Penn Highlands Tyrone

Empowering Communities:

Unveiling Health Needs, Driving Positive Change

COMMUNITY HEALTH NEEDS ASSESSMENT

2024

PREPARED BY **TRIPP UMBACH**

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A MESSAGE FROM
OUR PRESIDENT

Rhonda Halstead
Regional Market President
Central Region

Penn Highlands Healthcare

Dear Friends of Penn Highlands Tyrone:

As the President of Penn Highlands Tyrone, I am writing to discuss an important initiative we have recently undertaken: the Community Health Needs Assessment (CHNA). Our primary goal with the CHNA is to understand our community's specific health needs. By conducting this assessment, we can gain valuable insights into our residents' health challenges and concerns. This understanding is crucial for us to effectively plan and deliver healthcare services that meet your needs.

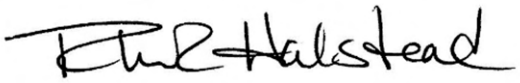
The importance of this assessment cannot be overstated. It allows us to make informed decisions about where to allocate our resources, ensuring we address our community's most pressing health issues. Additionally, it helps us develop targeted programs and services to improve health outcomes and enhance our residents' overall well-being. Our engagement in this comprehensive assessment assures we are fostering collaboration with local health experts, community leaders, and residents. This collaborative approach ensures that the solutions we implement are well-rounded and reflect our community's collective input and needs.

The CHNA will have a significant impact on our community. It enables us to prioritize our efforts and resources effectively, ensuring that we can make a meaningful difference in the lives of those we serve. Moreover, it strengthens the relationship between the hospital and the community, creating a sense of shared responsibility and partnership in our health improvement efforts.

We extend our heartfelt gratitude to the community organizations that have partnered with us, as their collaboration has been instrumental in identifying and addressing our community's health needs. Their support and dedication are invaluable in our shared mission and vision to improve the well-being of our residents. Together, we can create a healthier, stronger community where everyone has the opportunity to thrive.

Thank you for your continued support and partnership. We look forward to working together to achieve a healthier future for all.

Gratefully,



Rhonda Halstead

Regional Market President
Central Region

ABOUT
THIS REPORT

COMMUNITY HEALTH NEEDS ASSESSMENT INTRODUCTION

As a nonprofit organization, Penn Highlands Healthcare is required by the Internal Revenue Service (IRS) to conduct a Community Health Needs Assessment (CHNA) every three years. The Penn Highlands Tyrone CHNA report adheres to the Affordable Care Act (ACA) guidelines and complies with IRS requirements. This CHNA document thoroughly reviews primary and secondary data, analyzing socioeconomic, public health, and demographic information at local, state, and national levels. Penn Highlands Tyrone proudly present their 2024 CHNA report and findings to the community.

The community health needs assessment is crucial for Penn Highlands Tyrone as it enables a comprehensive understanding of the health needs and challenges faced by the local population. By systematically collecting and analyzing data on socioeconomic factors, public health trends, and demographic information, the hospital can identify key areas of concern and prioritize resources effectively. This process highlights the pressing health issues and uncovers social and environmental barriers that impact health outcomes. For Penn Highlands Tyrone, conducting a CHNA is essential for developing targeted strategies to improve health services, enhance patient care, and address the needs of underserved and vulnerable communities. By engaging with various stakeholders, including community-based organizations (CBOs) and public health experts, Penn Highlands Tyrone ensures a collaborative approach to health improvement, fostering a healthier, more resilient community.

The Penn Highlands Tyrone CHNA employed a systematic approach to identifying and addressing the needs of underserved and disenfranchised communities within the hospital's service area. The CHNA report and the subsequent Implementation Strategy Planning (ISP) report offer strategies to improve health outcomes for those affected by diseases and social and environmental barriers to health.

The community needs assessment process involved meaningful engagement and collection of input from community-based organizations, establishments, and institutions. The CHNA covered multiple Pennsylvania counties and included 151 ZIP codes. Conducted with project management and consultation by Tripp Umbach, the CHNA process included input from community representatives, particularly those with special knowledge of public health issues and data related to underserved, hard-to-reach, and vulnerable populations.

Penn Highlands Tyrone extends its gratitude to the region's stakeholders, community providers, and community-based organizations participating in this assessment. Penn Highlands Healthcare and Penn Highlands Tyrone appreciate their valuable input throughout the CHNA process.

IRS MANDATE

The CHNA report comprehensively analyzes primary and secondary data, examining demographic, health, and socioeconomic factors at local, state, and national levels. This report meets the Internal Revenue Code 501(r)(3) requirements, established by the Patient Protection and Affordable Care Act (PPACA), mandating that nonprofit hospitals conduct CHNAs every three years. The Penn Highlands Tyrone CHNA report adheres to the guidelines set forth by the Affordable Care Act. It complies with IRS regulations, ensuring a thorough assessment of community health needs and informing strategies to address them effectively.

CONSULTANT INFORMATION

Penn Highlands Healthcare engaged Tripp Umbach, a nationally renowned healthcare consulting firm, to conduct a Community Health Needs Assessment. With a portfolio of over 400 CHNAs and collaborations with more than 800 hospitals, Tripp Umbach brings extensive expertise to the project.[1] The changes introduced by the Patient Protection and Affordable Care Act have heightened the focus on population health and well-being. This has underscored the importance of collaborative efforts among healthcare providers, public health agencies, and community organizations. Together, these stakeholders aim to enhance overall community health and ensure access to essential services.

[1] Additional information on Tripp Umbach can be found in the Appendix.

COMMUNITY ENGAGEMENT

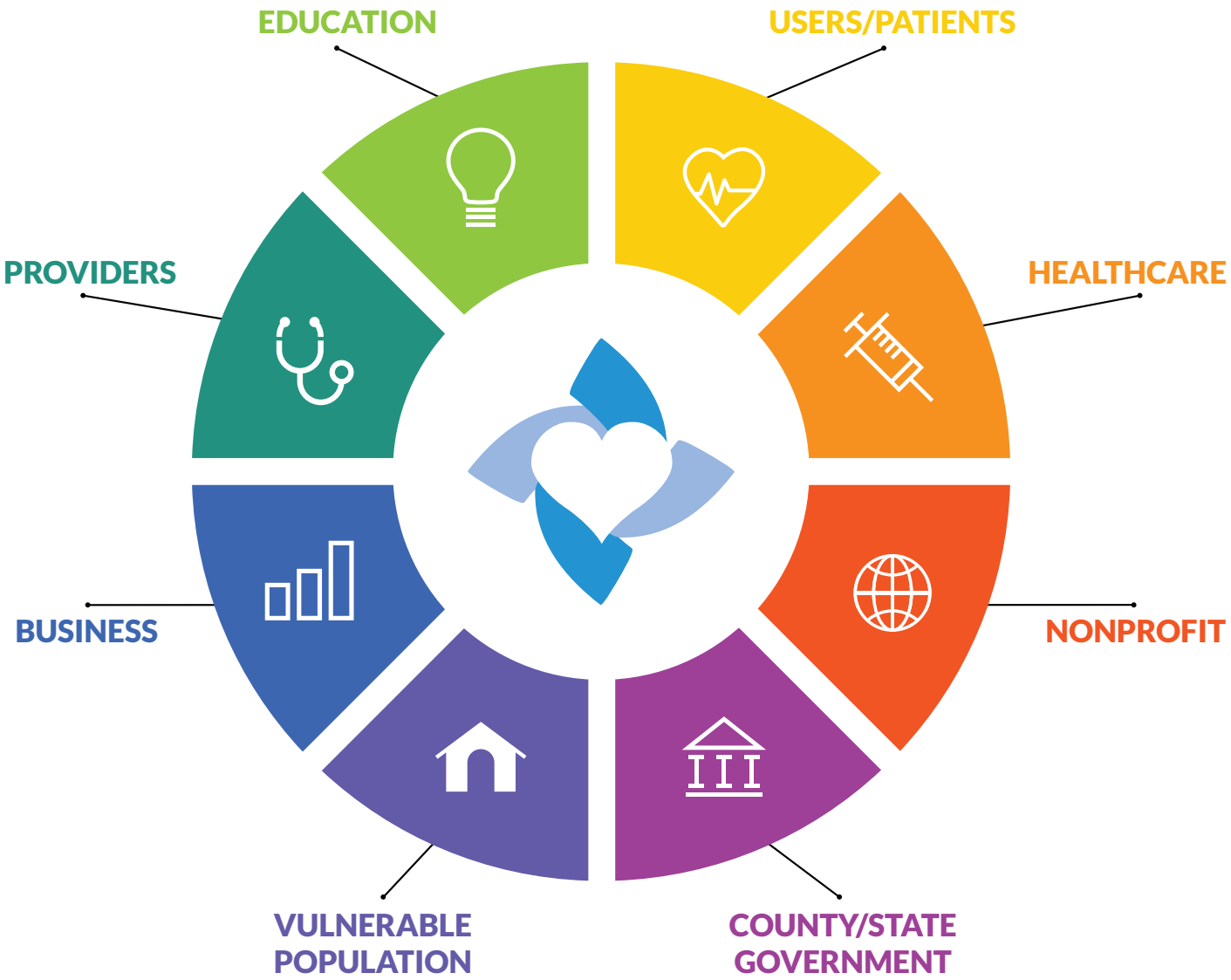
The CHNA process began in January 2024, and the collection of quantitative and qualitative data concluded in June 2024. As part of this needs assessment, a vast number of residents, educators, government and healthcare professionals, and health and human services leaders in the Penn Highlands Tyrone service area participated in the study. Information collected from leaders provided a deeper understanding of community matters, health equity factors, and community needs. Penn Highlands Tyrone collected community and key informant surveys, community stakeholder interviews, and focus group data to engage and capture the community's perspective.

Data types such as county demographics and chronic disease prevalence were gathered from local, state, and federal databases to compile secondary data.

Community surveys, along with stakeholder and low-income resident interviews, were initiated to garner participation from all members residing or working in the primary service area. The data collected identified the needs, high-risk behaviors, barriers, societal issues, and concerns of the underserved and vulnerable populations. Information from focus groups with seniors and healthcare professionals who interact with residents with chronic conditions was included in the collection phase.

While the CHNA process consisted of multiple steps, Tripp Umbach worked closely with working group members to collect, analyze, and identify the results to complete the hospital's assessment.

Figure 1: Community Engagement



ABOUT PENN HIGHLANDS HEALTHCARE AND PENN HIGHLANDS TYRONE

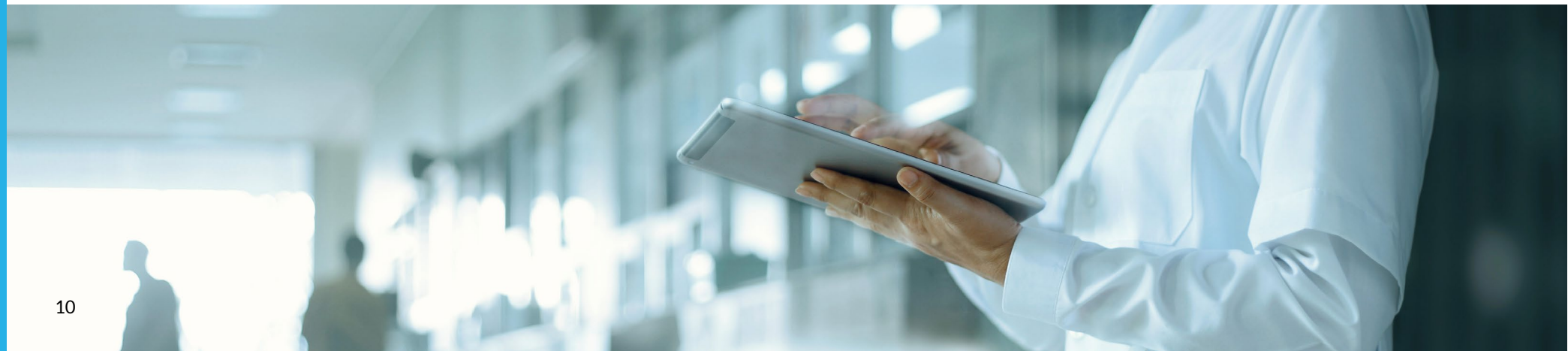
PENN HIGHLANDS HEALTHCARE

Penn Highlands Healthcare, established in 2011, is a health system in Northwestern/Central/Southwest Pennsylvania. Penn Highlands Healthcare serves a 26-county region that brings together the services of Penn Highlands Brookville, Penn Highlands Clearfield (a Campus of Penn Highlands DuBois), Penn Highlands Connellsville, Penn Highlands DuBois, Penn Highlands Elk, Penn Highlands Huntingdon, Penn Highlands Mon Valley, Penn Highlands Tyrone, and Penn Highlands State College (a Campus of Penn Highlands Huntingdon). Through this partnership, Penn Highlands Healthcare has evolved into an organization with over 6,200 employees in more than 100 regional locations, including community medical buildings, outpatient facilities, surgery centers, and physician practices.

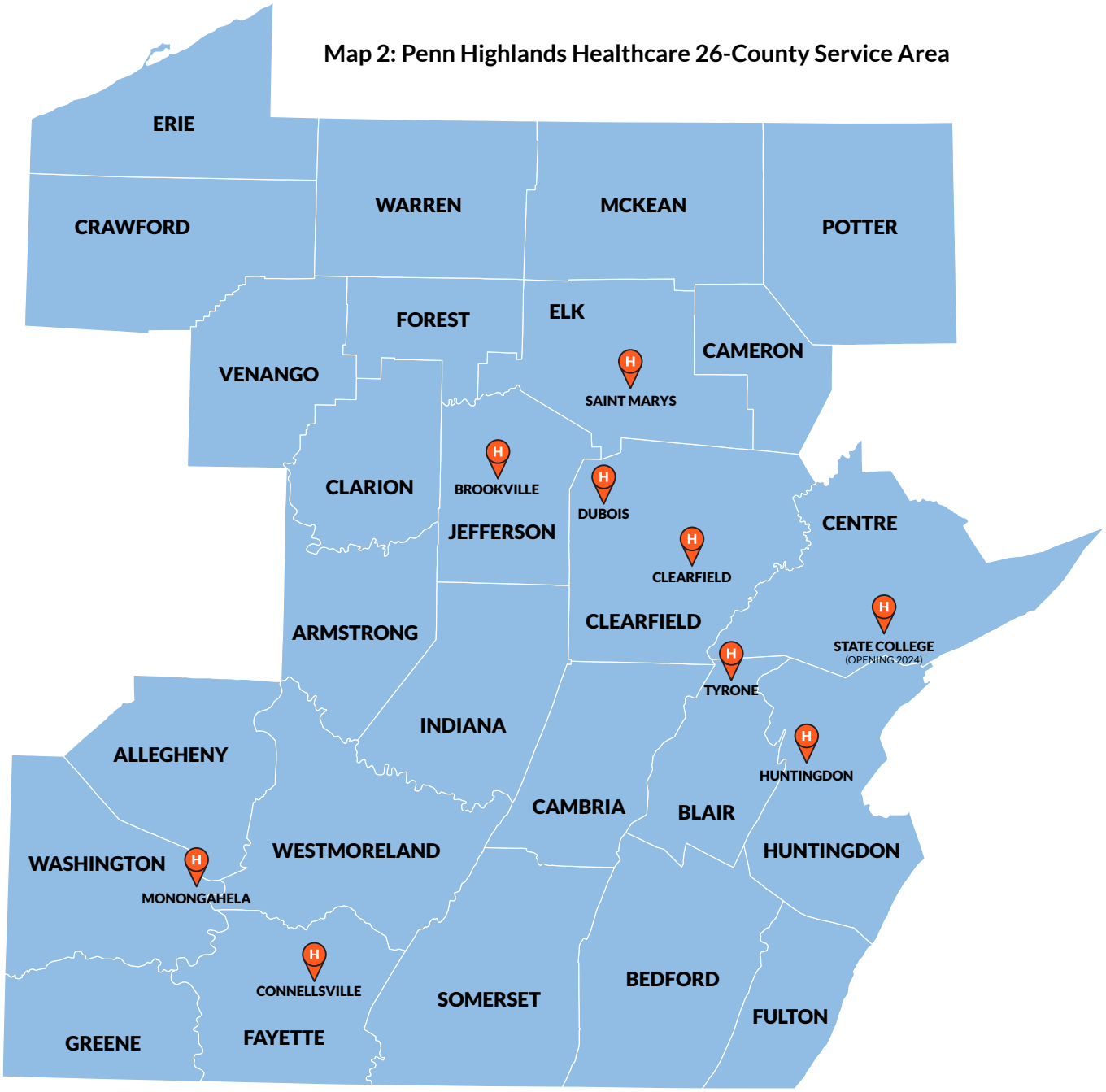
Penn Highlands Healthcare provides exceptional quality care to the region. Its staff includes 764 physicians and 389 advanced practice providers. The facilities have over 742 in-patient beds, 388 long-term care beds, 276-person care beds, and 174 independent living units.

