Geisinger

2024 Community Health Needs Assessment
Geisinger Jersey Shore Hospital

About Geisinger

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

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

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

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

Our goals:

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

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

2024 CHNA Collaborative

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

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

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

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

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

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2024 CHNA Background

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

Advisory Committees

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

CHNA Planning Committee

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

Regional Advisory Committee

Brenda Albertson, Operations Manager, Nursing, Geisinger
Tammy Anderer, CAO, Geisinger
Wendy Batschelet, VP and Chief Nursing Officer, Geisinger
Patricia Brofee, Training Coordinator, Geisinger
Cheryl Callahan, Director, Geisinger
Sherry Dean, Operations Manager, Geisinger
Mike DiMare, Administrative Director, Geisinger
Kirsten Fordahl, Project Manager, Geisinger
Regina Graham, Program Manager, Geisinger
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Kristy Hine, AVP and Chief Financial Officer, Geisinger
Rachel Manotti, Associate Chief Strategy Officer, Geisinger
Chase McKean, Community Engagement Coordinator, Geisinger
Mike Morgan, Administrative Director, Geisinger
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Deb Swayer, Marketing Strategist, Geisinger
Tina Westover, Senior Tax Accountant, Geisinger
Amy Wright, Business Development Director, Geisinger
Lynn Yasenchak, Compliance Specialist III, Geisinger
Dave Argust, Vice-President, Financial Services, Allied Services
Jim Brogna, Vice-President, Strategic Partnership Development, Allied Services
Karen Kearney, Vice-President, Inpatient Rehabilitation, Allied Services

Our Research Partner

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

2024 CHNA Research Methods

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

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

Secondary Data Analysis

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

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

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

Primary Research and Community Engagement

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

Primary research and community engagement study methods included:

- An online Key Stakeholder Survey completed by 86 individuals serving the North Central Region, who represent healthcare providers, social services professionals, educators, faith-based leaders, and community leaders, among others;
- Regional Community Forum bringing together 14 residents and diverse community representatives to review CHNA findings and collectively define challenges and co-develop meaningful strategies for health improvement; and
- Conversations with health system leaders to align community health planning with population health management and community engagement strategies.

Building Health Equity: Context for the Creation of this CHNA

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

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

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

Determining Community Health Priorities

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

Consistent Community Priorities and Contributing Factors

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

Focus on underlying Social Drivers of Health

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

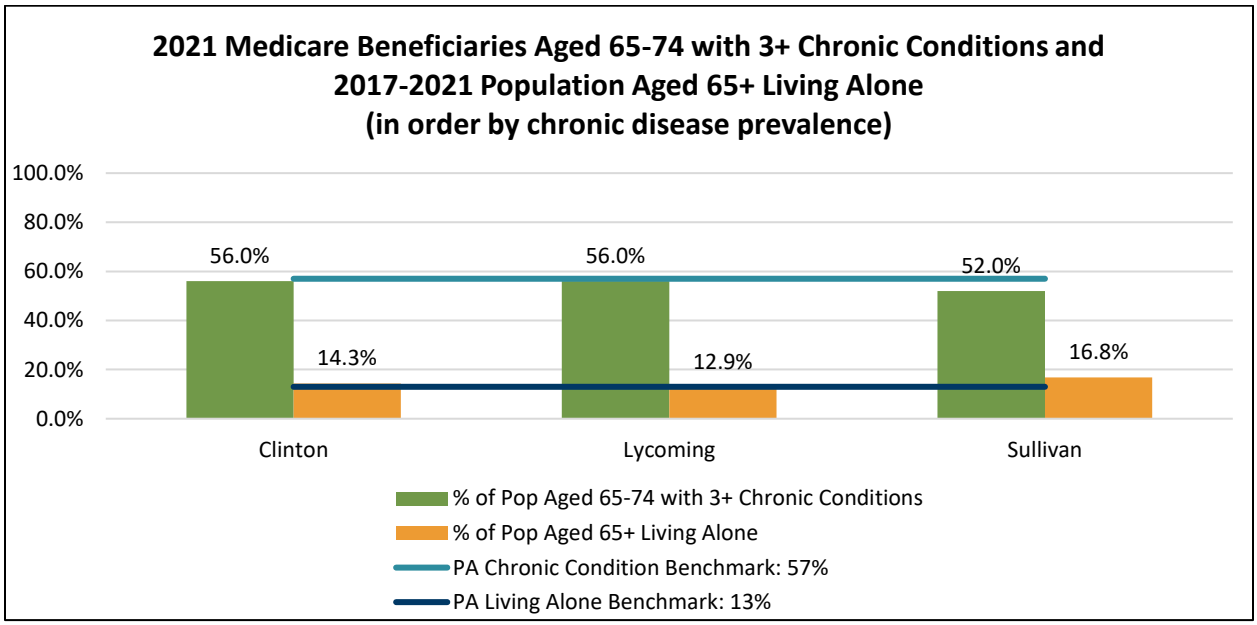
Executive Summary of CHNA Findings

Demographic and Priority Population Trends

The North Central Region is comprised of three rural Pennsylvania counties: Clinton, Lycoming, and Sullivan. The Center for Rural Pennsylvania defines a county as rural when population density, or the number of people per square mile within the county, is fewer than 291. Lycoming County is the most population dense (95) within the region, while Clinton and Sullivan counties have low population density of 44 and 14 respectively.

The total population in all three counties declined over the past decade. Sullivan County saw the largest population decline of -8.2% from 2010 to 2021. In contrast, the region saw significant growth in older adults. From 2010 to 2021, the number of adults aged 65 or older grew 8% (Sullivan) to 17% (Lycoming).

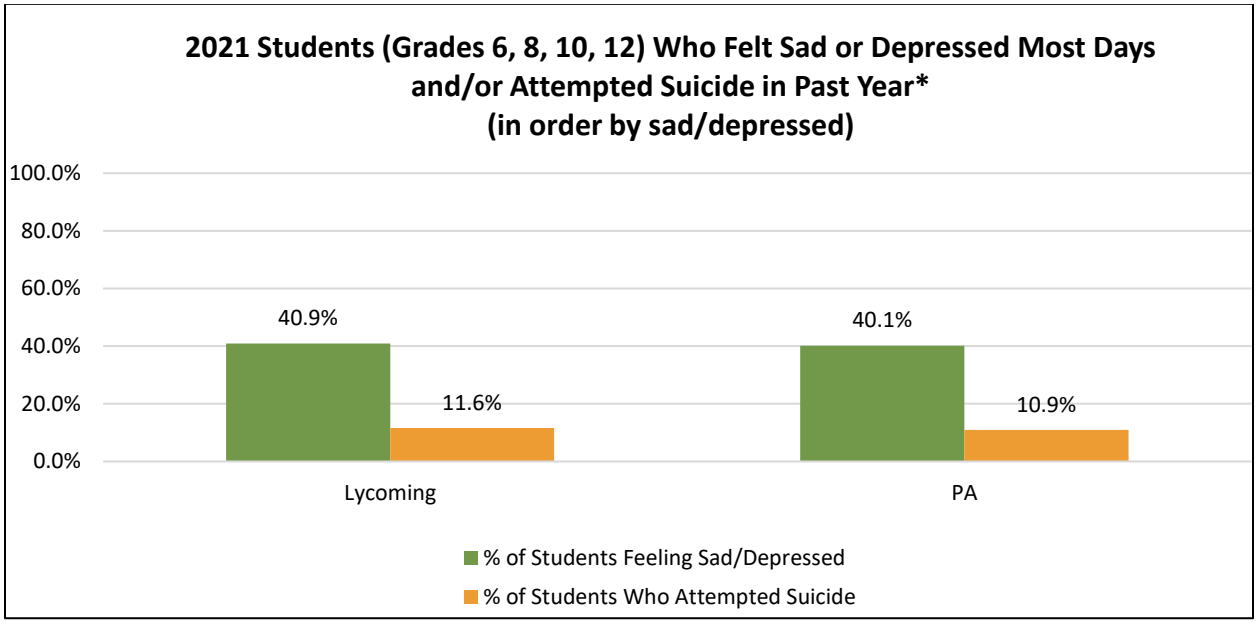
The growth of older adult populations will challenge communities to provide adequate support for aging residents, many of whom live alone and choose to age in place. Consistent with the state overall, approximately 50%-60% of Medicare beneficiaries aged 65-74 residing in the region had three or more chronic conditions in 2021, and disease prevalence increased with older age groups 75+. Sullivan County is an area of opportunity for improving older adult health and well-being. Approximately 28% of residents in the county are aged 65 or older, creating demand for services, and 17% of older adults live alone, potentially impeding wellness efforts.



Source: US Census Bureau, American Community Survey & CMS

North Central Region counties are aging, but children comprise approximately 1 in 5 residents, reinforcing the potential for upstream, preventive action. Critical to these upstream efforts is addressing social drivers of health (SDoH) barriers that have historically disproportionately affected children. For example, while poverty levels declined across the region, 14.5%-17.5% of children experience poverty compared to 12%-14% of all residents.

Top health concerns for children in the North Central Region, and statewide, include mental health issues. Child mental health was a growing concern before the pandemic, and the region continues to see a high proportion of children who report poor mental health. Reportable data for Lycoming County show that 2 in 5 students reported feeling consistently sad or depressed in 2021 and more than 1 in 10 students reported an attempted suicide. Data are not publicly available for other counties in the region.

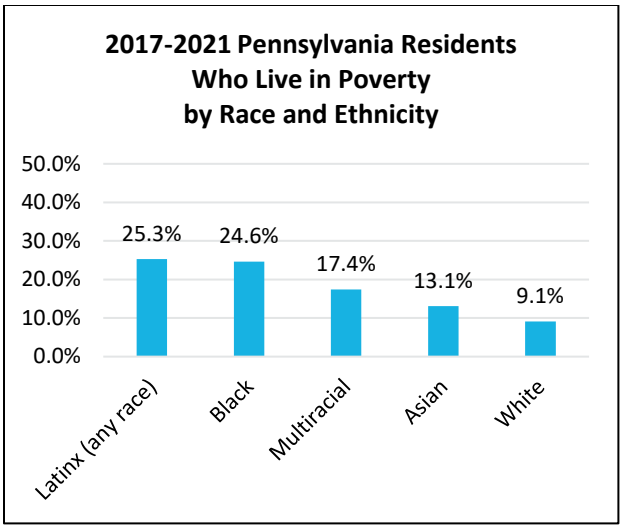


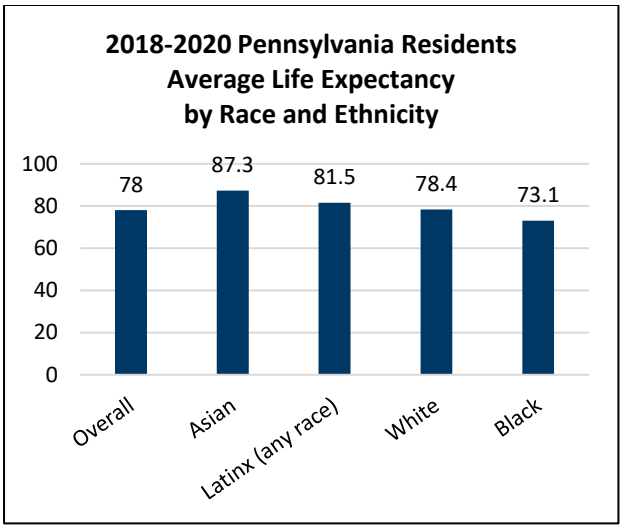
Source: Pennsylvania Youth Survey *Data are reported by county as available.

Commitment to school can be a protective factor for youth, reducing the likeliness of health concerns. School commitment indicators, like how important students feel school is to later life or how much they enjoy the experience, were declining even before the pandemic. Statewide, the percentage of youth who "feel school is going to be important for their later life" declined from 57.5% in 2017 to 41.8% in 2021. Lycoming County findings for these metrics were consistent with the state with 42% of students reporting school is important for their later life and 37% reporting that they enjoy school. Creating opportunities for youth engagement in schools and other settings and fostering future orientation is essential to improving their overall health and well-being.

The North Central Region is a majority white community, but consistent with state and national trends, people of color are the only growing populations. This demographic shift is slow across counties, accounting for a 1-3 percentage point change over the last decade. Growth among populations of color was most evident for individuals who identify as multiracial and/or Latinx.

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





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

Social Drivers of Health Opportunities

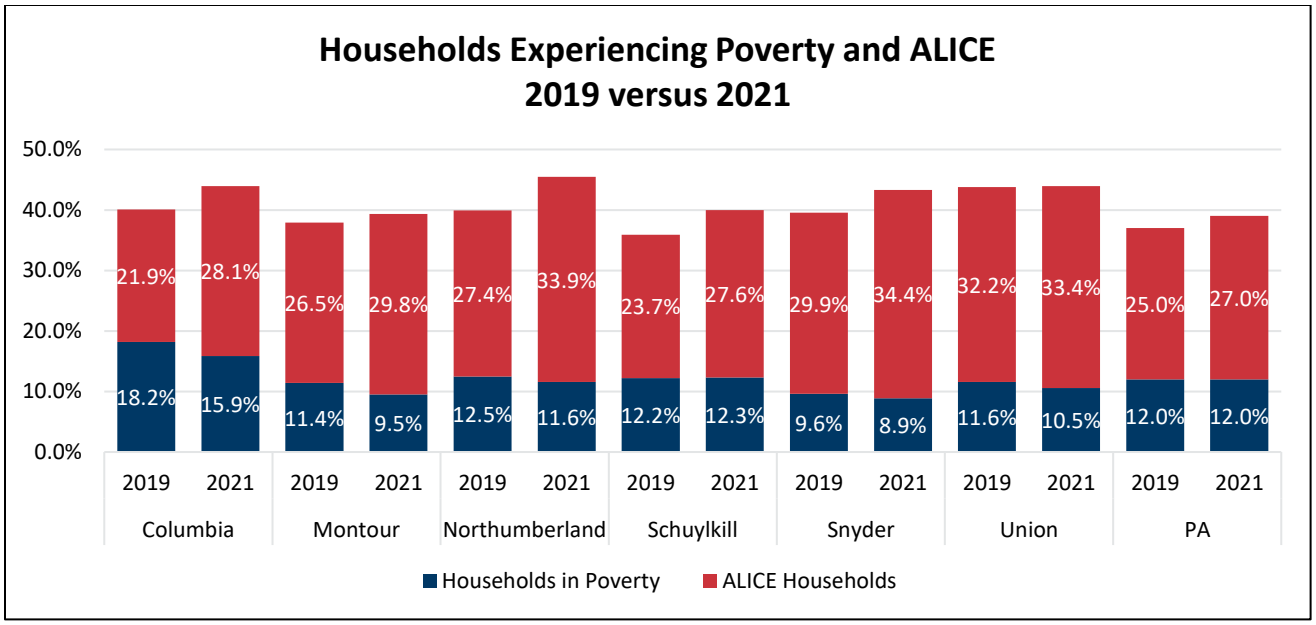
As part of the Key Stakeholder Survey, respondents were asked to share the top five priorities that their community should address to improve health and well-being of the populations they serve. While most respondents selected mental health conditions, the majority of the top five identified priorities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

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

Top Five Priority Responses	Percent of Responses
Mental health conditions	58.2%
Lack of transportation	38.0%
Childcare (affordable, quality)	34.2%
Ability to afford care	32.9%
Substance use disorder	32.9%

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

The opportunity to address financial hardship for ALICE households is demonstrated in Sullivan County. In 2021, 33% of Sullivan County households were ALICE, a 4-point increase from 2019. Sullivan County households also struggled with basic needs like housing and childcare. Despite lower housing costs, 26% of homeowners and 44% of renters were cost burdened, spending 30% or more of their income on housing-related expenses. For households with children, the average cost of childcare for two children was 27% of median household income. Note: Financial hardship was a concern across the region.



Source: United for ALICE

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

The Unmet Need Score (UNS) is a measure of access to primary and preventive healthcare services based on disparities in health status and SDoH. Scores range from 0 (least unmet need) to 100 (most unmet need). North Central Region counties have similarly high UNSs of 59-63. When analyzed by zip code, these scores increase to 70-83 in select communities shown in the table below, indicating significant unmet need and disparities in health and well-being.

The Social Vulnerability Index (SVI) provides a deeper analysis, scoring census tracts on a scale from 0.0 (lowest vulnerability) to 1.0 (highest vulnerability) based on SDoH factors. Areas of social vulnerability are largely concentrated in Clinton County, and many of these areas are associated with significant health disparities including lower life expectancy.

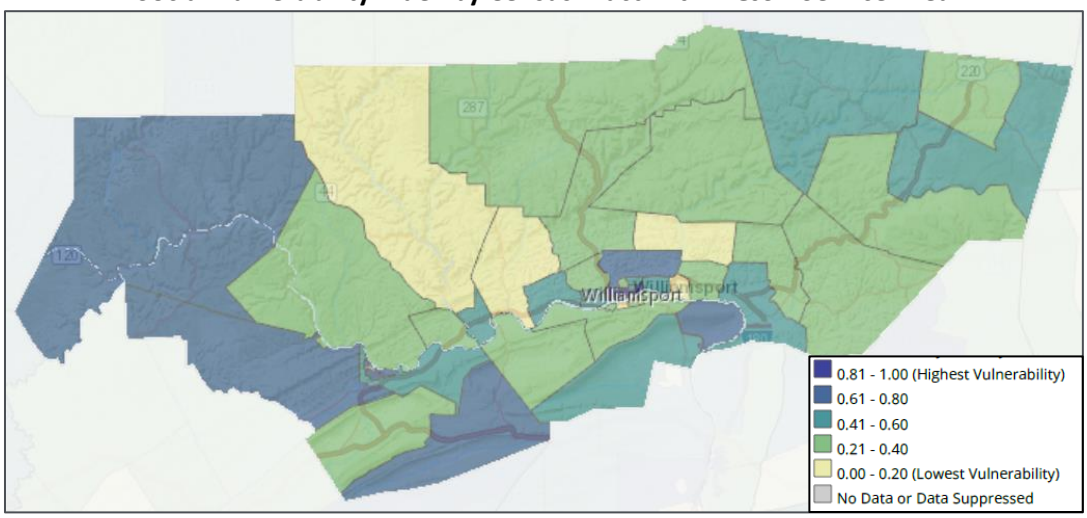
Residents of Renovo and surrounding areas in Clinton County experience more social vulnerabilities and have the lowest average life expectancy in the county of 73.1 years. In Lycoming County, downtown Williamsport is also an area of high social vulnerability, and residents of census tracts 3, 4, and 6 may live fewer than 74 years, a 10- to 13-year difference compared to surrounding communities. The maps below display the SVI and average life expectancy by census tract within the GJSH primary service area.

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

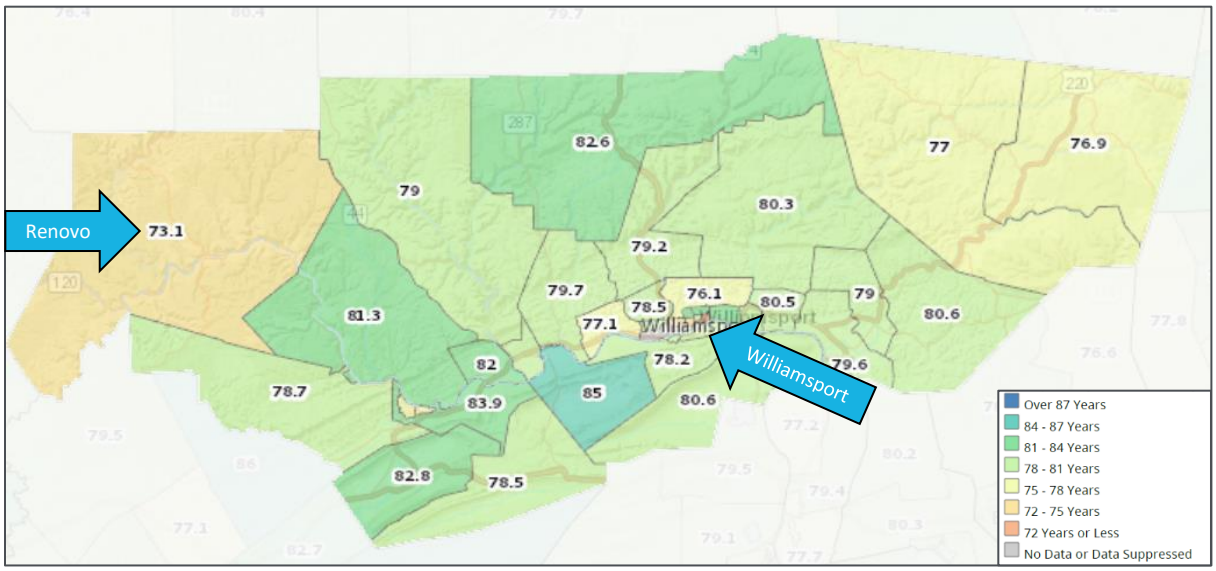
Zip Code (County)	Population in Poverty	Children in Poverty	No High School Diploma	No Health Insurance	UNS Score
17747, Loganton (Clinton)	10.3%	13.2%	24.8%	39.9%	83.1
17764, Renovo (Clinton)	21.5%	45.5%	10.2%	4.5%	78.3
17748 McElhattan (Clinton)	35.5%	52.4%	0.0%	2.5%	71.0
16822, Beech Creek (Clinton)	8.1%	10.4%	12.0%	5.3%	70.5
17745, Lock Haven (Clinton)	16.2%	11.9%	7.5%	6.2%	70.2
18614, Dushore (Sullivan)	13.7%	19.6%	9.8%	4.4%	70.2
Pennsylvania	11.8%	16.4%	8.6%	5.6%	NA

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

Social Vulnerability Index by Census Tract within GJSH Service Area



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

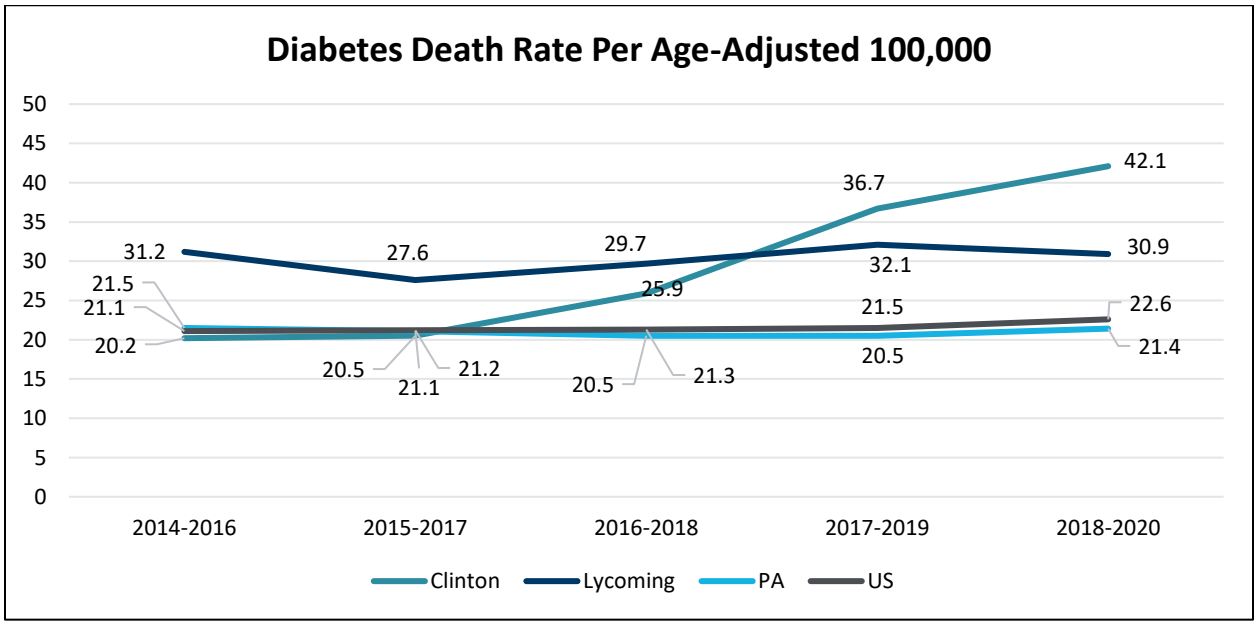


Priority Health Needs

The top health concerns for the Geisinger footprint, including the North Central Region, were confirmed as access to care, chronic disease prevention and management, and behavioral health. Central to addressing these areas is improving upstream SDoH and underlying inequities.

Chronic conditions are the leading causes of morbidity and mortality statewide and nationally. In the North Central Region, the prevalence of diseases like diabetes and heart disease is comparable to state and national trends, but residents die at higher rates from one or both conditions, potentially indicating barriers to diagnosis, treatment, and/or care management. The North Central Region is also home to more smokers and residents have a higher incidence of COPD compared to state and national trends. Incidence and death rates due to lung cancer are also elevated in Lycoming and Sullivan counties.

North Central Region adults have a similar prevalence of diabetes as their peers statewide and nationally, with approximately 1 in 10 adults affected, but death rates due to diabetes are 10-20 points higher in Clinton and Lycoming counties. These findings demonstrate access to care and other SDoH barriers. While the number of residents without health insurance declined and a similarly high percentage of adults report having an annual physical checkup, these factors alone do not ensure access to comprehensive healthcare when it is needed. Many other factors—like affordability, transportation, language, provider availability, and trust—can keep people from receiving the care they need.

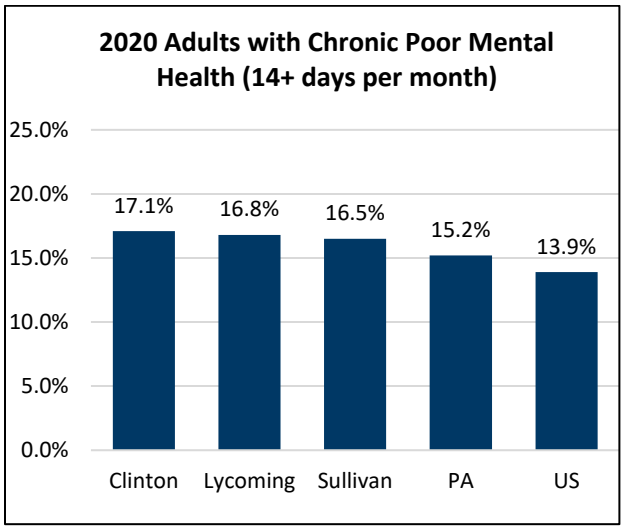


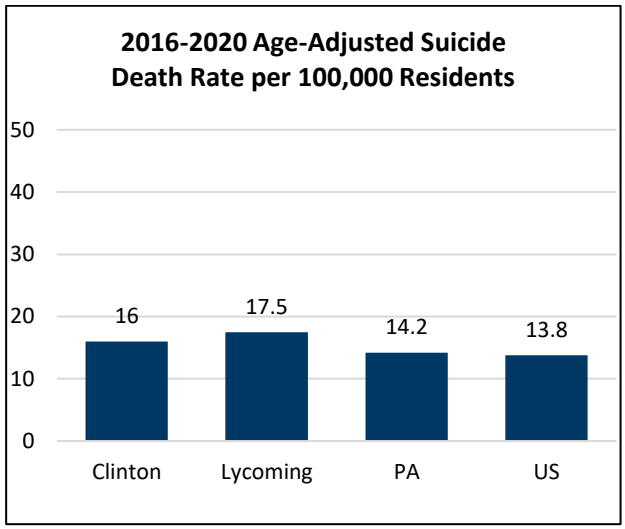
Source: Centers for Disease Control and Prevention
Note: Data are not reported for Sullivan County due to low death counts.

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

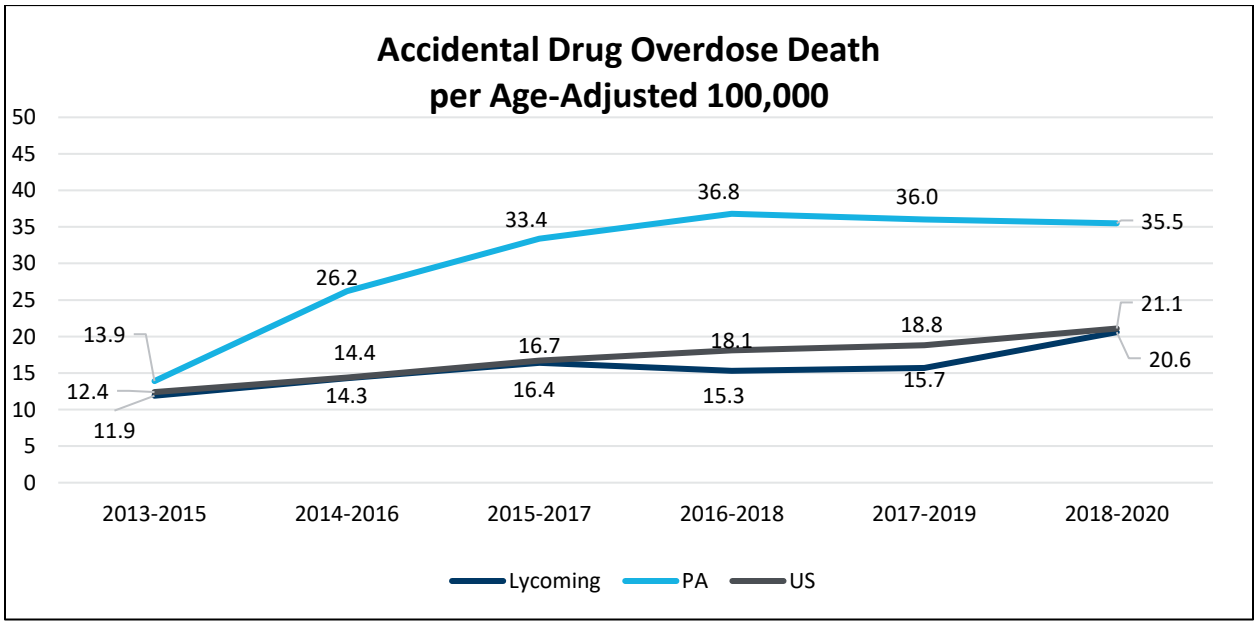
Opioid use disorder remains a more urgent issue in Lycoming County than in other parts of the region with elevated rates of hospitalization due to opioid use disorder and overdose, and an elevated rate of death in 2020.

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





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



Source: Centers for Disease Control and Prevention
Note: Data are not provided for Clinton and Sullivan counties due to low death counts.

Recommendations to Improve Health

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

Key Stakeholder Survey respondents and Community Forum participants shared feedback on what the community can do differently to address health and social concerns, better serve community members, and facilitate cross-sector collaboration. Consistent themes included addressing SDoH barriers, efforts to increase the capacity and quality of healthcare and social service providers, and improved community partnerships to collectively affect health. Select feedback and verbatim comments by representatives are included below, grouped by overarching theme.

Health Improvement Themes and Supporting Feeback by Community Representatives

Themes	Verbatim Comments by Community Representatives
Support multi-sector collaboration for better communication and non-competitive partnership, and to affect policy and funding	*"Work together through collaboration in an effort to establish a centralized closed loop referral system to meet community needs."* *"Continue to partner with community partners at the love center and the mobile food pantry. Excellent resources for our community."*
Go beyond addressing the immediate need, invest in upstream factors	*"Many of the individuals who we serve do not qualify for any type of medical assistance because they make too much money, but they do not make enough money to pay for their own healthcare and they are not insured by their employers- many working several part time jobs to pay the bills."* *"Attract more social workers and mental health professionals to the area with better wages, build more high-quality affordable housing, pay a living wage, intervene more/better with youth/mental health at an earlier age, work w school systems to support families."*
Bring services to the community, integrate/co-locate where residents naturally frequent	*"Dental and vision insurance/access seem to be lacking in our region, as they are generally not included in healthcare plans. Mobile clinics, which Geisinger and Evan already have, would be helpful in rural communities especially for Seniors. Childcare services can always be improved – within employers and healthcare systems."* *"Invest in rural wellness centers to move health conversations and initiatives closer to the population that has the greatest need to address the social determinants of health."*

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

Themes	Verbatim Comments by Community Representatives
Address cultural biases with staff training	*"There is clear division in our schools, among school administrators, and school boards. There is misinformation, culture wars, politicization of beneficial student programs like SEL (Social Emotional Learning) and a lack of understanding or willingness to engage with DEI."* *"Support development of a gender clinic. Increase funds for diversity and inclusion education and mental health services and groups for LGBTQ+ people. Support schools in being inclusive. Increase availability of MDs who provide gender affirmative care."*
Invest in supports for those historically placed at risk (youth, seniors, ALICE, etc.)	*"COVID pandemic disruptions in education has significantly set our youth back. Exposing them to opportunities in the healthcare field could help connect what they are learning in school with a successful future which has been proven to influence behavior and help them make good choices if they have hope for what their lives may look like after high school."* *"Individuals with ID, mental health or cognitive impairments without sufficient educated family or institutional supports are at higher risk due to the lack of community action, at risk of physical/financial exploitation or self-neglect."*

Approval and Adoption of CHNA

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

Geisinger is committed to advancing initiatives and community collaboration to support the issues identified through the CHNA. The 2024 CHNA report was presented to the Board of Directors and approved in November 2023.

