Penn Highlands Connellsville

Empowering Communities:

Unveiling Health Needs, Driving Positive Change

IMPLEMENTATION STRATEGY PLAN (ISP)

IN RESPONSE TO THE PENN HIGHLANDS CONNELLSVILLE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

2024

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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 statement focuses on improving regional access to a wide array of premier primary care and advanced services; it does so while supporting a reverence for life and the worth and dignity of each individual. The linkage provides the ability to keep control of the hospitals in the hands of a local board and provides many other community benefits. Increased local access to physician specialists, improved quality, coordination of care, and increased physician recruitment and retention are significant benefits of the linkage.

INTRODUCTION

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 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 742 inpatient beds, 388 long-term care beds, 276-person care beds, and 174 independent living units.

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 nonprofit community organizations for more than 100 years, a valued and cherished commitment.

PENN HIGHLANDS CONNELLSVILLE

On April 1, 2022, Penn Highlands Connellsville, formerly known as Highlands Hospital, officially joined Penn Highlands Healthcare. Penn Highlands Connellsville will continue to play a vital role in the local community by providing high-quality healthcare services and maintaining its strong presence as a trusted healthcare provider. As a member of Penn Highlands Healthcare, Penn Highlands Connellsville gains access to expanded resources, advanced medical technologies, and specialized care, ensuring that the community benefits from a broader range of services while receiving personalized care.

As such, the Penn Highlands Connellsville involvement in the CHNA becomes even more impactful.[1] Penn Highlands Connellsville can leverage additional resources, expertise, and data to conduct more comprehensive assessments of the community's health needs as part of a larger health system. The integration allows for greater collaboration across Penn Highlands Healthcare, ensuring that best practices and innovative strategies are shared to address health disparities and improve outcomes. Penn Highlands Connellsville can tap into the broader system's resources to implement targeted health programs, prioritize key issues such as chronic disease management or access to care, and allocate funding more efficiently to meet the identified needs. Penn Highlands Connellsville can foster stronger partnerships with other public health agencies and community organizations. This approach enhances the hospital's ability to drive initiatives that are sustainable and aligned with the health priorities identified in the CHNA. The Penn Highlands Connellsville role is to address local health needs, promote healthier communities, and ensure that the CHNA leads to meaningful, actionable improvements in community health.

Penn Highlands Connellsville is a locally managed, 64-bed hospital nestled in the picturesque Laurel Highlands of Southwestern Pennsylvania. Dedicated to providing healthcare in a competent, nurturing, and healing environment, the hospital supports the community during times of crisis and connects patients with the resources needed for a healthy life. The staff at Penn Highlands Connellsville understands that every patient has unique needs and concerns, serving not only as diagnosticians but also as sources of support and hope. Committed to delivering state-of-the-art facilities for residents of Fayette and Westmoreland counties, Penn Highlands Connellsville actively seeks innovative ways to offer the community optimal healthcare.

The Penn Highlands Connellsville CHNA employed a structured approach to identify and prioritize the needs of underserved communities throughout its service area. The findings and the Implementation Strategy Plan (ISP) report aim to improve health outcomes and address social and environmental health challenges.

Penn Highlands Connellsville extends its sincere thanks to the stakeholders, community providers, and organizations whose contributions were vital to the assessment's success. Their input is greatly valued and appreciated throughout this important process.

[1] It is important to note that Penn Highlands Connellsville will address their previous 2021 CHNA needs: Behavioral Health, Chronic Disease, Access to Care, and Women's and Children's Health, except for children's health. PH Connellsville will not address children's health needs due to limited specialized resources, a focus on adult patients, and funding and operational constraints. Women's Health will be addressed and nested under access to care's subcategory specialty care. For the current cycle, Penn Highlands Connellsville streamlined and prioritized its health issues, such as chronic disease, behavioral health, and access to care, which were pressing concerns for the broader community. Additionally, resource limitations constrained the Penn Highlands Connellsville ability to focus on multiple health areas simultaneously, leading them to allocate funding and efforts to issues that affect a larger portion of the population.

PENN HIGHLANDS CONNELLSVILLE
SERVICES

Autism Center
Behavioral Health
Breast Health
Cancer Care – Hematology, Medical Oncology
Cardiac Rehab
Cardiology
Concussion Treatment
Diabetes and Nutrition Wellness
Emergency Care
General Surgery
Inpatient and Intensive Care Units
Lab Services
Mammography
Medical Imaging (Radiology)
Orthopedics and Sports Medicine
Outpatient Surgery
Physical Therapy
Primary Care
Rehabilitation Services
Sleep Center
Speech Therapy
Surgical Services
Swing Bed
Transcranial Magnetic Stimulation
Walk-in Care

PENN HIGHLANDS CONNELLSVILLE
ACCREDITATIONS

2023 - 2027 American College of Radiology - Nuclear Medicine Accreditation of the Commission on Quality and Safety for Planar, Nuclear Cardiology

2023-2026 American College of Radiology Accreditation - MRI

2023 Mammography Quality Standards Act (MQSA) Certification - Mammography

2023 American College of Radiology (ACR) Accreditation- All Digital/3D Mammography

2022 - 2025 American College of Radiology - Mammography Accreditation of the Commission on Quality and Safety

2022 - 2025 US Department of Health and Human Services Food and Drug Administration - Certified Mammography Facility

2021 - 2024 American College of Radiology - Computed Tomography Accreditation of the Commission on Quality and Safety for Adult and Pediatric Patients Head/Neck, Chest, Abdomen

2021- 2024 American College of Radiology - Ultrasound Accreditation of the Commission on Quality and Safety for Gynecological, General, Vascular (including Cerebrovascular, Deep Abdominal Vascular, Peripheral Vascular)

2021 - 2025 American Diabetes Association Certification - Meeting National Standards for Diabetes Self-Management Education

2020 - 2023 American College of Radiology – Head Spine, Body, MSK, MRA

BACKGROUND

Under the Patient Protection and Affordable Care Act (PPACA), all nonprofit hospitals must perform a Community Health Needs Assessment every three years. This process ensures that hospitals stay responsive to the evolving health needs of their communities. The CHNA must define the hospital's community, gather input from a wide range of stakeholders, including public health experts and community members, and assess the most pressing health needs in the area. Once the health needs are identified, hospitals must prioritize them based on their significance and develop an implementation strategy to address them. The Implementation Strategy Plan should include potential measures, partnerships, and resources available to effectively tackle the identified issues, helping hospitals align their efforts with the well-being of their communities.