The system offers a wide range of care and treatments, with specialty units for cancer, cardiovascular/thoracic, lung, neurosurgery, orthopedics, behavioral health, and neonatal intensive care.

Penn Highlands Healthcare provides residents access to the region's best hospitals, physicians, two nursing homes, a home care agency, and other affiliates who believe that healthcare should be managed by board members who live and work in their communities. The hospitals of Penn Highlands Healthcare have been serving the residents of Northwestern/Central/Southwest Pennsylvania as non-profit community organizations for more than 100 years, a valued and cherished commitment.



Map 2: Penn Highlands Healthcare 26-County Service Area



PENN HIGHLANDS TYRONE

Founded by the community in 1954, Penn Highlands Tyrone, formerly known as Tyrone Hospital, was a twenty-five- bed community hospital that provides general medical and surgical care, three primary care physician offices, which included Tyrone Rural Health Center, Pinecroft Medical Center, and Houtzdale Rural Health Center. Its services included the Breast Cancer & Women's Health Institute, an orthopedic clinic, a cardiology clinic, Company Healthcare, and the Tyrone Fitness & Wellness Center. On November 4, 2020, Tyrone Hospital joined Penn Highlands Healthcare to expand its premier services available throughout more of Pennsylvania.

PENN HIGHLANDS TYRONE AWARDS

2022 The Chartis Center for Rural Health - Performance Leadership Award in Patient Perspective

PENN HIGHLANDS TYRONE ACCREDITATIONS

2021-2024 American College of Radiology - Computed Tomography Services Accreditation

2023 Mammography Quality Standards Act (MQSA) Certification - Mammography

2023 American College of Radiology (ACR) Accreditation- All Digital/2D Mammography

2024-2025

REGIONAL PRIORITIES

For more than 100 years, Penn Highlands Healthcare's hospitals have been dedicated to serving the residents of Northwest/Central/Southwest Pennsylvania as a non-profit, community-focused organization. Established on the principles of being community-based and ensuring controlled access to healthcare, Penn Highlands Healthcare was founded to improve regional access to premier primary and advanced healthcare services.

Penn Highlands Healthcare's vision is to be the integrated health system of choice, known for excellent quality, service, and outcomes. While many quality services are available within or near each community, additional advanced services are also accessible at various affiliates. As a comprehensive healthcare provider, Penn Highlands Healthcare serves a 26-county area and employs more than 6,200 people.

The 2024 CHNA for Penn Highlands Tyrone highlighted the following community needs. This CHNA assessed the community's health status and developed direct initiatives and planning strategies to enhance it. Through this assessment, new partnerships were established and existing relationships with local and regional agencies were strengthened, all with the overarching goal of improving health outcomes for residents in the region.

ACCESS TO CARE	BEHAVIORAL HEALTH[5]	CHRONIC DISEASES/CONDITIONS[6]
Infrastructure[2]		Health Behaviors[7]
Lack of Primary Care Physicians/Physician Specialists[3]		Social Determinants of Health (SDOH)[8]
Specialty Care[4]		

The above priority areas align with the health needs identified in the 2021 CHNA. The previous CHNA report is accessible to the community on Penn Highlands Healthcare's website. The Penn Highlands Healthcare Board approved the final CHNA report for Penn Highlands Tyrone on June 3, 2024.

[2] Infrastructure (e.g., care coordination, navigation, and transportation)
[3] Lack of primary care physicians (PCP)/Physician specialists
[4] Specialty care (e.g., cancer care, women's health)
[5] Behavioral Health (mental health and substance abuse)
[6] Chronic Diseases/Conditions (e.g., diabetes, chronic obstructive pulmonary diseases, high blood pressure)
[7] Health Behaviors (e.g., nutrition, physical activity, obesity)
[8] Social Determinants of Health (e.g., education, income etc.)

The CHNA roadmap was crafted to involve every segment of the community, including residents, community-based organizations, health and business leaders, educators, policymakers, and healthcare providers. Its purpose is to pinpoint healthcare needs and propose viable solutions to the identified health issues.

Figure 3: Roadmap for the Community Health Needs Assessment

THE PENN HIGHLANDS TYRONE
SERVICE AREA

Tyrone Hospital was founded by the community in 1954. Penn Highlands Tyrone is a twenty-five-bed community hospital that provides general medical and surgical care, three primary care physician offices which include Tyrone Rural Health Center, Pinecroft Medical Center, and Houtzdale Rural Health Center. Its services include the Breast Cancer & Women's Health Institute, an orthopedic clinic, a cardiology clinic, Company Healthcare, and the Tyrone Fitness & Wellness Center. On November 4, 2020, Tyrone Hospital joined Penn Highlands Healthcare to expand its premier services to more of Pennsylvania.

MISSION STATEMENT

To provide you with exceptional care through our community-based health system while maintaining a reverence for life.

VISION STATEMENT

To be the integrated health system of choice through excellent quality, service, and outcomes.

Penn Highlands Healthcare's mission is centered on enhancing regional access to a wide range of premier primary care and advanced services, while upholding a reverence for life and the inherent worth and dignity of every individual. This community-based approach ensures that control of the hospitals remains with a local board, yielding numerous community benefits. Among these are increased access to physician specialists, improved quality and coordination of care, and enhanced physician recruitment and retention.

DEFINED COMMUNITY

A community is defined as the geographic area from which many patients who utilize hospital services reside. Although the CHNA includes other types of healthcare providers, the hospital remains the largest provider of acute care services. Consequently, hospital service usage offers the clearest definition of the community. In 2024, nine ZIP codes were identified as the primary service area for Penn Highlands Tyrone. The following table highlights the study area focus for the Penn Highlands Tyrone 2024 CHNA, with these ZIP codes accounting for 80% of the hospital's patient discharges. While most discharges are from Blair and Centre counties, patients also come from neighboring counties.

The following table and map of the Penn Highlands Tyrone geographical location display the hospital's defined community, which relates to the nine ZIP codes.

Table 4: 2024 The Penn Highlands Tyrone Primary Service Area

ZIP Code	Town	County
16686	Tyrone	Blair
16601	Altoona	Blair
16602	Altoona	Blair
16617	Belwood	Blair
16651	Houtzdale	Blair
16877	Warriors Mark	Blair
16661	Madera	Blair
16680	Smithmill	Blair
16870	Port Matilda	Centre

COMMUNITY AT-A-GLANCE

	BLAIR COUNTY	CENTRE COUNTY	PENNSYLVANIA
POPULATION	**122,640**	**158,665**	**12,989,208**
		Source: U.S. Census Bureau, American Community Survey	
GENDER	MALE: **49.29%** FEMALE: **50.71%**	MALE: **52.91%** FEMALE: **47.09%**	MALE: **49.35%** FEMALE: **50.65%**
		Source: U.S. Census Bureau, American Community Survey	
MEDIAN HOUSEHOLD INCOME	2013-2017: **$43,871** 2015-2019: **$49,181** 2018-2022: **$59,386**	2013-2017: **$56,466** 2015-2019: **$60,403** 2018-2022: **$70,087**	2013-2017: **$56,951** 2015-2019: **$61,744** 2018-2022: **$73,170**
		Source: U.S. Census Bureau, American Community Survey	
AGE DISTRIBUTION	AGE 0-5: **4.8%** AGE 5-18: **15.0%** AGE 18-25: **8.4%** AGE 25-35: **11.1%** AGE 35-45: **11.5%** AGE 45-55: **12.4%** AGE 55-65: **14.6%** AGE 65+: **22.3%**	AGE 0-5: **3.9%** AGE 5-18: **11.1%** AGE 18-25: **26.0%** AGE 25-35: **13.1%** AGE 35-45: **9.9%** AGE 45-55: **10.0%** AGE 55-65: **10.9%** AGE 65+: **15.1%**	AGE 0-5: **5.1%** AGE 5-18: **15.2%** AGE 18-25: **9.3%** AGE 25-35: **12.9%** AGE 35-45: **11.9%** AGE 45-55: **12.3%** AGE 55-65: **14.2%** AGE 65+: **19.1%**
		Source: U.S. Census Bureau, American Community Survey 2020	

COMMUNITY AT-A-GLANCE

	BLAIR COUNTY	CENTRE COUNTY	PENNSYLVANIA
RACE	WHITE: **92.5%** BLACK: **2.1%** ASIAN: **0.7%** ALL OTHERS: **4.7%**	WHITE: **83.0%** BLACK: **3.5%** ASIAN: **7.2%** ALL OTHERS: **6.4%**	WHITE: **75.0%** BLACK: **11.0%** ASIAN: **3.9%** ALL OTHERS: **10.1%**
	Source: U.S. Census Bureau, American Community Survey 2020		
EDUCATION	NO HIGH SCHOOL DIPLOMA: **7.0%** HIGH SCHOOL: **44.8%** SOME COLLEGE: **15.6%** ASSOCIATE'S: **9.1%** BACHELOR'S: **15.7%** GRADUATE OR PROFESSIONAL DEGREE: **7.8%**	NO HIGH SCHOOL DIPLOMA: **5.2%** HIGH SCHOOL: **28.7%** SOME COLLEGE: **12.3%** ASSOCIATE'S: **7.6%** BACHELOR'S: **22.5%** GRADUATE OR PROFESSIONAL DEGREE: **23.7%**	NO HIGH SCHOOL DIPLOMA: **8.3%** HIGH SCHOOL: **33.5%** SOME COLLEGE: **15.6%** ASSOCIATE'S: **8.8%** BACHELOR'S: **20.2%** GRADUATE OR PROFESSIONAL DEGREE: **13.6%**
	Source: U.S. Census Bureau, American Community Survey 2020		
BACHELOR'S DEGREE OR HIGHER	**23.43%**	**46.20%**	**33.76%**
	Source: U.S. Census Bureau, American Community Survey 2020		
FAMILIES/MARRIED COUPLES	**23,392**	**27,208**	**2,431,979**
	Source: U.S. Census Bureau, American Community Survey 2020		
VIOLENT CRIME PER 100,000 POPULATION	**211.0**	**114.9**	**309.4**
	Source: U.S. Census Bureau, American Community Survey 2020		

COMMUNITY AT-A-GLANCE

	BLAIR COUNTY	CENTRE COUNTY	PENNSYLVANIA
HOUSING COST BURDEN	23.0%	31.4%	27.06%
	Source: U.S. Census Bureau, American Community Survey 2018-2020		
SUBSTANDARD HOUSING	23.0%	31.7%	27.2%
	Source: U.S. Census Bureau, American Community Survey 2018-2020		
AGE-ADJUSTED RATES OF SELECTED CAUSES OF DEATH	ALL CAUSES OF DEATH: **948.2**	ALL CAUSES OF DEATH: **623.9**	ALL CAUSES OF DEATH: **821.9**
	HEART DISEASE: **220.4**	HEART DISEASE: **151.4**	HEART DISEASE: **176.4**
	CANCER: **163.1**	CANCER: **123**	CANCER: **152.9**
	ACCIDENTS: **69.0**	ACCIDENTS: **33.6**	ACCIDENTS: **66.6**
	CEREBROVASCULAR DISEASES: **34.2**	CEREBROVASCULAR DISEASES: **32.5**	CEREBROVASCULAR DISEASES: **36.5**
	CHRONIC LOWER RESPIRATORY DISEASES: **38.7**	CHRONIC LOWER RESPIRATORY DISEASES: **23.3**	CHRONIC LOWER RESPIRATORY DISEASES: **32.8**
	DIABETES MELLITUS: **29.2**	DIABETES MELLITUS: **11.5**	DIABETES MELLITUS: **22.1**
	ALZHEIMER'S DISEASE: **29.5**	ALZHEIMER'S DISEASE: **29.4**	ALZHEIMER'S DISEASE: **22.0**
	NEPHRITIS, NEPHROTIC SYNDROME AND NEPHROSIS: **22.4**	NEPHRITIS, NEPHROTIC SYNDROME AND NEPHROSIS: **12.7**	NEPHRITIS, NEPHROTIC SYNDROME AND NEPHROSIS: **16.2**
	SEPTICEMIA: **14.3**	SEPTICEMIA: **6.2**	SEPTICEMIA: **13.3**
	INFLUENZA AND PNEUMONIA: **15.6**	INFLUENZA AND PNEUMONIA: **9.8**	INFLUENZA AND PNEUMONIA: **12.7**
	Source: Pennsylvania Department of Health		

EMERGENCY ROOM VISITS

ADULT ED VISITS PER 1,000/MONTH PRIMARY SERVICE AREA ZIP CODES

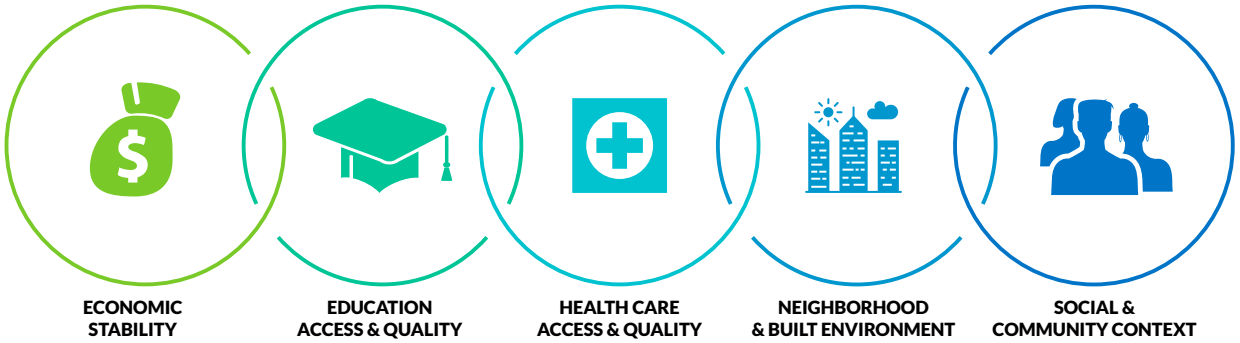
16601: 78.0	**16651:** 50.8	**16686:** 65.2
16602: 74.6	**16661:** 67.9	**16870:** 50.4
16617: 55.3	**16680:** 56.5	**16877:** 66.1

Source: Pennsylvania Department of Health

THE IMPACT OF SOCIAL DETERMINANTS

Social determinants of health profoundly impact our lives by shaping how we are born, grow, live, work, and age. Economic stability plays a crucial role, as higher income levels and stable employment provide financial security, allowing access to healthier food, better housing, and necessary healthcare services, thereby reducing stress and the risk of mental health issues. Education significantly influences health outcomes by improving health literacy, enabling informed health decisions, and opening better job opportunities, contributing to overall well-being. The social and community context also matters greatly; strong social connections and support networks can enhance mental health and offer assistance during challenging times, whereas experiences of discrimination and social exclusion can lead to chronic stress and adverse health outcomes. Additionally, the physical environment, including safe housing, clean air, and access to recreational spaces, directly affects physical health and quality of life. Access to healthcare, including preventive services and timely medical care, ensures that health issues are managed effectively. Overall, the interplay of these social determinants shapes our health outcomes and quality of life, highlighting the importance of addressing these factors to promote health equity and improve population health.

Figure 5: Social Determinants of Health



It is important to review rankings as they provide a clear and concise way to compare performances across different entities, helping identify areas of strength and weakness for targeted improvements. Pennsylvania's score of 1 represents the "healthiest" county in a given measure. According to County Health Rankings & Roadmaps, Figure 6 reveals that in 2023, Blair County's health factors, morbidity, and clinical care shifted slightly. It is also important to note that Blair County's physical environment has a poor ranking of 52 in 2020 and increasing to 58 in 2023.

Centre County's rankings got worse from 2020 to 2023, going from 2 to 51 in social and environmental factors. The physical environment is where individuals live, learn, work, and play. People interact with their physical environment through the air they breathe, the water they drink, the homes in which they live, and the transportation they use.[9]

Reviewing social and economic factors[10] are crucial as they significantly influence health outcomes and disparities, affecting access to resources such as education, employment, and healthcare. Understanding these factors helps identify underlying issues and develop targeted interventions to improve community health. Social and economic factors significantly influence our health and longevity.[11] These determinants underscore the profound impact of social and economic conditions on health outcomes, highlighting the importance of addressing these factors to improve overall well-being and achieve higher health rankings.

Figure 6: County Health Rankings: (1-67 Counties) (1=Healthiest)

		Health Outcomes	Health Factors	Mortality	Morbidity	Health Behaviors	Clinical Care	Social and Economic Factor	Physical Environment
Blair County	**2023**	44	26	47	33	25	43	21	**58**
	2020	43	37	46	36	40	49	26	52
Centre County	**2023**	2	5	1	5	6	9	2	**51**
	2020	2	5	1	8	16	8	3	2

Note: Figures in **red** indicate a poor ranking score.