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

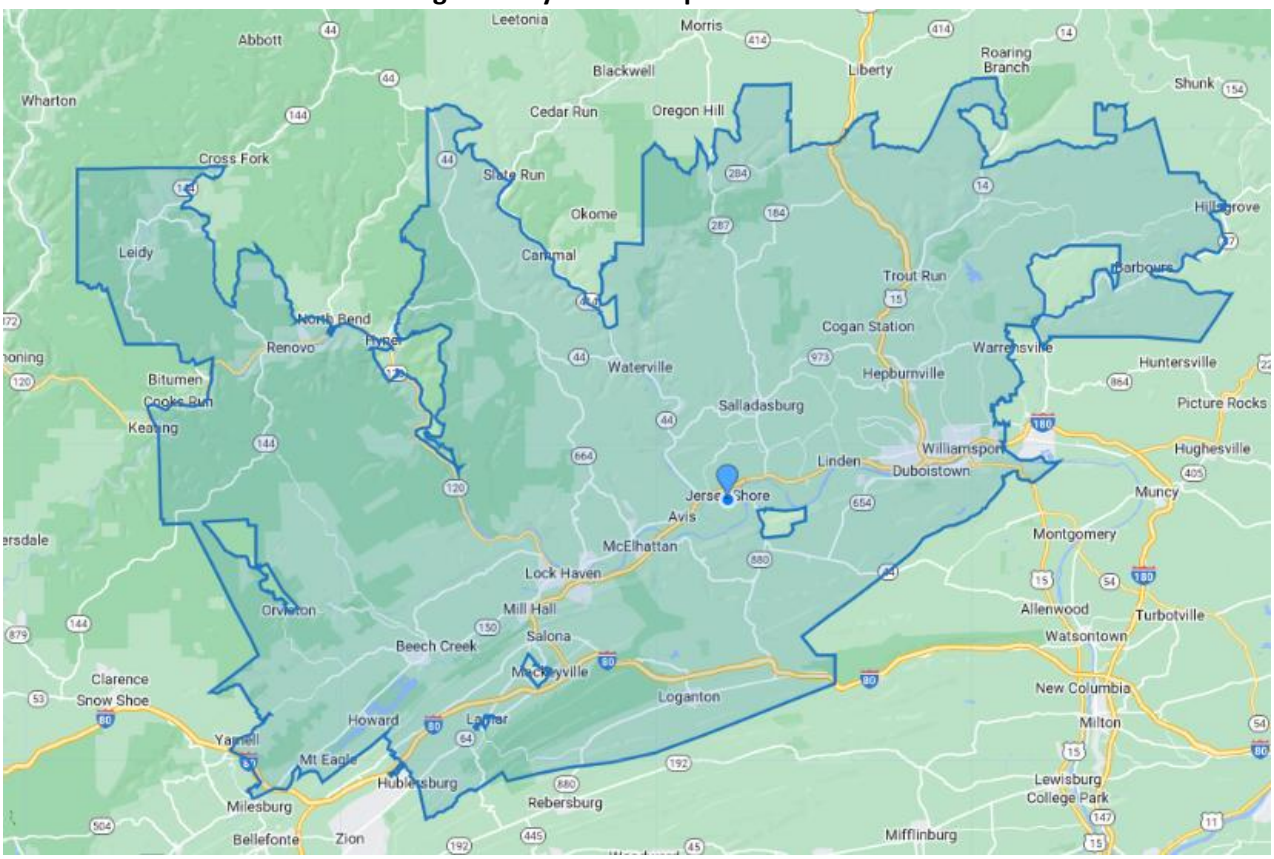
A full summary of CHNA data findings for the North Central Region and Geisinger Jersey Shore Hospital service area, with state and national comparisons, follows.

Geisinger Jersey Shore Hospital Service Area

Geisinger Jersey Shore Hospital (GJSH) is located in Jersey Shore, Lycoming County. Jersey Shore is located along the west shore of the Susquehanna River, approximately 15 miles west of Williamsport. Jersey Shore is the gateway to the Pine Creek Valley, known for its natural beauty and recreational opportunities like kayaking, biking, hiking, fishing, horseback riding, and more. The Pine Creek Rail Trail, a 65-mile converted railroad bed, begins in Jersey Shore and has been named one of 10 great places to take a bike tour by USA Today.

While many GJSH patients are residents of Jersey Shore or the surrounding area, the hospital serves people across central Pennsylvania. For the purposes of the 2024 CHNA, GJSH defined its service area as 17 zip codes, primarily within the North Central Region. The service area was identified based on the patient zip codes of origin comprising 90% or more of hospital discharges in 2021.

Geisinger Jersey Shore Hospital Service Area



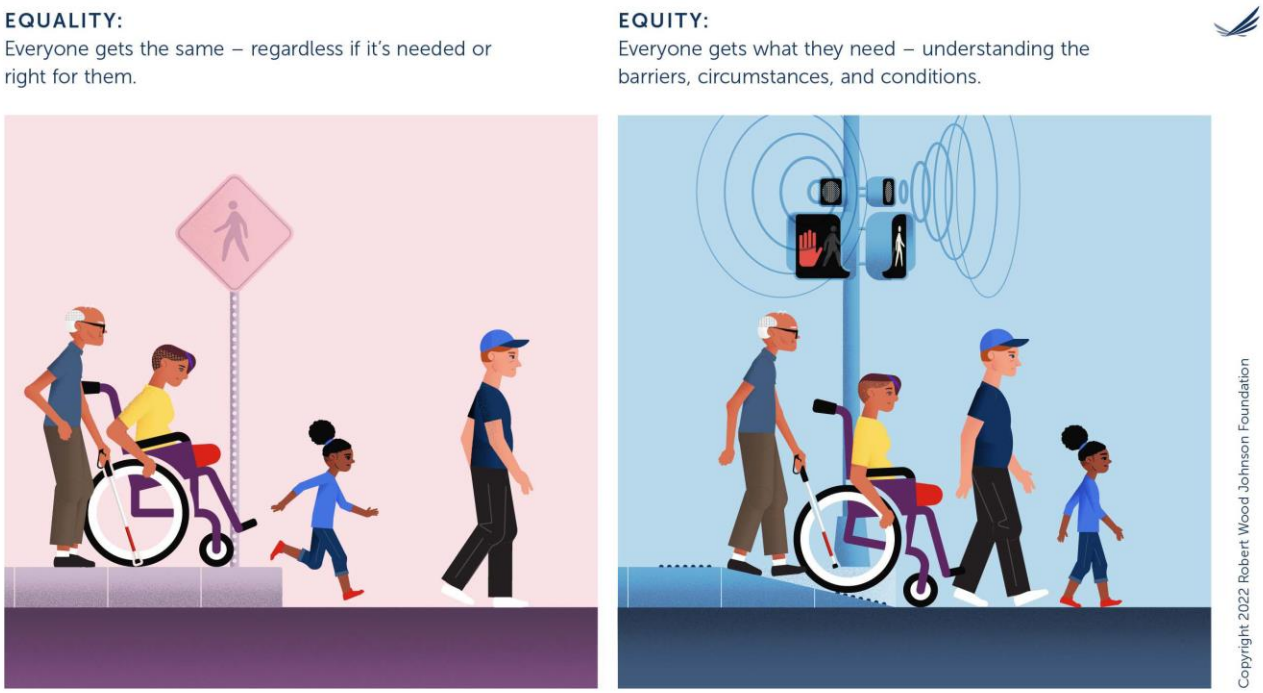
Social Drivers of Health & Health Equity:

Where we live impacts the choices available to us

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

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

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



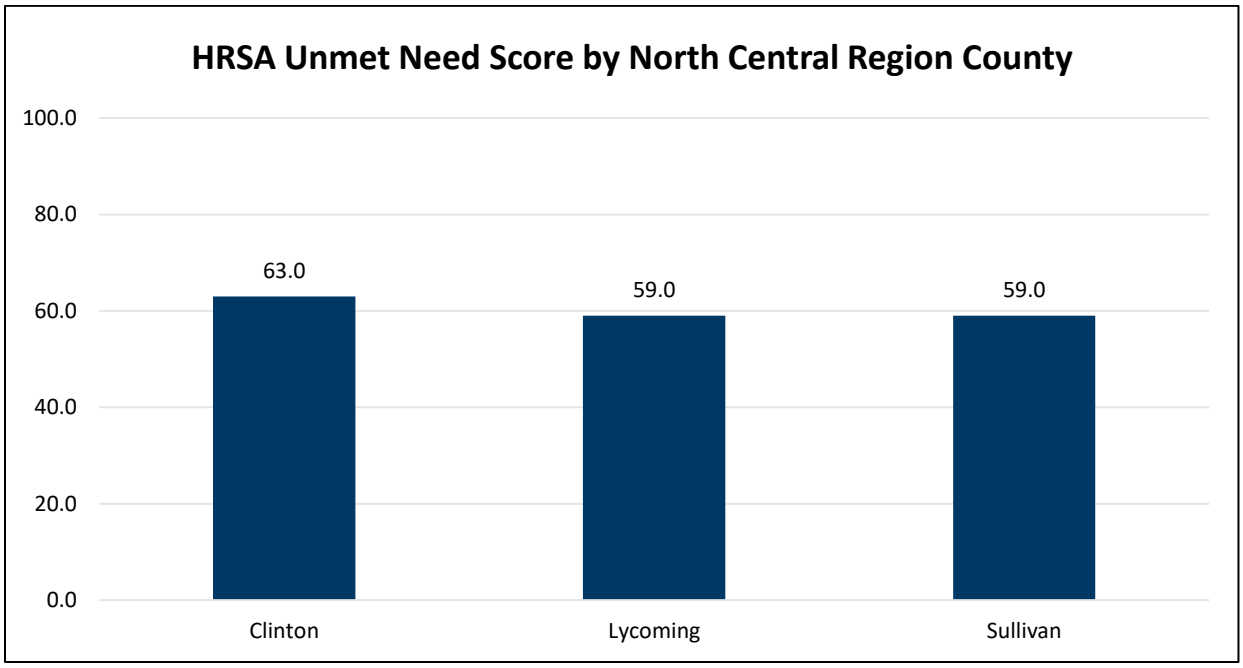
A host of indexes and tools are available to illustrate the potential for health disparities and inequities at the community-level based on SDoH. A description of each index is provided below followed by data visualizations of each tool that show how well the GJSH service area fares compared to state and national benchmarks.

- **Health Resources and Services Administration Unmet Need Score (UNS):** The UNS provides a zip code-based index of unmet need for primary and preventive healthcare services based on disparities in health status and SDoH. UNS scores are displayed on a scale from 0 (least unmet need) to 100 (most unmet need).
- **Social Vulnerability Index (SVI):** The CDC's SVI has historically been used to help public health officials and local planners better prepare for and respond to emergency events like hurricanes, disease outbreaks, or exposure to dangerous chemicals. The SVI identifies census tract-level community vulnerability to these events based on social factors, such as poverty, lack of access to transportation, and overcrowded housing. Each census tract receives a ranking from 0.0 (lowest vulnerability) to 1.0 (highest vulnerability).
- **Asset Limited Income Constrained Employed (ALICE):** The ALICE index measures the minimum income level required for survival for an average-sized household, based on localized cost of living and average household sizes. The ALICE index captures the percent of households whose income is above the federal poverty level, but below the threshold necessary to meet all basic needs.
- **Geisinger Health Innovations:** Geisinger aims to supplement conventional medical care by incorporating screening solutions to identify unmet social needs and offering recommendations, programming, and services tailored to the individual. As part of this effort, Geisinger launched an urgent social needs screening, largely within its primary care and pediatric clinics and women's health centers, that includes environmental and social drivers of health factors. Based on where the screening is administered, results are captured for either patients or their household to better respond to the multitude of factors affecting health and well-being.

Unmet Need Score and Social Vulnerability Index

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

North Central Region counties have similarly high unmet need scores of 59-63. This finding is reflective of both upstream social drivers of health like availability of care providers, educational attainment, and transportation, and downstream health outcomes like chronic disease prevalence. **Residents of Clinton County have historically experienced more negative health outcomes, and when analyzed by zip code, communities with an UNS exceeding 70 are all located within Clinton County.** It is worth noting that despite variability in unmet need and health outcomes, all three counties report a similar average life expectancy that is on par with the state average.



Source: Health Resources and Services Administration

2018-2020 Life Expectancy by Race and Ethnicity

	Overall Life Expectancy	Asian	Black	White	Latinx Origin (any race)
Clinton	78.0	NA	NA	NA	NA
Lycoming	77.4	NA	69.5	77.8	86.8
Sullivan	77.4	NA	NA	NA	NA
Pennsylvania	78.0	87.3	73.1	78.4	81.5

Source: National Vital Statistics System

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

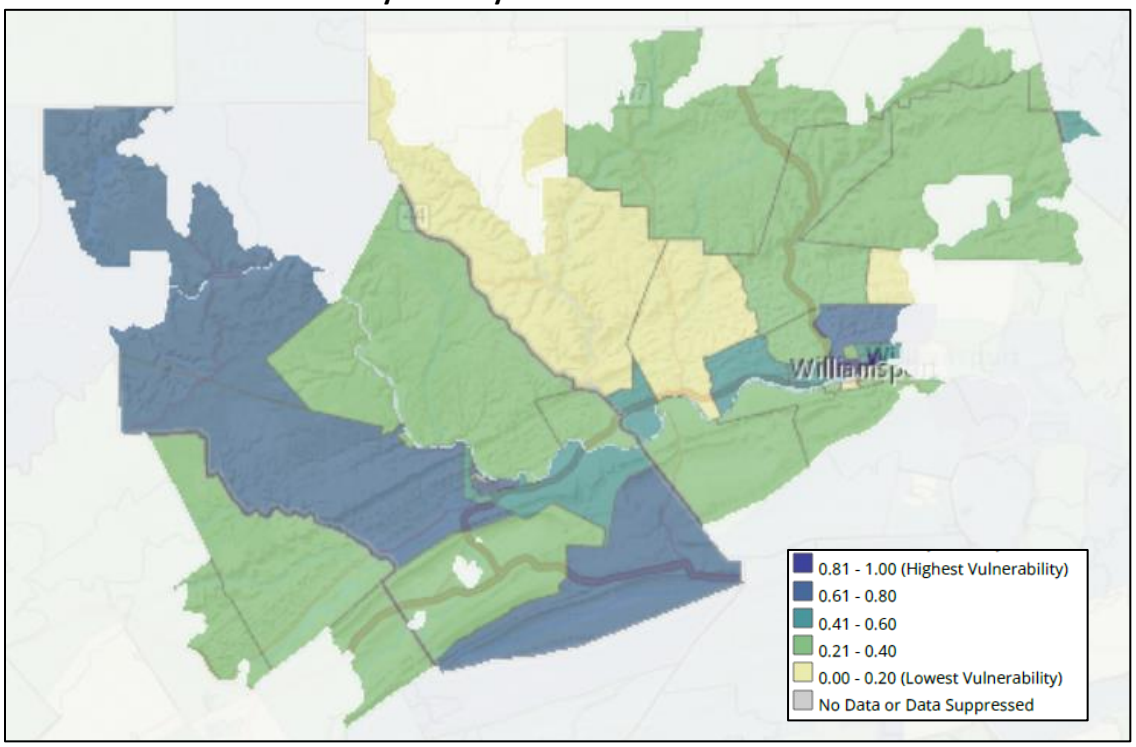
Zip Code	Population in Poverty	Children in Poverty	No High School Diploma	No Health Insurance	UNS Score
17747, Loganton (Clinton)	10.3%	13.2%	24.8%	39.9%	83.1
17764, Renovo (Clinton)	21.5%	45.5%	10.2%	4.5%	78.3
17748 McElhattan (Clinton)	35.5%	52.4%	0.0%	2.5%	71.0
16822, Beech Creek (Clinton)	8.1%	10.4%	12.0%	5.3%	70.5
17745, Lock Haven (Clinton)	16.2%	11.9%	7.5%	6.2%	70.2
18614, Dushore (Sullivan)	13.7%	19.6%	9.8%	4.4%	70.2
17751, Mill Hall (Clinton)	11.4%	15.6%	9.5%	8.7%	66.3
17776, Waterville (Lycoming)	6.1%	25.0%	8.4%	3.9%	65.0
Pennsylvania	11.8%	16.4%	8.6%	5.6%	NA

Source: US Census Bureau, American Community Survey

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

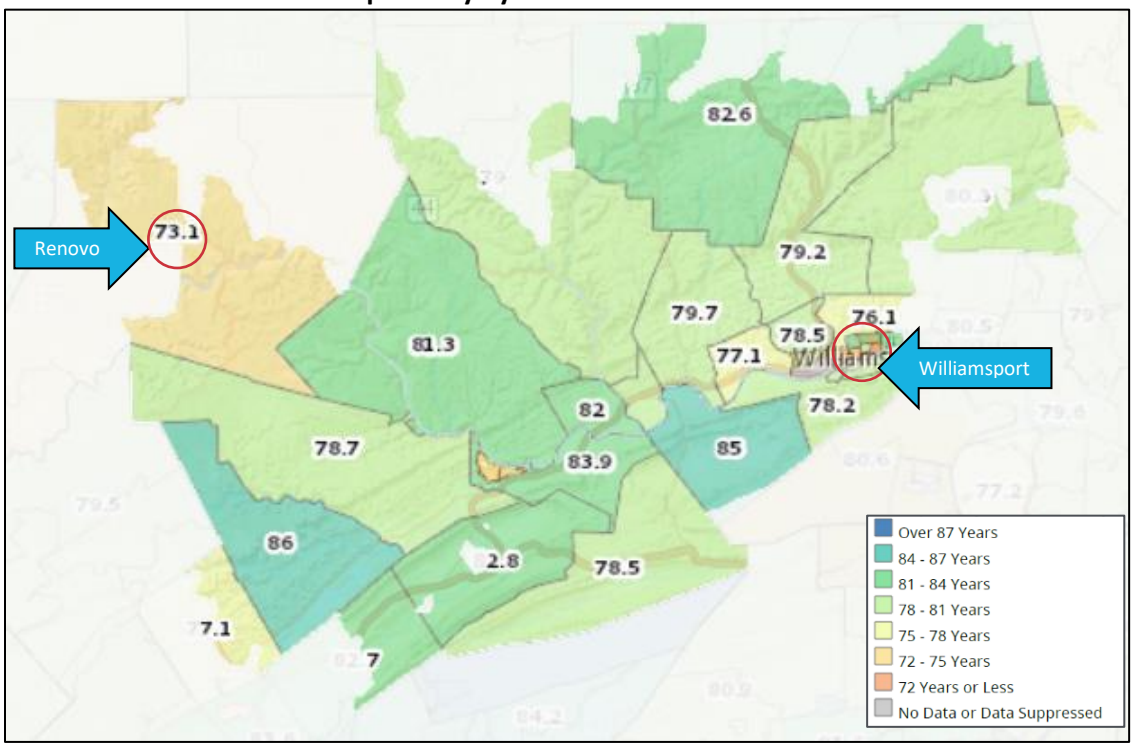
GJSH primarily serves Clinton and Lycoming counties. Consistent with UNS findings, areas of social vulnerability within the GJSH primary service area are concentrated in Clinton County, including Beech Creek, Mill Hall, Loganton, and Renovo. These findings are associated with significant health disparities. Residents of Renovo have an average life expectancy of 73.1 years, the lowest in the county. Downtown Williamsport is also an area of high social vulnerability, and residents of select communities, including census tracts 3, 4, and 6, may live fewer than 74 years, a 10- to 13-year difference compared to surrounding communities.

Social Vulnerability Index by Census Tract within GJSH Service Area



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

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



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

*Residents of communities highlighted in red have an average life expectancy of 74 years or less.

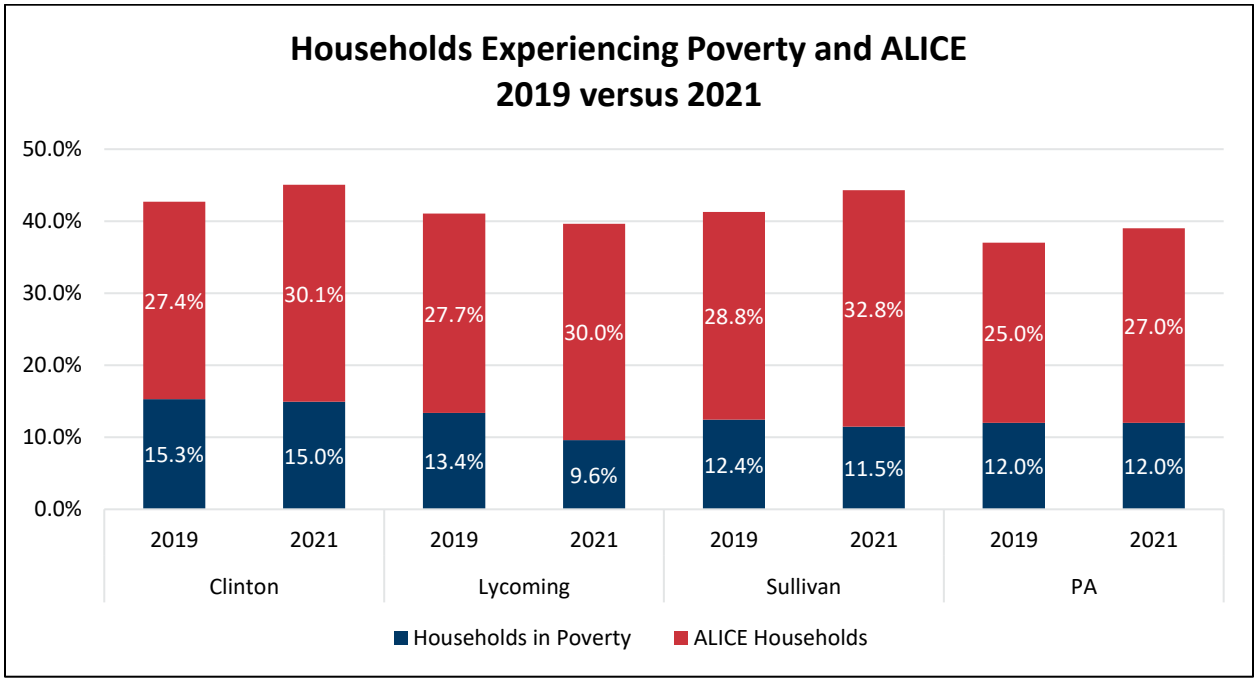
Asset Limited Income Constrained Employed (ALICE)

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

Across North Central Region counties in 2021, approximately one-third of households were ALICE compared to one-quarter statewide. When combined with households living in poverty, nearly half of all households in Clinton and Sullivan counties may have experienced financial hardship.

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

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



Source: United for ALICE

Geisinger Urgent Social Needs Screening

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

The following table provides a summary of urgent social needs screening results for Geisinger patients residing in the North Central Region. Note: Sullivan County results are excluded due to low survey participation. **It is worth noting that nearly 1 in 10 Clinton County patients were experiencing food insecurity and 1 in 10 households with children in both Clinton and Lycoming counties needed help with clothing.**

Geisinger Universal Health Risk Assessment North Central Region Patient Results

Top Identified Social Needs	Clinton	Lycoming
Top Need (All Adults)	Food Worry (8.0%, n=263)	Employment (6.0%, n=328)
Adults aged 18-64	Employment (10.3%, n=239)	Employment (8.2%, n=319)
Adults aged 65 or older	Medication (2.8%, n=28)	Connections (2.0%, n=32)
Top Need (Households with children under age 18)	Clothing (10.9%, n=133)	Clothing (11.3%, n=91)

Source: Geisinger Universal Health Risk Assessment, Oct .1, 2022 to Jul. 31, 2023
Note: Sullivan County results are excluded due to low survey participation.

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

Demographics: Who Lives in the North Central Region?

Our Community and Residents

All counties in the region experienced population decline from 2010 to 2021, most significantly in Sullivan County at over 8%. Given Sullivan County's small population size, and median age that is 13-17 years higher than its neighbors and state and national benchmarks, it is likely that the staggering decline in the youth population (-46%) is owed to a low birthrate, and the population decrease is most likely due to death, more than relocation. Bearing these factors in mind, there is an opportunity to focus on increasing and improving geriatric health and wellness initiatives in Sullivan County, as well as efforts to attract younger people and families to the region.

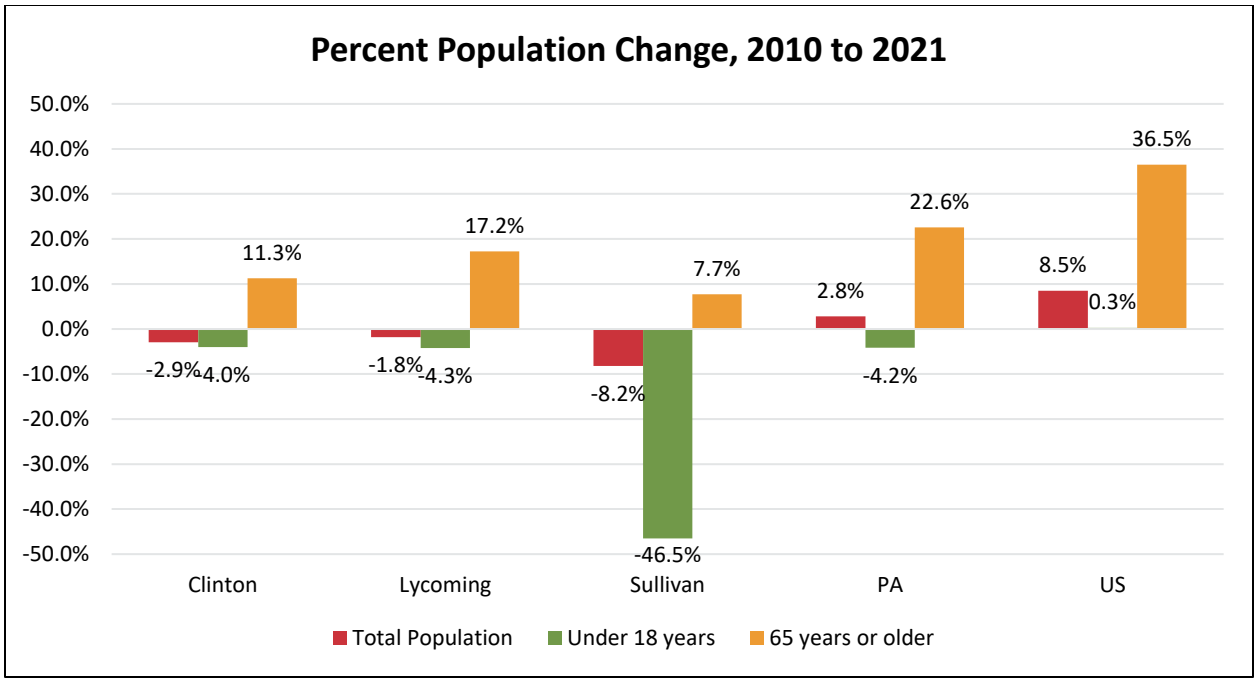
The North Central Region overall is aging, with a significant increase in the number of older adults from 2010 to 2021 in all counties. However, the region is aging slightly less rapidly than state and national trends.

North Central Region Communities

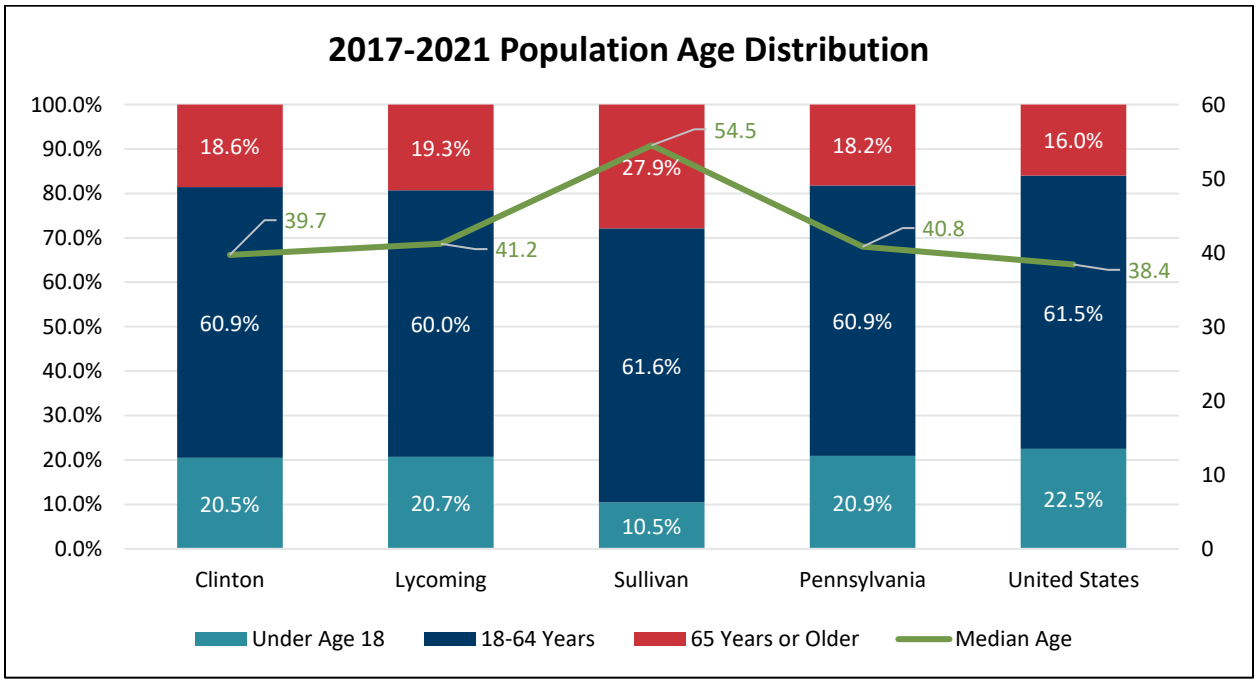
2017-2021 Total Population

	Total Population
Clinton	37,824
Lycoming	114,274
Sullivan	5,935
Pennsylvania	12,970,650
United States	329,725,481

Source: US Census Bureau, American Community Survey

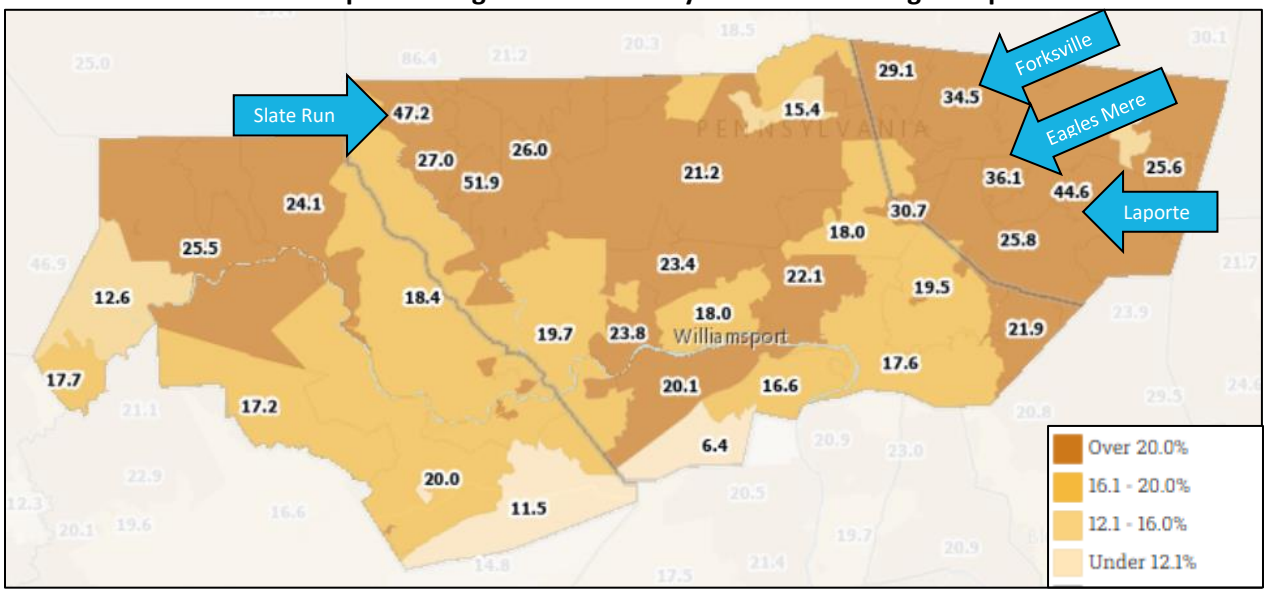


Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

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



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

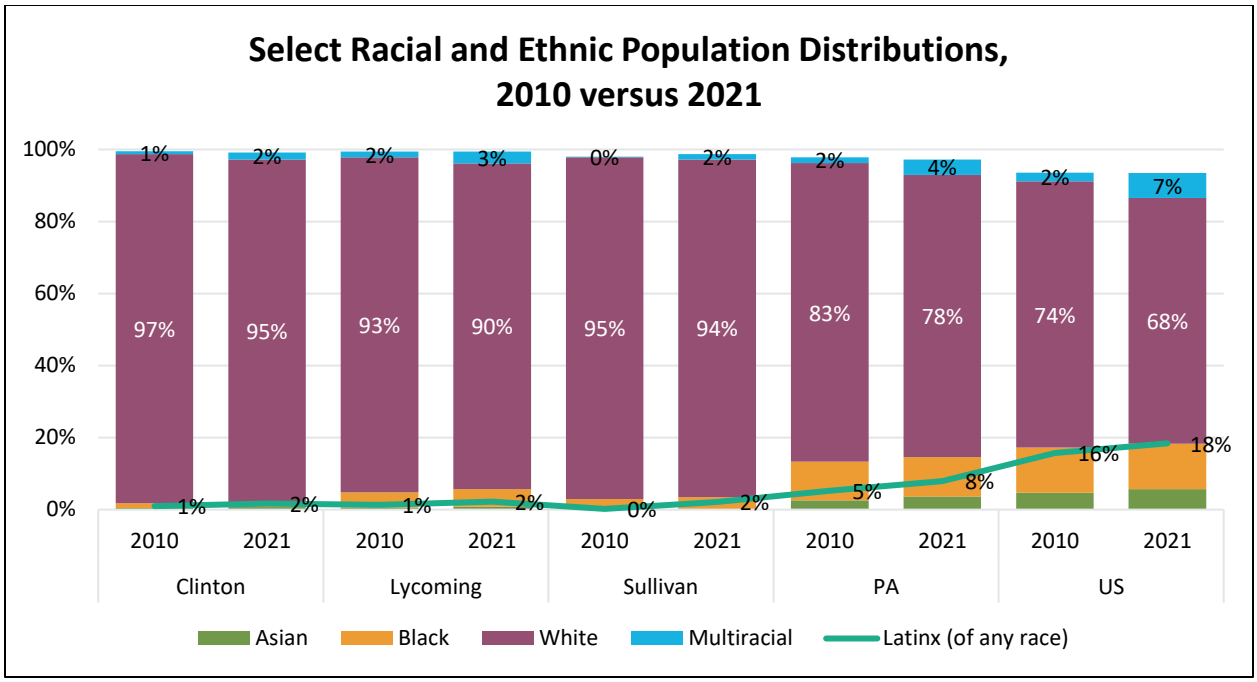
North Central Region counties are majority white communities with less racial diversity than state and national benchmarks. Lycoming County benefits from the most population diversity with 10% of residents identifying with a race other than white. The overwhelming majority of non-white residents are concentrated in Williamsport.