IMPLEMENTATION STRATEGY PLAN
REPORT PURPOSE

The ISP report for a CHNA is a critical document that outlines how identified health priorities will be addressed within a community. The ISP report aims to identify the goals, objectives, and strategies that Penn Highlands Connellsville will use to address the health priorities identified in the recent CHNA. The findings from the CHNA will outline actionable steps that healthcare organizations and their community partners will take to improve health outcomes. The ISP report details strategies, resources, and partnerships necessary to tackle the most pressing health issues, ensuring the proposed initiatives are impactful. By providing a clear roadmap, the ISP fosters collaboration among various sectors, aligning efforts to create meaningful improvements in the health and well-being of the community.

DEFINED COMMUNITY

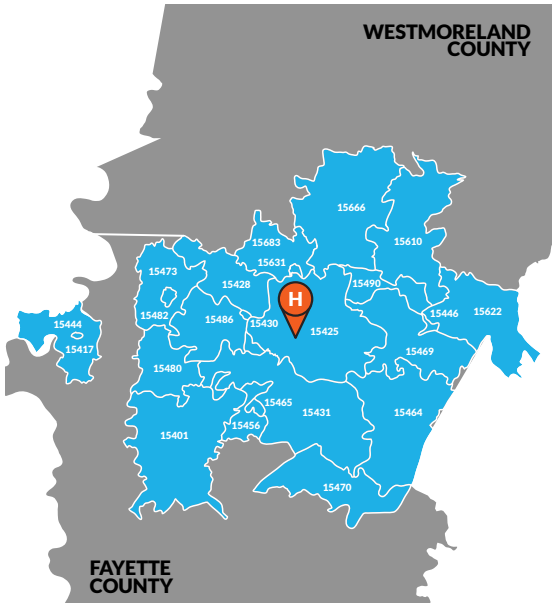
A community is defined as the geographic area where many patients who utilize hospital services reside. Although the CHNA includes other types of healthcare providers, the hospital remains the largest provider of acute care services. Consequently, hospital service usage offers the clearest definition of the community. In 2024, 24 ZIP codes were identified as the primary service area for Penn Highlands Connellsville. The following table highlights the study area focus for the Penn Highlands Connellsville CHNA, with these ZIP codes accounting for 80% of the hospital's patient discharges. While most discharges are from Fayette and Westmoreland counties, patients come from neighboring counties.

The following table and map of the Penn Highlands Connellsville geographical location display the hospital's defined community related to the 24 ZIP codes.

Table 1: Penn Highlands Connellsville Primary Service Area

ZIP Code	Town	County
15401	Uniontown	Fayette
15417	Brownsville	Fayette
15425	Connellsville	Fayette
15428	Dawson	Fayette
15430	Dickerson Run	Fayette
15431	Dunbar	Fayette
15444	Brownsville	Fayette
15446	Indian Head	Fayette
15455	Leisenring	Fayette
15456	Lemont Furnace	Fayette
15464	Mill Run	Fayette
15465	Mount Braddock	Fayette
15469	Normalville	Fayette

ZIP Code	Town	County
15470	Ohiopyle	Fayette
15473	Perryopolis	Fayette
15480	Smock	Fayette
15482	Star Junction	Fayette
15486	Dickerson Run	Fayette
	Leisenring	Fayette
	Vanderbilt	Fayette
15490	White	Fayette
15610	Acme	Fayette
15622	Champion	Fayette
15631	Everson	Fayette
15666	Mount Pleasant	Westmoreland
15683	Scottdale	Westmoreland



PENN HIGHLANDS HEALTHCARE

OVERALL PRIORITIZED NEEDS

Extensive primary and secondary research identified key regional priorities for community members, leaders, and project leadership. The research illustrated the need to address access to care, behavioral health, and chronic diseases/conditions. Each key need area had subareas of concentration. The table below illustrates how each hospital within Penn Highlands Healthcare will address the needs within its region.

	ACCESS TO CARE			BEHAVIORAL HEALTH[2]	CHRONIC DISEASES/CONDITIONS[3]	
	Infrastructure[4]	Lack of PCP/Specialist[5]	Specialty care[6]		Health Behaviors[7]	Social Determinants of Health[8]
Penn Highlands Brookville	●	●	●	●	●	●
Penn Highlands Clearfield/Penn Highlands Dubois	●	●	●	●	●	
Penn Highlands Elk	●	●	●	●	●	
Penn Highlands Huntingdon/Penn Highlands State College	●	●	●	●	●	●
Penn Highlands Tyrone	●	●	●	●	●	●
Penn Highlands Connellsville	●	●	●	●	●	●
Penn Highlands Mon Valley[9]	●	●	●	●	●	●

[2] Behavioral health (Mental Health & Substance Abuse)
[3] Chronic diseases/conditions (e.g., diabetes, chronic obstructive pulmonary diseases, high blood pressure)
[4] Infrastructure (e.g., care coordination, navigation, and transportation)
[5] Lack of primary care physicians (PCP)/Physician specialists
[6] Specialty care (e.g., cancer care, women's health)
[7] Health behaviors (e.g., nutrition, physical activity, obesity)
[8] Social determinants of health (e.g., education, income etc.)
[9] PH Mon Valley CHNA needs are Diabetes Deaths, Stroke Deaths, Mammography/Breast Cancer, and Colorectal Cancer Deaths. Therefore, it has been classified under Chronic Diseases/Conditions.

2024-2027 PENN HIGHLANDS CONNELLSVILLE
PRIORITIZED NEEDS

Senior leaders from Penn Highlands Connellsville reviewed the previous Implementation Strategy Plan and refined and reinforced key strategies. They prioritized specific initiatives and explored ways to sustain and enhance services for the broader community through the updated plan. Senior leadership from Penn Highlands Healthcare and Penn Highlands Connellsville contributed to the CHNA/ISP working group. Moving forward, senior leaders will regularly evaluate the strategy plan, making adjustments as needed to better align with the community's evolving health needs.

The CHNA for Penn Highlands Connellsville highlighted the following community needs. This assessment evaluated 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.

PENN HIGHLANDS CONNELLSVILLE CHNA NEEDS

ACCESS TO CARE	BEHAVIORAL HEALTH	CHRONIC DISEASES/CONDITIONS
Infrastructure		Health Behaviors
Lack of Primary Care Physicians/Physician Specialists		Social Determinants of Health (SDOH)
Specialty Care		

IMPLEMENTATION STRATEGY ADDITIONAL NOTES

The ISP is not meant to provide an exhaustive list of how each hospital addresses the community's needs. Instead, it highlights specific actions the hospital commits to pursuing and tracking in response to the identified priorities. While the strategy tables list internal and external partners, numerous clinical departments will collaborate on these efforts. Their involvement may include participation in clinical programs and protocols or contributing to educational outreach by sharing knowledge individually or as a team, all with the goal of addressing the community's health needs.

