group participants were asked to identify and discuss what they perceived to be the top health issues and/or concerns in their communities. The focus group process gathers valuable qualitative and anecdotal data regarding the broad health interests of the communities served by the healthcare facilities within the service area of Evangelical Community Hospital. Focus group input is subject to the limitations of the identified target populations (i.e., vocabulary, perspective, knowledge, etc.), and therefore, is not factual and inherently subjective in nature.

The three focus group audiences were:

- ✓ Healthcare Providers
  - Conducted at Community Health Education Center (Lewisburg, PA)
- ✓ Latino Residents
  - Conducted at Congrecion Mennonita in (New Columbia, PA)
- ✓ Under/Uninsured Residents
  - Conducted at A Community Clinic (Sunbury, PA)

HEALTHCARE PROVIDERS FOCUS GROUP INPUT

The purpose of this discussion group was to identify community health needs and concerns affecting residents with chronic illness seen by healthcare providers in the Evangelical Community Hospital service area, as well as ways to address those concerns for this population.

Note: The decision was made to hold a focus group with healthcare providers instead of their patients in an attempt to identify the health needs of residents with chronic illness.

PROBLEM IDENTIFICATION:

During the discussion group process, healthcare providers discussed two community health needs and concerns for school-aged children in their communities. These were:

1. **Access to primary, preventive and mental healthcare**
2. **Transportation**

ACCESS TO PRIMARY, PREVENTIVE AND MENTAL HEALTHCARE:

Healthcare providers perceived that access to primary, preventive and mental healthcare in their communities may be limited in the areas of consumer expectations, senior services, mental health, transportation, lifestyle choices and accessibility of care.

Perceived Contributing Factors:

- Participants believed that some younger residents have expectations about communication from medical providers that may not be realistic (i.e., teenager expect an instant response from their medical providers).
- Participants gave the impression that seniors are a growing population due to baby-boomers aging. Additionally, participants believed that there is an increase in residents living with chronic illness in the community, which when coupled with the size of the baby-boomer generation, may require more medical resources and treatment capacity than is currently available (i.e., there is a shortage of elder care, transitional services, nurses and a decrease in reimbursement rates).
- Participants believed that seniors are presenting to the emergency room too ill to be treated at home, and yet not ill enough to meet admission criteria. Additionally, if there are not family members available to provide care, then the patient must be placed in a transitional nursing home until they have regained the ability to function. Participants indicated that nursing home daily rates may be unaffordable for many residents receiving Medicare.
- Participants were under the impression that insurance regulations limit the number of hospital admissions available to senior residents to one admission every 30 days, which may not meet the needs of chronically ill aging residents; particularly if they have more than one diagnosis.

- Participants were under the impression that residents are not practicing prevention which may lead to an increase healthcare consumption.
- Participants believed that some residents are not always able to afford medical care, which participants gave the impression often leads to minor medical issues becoming emergency situations because residents try to forgo medical treatment.
- Participants gave the impression that obesity is a growing trend among resident in their community due to the limited access some residents may have to affordable healthy options, as well as the limited motivation of some residents to live healthy lifestyles.
- Participants believed that physicians may be practicing defensive medicine at times due to the fear of being sued. Participants were under the impression that physicians that train in Pennsylvania, ultimately leave the state due to the risk of law suits, which is causing a shortage of primary care physicians throughout the state.
- Participants believed that the emergency medical department can be overcrowded at times due to residents presenting to the emergency room instead of a primary care physician. Participants believed residents are over-utilizing the emergency department because payment is not required at the time of treatment; whereas most primary care physicians operate on a fee for service basis.
- Participants believed that some residents avoid seeking care for mental health issues due to a fear of the stigma associated with mental illness. However, participants indicated that one in five residents that present to the emergency medical department have a mental health diagnosis, and there is not always adequate staffing. Additionally, participants felt that many physicians do not have specialized training in mental healthcare and are only able to keep mental health patients from harming themselves.
- Participants believed that mental health services can be difficult to navigate for some residents due to lengthy waits for available appointments, insurance restrictions, limited inpatient resources, being denied treatment at some local medical facilities, etc.
- Participants were under the impression that the lack of transportation after hours may cause emergency departments to house residents that could otherwise be discharged because they cannot get home.

Mitigating Resources:

Healthcare providers identified the following existing resources in their communities that they felt could improve the access to primary, preventive and mental healthcare:

- Striving to provide health education to the community.
- The local emergency department will treat patients.
- Local providers are beginning to make changes that are focused on reducing the consumption of healthcare resources.
- Local providers are beginning to collaborate with one another.
- Training for nurses has improved according to participants.

Group Suggestions/Recommendations:

Healthcare providers offered the following as possible solutions to help improve the access to primary, preventive and mental healthcare in their communities.