Consistent with state and national trends, population diversity is increasing within the region, though only marginally, with the white population decreasing by 1-3 percentage points over the last 10 years.

2017-2021 Population by Race and Ethnicity

	American Indian / Alaska Native	Asian	Black or African American	Native Hawaiian / Pacific Islander	White	Other Race	Two or More Races	Latinx Origin (any race)
Clinton	0.4%	0.7%	1.2%	0.0%	95.3%	0.3%	2.0%	1.7%
Lycoming	0.1%	0.8%	4.9%	0.1%	90.4%	0.5%	3.3%	2.2%
Sullivan	0.1%	0.1%	3.5%	0.2%	93.7%	0.8%	1.5%	2.1%
Pennsylvania	0.2%	3.6%	11.0%	0.0%	78.3%	2.7%	4.3%	7.9%
United States	0.8%	5.7%	12.6%	0.2%	68.2%	5.6%	7.0%	18.4%

Source: US Census Bureau, American Community Survey

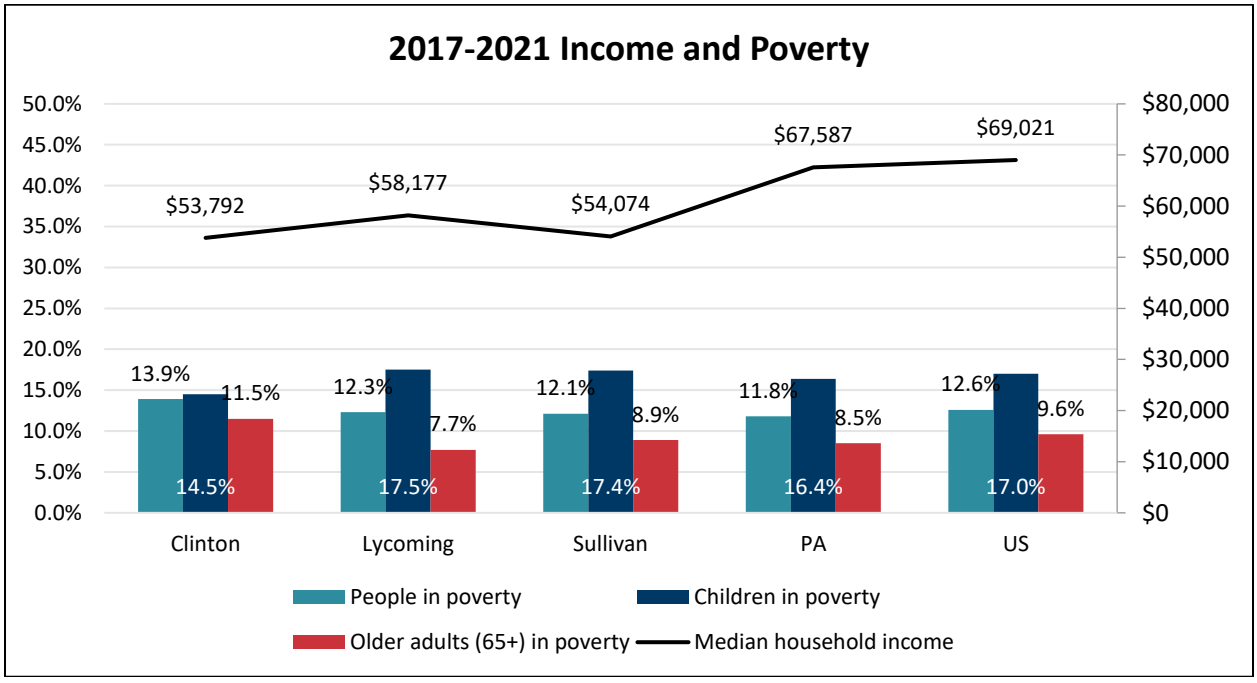


Source: US Census Bureau, American Community Survey

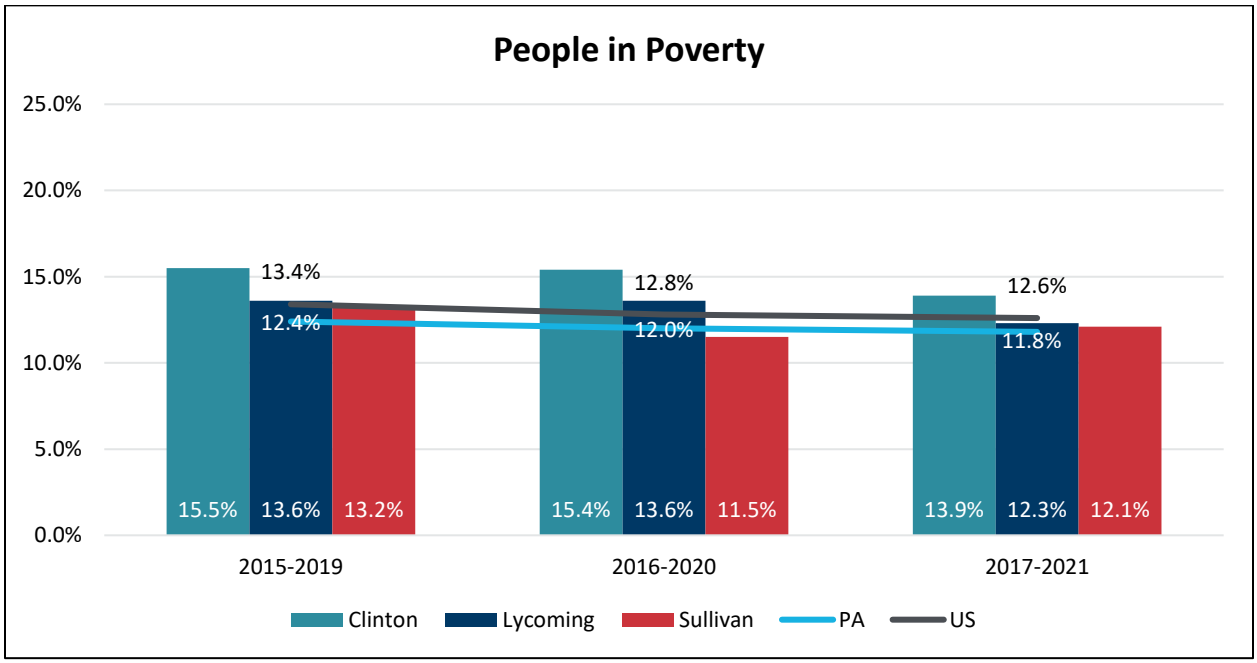
Note: Data by race and ethnicity are provided for North Central Region counties as available.

Income and Work

All North Central Region counties have lower median household incomes than state and national medians. **County-wide poverty levels are slightly elevated in Clinton, and Lycoming and Sullivan counties have slightly more children living in poverty than the state benchmark.**

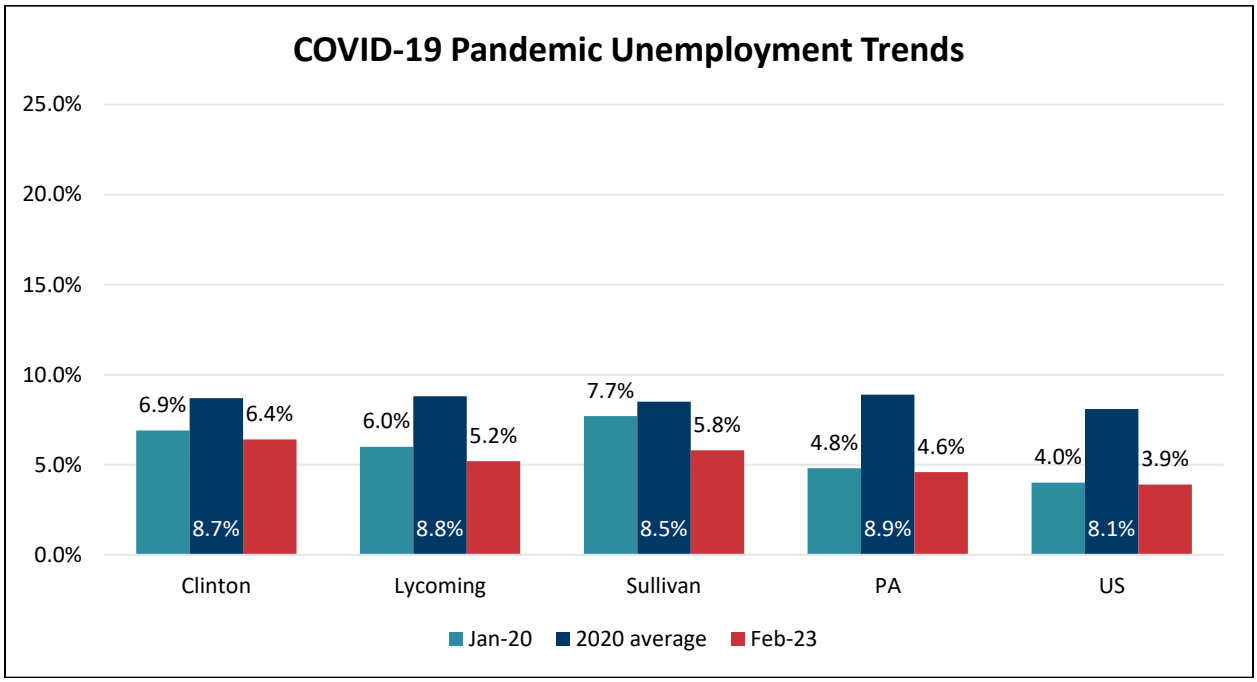


Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

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

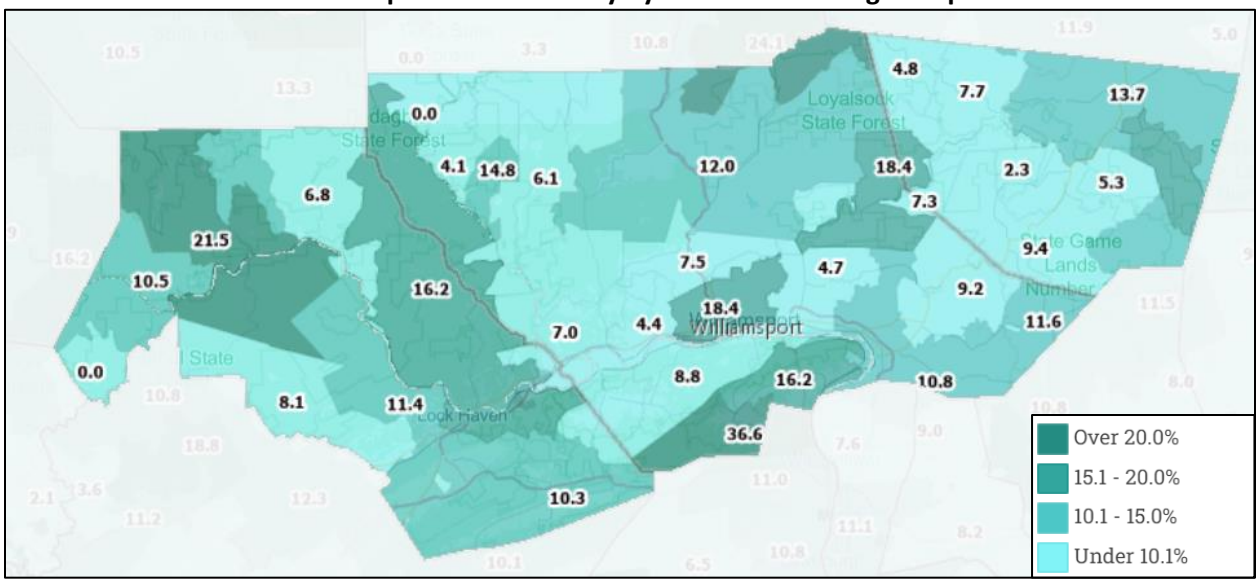


Source: US Bureau of Labor Statistics

When analyzed by zip code, pockets of high poverty are largely seen within Clinton County communities. **Children are historically disproportionately affected by poverty, and within the communities of Renovo and McElhattan (both in Clinton County) approximately half of children live in poverty.**

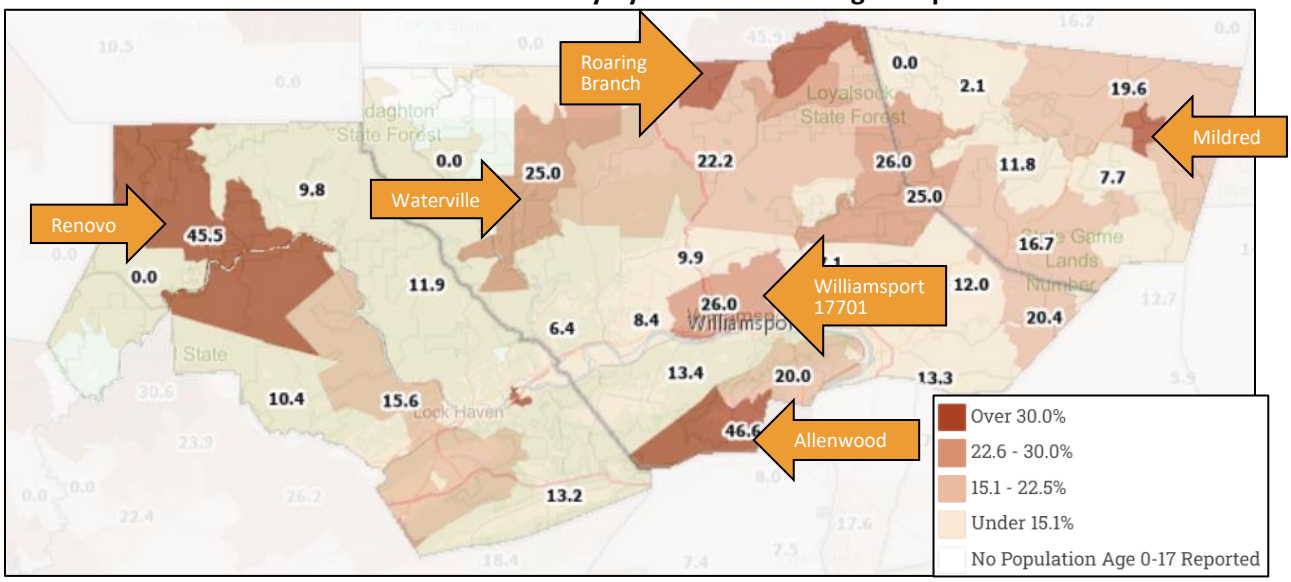
Poverty is not experienced by every community equally and contributes to further inequalities such as access to safe living and working conditions, health services, and basic needs, among other things. While Clinton County has the highest overall rates of poverty, they are relatively consistent across racial and ethnic groups. However, in Lycoming and Sullivan counties, there are significant socioeconomic disparities between racial groups; only 11% of white residents in both counties live in poverty, compared to 46% and 43% of Black residents, respectively. **While the region has few residents who identify as non-white or non-white Hispanic, they do exist, and their lack of visibility may contribute to these disparate experiences.**

2017-2021 Population in Poverty by North Central Region Zip Code

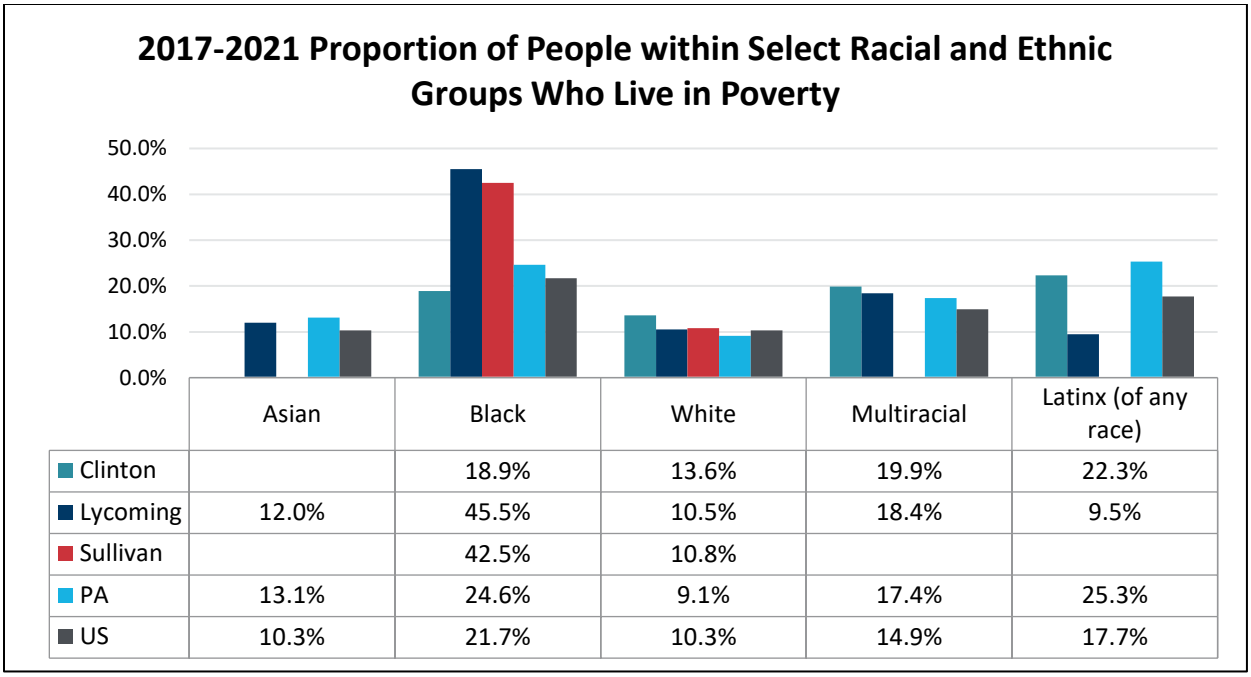


Source: US Census Bureau, American Community Survey & Center for Applied Research and Engagement Systems

2017-2021 Children in Poverty by North Central Region Zip Code



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

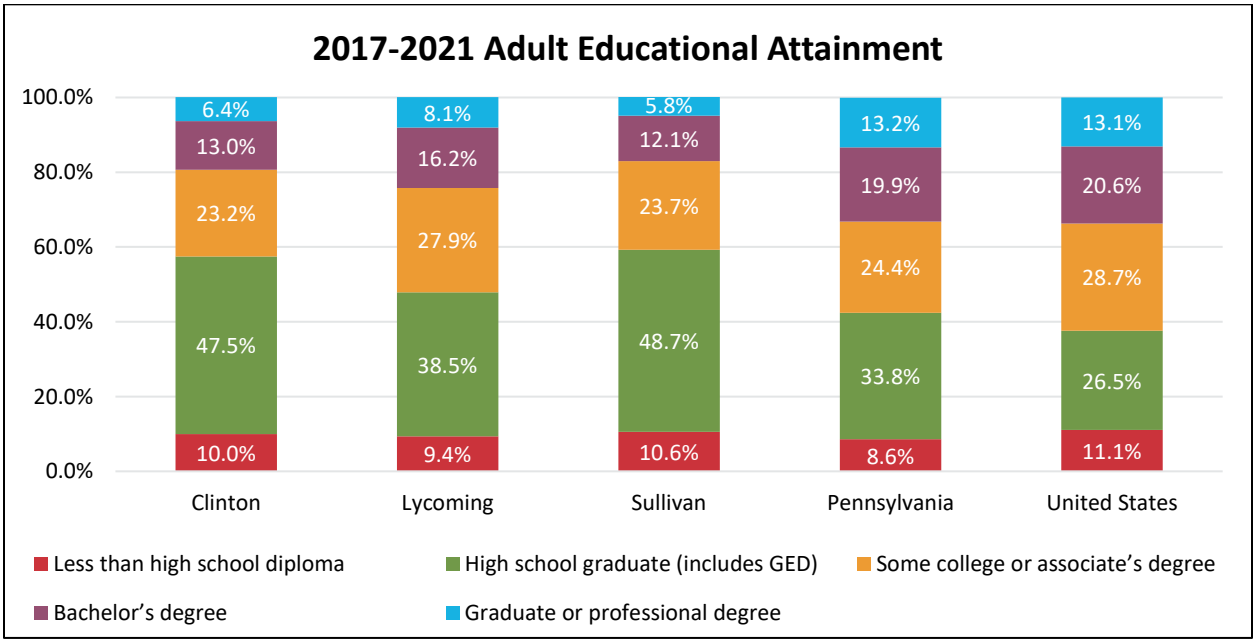


	Asian	Black	White	Multiracial	Latinx (of any race)
Clinton		18.9%	13.6%	19.9%	22.3%
Lycoming	12.0%	45.5%	10.5%	18.4%	9.5%
Sullivan		42.5%	10.8%		
PA	13.1%	24.6%	9.1%	17.4%	25.3%
US	10.3%	21.7%	10.3%	14.9%	17.7%

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

Education

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



Source: US Census Bureau, American Community Survey

Our Homes and Where We Live

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

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

In general, a similar or higher proportion of North Central Region residents own their home when compared to state and national benchmarks. Homeownership increases in more rural communities like Sullivan.

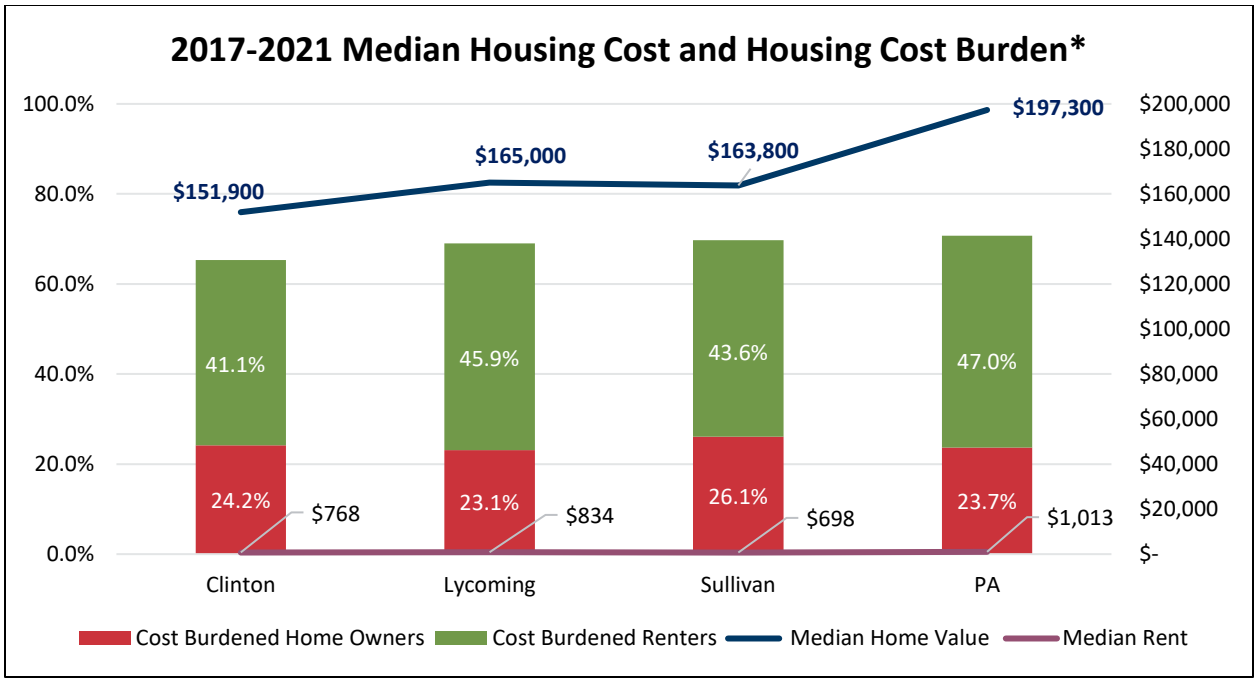
2017-2021 Housing Occupancy

	Owner Occupied Units	Renter Occupied Units
Clinton	70.1%	29.9%
Lycoming	69.5%	30.5%
Sullivan	83.4%	16.6%
Pennsylvania	69.2%	30.8%
United States	64.6%	35.4%

Source: US Census Bureau, American Community Survey

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

The graph below demonstrates that renters, who may already experience the stresses that accompany less stability as compared to homeowners, are also, on average, more cost-burdened than the homeowners in their communities. **Rental costs have ballooned across the country since COVID-19, leaving many to struggle to continue to afford their current rent, while also having less and less opportunity to save money to make future home ownership possible.** The North Central Region is no exception to these trends. The percentage of all cost-burdened residents is consistent across the region, indicating that income levels and housing costs are proportionate across geographies, but one-quarter of homeowners and more than 40% of renters *still* meet the criteria of being cost-burdened.



Source: US Census Bureau, American Community Survey

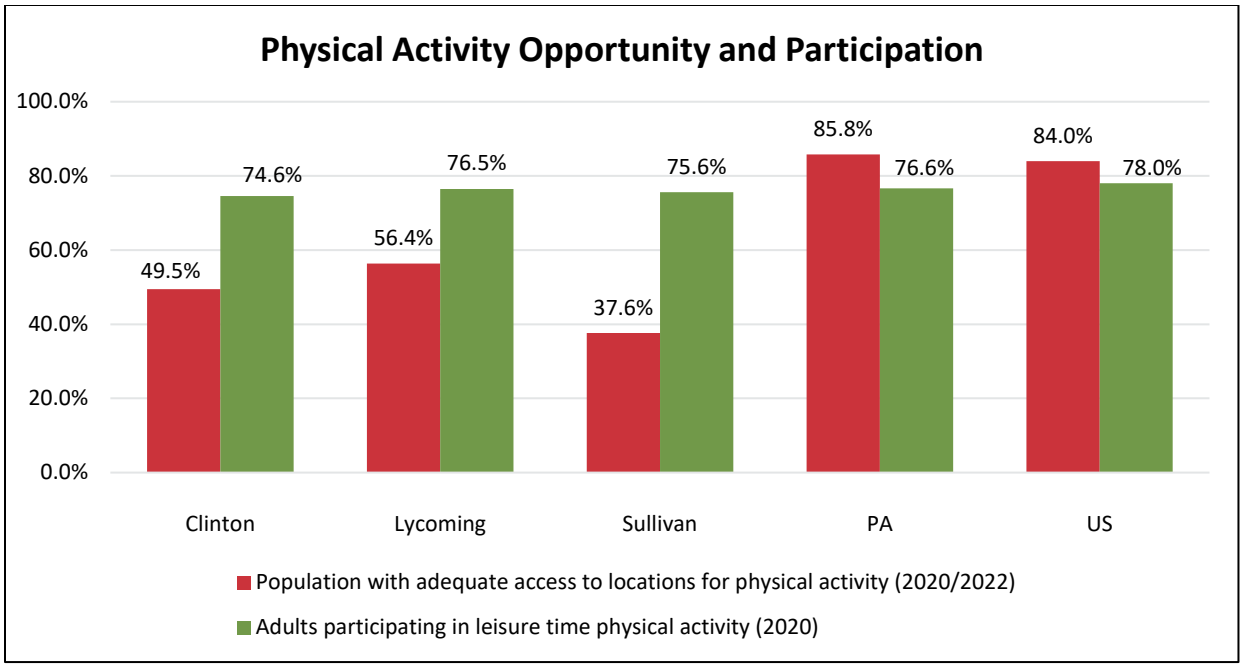
*Defined as spending 30% or more of household income on rent or mortgage expenses.

Neighborhood and Built Environment

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

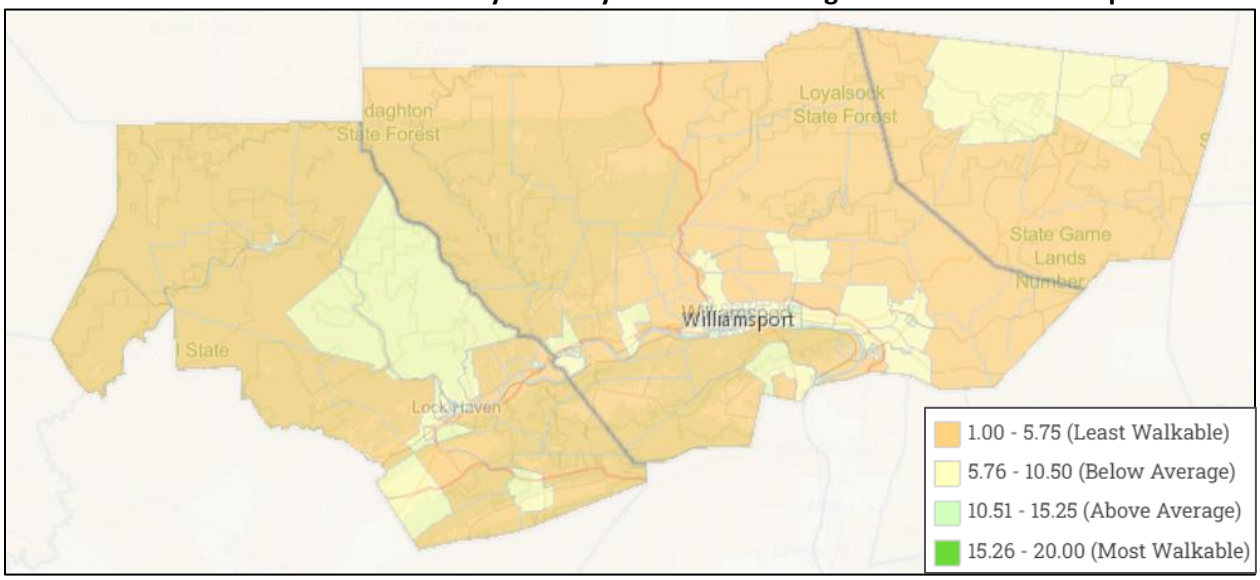
Feedback from Key Stakeholder Survey participants centered around the scarcity of reliable and affordable public transportation options available to residents. Combined with a region that is, on the whole, "below average" in its walkability rating, as well as a rapidly aging population, it can be difficult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

Despite these concerns, residents of the North Central Region have demonstrated resilience in prioritizing physical activity. Across the region, the percentage of the population with adequate access to locations for physical activity is far below state and national benchmarks, with adults in Sullivan County only *half as likely* to have adequate access. Yet, across counties, the percentage of adults who participate in leisure time physical activity is on par with state and national benchmarks, and far outpaces what would be expected given the reported lack of access.