Rankings in county health assessments are of paramount importance. They serve as a benchmark for counties, allowing them to compare their health outcomes and factors against others. This comparative analysis helps identify strengths and weaknesses, guiding targeted interventions. Rankings also play a critical role in resource allocation, as counties with poorer rankings might receive additional state or federal aid to address health disparities. Publicizing rankings increases community awareness about local health issues, galvanizing support for health improvement programs. Health departments and organizations use rankings to create strategic health improvement plans, identify priority areas, and track progress over time. Rankings also highlight health disparities between counties, prompting efforts to address these inequities. Overall, rankings are essential for monitoring progress, fostering community engagement, and ensuring informed decision-making in public health.

[9] County Health Rankings & Roadmaps

[10] Social and economic factors include income, education, employment, community safety, injury and death rates, social support, and the prevalence of children in poverty.

[11] County Health Rankings & Roadmaps

ACCESS
TO CARE

Access to care is a cornerstone of a healthy community and is crucial in ensuring that individuals receive timely and appropriate medical services. It encompasses factors including healthcare providers' availability, service affordability, transportation options, and insurance coverage. When access is optimal, individuals can receive preventive services, manage chronic conditions, and obtain urgent treatment, contributing to improved health outcomes and reduced healthcare costs. Conversely, barriers to access can lead to delayed diagnoses, untreated conditions, and increased reliance on emergency services, ultimately resulting in poorer health and higher medical expenses.

The Office of Disease Prevention and Health Promotion underscores the importance of comprehensive, quality healthcare services in promoting and maintaining health, preventing and managing diseases, reducing unnecessary disability and premature death, and achieving health equity for all Americans. Although in Pennsylvania's case, meeting that challenge could become even more difficult going forward. According to the Association of American Medical Colleges (AAMC), a shortage of 86,000 physicians by 2036 is predicted across the United States because of a growing older patient population and physicians retiring.[12] The Robert Graham Center reports that to maintain current utilization rates, Pennsylvania will need an additional 1,039 primary care physicians by 2030, an 11% increase compared to the state's (as of 2010) 9,096 PCP workforce.[13]

The ability to seek services from primary and specialty physicians is essential for maintaining and enhancing overall health. Primary care physicians are often patients' first point of contact, providing essential services such as preventive care, routine check-ups, and management of common illnesses. They play a vital role in early detection and intervention, which can prevent more serious health issues down the line. Access to specialty physicians is equally important, as these professionals have advanced expertise in specific areas of medicine, enabling them to diagnose and treat complex conditions that require specialized knowledge and equipment. Timely access to primary and specialty care ensures comprehensive healthcare management, reduces the risk of complications, and enhances the quality of life for patients. It also helps to reduce the burden on emergency services and ensures that health issues are addressed more cost-effectively and efficiently. Therefore, ensuring access to a full spectrum of healthcare providers is essential for achieving optimal health outcomes and maintaining a robust healthcare system.

[12] Association of American Medical Colleges
[13] The Robert Graham Center

Specialty services such as cancer and women's care are vital for ensuring comprehensive and effective healthcare. Specialty services provide targeted and advanced medical attention that general practitioners may not be equipped to offer. Access to specialized cancer care enables early detection, precise diagnosis, and personalized treatment plans that can significantly improve patients' survival rates and quality of life. Similarly, women's care encompasses a wide range of services from reproductive health to prenatal and postnatal care, ensuring that women receive the necessary medical attention throughout different stages of life. These services are critical for managing specific health conditions, reducing risks, and promoting overall well-being. Without such specialized care, individuals may face delayed diagnoses, inadequate treatment, and poorer health outcomes. Therefore, ensuring the availability and accessibility of specialty services like cancer care and women's care is essential for addressing complex health needs, enhancing patient outcomes, and fostering a healthier community.

Addressing transportation challenges is crucial, as reliable and affordable transportation options enable residents to reach healthcare facilities, thus reducing delays in receiving necessary medical attention. Obtaining medical services ensures that routine and preventive care is available, facilitating early detection and the management of health conditions.

Ensuring access to care is fundamental to promoting health and well-being within a community. Improving access to care is essential for promoting health equity, enhancing the quality of life, and fostering a healthier population. It is vital for vulnerable groups, such as low-income individuals and those living in rural areas, who are often disproportionately affected by these barriers. Ensuring everyone access necessary healthcare services is fundamental to achieving overall community well-being and sustainable health improvements. In line with this, Penn Highlands Tyrone is dedicated to addressing access to care based on the specific needs of its communities. Penn Highlands Tyrone is committed to improving access by increasing the number of primary and specialty physicians, enhancing specialty services, and improving access to transportation for receiving care.

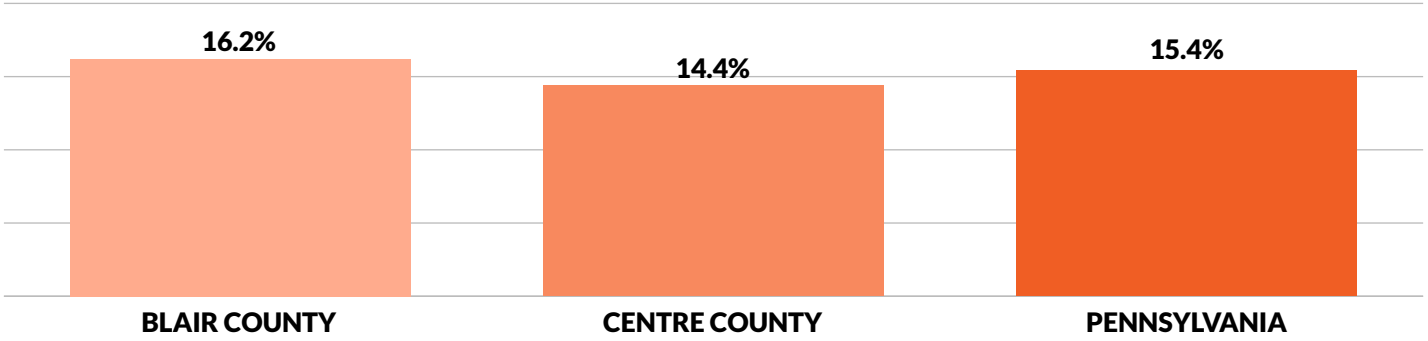
Figure 7 delineates the responses from the community leader stakeholder interviews, community surveys, and focus groups/interviews regarding the needs the community is facing.

Figure 7: Engaging the Community

Stakeholder Interviews	Community Surveys	Focus Groups/Interviews
• Lack of transportation (i.e., limited services). • Securing transportation is a challenge. • No insurance coverage. • Affordability. • Public transportation, access to care would improve quality of life for residents. • Care coordination, health education, and access to telemedicine would assist vulnerable populations meet their health needs.	• Affordable healthcare services, more healthcare providers. • Lack of available physicians, time (cannot take time off work), inability to pay deductibles, and transportation are issues that keep residents from accessing care.	• Health and social needs in a rural area. • Transportation challenges in rural Pennsylvania. • Transportation barriers to medical appointments and potential solutions such as home visits by healthcare providers. • Healthcare access and transportation barriers in a small town. • Community needs in rural Western Pennsylvania, including access to care, behavioral health, and transportation issues. • Transportation and chronic condition management challenges in a healthcare setting. • Recruiting and retaining healthcare professionals in a rural area. • Healthcare access issues. • Adequate health insurance coverage. • Specific health services and programs that are lacking in the community. • Challenges in accessing medical care and service

Figure 8 reports the percentage of adults aged 18 and older who self-report their general health status as "fair" or "poor."

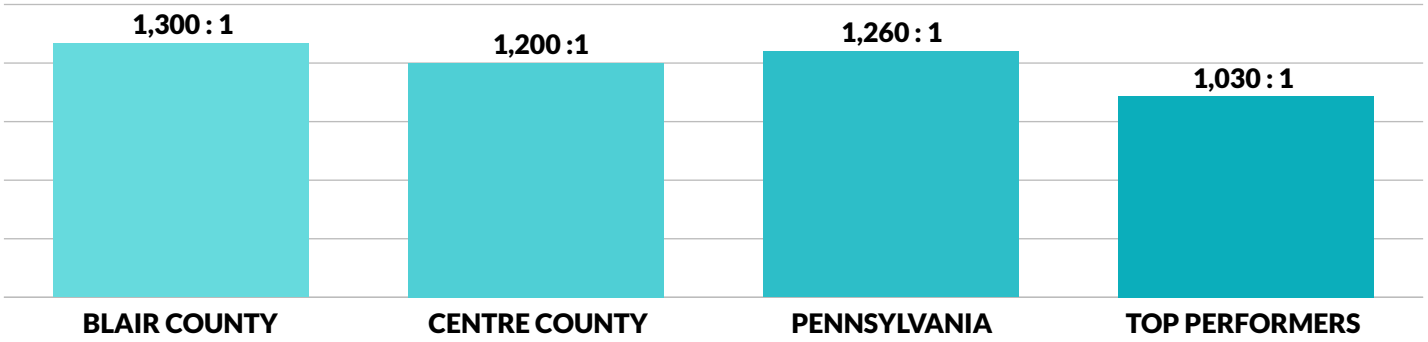
Figure 8: Adults 18+ General Health as Poor or Fair



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2021

The data below report one primary care physician per 1,300 Blair County residents and one primary care physician per 1,200 Centre County residents, compared to 1,260 in Pennsylvania.

Figure 9: Ratio of Available Primary Care Physicians

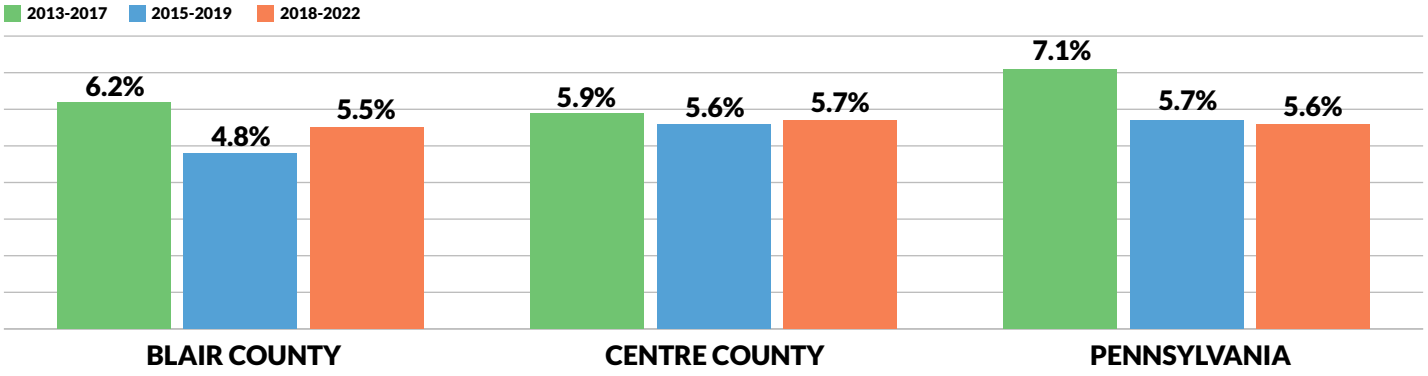


Source: County Health Rankings 2024

Note: Top performers are the top 10% of counties in the United States faring better in a particular value. Top U.S. performers are calculated by the 90th percentile or 10th percentile, depending on whether the measure is framed positively (where a high value is better than a lower value) or negatively (where a low value is better than a higher value).

Figure 10 reports the lack of health insurance as a primary barrier to health care access, contributing to poor health status.

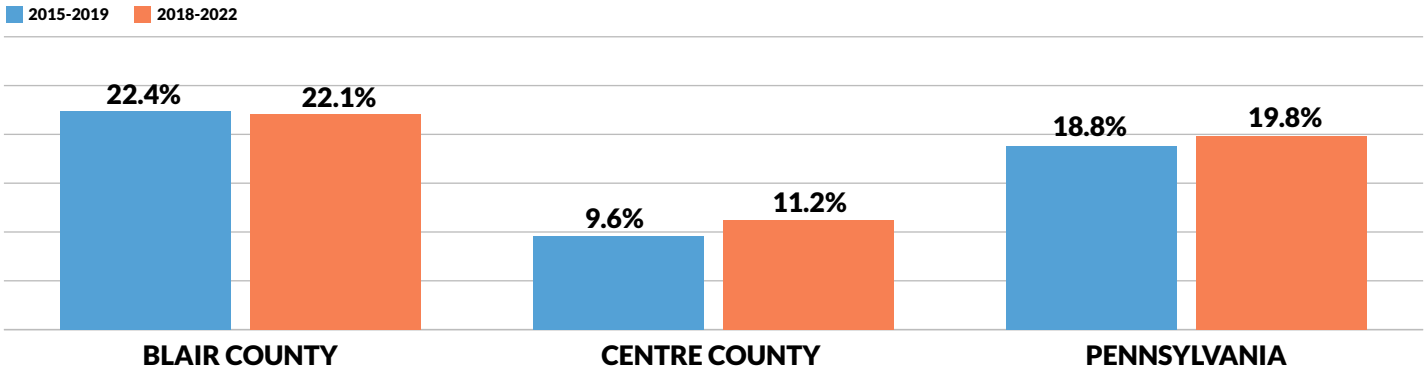
Figure 10: Health Insurance - Uninsured Population



Source: U.S. Census Bureau, American Community Survey 2018-2022

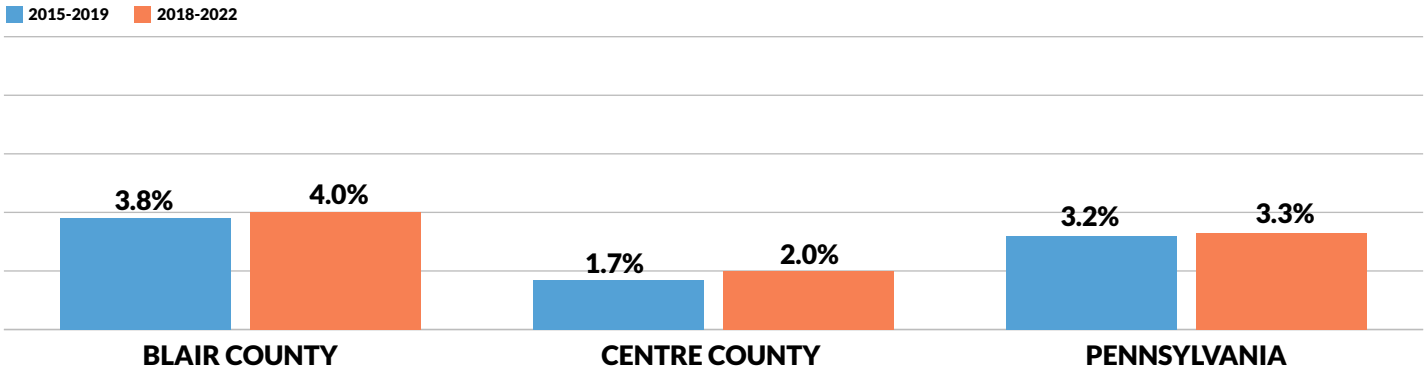
The data below shows the percentage of the population with insurance enrolled in Medicaid/Medicare. This indicator is relevant because it assesses vulnerable populations that are more likely to have multiple health access, health status, and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.

Figure 11: Population Receiving Medicaid/Medicare



Source: U.S. Census Bureau, American Community Survey

Figure 12: Public Assistance Income

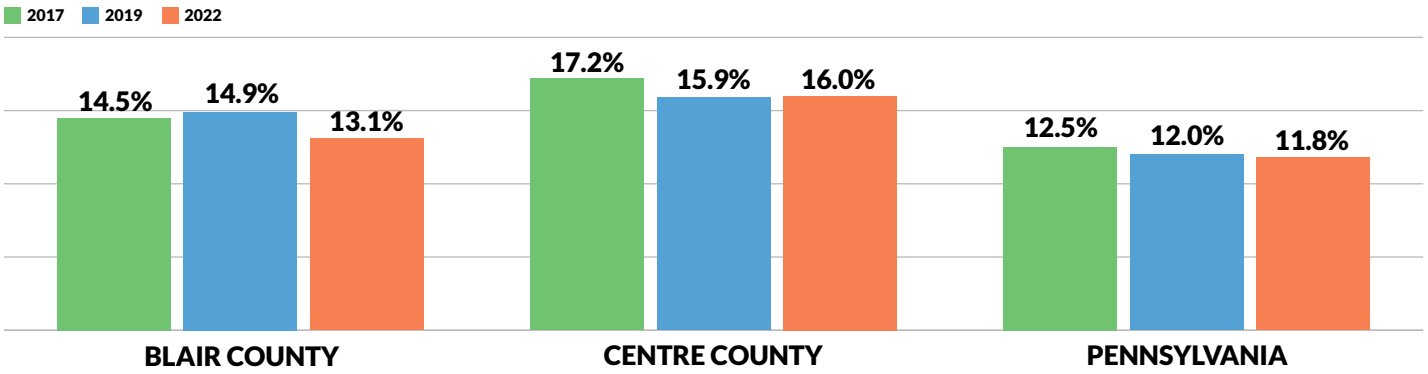


Source: U.S. Census Bureau, American Community Survey

Poverty is considered a key driver of health status. The 2024 Annual Guidelines state that a family of four below 100% FPL has an average household income below $31,200.

