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Introduction

Penn Highlands Healthcare provides residents with access to the region's best hospitals, physicians, nursing homes, home health agencies, medical supply companies and other affiliates who believe that healthcare should be managed by local board members who live and work in the communities they serve.

By combining the best services from Brookville Hospital, Clearfield Hospital, DuBois Regional Medical Center and Elk Regional Health Center, Penn Highlands Healthcare strives to provide exceptional quality, safety, and service. These facilities are now known as Penn Highlands Brookville, Penn Highlands Clearfield, Penn Highlands DuBois and Penn Highlands Elk.

Each facility is the largest employer in its hometown and is rooted deeply in the fabric of their communities. The vision is to be an integrated health care delivery system that provides premier care with a personal touch, no matter where one lives in the region.
In 2015, Penn Highlands Healthcare retained Tripp Umbach to facilitate a comprehensive Community Health Needs Assessment (CHNA). The CHNA was conducted between November 2014 and May 2015. Penn Highlands Healthcare collaborated with hospitals and outside organizations in the surrounding region (Cameron, Clearfield, Elk, and Jefferson counties) during the CHNA process.

Penn Highlands Healthcare thanks the following organizations for their cooperation and commitment:

- Alcohol and Drug Abuse Services
- Alcoholics Anonymous
- Behavioral Health Alliance of Rural PA
- Brookville Chamber of Commerce
- Brookville Police Department
- Cameron County Chamber of Commerce
- CAPSEA
- Cen-Clear Services, Inc.
- Child Care Information Services
- Citizens Against Physical Sexual Emotional Abuse
- City of DuBois
- Clearfield and Jefferson Drug & Alcohol Commission
- Clearfield CAL (Center for Active Living)
- Clearfield County Area Agency on Aging, Inc.
- Clearfield County CYS
- Coldwell Banker
- Community Care Behavioral Health
- Community Connections
- Community Guidance Center
- Courier Express
- Dickinson Center, Inc.
- DuBois Area Chamber of Commerce
- DuBois Area School District
- Dubois CGC
- DuBois Regional Airport
- Dubois YMCA
- DuFAST Transit
- Elk County Catholic School System
- Emporium WIC Office
- Fox Senior Center
- Free Clinic of DuBois
- Good Samaritan Men's Shelter
- Jay Township Senior Center
- Jefferson Co. E.M.S.
- Jefferson County AAA
- Jefferson Manor Health Center
- Johnsonburg Senior Center (JBGSC)
- Keystone Rural Health Consortia, Inc.
- KMA Remarketing
- Leonard Court
- Life and Independence for Today
- Life Line services for pregnant women & families with infants
- Marian House Emergency Shelter for Women and Children
- MoValley Economic Development
- MoValley YMCA
- Northern Tier Community Action Center
- PA CareerLink of Clearfield County
- PA Department of Health
- Penn Highlands Brookville
- Penn Highlands Clearfield
- Penn Highlands DuBois
- Penn Highlands Elk
- Philipsburg Osceola S.D.
- SAM, Inc.
- Sandy Township
- St. Mary's Food Bank
• Stackpole Hall Foundation
• Susquehanna Rural Free Clinic
• Swift Kennedy Group
• Tri County Church

• United Way
• Women Infants and Children
• YMCA
• Young People Who Care, Inc.
Community Definition

The communities served by Penn Highlands Brookville include the following zip codes. The Penn Highlands Brookville primary service area includes 11 populated zip code areas (excluding zip codes for P.O. boxes and offices) where 80% of the hospital’s inpatient discharges originated (see Table 1).

Table 1: Penn Highlands Brookville Hospital Community Zip Codes

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>City</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>16240</td>
<td>Mayport</td>
<td>Armstrong</td>
</tr>
<tr>
<td>16242</td>
<td>New Bethlehem</td>
<td>Clarion</td>
</tr>
<tr>
<td>16214</td>
<td>Clarion</td>
<td>Clarion</td>
</tr>
<tr>
<td>16255</td>
<td>Sligo</td>
<td>Clarion</td>
</tr>
<tr>
<td>15801</td>
<td>DuBois</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16239</td>
<td>Marienville</td>
<td>Forest</td>
</tr>
<tr>
<td>15825</td>
<td>Brookville</td>
<td>Jefferson</td>
</tr>
<tr>
<td>15860</td>
<td>Sigel</td>
<td>Jefferson</td>
</tr>
<tr>
<td>15767</td>
<td>Punxsutawney</td>
<td>Jefferson</td>
</tr>
<tr>
<td>15864</td>
<td>Summerville</td>
<td>Jefferson</td>
</tr>
<tr>
<td>15829</td>
<td>Corsica</td>
<td>Jefferson</td>
</tr>
</tbody>
</table>
Consultant Qualifications

Tripp Umbach is a recognized national leader in community health research, economic analysis, feasibility studies, and market research, having conducted more than 500 projects over the past 25 years in communities across the United States and internationally. Past community health projects have included: needs assessments; population health surveys; market analysis; program implementation plans; and processes for tracking, measuring, and evaluating community health programs. Today, more than one in four Americans lives in a community where Tripp Umbach has completed a community health assessment. Tripp Umbach:

- Has developed a deep understanding of the communities and health needs in the area through the CHNAs and implementation plans completed for all four Penn Highlands hospitals between 2011 and 2013, as well as the health system strategic planning and implementation process completed in 2013.

- Has established relationships with stakeholders and providers in the Penn Highlands primary service area: Cameron, Clearfield, Elk, and Jefferson counties.

- Has a national perspective of best practices and community health improvement projects being used to improve population health.

Many of our projects are national pilots and have received statewide and national recognition. Tripp Umbach completed a series of 40 community health needs assessments in the 1990s in partnership with the Healthcare Association of Pennsylvania and has a longstanding consulting relationship with hospitals, medical schools, and research institutes throughout the Commonwealth. Tripp Umbach has completed a series of more than 50 community health needs assessments between 2011 and 2013, which met the industry standards and Internal Revenue Code § 501(r) requirements.

Internal Revenue Code § 501(r) mandates that nonprofit hospitals conduct needs assessments every three years. Tripp Umbach, a national leader in conducting community health needs assessments has closely monitored 501(r) requirements, reflecting the most current information in this proposal.
The mission of the Penn Highlands CHNA is to understand and plan for the current and future health needs of residents in its community. The goal of the process is to identify the health needs of the communities served by the hospital, while developing a deeper understanding of community needs and identifying community health priorities. Important to the success of the community needs assessment process is meaningful engagement and input from a broad cross-section of community-based organizations, who were partners in the community health needs assessment.

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

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

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

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

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

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

Tripp Umbach facilitated and managed a comprehensive community health needs assessment on behalf of Penn Highlands Healthcare. The assessment process included input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge and expertise of public health issues.