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

2021 National Walkability Index by North Central Region Census Block Group



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

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

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

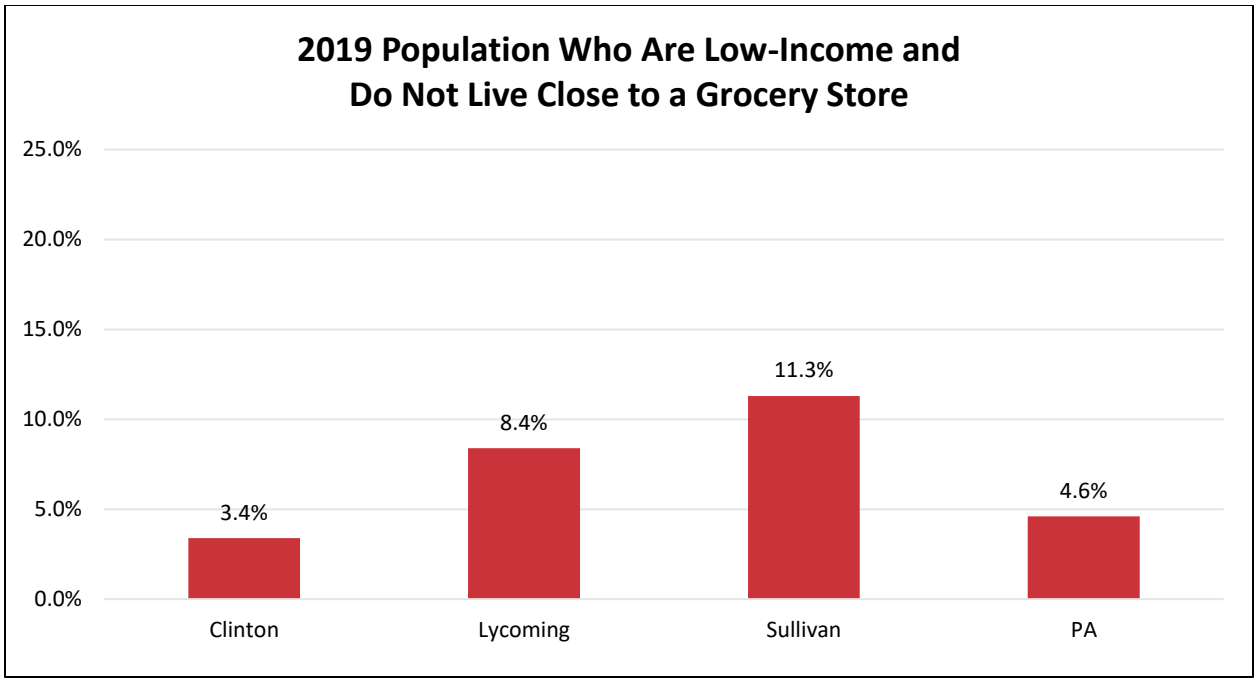
Across the North Central Region in 2021, approximately 1 in 10 residents were estimated to be food insecure. **While the percentage of children who experience food insecurity outpaces that for adults, the percentage of children experiencing food insecurity declined *more rapidly* in recent years than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

It is worth noting disparities among individuals with low income living in Sullivan County. **Sullivan County overall has a slightly lower proportion of residents living in poverty and/or experiencing food insecurity as neighboring communities, but approximately 11% of residents with low income do not live close to a grocery store, the highest proportion in the region.** Sullivan County's rural status likely contributes to residents' – including low-income residents' – distance from grocery stores, compounding health and financial hardships, especially for the large population of older adults.

Food Insecurity

	Clinton	Lycoming	Sullivan	PA	US
Food Insecure Residents					
2021	11.6%	10.7%	10.8%	9.4%	10.4%
2020	13.0%	12.1%	10.9%	8.9%	11.8%
2019	13.3%	12.1%	12.1%	10.6%	10.9%
Food Insecure Children					
2021	12.5%	13.9%	14.2%	12.2%	12.8%
2020	16.2%	18.0%	15.9%	13.1%	16.1%
2019	17.1%	17.2%	17.6%	14.7%	14.6%

Source: Feeding America & USDA Food Environment Atlas



Source: Health Resources and Services Administration

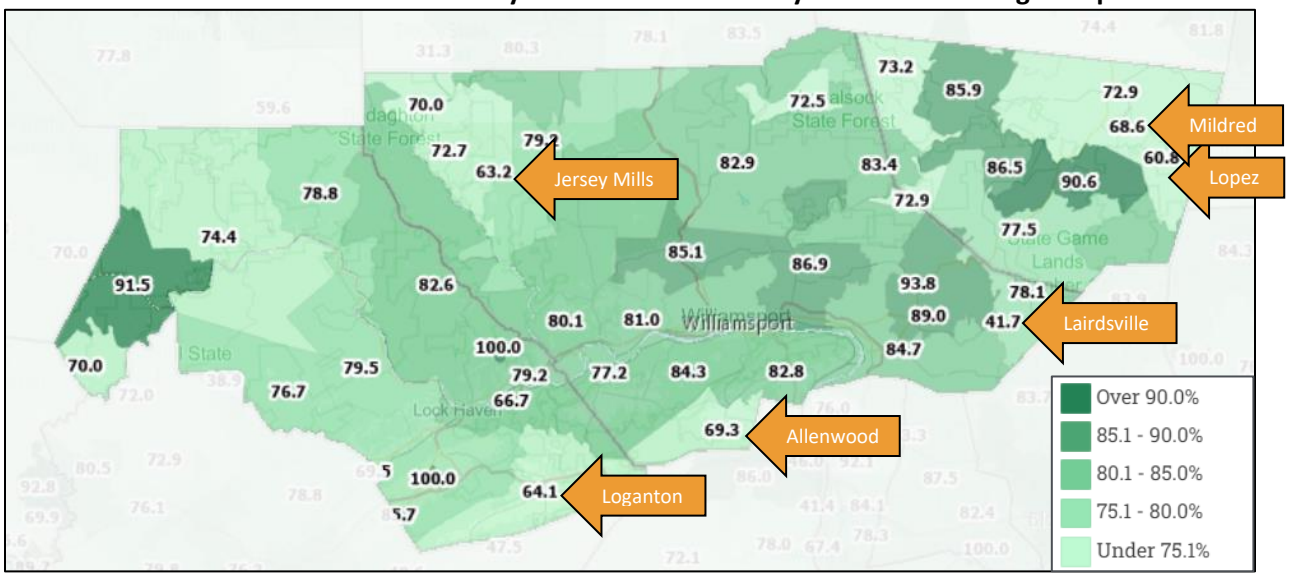
During the COVID pandemic, we were able to use technology to bring services to people in their homes, but not uniformly. We need to bridge the wide digital divide within our communities to effectively reach all residents. Residents across the North Central Region generally have lower digital access as compared to state and national benchmarks. Sullivan County has the fewest residents with an internet subscription, a likely result of the predominantly older population, but disparities exist across the region. **In several smaller communities, highlighted on the map below, fewer than 65% of residents have reliable internet access.** In the community of Lairdsville, Lycoming County, only 42% of residents have reliable internet access.

2017-2021 Households by Digital Access

	With Computer Access			With Internet Access	
	Computer Device	Desktop / Laptop	Smartphone	Internet Subscription	Broadband Internet
Clinton	85.9%	72.4%	75.6%	80.3%	79.5%
Lycoming	90.0%	73.5%	77.6%	84.4%	83.7%
Sullivan	88.1%	76.0%	66.7%	78.6%	76.7%
Pennsylvania	90.9%	77.3%	82.0%	86.1%	85.8%
United States	93.1%	78.9%	86.5%	87.2%	87.0%

Source: US Census Bureau, American Community Survey

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



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

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

Central to concerns around economic recovery for residents is the lack of *any* childcare options for children who are younger than school-aged (3.5 per 1,000 children under age 5 in Clinton County), as well as the prohibitive cost. **In Lycoming County, where most of the North Central Region's children reside, residents with small children may spend 27% of their income on just childcare.**

Childcare Availability and Affordability

	Number of Childcare Centers per 1,000 Population Under 5 Years Old	Childcare Costs for a Household with Two Children as a Percent of Median Household Income
Clinton	3.5	22.4%
Lycoming	6.8	26.8%
Sullivan	10.3	27.1%
Pennsylvania	5.2	27.2%
United States	7.0	27.0%

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

Our Health Status as a Community

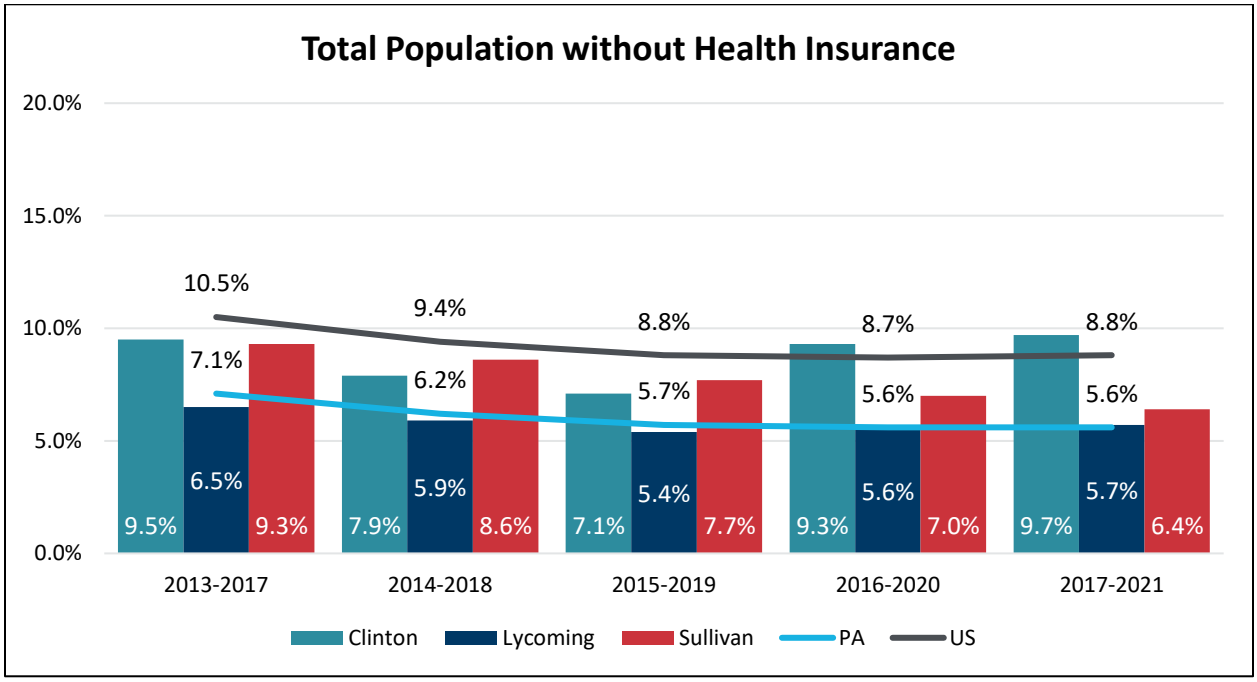
Access to Care

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

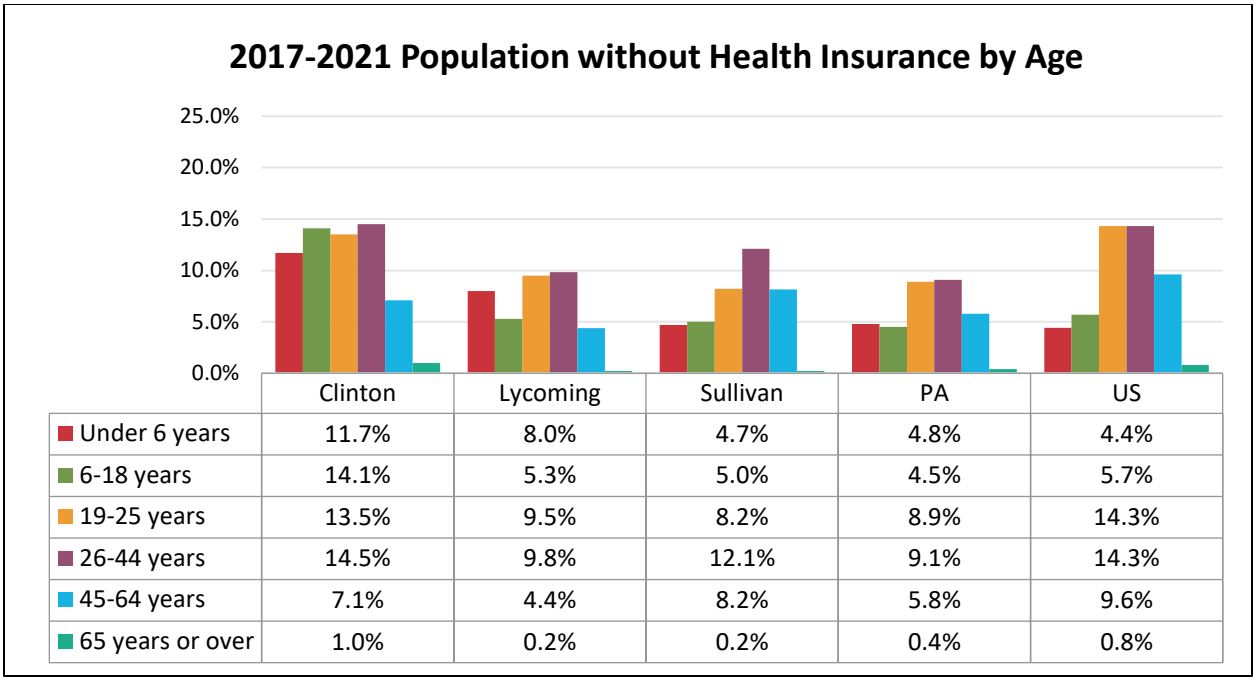
While many North Central Region residents *have* health insurance, there is a relatively high percentage of young adults (ages 19-25) who are uninsured across all counties. This population may be eligible to remain insured through their guardians under the Affordable Care Act, presenting an opportunity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

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

Clinton County demonstrates the highest proportion of uninsured residents across age groups. This finding may reflect several factors including Plain Community members who do not participate in health insurance programs, or, regarding the county's children, a gap in eligibility awareness for PA Children's Health Insurance Program (CHIP). **No family makes too much for CHIP, presenting an opportunity to increase community awareness and education around what options *are* available for the region's children.**

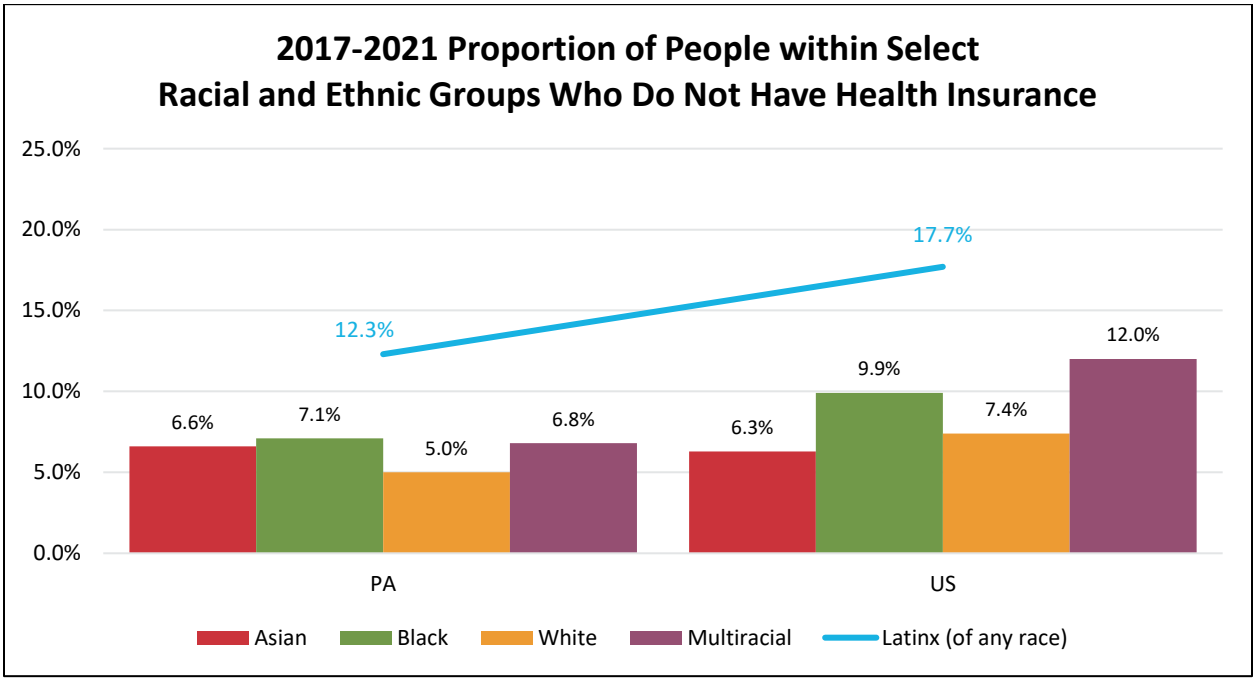


Source: US Census Bureau, American Community Survey

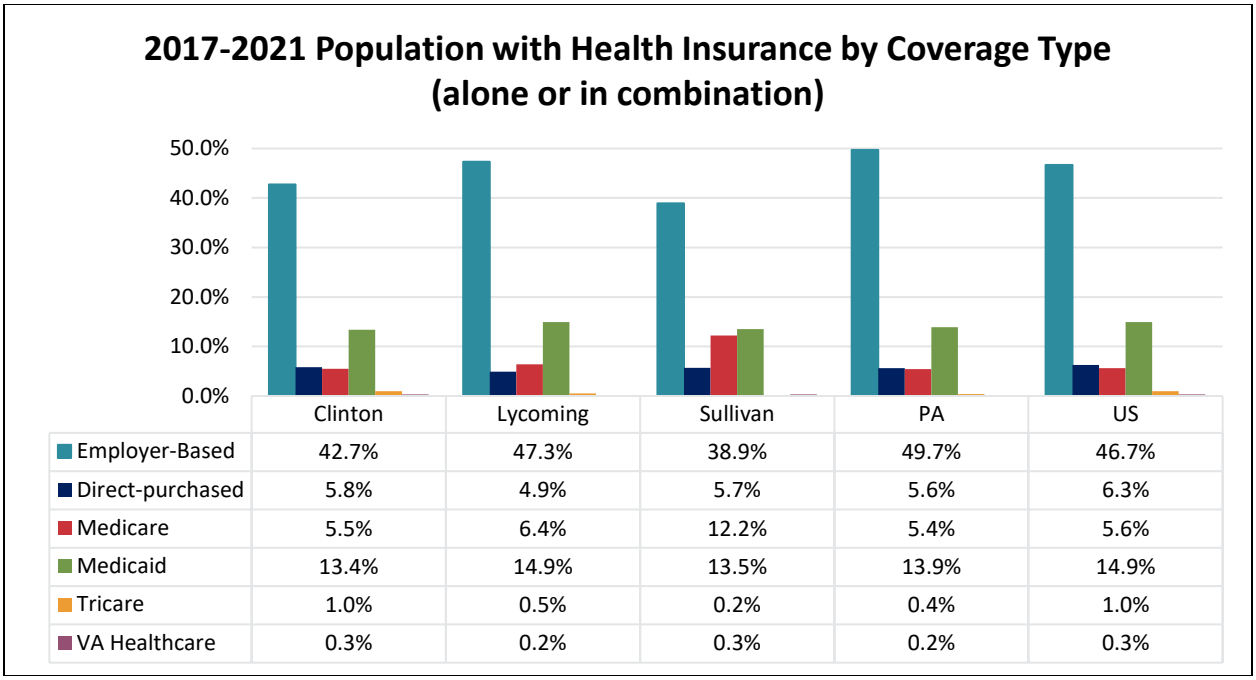


	Clinton	Lycoming	Sullivan	PA	US
Under 6 years	11.7%	8.0%	4.7%	4.8%	4.4%
6-18 years	14.1%	5.3%	5.0%	4.5%	5.7%
19-25 years	13.5%	9.5%	8.2%	8.9%	14.3%
26-44 years	14.5%	9.8%	12.1%	9.1%	14.3%
45-64 years	7.1%	4.4%	8.2%	5.8%	9.6%
65 years or over	1.0%	0.2%	0.2%	0.4%	0.8%

Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey



	Clinton	Lycoming	Sullivan	PA	US
Employer-Based	42.7%	47.3%	38.9%	49.7%	46.7%
Direct-purchased	5.8%	4.9%	5.7%	5.6%	6.3%
Medicare	5.5%	6.4%	12.2%	5.4%	5.6%
Medicaid	13.4%	14.9%	13.5%	13.9%	14.9%
Tricare	1.0%	0.5%	0.2%	0.4%	1.0%
VA Healthcare	0.3%	0.2%	0.3%	0.2%	0.3%

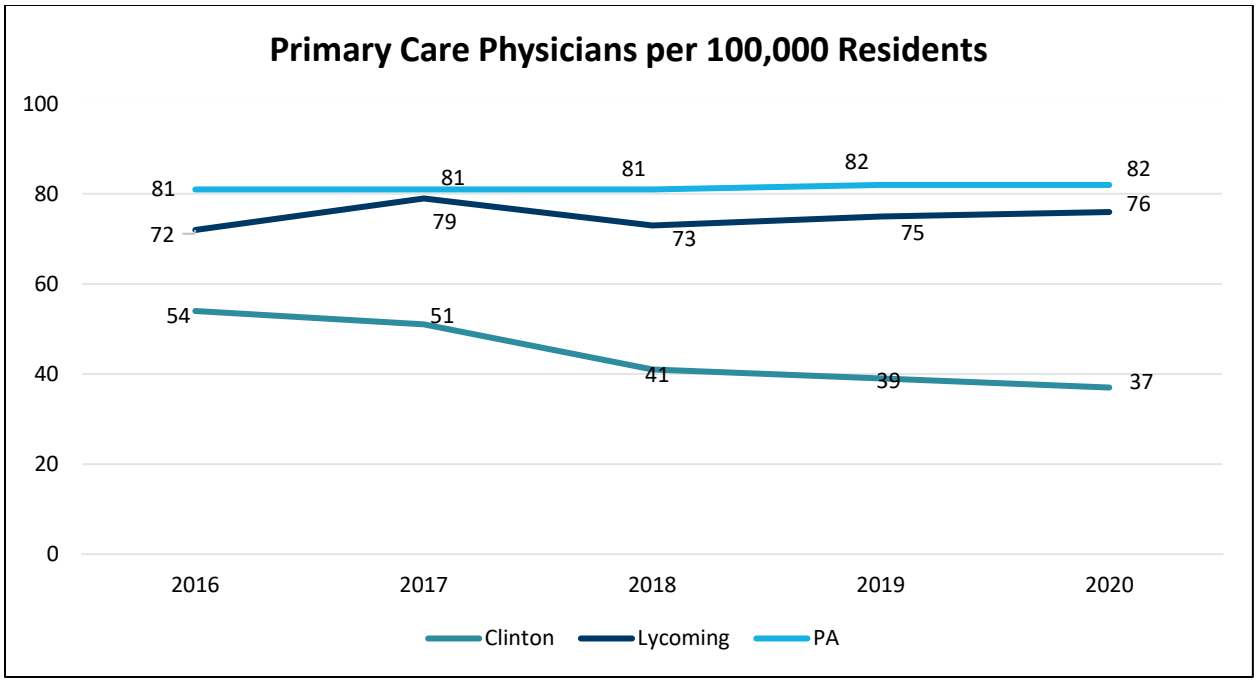
Source: US Census Bureau, American Community Survey

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

There is an opportunity to grow primary and preventive care services within the North Central Region. **The entire region is a Health Professional Shortage Area (HPSA) for dental care for individuals with low income. The northern portion of Clinton County is a primary care HPSA for all residents, and the northeast portion of Lycoming County and the northwest portion of Sullivan County are primary care HPSAs for individuals with low income.** These shortages further compound care access barriers for a population that is historically less likely to receive regular and preventive care.

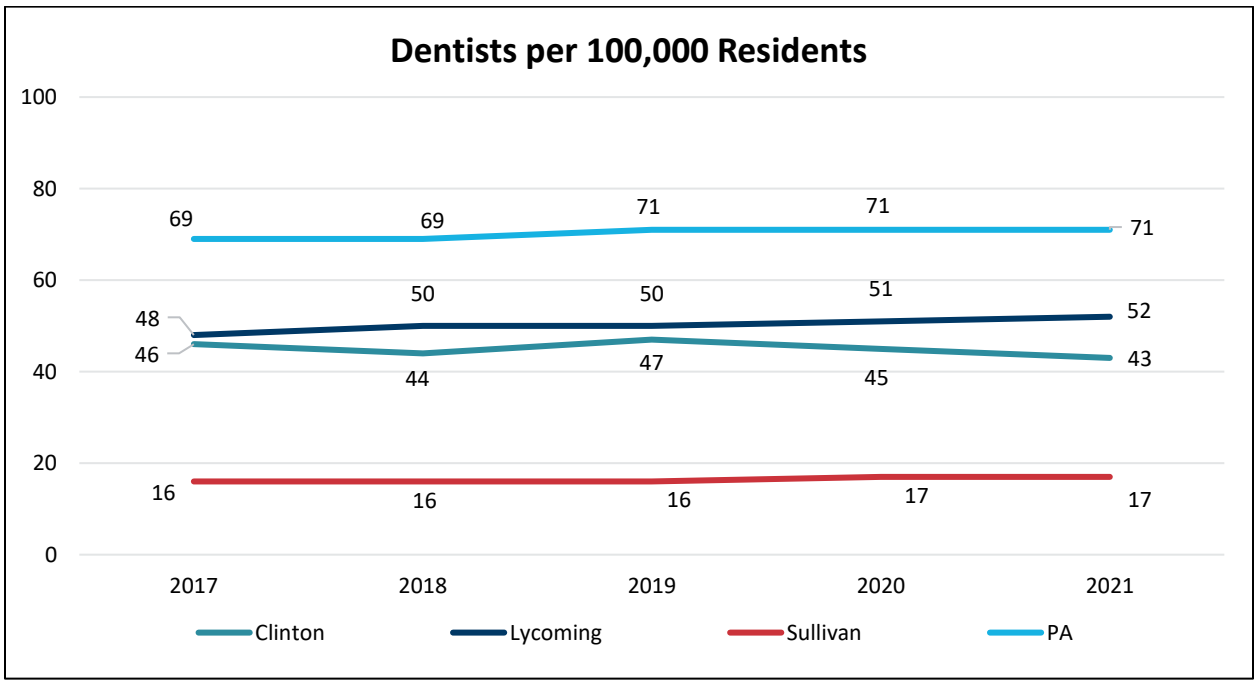
Despite a lack of doctors, adult residents of the North Central Region report preventive visits within the last year on par with state and national benchmarks – about three-quarters of adults. They report regular dental checkups with slightly less frequency, 61%-63% of adults, compared to 68% across Pennsylvania.

When analyzed by zip code, the proportion of adults receiving preventive visits is generally consistent across the region, while receipt of regular dental care is more varied. In Clinton County, the proportion of adults with regular dental care falls to 57%-58% in North Bend, Renovo, Westport, and Loganton. Other areas of disparity include downtown Williamsport, Montgomery, Allenwood, Mildred, and Dushore. Allenwood also has the lowest proportion of adults receiving regular primary care check-ups in the region (74%).

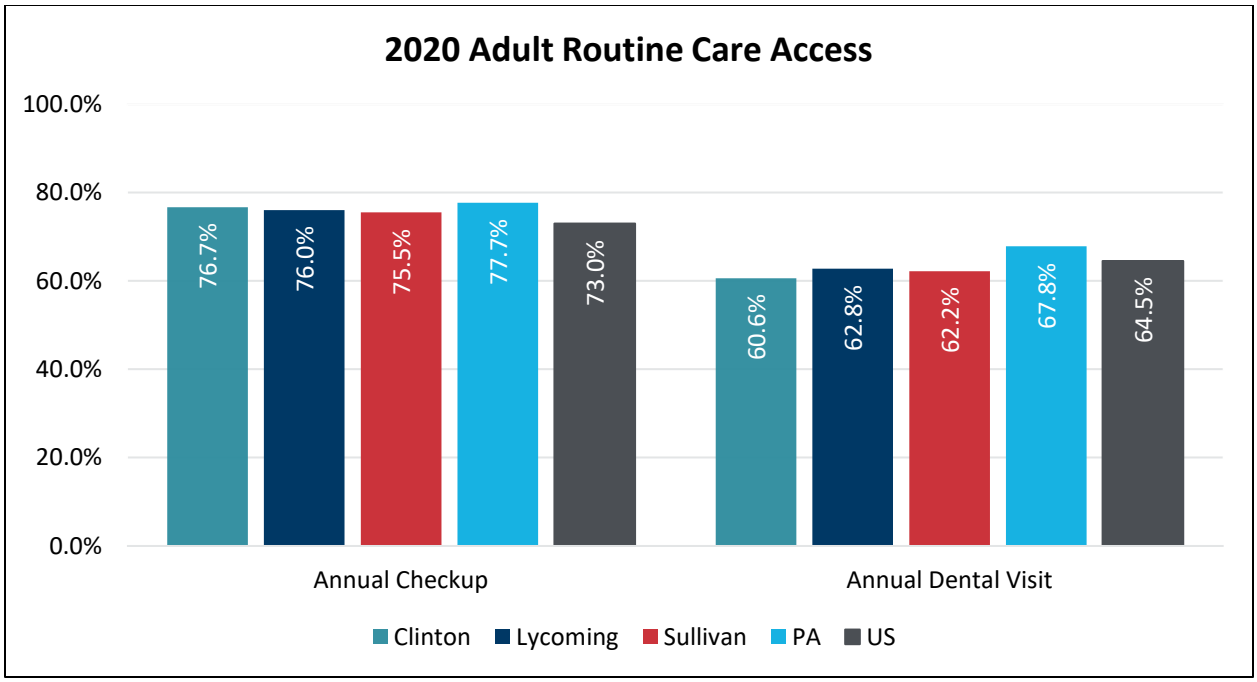


Source: Health Resources & Services Administration

Note: There were no primary care physicians identified in Sullivan County for 2016 and 2018-2020. Providers are identified based on their preferred business mailing address; rates do not take into account providers that serve multiple counties or satellite clinics.