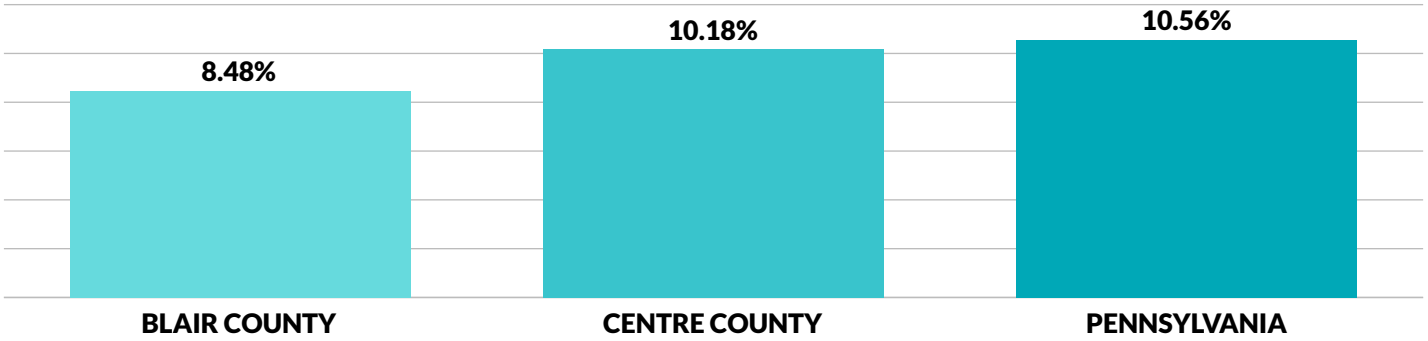
Figure 13 reports the lack of health insurance as a primary barrier to health care access, contributing to poor health status.

Figure 13: Poverty - 100% Below Federal Poverty Line



Source: U.S. Census Bureau, American Community Survey

Figure 14: Households with No Motor Vehicle



Source: U.S. Census Bureau, American Community Survey 2018-2022

Graduate Medical Education (GME) is paramount for communities and hospitals, as it ensures a steady pipeline of well-trained physicians equipped to meet the healthcare needs of diverse populations. For communities, GME programs often place residents in local healthcare settings, which increases access to medical care, especially in underserved and rural areas where physician shortages are common. This improves immediate healthcare access and encourages new doctors to establish their practices in these communities after training, contributing to long-term health improvements and stability. For hospitals, GME programs enhance the quality of care by integrating the latest medical knowledge and practices into everyday patient care. The presence of GME programs can elevate a hospital's status, attract top medical talent, and increase its capacity to offer specialized services. This symbiotic relationship among GME, communities, and hospitals ultimately leads to better healthcare outcomes, more equitable healthcare distribution, and medical education and practice advancement.

GME opportunities are offered to address the growing physician shortage in Pennsylvania and improve healthcare access and quality of life for Penn Highlands Healthcare service area residents. These programs aim to enhance physician retention and recruitment, improve health outcomes, and reduce healthcare costs. Penn Highlands Healthcare is committed to meeting community needs; as such, it offers a residency program in family medicine and psychiatry and a fellowship program in sports medicine.

Pennsylvania urgently needs more physicians, particularly in underserved areas. Residents in rural regions face significant health challenges, as the distance from healthcare providers creates disparities that are difficult to overcome. Issues such as lack of health insurance, insufficient available providers, and healthcare affordability contribute to increased risks of illness and death.

Penn Highlands Healthcare is at the forefront of addressing this physician shortage. Recognizing that GME supports underserved areas, Penn Highlands Healthcare offers ACGME-accredited programs, including family medicine and psychiatry residency programs. These initiatives aim to educate and produce the next generation of high-quality physicians while increasing the number of healthcare professionals who choose to remain and practice in Pennsylvania. Northwestern, Southwest, and Central Pennsylvania have a significant need for healthcare providers, as population health indicators in these areas are among the worst in the state. (Click here to learn more about Penn Highlands Healthcare residency programs.)

BEHAVIORAL HEALTH

Behavioral health, encompassing both mental health and substance use disorders, plays a pivotal role in community health and overall well-being. Addressing behavioral health is crucial, as it directly impacts a community's overall health outcomes and quality of life. Mental health conditions, such as depression, anxiety, and bipolar disorder, along with substance use disorders, often lead to significant physical health problems, disability, and reduced productivity.

Nearly 20% of adults in Pennsylvania reported experiencing a mental illness in the past year, according to the Pennsylvania Department of Health. Mental health is an important part of Pennsylvanians' overall health and well-being, and the prevalence of mental health-related issues is increasing. Specifically, the percentage of adults reporting that their mental health was not good for 14 or more days in a month increased from 12% in 2014 to 14% in 2021, with higher prevalence among people with income less than $15,000 and who identify as lesbian, gay, or bisexual. Suicide continues to be a critical public health issue that requires both a comprehensive understanding and immediate attention to be effectively addressed. In 2020, there were 1,686 Pennsylvanians who died by suicide. Suicide rates increased by 5% from 2010 to 2020, with the most significant increase among Black, Hispanic, and older adults.[14]

Furthermore, the opioid crisis continues to be a significant challenge, with Pennsylvania experiencing one of the highest rates of drug overdose deaths in the nation. In 2021, 5,168 Pennsylvanians died from overdoses. An average of 14 Pennsylvanians die every day from overdose, and based on available data, the death toll will only continue to rise.[15]

By including behavioral health in CHNAs, communities can better understand the prevalence and impact of these conditions, allowing for the development of targeted interventions and resource allocation to address these pressing issues. Integrating behavioral health helps identify and address barriers to accessing care. Stigma, lack of insurance, and insufficient provider availability often hinder individuals from seeking necessary treatment. Additionally, rural areas in Pennsylvania face a shortage of mental health professionals, exacerbating the challenge of access to care. By highlighting these gaps in the CHNA process, communities can advocate for increased funding, policy changes, and implementing programs that expand access to behavioral health services. This approach not only improves individual health outcomes but also enhances the overall health and resilience of the community. Addressing behavioral health issues within a community requires a comprehensive and collaborative approach involving healthcare providers, policymakers, community organizations, and residents.

[14] Pennsylvania Department of Health; the State of our Health, A Statewide Health Assessment of Pennsylvania

[15] Pennsylvania Office of the Attorney General

A multifaceted approach is essential to improve behavioral health outcomes. This includes integrating behavioral health services with primary care to ensure holistic treatment, expanding access to services through telehealth, and addressing financial barriers to care. Creating support systems such as peer support groups and family support programs can foster a sense of community and mutual assistance. By adopting these strategies and leveraging data to identify and address gaps, communities can effectively promote behavioral health, enhance access to care, and improve the overall well-being of their residents.

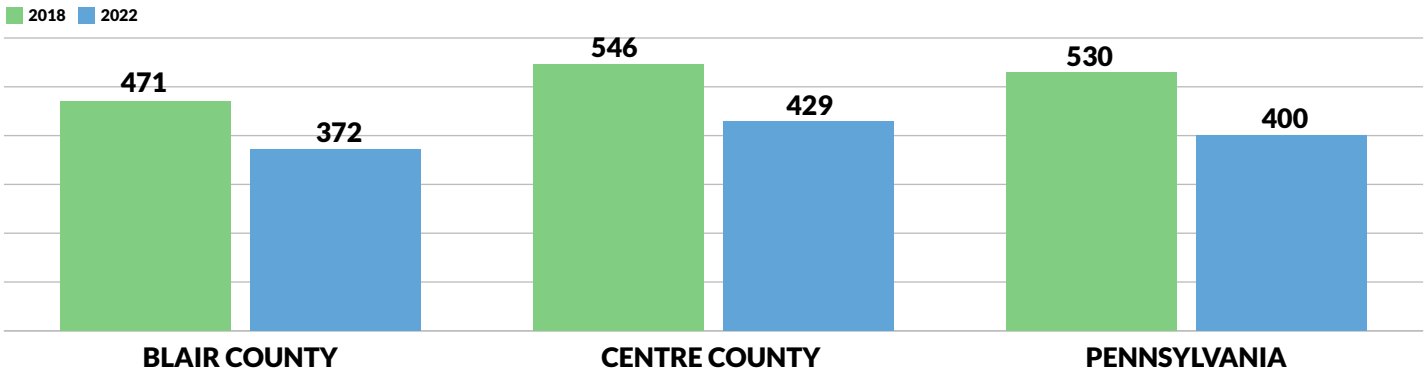
Figure 15 delineates the responses from the community leader stakeholder interviews, community surveys, and focus groups/interviews regarding the behavioral health needs the community is facing.

Figure 15: Engaging the Community

Stakeholder Interviews	Community Surveys	Focus Groups/Interviews
• Lack of behavioral health services. • Securing behavioral health services is a challenge. • Substance abuse is a persistent high-risk behavior. • Substance abuse support and accessibility would improve quality for life for residents	• Drug/alcohol use and poor mental health are significant problems. • Access to behavioral health services would improve the quality of life and health of residents. • Residents need more information on substance abuse prevention services.	• Mental health services in rural Pennsylvania. • Lack of mental health and substance abuse services in the community. • Improving mental health support systems. • Insufficient mental health resources.

Figure 16 illustrates the number of mental health providers (per 100,000 population) in Blair and Centre counties compared to the state.

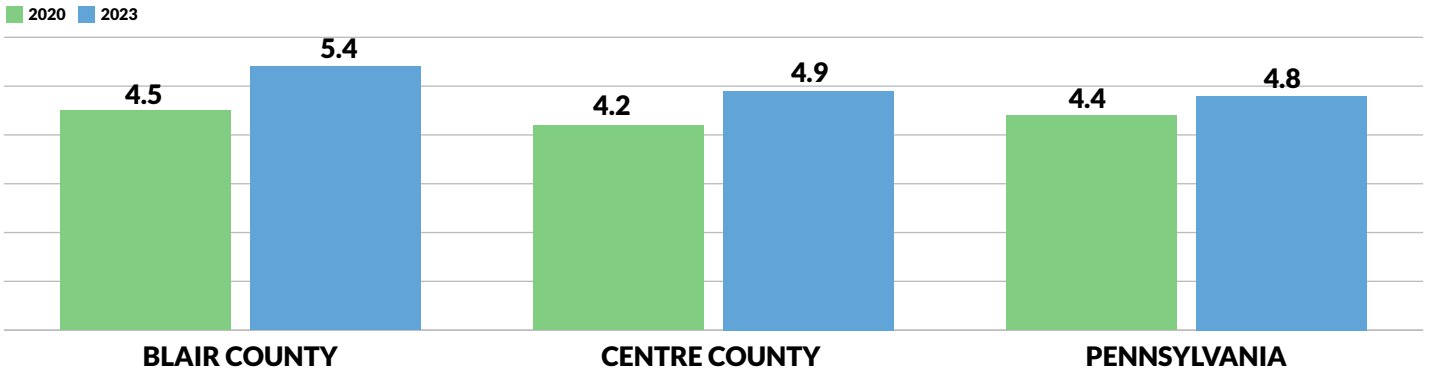
Figure 16: Access to Mental Health Providers (per 100,000 population)



Source: County Health Rankings & Roadmaps

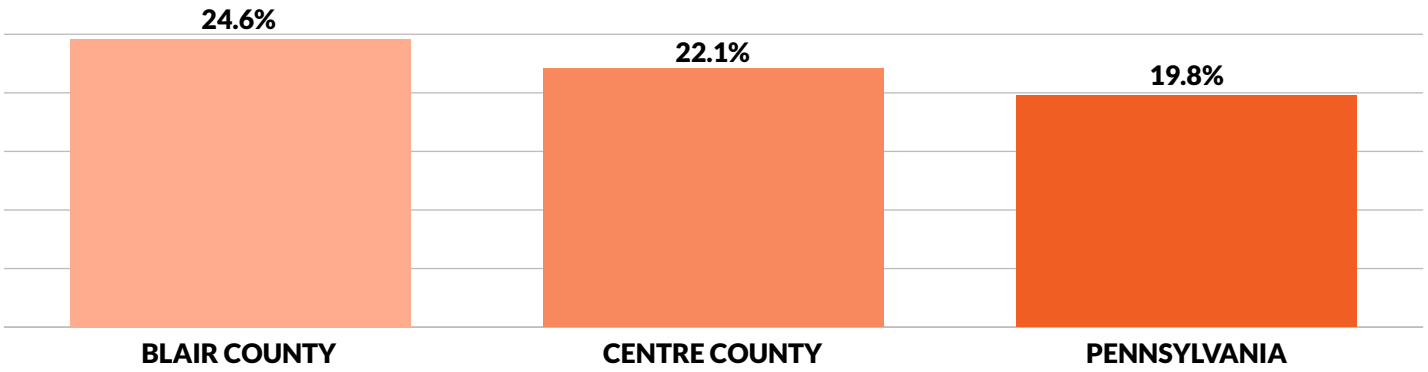
In 2023, Blair County residents reported 5.4 poor mental health days and Centre County residents reported 4.9 poor mental health days of the previous 30 days.

Figure 17: Poor Mental Health Days



Source: County Health Rankings & Roadmaps

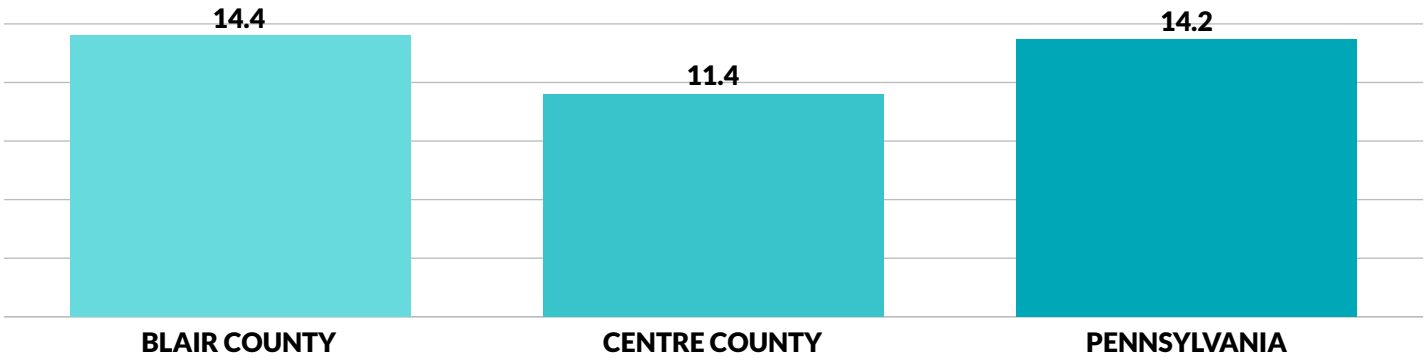
Figure 18: Depression Among Adults >18 years



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2021

Figure 19 reports the rate of death due to suicide per 100,000 population. This data point is relevant because suicide is an indicator of poor mental health.

Figure 19: Suicide Mortality (Age-Adjusted Per 100,000 Population)

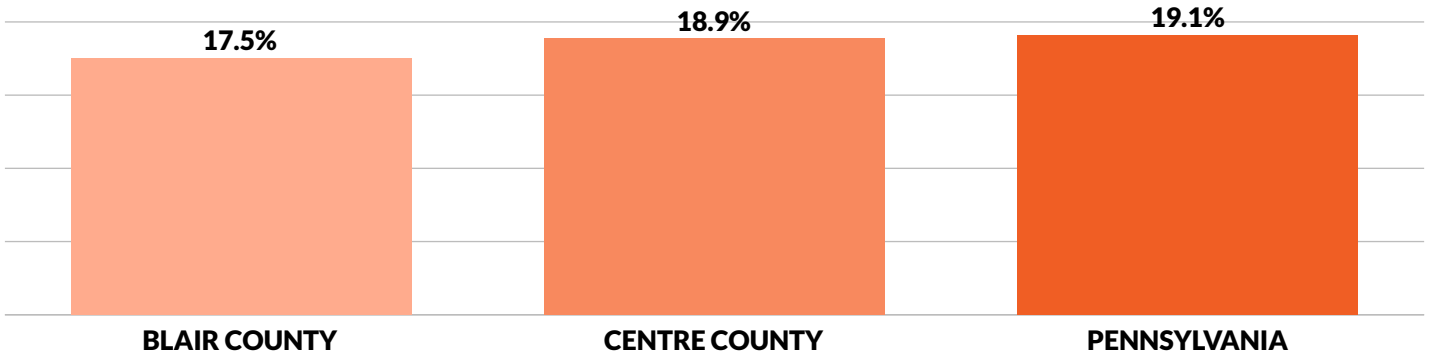


Source: Centers for Disease Control and Prevention, National Vital Statistics System 2016-2020

Alcohol and tobacco use are root causes and can further exacerbate behavioral health conditions. In Pennsylvania, alcohol and tobacco use pose significant health risks. When analyzing alcohol consumption of binge drinkers, rates are better in Blair and Centre counties when compared to the state.