PENN HIGHLANDS HEALTHCARE HOSPITALS

Each Penn Highlands Healthcare hospital conducted a CHNA and ISP; however, each report varies because of the distinct characteristics and needs of each hospital's primary service area and the research and discovery process used to determine the community health needs. A workgroup of representatives from the Penn Highlands Healthcare hospitals collaborated to define a consistent format and approach to the CHNA and ISP.

ACCESS
TO CARE

Access to healthcare is essential for fostering a healthy community by ensuring individuals receive timely and appropriate medical services. It involves factors such as the availability of healthcare providers, affordability of services, transportation options, and insurance coverage. When access is optimized, people can benefit from preventive care, manage chronic conditions effectively, and receive urgent treatment, leading to improved health outcomes and reduced healthcare costs. However, barriers to access can result in delayed diagnoses, untreated conditions, and increased reliance on emergency services, negatively impacting health and driving up medical expenses. The Office of Disease Prevention and Health Promotion emphasizes the importance of comprehensive, high-quality healthcare services in preventing disease, managing chronic conditions, and promoting health equity. Meeting these challenges is becoming increasingly complex, particularly in states like Pennsylvania, where physician shortages are projected to exacerbate access issues. The Association of American Medical Colleges predicts a nationwide shortage of 86,000 physicians by 2036 because of a growing elderly population and physician retirements.[10] To maintain current care levels, Pennsylvania will need an additional 1,039 primary care physicians by 2030, an 11% increase from the 2010 workforce.[11]

Primary and specialty physicians are essential for comprehensive healthcare management, with primary care providers often serving as the first point of contact, offering preventive care, routine checkups, and early intervention for common conditions. On the other hand, specialty physicians provide advanced expertise for diagnosing and treating complex conditions requiring specialized care. Access to these services reduces the burden on emergency departments and ensures more cost-effective and efficient healthcare. Specialty care, such as cancer treatment and women's health services, is critical in addressing unique health needs by offering early detection and tailored treatment plans, significantly improving patient outcomes. However, transportation challenges can pose significant barriers to accessing care, especially for vulnerable populations in rural and low-income areas. Penn Highlands Connellsville is committed to overcoming these barriers by expanding primary and specialty care availability, enhancing specialty services, and addressing transportation gaps to ensure equitable access to healthcare. This focus on community-specific needs fosters sustainable health improvements and promotes overall well-being for the populations it serves.

[10] Association of American Medical Colleges
[11] The Robert Graham Center

Goal: Increase access to care services focusing on development and implementation of best practice standards of care with the overall goal of improving health outcomes.						
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**	
Access to Care	Specialty Care	Community residents, veterans, all socioeconomic status, and those with behavioral health issues	Increase access to and utilization of preventive and well-care health services.	• Collaborate with primary care and other health providers, identifying, treating, or referring patients identified with health concerns or diagnoses. • Track the number of new partners	• Primary Care/Specialty Care Providers • Behavioral Health Providers • Advanced Practice Providers • Local Hospitals and Health Systems • Community Health Centers • Social Workers and Case Managers • Public Health Departments	• Health Education Professionals • Local Nonprofits and Community Organizations • Insurance Providers • Veterans' Health Services • Telemedicine Providers • Rehabilitation Centers • Government Health Agencies (e.g., Medicaid, Medicare)
	Specialty Care	Community residents, veterans, all socioeconomic status, and those with behavioral health issues	Coordinate efforts along multiple continuums to ensure that health care needs are identified and addressed through direct care and referrals.	• Hire an Advanced Practice Provider (Doctor of Nursing Practice) to build and supervise a Chronic Care Management Program with the goal of developing individualized. • Create a comprehensive care plan addressing all health issues.	• Advanced Practice Providers • Primary Care Physicians • Chronic Care Specialists • Behavioral Health Providers • Care Coordinators and Case Managers • Social Workers • Rehabilitation Centers • Home Health Care Providers • Pharmacists and Medication Management Teams • Telemedicine Providers	• Local Hospitals and Health Systems • Health Information Technology Teams (for care plan documentation and follow-up) • Palliative Care and Hospice Providers • •Nutritionists and Dietitians • Government Health Agencies (e.g., Medicare, Medicaid) • Community Health Workers
	Specialty Care	Community residents, veterans, all socioeconomic status, and those with behavioral health issues	Increase access to primary care and behavioral health by structuring a blended care model to combine services in one location.	• Track the number of patients served • Track new of new patients	• Primary Care/Behavioral Health Providers • Advanced Practice Providers • Social Workers/Case Managers • Community Health Centers • Telemedicine Providers • Local Hospitals and Health Systems • Substance Abuse and Rehabilitation Centers • Public Health Departments	• Community Agencies (e.g., local nonprofits, outreach programs) • Insurance Providers • Health Information Technology Providers (for integrated patient records) • Health Education Professionals • Local Government Health Agencies • Transportation Services (to address access issues)

Goal: Increase access to care services focusing on development and implementation of best practice standards of care with the overall goal of improving health outcomes. (Continued)						
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**	
Access to Care	Specialty Care	Community residents, veterans, all socioeconomic status, and those with behavioral health issues	Increase the number of primary care providers and provide education on the integration of health care needs and services.	• Engage in the research and development of best practices and expertise in identifying, treating, and referrals of health care needs.	• Medical Schools and Residency Programs • Primary Care/Specialty Care Providers • Advanced Practice Providers • Health Education Institutions and Training Programs • Public Health Departments • Research Institutions • Local Hospitals and Health Systems • Health Information Technology Providers (for integrating care)	• Telemedicine Providers • Professional Medical Associations (e.g., American Medical Association) • Continuing Medical Education (CME) Providers • Health Policy and Advocacy Organizations • Government Health Agencies • Community Health Workers and Outreach Programs • Social Workers and Case Managers
	Infrastructure	Community residents, veterans, all socioeconomic statuses, those with behavioral health issues	Engage in research and development of best practices for identifying, treating, and referring patients.	• Track the number of evidence-based practices or guidelines developed and implemented.	• Research Institutions • Professional Medical Associations • Local Hospitals • Community Health Providers • Government Health Agencies	
	Infrastructure	Community residents, veterans, all socioeconomic statuses, those with behavioral health issues	Promote health education throughout the community.	• Track the number of community outreach activities, such as health education promotions or events.	• Health Education Professionals • Public Health Departments • Local Schools • Community Agencies • Media Partners.	
	Infrastructure	Community residents, veterans, all socioeconomic statuses, those with behavioral health issues	Increase access to and utilization of preventive and well-care health services.	• Track the number of new partners involved in healthcare initiatives. • Track the number of patients served and new patients identified.	• Primary Care/ Specialty Care Providers • Advanced Practice/Behavioral Health Providers • Community Health Providers • Social Workers/Case Managers • Health Education Professionals • Community Agencies	• Local and State Officials • Veterans Services Organizations • Housing Authorities • HUD • Dieticians • Gyms in the Community • Drug and Rehab Centers.
	Infrastructure	Community residents, veterans, all socioeconomic statuses, those with behavioral health issues	Coordinate efforts along multiple continuums to address healthcare needs through direct care and referrals.	• Measure the number of referrals made to specialty care or behavioral health services.	• Primary Care/Specialty Care/ Behavioral Health Providers • Community Health Providers • Social Workers/Case Managers • Health Education Professionals • Community Agencies • Local and State Officials	• Veterans Services Organizations • Housing Authorities • HUD • Dieticians • Gyms in the Community • Drug and Rehab Centers.