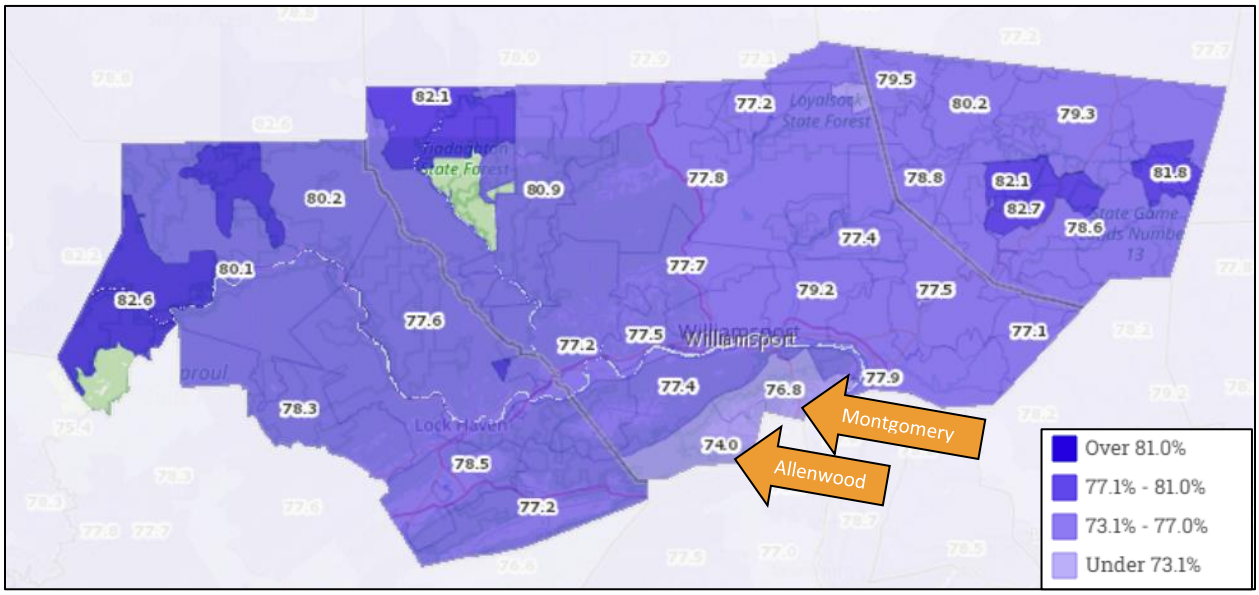


Source: Health Resources & Services Administration



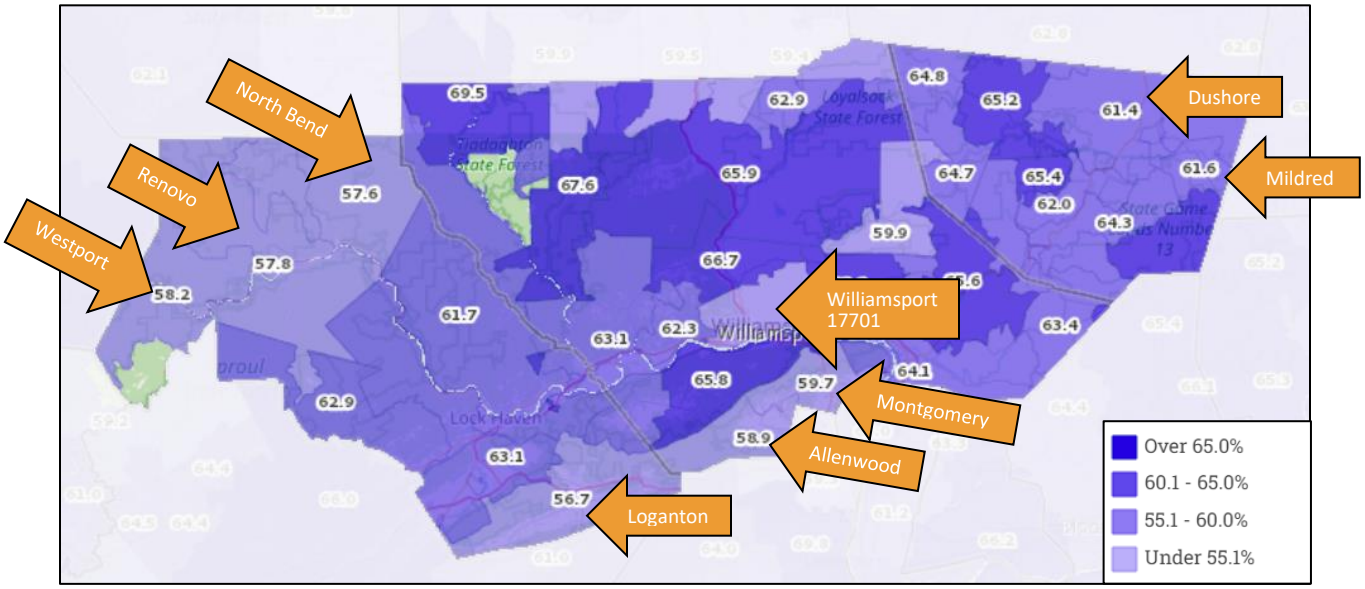
Source: Centers for Disease Control and Prevention

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



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

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



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

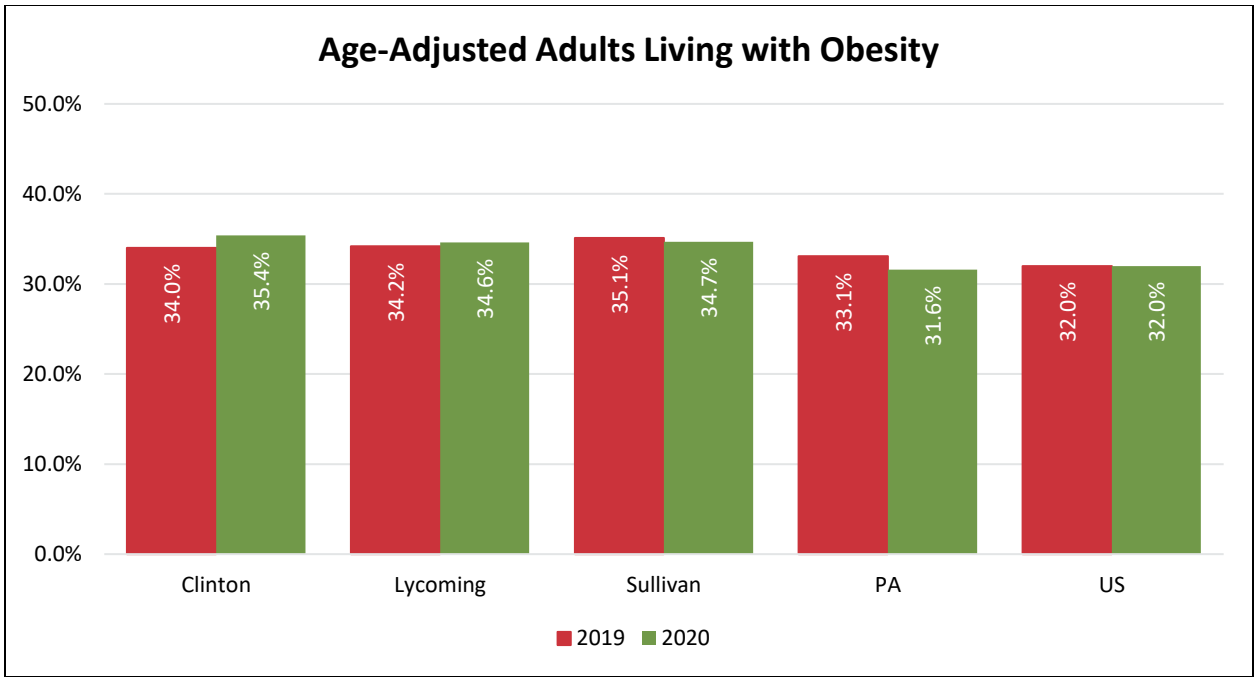
Health Risk Factors and Chronic Disease

Prior to COVID-19, the top leading causes of death for Pennsylvania and US residents were chronic diseases. **Across the North Central Region, diabetes and heart disease incidence are comparable to state and national trends, but residents die at higher rates from one or both conditions, potentially indicating barriers to diagnosis, treatment, and/or care management. The diabetes death rate in Clinton County was *twice* that of the state in 2020.**

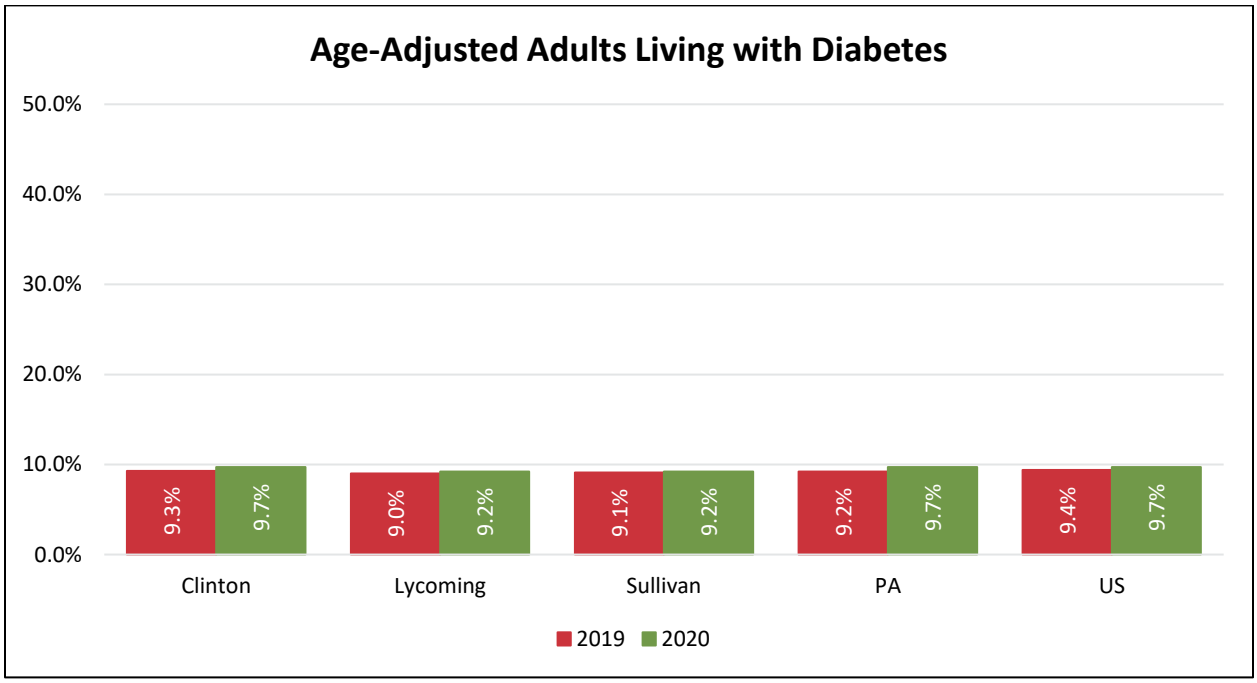
The North Central Region is home to more smokers and a higher incidence of COPD compared to state and national benchmarks. Incidence and death rates due to lung cancer are also elevated in Lycoming and Sullivan counties.

Lycoming and Sullivan counties have a marginally higher incidence of cancer than the state of Pennsylvania, while incidence in Clinton County is about equal. All-cancer death rates are also lower in Clinton County, compared to its neighbors and the state, suggesting early and effective intervention.

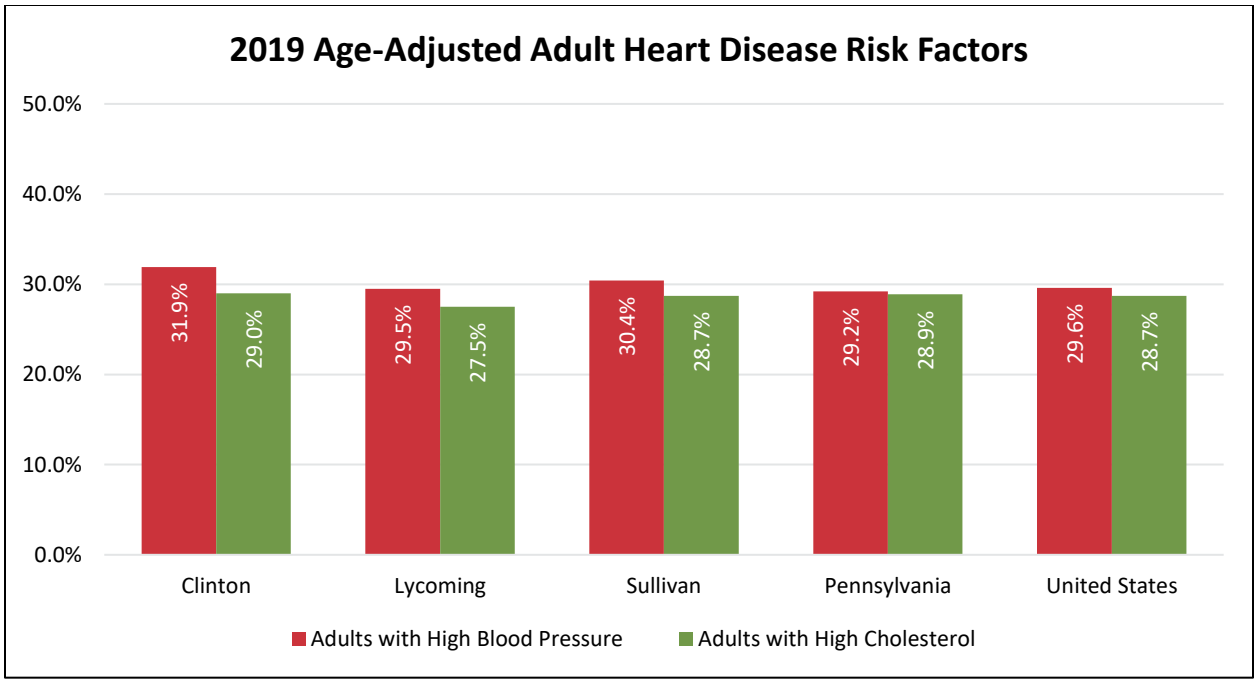
It is clear that social drivers of health directly impact health risk factors and ultimately chronic disease, resulting in inequities in quality of life and life expectancy. Across the state of Pennsylvania, death rates for Black residents attributed to diabetes and heart disease far outpace death rates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



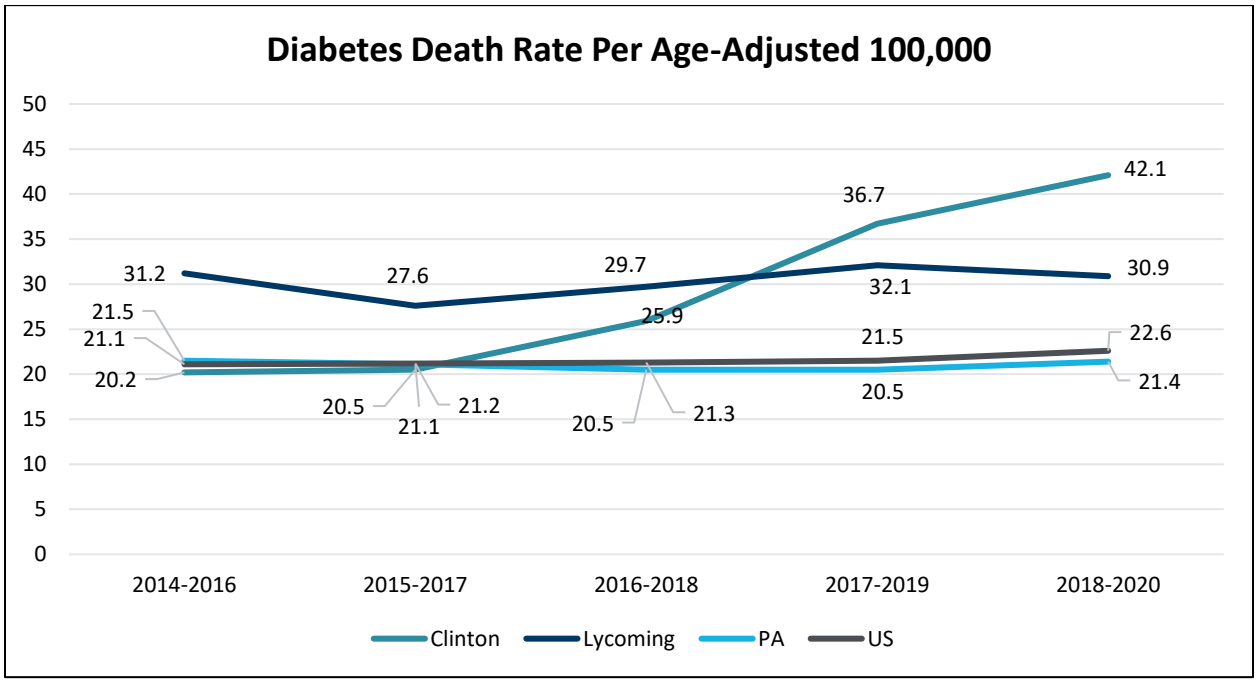
Source: Centers for Disease Control and Prevention



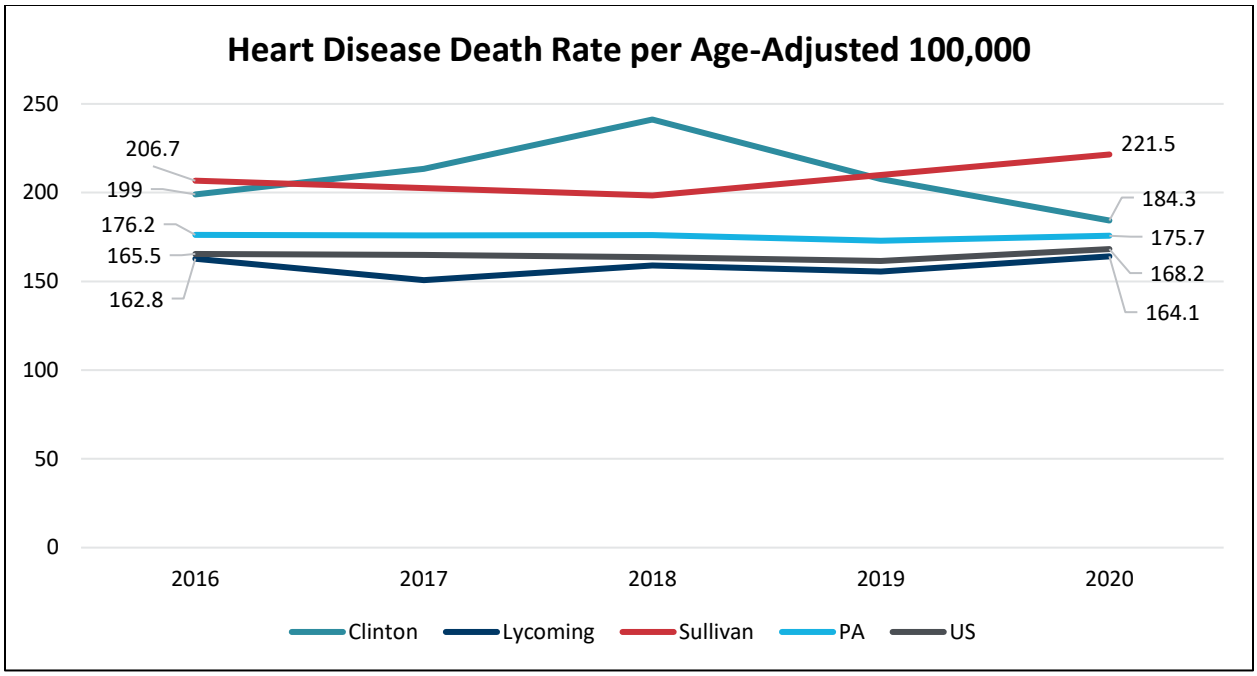
Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention

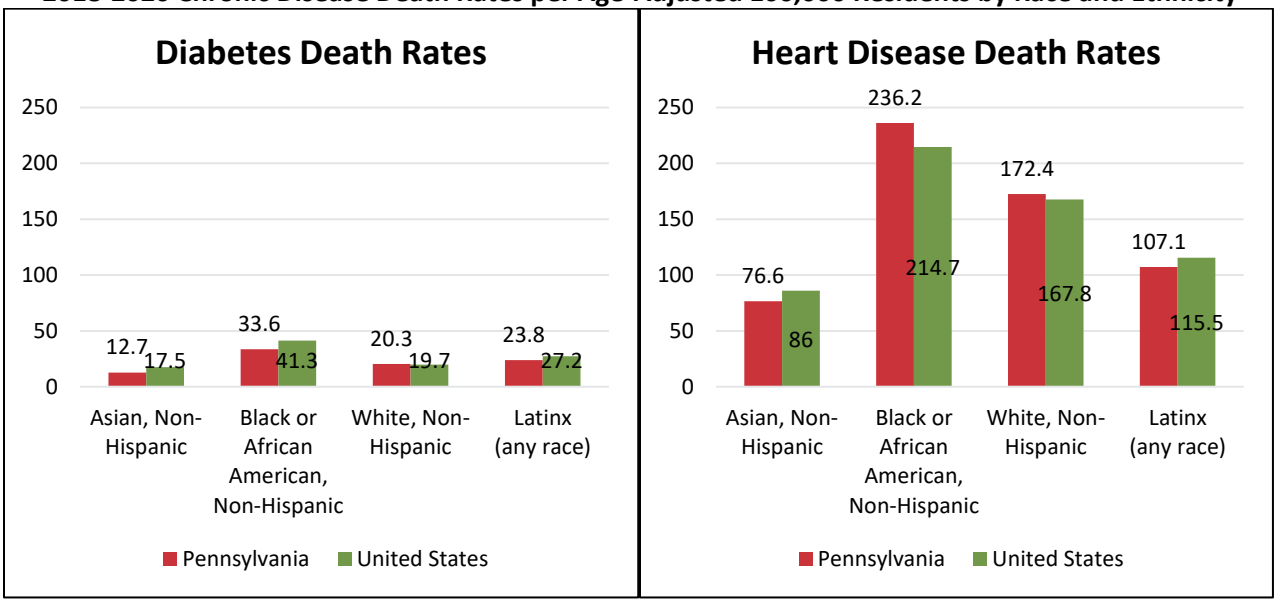


Source: Centers for Disease Control and Prevention
Note: Data are not reported for Sullivan County due to low death counts.

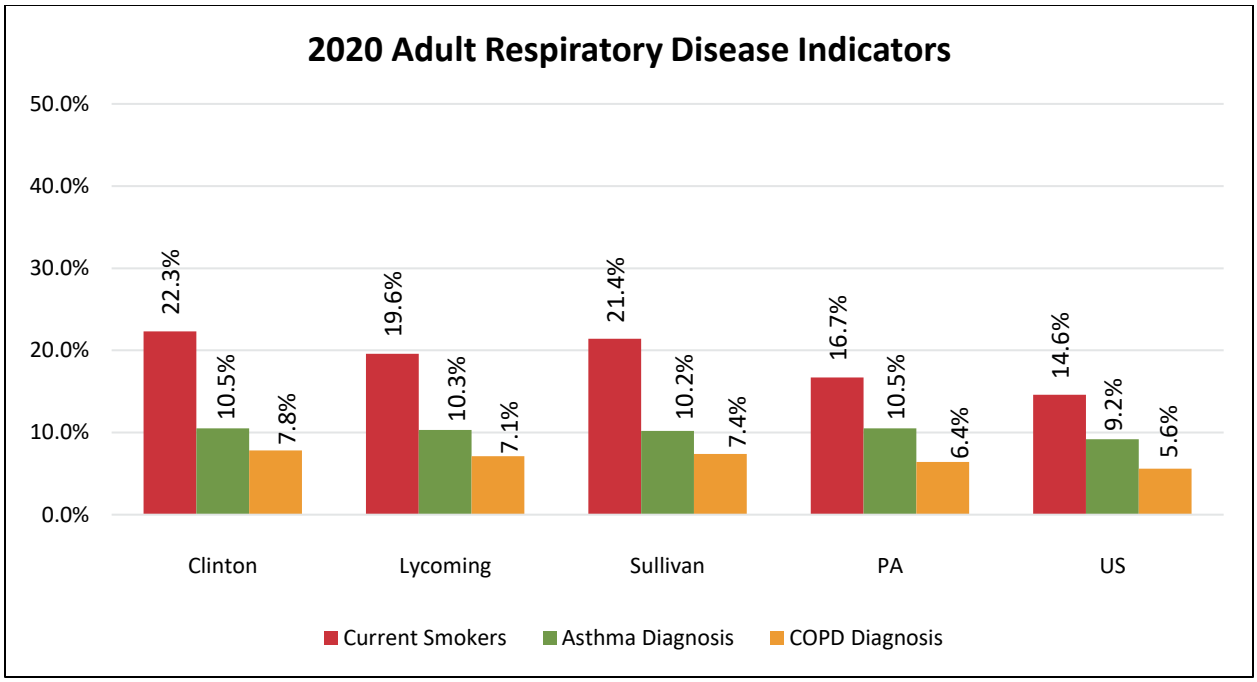


Source: Centers for Disease Control and Prevention

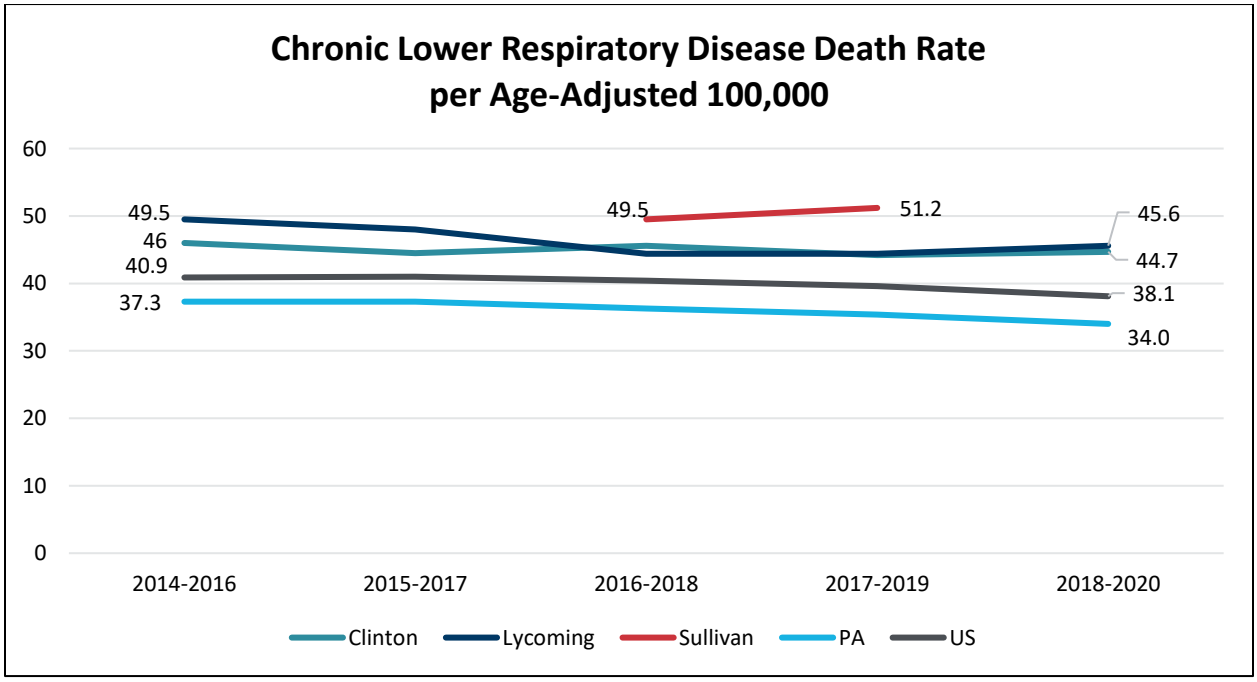
2018-2020 Chronic Disease Death Rates per Age-Adjusted 100,000 Residents by Race and Ethnicity



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



Source: Centers for Disease Control and Prevention



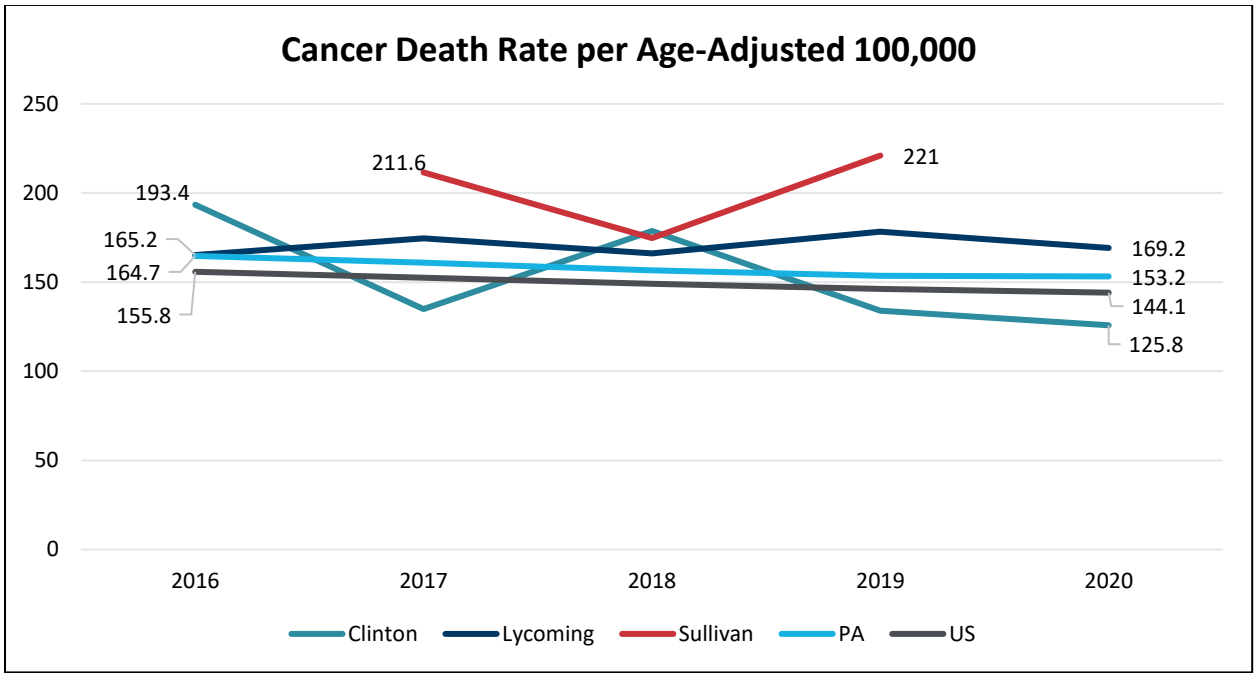
Source: Centers for Disease Control and Prevention

Note: Data for Sullivan County are masked for 2014-2016, 2015-2017, and 2018-2020 due to low death counts.

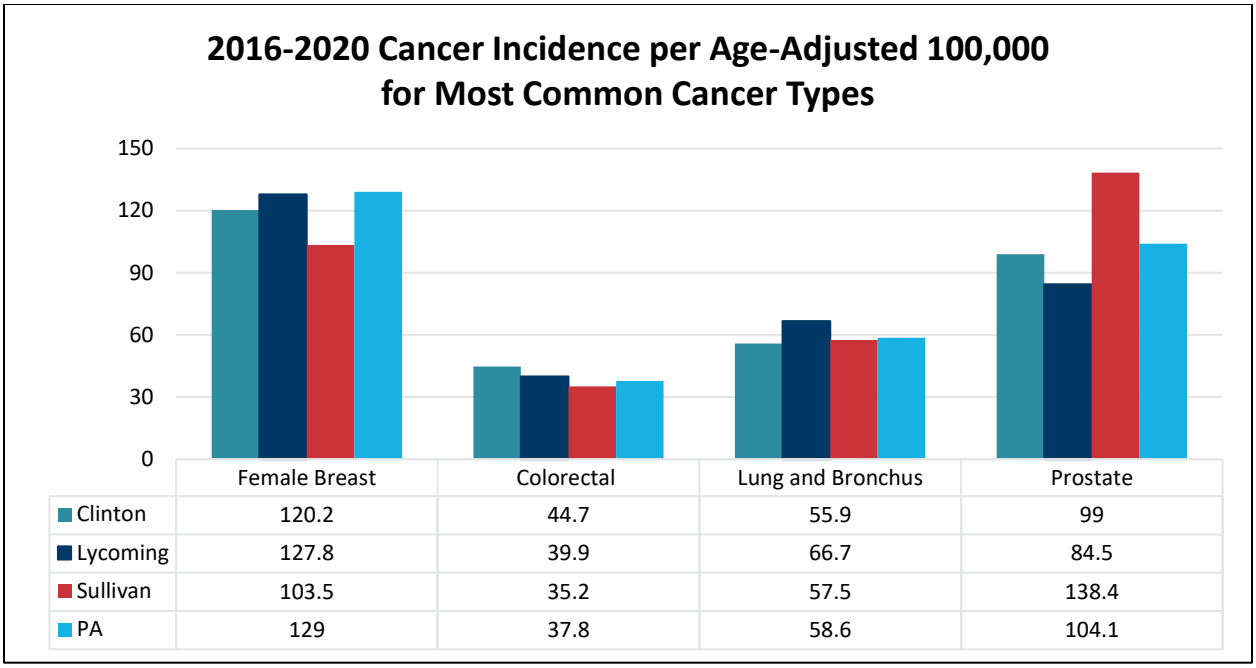
2016-2020 Cancer Incidence (All Types) per Age-Adjusted 100,000

	Cancer Incidence Rate
Clinton	447.2
Lycoming	472.2
Sullivan	457.6
Pennsylvania	448.4

Source: Pennsylvania Department of Health & Centers for Disease Control and Prevention
Note: Data are not available for the United States for 2016-2020.

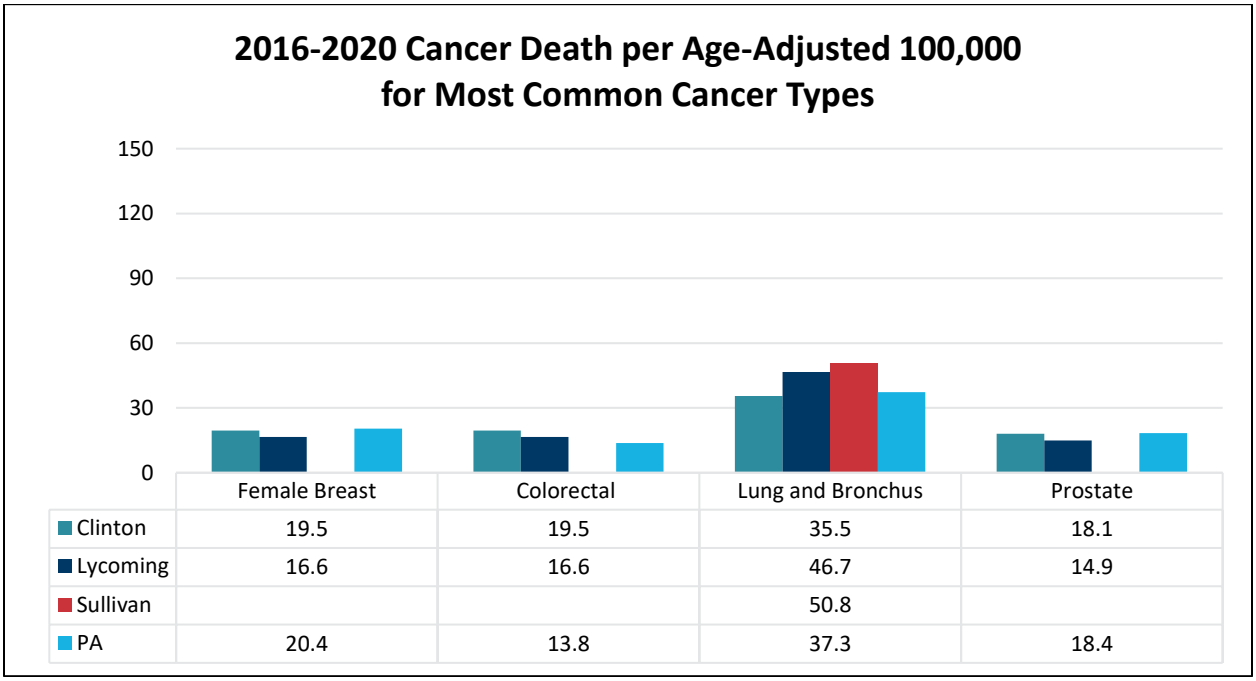


Source: Centers for Disease Control and Prevention
Note: Data for Sullivan County are masked for 2016 and 2020 due to low death counts.