Figure 20 shows adults 18 and older who are excessive drinkers. Excessive drinkers among men consume five or more drinks daily or 15 or more per week. Among women, excessive drinkers consume four or more on any day or eight or more drinks per week.

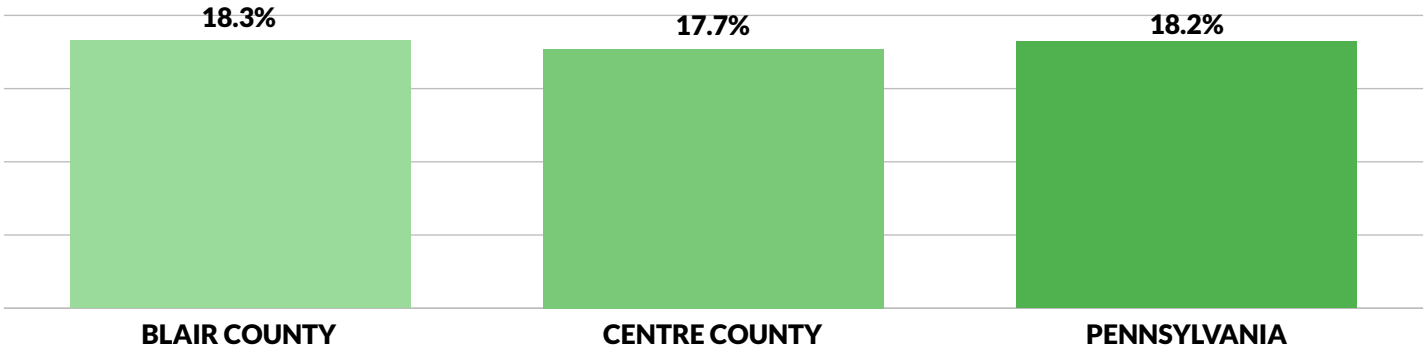
Figure 20: Alcohol Consumption: Adults 18 + Who Are Excessive Drinkers



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2021

A binge drinker is defined as consuming five or more drinks on the same occasion for males or four or more drinks on the same occasion for females on at least one day in the past 30 days.

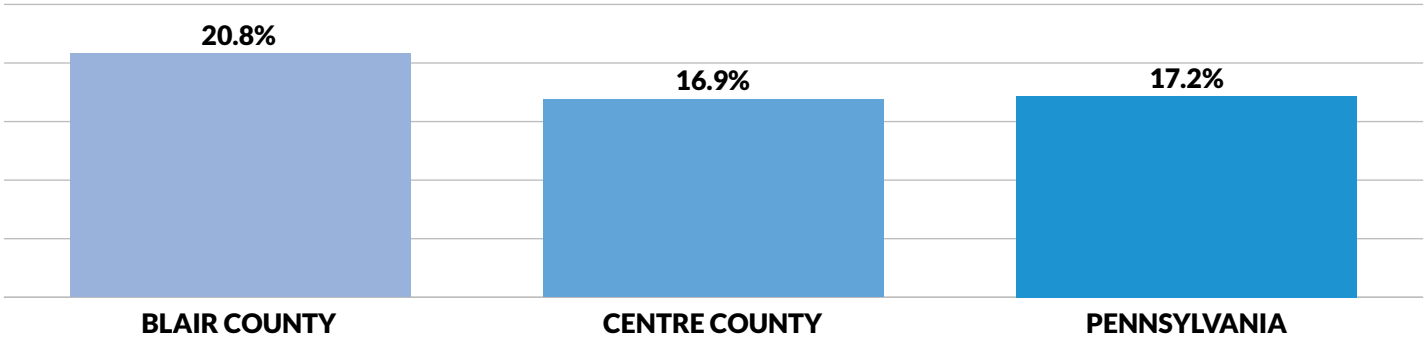
Figure 21: Alcohol Consumption: Adults 18+ Who Are Binge Drinkers in the Past 30 Days



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2021

Figure 22 shows adults 18 and older who smoke daily or some days in Blair and Centre counties and the state.

Figure 22: Adults Age 18+ as Current Smokers



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2021

CHRONIC
DISEASES/CONDITIONS

Chronic diseases are long-lasting conditions that progress slowly and can significantly impact an individual's quality of life. Broadly defined, chronic conditions are health issues that last more than a year, require ongoing medical attention, or limit daily activities. Common chronic diseases include heart disease, diabetes, cancer, and respiratory diseases. These conditions are among the leading causes of death and disability worldwide, often resulting from a combination of genetic, environmental, and lifestyle factors. Risk factors such as poor nutrition, lack of physical activity, smoking, and excessive alcohol consumption play a crucial role in the development and exacerbation of chronic diseases.

Heart disease, cancer, and diabetes are among the leading causes of death and disability in the United States and are significant drivers of the nation's healthcare costs. Ninety percent of the $4.5 trillion in annual healthcare expenditures, up from $3.8 trillion in 2021, are for people with chronic and mental health conditions.[16] Engaging in healthy behaviors and positive habits, such as regular physical activity, adequate sleep, a healthy diet, and eliminating tobacco and alcohol use, can significantly reduce disease risk and improve quality of life. A healthy lifestyle is essential for addressing specific health problems, maintaining overall health, and reducing the likelihood of being diagnosed with a chronic disease.

An estimated 129 million people in the United States have at least one major chronic disease, according to the U.S. Department of Health and Human Services.[17] Regular physical activity can help people live longer and reduce the risk of serious health problems such as heart disease, type 2 diabetes, obesity, and certain cancers. For those already living with chronic diseases, physical activity can aid in managing these conditions and preventing complications. However, only one in four U.S. adults meets the physical activity guidelines for aerobic and muscle-strengthening activities. Insufficient physical activity carries high health and financial costs, totaling $117 billion nationally in annually related healthcare expenses.[18]

[16] Centers for Disease Control and Prevention
[17] Centers for Disease Control and Prevention
[18] Centers for Disease Control and Prevention

Obesity impacts 20% of children and 42% of adults in the United States, raising their risk for chronic diseases. Furthermore, more than 25% of young people aged 17 to 24 are too overweight to qualify for military service.[19] Healthy eating is a cornerstone of well-being and significantly prevents and manages chronic conditions. A diet rich in fruits, vegetables, whole grains, lean proteins, and healthy fats provides essential nutrients that support bodily functions and enhance immune response. These nutrient-dense foods help maintain a healthy weight, reduce inflammation, and improve cardiovascular health, lowering the risk of chronic diseases. Conversely, poor dietary choices, such as high consumption of processed foods, sugary beverages, and unhealthy fats, can lead to obesity, hypertension, and elevated blood sugar levels, exacerbating chronic conditions.

Chronic diseases, though prevalent, are among the most preventable health problems. Proper management of chronic diseases involves a combination of regular screenings, routine check-ups, and vigilant monitoring of treatment plans. These proactive measures help in early detection and effective management of conditions, thereby improving patient outcomes. Patient education is also crucial, as it empowers individuals to manage their conditions better, adhere to prescribed treatments, and make lifestyle changes that promote overall well-being.

In managing chronic diseases, Penn Highlands Tyrone takes a comprehensive approach that includes regular monitoring, patient education, and coordinated care among healthcare providers. By implementing community-based programs that focus on lifestyle changes, such as diet and exercise, and ensuring access to necessary medical services, residents can better manage conditions like diabetes, hypertension, and heart disease. Health outcomes for residents have shown improvement with these proactive measures, leading to reduced hospital admissions, improved quality of life, and decreased healthcare costs. Collaboration among local healthcare organizations, government agencies, and community groups has been pivotal in fostering a supportive environment that encourages residents to actively participate in their health management, ultimately leading to more sustainable and positive health outcomes.

[19] Centers for Disease Control and Prevention

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the conditions in which people are born, grow, live, work, and age, profoundly impacting health outcomes. These determinants include socioeconomic status, education, neighborhood and physical environment, employment, social support networks, and access to healthcare. Residents living in poverty may experience higher levels of stress, limited access to nutritious food, inadequate housing, and reduced opportunities for physical activity, all of which can contribute to poorer health outcomes. Educational attainment influences health literacy and the ability to navigate the healthcare system effectively. Employment conditions affect physical health through exposure to workplace hazards and mental health through job-related stress. Social support networks provide emotional and practical assistance, which can help individuals cope with health challenges. Access to healthcare determines the ability to receive preventive services, manage chronic conditions, and obtain timely treatment for illnesses. Collectively, these social determinants create a complex interplay of factors that significantly influence an individual's health, contributing to disparities and inequities within and between communities.

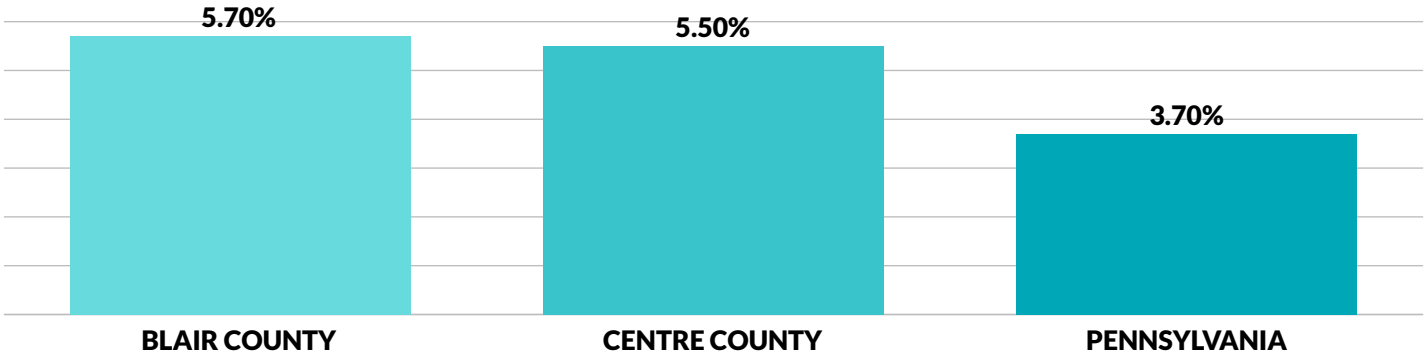
Figure 23 delineates the responses collected from the community leader stakeholder interviews, community surveys, and focus groups/interviews regarding care for chronic diseases and conditions.

Figure 23: Engaging the Community

Stakeholder Interviews	Community Surveys	Focus Groups/Interviews
• Heart disease, diabetes, and cancers are persistent community problems. • Economic disparities block health improvement and stem quality of life. • Poor eating habits and lack of exercise are persistent high-risk behaviors.	• Cancers and the lack of exercise are significant problems. • Higher paying jobs are community needs to improving quality of life and health. • Residents need more information on chronic diseases prevention, managing weight and eating well (i.e., nutrition). • Joint/back pain, overweight/obesity, and arthritis are top health challenges residents face. • Blood pressure, cholesterol, cancer, and diabetes are types of health screenings that would keep families healthy.	• Affordable senior housing options. • Food access and healthy eating habits among older adults. • Health challenges in a rural community.

The data from Figure 24 is significant as coronary heart disease is a leading cause of death in the U.S. and is also related to high blood pressure, high cholesterol, and heart attacks.

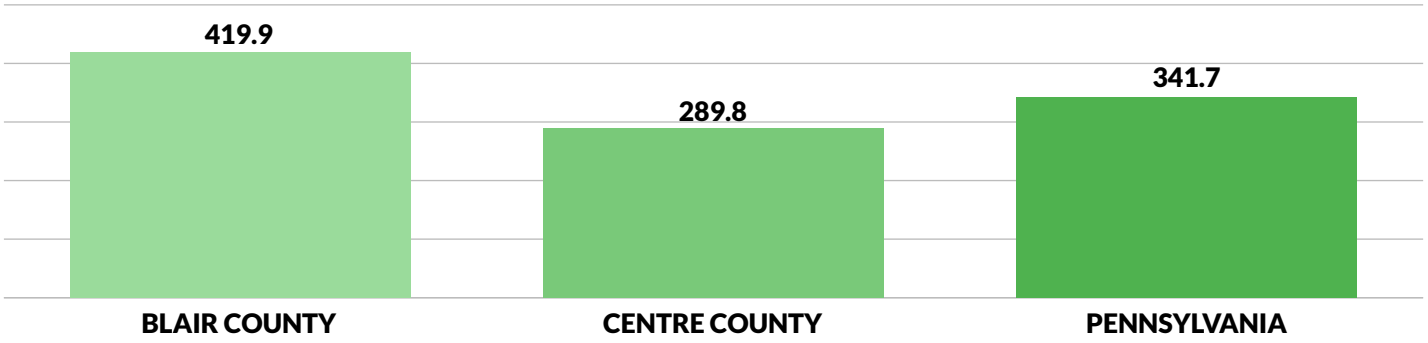
Figure 24: Adults with Heart Disease



Source: Centers for Disease Control and Prevention, 2021

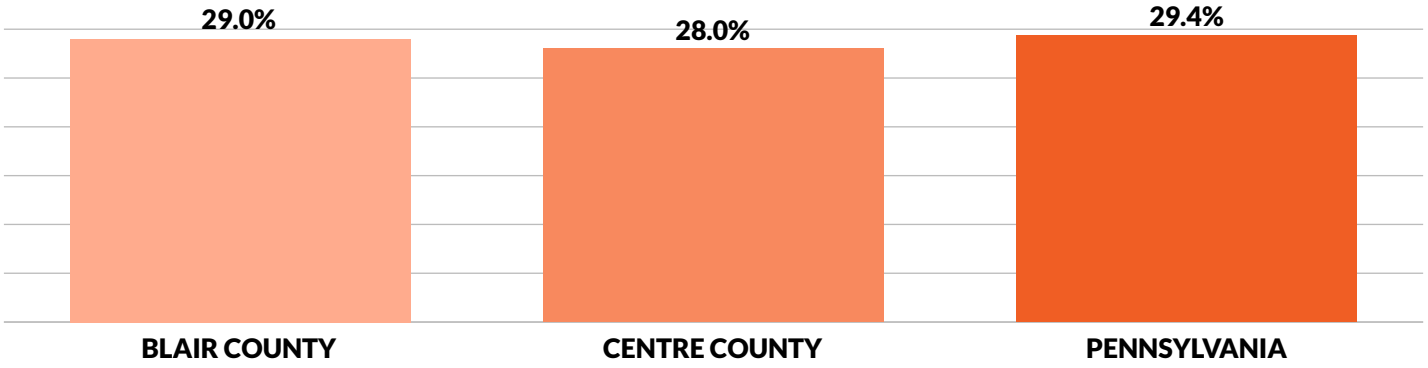
The data from Figure 25 is relevant because heart disease is a leading cause of death in the U.S.