Key steps and data sources in the community health needs assessment included:

- **Community Health Assessment Planning** – A series of meetings was facilitated by the consultants and the CHNA oversight committee consisting of leadership from Penn Highlands Healthcare and other participating hospitals and organizations (i.e., Penn Highlands Brookville, Penn Highlands Clearfield, Penn Highlands DuBois, and Penn Highlands Elk). This process lasted from October 2014 until April 2015.

- **Public Commentary** – Tripp Umbach solicited public commentary from community leaders and residents. Commenters were asked to review the previous CHNA and action plan adopted by the facility and were provided access to each document for review. Commenters were then asked to respond to a questionnaire which provided open and closed response questions. Questionnaires were developed by Tripp Umbach and previously reviewed by Penn Highlands steering committee. The questionnaire was offered in hard copy inside the hospital as well as electronically using a web-based platform. The CHNA and implementation plan were provided to commenters for review in the same manner (i.e., hard copy at the hospital and electronically). There were no restrictions or qualifications required of public commenters. Flyers were circulated for public comment throughout the collection period which lasted from December 2014 until January 2015.

- **Secondary Data Collection and Analysis** – Tripp Umbach managed and analyzed existing data sources to prepare a secondary data profile for each hospital service area, including state and national baseline data on relevant health measures using data from a variety of sources. This process lasted from February 2015 until March 2015.

- **Stakeholder Interviews** – Tripp Umbach completed interviews with key stakeholders (regionally), to secure insight and understanding of community health needs drawing upon past CHNAs and implementation plans. Stakeholders included persons with public health expertise, persons who represented agencies with access to relevant data, and who represented underserved populations and populations with chronic illnesses. This process lasted from December 2014 until January 2015.

- **Hand-Distributed Survey** – Tripp Umbach employed a hand-distribution methodology working closely with the Penn Highlands Healthcare working group to identify partners to capture the individual characteristics of the study area which included (but was not limited to): underserved populations, chronically ill, specific barriers to accessing services, the types of services in greatest demand, health status and insight into health needs identified in previous CHNA. This process lasted from December 2014 until March 2015.
• **Implementation Plan Assessment** – Tripp Umbach reviewed the previous implementation plan and documented: efforts to implement, progress made, barriers to progress, and carry-over recommendations. This process lasted from March 2015 until April 2015.

• **Community Health Forum** – Tripp Umbach presented the study findings and facilitated a community health planning retreat resulting in the identification of significant community health needs and the development of community specific community health improvement strategies. This process lasted from March 2015 until April 2015.

• **Provider Inventory** – Tripp Umbach formulated a provider inventory in Excel format highlighting areas of deficits in specific categories related to identify community health needs. This process lasted from March 2015 until April 2015.

• **Implementation Planning** – Tripp Umbach facilitated a planning process that maximized system cohesion and synergies during which leaders from each hospital. This process lasted from March 2015 until May 2015.

• **Final Report and Presentation** – Tripp Umbach provided a final community health needs assessment and implementation plan for each hospital in the Penn Highlands Healthcare system that meets the most recent industry and IRS standards and can be used to file Schedule H of the IRS 990 for FY-2016. This process lasted from April 2015 until May 2015.
Key Community Health Priorities

Community leaders reviewed and discussed existing data, in-depth interviews with community stakeholders representing a cross-section of agencies, and survey findings presented by Tripp Umbach in a forum setting, which resulted in the identification and prioritization of five community health priorities in the Penn Highlands Healthcare. Community leaders identified the following top community health needs that are supported by secondary and/or primary data: 1) drug and alcohol services 2) nutrition and wellness; 3) access to care 4) free clinics 5) navigation and coordination. A summary of the top five needs in the Penn Highlands Brookville service area are as follows:

**DRUG AND ALCOHOL**

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. There are not enough providers to meet the demand among residents who are suffering through substance abuse problems.
2. The economy and socioeconomic status of the region is a major factor that leads people to abusing drugs and alcohol.
3. People are self-medicating and resorting to substances to deal with an array of other issues they are facing.
4. There is a lack of coordinated services and advocacy for individuals with substance abuse issues.

Addressing needs related to substance abuse is identified as the top health priority by community leaders at the community forum. It was also, by far, the most discussed health need among stakeholders during one-on-one interviews and survey respondents indicated that they are facing a drug and alcohol problem in their communities.

Secondary data, community leaders, stakeholders and survey respondents agree that substance abuse is a top health priority:

- Secondary data
  - A lower percentage of residents (35.2%) than the state average (38.2%) have the perception that having more than 5 drinks per week can be a great risk.
- Community Forum
  - Substance abuse services were the most discussed needs at the community forum.
Community leaders focused their discussions primarily on the limited number of services for drug and alcohol issues, the substance abuse problems of the area, and affordability of treatment and services.

Interview Key Findings

- Drug use is perceived as the biggest health risk of the region overall.
- Drug and alcohol abuse = mentioned 11 times as biggest health risk.
- The second biggest health risk (aging population) was mentioned only 6 times.
- There is a large perception that drug and alcohol abuse is a problem for the communities of Penn Highlands.

Survey Results

- Cameron County - 73.3% of respondents marking this as the #1 community priority.
- Clearfield County - 56.8% of respondents marking this as the #1 community priority.
- Elk County - 72.2% of respondents marking this as the #1 community priority.
- Jefferson County - 65.7% of respondents marking this as the #1 community priority.

That previous CHNA in 2012 identified substance abuse, whether alcoholism or drug abuse, as a top community concern. The planning group identified this behavioral issue as a topic that was not readily discussed and was often ignored (at the time). In 2012, the Behavioral Health Risks Survey found 17% of Pennsylvania adults admitted to binge drinking (5 or more alcoholic drinks for men four or more alcoholic drinks for women).

The planning participants believed in strong community collaboration efforts as a remedy to the issue. The group was aware of existing resources that can be utilized and built upon for further prevention success.

In regards to action, the first step was planning an abuse prevention program to assess the type of problem and determine the level of risk factors affecting the problem.

Assessing the community’s readiness for prevention can help determine additional steps needed to educate the community before launching the prevention effort. A review of programs was needed to determine existing resources and gaps in addressing community needs, and to identify additional resources.

Lastly, the plan called to collect the expertise of community organizations that provide services.
NUTRITION AND WELLNESS

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Residents are not as active as they may need to be to remain healthy contributing to the rates of diabetes, obesity, and poor health outcomes.
2. People are not educated enough on the long-term effects of an unhealthy lifestyle.
3. The prevalence of diabetes contributes to poor health outcomes in the area.
4. Residents do not always have access to healthy nutrition and may need additional resources.
5. The poor socioeconomic status of the region leads to poor health choices.

Community leaders identified lifestyle-related health concerns as the second community health priority. Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes. It was discussed as a major health need among stakeholders during one-on-one interviews and survey respondents indicated that they are facing healthy lifestyle problem in their communities.