	Female Breast	Colorectal	Lung and Bronchus	Prostate
Clinton	120.2	44.7	55.9	99
Lycoming	127.8	39.9	66.7	84.5
Sullivan	103.5	35.2	57.5	138.4
PA	129	37.8	58.6	104.1

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



	Female Breast	Colorectal	Lung and Bronchus	Prostate
Clinton	19.5	19.5	35.5	18.1
Lycoming	16.6	16.6	46.7	14.9
Sullivan			50.8	
PA	20.4	13.8	37.3	18.4

Source: Pennsylvania Department of Health & Centers for Disease Control and Prevention
Note: Data are provided for Sullivan County as available due to low death counts.

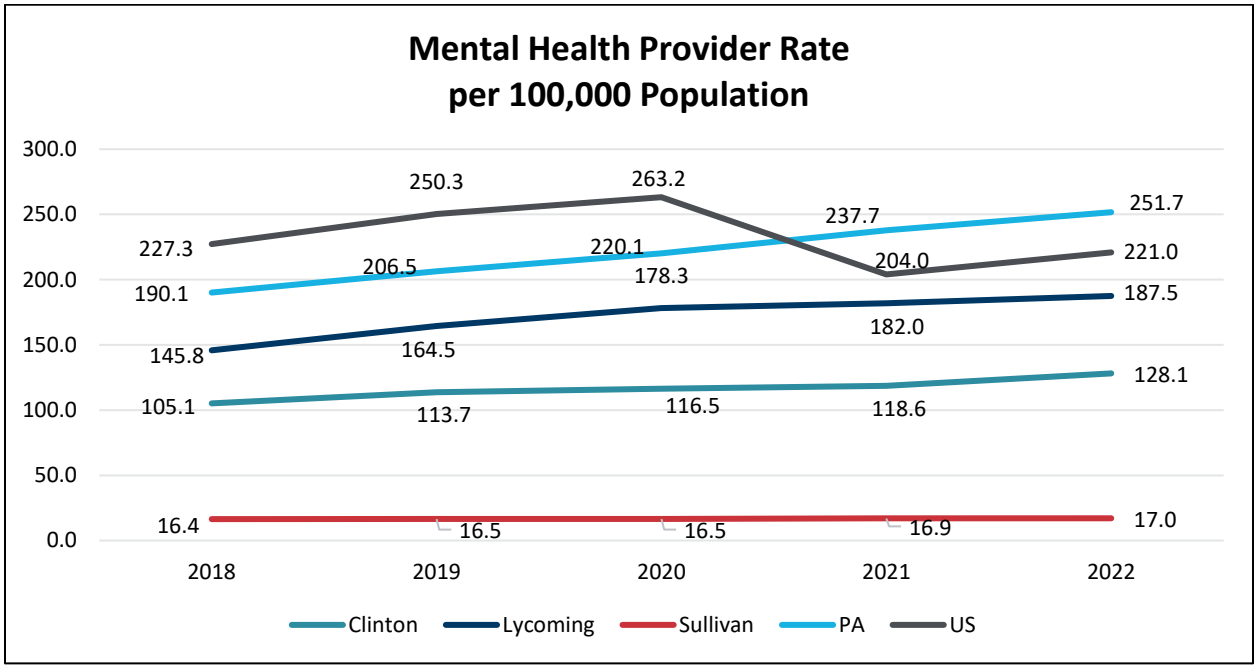
Mental Health and Substance Use Disorder

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

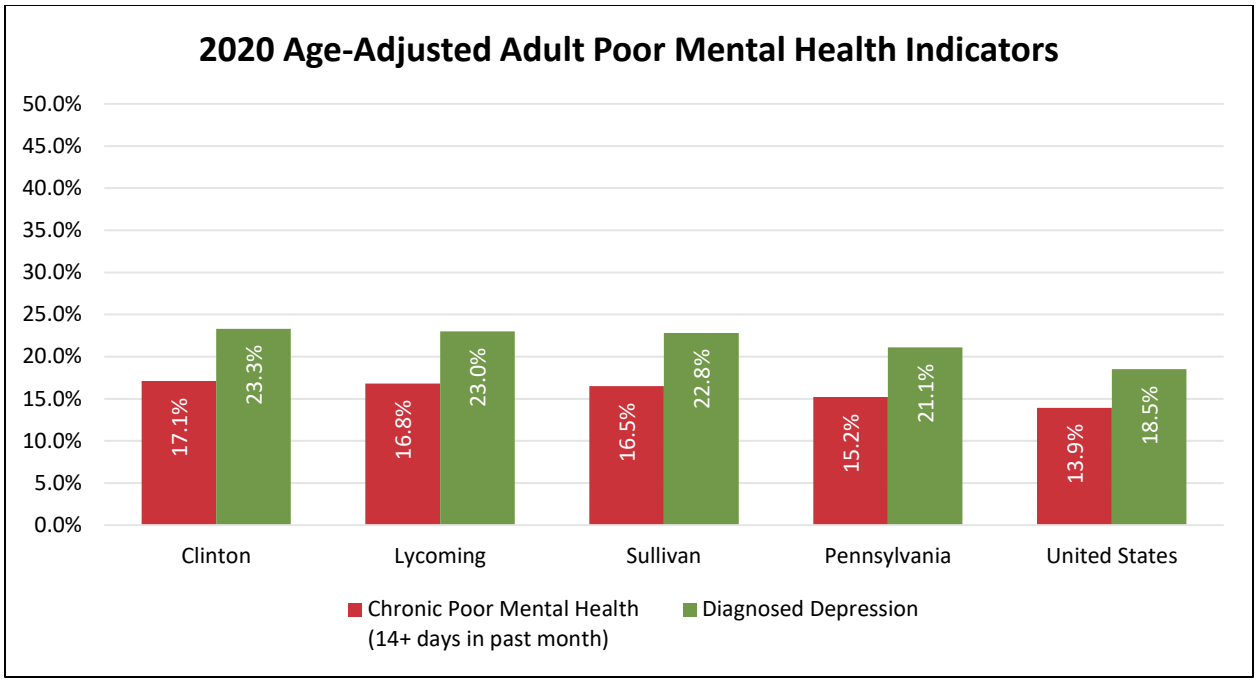
Social service and healthcare agencies are consistently reporting difficulty hiring and retaining mental health providers since COVID-19, an issue that is especially exacerbated in more rural communities. North Central Region counties have fewer mental health providers than the state or nation overall. Clinton and Lycoming counties are mental healthcare HPSAs for all residents; Sullivan County is a HPSA for individuals with low income. Sullivan County is an extreme outlier with only 17 mental health providers per 100,000 population.

At the other end of the spectrum, **the region suffers high rates of death by suicide compared to state and national rates. In Lycoming County, the death rate by suicide is 23% and 27% higher than state and national rates respectively. Additionally, across all counties, more than one in five adults report a diagnosis of depression.** These findings, when considered with underlying social drivers, isolation due to the COVID-19 pandemic and a more rural setting, and limited access to mental healthcare, point to a growing mental health crisis in the region.

When analyzed by zip code, the proportion of adults reporting mental distress is generally consistent across the region, with few areas of notable disparity. Areas of disparity include communities with previously identified health barriers, including poverty and lack of healthcare access (e.g., downtown Williamsport, Montgomery, and Loganton), as well as Lock Haven, which reports the highest proportion of adults with mental distress in the region at nearly 18%.

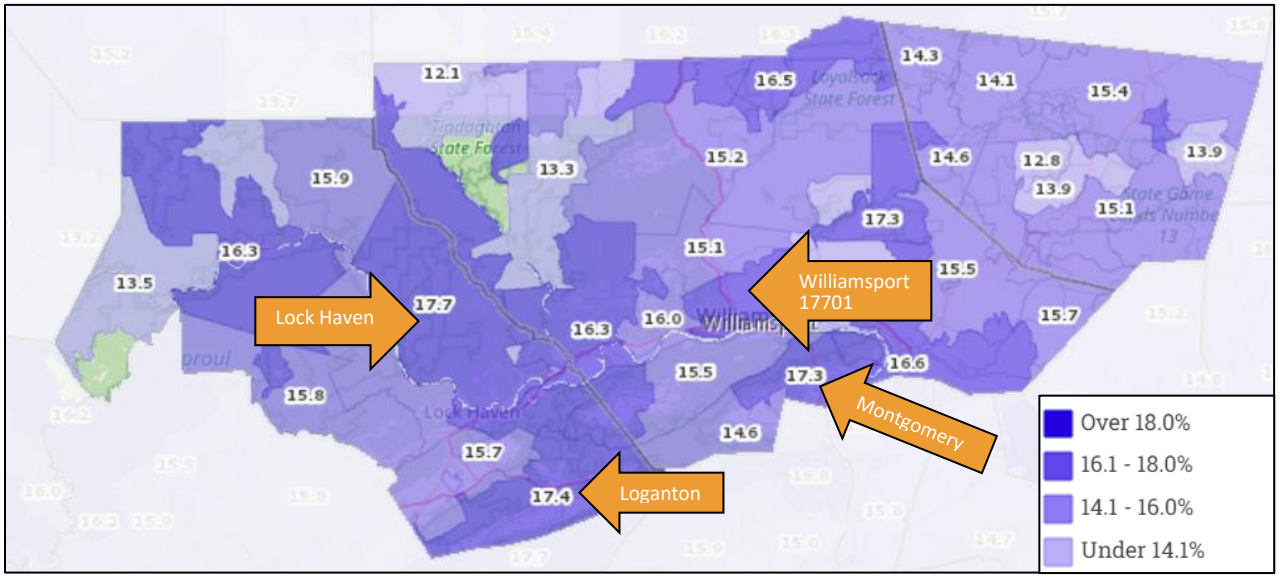


Source: Centers for Medicare and Medicaid Services

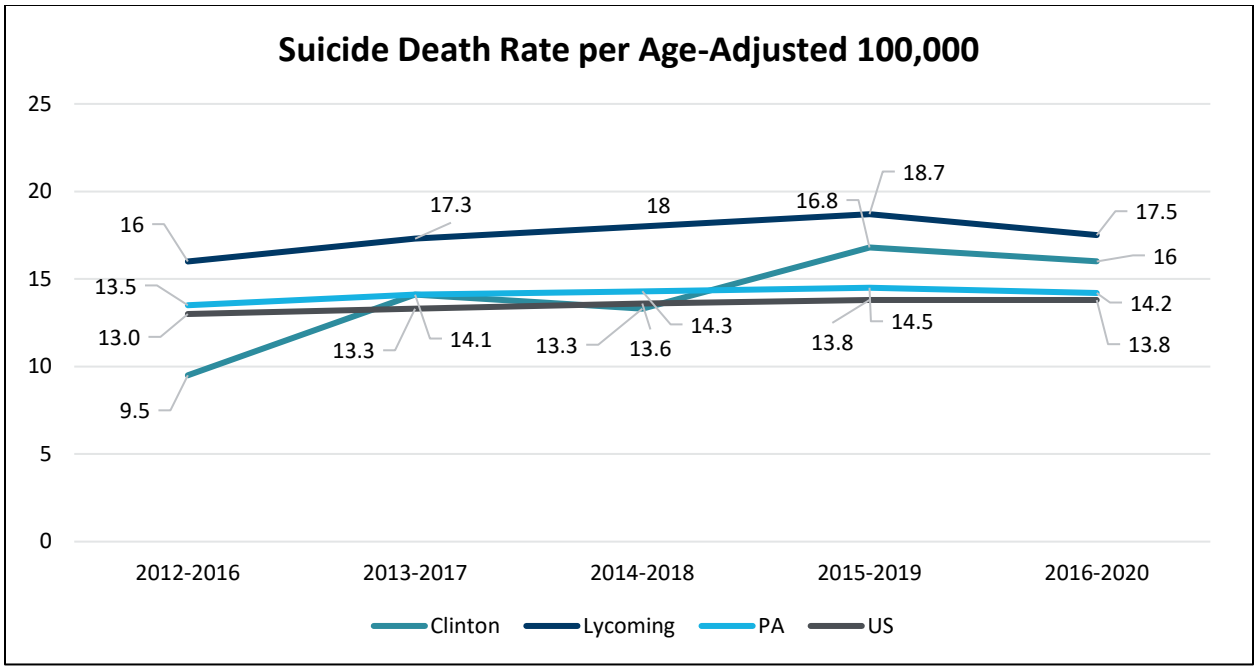


Source: Centers for Disease Control and Prevention

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



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



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

Opioid use disorder remains a more urgent issue in Lycoming County than in other parts of the region, with elevated rates of hospitalization due to opioid use disorder and overdose, and an elevated rate of death in 2020.

A cross-cutting regional concern is alcohol misuse. **Adults across the region report similarly high levels of binge drinking.** Lycoming and Sullivan county residents also experience approximately double the rate of alcohol-related hospitalizations than neighboring Clinton County. In all counties, the rate of alcohol-related hospitalizations outpaces hospitalization rates for other substances.

Alcohol Use Disorder Indicators

	2020 Adults (age-adjusted) Reporting Binge Drinking	2016-2020 Driving Deaths due to Alcohol Impairment
Clinton	20.4%	24.2%
Lycoming	19.5%	30.3%
Sullivan	20.9%	0%
Pennsylvania	18.5%	25.3%
United States	16.7%	27.0%

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

2019 Substance Use Disorder Hospitalizations per 100,000 by Substance

	Alcohol Hospitalization Rate	Opioid Hospitalization Rate	Amphetamine Hospitalization Rate	Cocaine Hospitalization Rate
Clinton	275.5	241.4	NA	NA
Lycoming	413.2	338.8	31.9	64.8
Sullivan	448.4	215.2	NA	NA
Pennsylvania	568.4	293.2	63.7	164.1

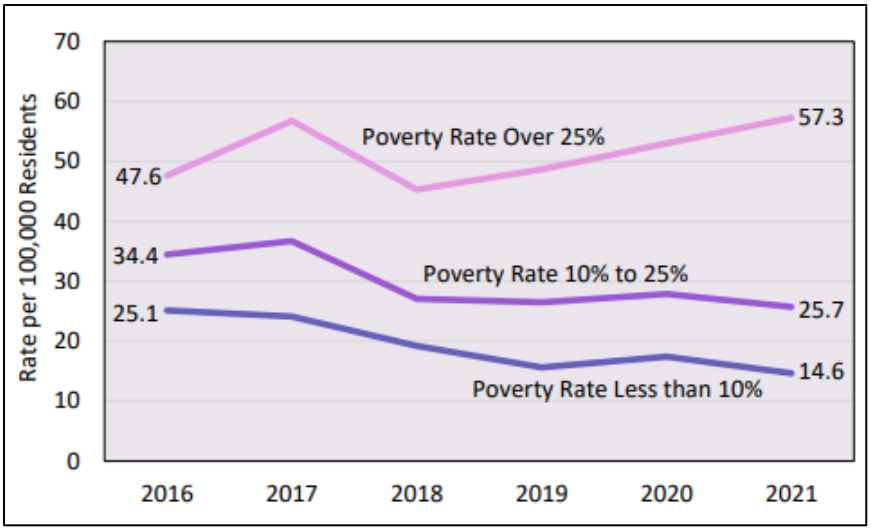
Source: Pennsylvania Health Care Cost Containment Council (PHC4)

Opioid Overdose Hospitalization Rates per 100,000 Residents

	2016	2017	2018	2019	2020	2021
Clinton	NA	NA	NA	NA	31.6	NA
Lycoming	33.6	27.4	23.2	20.1	27.6	26.6
Sullivan	NA	NA	NA	NA	NA	NA
Pennsylvania	31.6	33.0	25.1	23.2	24.8	22.9

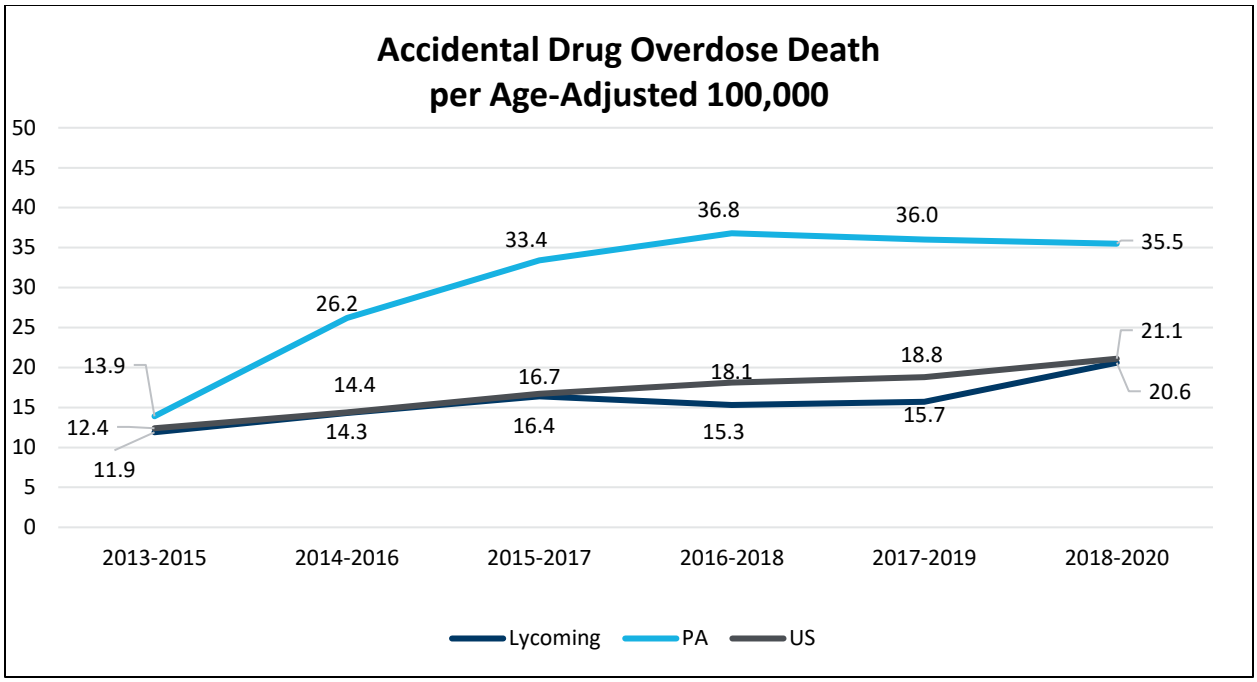
Source: Pennsylvania Health Care Cost Containment Council (PHC4)

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



Source: Pennsylvania Health Care Cost Containment Council (PHC4)

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



Source: Centers for Disease Control and Prevention
Note: Data are not provided for Clinton and Sullivan counties due to low death counts.

COVID-19

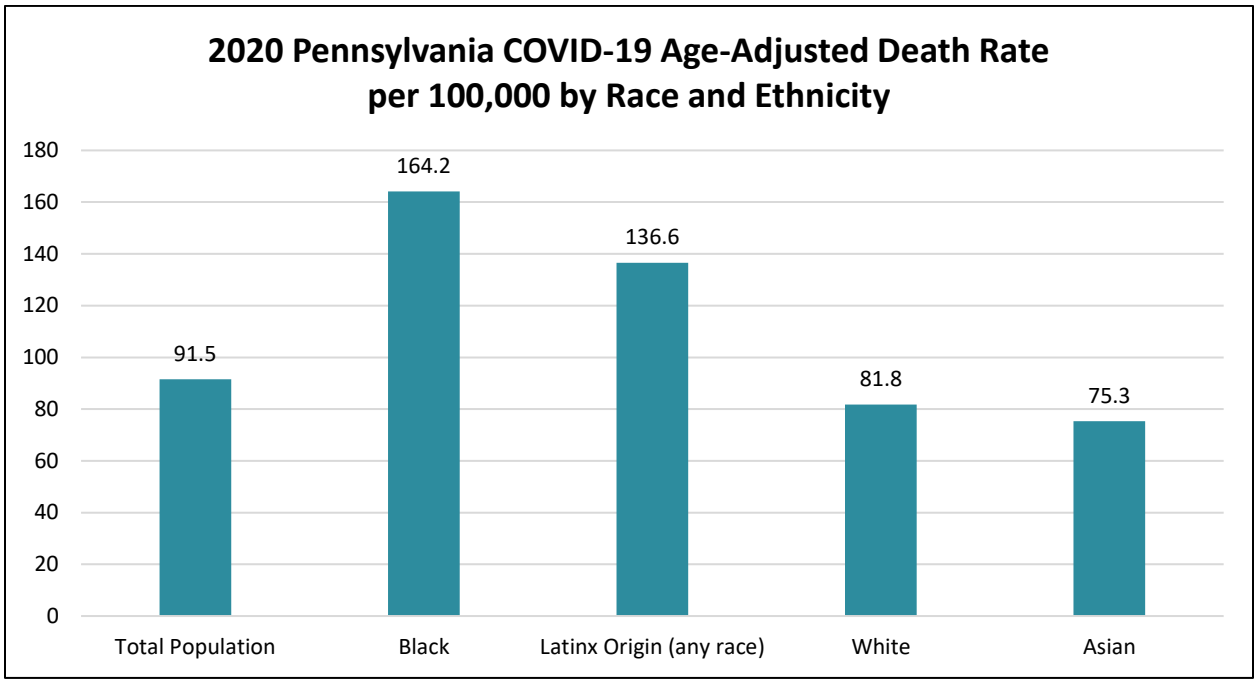
The COVID-19 pandemic both highlighted and deepened socioeconomic and health inequities and exposed disparities within the health and social service systems. The pandemic has not impacted all people equally. Rather, certain structural issues—population density, low income, crowded workplaces, etc.—contribute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

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

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

COVID-19 was the leading cause of death (by death count) for Pennsylvania residents who identified as Latinx and Asian/Pacific Islander in 2020. While COVID-19 was the third leading cause of death for Black residents – who also suffer the highest rates of co-morbid conditions that would exacerbate or be exacerbated by COVID-19 – the death rate for Black residents was the highest of any group, followed by residents who identify as Latinx. **Black and Latinx groups experienced the largest decline (5%) in life**

expectancy due to COVID-19, but Black people have the lowest overall life expectancy at now 71.5 years, 5.5 years below the average for all citizens, and closer to 6 years below any other single group.

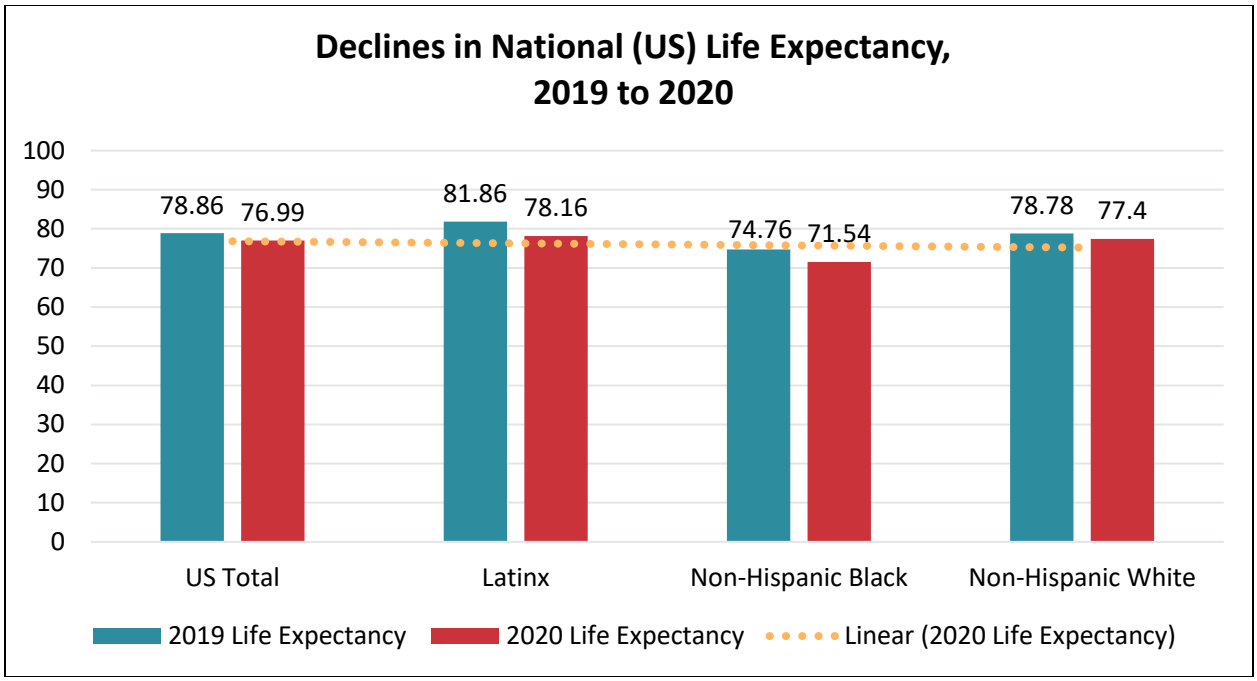


Source: Pennsylvania Department of Health

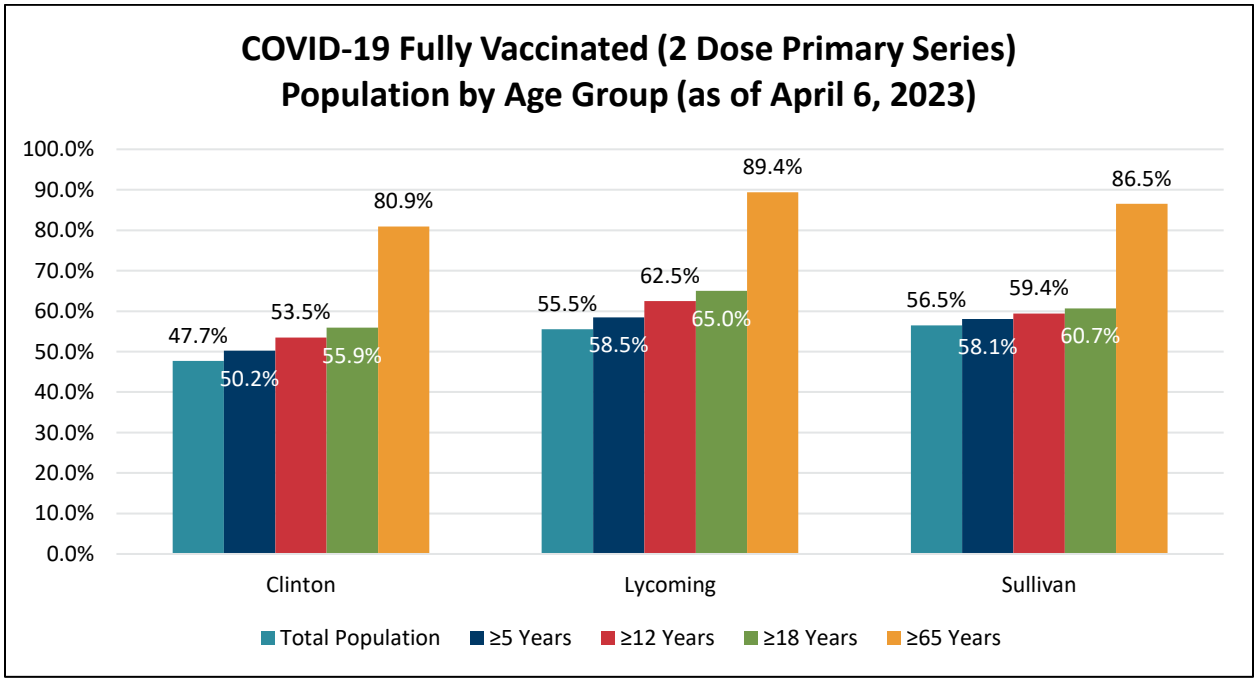
Leading Causes of Death among Pennsylvania Residents by Race and Ethnicity in 2020

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

Source: Pennsylvania Department of Health



Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention

Populations of Special Interest

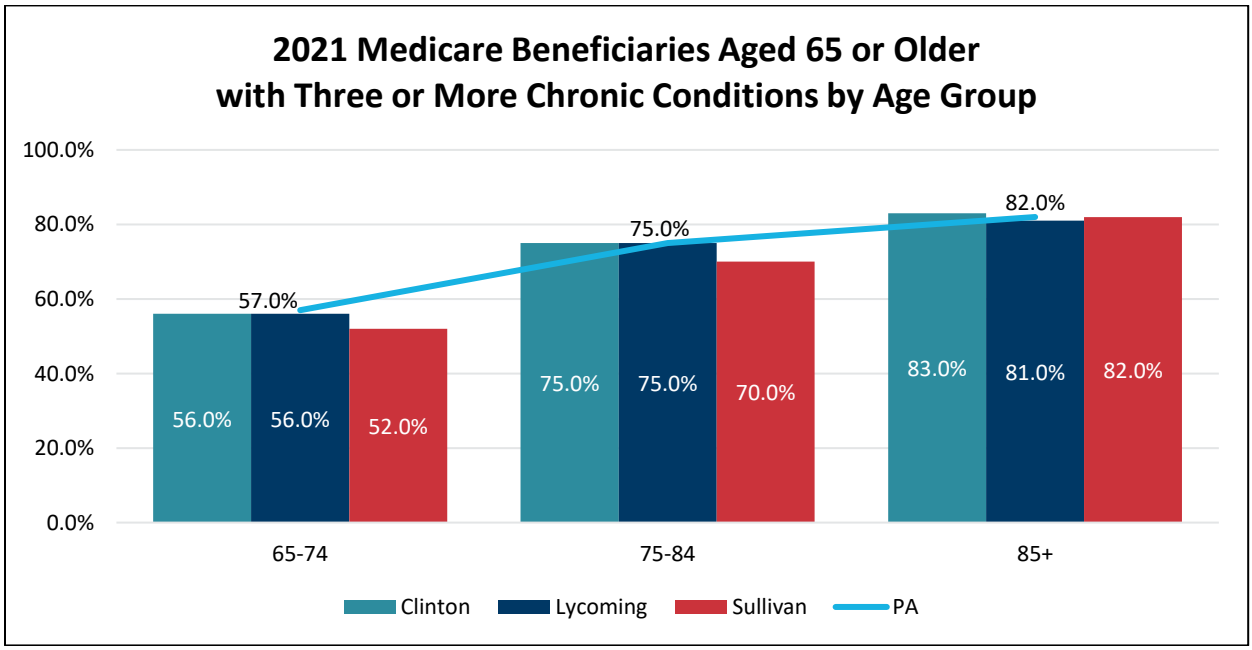
Aging Population

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

Nationally, among Medicare beneficiaries aged 65 years or older, the most common chronic conditions are hypertension, high cholesterol, and arthritis. Those trends persist in the North Central Region, with hypertension and high cholesterol affecting 6 out of 10 Medicare Beneficiaries aged 65+, and rheumatoid arthritis affecting more than one-third.