Figure 25: Heart Disease Mortality (Per 100,000 Population Ages 35+)



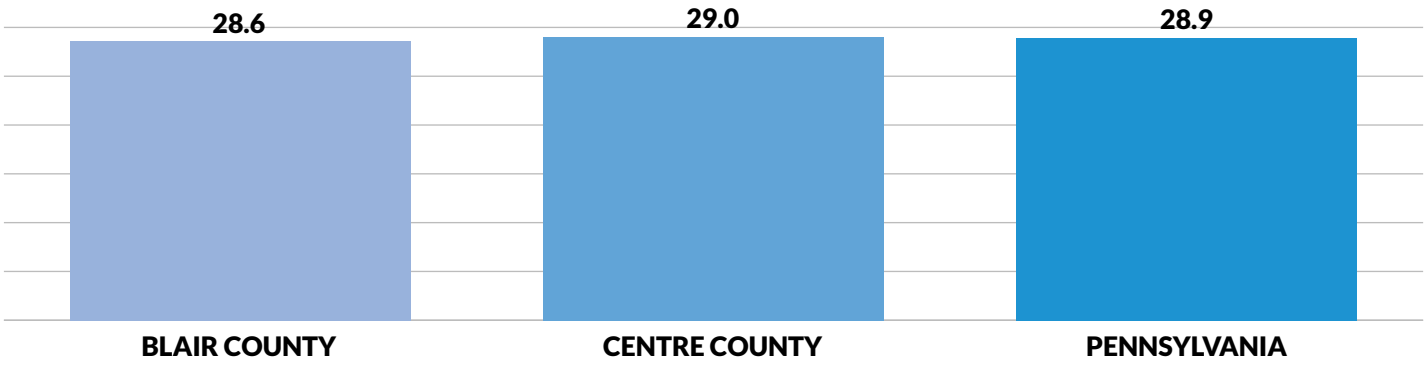
Source: Centers for Disease Control and Prevention, National Vital Statistics, 2021

Figure 26: High Blood Pressure



Source: Centers for Disease Control and Prevention 2021

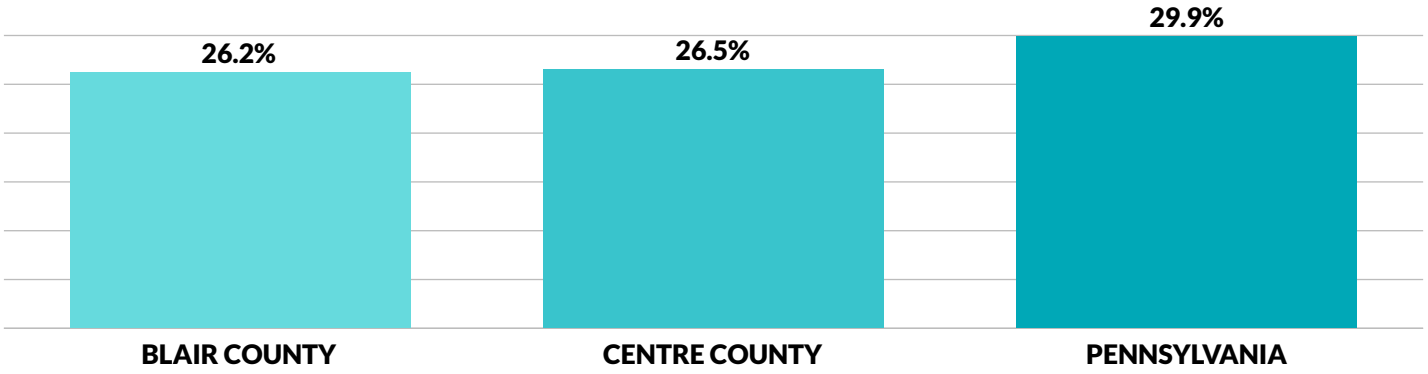
Figure 27: Adults with High Cholesterol



Source: Centers for Disease Control and Prevention 2021

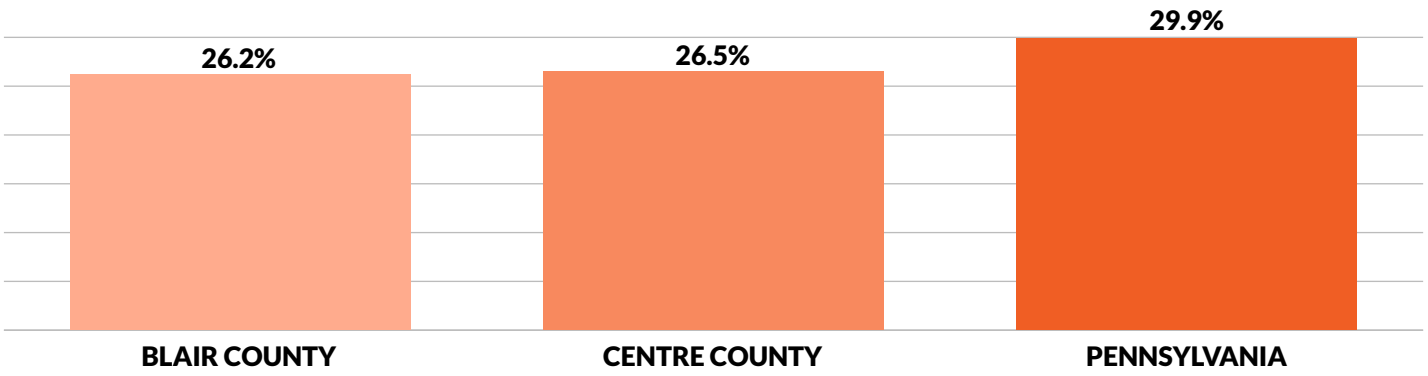
Figure 28 illustrates the percentage of obese residents in Blair and Centre counties. Excess weight may indicate an unhealthy lifestyle and put individuals at risk for further health issues. A BMI below 18.5 is underweight; 18.5-24.9 is normal or healthy; 25.0-29.9 is overweight; 30.0 and above is obese.

Figure 28: Obesity



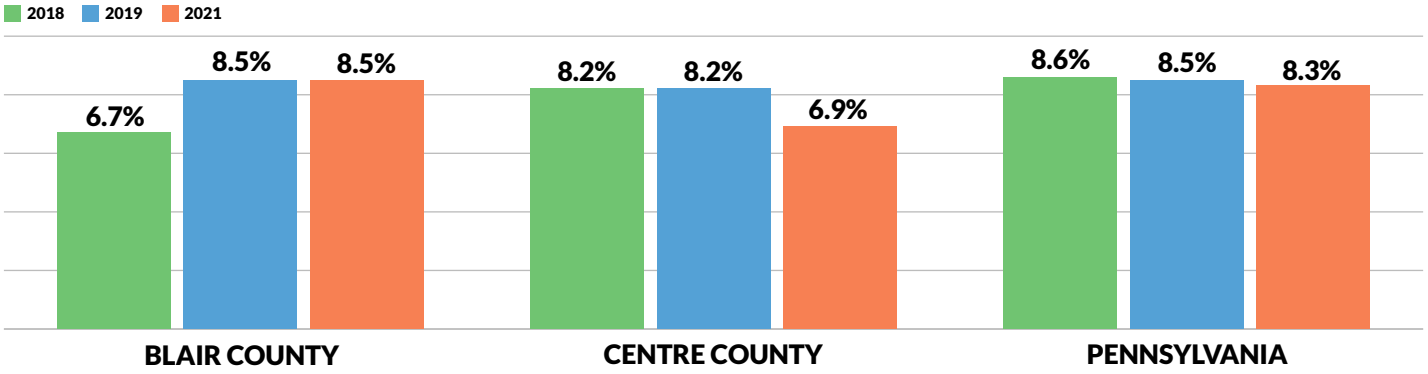
Source: Centers for Disease Control and Prevention 2021

Figure 29: Obese Adults with BMI > 30.0



Source: Centers for Disease Control and Prevention, 2021

Figure 30: Adults 21 Years+ with Diabetes



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion

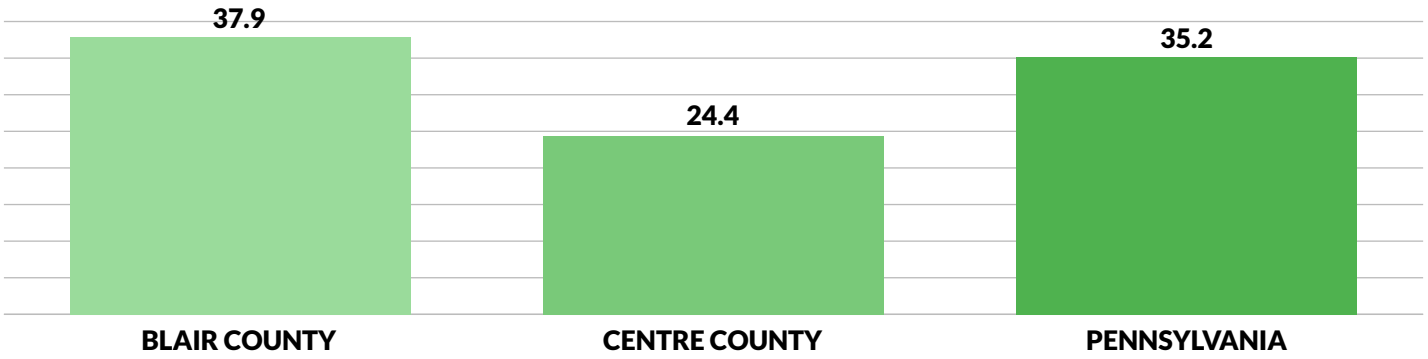
Cancer screenings play a crucial role in reducing cancer incidence rates by enabling the early detection of pre-cancerous conditions and early-stage cancers. Through regular screenings, abnormalities can be identified before they develop into full-blown cancers, allowing for timely interventions that can remove or treat these abnormalities effectively. This early detection often leads to more successful and less aggressive treatment options, reducing the likelihood of the cancer advancing to more severe stages. Consequently, widespread and routine cancer screenings can significantly lower the overall incidence of advanced cancers, improving patient outcomes and reducing the burden of the disease on healthcare systems.

Table 31: Cancer Incidence Rates

Pennsylvania (per 100,000 population)	Breast Cancer Incidence (women only)	Colon/Rectum Cancer Incidence (all genders)	Lung Cancer Incidence (all genders)	Prostate Cancer Incidence (men only)
Blair County	128.6	**43.8**	50.4	**112.1**
Centre County	140.5	30.7	38.0	102.4
Pennsylvania	467.4	38.2	59.5	108.9

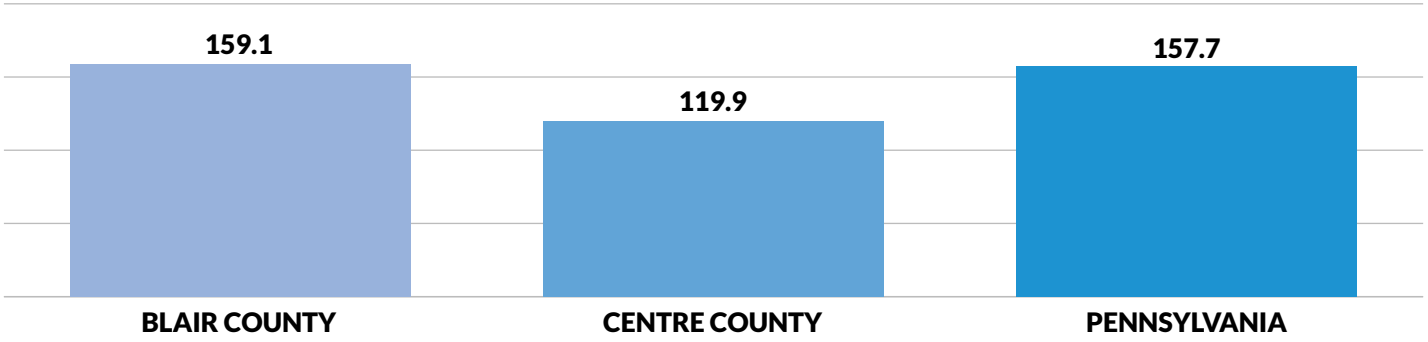
Note: Figures in **red** indicate higher rates when compared to state rates.
Source: State Cancer Profiles 2016-2020

Figure 32: Lung Disease Mortality (Per 100,000 Population)



Source: Centers for Disease Control and Prevention, 2016-2020

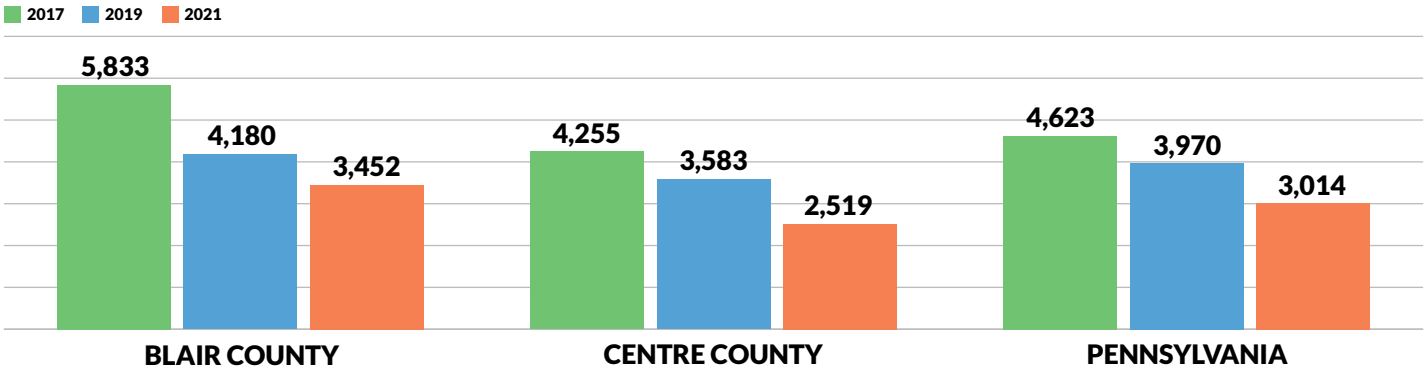
Figure 33: Cancer Mortality (per 100,000 Population)



Source: Pennsylvania State Cancer Profiles, 2016-2020

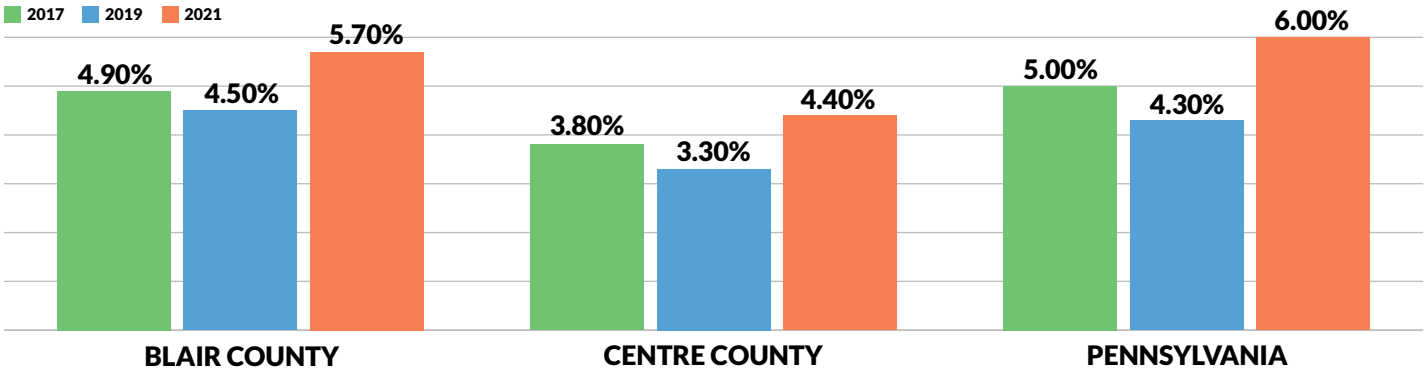
Figure 34 shows the preventable hospitalization rate among Medicare beneficiaries. Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection.

Figure 34: Preventable Hospital Events (Per 100,000 Medicare Beneficiaries)



Source: Centers for Medicare and Medicaid Services

Figure 35: Unemployment

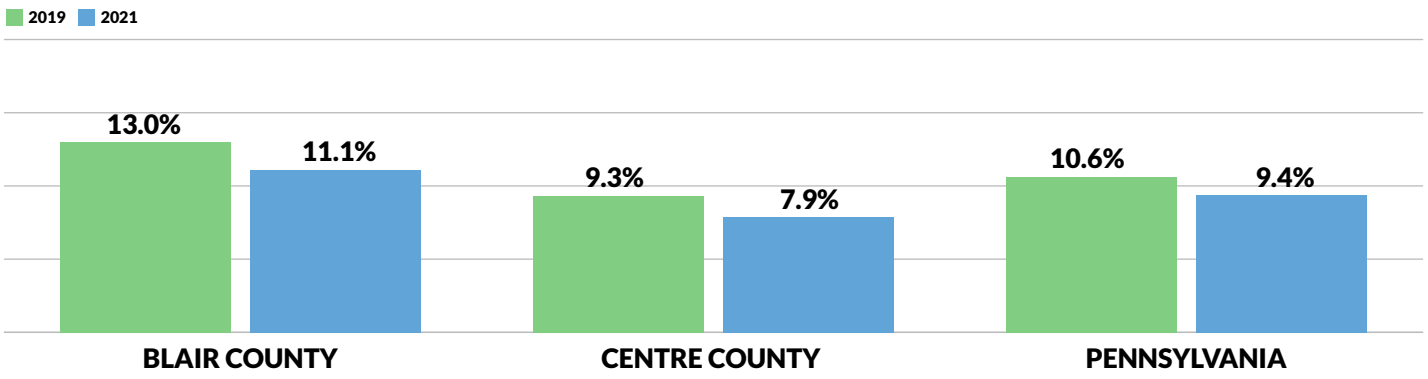


Source: U.S. Department of Labor, Bureau of Labor Statistics

Food insecurity significantly impacts health by limiting access to nutritious foods, leading to poor dietary intake and various health problems. Individuals experiencing food insecurity are more likely to suffer from chronic conditions such as obesity, diabetes, hypertension, and heart disease due to the consumption of low-cost, calorie-dense, but nutrient-poor foods. Additionally, food insecurity can cause stress and anxiety, which further exacerbate mental health issues such as depression and anxiety disorders. For children, insufficient nutrition can impair growth and development, weaken the immune system, and hinder academic performance. Overall, the lack of consistent access to adequate and nutritious food can have profound and long-lasting effects on physical and mental health.