Secondary data, community leaders, stakeholders and survey respondents agree that substance abuse is a top health priority:

- Secondary Data
  - Only 51% of Jefferson County reports being able to access exercise opportunities.
  - Cameron, Clearfield, and Elk counties all saw rises in the rates of adults who are sedentary; Elk County reports the highest rate for the study area at 30.9% in 2010.
  - More than one in every four children (under 18 years) in Cameron County live in households that experienced food insecurity at some point in the past year.
• **Community Forum**
  - Community leaders identified lifestyle-related health concerns as a top health priority.
  - Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes.

• **Interview Key Findings**
  - Obesity was mentioned third most when stakeholders listed their largest health concerns for the region.
  - The low socioeconomic status of the region is a massive source for the health concerns and risks of the region. It is perceived that things like nutrition, a proper diet and lack of consistent exercise are all related to the low incomes and high unemployment of the region.

• **Survey**

<table>
<thead>
<tr>
<th>Health Concern</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>31.1%</td>
<td>38.9%</td>
<td>36.5%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Obesity</td>
<td>37.4%</td>
<td>40.5%</td>
<td>35.7%</td>
<td>38.4%</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>33.3%</td>
<td>32.6%</td>
<td>26.2%</td>
<td>30.3%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>22.2%</td>
<td>36.3%</td>
<td>34.9%</td>
<td>34.9%</td>
</tr>
</tbody>
</table>

The previous CHNA focused on increasing education and access to information—something that goes hand in hand with increasing one’s health and wellness. The planning group identified the need for a convenient method to assist community residents in obtaining existing information and the growing pool of community information. A community health education effort was identified as an important part of region becoming healthier.

In 2012, community leaders and focus group participants reported that exercise is not considered a priority. This was a consistent theme within the report. Factors such as self-motivation, financial difficulties, and the overexposure of information (overexposure of healthy diet information) are reasons why participants do not engage in regular physical activities. Also, thirty-six percent (36%) of adults were considered overweight, thirty-one percent (31%) of Pennsylvania adults had been told by a doctor that they had high blood pressure, and nine percent (9%) of Pennsylvania adults were told by a physician that they have diabetes.
ACCESS TO CARE

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Residents do not always have access to care due to a lack of transportation. This is most often true for more rural residents that do not have reliable forms of transportation (because of financial instability or other reasons).
2. Health services (i.e., primary care, clinics) are not always readily available due to a shortage of providers, which can cause lengthy wait times to secure appointments.
3. Residents are not always able to afford behavioral health care when it is needed due to the lack of insurances and cost of care.
4. Substance abuse has remained a health concern in the area. The need for clinics who offer services for substance abuse is very high.

Increasing access to healthcare is identified as the third community health priority by community leaders. Access to health care is an ongoing health need in rural areas across the U.S. Apart from insurance issues, access to healthcare in the hospital services area is limited by provider to population ratios that cause lengthy wait times to secure appointments, location of providers, transportation issues, limited awareness of residents related to the location and eligibility of health programs as well as ways to be healthier. As the ACA has been implemented and the consolidation of health services has taken place across the country; this issue has worsened in many rural areas.

Access to care was identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

- **Secondary Data**
  - All four of the study area counties report lower PCP rates than seen across the state (80 per 100,000 population for the state).
    - Cameron = 60 per 100,000
    - Clearfield = 65 per 100,000
    - Elk = 47 per 100,000
    - Jefferson = 47 per 100,000
- **Community Forum**
  - Community leaders identified access to health care as a health priority.
  - Leaders focused their discussions primarily on the limited number of providers and transportation options.
- **Stakeholder Interviews**
- Transportation is a barrier in people receiving the care that they need. However, attitudes seem to be shifting towards an acceptance that it is necessary to travel for specialized care.
- There is a perception that many people in the community are uninsured and cannot afford the services they need.

- **Survey**
  - Twenty seven percent of all survey respondents did not have insurance, with “unable to afford” being the most common reason why (57.2%).
  - Fifteen percent of all survey respondents say transportation is a barrier in receiving necessary healthcare.

In 2012, the planning retreat bred a one-stop shop idea (a central location for public and professional health education information to be accessed, obtained and readily available for the community). It was important to the group that available resources of information bridge the gap between service providers and end users. Community leaders felt that making healthcare information more readily available to the public was vital to strengthening the knowledge of the community and its residents. Access to healthcare information had to be organized, communicated, and preserved for current and future use.

The previous plan called for a formal strategic plan or system created by the hospitals and other partnering community organizations which would create a strong partnership and a team approach. It was theorized that the creation of this partnership would allow the hospitals and the organizations to dismantle organizations who are not contributing positively to the partnership effort.

Penn highlands Brookville has been successful in creating a systematic, centralized location of information—both through the formation of the Penn highlands network and the formation of the Penn highlands healthcare website.
FREE CLINICS

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. While residents may have health insurance; they cannot always afford to use their health insurance due to unaffordable deductibles and copays.

2. The poor socioeconomic status of the region has created a lot of people who cannot afford services.

Individuals in the Penn Highlands Healthcare service area are struggling to pay the costs of the services and treatments they need. It is perceived that things like nutrition, family planning, drug use and alcohol use are all tied back to the low incomes and high unemployment of the region. With so many jobs leaving the area, individuals having a hard time keeping consistent employment, and many jobs being low quality, community leaders recognized the need for free clinics in the area.

The need for free clinics was identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

- Secondary Data

  - Elk County reports the highest rate for the study area of residents with inadequate social support at 21.2% of the population.
  - More than one in every 10 residents of Clearfield County are unable to see a doctor due to cost.
  - Jefferson and Elk counties report higher uninsured rates as compared with the state (Jefferson = 14%, Elk = 13%, PA = 12%).
  - Secondary data shows that all four counties in the region report lower average household incomes (Cameron = $50,522, Clearfield = $51,133, Elk = $54,840, Jefferson = $50,827) as compared with the state of Pennsylvania ($71,088).
There is a growing group of individuals – the “poor middle class” – who do not qualify for Medicaid but struggle to pay for the healthcare they need.

Stakeholder Interviews:
- The regional economy has stagnated. Following years of many quality jobs leaving the area, local communities are seeing many people struggle financially. This has created problems in the region, including a low number of living wage jobs, and a number of residents with limited or no health coverage.
- Due to poor public transportation and the low socioeconomic status of the region, it can be difficult for some residents to access or afford the health care they need.

Survey:
- Twenty two percent of survey respondents receive their healthcare from free or reduced services.
- Seventeen percent of survey respondents have Medicaid as their primary insurance.
- Fifty seven percent of survey respondents who do not have any type of insurance are without it because they cannot afford it.
- Forty three percent of survey respondents made less than $20,000 a year.