Goal: Increase access to care services focusing on development and implementation of best practice standards of care with the overall goal of improving health outcomes. (Continued)					
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**
Access to Care	Infrastructure	Community residents, veterans, all socioeconomic statuses, those with behavioral health issues	Increase access to a full complement of health services with a focus on collaborating with hospital and community providers to develop best practices to identify, treat, and refer patients.	• Track the number of evidence-based practices or guidelines developed and implemented.	• Research Institutions • Government Health Agencies • Professional Medical Associations • Community Health Centers • Local Hospitals and Health Systems.
	Infrastructure	Underserved and Rural Community Members, Patients in Remote Areas with Limited Access to Specialists	Implement telemedicine services to extend specialist access to underserved populations.	• Track the number of telemedicine appointments conducted with specialists • Monitor patient satisfaction and outcomes related to telemedicine services • Measure changes in access to specialist care among underserved populations	• Telemedicine Providers • Community Health Centers • Local Hospitals and Health Systems • Health Information Technology Providers • Public Health Departments • Government Health Agencies
	Lack of PCP/ Specialist	New Medical Graduates and Residents, Underrepresented and Rural Health Professionals, Community Residents in Need of Increased Healthcare Access, Healthcare Providers Seeking Additional Training Opportunities	Collaborate with medical schools and residency programs to create a pipeline for new graduates.	• Track the number of partnerships established with medical schools, residency programs, and healthcare systems.	• Medical Schools • Health Education Institutions • Professional Medical Associations • Nonprofit Organizations.
	Lack of PCP/ Specialist	Primary Care Providers (PCPs) and Specialists in Training or Early Career, Experienced PCPs and Specialists Considering Relocation, Healthcare Professionals with Financial Barriers, Rural and Underserved Community Members	Provide competitive incentives (e.g., loan forgiveness, signing bonuses) to attract PCPs and specialists to the area.	• Track the number of new PCPs and specialists recruited annually through incentive programs. • Monitor the retention rate of PCPs and specialists recruited with incentives over 1, 3, and 5 years. • Measure the effectiveness of various incentives (e.g., loan forgiveness vs. signing bonuses) in attracting providers to the area.	• Medical Schools and Residency Programs • Recruitment Agencies Specializing in Healthcare • Local Hospitals and Health Systems • Government Health Agencies (e.g., HRSA for rural healthcare incentives) • Professional Medical Associations • Nonprofit Organizations Focused on Rural Healthcare Access
	Lack of PCP/ Specialist	Underserved and Rural Community Members, Specialists and Healthcare Providers	Implement telemedicine services to extend specialist access to underserved populations	• Measure the utilization of telemedicine services for specialist consultations.	• Telemedicine Providers • Community Health Centers • Health Information Technology Providers

Goal: Increase access to care services focusing on development and implementation of best practice standards of care with the overall goal of improving health outcomes. (Continued)					
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**
Access to Care	Lack of PCP/ Specialist	Primary Care Providers (PCPs) and Specialists seeking new career opportunities, Medical Students and Residents nearing graduation, Healthcare Providers open to relocation for career advancement, Community Residents in need of improved access to primary and specialty care (indirect beneficiaries)	Increase recruitment efforts to hire more primary care providers (PCPs) and specialists.	• Track the number of new PCPs and specialists recruited each year. • Measure the success of recruitment campaigns by analyzing the number of applications and hires from target locations or demographics. • Monitor the retention rate of newly recruited providers over 1, 3, and 5 years. • Assess provider satisfaction with recruitment and onboarding processes through regular surveys.	• Medical Schools and Residency Programs • Healthcare Recruitment Agencies • Local Hospitals and Health Systems • Government Health Agencies • Professional Medical Associations • Local Chambers of Commerce and Community Organizations (to promote the area as an attractive place to live and work)
	Lack of PCP/ Specialist	Community Residents Lacking Access to Specialists, Hospitals and Health Systems in Nearby Regions	Establish partnerships with nearby hospitals and healthcare systems to share specialist services.	• Track the number of partnership agreements established with nearby hospitals and healthcare systems • Monitor the number of patients served through shared specialist services • Measure patient satisfaction related to access and quality of specialty care	• Local Hospitals • Regional Healthcare Systems • Specialty Care Providers • Community Health Centers • Health Information Technology Providers (for coordinated scheduling) • Government Health Agencies
	Lack of PCP/ Specialist	Local students, young Adults, and community members interested in healthcare careers	Engage in community outreach to raise awareness of healthcare career opportunities locally.	• Track the number of outreach events and participants • Measure interest in healthcare career programs through follow-up surveys or enrollment in healthcare training • Monitor the number of internships or mentorships established as a result of outreach.	• Local Schools and Educational Institutions • Community Health Centers • Local Hospitals and Health Systems • Healthcare Career Organizations • Community Organizations and Nonprofits
	Lack of PCP/ Specialist	Patients Requiring Specialty Referrals and Coordinated Care, Primary and Specialty Care Providers	Increase collaboration between primary care and specialty care providers to ensure seamless referrals and care coordination.	• Track the number of referrals made and completed between primary and specialty providers. • Monitor patient satisfaction with the referral process and care coordination. • Measure changes in health outcomes related to improved care coordination.	• Primary Care/Specialty Care Providers • Health Information Technology Providers • Local Hospitals and Health Systems • Community Health Centers • Public Health Departments
	Lack of PCP/ Specialist	Current Primary Care Providers (PCPs) and Specialists, Healthcare Providers in Rural and Underserved Areas	Develop continuing education and professional development programs to retain current PCPs and specialists.	• Track the number of continuing education sessions offered and provider participation rates. • Monitor retention rates of PCPs and specialists who participate in professional development programs. • Survey providers on satisfaction with available professional development opportunities.	• Professional Medical Associations • Continuing Medical Education (CME) Providers • Health Education Institutions • Local Hospitals and Health Systems • Government Health Agencies