Figure 36 reports the estimated percentage of Blair and Centre County residents who experience food insecurity at some point during the reported year. Food insecurity is a broadly- used measure of food deprivation in the U.S. The USDA defines food insecurity as "consistent access to adequate food is limited by a lack of money and other resources during the year."

Figure 36: Food Insecurity

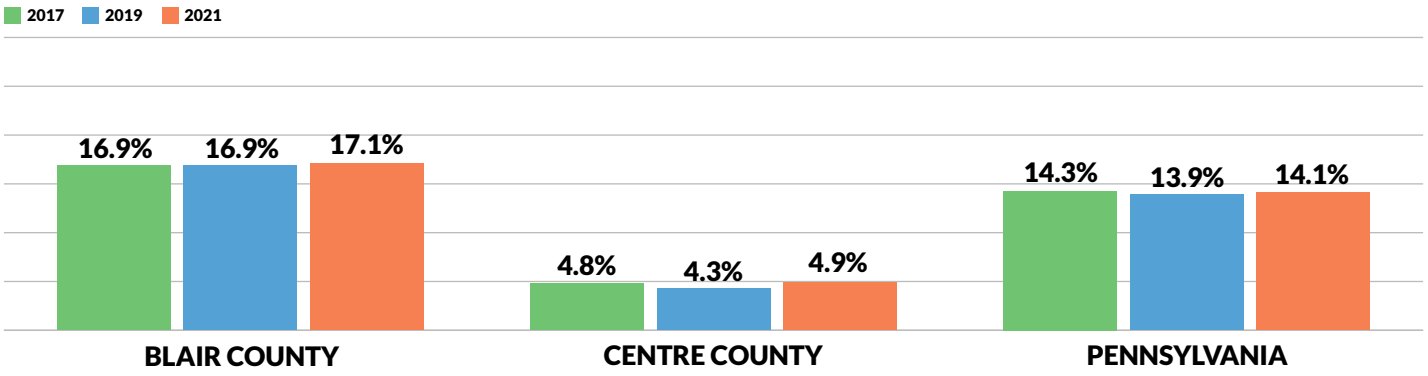


Source: Feeding America

SNAP benefits are crucial because they enhance food security for low-income individuals and families, ensuring access to nutritious food and reducing hunger. By improving dietary quality, SNAP contributes to better health outcomes, lowering the incidence of chronic diseases. The program also supports economic stability by freeing up household resources for other essential needs and stimulates local economies through food purchases. SNAP is vital for proper growth and cognitive development for children, contributing to better academic performance and overall well-being. Ultimately, SNAP plays a key role in alleviating poverty and promoting a healthier, more stable society.

Figure 37 assesses vulnerable populations more likely to have multiple health access, health status, and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.

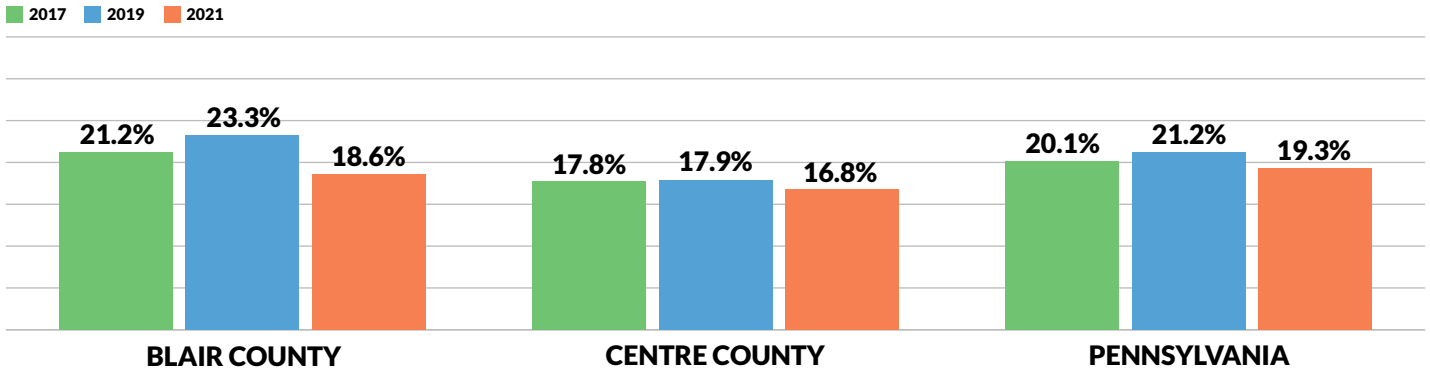
Figure 37: Population Receiving SNAP Benefits



Source: U.S. Census Bureau, American Community Survey

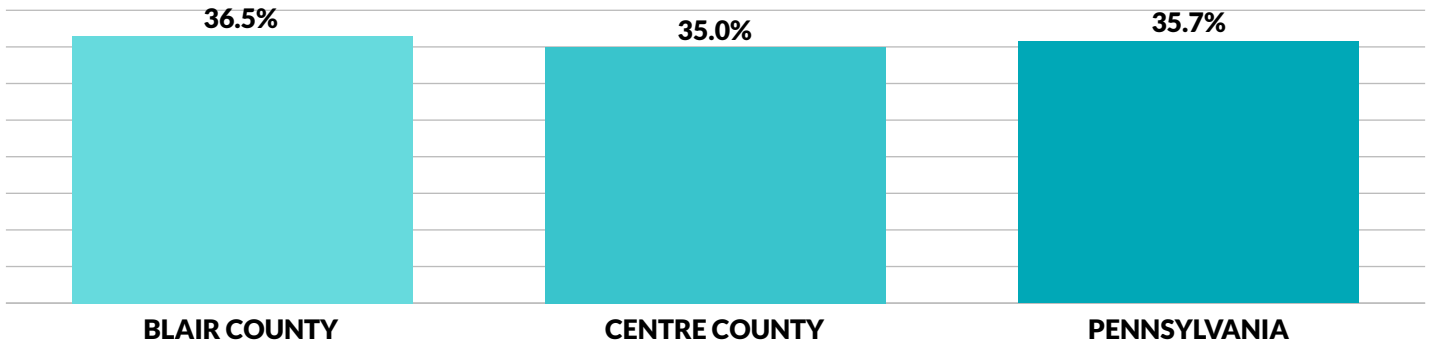
The data below is important as current behaviors are determinants of future health and may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health. Physical activity is important to prevent heart disease and stroke, two of the leading causes of death in U.S. In order to improve overall cardiovascular health, The American Heart Association suggests at least 150 minutes per week of moderate exercise or 75 minutes per week of vigorous exercise.

Figure 38: Adults who No Leisure Time Physician Activity



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion

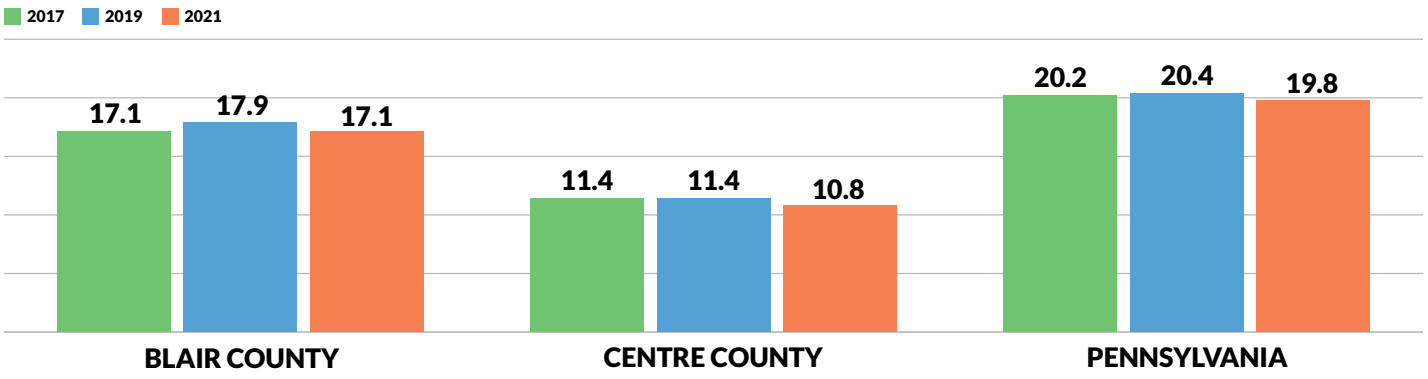
Figure 39: Adults 18+ Sleeping Less Than 7 Hours on Average



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2020

Grocery stores are defined as supermarkets and smaller grocery stores primarily retailing a general line of food, such as canned and frozen foods, fresh fruits and vegetables, and fresh and prepared meats, fish, and poultry. This indicator is relevant because it measures healthy food access and environmental influences on dietary behaviors.

Figure 40: Grocery Store Access (per 100,000 per population)



Source: U.S. Census Bureau

Health outcomes and social and economic factors are deeply intertwined, as the conditions in which people live, work, and learn significantly influence their health. Socioeconomic status determines access to nutritious food, safe housing, quality education, and healthcare services. Individuals with higher socioeconomic status often enjoy better health outcomes due to their ability to afford healthier lifestyles, preventative care, and medical treatments. Conversely, those with lower socioeconomic status face greater exposure to health risks such as poor nutrition, unsafe living conditions, and limited access to healthcare, leading to higher rates of chronic diseases and shorter life expectancy. Social factors such as community support, stress levels, and discrimination also impact mental and physical health. Thus, improving social and economic conditions is essential for promoting better health outcomes and reducing health disparities within populations.

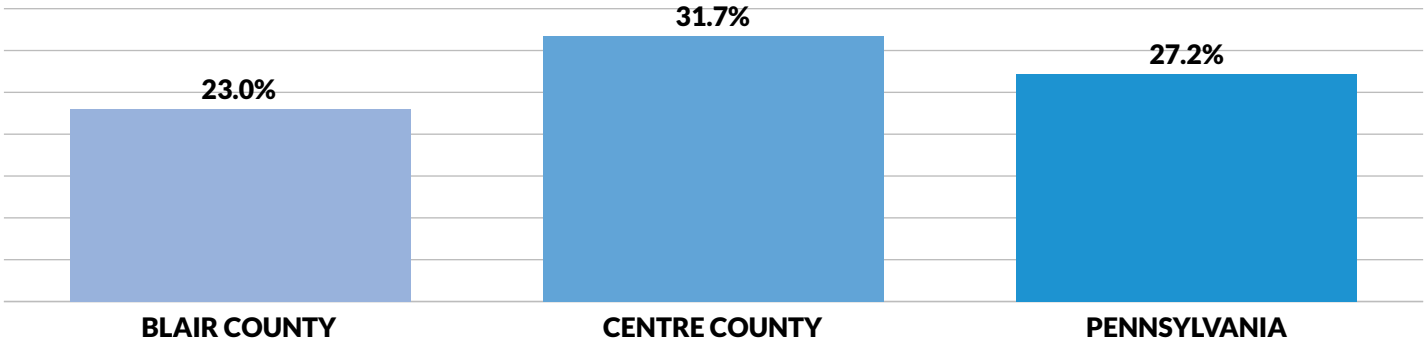
Table 41: Health Outcomes and Social and Economic Factors

2023	Health Outcomes	Social and Economic Factors
Blair County	44	58
Centre County	2	51

Note: Pennsylvania is home to 67 counties. A ranking of 1 indicates that the county is the best for a particular health outcome or factor.
Source: County Health Rankings & Roadmaps

Figure 42 reports the percentage of occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with one or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. This data is used to easily identify homes where the quality of living and housing can be considered substandard.

Figure 42: Housing - Units with One or More Substandard Conditions



Source: U.S. Census Bureau, American Community Survey 2018-2022

CONCLUSION

Improving health equity remains a formidable challenge, as it extends well beyond the hospital and health system, deeply influencing community sectors and local and state governments where health policies are crafted. Recognizing the need for a multi-sectoral approach, the healthcare environment increasingly acknowledges that achieving health equity requires the active engagement and mobilization of the broader community to address social, economic, and environmental determinants of health. Inadequate public transportation not only limits access to healthcare but also impacts employment, access to affordable healthy food, and other critical drivers of health and wellness. In response, Penn Highlands Tyrone will take the next step by aligning and integrating the voices and ideas gathered from the community through focus groups, surveys, and stakeholder interview feedback. Penn Highlands Tyrone will develop the CHNA Implementation Strategy Plan by engaging and collaborating with community partners, reinforcing its commitment to improving health outcomes and achieving health equity.

NEXT STEPS

Penn Highlands Tyrone will leverage its strengths, extensive resources, and broad outreach capabilities to collaborate effectively with community partners. Together, Penn Highlands Tyrone will identify and implement the most impactful strategies to address the unique health needs of their communities. This concerted effort aims to enhance overall health, address urgent health needs, and improve the well-being of residents within their service areas. The careful prioritization of identified needs will shape and drive community health improvement initiatives, ensuring that the Penn Highlands Tyrone efforts benefit the residents they serve.

ADDITIONAL INFORMATION

Penn Highlands Healthcare will create implementation plans that utilize the organization's strengths and resources to effectively meet the health needs of their communities and enhance the overall health and well-being of residents in Northwestern, Southwest, and Central Pennsylvania. For more details about the CHNA and its specific findings, please contact:

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APPENDIX

PRIMARY RESEARCH
KEY FINDINGS

METHODOLOGY

Penn Highlands Healthcare and Penn Highlands Tyrone worked closely with Tripp Umbach to conduct the system's 2024 CHNA. The CHNA report complies with the Internal Revenue Service's (IRS) guidelines for charitable 501(c)(3) tax-exempt hospitals and includes input from individuals representing the broad interests of the communities served by Penn Highlands Tyrone, including those with direct knowledge of the needs of the medically underserved, disenfranchised, and chronic disease populations.

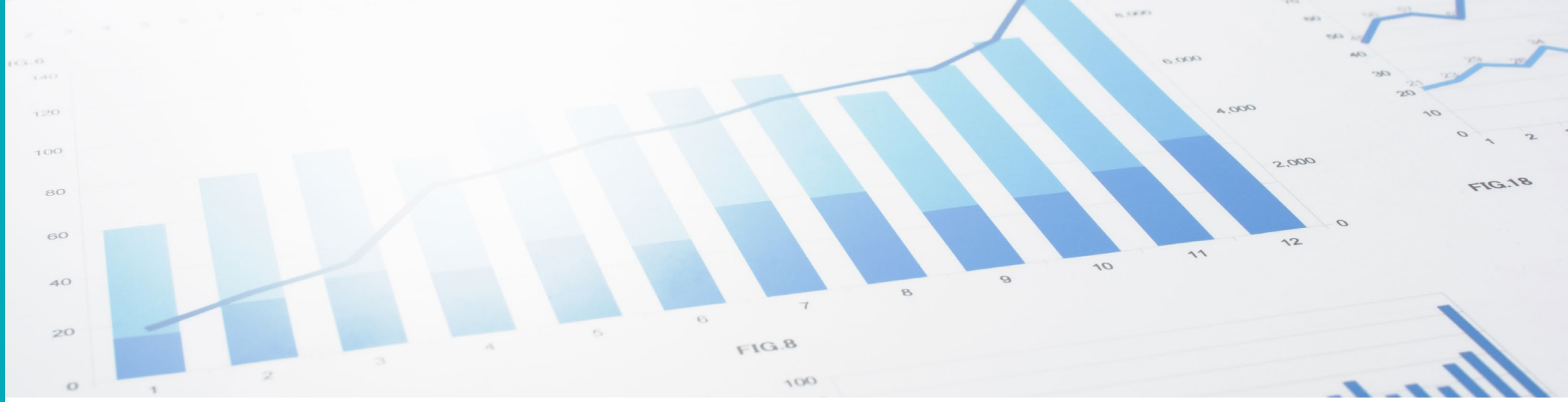
The data collected allows for further group engagement to inform the CHNA needs and deliverables. While multiple steps made up the overall CHNA process, Tripp Umbach worked closely with members of the CHNA working group to collect, analyze, and identify the results to complete Penn Highlands Healthcare's assessment.