NAVIGATION AND COORDINATION

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Often times, many residents have several health problems they are dealing with and better coordination among providers could lead to better outcomes.
2. Residents without much education are sometimes overwhelmed and easily confused when attempting to navigate their healthcare options.
3. Care coordination and transitional care are not always available due to lack of funding for these activities, though it is a need among vulnerable residents.

Individuals struggle with coordinating their various healthcare services and providers. The poor economic landscape of the region causes, people to deal with inconsistent insurance, a blend of Medicaid and Medicare, and do not receive the needed amount of information to understand their options.

Leaders acknowledged the need for more consistent coordination among services in the region as well as a need for trained, educated navigators to assist various populations in receiving the care they need. Community leaders feel
that people find the healthcare landscape confusing and sometimes overwhelming.

- **Stakeholder Interview**
  - A majority of respondents discussed the organizational changes in terms of health care in the Penn Highlands region. Almost all interviewees mentioned the reorganization and formation of the Penn Highlands network as a significant change. This had lead to a certain degree of unfamiliarity with the Penn Highlands Healthcare network and people are still not totally comfortable with the new network.

- **Survey**
  - Five percent of survey respondents say they do not know how to receive insurance.
  - Twelve percent of survey respondents say they are using multiple insurances.
  - Fifteen percent of survey respondents say they once had insurance but have since lost it.
Community Health Needs Identification Forum

The following qualitative data was gathered during a regional community planning forum held on March 12, 2015 in DuBois, PA. The community planning forum was facilitated by Tripp Umbach with more than 25 community leaders from a four county region (Cameron, Clearfield, Elk and Jefferson) and lasted approximately four hours. Community leaders were identified by the community health needs assessment oversight committee for Penn Highlands Healthcare.

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

GROUP RECOMMENDATIONS

The group provided many recommendations to address community health needs and concerns for residents of the four counties. Below is a brief summary of the recommendations:

- Community leaders made the following recommendations related to substance abuse:
  - Create a larger menu of rehabilitation programs.
  - Coordinate advocacy efforts for individuals struggling with substance abuse problems more effectively.
  - Establish addiction medicine programs.
  - Offer pain management solutions.
- Community leaders made the following recommendations related to nutrition and wellness:
  - Provide education.
  - Increase awareness on healthy choices.
- Community leaders made the following recommendations related to access to care:
  - Create affiliations with larger health systems for specialty care.
  - Utilize tele-healthcare.
  - Rotate specialty physicians to make them more accessible.
  - Increase the number and options for providers.
• Community leaders made the following recommendations related to the need of more clinics:
  ▪ Formulate better partnerships with the free clinics in the area (such as the one happening at the Susquehanna Rural Free Clinic to handle issues with diabetes).
  ▪ Offer free or reduced services.
  ▪ Adapt more effectively to the populations who need these services most.
• Community leaders made the following recommendations related to navigation and coordination of services:
  ▪ Utilize (or create) healthcare navigators to break down the “silos” of care.
  ▪ Create improved communication to effectively capitalize on the services already offered.
  ▪ Support opportunities to obtain a degree for healthcare navigation.

PROBLEM IDENTIFICATION

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

1. Drug and Alcohol services/treatment
2. Nutrition and wellness
3. Access to care
4. Need for more free clinics
5. Navigation/Coordination

The following summary represents the most important topic areas within the community discussed at the planning retreat in order of priority. Community leaders believe the following concerns are the most pressing problems and are identified as the most manageable to address and resolve.
1. Drug and Alcohol Services

Substance abuse services were most discussed at the community forum. Community leaders focused their discussions primarily on the limited number of services for drug and alcohol issues, the substance abuse problems of the area, and affordability of treatment and services.

*Perceived Contributing Factors*

- There are not enough providers to meet the demand among residents who are suffering through substance abuse problems.
- The economy and socioeconomic status of the region are major factors that lead people to abusing drug and alcohol.
- People are self-medicating and resorting to substances to deal with an array of other issues they are facing.
- There is a lack of coordinated services and advocacy for individuals with substance abuse issues.

2. Nutrition and Wellness

Community leaders identified lifestyle-related health concerns as a top health priority. Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes.

*Perceived Contributing Factors*

- Residents are not as active as they may need to be to remain healthy contributing to the rates of diabetes, obesity, and poor health outcomes.
- People are not educated enough on the long-term effects of an unhealthy lifestyle.
- The prevalence of diabetes contributes to poor health outcomes in the area.
- Residents do not always have access to healthy nutrition and may need additional resources.
- The poor socioeconomic status of the region leads to poor health choices.
3. Access to Care

Community leaders identified access to health care as a health priority. Community leaders focused their discussions primarily on the number of providers and limited transportation options.

**Perceived Contributing Factors**

- Residents do not always have access to care due to a lack of transportation. This is most often true for more rural residents that do not have reliable forms of transportation.
- Health services (i.e., primary care, clinics) are not always readily available due to a shortage of providers, which can cause lengthy wait times to secure appointments.
- There are not enough providers to meet the demand among residents. Where there are services, the wait times can be lengthy to secure an initial appointment.

4. Free Clinics

There is a growing group of individuals – the “poor middle class” – who do not qualify for Medicaid but struggle to pay for the healthcare they need.

**Perceived Contributing Factors**

- While residents may have health insurance; they cannot always afford to use their health insurance due to unaffordable deductibles and copays.
- The poor socioeconomic status of the region has created a population of people who cannot afford services.
- Residents are not always able to afford behavioral health care when it is needed due to the lack of insurances and cost of care.
- Substance abuse has remained a health concern in the area. The need is very high for clinics that offer services for substance abuse.

5. Navigation and Coordination

Leaders acknowledged the need for more consistent coordination among services in the region as well as a need for trained, educated navigators to assist various populations in receiving the care they need.

**Perceived Contributing Factors**
• Often times, many residents have several health problems they are dealing with and better coordination among providers could lead to better outcomes.

• Due to the poor socioeconomic status of the region, residents are overwhelmed and easily confused when attempting to navigate their healthcare options.

• Care coordination and transitional care are not always available due to lack of funding for these activities, though it is a need among vulnerable residents.
Secondary Data

Tripp Umbach worked collaboratively with the Penn Highlands Healthcare community health needs assessment oversight committee to develop a secondary data process focused on three phases: collection, analysis, and evaluation. Tripp Umbach obtained information on the demographics, health status and socio-economic and environmental factors related to the health and needs of residents from the multi-community service area of Penn Highlands Brookville. The process developed accurate comparisons to the state baseline of health measures utilizing the most current validated data. In addition to demographic data, specific attention was focused on two key community health index factors: Community Need Index (CNI) and Prevention Quality Indicators Index (PQI). Tripp Umbach provided additional comparisons and trend analysis for County Health Rankings, Prevention Quality Indicators and CNI data from 2012 to present.