Healthcare utilization and care costs increase significantly with a higher number of reported chronic diseases, due in part to increased emergency department (ED) visits and hospital readmissions. **Across the region in 2021, between 52% (in Sullivan County) and 56% (in Clinton and Lycoming counties) of Medicare beneficiaries aged 65-74 reported three or more chronic conditions. Disease prevalence increased to between 81% and 83% at age 85+.**

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



Source: Centers for Medicare & Medicaid Services

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

	Clinton	Lycoming	Sullivan	PA	US
Alzheimer's disease, related disorders, senile dementia	2%	2%	2%	2%	2%
Cancer (breast, lung, colorectal, prostate)	9%	9%	9%	10%	9%
Depression	17%	17%	15%	16%	15%
Diabetes	25%	23%	24%	24%	24%
High cholesterol	63%	66%	59%	65%	58%
Hypertension	61%	61%	62%	60%	59%
Obesity	25%	20%	15%	27%	21%
Rheumatoid arthritis	32%	33%	30%	31%	30%

Source: Centers for Medicare & Medicaid Services

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

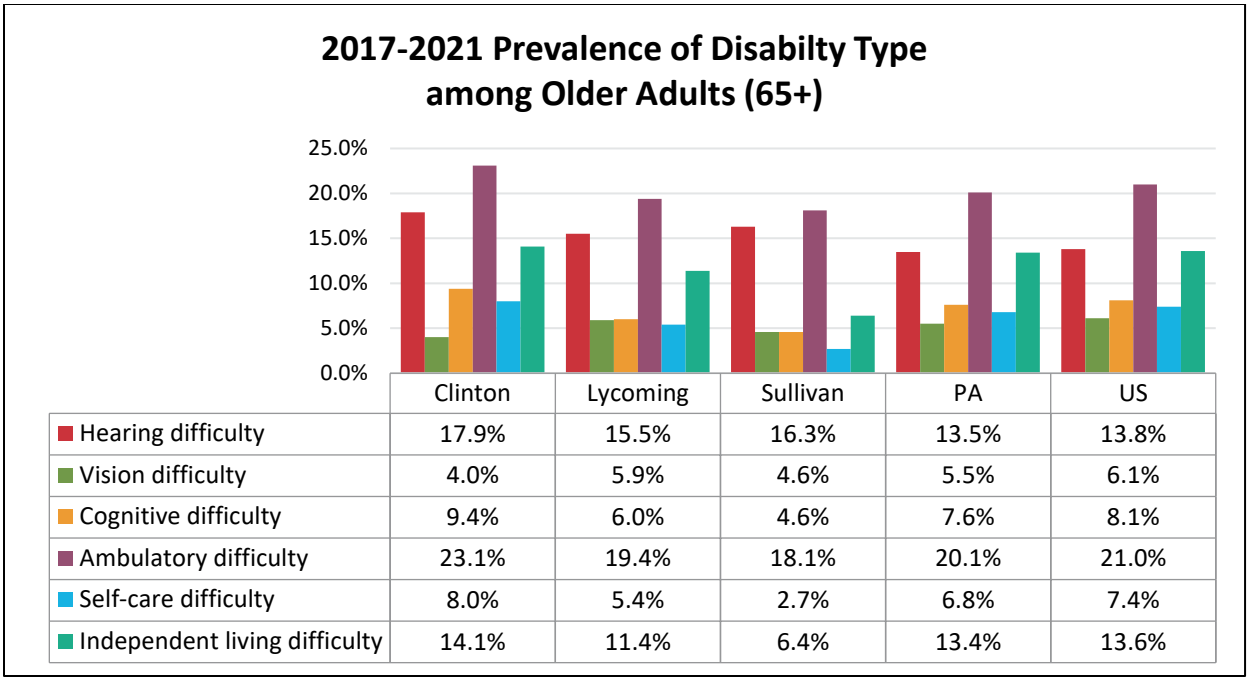
	Clinton	Lycoming	Sullivan	PA	US
Alzheimer's disease, related disorders, senile dementia	10%	9%	10%	9%	9%
Cancer (breast, lung, colorectal, prostate)	16%	15%	13%	15%	14%
Depression	19%	21%	19%	18%	17%
Diabetes	31%	31%	30%	30%	29%
High cholesterol	75%	76%	72%	76%	72%
Hypertension	78%	78%	76%	78%	75%
Obesity	21%	18%	17%	25%	19%
Rheumatoid arthritis	42%	41%	36%	41%	39%

Source: Centers for Medicare & Medicaid Services

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

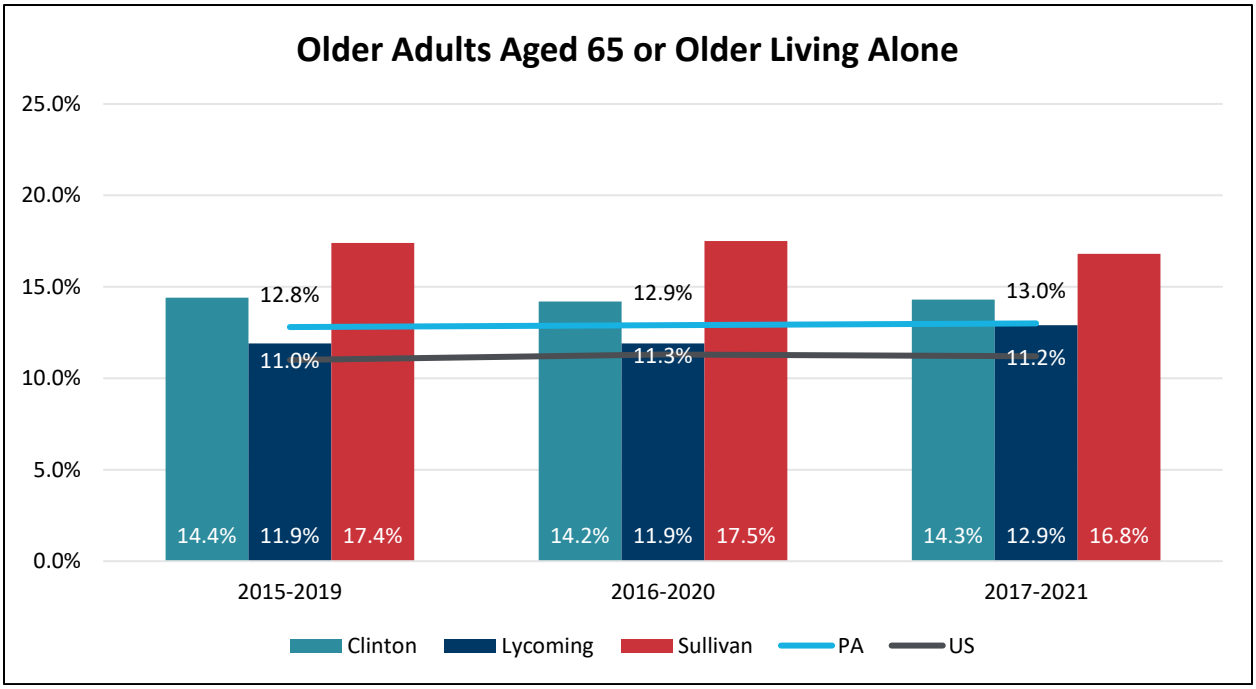
	Clinton	Lycoming	Sullivan	PA	US
Alzheimer's disease, related disorders, senile dementia	25%	26%	24%	26%	25%
Cancer (breast, lung, colorectal, prostate)	14%	15%	16%	15%	14%
Depression	23%	24%	22%	23%	21%
Diabetes	28%	27%	27%	27%	27%
High cholesterol	70%	70%	68%	71%	67%
Hypertension	85%	84%	84%	85%	83%
Obesity	13%	10%	11%	14%	11%
Rheumatoid arthritis	48%	46%	45%	48%	45%

Source: Centers for Medicare & Medicaid Services



	Clinton	Lycoming	Sullivan	PA	US
Hearing difficulty	17.9%	15.5%	16.3%	13.5%	13.8%
Vision difficulty	4.0%	5.9%	4.6%	5.5%	6.1%
Cognitive difficulty	9.4%	6.0%	4.6%	7.6%	8.1%
Ambulatory difficulty	23.1%	19.4%	18.1%	20.1%	21.0%
Self-care difficulty	8.0%	5.4%	2.7%	6.8%	7.4%
Independent living difficulty	14.1%	11.4%	6.4%	13.4%	13.6%

Source: US Census Bureau, American Community Survey



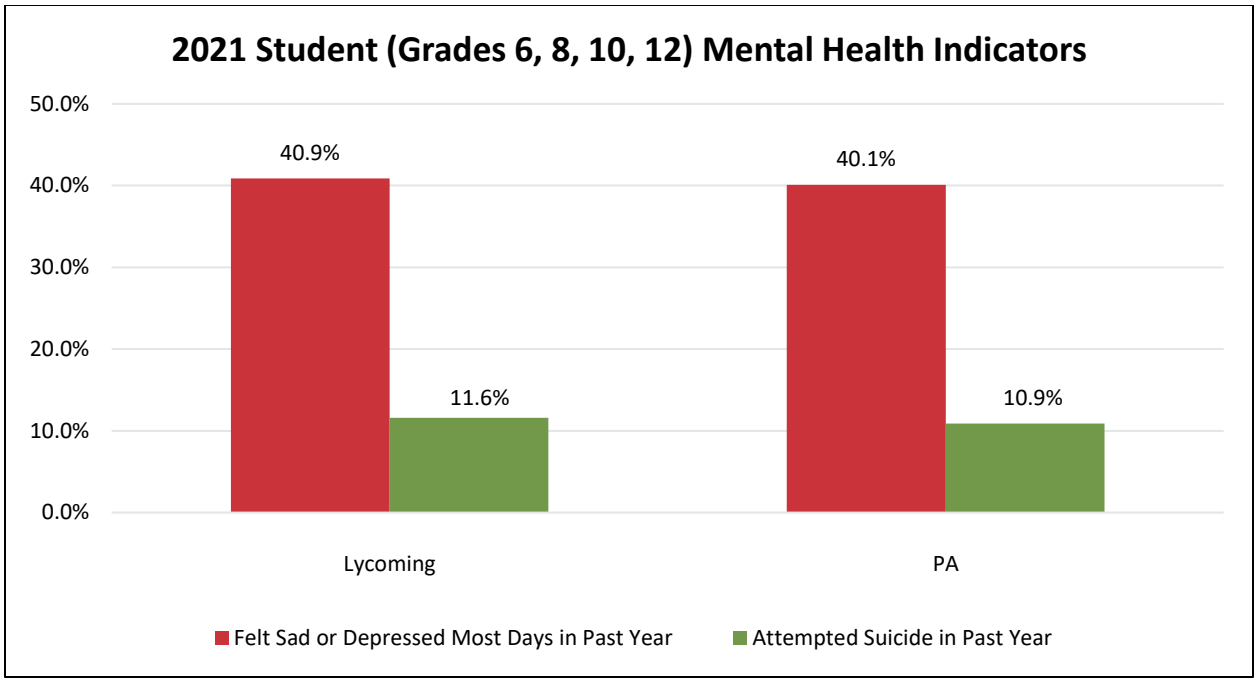
Source: US Census Bureau, American Community Survey

Youth

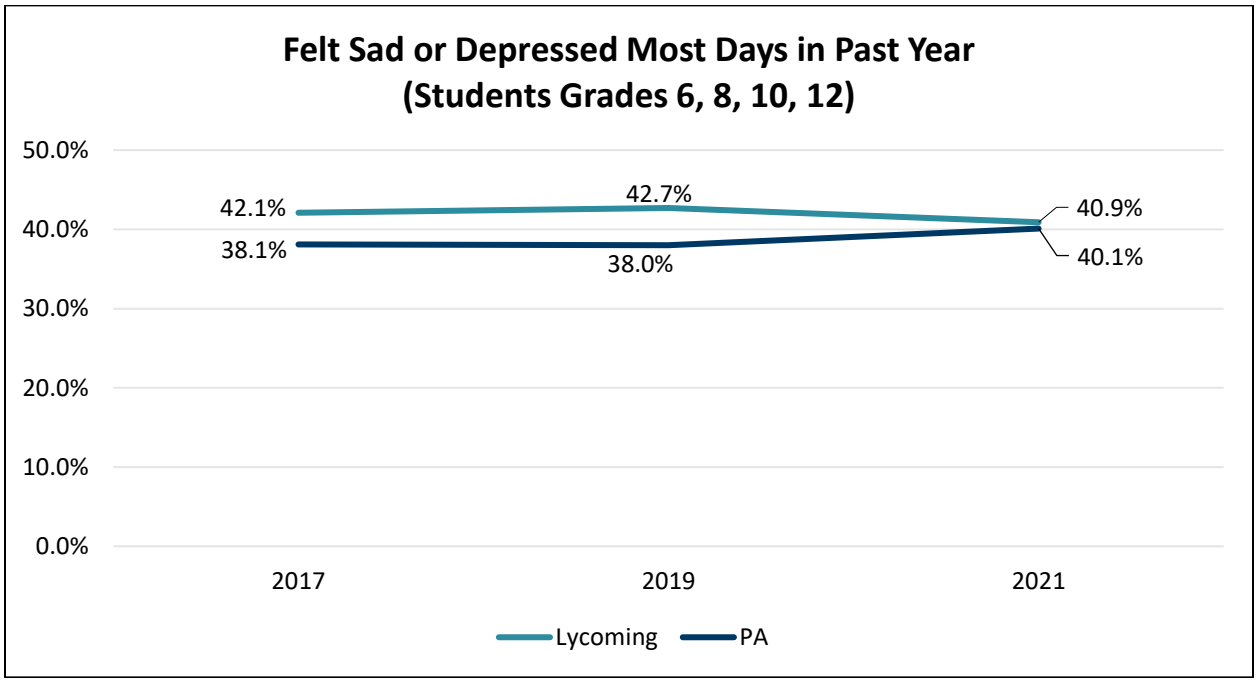
The COVID-19 pandemic has made unprecedented changes to the lives and experiences of young people worldwide. These concerns represent Adverse Childhood Experiences (ACEs), defined as traumatic or stressful events that occur before the age of 18. ACEs can have lifelong impacts on economic, educational,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

Mental and behavioral health disorders can be both the result of and the cause of ACEs. Related student data are limited to Lycoming County in the North Central Region. Within Lycoming County, and across Pennsylvania, students are showing a steady decline in substance use of all kinds, although prevalence of e-cigarette use remains higher in Lycoming County than neighboring geographies. **The decline in substance use is an especially helpful measure given the ongoing rise in mental health concerns.** Mental health challenges among youth were proportionately high prior to the COVID-19 pandemic and are higher still in recent years.

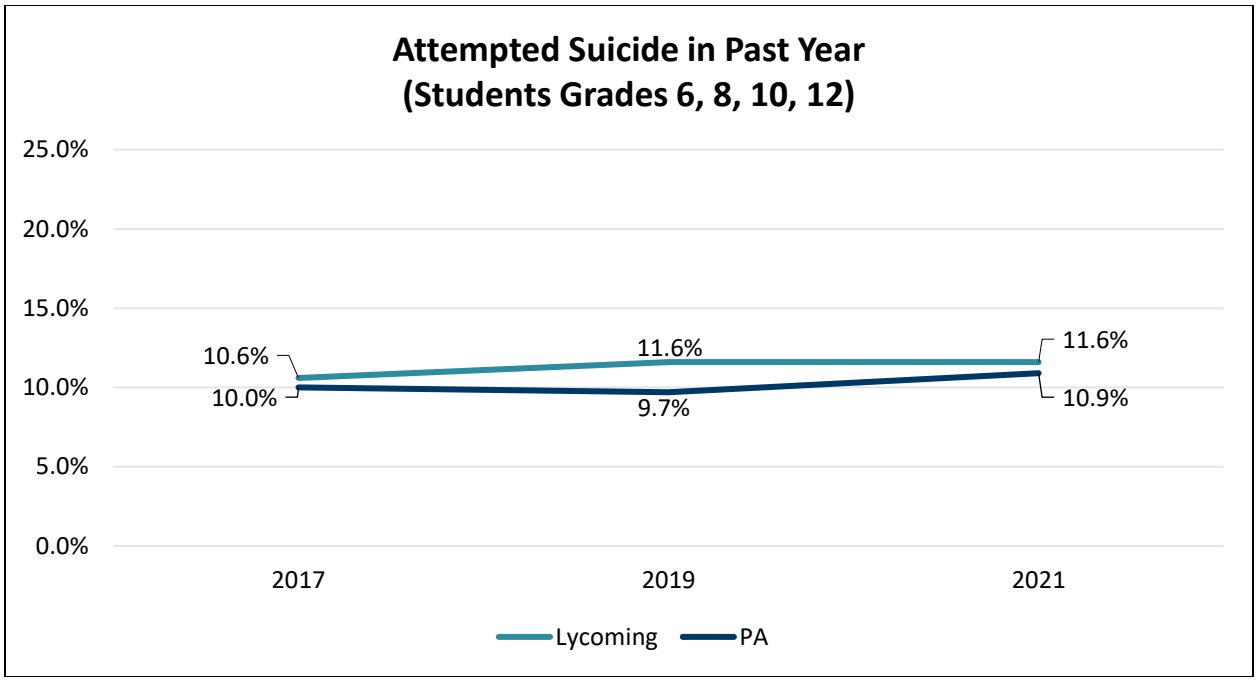
Schools, as they have finally re-opened to "normal" capacity in the last year are feeling the impact of these numbers in tangible ways. **Young people are struggling. In particular, fewer than half of students in Lycoming County "feel that school is going to be important for their later life."** Despite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



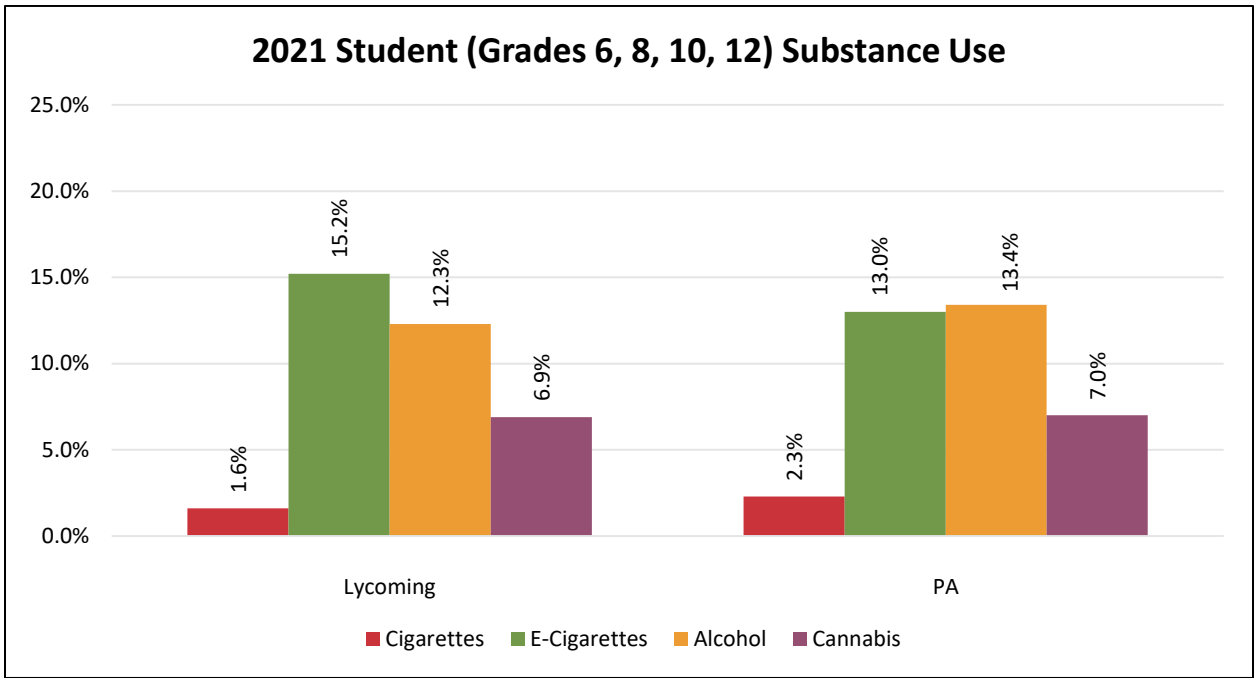
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Clinton and Sullivan counties.



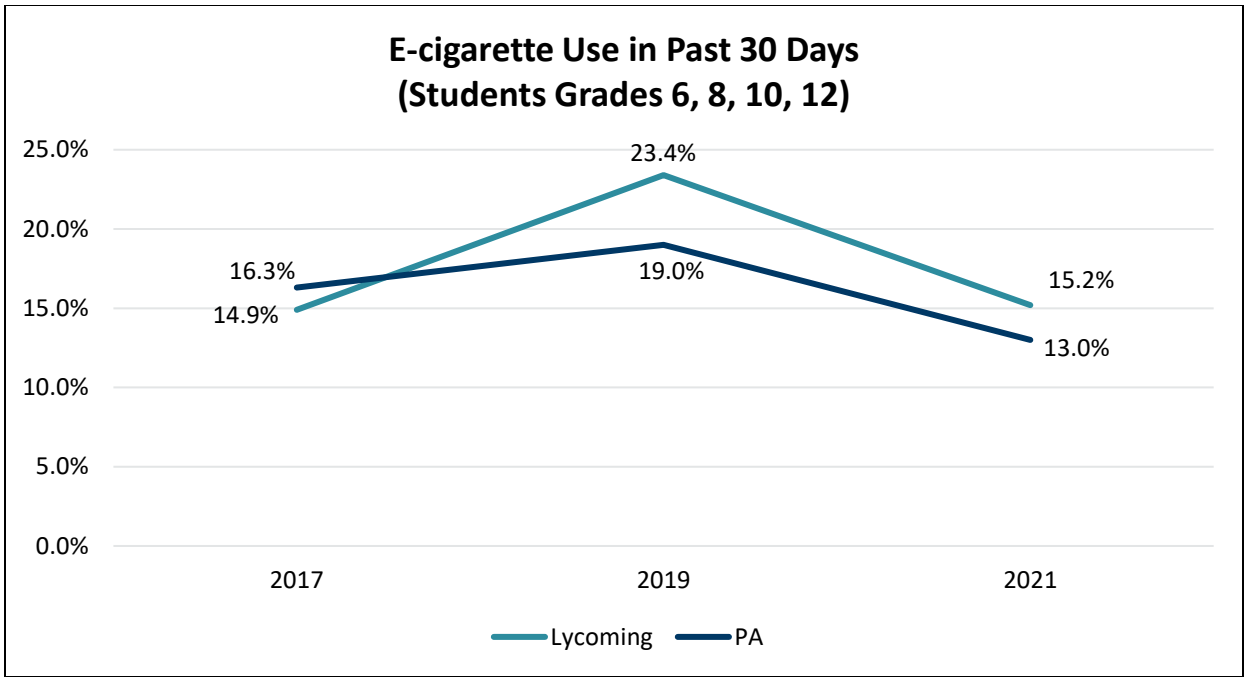
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Clinton and Sullivan counties.



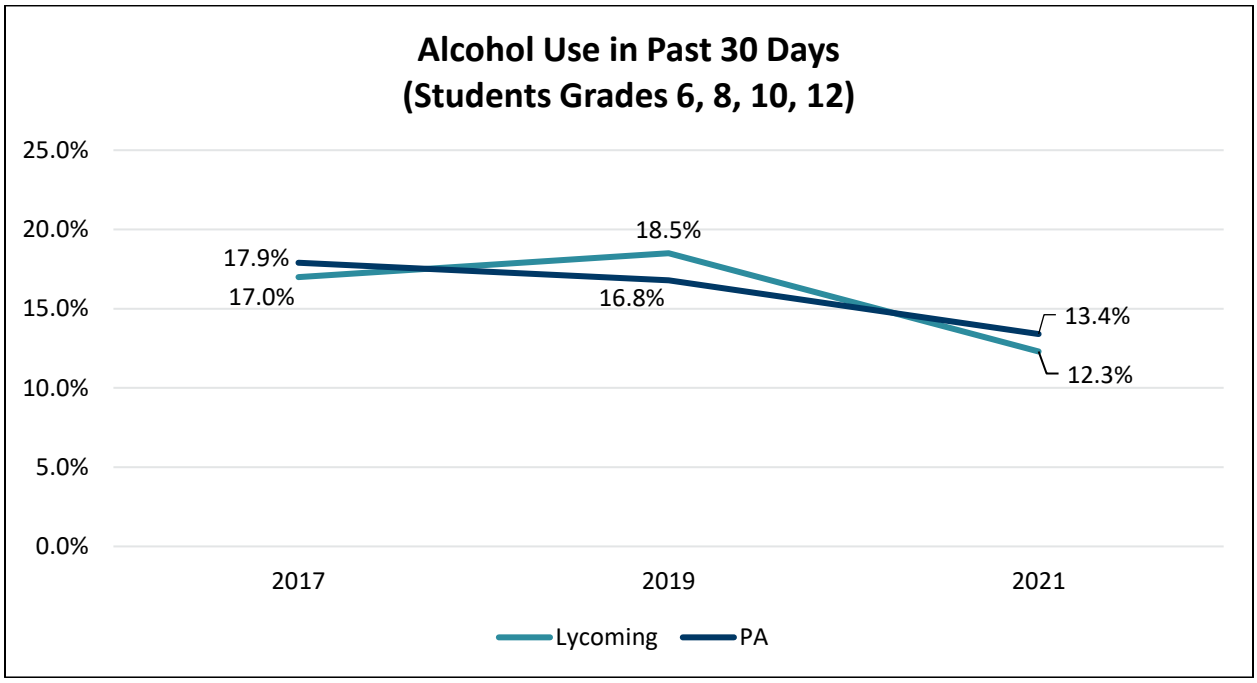
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Clinton and Sullivan counties.



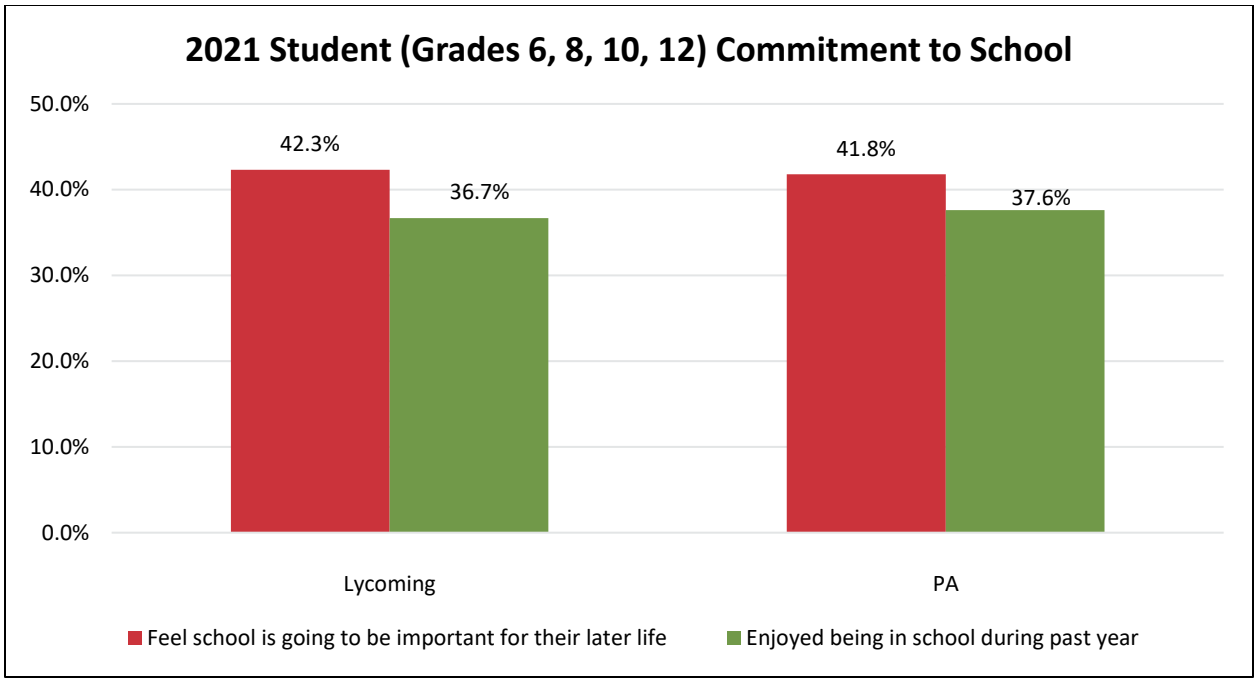
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Clinton and Sullivan counties.



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



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



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

LGBTQIA+

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

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

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

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

General Health

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

Healthcare

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

Discrimination

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

Basic Needs

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

Mental Health & Substance Use Disorder

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

Sexual Health

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

Pregnancy, Birth, and Babies

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

Across the region, there is an opportunity for improvement in pregnancy outcomes, notably around prenatal care access and smoking during pregnancy. No county meets the national benchmark or Healthy People 2030 (HP2030) goal for first trimester prenatal care access. **Smoking prevalence among adults in the region is higher than across the rest of the state and the nation, a trend that continues among pregnant people. Across the region, between 13% and 16% of people reportedly continued to smoke during pregnancy, compared to 9% across the state and only 5% nationwide.**

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

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

	All Births		White Birth %	Black/African American Birth %	Latinx (any race) Birth %
	Count	Birth Rate per 1,000			
Clinton	411	21.8	95.6%	1.2%	1.2%
Lycoming	1,172	20.3	84.6%	7.8%	2.9%
Sullivan	46	16.4	95.7%	2.2%	2.2%
Pennsylvania	130,730	19.9	69.4%	14.2%	12.8%
United States	3,613,647	11.0	51.0%	14.7%	24.0%

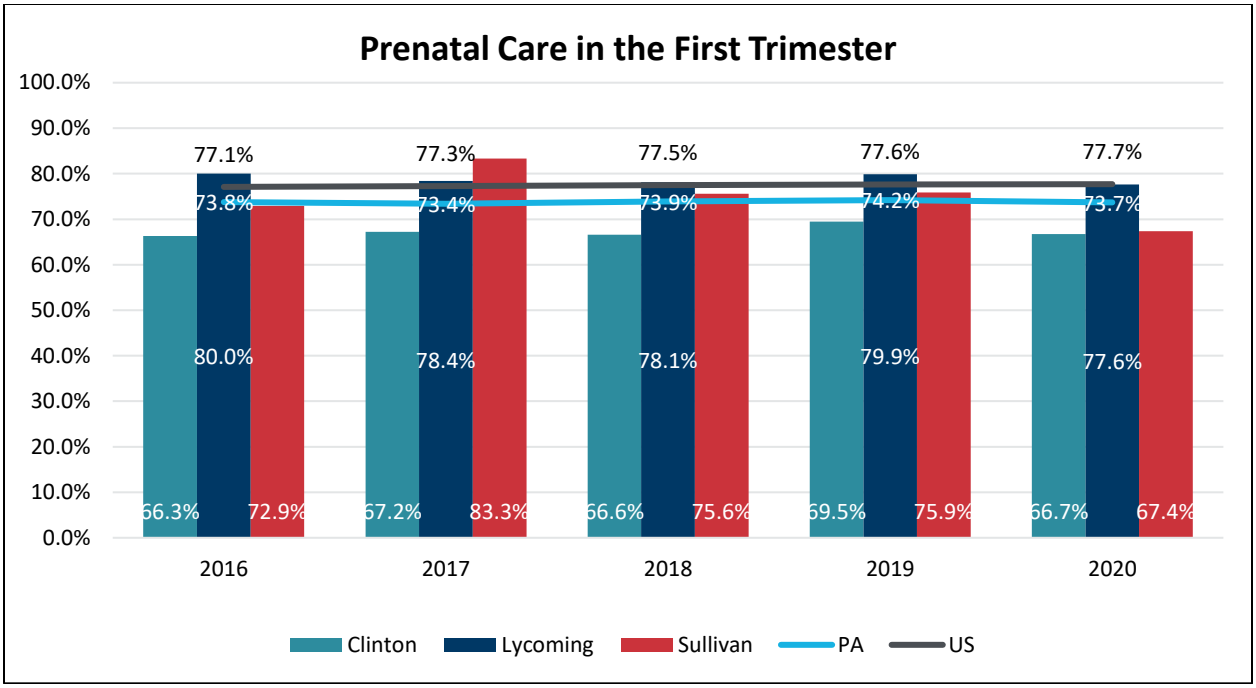
Source: Pennsylvania Department of Health & Centers for Disease Control and Prevention

2020 Maternal and Infant Health Indicators

Opportunities for improvement based on HP2030 goals are highlighted

	Teen (15-19) Births	First Trimester Prenatal Care	Premature Births	Low Birth Weight Births	Non-Smoking during Pregnancy
Clinton	3.9%	66.7%	7.3%	7.1%	85.6%
Lycoming	4..9%	77.6%	9.7%	7.9%	83.8%
Sullivan	NA	67.4%	NA	NA	87.0%
Pennsylvania	3.7%	73.7%	9.6%	8.3%	91.3%
Black/African American	6.8%	64.8%	14.0%	14.5%	93.1%
White	2.6%	77.2%	8.6%	6.8%	90.1%
Latinx (any race)	8.5%	65.3%	10.2%	8.5%	95.5%
United States	4.4%	77.7%	10.0%	8.2%	94.5%
Black/African American	6.4%	68.4%	14.3%	14.1%	95.5%
White	3.0%	82.8%	9.1%	6.8%	91.9%
Latinx (any race)	6.8%	72.3%	9.8%	7.4%	98.6%
HP2030 Goal	NA	80.5%	9.4%	NA	95.7%

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



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

2016-2020 Infant Death per 1,000 Live Births

	Infant Deaths
Clinton	5.4 (n=11)
Lycoming	7.2 (n=43)
Sullivan	NA
Pennsylvania	5.9 (n=4,012)
Black/African American	13.0
White	4.6
Latinx (any race)	6.5
HP2030 Goal	5.0

Source: Pennsylvania Department of Health

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

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

Source: Pennsylvania Department of Health

Key Stakeholder Survey

Background

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

A total of 86 individuals representing the North Central Region responded to the survey. A list of the represented community organizations and the participants' respective titles is included in Appendix B.

Many of the stakeholders' organizations served residents of more than one Pennsylvania county, and a few organizations provided statewide, or even nationwide, services. In total, stakeholder organizations served more than 40 Pennsylvania counties. More than 80% of respondents worked with organizations serving Lycoming County within the North Central Region. Most considered their services to be open to all populations, regardless of age, race, religion, health needs, or income. Beyond that, the populations most served were children (age 0-11 years) and older adults/seniors.

Populations Served by Key Stakeholder Survey Participants

	Number of Participants	Percent of Total
No specific focus-serve all populations	56	65.1%
Children (age 0-11)	13	15.1%
Older adults/Seniors	12	14.0%
People or families with low income or in poverty	11	12.8%
People with behavioral health concerns	11	12.8%
Young adults (age 19-24)	11	12.8%
Adolescents	10	11.6%
Other	8	9.3%
People with disabilities (physical, intellectual, developmental, etc.)	8	9.3%
LGBTQ+ community	6	7.0%
People of families experiencing homelessness	5	5.8%
People or families without health insurance or underinsured	4	4.7%
Pregnant or postpartum people	4	4.7%
African American/Black	3	3.5%
Veterans	3	3.5%
Undocumented citizens	2	2.3%
American Indian/Alaska Native	1	1.2%
Asian/South Asian	1	1.2%
Hispanic/Latinx	1	1.2%
New Americans/Immigrants/Refugees	1	1.2%
Pacific Islander/Native Hawaiian	1	1.2%
People with memory care (Alzheimer's disease, dementia) concerns	1	1.2%

Survey Findings

Health and Quality of Life

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

While most stakeholders described the overall quality of life of the people they serve as average (53%), about one in six respondents described the quality of life as "above average" or "excellent," and all stakeholders identified numerous strengths within the community. These strengths, listed below, can be drawn upon to improve the quality of life for all people in the North Central Region.