Beginning in January 2024, the working group, which included representatives from Penn Highlands Tyrone, held monthly conference calls. These project calls provided working group members with insights and awareness of all components of the CHNA project. To meet IRS requirements related to the ACA, the study methodology included qualitative and quantitative data methods to identify the needs of underserved and disenfranchised populations.

DEFINED COMMUNITY

In the context of a CHNA, the defined community refers to the specific population or geographic area that is the focus of the assessment. This community can be delineated by geographic boundaries (e.g., counties, cities, or neighborhoods), demographic characteristics (e.g., age, race, or socioeconomic status), or the population served by a healthcare provider or organization. Clearly defining the community is essential for accurately assessing health needs, as it ensures that the data being collected and analyzed reflects that specific population's unique characteristics and health challenges. By focusing on a well-defined community, the CHNA provides precise and actionable insights, facilitating the development of targeted health interventions, policies, and programs tailored to residents' needs. This approach helps to ensure that health resources are allocated effectively and that efforts to improve health outcomes are concentrated where they are most needed, ultimately enhancing the community's overall well-being.

The Penn Highlands Tyrone defined community is the geographic area from which a significant number of the patients utilizing hospital services reside. While the CHNA considers other healthcare providers, the hospital is the largest provider of acute care services. For this reason, utilizing hospital services provides the most precise definition of the community.



SECONDARY DATA

Secondary data sources at the local, state, and national levels included information on disparities, public health priorities related to disease prevalence, socioeconomic factors, health outcomes, and health determinants. This data was used to create a regional community health profile based on the location and service areas of Penn Highlands Tyrone. The primary and secondary data source was Community Commons, a publicly available dashboard of multiple health indicators drawn from national data sources that allowed for reviewing past developments and changes in demographics, health, social, and economic factors. Additional data sources included County Health Rankings and the U.S. Census Bureau. The data was peer-reviewed and substantiated, providing a high-level of validity.

The comprehensive community profile generated a deeper understanding of regional issues, particularly in identifying regional and local health and socioeconomic challenges. The secondary quantitative data collection process included the following:

1. America's Health Rankings
2. Centers for Disease Control and Prevention (CDC)
3. Centers for Medicare and Medicaid Services
4. Community Commons Data
5. County Health Rankings
6. Dartmouth College Institute for Health Policy & Clinical Practice
7. Federal Bureau of Investigation
8. Feeding America
9. Kids Count Data Center
10. National Center for Education Statistics
11. Pennsylvania Department of Health
12. U.S. Department of Agriculture
13. U.S. Census Bureau
14. U.S. Department of Health & Human Services
15. U.S. Department of Housing and Urban Development
16. U.S. Department of Labor

EVALUATION OF PREVIOUS IMPLEMENTATION STRATEGY

Representatives from Penn Highlands Tyrone have worked over the last three years to develop and implement strategies to address the health needs and issues in the study area and evaluated the effectiveness of the strategies created to meet goals and combat health problems in the community. The evaluation aimed to determine the effectiveness of the methods identified by the previous ISP.

The working group tackled the goals for each past priority, evaluating each goal, objective, and strategy to develop ways to better address the effectiveness of each aim. The self-assessments on each strategy are internal markers that denote improving and tracking each strategy and action step within the next three years. Penn Highlands Tyrone addressed each of the strategies below. Specific metric information/measurable indicators can be obtained from Penn Highlands Healthcare's administrative department.

HEALTH PRIORITY: ACCESS TO HEALTHCARE

Goal: Early detection and prevention

Objectives/Strategies
Recruit primary and specialty care providers using PHH recruitment plan.
Strengthen ALS/BLS transports within PHH system.
Implement infusion center for cancer care.
Strengthen swing bed services and increase acuity to include ventilator services.

HEALTH PRIORITY: CHRONIC DISEASES AND CONDITIONS

Goal: Expand awareness and services to promote preventive health and wellness throughout the community.

Objectives/Strategies
Explore personnel resources to ensure adequate coverage by a registered dietician.
Strengthen care coordination through community partnerships, including use of referral software/website to support e-referral process to community resources to address SDOH needs.

UNMET OBJECTIVES AND STRATEGIES

IMPLEMENTATION STRATEGY PLAN

Penn Highlands Tyrone was unable to address certain specific objectives and strategies in its Implementation Strategy Plan due to significant constraints in resources and staffing. The limited availability of financial and human resources hindered their ability to fully execute the comprehensive strategies initially outlined. Staffing shortages posed a critical challenge, affecting the hospital's capacity to allocate sufficient personnel to various initiatives. This shortage impacted the ability to sustain long-term projects and effectively manage additional workloads. Consequently, the need to prioritize essential services and immediate operational requirements led to deferring some strategic objectives in the ISP. This prudent decision was necessary to maintain the quality of patient care and operational stability, ensuring that the community's most critical needs were met within the constraints faced by Penn Highlands Tyrone.

While still important to the community's health, the identified objectives and strategies will be further evaluated in the 2024 ISP phase. Penn Highlands Tyrone will continue to meet the needs of its community through existing health/human and clinical services in collaboration and partnership with other healthcare and community organizations.

COMMUNITY LEADER INTERVIEWS

During the CHNA process, telephone interviews were conducted with community stakeholders in the service area to better understand the evolving environment. These interviews allowed community leaders to offer feedback on community needs, suggest secondary data resources for review, and share other relevant information for the study. The interviews with community stakeholders took place from February to April 2024 and included individuals from professional backgrounds, including:

1. Government leaders
2. Professionals with access to community health-related data
3. Public health experts
4. Representatives of underserved populations
5. Social service representatives

Thirty-six interviews were conducted with community leaders and stakeholders as part of the assessment. The qualitative data gathered from these interviews reflect the opinions, perceptions, and insights of the CHNA participants. This information provided valuable insights and added significant depth to the qualitative data.

Overall health needs, themes, and concerns were identified during the interview and discussion. Each overarching theme encompassed several specific topics. Below are key themes that community stakeholders highlighted as the largest health concerns in their community.

1. Transportation issues
2. Lack of available services
3. Healthcare coordination (lack of healthcare coordination services)
4. Insurance coverage/issues
5. Affordability
6. Behavioral health (mental health and substance abuse)
7. Economic disparities
8. Mobility issues (physical difficulty getting around)
9. Lifestyle and health habits (unhealthy eating habits and inadequate physical activity)
10. Aging problems
11. Chronic conditions/diseases (heart disease, diabetes, cancers, etc.)
12. Lack of education

PUBLIC COMMENTARY

As part of the CHNA, Tripp Umbach solicited comments related to the 2021 CHNA and Implementation Strategy Plan on behalf of Penn Highlands Tyrone. Feedback was solicited from community stakeholders identified by the working group. Observations allowed community representatives to react to the methods, findings, and subsequent actions taken because of the 2021 CHNA and ISP process. Stakeholders have posed questions developed by Tripp Umbach. The public comments below summarize stakeholders' feedback regarding the former documents. The collection period for the study occurred from February to April 2024.

- When asked whether the assessment "included input from community members or organizations," 48.4% reported it did.
- In the survey reviewed, 38.7% reported that the report did not exclude community members or organizations that should have been involved.
- In response to the question, "Are there needs in the community related to health that were not represented in the CHNA?" 40.0% reported that there weren't.
- Slightly less than one-third, 32.3% of respondents, indicated that the ISP was directly related to the needs identified in the CHNA.

According to respondents, the CHNA and the ISP benefited them and their community in the following manner (in no specific order):

- The more data, the better. Data drives areas of improvement and helps determine how to improve and utilize better services.
- It's a good starting point for individuals and organizations to examine and implement ideas. It contains a lot of information.
- It did not. They took care away. Distance to care is a problem — complete assessments to check.
- There is great information in sharing the plan with participating organizations. This can create more collaborative meetings.
- It implemented adding a pulmonologist.
- Transportation is talked about but not addressed.
- A lot of implementations surrounding education, but infrastructure is still lacking.
- Improvements to healthcare and services.
- It benefited our community. Anything we can do to help our community is a hand up, not a handout — it is the messaging of the people you are trying to connect with.
- The whole county faces disparities.
- Continue to build the services and the care in the region. Better access to quick care.
- We do not have tracks to evaluate all of the programs. Tyrone lost some of its behavioral health capacity, but I understand the logistics of being cost-effective and having it relocated.
- Better collaboration and more effective partnerships.

COMMUNITY SURVEY

A community survey was conducted to gather data from residents within the Penn Highlands Tyrone service area and the region. The survey identified the community's specific health needs and concerns, including those of vulnerable populations that might not be evident through other means. By gathering detailed feedback from community members and stakeholders, organizations can make more informed decisions about where to allocate resources and how to develop targeted interventions. The survey also provides valuable insights into how health needs have evolved, especially during significant events such as the COVID-19 pandemic. Overall, the community survey ensured that health and social initiatives are responsive to the community's actual needs, leading to more effective and efficient healthcare delivery.

Working with the CHNA working group, a quality-of-life survey instrument was created and distributed to patients and community residents using Penn Highlands Healthcare services. The survey was also sent to residents identified from the Tyrone County Family Resource Network, St. Marys Area United Way, the Stackpole-Hall Foundation, and the Stackpole-Hall Foundation's William C. Conrad Summer Jobs Program employers.

The community survey was active from March to April 2024, and 1,254 surveys were collected. Below are the top health problems providers reported in their community, descending from the most identified to the least identified.

1. Aging problems
    - Arthritis
    - Eldercare
2. Behavioral health, mental health, and substance abuse
3. Chronic disease prevention/management
    - Cancers
4. Overweight/obesity
    - Eating well/nutrition
    - Lack of exercise
    - Managing weight

FOCUS GROUPS

Qualitative data was collected from two focus groups representing the Northwest and Southwest regions of Penn Highlands Healthcare. The focus groups were seniors, who represented the Northwest Region, which had nine participants, and providers of residents with chronic conditions, with six participants. The working group agreed upon the focus groups based on secondary and primary data presented. Feedback from key informants, secondary data, and community surveys provided information through the lens of representatives who provide services and directly interact with community residents.

SENIOR FOCUS GROUP

The focus group identified health issues, needs, and concerns affecting community residents and identified ways to address those concerns. Seniors specifically discussed challenges and opportunities in healthcare services for seniors in rural Pennsylvania, including transportation, affordability, and accessibility. They highlighted the importance of understanding residents' experiences to inform programming efforts and address health and social needs. Seniors also discussed the limited availability of senior housing in rural areas and the need for more affordable and accessible housing options. Additionally, they emphasized the importance of mental health services, and the challenges seniors face in accessing telemedicine platforms and healthy food options during COVID-19.

The themes from the focus group included:

- Health and social needs in a rural area.
- Transportation challenges in rural Pennsylvania.
- Transportation barriers to medical appointments and potential solutions such as home visits by healthcare providers.
- Affordable senior housing options.
- Building trust in healthcare organizations through advocacy and word of mouth.
- Healthcare access and transportation barriers in a small town.
- Mental health services in rural Pennsylvania.
- Food access and healthy eating habits among older adults.

PROVIDERS OF RESIDENTS WITH CHRONIC CONDITIONS FOCUS GROUP

Providers discussed rural healthcare's challenges and opportunities, including access to care, specialist shortages, and the importance of community-based initiatives. They highlighted the need for walkability and accessibility, youth programs that promote exercise, and resources for the geriatric population. Speakers also addressed transportation issues, affordable personal care homes, and educating patients about available resources. To attract and retain high-quality healthcare providers, speakers proposed ideas such as competitive salaries, opportunities for professional growth, and investment in new technology. Overall, the conversation emphasized the need for a comprehensive approach to address rural healthcare's unique challenges, particularly for residents who face chronic diseases.

The theme from the focus group included:

- Positive aspects of living in a rural community and its impact on health outcomes.
- Community needs in rural Western Pennsylvania, including access to care, behavioral health, and transportation issues.
- Transportation and chronic condition management challenges in a healthcare setting.
- Recruiting and retaining healthcare professionals in a rural area.
- Lack of mental health and substance abuse services in the community.
- Improving mental health support systems.
- Improving patient access to healthcare services.
- Telemedicine, technology, and patient population in healthcare.
- Health challenges in a rural community.

INTERVIEWS WITH LOW-INCOME RESIDENTS

Tripp Umbach conducted eight interviews with low-income residents as part of the CHNA. This is critical in understanding and addressing this demographic's unique health challenges. The interviews provide valuable firsthand insights into the barriers and disparities experienced by low-income individuals, such as limited access to healthcare, inadequate housing, food insecurity, and chronic stress. By engaging directly with residents, researchers can gather nuanced data that quantitative methods alone may not capture, ensuring that the assessment reflects the true needs and priorities of the community. The interviews empowered residents by giving them a voice in the assessment process and continued to build trust with the community-based organization that recruited them for the interview. The information gleaned from these interviews informs targeted interventions and policies, ultimately leading to more equitable and effective health outcomes for all community members.

The themes from the interviews included:

- Healthcare access issues.
- Adequate health insurance coverage.
- Specific health services and programs that are lacking in the community.
- Challenges in accessing medical care and services.
- Insufficient mental health resources.

PRIORITIZATION PLANNING SESSION

Tripp Umbach conducted an internal hospital prioritization session with working group members to present the CHNA findings and gather input on the community's overall needs and concerns. A 90-minute virtual prioritization meeting took place to rank, target, and align resources while focusing on achievable goals and strategies to address community needs. The priorities were identified by examining data and overarching themes from the CHNA findings. During the virtual meeting on Teams, attendees received a brief presentation on the key findings from the CHNAs.

CONSENSUS DEVELOPMENT STEPS

1. Group discussions on the top health need to identify similarities and differences.
2. Sharing the health needs identified by working group members.
3. Clustering similar health needs into themes.
4. Determine the final health need.
5. Comparing and discussing new needs with those from the previous CHNA.

CRITERIA FOR PRIORITIZATION

The following decision-making criteria were used to guide prioritization processes for the assessment cycle.

- Consider the CHNA needs from the previous assessment. Were those needs addressed? Or are they still being addressed?
- What were the top needs/issues from the community stakeholder's data?
- What were the top needs/issues from the community surveys?
- What were the top needs/issues from the secondary data?
- What is the magnitude/severity of the problem?
- What are the needs of vulnerable populations?
- What is the community's capacity and willingness to act on the issue?
- What is the hospital's ability to have a measurable impact on the issue?
- What hospital and community resources are available?

PRIORITIZATION PROCESS

The prioritization process was designed to be inclusive, participatory, and data-driven. Meeting participants were encouraged to reflect on and discuss the data, provide narratives relevant to each community need, and offer their perspectives on issues. After a thorough group data review and reaching a consensus, the group identified and agreed upon the following CHNA needs. The collaborative process ensured that all perspectives were considered, comprehensively understanding the community's health priorities. These agreed-upon needs reflect the collective commitment to addressing the most pressing health concerns in Penn Highlands Healthcare's community.

COMMUNITY RESOURCE INVENTORY

Tripp Umbach created a comprehensive inventory of programs and services available in the region. The inventory highlighted programs and services within the service areas corresponding to each priority need area. It identified the organizations and agencies serving the target populations within these priority needs, provided detailed program descriptions, and gathered information on the potential for coordinating community activities and establishing linkages among agencies. The interactive community resource can be found on Penn Highlands Healthcare's website.

DATA LIMITATIONS

It is important to note that the data collected for the 2024 CHNA has limitations. Secondary data utilized for the report is not specific to the Penn Highlands Tyrone primary service area but provides a larger geographic region scope. Primary data obtained through interviews, community surveys, and focus groups were also limited in representing the Penn Highlands Tyrone service area, as information was collected through convenience sampling.

ABOUT
TRIPP UMBACH

Tripp Umbach, a private consulting company, is a nationally renowned firm with extensive experience in conducting CHNAs across diverse regions and populations. In fact, more than one in five Americans lives in a community where our firm has worked. With a deep understanding of healthcare dynamics, Tripp Umbach employs a comprehensive approach combining quantitative and qualitative data collection methods. This enables them to capture a holistic view of community health needs, including the perspectives of medically underserved and vulnerable populations. Tripp Umbach's methodology ensures that regional stakeholders, from local healthcare providers to community leaders, are engaged, ensuring that the CHNA reflects a broad spectrum of community insights and priorities.

Over the years, Tripp Umbach has completed numerous CHNAs for hospitals and healthcare systems, non-profit organizations, and state entities. Tripp Umbach leverages expertise in identifying pressing health needs and assists organizations in developing targeted strategies to address these issues effectively. Tripp Umbach's CHNAs comply with IRS guidelines for charitable 501(c)(3) tax-exempt hospitals, ensuring that healthcare providers meet regulatory requirements while improving community health outcomes. Through its rigorous and inclusive process, Tripp Umbach has consistently enabled communities to enhance their healthcare services, address disparities, and improve overall public health.

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