Goal: Increase access to care services focusing on development and implementation of best practice standards of care with the overall goal of improving health outcomes. (Continued)					
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**
Access to Care	Lack of PCP/ Specialist	Community Members in Areas with Identified Gaps in Care, Healthcare Administrators and Recruiters	Conduct workforce planning and needs assessments to identify gaps in care and strategically target recruitment.	• Track the number of workforce assessments completed and gaps identified. • Measure the recruitment rate for positions identified as high need. • Monitor changes in healthcare access and patient outcomes in areas with newly recruited providers.	• Local Hospitals and Health Systems • Community Health Centers • Government Health Agencies • Health Information Technology Providers (for data collection and analysis) • Medical Schools and Recruitment Agencies
	Lack of PCP/ Specialist	Specialists Seeking Flexible Work Options, Experienced Providers Open to Part-Time or Locum Tenens Roles, Community Residents in Need of Increased Access to Specialist Care	Offer flexible work arrangements (e.g., part-time positions, locum tenens) to attract a broader range of specialists.	• Track the number of specialists hired through flexible work arrangements. • Monitor patient access to specialists in areas with flexible work arrangements. • Measure satisfaction of providers with flexible arrangements and their retention rates.	• Recruitment Agencies Specializing in Healthcare • Local Hospitals and Health Systems • Community Health Centers • Professional Medical Associations
	Lack of PCP/ Specialist	Healthcare Administrators and Recruiters, Community Members in Areas with Changing Healthcare Needs	Use data analytics to track patient demand and project future needs for PCPs and specialists.	• Measure changes in patient wait times for PCP and specialist appointments. • Track projections of provider needs and compare them with actual recruitment efforts. • Assess the accuracy of data analytics in forecasting workforce needs and adjust methods as needed.	• Health Information Technology Providers • Local Hospitals and Health Systems • Government Health Departments • Medical Schools and Recruitment Agencies
	Lack of PCP/ Specialist	Primary care and specialty providers seeking expanded skills, community residents in need of comprehensive care	Encourage cross-training of healthcare providers to allow for an expanded scope of practice where appropriate.	• Track the number of providers cross-trained and the areas of expanded scope. • Monitor patient access improvements resulting from cross-trained providers. • Survey provider satisfaction with cross-training programs and their impact on care delivery.	• Professional Medical Associations • Continuing Medical Education (CME) Providers • Local Hospitals and Health Systems • Health Education Institutions
	Lack of PCP/ Specialists	Community residents, veterans, all socioeconomic status, those with behavioral health issues	Increase the number of primary care providers and provide education on integrating healthcare needs and services.	• Track the number of new primary care and behavioral health providers recruited and hired. • Track the number of training programs or continuing education opportunities provided to healthcare providers.	• Primary Care Providers • Advanced Practice Providers • Medical Schools • Health Education Institutions • Government Health Agencies.

Goal: Early Detection and Prevention.					
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**
Cancer	Specialty Care/Cancer	Community Residents	To increase availability of Behavioral Health services for the surrounding community. To promote behavioral health awareness and reduce the stigma that surrounds mental health.	• Conduct yearly Behavioral Health Awareness Month Fair for the community. Teach the surrounding area about the importance of getting patients the help that they need.	• Child Youth Services, Crisis • Adult Protective Services (APS) • Fayette Drug & Alcohol
	Specialty Care/Cancer	Community Residents	To make available more drug and alcohol rehabilitation services available to the patients in need. Obtain contracts with county delegates to expand the places that patients may go.	• Track how many patients are being referred to Rehab centers monthly. Have social workers/ case management get involved with the process.	• County Delegates • Social Workers • Drug and Rehab Centers
	Specialty Care/Cancer	Homeless population	Obtain information for the homeless in the area regarding federal programs, section 8 Housing. Use social workers to assist in finding shelter for these individuals.	• Track the number of people who are homeless/ poverty in the surrounding area.	• State and Federal government HUD • Social workers • Area on Aging
	Specialty Care/Cancer	Residents who suffer from obesity and physical inactivity.	Offer patient education on the importance of maintaining a healthy lifestyle in regard to diet and exercise.	• Track patient progress in regard to weight loss goals and physical fitness.	• Dieticians • Gyms in the community • Health educators
	Specialty Care/Cancer	Residents who are low-income, not employment, poorly educated, and have difficulties securing housing	To determine a pattern and the root cause of how social determinants play a role in people's health.	• Analyze and track the amount of unemployed, homeless, and low-income residents in the county.	• Food Pantries • Social Workers/Case Managers • HUD Housing • Adult Protective Services (APS) • Housing Authority

BEHAVIORAL HEALTH

Behavioral health, encompassing mental health and substance use disorders, plays a vital role in shaping overall community health and well-being. Conditions such as depression, anxiety, and bipolar disorder, along with substance use disorders, can lead to significant physical health problems, disability, and reduced productivity. In Pennsylvania, nearly 20% of adults reported experiencing a mental illness in the past year, with mental health-related issues increasing over time.[12] The percentage of adults reporting poor mental health for 14 or more days in a month rose from 12% in 2014 to 14% in 2021, with higher rates among those earning less than $15,000 and individuals identifying as lesbian, gay, or bisexual. Suicide remains a pressing public health issue, with 1,686 Pennsylvanians dying by suicide in 2020, marking a 5% increase over the previous decade. Particularly concerning are rising suicide rates among Black, Hispanic, and older adults. Concurrently, Pennsylvania continues to grapple with the opioid crisis, recording 5,168 overdose deaths in 2021, underscoring the urgency of addressing behavioral health issues.[13]

Including behavioral health in CHNAs allows communities to better understand the prevalence and impact of these conditions, facilitating targeted interventions and resource allocation. Stigma, lack of insurance, and insufficient provider availability often prevent individuals from accessing necessary behavioral health services, with rural areas facing an acute shortage of mental health professionals. By identifying these gaps, communities can advocate for increased funding, policy reforms, and implementing programs that improve access to behavioral health services. A multifaceted approach to behavioral health involves integrating services with primary care to provide holistic treatment, expanding access through telehealth, and reducing financial barriers. Fostering support networks, such as peer and family support programs, can strengthen community resilience. Through these strategies and leveraging data to address service gaps, communities can enhance behavioral health outcomes, promote well-being, and build healthier, more resilient populations.