- ***Increase primary and preventive medical services for seniors:*** Participants believed that there is already a shortage of healthcare resources for seniors. Participants believed that local medical facilities will need to increase the amount of elder care available in the community (i.e., medical transportation, transitional care, etc.

- ***Provide a nurse-on-call service:*** Participants believed that the availability of a nurse-on-call service could reduce visits to the emergency room for non-emergent medical issues by offering residents the reinforcement, support and education about preventive care, and when emergency medical care is necessary.

- ***Provide a mental health resource for physicians:*** Participants felt that a 24-hour mental health advice line for physicians to use when they are treating residents with mental illness could ensure that the medical treatment provided is able to compliment the mental health treatment they may be receiving.

- ***Increase the participation of residents in preventive medical care:*** Participants felt that residents would be more likely to participate in preventive care if there were incentives for doing so.

TRANSPORTATION:

Medical providers perceived that transportation in their communities is limited due to the limited availability of affordable transportation throughout the community and complete lack of available transportation after hours.

Perceived Contributing Factors:

- Participants believed that many residents do not have access to transportation due to the limitations of the public transportation system, which participants believed restricts the access residents have to viable employment, healthy food options and healthcare.
- Participants were under the impression that residents often find themselves trapped at the emergency department after hours due to the lack of transportation, being unable to drive after medical treatment or having been transported to the hospital.
- Participants were under the impression that funding for the local transportation system has been reduced.

Mitigating Resources:

Medical providers did not identify any existing resources in their community that they felt could improve access to transportation.

Group Suggestions/Recommendations:

Medical providers offered the following as a possible solution to help improve access to transportation in their communities:

- ***Increase access to transportation:*** Participants felt that the access residents have to many resources is limited by the lack of public transportation. Participants suggested that counties pool their resources and increase taxes to provide transportation. Participants believed that increasing the access residents have to transportation would allow residents to be healthier and increase the access residents have to employment, primary, preventive, mental and dental healthcare.

LATINO RESIDENT FOCUS GROUP INPUT

The purpose of this discussion group was to identify community health needs and concerns affecting Latino residents in the Evangelical Community Hospital service area, as well as ways to address those concerns for this population.

PROBLEM IDENTIFICATION:

During the discussion group process, Latino residents discussed three community health needs and concerns affecting residents in their communities. These were:

1. **Access to primary, preventive and dental healthcare**
2. **Healthy behaviors**
3. **Community infrastructure**

ACCESS TO PRIMARY, PREVENTIVE AND DENTAL HEALTHCARE:

Latino residents perceived that access to primary and preventive healthcare in their communities may be limited in the areas of emergency medical care, translation services, patient/staff interactions, affordable health insurance and utilization of healthcare resources.

Perceived Contributing Factors:

- Participants gave the impression that in their country of origin, when a child is taken to the physician lab work is done automatically; however, residents are under the impression that when children are taken to the emergency room they are not automatically given lab work, which participants interpret as a sign of poor emergency medical service.
- Participants believed that the medical care they receive at their primary care physicians' and pediatricians' in their community is more comprehensive than the services they receive at the local emergency medical departments due to a lack of translation services, lengthy wait times, limited treatment provided and what participants perceived to be discrimination.
- Participants gave the impression that they perceive the care that they receive at medical facilities outside of their community to be lower quality than native born residents may receive at the same facilities.
- Participants believed that some residents may have a difficult time communicating with their physicians at local hospitals due to limited translation services, which participants believed may, at times, lead to miscommunication, misunderstanding, frustration for both patient and physician, as well as the potential for improper medical treatment. While participants gave the impression that there are some physicians that speak Spanish; participants were under the impression that there are very few, which at times will cause residents to miss appointments. Additionally, participants indicated that they often take bilingual residents with them to translate at medical appointments, which participants believed can be uncomfortable at times. Also, participants were under the impression that when translation

services are offered at local hospitals they are not always matched by gender, which can mean a male or female resident has to be in the exam room with someone of the opposite sex.

- Participants were under the impression that healthcare provided by local for-profit hospitals were of poor quality due to lengthy waits and denial of service.
- Participants believed that under/uninsured healthcare may be limited and unaffordable for some residents, including prescription medications.
- Participants believed that affordable health insurance is limited for residents that do not qualify for health insurance through the public assistance office, while at the same time do not make enough money to afford private health insurance; particularly for married couples and residents with pre-existing conditions. Participants believed that the limited access residents have to health insurance also limits their access to healthcare.
- Participants were under the impression that there limited dental providers in their community and residents have to drive up to two hours to secure dental care.