DEMOGRAPHIC PROFILE

The Penn Highlands Brookville study area encompasses Clearfield and Jefferson counties (as well as Armstrong, Clarion and Forest—however those counties are not part of the study area for this CHNA), and is defined as a zip code geographic area based on 80% of the hospital’s inpatient volumes. The Penn Highlands Brookville community consists of 11 zip code areas.

Key Findings:

- Of the four counties in the study area, Clearfield County reports the largest population at more than 81,500 residents.
- Jefferson County reports the highest rate of residents aged 0-14 (17.7%); this is equal to that of the state.
- All four counties in the region report lower average household incomes ($51,133 for Cameron and $50,827 for Jefferson) as compared with the state of Pennsylvania ($71,088).
- Clearfield County reports the highest rate of households earning less than $15K per year (15.2%); this rate is higher than the rate seen for the state (12.5%).
- 14.4% of the households in Jefferson County report earning less than $15K per year (PA average is 12.5%).
- Three of the four study area counties (Cameron, Clearfield, and Jefferson) report higher rates of households earning less than $15K per year as compared with the state.
- Clearfield County reports a higher rate of residents with less than a high school education as compared with the state as well (3.9% for Clearfield County, 3.7% for PA).
- Clearfield County reports the most racial/ethnic diversity with 4.2% of the population identifying as a race/ethnicity other than ‘White, Non-Hispanic’.
Jefferson County reports the highest rate for the study area of residents with no health insurance (12%).

Clearfield County reports 10.7% of the population not having health insurance.

COUNTY HEALTH RANKINGS

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

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

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

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

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

Pennsylvania has 67 counties; therefore, the rank scale for Pennsylvania is one to 67 (one being the healthiest county and 67 being the most unhealthy). The median rank is 34. Data for the
County Health Rankings is only defined as far as the county level, zip code level data is not available.

✓ Of the 8 County Health Rankings for the four counties in the study area:
  ▪ Jefferson County ranked the highest for:
    ✓ Mortality (61 – seventh worst in the state)
    ✓ Clinical Care (61 – seventh worst in the state)
  ▪ Clearfield County ranked the highest for:
    ✓ Physical Environment (52)

✓ Jefferson county report higher uninsured rates as compared with the state (Jefferson = 14%, PA = 12%).

✓ Jefferson county report higher rates of diabetic residents as compared with the state (13% for Jefferson county, 10% for PA).

✓ Clearfield County saw a decline in adult obesity (29% to 31%); while Jefferson county saw rises (28% to 29% for Jefferson). The state also saw a rise in adult obesity going from 28% of the population to 29%.

✓ All four of the study area counties (Cameron, Clearfield, Elk, and Jefferson) as well as the state saw declines or no change in uninsured rates.

✓ All four of the counties as well as the state saw declines in the rates of residents getting mammography screenings.

✓ Unemployment rates went down across the board.
PREVENTION QUALITY INDICATORS INDEX (PQI)

The Prevention Quality Indicators Index (PQI) was developed by the Agency for Healthcare Research and Quality (AHRQ). The AHRQ model was applied to quantify the PQI within the Penn Highlands markets and Pennsylvania. The PQI Index identifies potentially avoidable hospitalizations for the benefit of targeting priorities and overall community health.

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

From 2011 to 2014, there were a handful of data methodology changes. For each, Tripp Umbach went to past data and adjusted as necessary to make comparable. They are as follows:

- In the past, PQI data was presented as a value per 1,000/population. The AHRQ has revised this and the current data is presented as a value per 100,000/population. Tripp Umbach adjusted to match these as needed.
- PQI 2 changed from Perforated Appendix in Males 18+ for the past study to Perforated Appendix in Total 18+ population as a rate per 1,000 ICD-9 code admissions for appendicitis. This shift has changed the values for this measure drastically and therefore, Tripp Umbach did not adjust.
- PQI 5 changed from COPD in 18+ populations to COPD or Asthma in “Older adults” 40+ populations. Tripp Umbach did not adjust.
- Although not clearly explained by the AHRQ, it would seem that a definition of Newborn population has shifted for PQI 9 because the values are drastically lower in 2014 than in previous years (2011). This has shifted PQI 9 values drastically. Tripp Umbach did not adjust.
- PQI 15 changed from Adult Asthma in 18+ populations for past study to Asthma in Younger Adults 18-39 populations. Tripp Umbach did not adjust.

**Overall:**

- All four study area counties report higher PQI rates (indicating more preventable hospitalizations) than the state for:
  - Diabetes Short-Term Complications Admission Rate (PQI 1)
  - Perforated Appendix Admission Rate (PQI 2)
  - Congestive Heart Failure Admission Rate (PQI 8)
  - Bacterial Pneumonia Admission Rate (PQI 11)
- All four study area counties report lower PQI rates (indicating fewer preventable hospitalizations) than the state for:
  - Hypertension Admission Rate (PQI 7)
- **Low Birth Weight Rate Admission Rate (PQI 9)**

- **Clearfield County** reports the highest PQI rates for the study area for 1 of the 14 measures: Diabetes Short-Term Complications (303.80 per 100,000 pop.).

- **Jefferson County** reports the highest PQI rates for the study area for 3 of the 14 measures: Angina without Procedure (33.33 per 100,000 pop.), Dehydration (91.66 per 100,000 pop.), and Urinary Tract Infections (336.07 per 100,000 pop.).

**Table 3: Prevention Quality Indicators – Clearfield and Jefferson Compared to Pennsylvania**

<table>
<thead>
<tr>
<th>Prevention Quality Indicators (PQI)</th>
<th>Clearfield</th>
<th>Jefferson</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Short-Term Admission Rate (PQI 1)</td>
<td>303.80</td>
<td>222.20</td>
<td>115.16</td>
</tr>
<tr>
<td>Perforated Appendix Admission Rate (PQI 2)</td>
<td>391.30</td>
<td>500.00</td>
<td>343.91</td>
</tr>
<tr>
<td>Diabetes Long-Term Admission Rate (PQI 3)</td>
<td>64.64</td>
<td>77.77</td>
<td>119.79</td>
</tr>
<tr>
<td>COPD or Adult Asthma Admission Rate (PQI 5)</td>
<td>460.97</td>
<td>555.65</td>
<td>578.80</td>
</tr>
<tr>
<td>Hypertension Admission Rate (PQI 7)</td>
<td>33.94</td>
<td>25.00</td>
<td>53.99</td>
</tr>
<tr>
<td>Congestive Heart Failure Admission Rate (PQI 8)</td>
<td>528.42</td>
<td>433.29</td>
<td>418.29</td>
</tr>
<tr>
<td>Low Birth Weight Rate (PQI 9)</td>
<td>17.68</td>
<td>14.78</td>
<td>37.50</td>
</tr>
<tr>
<td>Dehydration Admission Rate (PQI 10)</td>
<td>53.33</td>
<td>91.66</td>
<td>61.90</td>
</tr>
<tr>
<td>Bacterial Pneumonia Admission Rate (PQI11)</td>
<td>403.99</td>
<td>455.50</td>
<td>326.16</td>
</tr>
<tr>
<td>Urinary Tract Infection Admission Rate (PQI 12)</td>
<td>116.35</td>
<td>336.07</td>
<td>197.51</td>
</tr>
<tr>
<td>Angina Without Procedure Admission Rate (PQI 13)</td>
<td>14.54</td>
<td>33.33</td>
<td>11.80</td>
</tr>
<tr>
<td>Uncontrolled Diabetes Admission Rate (PQI 14)</td>
<td>4.85</td>
<td>11.11</td>
<td>14.20</td>
</tr>
<tr>
<td>Asthma in Younger Adults Admission Rate (PQI 15)</td>
<td>66.39</td>
<td>44.77</td>
<td>63.34</td>
</tr>
<tr>
<td>Lower Extremity Amputation Rate For Diabetic Patients (PQI 16)</td>
<td>19.39</td>
<td>19.44</td>
<td>26.40</td>
</tr>
</tbody>
</table>