[12] Pennsylvania Department of Health

[13] Pennsylvania Department of Health: the State of our Health, A Statewide Health Assessment of Pennsylvania

Goal: Increase access to behavioral health services.					
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**
Behavioral Health	Behavioral Health	Individuals with Behavioral Health or substance abuse of all socioeconomic status.	Restructure the Highlands Hospital Outpatient Behavioral Health Program to increase the number of and the expertise of the program providers.	• Track the number of BH providers • Track the number of new providers recruited and hired within a specified timeframe. • Track the number of training programs or continuing education opportunities offered to providers. • Total the number of patients seen per month.	• Primary Care Providers • Community Health Providers • Community Agencies • Social Workers • Case Managers • Drug and Rehab Centers
	Behavioral Health	Individuals with behavioral health or substance abuse of all socioeconomic status.	Promote the Outpatient Behavioral Health Program restructure to primary care providers, community health providers, community agencies, and community members.	• Track the number of outreach activities (e.g., meetings, webinars, presentations) conducted for each target group. • Track the number of primary care providers, community health organizations, and agencies reached. • Track the number of community members reached through promotional campaigns (via events, social media, or other channels). • Track the attendance at webinars, meetings, and presentations.	• Primary Care Providers • Community Health Providers • Community Agencies • Social Workers • Case Managers • Drug and Rehab Centers
	Behavioral Health	Individuals with behavioral health or substance abuse of all socioeconomic status.	Educate providers on the use of the PHQ-9 and Pain Assessment screening tools to identify individuals endorsing depression severity.	• Track the number and percentage of eligible providers who completed the PHQ-9 and Pain Assessment training. • Measure how many providers completed the entire educational program or module. • Track the percent of providers who completed the training versus those who were offered it. • Track the attendance at live training sessions, webinars, or online courses. • Track the attendance rates using different training formats (live, online, etc.).	• Primary Care Providers • Community Health Providers • Community Agencies • Social Workers • Case Managers • Drug and Rehab Centers
	Behavioral Health	Individuals with behavioral health or substance abuse of all socioeconomic status.	Promote the Transcranial Magnetic Stimulation (TMS) Program to treat Major Depressive Disorder.	• Track the number of events, campaigns, and activities promoting the TMS Program. • Track the number of healthcare providers or community members reached via promotional channels (email, social media, webinars, etc.).	• Primary Care Providers • Community Health Providers • Community Agencies • Social Workers • Case Managers • Drug and Rehab Centers

Goal: Increase access to behavioral health services. (Continued)					
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**
Behavioral Health	Behavioral Health	Individuals with behavioral health or substance abuse of all socioeconomic status.	Identify community leaders and maintain a strong community presence with local and state officials with the goal of identifying social determinants of health that impede behavioral health diagnosis and treatment.	• Track the number of community leaders identified by sector (e.g., healthcare, education, faith-based, civic leaders). • Record meetings, introductions, and discussions with these leaders to establish a relationship. • Track the meetings held with identified community leaders to discuss behavioral health and social determinants. • Track the percent of community leaders who have committed to being involved in initiatives related to SDOH and behavioral health. • Track the number of meetings or engagements with local and state officials.	• Primary Care Providers • Community Health Providers • Community Agencies • Social Workers • Case Managers • Drug and Rehab Centers
	Behavioral Health	Community Residents Veterans All Socioeconomic Status Those with behavioral health Issues	Promote the Outpatient Behavioral Health Program as restructured to address behavioral health concerns that may prevent access to necessary and appropriate health care.	• Promote health education through healthcare offices, community agencies, and the community. • Track the distribution of materials	• Primary care and behavioral health providers • Community Health Centers • Local Hospitals and Health Systems • Social Workers/Case Managers • Community Agencies • Public Health Departments • Health Education Professionals • Educational Institutions • Telemedicine Providers • Faith-Based Organizations • Health Information Technology Providers (for patient outreach) • Community Outreach Programs • Local Government Health Agencies • Media and Communication Partners (e.g., social media, local news outlets) • Rehabilitation and Substance Abuse Centers
	Behavioral Health	Community Residents Veterans All Socioeconomic Status Those with behavioral health Issues	Promote the Outpatient Behavioral Health Program to address behavioral health concerns and increase access to healthcare.	• Monitor the distribution and impact of health education materials throughout the community.	• Behavioral Health/Primary Care Providers • Media and Communication Partners • Community Health Centers • Public Health Departments
	Behavioral Health	Community Residents Veterans All Socioeconomic Status Those with behavioral health Issues	Increase access to primary care and behavioral health services by structuring a blended care model.	• Track the number of primary care and behavioral health providers recruited and hired.	• Primary Care/Behavioral Health Providers • Community Health Providers • Advanced Practice Providers • Social Workers/Case Managers • Telemedicine Providers • Local Hospitals and Health Systems • Substance Abuse and Rehabilitation Centers • Public Health Departments

CHRONIC
DISEASES/CONDITIONS

Chronic diseases are long-lasting conditions that develop gradually, significantly affecting an individual's quality of life. These health issues, which persist for over a year and require ongoing medical attention or limit daily activities, include heart disease, diabetes, cancer, and respiratory conditions. Chronic diseases are the leading causes of death and disability worldwide, driven by a combination of genetic, environmental, and lifestyle factors. Key risk factors—such as poor nutrition, physical inactivity, smoking, and excessive alcohol consumption—exacerbate these conditions. In the United States, chronic diseases such as heart disease, cancer, and diabetes are significant contributors to healthcare costs, with 90% of the nation's $4.5 trillion annual healthcare expenditure going toward treating individuals with chronic and mental health conditions.[14] However, engaging in healthy behaviors—such as regular physical activity, a balanced diet, and eliminating tobacco and alcohol use—can reduce the risk of chronic disease and improve quality of life.

Healthy lifestyle choices, including physical activity and balanced nutrition, are essential for managing chronic diseases and maintaining overall well-being. Although regular physical activity can help prevent conditions such as heart disease, type 2 diabetes, and obesity, only one in four U.S. adults meets recommended physical activity guidelines.[15] Obesity affects 20% of children and 42% of adults, increasing their risk for chronic conditions, and more than 25% of young people aged 17 to 24 are too overweight to qualify for military service.[16] Effective management of chronic diseases involves regular screenings, patient education, and adherence to treatment plans. At Penn Highlands Connellsville, a comprehensive approach includes monitoring patients' health, promoting education, and coordinating care among providers. Community-based programs focused on lifestyle changes, such as improved nutrition and increased physical activity, have led to better management of diabetes, hypertension, and heart disease. These initiatives have resulted in fewer hospital admissions, enhanced quality of life, and reduced healthcare costs. Collaboration among healthcare providers, government agencies, and community organizations fosters a supportive environment, encouraging residents to participate actively in their health management and promoting sustainable, positive health outcomes.