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

	Number of Participants	Percent of Total
Access to healthcare services	31	39.2%
Safe neighborhoods	27	34.1%
Good schools	24	30.4%
Community connectedness	16	20.3%
Available social services	14	17.7%
Clean environment	14	17.7%
Strong family life	13	16.5%
Resources for seniors	10	12.7%
Walkable, bike friendly communities	10	12.7%
Access to crisis support services (e.g., Neighborly, United Way 211, 988 National Suicide Hotline)	9	11.4%

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

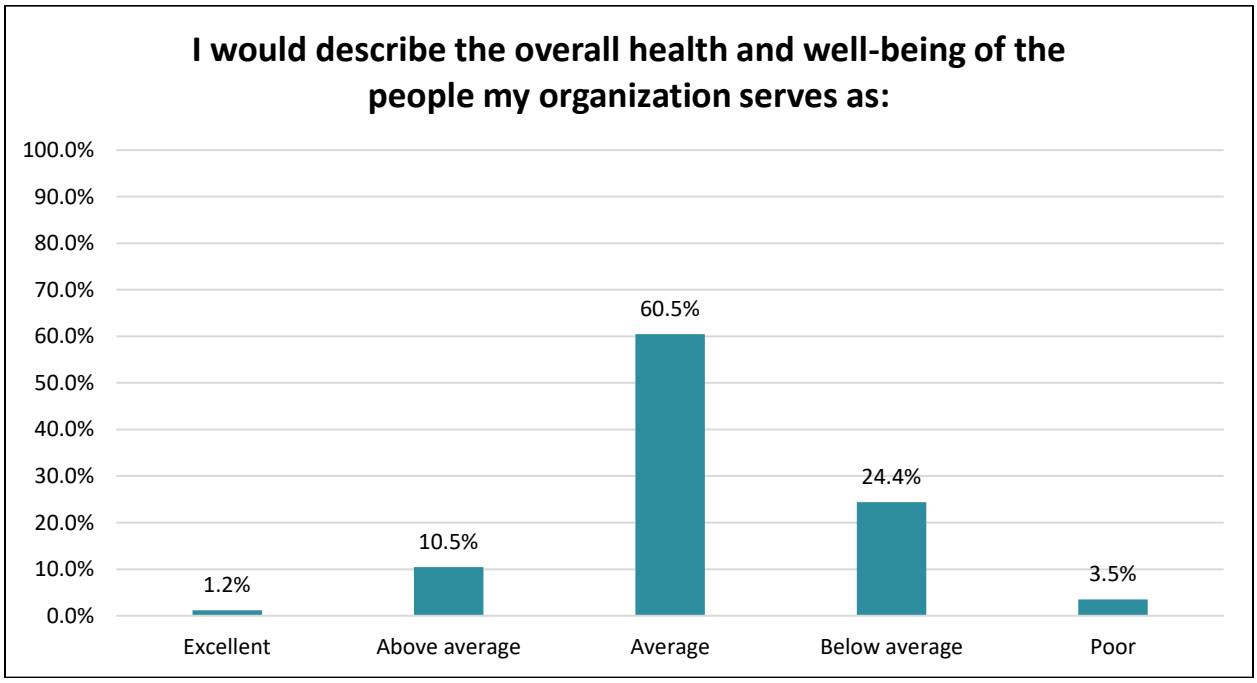
Additionally, stakeholders identified feelings of safety within the community, both from violence and within interpersonal relationships, community connectedness and cleanliness, as well as *some* opportunities for social mobility (e.g., good schools and available stop-gap resources for those who fall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

Thinking about the people their organization serves, key stakeholders were asked to describe the overall health and well-being of individuals and the most pressing concerns affecting them. Approximately 60% of stakeholders described overall health and well-being as "average" and 28% described it as "below average" or "poor," indicating opportunity for health improvement.

When asked to identify the top five most pressing concerns affecting the people their organization serves, an overwhelming 58% of respondents selected mental health conditions. One-third or more of respondents identified lack of transportation, childcare (affordable, quality), ability to afford healthcare, and substance use disorder as top five concerns among constituents.

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

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



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

	Number of Participants	Percent of Total
Mental health conditions	46	58.2%
Lack of transportation	30	38.0%
Childcare (affordable, quality)	27	34.2%
Ability to afford healthcare	26	32.9%
Substance use disorder (dependence/misuse of alcohol, opiates, heroin, etc.)	26	32.9%
Ability to afford health foods	24	30.4%
Economic stability (employment, poverty, cost of living)	21	26.6%
Housing (affordable, quality)	21	26.6%
Overweight/Obesity	17	21.5%
Stress (work, family, school, etc.)	16	20.3%
Older adult health concerns	15	19.0%
Limited healthcare capacity (appointments, convenient time/location, etc.)	12	15.2%
Limited healthcare providers	12	15.2%
Health literacy (ability to understand health information)	11	13.9%
Availability of parks and recreation	7	8.9%

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

- *"Ask those in the LGBTQ community for input and suggestions as to what is helpful for education in a particular time and place, since different strategies may be appropriate to different situations. Need to educate without causing backlash which may make situations worse."*
- *"Provide more transportation options and in home care post procedures/surgery for those living alone."*
- *"Lack of daycares, both affordability and access would help young mothers get back in to the workforce."*
- *"Dental and vision insurance/access seem to be lacking in our region, as they are generally not included in healthcare plans. Mobile clinics, which Geisinger and Evan already have, would be helpful in rural communities especially for Seniors. Childcare services can always be improved – within employers and healthcare systems."*
- *"Invest in projects that make wellness opportunities (fitness classes, cardiac rehab, nutritional counseling, physical therapy, etc.) available to the entire Sullivan County population and not just to those who are able to allocate the money and time to travel outside our county to address the social determinants of health and change the health paradigm for people of all ages."*

- *"Work together through collaboration in an effort to establish a centralized closed loop referral system to meet community needs."*
- *"COVID pandemic disruptions in education has significantly set our youth back. Exposing them to opportunities in the healthcare field could help connect what they are learning in school with a successful future which has been proven to influence behavior and help them make good choices if they have hope for what their lives may look like after high school."*
- *"I think the payment methodology for physical and behavioral health services in unfair for rural areas. The 'rate per unit' model benefits areas where there is a larger number of service recipients in a smaller geographic area accessing the services and therefore allowing the provider to generate enough income to cover costs and attract employees. But in a rural area, where the population is lower and more dispersed, this method leaves providers scrambling to cover costs and ultimately leads to fewer providers and services. There needs to be an alternative methodology for rural areas the allows for a 'program funded' model that is not dependent on the number of individuals served and recognizes the difficulties of limited transportation and the realities that many provider costs are fixed regardless of whether they are in an urban or rural area."*
- *"Recognize, train and hire individuals in community health worker roles in both healthcare and social service settings. Individuals in these positions can connect and serve individuals and communities to resources and services that promote a healthier lifestyle/setting/community."*
- *"Need more mental health inpatient facilities and programs."*
- *"Focus on pediatric health care so we can attract young families to our area. EconDev is working on affordable housing and investments in the community – but we need more access to healthcare."*
- *"When foster children are moved from place to place, make sure meds and information goes with them."*
- *"Attract more social workers and mental health professionals to the area with better wages, build more high-quality affordable housing, pay a living wage, intervene more/better with youth/mental health at an earlier age, work w school systems to support families."*

Social Drivers of Health

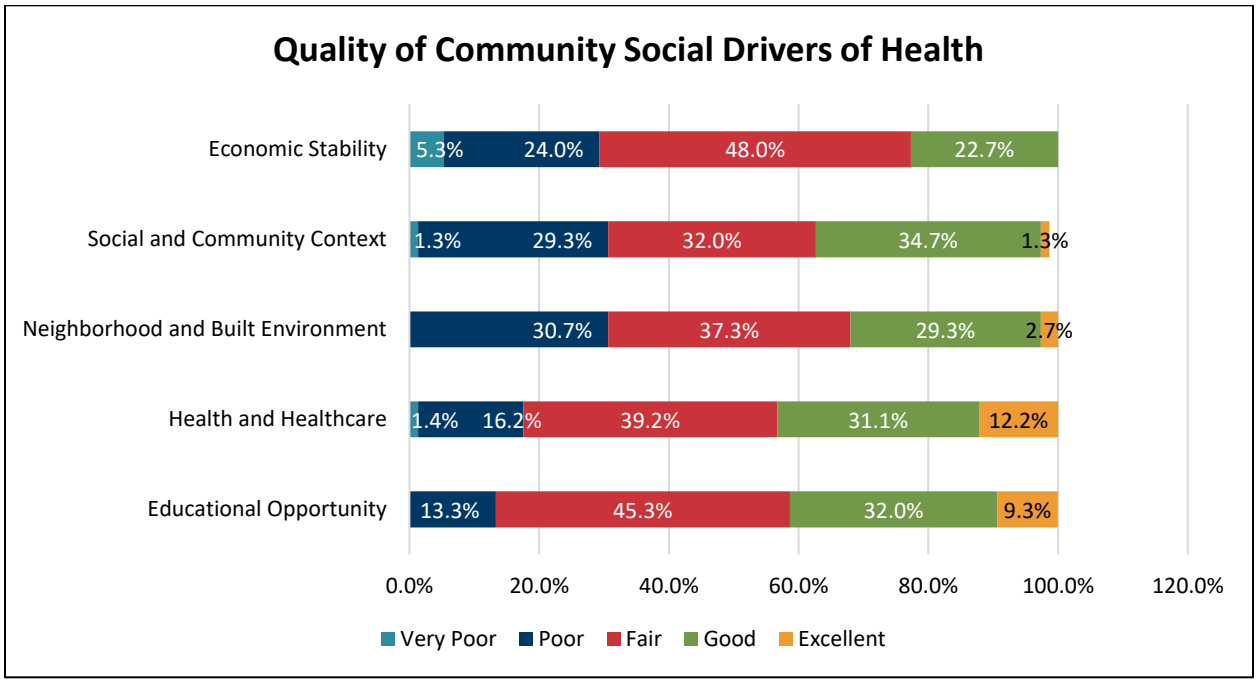
Key stakeholders were asked to rate the quality of the social drivers of health (SDoH) within the community(ies) their organization serves, focusing on the five key domains identified by Healthy People 2030: economic stability, education access and quality, healthcare access and quality, neighborhood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

The mean score for each SDoH domain is listed in the table below in rank order, followed by a graph showing the scoring frequency. Educational opportunity was seen as the strongest community SDoH with 41% of stakeholders rating it as "good" or "excellent." Economic stability was seen as the weakest SDoH with 48% rating it as "fair" and 29% rating it as "poor" or "very poor;" it was the only measure that did not receive a single "excellent" rating.

Approximately 55% (n= 42) of stakeholders stated that their organization currently screens the people their organization serves for needs related to SDoH.

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

	Mean Score
Educational Opportunity (Consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)	3.37
Health and Healthcare (Consider access to healthcare, access to primary care, health literacy)	3.36
Social and Community Context (Consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	3.05
Neighborhood and Built Environment (Consider access to healthy foods, quality of housing, crime and violence, environmental conditions, transportation)	3.04
Economic Stability (Consider poverty, employment, food security, housing stability)	2.88



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

- *"Hard to retain workforce and pay a living wage. Limited healthcare workforce pipeline. Many rural areas face critical issues with transportation, health care access, healthy food, childcare, etc."*
- *"There are waiting list for public housing and the housing available is limited and rent is very high for seniors and people with physical disabilities."*
- *"There are many occasions where the built environment is not very wheelchair/disability friendly and public transportation options are very limited."*

- *"Economic stability- this was rated as 'poor' because my residents in Geisinger's service area are struggling to provide basic needs for their families. Inflation has skyrocketed yet wages have stayed the same. My household income is well over the poverty line, but I am still shocked when I check out at the grocery store."*

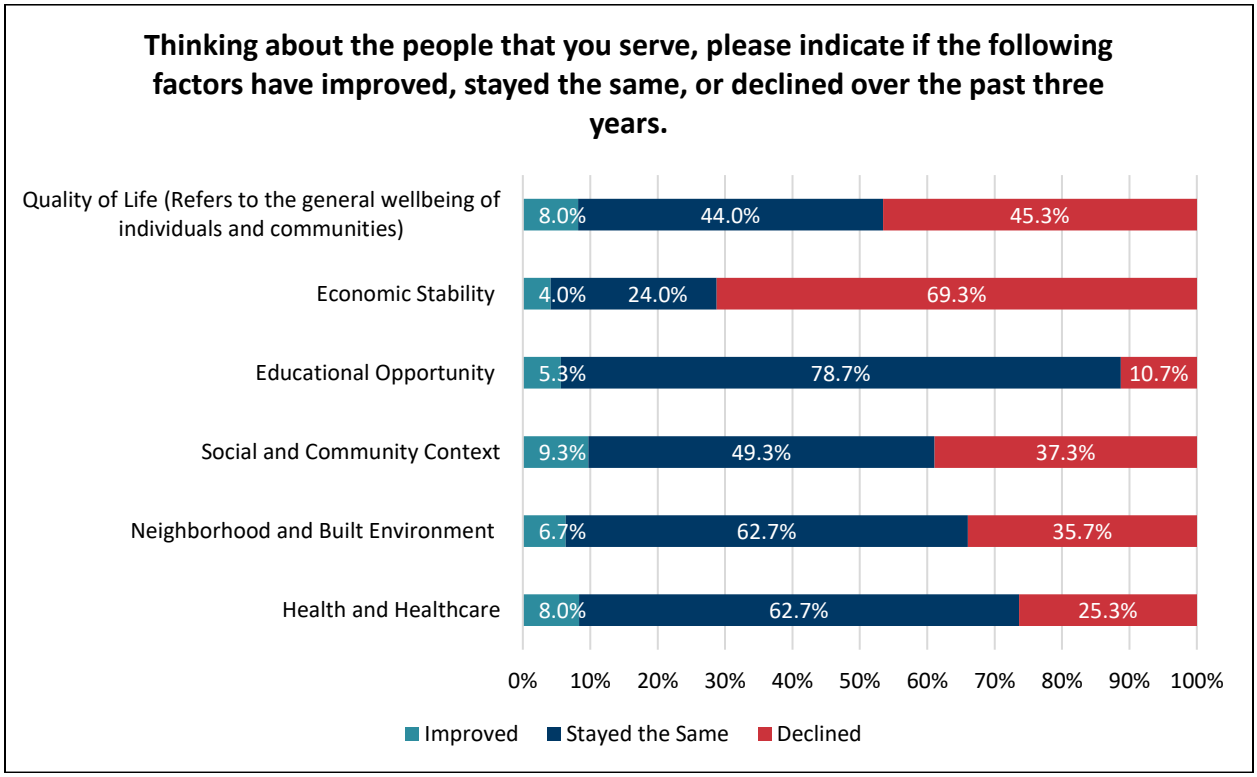
- *"Many of the individuals who we serve do not qualify for any type of medical assistance because they make too much money, but they do not make enough money to pay for their own healthcare and they are not insured by their employers- many working several part time jobs to pay the bills."*
- *"Economic Stability: food security is a real concern in our communities. Local organizations are being leveraged more than ever…Social and Community Context: There is a major cultural divide in our communities. There are negative perceptions of minoritized populations as well as a sense that these populations should leave the area. Perceptions of cultural diversity is that it is a threat to the area versus enrichment…Neighborhood: crime is truly out of control. There has been an uptick in violence against women."*
- *"There is clear division in our schools, among school administrators, and school boards. There is misinformation, culture wars, politicization of beneficial student programs like SEL (Social Emotional Learning) and a lack of understanding or willingness to engage with DEI."*
- *"Deep political / social divide in our communities influenced by the national political landscape. Limits the public discourse on discrimination and equity and the ability to address systems that maintain the status quo."*
- *"Schools, most houses of worship and social institutions not LGBTQ+ supportive in general and some are hostile. Same for families. No LGBTQ Center in the immediate area. Very few GSA clubs or LGBTQ+ youth groups."*
- *"The members who struggle with transition do not have engagement with community programs that foster connection with others in their community. Those communities struggle with transportation, adequate housing and behavioral health needs."*
- *"Individuals with ID, mental health or cognitive impairments without sufficient educated family or institutional supports are at higher risk due to the lack of community action, at risk of physical/financial exploitation or self-neglect."*
- *"Transportation is a big issue in the availability and cost. Stigma is an issue in the community for mental health consumers."*
- *"We work in many isolated rural communities with limited services and transportation options."*

COVID-19 Insights and Perspectives

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

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

employment, food security, and housing stability. Conversely, the largest improvement was seen in social and community context (9%), despite concerns shared about divisions among diverse community members and increased politicization of certain discussions and curricula in schools.



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

- *"Flexibility in scheduling for the elderly and those travelling 40 (or whatever) miles for service."*
- *"Invest in rural wellness centers to move health conversations and initiatives closer to the population that has the greatest need to address the social determinants of health.*

- *"Access to primary care/pediatrics for all, whether insured or not."*
- *"Ensure patients are being provided sufficient time with providers to express concerns about their health. Healthcare, even preventative healthcare can induce anxiety, trauma, or potentially trigger PTSD related issues and concerns for survivors of violence. Having providers who are willing to not only listen, but really hear their patients will be more effective in helping community members achieve health and well-being."*
- *"Support and employ more support staff positions – health navigators, CHWs, etc. who can bridge the gaps between those in need and the healthcare and social services providers."*
- *"Students need to be supported more than ever. We are working with school districts that have seen significant declines in academic performance, poor behavior in school, and increased truancy rates. Anything that your organizations can do to help students connect school with a future in*

healthcare or another field could help. Job shadows, mentorships, internships, and apprenticeships are wonderful tools that can help expose students to the vast amount of healthcare careers in Northeastern Pennsylvania."

- *"Many of the individuals we care for are below the poverty level that qualify for personal assistant services at home. (Community Health Choices) The need to continue to advocate and educate these individuals is very important to keep them living independently."*
- *"Monitor transitions from minority to majority as to services available for impaired individuals by educating family/supports or to identify those without supports, educate aged patients or family members as to resources to age in place with services available."*
- *"Support development of a gender clinic. Increase funds for diversity and inclusion education and mental health services and groups for LGBTQ+ people. Support schools in being inclusive. Increase availability of MDs who provide gender affirmative care."*
- *"Continue to educate on bias and DEI issues."*
- *"Many people have lost confidence in healthcare through decisions made during COVID-19. Rebuilding trust through education and community services.*
- *"By continuing to ride the wave of technology used to increase and improve connectivity with members."*

In closing, key stakeholders were asked to leave any parting or summary thoughts regarding the COVID-19 pandemic. A total of 44 stakeholders responded, and their responses are grouped thematically below.

COVID-19 Pandemic Feedback Themes	Number of Responses
Necessity of teamwork and partnerships (between community-based organizations, among healthcare providers, and between and amongst members of the community in "big" and "small" ways)	10
Health education (the necessity of providing consistent, accurate, and accessible health information to members of the community to promote health)	9
Necessity of addressing mistrust (in the government, in the healthcare system, between diverse community members)	8
Importance of prevention and preparedness, and implementing lessons learned	7
Current economic crisis (disparate impact of all factors on the poor, need to address SDoH)	6
Address ongoing barriers to accessing healthcare (transportation, insurance concerns, etc.)	5
Mental health (the ongoing impact on people's mental health and the need for increased services, especially for youth)	5
Strengthening capacity of healthcare and social services organization (hiring and retention, training, availability)	4
More support solutions for vulnerable populations (elderly, people with disabilities)	3

Next Steps and Future Collaboration

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

- *"Better data sharing and seeing the big picture/connectedness of all resources."*
- *"Childcare options for all income levels and additional opportunities for low-to-moderate income families."*
- *"Ensure vulnerable populations are connected with a healthcare based social worker or medical advocate."*
- *"Use 211/Help Line and Warm Line as a resource more to reduce crisis and access to services."*
- *"Establish a healthcare specific transportation system."*
- *"Frequent touchpoints with key stakeholders from these mentioned organizations to provide updates on one another's efforts to encourage better collaboration."*
- *"They could sponsor activities at a facility like ours: we have a lot of low-income families who come to the pool. Provide education and recreation opportunities. We would welcome that."*
- *"Have information at hospitals and medical offices of programs you support (eg: Girls on the Run)."*
- *"Keep resource lists for LGBTQ+ people for all ages, and their families and keep them updated. Make it easy for people to search and find gender affirmative care. Work with LGBTQ+ groups, family groups such as PFLAG and Trans Central PA. Make medical record gender affirming."*
- *"Reach out to county BH/ID / Aging offices for transitioning impaired individuals to supportive communities to reduce revolving door of admission/discharge and to ensure least restrictive housing opportunities with necessary services."*
- *"Bring services closer to us. You have done this with the opening of Geisinger at Muncy but it still is a drive which not everyone can access."*
- *"Since you asked! Junior Achievements across the country are effectively partnering with healthcare organizations to address problems like those facing our local youth. Partnerships have produced positive outcomes that connect students directly to healthcare jobs out of high school, internships, jobs that require certificates, etc. Underestimated students have great potential when they are exposed to the right people and interactions that they do not have opportunity to experience in their daily lives."*
- *"Partnerships like Healthy Kids Day at the Miller Center where families can learn about healthy lifestyles and receive free information about healthy food, bike helmets for kids, be active together, etc. are fantastic! I'd love to see more of that, partnering with the downtown groups/Chambers/Visitors Bureaus in every community."*
- *"Continue to partner with community partners at the love center and the mobile food pantry. Excellent resources for our community."*

North Central Region Community Forum

Background

Geisinger, Allied Services, and Evangelical Community Hospital hosted a Community Forum on September 12, 2022, at the Holiday Inn in Williamsport. The forum convened 14 representatives of health and social service agencies, education sectors, senior services, local government, and civic organizations, among others. The objective of the forum was to share data from the CHNA and garner feedback on community health priorities and opportunities for collaboration among partner agencies.

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

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

New or Emerging Community Needs

- Community childcare options are limited and increasingly expensive, affecting family work-life balance and financial security, as well as community economic potential.
    - People experiencing homelessness struggle to secure employment because they cannot afford childcare.
    - The region (and nation) is experiencing a childcare staffing crisis with fewer people entering the workforce due to low wages.
    - Childcare related call-offs by employees are hindering employer operations.
    - Employers are adopting flexible work schedules and environments that allow for working from home and/or bringing children to the workplace.
- The rural EMS is an under-resourced and aging staff serving a hard-to-reach population.
    - EMS is a volunteer-based service with low recruitment of new members.
    - Limited EMS resources are challenged to reach patients living in rural communities.
- Telehealth is a growing resource, but access is limited for older residents.
    - Older adults may not have access to digital devices, may be less comfortable using a computer or smartphone, and/or experience physical or cognitive barriers that reduce their ability to access telehealth.
- School budget constraints and staff shortages have limited youth extracurricular sports and activities, and more families struggle to afford extracurricular programming due to inflation.
- Mental health concerns increased across age groups, but particularly for youth. The community lacks adequate crisis response or walk-in services. Protective factors for youth, like extracurricular activities, are less accessible.

- Increases in substance use during the pandemic and legalization of drugs like cannabis diminished perception of substance use disorder as a community issue. More public awareness and education is needed.
- More children are being placed in kinship care as an alternative to entering the foster care system. These children are not captured by foster care population data. Kinship caregivers are typically older adults, often grandparents, and may not receive adequate assistance and services.

Community Solutions and Opportunities

- Sustained, collective impact will require broad-based and multi-sector collaboration. Success factors for collaboration include:
    - Consistent inter-agency communication to share available resources and conduct joint outreach efforts;
    - Non-competitive forums to foster collaboration and address duplication of services;
    - Government and elected official involvement to impact policy and funding; and
    - Intentional outreach to organizations that may not have the capacity to take part in collaborative efforts outside of direct service delivery.
- Schools would benefit from partnerships with community organizations to make available and better connect youth with afterschool programming.
    - Mentoring and job shadowing programs would benefit youth development and help build a workforce pipeline for industries like education and healthcare.
    - Collecting data to demonstrate the impact of lost extracurricular activities on youth well-being may be used to advocate for more funding from school boards and others.
- Employers are beginning to explore creative solutions to childcare challenges.
    - Employee assistance programs may offer a stipend for services like Care.com to hire emergency caregivers.
    - Employers, including Evangelical Community Hospital, are piloting onsite childcare centers for employees with emergency care needs. The center at Evangelical is provided on a sliding scale based on income and in partnership with Patch Caregiving.
- The Loyalsock Foundation is in the planning phase for a community recreational wellness facility for all ages in Sullivan County. The community does not currently have an indoor facility.
- The pandemic highlighted the needs of populations placed at risk, including older adults and single-parent families. Organizations have refocused their efforts to better serve these groups.

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

Evaluation of Health Impact

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

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

Our goals:

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

In 2020, Geisinger completed a CHNA and developed a supporting three-year Implementation Plan to advance systemwide goals for community health improvement. The Implementation Plan outlined our strategies for measurable impact on identified priority health needs, including Access to Care, Behavioral Health, and Chronic Disease Prevention and Management. The following sections outline our work to impact the priority health needs in our communities, as well as our ongoing efforts to respond to COVID-19.

Priority – Access to Care

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

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

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

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

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

Surveys conducted by the Junior Achievement event organizers found that:

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

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

Priority – Behavioral Health

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

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

Program and Strategy Highlights:

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

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

Geisinger Marworth, located near Scranton, offers individualized, holistic inpatient and outpatient treatment to help people overcome alcohol and substance use disorder, including medication-assisted treatment, individual and family therapy, and support groups. Marworth cares for patients from Pennsylvania, New Jersey, New York, and New England, and more than 40,000 people have chosen Marworth for treatment since 1982.

Priority – Chronic Disease Prevention and Management

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

- Conducted screening and referral practices to identify and respond to social drivers of health needs for patients.
- Provided Geisinger Mobile Care Gap bus to reach individuals with diabetes who have a care gap in their preventive health and require critical screenings and services.
- Implemented the ZING543210 online website and program for community-based healthy lifestyle education.
- Supported and sponsored community-based programs, trainings, and events to promote community wellness and prevention.
- Partnered with The New Love Center in Jersey Shore to serve individuals with food insecurity residing in Western Lycoming County or Eastern Clinton County.
- Dr. Ruiz, Chair of Cardiology, attended 28 community events in 2023 to educate the community on topics such as stress in the workplace, heart health and prevention, and heart disease.
- Implemented best practices in cancer detection, including low-dose CT scans for lung cancer and machine-learning algorithm to identify and conduct outreach for patients with high-risk for colorectal cancer.
- Continued multi-phase project to upgrade the GJSH Radiology Department, including a new magnetic resonance imaging (MRI) unit.

Program and Strategy Highlights:

Geisinger Jersey Shore Hospital is a long-time partner and sponsor of The New Love Center. The New Love Center serves thousands of households in Clinton and Lycoming counties each year, providing needed food resources based on income guidelines. The Center offers drive-thru food distribution at its site in Jersey Shore and a food pantry and shopping experience at its Annex location in Avis. Other sponsored programs include The Café at Trinity United Methodist Church in Jersey Shore (daily free lunch to all); Military Shares (monthly food box to area veterans); Elder Share (food resources for older adults aged 60+); Backpack Program (over 200 backpacks each week with food for students of the Jersey Shore Area School District); and monthly Peanut Butter & Jelly program for any family.

The Annex location is a partner and food distribution site for the Geisinger Fresh Food Farmacy program. The Fresh Food Farmacy's objective is to provide nutritious food and education to empower patients with the ability to make healthy decisions for their bodies. With healthy food, diabetes education, and support, the program provides patients with a special kind of medicine that doesn't come from a bottle. Food-insecure individuals with A1C levels greater than 8.0 are referred to the food pantry for nutrition education, health coaching services, recipes, and a referral to The New Love Center, where they will receive enough food to make ten meals a week that will support a healthy lifestyle.

Geisinger's COVD-19 Response

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

Vaccine Distribution

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

Contact Tracing

- Typically a public health responsibility, Geisinger worked to get upstream of the virus' spread as prevention.
- Redeployed dozens of employees for contact tracing.
- Completed more than 3,000 notifications in the spring and summer of 2020.

Community

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

Next Steps

Geisinger welcomes your partnership to meet the health and medical needs of our community. We know we cannot do this work alone and that sustained, meaningful health improvement will require collaboration to bring the best that each of community organizations has to offer. To learn more about our community health improvement work or to discuss partnership opportunities, please visit our website: https://www.geisinger.org/about-geisinger/community-engagement/chna/contact-us or contact GeisingerCommunity@geisinger.edu.

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Appendix B: Key Stakeholder Survey Participants

AIDS Resource, Executive Director

Allied In-Home Services, AVP

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

American Rescue Workers, Director of Development and Community Engagement

B.I.D.A., Executive Director

BARRASSE LAW, owner

Bradford/Sullivan Infant/Toddler EI, EI Program Coordinator

Busy Little Beavers, CEO

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

Central Susquehanna Intermediate Unit, Career Coach

CSIU, Career Counselor

DACC, Director of Operations

Department of Emergency Services, Director

Downtown Lock Haven Inc., Assistant

Evangelical Community Hospital, HR

Evangelical Community Hospital, EVP/COO

Evangelical Community Hospital, Manager

Evangelical Community Hospital, Vice President

Evangelical Community Hospital, President & CEO

Evangelical Community Hospital, Controller

Evangelical Community Hospital, Director

Evangelical Community Hospital, Chief of EMS Services

Evangelical Community Hospital, Director Care Coordination

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

Evangelical Community Hospital, Director/RN

Evangelical Community Hospital, Office Supervisor

Evangelical Community Hospital, Vice President, Clinical Operations

Evangelical Community Hospital, RN Practice Manager

Evangelical Community Hospital, AVP of Surgical Services

Evangelical Community Hospital, OB Nurse Manager

Evangelical Community Hospital, Real Estate Manager

Evangelical Community Hospital, Manager

Evangelical Community Hospital, Director, Miller Center and Community Health Initiatives

Evangelical Community Hospital, Director Quality, Patient Safety & Risk Management
Family Service Association of Northeastern Pennsylvania, CEO
First Order Painting, Owner
Foster Grandparent Program of Central PA, Program Coordinator
Foster Grandparent Program of Central PA, Director
Geisinger, Inpatient Social Work Care Manager
Geisinger, Community Engagement Strategist, Senior
Geisinger, VP, Strategy & Market Advancement
Geisinger, Community Benefit Coordinator
Geisinger, Director
Geisinger, Geisinger
Geisinger, Director
Geisinger, Director
Geisinger, CMO
Geisinger Health Plan, Chief Administrative Officer, Geisinger Clinic
Geisinger Health Plan, RN Case Manager
Geisinger Health Plan, Director
Geisinger Health System, Program Director, DEI
Geisinger Home Infusion, Director
Geisinger Jersey Shore, Geisinger Jersey Shore
Geisinger Medical Center, Breast and Cervical Cancer Early Detection Program Navigator
Geisinger Medical Center, Outreach/Injury Prevention Coordinator for Adult Trauma
Girls on the Run Mid State PA, Executive Director
Hospice of Evangelical, Director
Individual Abilities in Motion, President
Innovative Manufacturers Center (IMC), Manager, Outreach & Special Projects
Junior Achievement, President
Lewisburg Children's Museum, Executive Director
Lewisburg YMCA, Associate Executive Director
Loyalsock Foundation, Founder/President
Lycoming-Clinton Joinder Board Programs, Administrator
Moses Taylor Foundation, President and CEO
Northern Montour Recreation Association (Exchange Pool), Board Secretary
PA Department of Health, PA Department of Health
PA Education for Children & Youth Experiencing Homelessness, Consultant
Penn State Extension, Registered dietitian/ extension educator

Perspectives Counseling, Therapist/Owner

PFLAG Danville / Central Susquehanna Valley, President

Sullivan County Recreation Association, president

Susquehanna Council, BSA, Seven Bridges District Executive

Susquehanna University, Chief of Staff

Susquehanna Valley CASA - Voices for Children, Board Vice President and CASA Volunteer

Susquehanna Valley CASA - Voices for Children, Board President

Susquehanna Valley Ethical Society, Founder/Board President

The Bloomsburg Children's Museum, Director

The Miller Center, Marketing & Communications

Transitions of PA, CEO

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

VNA Health System, Community Liaison, Events coordinator

Weis Center for the Performing Arts, Marketing Director

Appendix C: North Central Region Community Forum Participants

Tammy Anderer, Geisinger

Valerie Fessler, American Rescue Workers

Danielle Forker, Geisinger

John Grabusky, Geisinger

Sandee Kyler, Pennsylvania Office of Rural Health

Jennifer Lake, Dwell Orphan Care

Chase McKean, Geisinger

Ryan McNally, Evangelical Community Hospital

Jessica Pennella, Loyalsock Foundation

Chelsea Reichard, Geisinger

Deb Sawyer, Geisinger

Jason Schauer, Geisinger

Melanie Shutt, American Rescue Workers

Maria Welch, Geisinger