Mitigating Resources:

Latino residents identified the following existing resources in their communities that they felt could improve the access to primary and preventive healthcare:

- There is a community clinic that provides under/uninsured healthcare
- The primary healthcare in the community is strong

Group Suggestions/Recommendations:

Latino residents offered the following as possible solutions to help improve the access to primary and preventive healthcare in their communities:

- *Increase the number of Hispanic medical staff:* Participants were under the impression that Hispanic residents utilize Evangelical Community Hospital more often than some other local hospitals and believed that residents' access to medical care would be increased if local healthcare facilities could employ additional Hispanic healthcare staff. Increasing the number of Hispanic healthcare staff could improve the access residents have to healthcare.

- *Increase the availability of translation services:* Participants believed that some local healthcare facilities offer limited translation services. Participants felt that residents' access to healthcare would be increased if local healthcare facilities made male and female translators available that speak a variety of Spanish dialects and have healthcare training/knowledge.

- *Increase sensitivity training among healthcare staff:* Participants believed that healthcare staff could receive additional sensitivity training to ensure equitable treatment of all consumers of healthcare services regardless of race, socio-economic status or insurance status.

- *Increase local dental providers:* Participants believed that residents could be healthier if there was a local dental provider that offered routine and specialty dental care.

- *Increase access to healthcare insurance:* Participants believed that the access residents have to healthcare is linked to the affordability of under/uninsured healthcare and/or access to affordable health insurance. Participants believed that residents would be healthier if there was universal health insurance.

- *Increase the provision of pediatric lab work:* Participants are accustomed to children receiving lab work when they are seen in the emergency department. Participants believed that pediatric lab screening is needed to ensure that children are properly diagnosed.

HEALTHY BEHAVIORS:

Latino residents perceived that healthy behaviors in their communities are limited in the areas of diet, physical activity and individual choices.

Perceived Contributing Factors:

- Participants believed that residents are not always eating a healthy diet.
- Participants were under the impression that residents are not always getting enough physical activity.
- Participants gave the impression that residents may not be as healthy as they could be.

Mitigating Resources:

Latino residents did not identify any existing resources in their communities that they felt could improve the practice of healthy behavior.

Group Suggestions/Recommendations:

Latino residents offered the following as a possible solution to help improve the practice of healthy behavior in their communities:

- *Improve diet and exercise:* Participants felt that residents may not always be eating the healthiest diet and or getting enough physical activity. Participants believed that residents could be healthier if they would eat a healthier diet and increase their level of physical activity.

COMMUNITY INFRASTRUCTURE:

Latino residents perceived that the infrastructure of their communities was limited in the areas of transportation, availability of employment and working conditions.

Perceived Contributing Factors:

- While participants were under the impression that employment was less readily available to residents that do not speak fluent English; they also did not feel employment was readily available to professionally qualified bilingual residents. Additionally, participants felt that the working conditions are poor in the industries that readily employ Hispanic residents.
- Participants believed that many employers in the area will only employ as many Hispanic residents as they are legally required to employ, which may limit the access residents have to employment, medical benefits, etc.
- Participants believed that while there is medical transportation available in the community, it is limited and language is a barrier to accessing transportation of any kind for many residents.

Mitigating Resources:

Latino residents identified the following existing resources in their communities that they felt could improve the infrastructure of their communities:

- Some residents are employed in the community.
- Hispanic residents are hard workers.
- Transportation is available for medical purposes.

Group Suggestions/Recommendations:

Latino residents offered the following as possible solutions to help improve the infrastructure in their communities:

- *Increase the employment rate of Hispanic residents in local industry:* Participants believed that they could start a dialogue with community employers about hiring more Hispanic residents. Developing partnerships with employers could increase the availability of employment for residents

- *Enforce affirmative action regulations among local employers:* Participants believed that local authorities could enforce the laws already established to ensure equitable employment practices by monitoring the employment practices of local employers.

UNDER/UNINSURED RESIDENTS FOCUS GROUP INPUT

The purpose of this discussion group was to identify community health needs and concerns affecting under/uninsured residents in the Evangelical Community Hospital service area, as well as ways to address those concerns for this population.

PROBLEM IDENTIFICATION:

During the discussion group process, under/uninsured residents discussed two community health needs and concerns affecting under/uninsured residents in their community. These were:

1. **Access to primary and preventive healthcare**
2. **Community infrastructure**

ACCESS TO PRIMARY AND PREVENTIVE HEALTHCARE:

Under/uninsured residents perceived that access to quality primary care in their community can be limited in the areas of availability of affordable under/uninsured healthcare, medical insurance coverage, patient navigation, funding for charity and medical billing.