[14] Centers for Disease Control and Prevention
[15] Centers for Disease Control and Prevention
[16] Centers for Disease Control and Prevention

Goal 1: Decrease preventable chronic disease by ensuring access to resources and knowledge for individuals to adopt healthy behaviors.						
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**	
Chronic Diseases/Conditions	Health Behaviors	Community Residents	Increase primary care provider (PCP) adherence to preventive screenings per guidelines for age and risk factors for all individuals.	• Track the percentage of patients who received a preventative screening (e.g., cervical cancer screenings and lipid panels for cardiovascular risk). • Track the percentage of patients eligible for screenings who have not completed them within the recommended period.	• Primary care, specialty care providers, health care practitioners • Health Information Technology Providers (for tracking and reminders) • Public Health Departments • Local Hospitals and Health Systems • Community Health Centers • Telemedicine Providers • Health Insurance Providers • Laboratories and Diagnostic Testing Centers	• Health Education Professionals • Medical Schools and Training Institutions • Government Health Agencies • Nonprofit organizations Focused on Preventive Health • Community Outreach Programs • Social Workers and Case Managers • Patient Advocacy Groups • Pharmacies (for preventive health reminders and education)
	Health Behaviors	Community Residents	Offer referrals and provide education to high-risk populations.	• The number of high-risk patients who are offered referrals to specialists, screening programs, or support services (e.g., genetic counseling, oncology, cardiology). • The number of patients who complete the referred service (e.g., attending the specialist appointment or undergoing recommended tests) after a referral is made.	• Primary care, specialty care providers, health care practitioners • Community Health Centers • Local Hospitals and Health Systems • Public Health Departments • Social Workers and Case Managers • Health Insurance Providers • Telemedicine Providers (for remote consultations) • Health Education Professionals • Nonprofit Organizations	• Rehabilitation Centers • Patient Advocacy Groups • Laboratories and Diagnostic Testing Centers • Pharmacists (for patient education and support) • Health Information Technology Providers (for tracking referrals and follow-ups) • Government Health Agencies Community Outreach Programs

Goal 1: Decrease preventable chronic disease by ensuring access to resources and knowledge for individuals to adopt healthy behaviors. (Continued)						
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**	
Chronic Diseases/Conditions	Health Behaviors	Community Residents	Improve Diabetes Management and Care Coordination for At-Risk Populations and Patients with Diabetes.	• Track the number of referred patients who attend follow-up visits or complete additional recommended services at Highland's Diabetes Center. • Track the number of patients who participate in specific programs offered by the Diabetes Center (e.g., nutrition counseling, diabetes self-management education, or lifestyle change programs). • Track the number of behavioral health inpatients screened for diabetes and the percentage of inpatients screened during admission. • Track the percentage of diabetes patients readmitted to the hospital within 30 days of discharge and the percentage of readmissions due to diabetes-related complications or infection. • Track the number of diabetes patients scheduled for follow-up appointments before leaving the healthcare facility, and track follow-up attendance and missed appointments. • Track the number of patients who receive and complete education on continuous glucose monitors, as well as the improvement in their knowledge (measured by pre-and post-education assessments). • Track the number of patients who complete their A1c test on time, attend scheduled follow-up appointments, and miss their follow-up appointments.	• Highland's Diabetes Center • Primary Care providers, health care practitioners, behavioral health providers • Community Health Centers • Local Hospitals and Health Systems • Telemedicine Providers (for follow-up appointments) • Social Workers and Case Managers • Health Education Professionals (for diabetes education and continuous glucose monitors)	• Nutritionists and Dietitians • Public Health Departments • Health Information Technology Providers (to track follow-ups, screenings, and readmissions) • Nonprofit Organizations • Patient Advocacy Groups • Pharmacists (for medication and device education) • Insurance Providers (for coverage of services and devices)
	Health Behaviors	Community Residents	Coordinate continuity of care between departments of the hospital system: inpatient, ER, behavioral health, outpatient.	• Track the number of patients who complete follow-up appointments in outpatient, behavioral health, or specialist departments after being discharged from inpatient or emergency settings.	• Inpatient Care Providers • Emergency Room Physicians and Staff • Behavioral Health Providers • Outpatient Care Providers • Primary Care Physicians, Specialty Care Providers • Care Coordinators and Case Managers • Social Workers • Discharge Planning Teams • Health Information Technology Providers (for patient record integration and follow-up tracking)	• Telemedicine Providers (for follow-up consultations) • Community Health Centers • Local Hospitals and Health Systems • Rehabilitation Centers (for post-discharge care) • Home Health Care Providers • Patient Advocacy Groups • Health Insurance Providers (to ensure coverage for follow-up care) • Pharmacists (for medication follow-up and adherence)

Goal 1: Decrease preventable chronic disease by ensuring access to resources and knowledge for individuals to adopt healthy behaviors. (Continued)						
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**	
Chronic Diseases/Conditions	SDOH	Community Residents	Identify and Collaborate with Community Leaders and Agencies to Address Social Determinants of Health (SDOH) and Remove Barriers to Healthcare Access.	• Track the number of key community leaders and agencies identified for collaboration. • Track the number of formal partnerships established with community leaders and agencies. • Track the number of meetings, town halls, or events held with community leaders and agencies to discuss health issues, barriers to care, and potential solutions. • Track the number of identified community partners who actively participate in healthcare initiatives and programs.	• Local/State Government Officials • Community Leaders • Local Nonprofit Organizations • Public Health Departments • Social Workers/Case Managers • Community Health Centers • Local Hospitals and Health Systems • Educational Institutions • Health Advocacy Groups • Local Business Leaders and Employers • Housing Authorities	• Transportation Services Providers • Community Outreach Programs • Law Enforcement and Public Safety Officials • Veterans Affairs • Patient Advocacy Groups • Faith-Based Organizations • Health Information Technology Providers (for tracking meetings and collaboration efforts)
	SDOH	Community Residents	Identify the problems and barriers that prevent vulnerable populations from receiving medical care.	• Track the number of barriers identified (e.g., transportation issues, financial constraints, lack of insurance, language barriers, health literacy) that prevent vulnerable populations from accessing medical care.	• Primary Care/Specialty Care Providers • Social Workers/Case Managers • Community Health Centers • Local Hospitals and Health Systems • Public Health Departments • Local Nonprofit Organizations (focused on healthcare access) • Health Insurance Providers • Health Literacy and Education Professionals • Transportation Services Providers • Housing Authorities	• Legal Aid Services (to assist with insurance and healthcare access issues) • Community Outreach Programs • Patient Advocacy Groups • Immigrant and Refugee Services Organizations • Faith-Based Organizations • Local Government and Health Departments • Community Leaders • Language Translation and Interpretation Services (to address language barriers)
	SDOH	Community Residents	Identify structural barriers, including transportation, to improve health outcomes by increasing access to care and housing instability	• Track the number of individuals or populations who report specific structural barriers, such as lack of transportation, as obstacles to receiving care. • Track the number of geographic areas where structural barriers like transportation and housing instability are most prevalent.	• Local Transportation Services Providers • Housing Authorities • Social Workers and Case Managers • Community Health Centers • Local Hospitals and Health Systems • Public Health Departments • Nonprofit Organizations • Local Government Officials • Faith-Based Organizations • Community Outreach Programs • Patient Advocacy Groups	• Health Insurance Providers (for coverage of non-emergency medical transportation) • Telemedicine Providers (to provide care to areas with transportation barriers) • Legal Aid Services (to assist with housing and transportation issues) • Local Employers and Business Coalitions • Local nonprofits and shelters • Educational Institutions • Veterans Affairs • Community Leaders