**HEALTHY COMMUNITIES INSTITUTE (HCI) INDICATOR DATA**

The Healthy Communities Institute (HCI) mission is to improve the health and environmental sustainability of cities, counties and communities worldwide.

The Healthy Communities Institute is a multi-disciplinary team comprising healthcare information technology veterans (professional internet-system developers and evaluators), academicians (health informatics experts, urban planners, and epidemiologists) and former
senior government officials. The company is rooted in work started in 2002 in concert with the Healthy Cities Movement and the University of California at Berkeley. The management team from Harvard University, Cornell University and the University of California, Berkeley has expertise in informatics, public health, urban sustainability, community planning and high volume Internet sites.

- HCI Data includes:
  - Over 100 Health and Quality of Life Indicators
  - Healthy People 2020 Trackers
  - Performance Tracking
  - Database of Over 2,000 Proven Programs

**Key findings**

**Health and Risk Behaviors:**

- Jefferson County reports the lowest rate of residents being able to access exercise opportunities as compared with the other counties in the study area with only 51% of the population having access.

- Clearfield, Elk, and Jefferson County all report rises in Teen Obesity rates from 2009 to 2011; Cameron County is the only county to report a decline. Clearfield County reports the largest rise going from 19.3% to 20.0%, but Jefferson County reports the highest rates overall at 21.5% in 2009-2010 and 21.8% in 2010-2011.

- Jefferson County saw a rise in the rates of adults who drink excessively from 18.5% in 2005-2011 to 21.1% in 2006-2012. Even though Elk County reported a decline it still reports the highest rate for the study area with 24.1% of adults drinking excessively.

- Jefferson County reports the highest rate of alcohol-impaired driving deaths at 52.9%.

- Clearfield County reports the highest rate of deaths due to drug-poisoning at 12.7 per 100,000 pop.
**Health Access and Health Concerns:**

- Clearfield County reports the highest rate for the study area of residents unable to afford to see a doctor at 10.6% of the population (more than one in every 10 residents of Clearfield County are unable to see a doctor due to cost).

- All four counties (Cameron, Clearfield, Elk and Jefferson) are reporting declines in age-adjusted death rates due to coronary heart disease; men are more likely to die from coronary heart disease than women (across all four study area counties).

- In Clearfield and Jefferson counties, Lyme disease has been on the rise between 2010 and 2011. Men and younger individuals (aged less than 15 years) are more likely to contract Lyme disease compared to the gender and age counterparts.

**Cancer**

- Clearfield and Jefferson County report declines in their breast cancer incidence rates while Cameron and Elk County report rises.

- Jefferson County reported a rise in colorectal cancer death rate; however, it is still the lowest in the region. Clearfield and Elk County reported declines in deaths due to colorectal cancer however Clearfield still holds the highest rate for the region at 21.6 per 100,000 pop. Men are more likely to die as a result of colorectal cancer than women.

- Jefferson has been reporting a steady rise in age-adjusted deaths due to prostate cancer from 2005 to 2011; while it is still currently the lowest at 20.4 per 100,000 pop., at the current trajectory, it will soon be the highest for the study area.

- Clearfield and Elk County report rises in oral cavity and pharynx cancer incidence rates from 2005 to 2011. Clearfield County now reports the highest for the region at 11.8 per 100,000 pop.

**Accidents, Maternal, and Child Care:**

- Clearfield, Elk, and Jefferson County have all experienced declines in the age-adjusted death rates due to motor vehicle collisions.

- Clearfield, Elk, and Jefferson County have all experienced rises in the age-adjusted death rates due to suicide; Elk County has the highest rate at 19.9 per 100,000 pop. in 2009-2011.

- Cameron, Elk, and Jefferson County all report declines in the rates of mothers who receive adequate pre-natal care from 2010 to 2011. Jefferson County reports the lowest at 56.7%.

- All four of the study area counties report raises in the rates of mothers who breast-feed their babies. Jefferson County still reports the lowest at 58.6%.

- Jefferson County reports an infant mortality rate of 8 per 1,000 births; this is nearly double the rate seen for Clearfield County.
Jefferson County (the only of the four counties) saw a rise in the rate of people living below the poverty level going from 14.1% in 2007-2011 to 14.5% in 2008-2012; it is now the highest rate for the study area. Women and children are more likely than their counterparts to live below the poverty level.

Jefferson County is also the only county (of the four) to see a rise in children living below the poverty level.

Clearfield County reports the highest rate for the study area region for low income households that are also more than 1 mile from a grocery store (4.9%).

In 2008-2012, 48.6% of the renters in Clearfield County spend more then 30% of their household income on rent.

Clearfield County is the only county to report a rise in the rate of Medicare population with diabetes; in 2012 it reached 28.8% (although Cameron County is still slightly higher at 28.9%).
Key Stakeholder Interviews

DATA COLLECTION

From January 5th to the 21st 2015, Tripp Umbach conducted interviews with seven key stakeholders in the Penn Highlands Brookville service area. Tripp Umbach representatives conducted a 30-60 minute interview with each interviewee. All of the key stakeholders identified by Penn Highlands were willing to invest their time and provide information relating to the services of the hospital, the needs of the community county, and anything else pertaining to those topics. The key stakeholders work in community based organizations, private businesses, public positions, medical centers and typically are leaders in the community. The following table shows all of the individuals who completed an interview, along with their affiliation.

Table 4: Organizations That Participated in Stakeholder Interviews

<table>
<thead>
<tr>
<th>Participating Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brookville Chamber of Commerce</td>
</tr>
<tr>
<td>Brookville Police Dept.</td>
</tr>
<tr>
<td>Jefferson Manor Health Center</td>
</tr>
<tr>
<td>Jefferson Co. E.M.S.</td>
</tr>
<tr>
<td>Community Connections</td>
</tr>
<tr>
<td>Jefferson County AAA</td>
</tr>
<tr>
<td>KMA Remarketing</td>
</tr>
</tbody>
</table>

Key Findings

✔ Stakeholders describe the Penn Highlands Brookville community as a blue-collar, hardworking community that is a great place to raise a family. At the same time, the community has low socioeconomic status, an aging population, and drug issues that play a role in negatively affecting the overall health of the community.