Perceived Contributing Factors:

- Participants believed that under/uninsured medical care, including emergency medical transportation, can be unaffordable for some residents. Additionally, participants gave the impression that when they are unable to pay medical bills some local medical facilities will turn their accounts over to a collection agency, which damages a credit rating and insights an onslaught of debt collection calls.
- Participants believed that affordable health insurance is limited for residents that do not qualify for health insurance through the public assistance office, while at the same time do not make enough money to afford private health insurance; particularly for residents with pre-existing or chronic conditions. Additionally, participants were under the impression that once they file a major claim with their private pay medical insurance company their premiums can be increased and they may eventually be denied coverage. Participants believed that the limited access residents have to health insurance and restrictions or health insurance also limits their access to medical care.
- Participants gave the impression that there may not always be adequate substance abuse services; particularly ongoing and follow-up services. Additionally, participants did not believe that physicians are always aware of appropriate treatment options for residents with a substance abuse history.
- Participants were under the impression that the healthcare provided by local for-profit hospitals may be unaffordable for under/uninsured residents and poor quality due to lengthy waits and denial of service.

- Participants were under the impression that some non-profit hospitals will not provide non-emergent medical care if residents are uninsured and owe a balance on previous care.
- Participants believed that some residents would not use the free clinic due to the stigma associated with under/uninsured medical services.

Mitigating Resources:

Under/uninsured residents identified the following existing resources in their community that they felt could improve the access to primary and preventive healthcare:

- A Community Clinic offers consistent under/uninsured healthcare
- Geisinger Medical Center provides many under/uninsured healthcare services and financial charity

Group Suggestions/Recommendations:

Under/uninsured residents offered the following as possible solutions to help improve the access to primary and preventive healthcare in their community:

- ***Increase funding for under/uninsured healthcare:*** Participants were under the impression that the clinic in their community may need stable funding to continue to provide under/uninsured healthcare to residents. Additionally, participants believed that the clinic has agreements with local non-profit hospitals that support diagnostic lab work; however, more costly tests like MRI and CT scans are not yet available as part of the agreement. Participants believe it would increase the effectiveness of the community clinic if they had access to a set number of more expensive testing procedures annually.

- ***Provide basic consumer information to patients:*** Participants believed that insurance companies could offer resources that would help residents navigate the healthcare industry, including benefits explanations.

- ***Increase access to healthcare insurance:*** Participants believed that the access residents have to healthcare is linked to the affordability of under/uninsured healthcare and/or access to affordable health insurance. Participants believed that all residents that are employed should have access to affordable health insurance.

COMMUNITY INFRASTRUCTURE:

Under/uninsured residents perceived that the infrastructure of their communities were limited in the areas of resident awareness, transportation, employment, housing and capacity to provide services.

Perceived Contributing Factors:

- Participants were under the impression that there is limited awareness among residents about what services and resources are available in the community and how to access those services.
- Participants believed that many residents do not have access to transportation due to the limitations of the public transportation system, which participants believed restricts the access residents have to viable employment, healthy food options and healthcare.
- Participants perceived that the capacity to provide services in the community does not always meet resident demand.
- Participants gave the impression that local employers are hiring part-time employees, which limits the earning power of residents and access to health benefits.
- Participants felt as though they were penalized for becoming gainfully employed due to the strict public assistance eligibility requirements, which cause residents to lose a significant amount of benefits when their income reaches a level that will disqualify them for public assistance (e.g., when the income is only slightly above the income eligibility cut-off, public assistance can potentially be denied, this can be more than a $1,000 a month in benefits).
- Participants were under the impression there is a five-year waiting list for affordable housing in their community.
- Participants did not believe that the funding priorities of grant-making institutions are always focused on the most pressing needs in the community (i.e., grant money is available for landscaping, but not economic development job creation).

Mitigating Resources:

Under/uninsured residents identified the following existing resource in their communities that they felt could improve the infrastructure:

- While residents may not always be aware of them, there are a lot of services available in the community.

Group Suggestions/Recommendations:

Under/uninsured residents offered the following as possible solutions to help improve the infrastructure in their communities:

- ***Increase access to transportation:*** Participants felt that the access residents have to many resources is limited by the lack of public transportation. Participants suggested that transportation be increased in the community. Participants believed that increasing the

access residents have to transportation would allow residents to be healthier and increase the access residents have to employment, primary, preventive, mental and dental healthcare.

- ***Increase awareness about the services that are available in the community:*** Participants believed that residents are not always aware of the programs and services that are available in their communities. Participants felt that the awareness of residents about available programs and services could be increased.

- ***Redefine income standards for lower class***: Participants were under the impression that politicians believe that people in the lower class are making $25,000 to $30,000 a year, when the actual income of some residents is under $10,000 a year. Participants believed that increasing the awareness of politicians regarding the actual income of residents in their community may improve the policies that are passed regarding help for low-income residents.

- ***Revitalize vacant buildings:*** Participants were under the impression that local schools are closing. Participants believed that residents could be employed by the city in an effort to revitalize vacant buildings in the community. This would create a sustainable employment program that could offer a living wage. Additionally, participants believed that the priorities of grant-making institutions need to be refocused on the most pressing needs, which participants felt are employment and meeting the basic necessities of residents.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