Goal 1: Decrease preventable chronic disease by ensuring access to resources and knowledge for individuals to adopt healthy behaviors. (Continued)						
CHNA Need	**Subcategory**	**Target Population**	**Objectives/Strategies**	**Evaluation Methods/Metrics (Goals)**	**Partners**	
Chronic Diseases/Conditions	SDOH	Community Residents	Provide support to link patients with social services and health initiatives to address barriers and improve outcomes.	• Track the number of patients identified as needing social services (e.g., housing, food assistance, transportation) referred to appropriate programs. • Track the number of patients who successfully connect with the social service programs to which they were referred (e.g., complete intake, receive services).	• Social Workers/Case Managers • Community Health Centers • Local Hospitals and Health Systems • Public Health Departments • Housing Authorities • Food Assistance Programs (e.g., local food banks, SNAP) • Transportation Services Providers (e.g., public transit, non-emergency medical transport) • Nonprofit Organizations • Legal Aid Services (for assistance with housing and healthcare access issues) • Government Health Agencies	• Local Nonprofits and Charitable Organizations • Faith-Based Organizations • Telemedicine Providers (for remote consultations and service access) • Health Insurance Providers (for covering social service-linked care) • Veterans Affairs (for veteran-specific social services) • Rehabilitation and Substance Abuse Centers (for addiction-related social services) • Educational Institutions • Local Government Agencies • Community Outreach Programs
	SDOH	Community Residents	Identify the barriers that restrict primary care access and lead to primary care treatment being sought through a hospital emergency department.	• Track the barriers preventing patients from accessing primary care services (e.g., lack of transportation, financial barriers, lack of insurance, clinic hours, language barriers). • Track the number of patients reporting specific barriers that prevent them from accessing primary care.	• Primary Care Providers • Social Workers and Case Managers • Community Health Centers • Local Hospitals and Health Systems • Public Health Departments • Health Insurance Providers • Telemedicine Providers (to offer virtual primary care services) • Transportation Services Providers • Housing Authorities • Nonprofit Organizations (focused on healthcare access)	• Legal Aid Services (for assistance with insurance and financial barriers) • Community Outreach Programs • Patient Advocacy Groups • Faith-Based Organizations • Local Government Health Agencies • Health Information Technology Providers (to track and analyze barriers) • Educational Institutions • Local Employers (for employee healthcare access support) • Language Translation and Interpretation Services (Veterans Affairs)

STRATEGIES
NO LONGER BEING ADDRESSED

Penn Highlands Connellsville streamlined and combined some strategies from their implementation planning documents to enhance the report's clarity, focus, and overall effectiveness. By consolidating overlapping or related strategies, the ISP document avoids redundancy and presents a more cohesive and unified approach to achieving the desired goals. The final report helps to simplify the execution process by aligning resources and efforts, reducing confusion or fragmentation across different teams. It also enables clearer communication of priorities to stakeholders, making it easier to track progress and measure success. Furthermore, integrating strategies allows for better allocation of resources, as efforts are concentrated on the most impactful actions, improving overall efficiency. A more streamlined report also demonstrates a strategic vision, showcasing an organization's ability to adapt, innovate, and implement solutions in a coordinated, impactful manner.

Penn Highlands Connellsville acknowledged a number of health needs that emerged from the CHNA process. Penn Highlands Connellsville focused on areas of need where effective use of existing knowledge and resources offered the greatest potential impact. Accordingly, some objectives and strategies from the previous ISP were not removed entirely but rather streamlined and combined to enhance their effectiveness. This approach eliminates redundancy, ensures better alignment of efforts, and allows for a more focused execution to achieve the desired outcomes efficiently. Specifically, Penn Highlands Connellsville streamlined and updated their ISP document and retained some aspects of their previous plan into the 2024-2027 plan, including:

COMBINED SECTIONS:

- While the updated document separates individual strategies to ensure clear metrics and evaluation methods, efforts were made to reduce redundancy where objectives overlapped. For example, elements of SDOH and Health Behaviors remain aligned with broader categories but are now clearly delineated with individual goals and measurable outcomes.

OBJECTIVES/STRATEGIES STREAMLINING:

- The current ISP focuses on separating each objective for clarity and tracking. Rather than combining objectives like referrals, screenings, and education under a unified strategy, these are now separated into distinct goals with unique metrics.

PARTNERS CONSOLIDATION:

- Partners were reviewed and updated, with efforts made to ensure relevance and clarity for each specific objective. While some partner lists remain comprehensive, they are now tailored to individual strategies to avoid overgeneralization.

TRACKING AND METRICS SIMPLIFICATION:

- Metrics were separated to reflect specific strategies. For example, diabetes-related metrics (e.g., screenings, referrals, A1c follow-ups) and SDOH metrics (e.g., number of partnerships or community events) are assigned to their respective objectives rather than unified under broader categories.

REMOVED REDUNDANCIES:

- Redundant elements from the previous version have been addressed. For instance, repeated mentions of similar partners or objectives have been streamlined without losing the necessary detail or focus.

Penn Highlands Connellsville will continue supporting community partners with the expertise, capacity, and focused resources to address the region's needs effectively.

MOVING FORWARD

The Penn Highlands Connellsville community health needs identified in the CHNA are multifaceted. Reducing/decreasing, eliminating, or improving access to care, behavioral health, and chronic diseases/conditions requires continued collaboration among the local health, human, and social services agencies, community partners, and residents.

With continued alignment and partnership with organizations and community residents, Penn Highlands Connellsville will continue to engage residents as part of the CHNA and ISP. The implemented strategies and initiatives will strengthen Penn Highlands Connellsville for all citizens within the service area.

RESOURCE COMMITMENT

Penn Highlands Connellsville will commit in-kind and financial resources during FY24-27 to implement the identified initiatives and programs. Resources may include clinical and non-clinical services, partnerships, collaboration for solutions, dedicated staff time to advance the Penn Highlands Connellsville work, charitable contributions, and volunteerism that will occur naturally within the ISP phase.

Penn Highlands Healthcare welcomes and values your feedback regarding the Community Health Needs Assessment and the Implementation Strategy Plan. Your insights are essential in helping us better understand the community's needs and ensuring our strategies effectively address them. Please share your thoughts, suggestions, or concerns to help us refine our efforts and create a healthier, more vibrant community.

Danyell Bundy

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