✔ Drug use/abuse is one of the most significant health issues in the region, in terms of general health issues, behavioral health issues, and risks/needs of children in the community. Obesity and nutrition are also major health concerns in the region.

✔ Healthcare is accessible in the region, but transportation, physician recruitment issues, and a lack of specialty care serve as barriers to accessing care. While people are likely to go to Penn Highlands Brookville for care, the elimination of some services, such as the ICU and the maternity unit, make it a less comprehensive facility.
It is critical to educate the people of the Brookville community on health issues as a means to begin to address some of the major health problems in the community. Workshops and community forums, facilitated by hospitals and community organizations, can serve as places that people in the community can come to learn about health issues in the area and voice their opinions on the best ways to combat these issues.
Survey of Vulnerable Populations

Tripp Umbach worked closely with the CHNA oversight committee to assure that community members, including under-represented residents, were included in the needs assessment through a survey process.

DATA COLLECTION

Vulnerable populations were identified by the CHNA oversight committee and through stakeholder interviews. Vulnerable populations targeted by the surveys were seniors, low-income residents (including families), residents with behavioral health needs and residents that are uninsured.

A total of 484 surveys were collected in the Penn Highlands Healthcare hospital service area which provides a +/-5.59 confidence interval for a 95% confidence level. Tripp Umbach worked with the oversight committee to design a 30 question health status survey. The survey was administered by community based organizations (i.e., Cenclear, Free Medical Clinic, CCAAA, Clearfield CAL Center for Active Living, Susquehanna Rural Free Clinic, YMCA, etc.) that provide services to vulnerable populations in the hospital service area. Community based organizations were trained to administrate the survey using hand-distribution.

- Surveys were administered onsite and securely mailed to Tripp Umbach for tabulation and analysis.
- Surveys were analyzed using SPSS software.

Limitations of Survey Collection:

There are several inherent limitations to using a hand-distribution methodology when collecting surveys. The demographics of the population are not intended to match the general population of the counties surveyed. Often, the demographic characteristics of populations that are considered vulnerable populations are not the same as the demographic characteristics of a general population. For example, vulnerable populations by nature may have significantly less income than a general population. For this reason the findings of this survey are not relevant to the general populations of the counties they were collected in. Additionally, hand-distribution is limited by the locations where surveys are administered. In this case, Tripp Umbach asked CBOs to self-select into the study and as a result there are several populations that have greater representation in raw data (i.e., seniors, low-income, etc.).
Demographics:

- By March 4, 2015, Tripp Umbach received a total of 484 completed surveys
- Of the surveys gathered: 62.7% were female, 37.3% were male
- The age breakout was as such:

  **Table 5: Age Distribution of Survey Respondents**

<table>
<thead>
<tr>
<th>Age</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>41</td>
<td>8.7</td>
</tr>
<tr>
<td>26-35</td>
<td>76</td>
<td>16.1</td>
</tr>
<tr>
<td>36-45</td>
<td>83</td>
<td>17.6</td>
</tr>
<tr>
<td>46-55</td>
<td>102</td>
<td>21.7</td>
</tr>
<tr>
<td>56-65</td>
<td>90</td>
<td>19.1</td>
</tr>
<tr>
<td>66-75</td>
<td>43</td>
<td>9.1</td>
</tr>
<tr>
<td>76-85</td>
<td>23</td>
<td>4.9</td>
</tr>
<tr>
<td>86+</td>
<td>13</td>
<td>2.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>484</td>
<td></td>
</tr>
</tbody>
</table>

- The majority of the survey respondents reported their race as white (89.0%); the next largest racial group was multiracial at 5.1% of the survey population.
- The household income level with the most responses was $10,000 to $19,999 with 22.6% of the respondents answering this.

**Key Findings:**
*Note: percentages are listed in order of Cameron, Clearfield, Elk, and Jefferson Counties, respectively.*

**Table 6: Average Weight and Height of Survey Respondents**

<table>
<thead>
<tr>
<th>Weight &amp; BMI</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>Avg. Female (5′4″)*</th>
<th>Avg. Male (5′9″)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>189.6 lbs.</td>
<td>183.7 lbs.</td>
<td>188.8 lbs.</td>
<td>182.0</td>
<td>108-144 lbs.</td>
<td>121-163 lbs.</td>
</tr>
<tr>
<td>BMI</td>
<td>30.49</td>
<td>29.56</td>
<td>29.62</td>
<td>28.57</td>
<td>26.5</td>
<td>26.6</td>
</tr>
</tbody>
</table>
Table 7: Percentage of Survey Respondents Having Taken the Following Tests

<table>
<thead>
<tr>
<th>Test Received</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood test</td>
<td>73.5%</td>
<td>71.3%</td>
<td>72.1%</td>
<td>75.7%</td>
</tr>
<tr>
<td>Check up</td>
<td>61.2%</td>
<td>61.4%</td>
<td>63.6%</td>
<td>53.4%</td>
</tr>
<tr>
<td>Flu shot</td>
<td>42.9%</td>
<td>48.0%</td>
<td>38.8%</td>
<td>32.0%</td>
</tr>
<tr>
<td>Cholesterol test</td>
<td>40.8%</td>
<td>47.5%</td>
<td>41.9%</td>
<td>32.0%</td>
</tr>
</tbody>
</table>

Less common responses included: Colonoscopy, EKG, Urinalysis, Pneumonia vac., Mammogram, and Prostate test.

- The most popular place for residents to seek care is a doctor’s office – 77.1%, 59.6%, 76.8%, and 49.5% respectively.
- The insurance category with the highest response rate was Private- 32.7%, 17.1%, and 28.9% respectively. Jefferson’s was Medicaid at 19.4%.
- The most common reason why individuals do not have health insurance is because they can’t afford it – 40%, 80.3%, 63.6%, and 51.9% respectively.
- Individuals report being examined by a medical doctor “1-2 times” in the past year for all four counties as the most popular choice- 34.7%, 38.9%, 33.6%, and 44.8% respectively.
- The most common responses to “how is your health?” is “Good”-35.4%, 47.8%, 41.1%, and 38.8% respectively.
- And when people exercise, they most commonly do it “3-4 times per week” (45.8%, 37.2%, and 36.7% respectively) and Jefferson respondents most commonly did it 1-2 times (44.8%).
- The majority of respondents reported that they have been told they do not have a substance abuse problem (91.8%, 93.4%, 87.4%, and 66.0% respectively).
- The majority of respondents report “Yes” to having their children or grandchildren being up to date with immunizations (60.9%, 52.1%, 57.1%, and 55.6% respectively).
- 19.6%, 31.1%, 28.6%, and 35.4% respectively of respondents answered “Doesn’t apply to me”.
- The most popular form of finding out about services in the community is via “word-of-mouth” (76.6%, 64.6%, 75%, and 76.5% respectively).
- Their personal car is the most common form of transportation (73.5%, 70.9%, 65.1%, and 59.8% respectively).
- Only 4.1%, 9.2%, 11.6%, and 7.8% registered as taking public transportation.
- The majority of respondents report not consuming alcohol at all (58.3%, 64.4%, 68.0%, 75.2%).
- 1 in 10 respondents in Montour County (10.2%) indicated that they needed and could not secure services for a physical health condition (i.e., injury or illness) in the last year.
Common Health Issues:

Table 7: Survey Responses – Health Issues Respondents Reported Ever Diagnosed with

<table>
<thead>
<tr>
<th>Ever with</th>
<th>Diagnosed</th>
<th>Cameron County</th>
<th>Clearfield County</th>
<th>Elk County</th>
<th>Jefferson County</th>
<th>PA*</th>
<th>U.S.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>64.6%</td>
<td>37.2%</td>
<td>60.5%</td>
<td>62.1%</td>
<td>18.3%</td>
<td>18.7%</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>14.3%</td>
<td>13.6%</td>
<td>21.7%</td>
<td>10.7%</td>
<td>10.1%</td>
<td>9.7%</td>
<td></td>
</tr>
<tr>
<td>Heart Problem</td>
<td>22.4%</td>
<td>19.9%</td>
<td>18.1%</td>
<td>15.5%</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>10.2%</td>
<td>9.6%</td>
<td>7.0%</td>
<td>2.9%</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>

*Source: CDC

✓ 64.6%, 37.2%, 60.5%, and 62.1% respectively of individuals report being told by a doctor, nurse, or health professional that they have depression.

✓ 14.3, 13.6%, 21.7%, and 10.7% respectively of individuals report being told by a doctor, nurse, or health professional that they have diabetes.

✓ A majority of respondents report being told they have a heart problem (22.4%, 19.9%, 18.1%, and 15.5% respectively).

✓ The majority of respondents report “No” to having been told they have cancer (89.8%, 90.4%, 93.0%, and 97.1% respectively).
Table 8: Survey Responses – Smoking Rates Reported by Respondents

<table>
<thead>
<tr>
<th>Smoking</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>PA*</th>
<th>U.S.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everyday</td>
<td>35.4%</td>
<td>24.4%</td>
<td>30.5%</td>
<td>59.6%</td>
<td>15.7%</td>
<td>13.4%</td>
</tr>
<tr>
<td>Not at all</td>
<td>60.4%</td>
<td>67%</td>
<td>64.1%</td>
<td>32.4%</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

- The majority of respondents report not smoking at all (60.4%, 67%, 64.1%, and 32.4% respectively); however, (35.4%, 24.4%, 30.5%, and 56.9%) smoke every day.

Table 9: Survey Responses – Physical Activity Rates Reported by Survey Respondents

<table>
<thead>
<tr>
<th>Physical Activities</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>PA*</th>
<th>U.S.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>49.0%</td>
<td>62%</td>
<td>62.7%</td>
<td>56.3%</td>
<td>73.7%</td>
<td>74.7%</td>
</tr>
<tr>
<td>No</td>
<td>51.0%</td>
<td>38%</td>
<td>37.3%</td>
<td>43.7%</td>
<td>26.3%</td>
<td>25.3%</td>
</tr>
</tbody>
</table>

- 49%, 62%, 62.7%, and 56.3% respectively of respondents claimed to have exercised in the last 30 days.
Conclusions and Recommended Next Steps

Penn Highlands Brookville, working closely with community partners, understands that the community health needs assessment document is only a first step in an ongoing process. It is vital that ongoing communication and a strategic process follow the assessment process. With Penn Highlands Healthcare having such a large presence in the community, Brookville has access to many resources within Brookville and at the other three facilities. However, Penn Highlands Healthcare understands that accessing these services can be a major challenge for individuals living in the community. Residents of the Penn Highlands Brookville service area have limited access to the healthcare resources in the region due to the need for an increase in healthcare providers and transportation to healthcare facilities, including free clinics. Collaboration and partnership are a strategy that Penn Highlands Healthcare must employ more so in order to affect the other needs facing the community—substance abuse, nutrition and wellness. It is important to create or expand existing partnerships with multiple community organizations when developing strategies to address the top identified needs. Implementation strategies will need to consider the higher need areas in the poorest areas within Cameron, Clearfield, Elk and Jefferson County. Tripp Umbach recommends the following actions be taken by the hospital sponsors in close partnership with community organizations over the next six to nine months.

Recommended Action Steps:

- Widely communicate the results of the community health needs assessment document to Penn Highlands Brookville staff, providers, leadership and boards.
- Conduct an open community forum where the community health needs assessment results are presented widely to community residents, as well as through multiple outlets such as: local media, neighborhood associations, community-based organizations, faith-based organizations, schools, libraries and employers.
- Utilize the inventory of available resources in the community in order to explore further partnerships and collaborations.
- Implement a comprehensive “grass roots” community engagement strategy to build upon the resources that already exist in the community and the energy of and commitment of community leaders that have been engaged in the community health needs assessment process.
- Develop three “working groups” to focus on specific strategies to address the top identified needs of the facility. The working groups should meet for a period of four to six months to develop action plans and external funding requests.
Community Definition

The communities served by Penn Highlands Clearfield include the following zip codes. The Penn Highlands Clearfield primary service area includes 16 populated zip code areas (excluding zip codes for P.O. boxes and offices) where 80% of the hospital’s inpatient discharges originated.

Table 1: Penn Highlands Clearfield Hospital Community Zip Codes

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>City</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>16866</td>
<td>Philipsburg</td>
<td>Centre</td>
</tr>
<tr>
<td>16830</td>
<td>Clearfield</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16833</td>
<td>Curwensville</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16881</td>
<td>Woodland</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16843</td>
<td>Hyde</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16836</td>
<td>Frenchville</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16863</td>
<td>Olanta</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16825</td>
<td>Bigler</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16845</td>
<td>Karthaus</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16855</td>
<td>Mineral Springs</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16837</td>
<td>Glen Richey</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16873</td>
<td>Shawville</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16850</td>
<td>Lecontes Mills</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16651</td>
<td>Houtzdale</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16858</td>
<td>Morrisdale</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16666</td>
<td>Osceola Mills</td>
<td>Clearfield</td>
</tr>
</tbody>
</table>
Consultant Qualifications

Tripp Umbach is a recognized national leader in community health research, economic analysis, feasibility studies, and market research, having conducted more than 500 projects over the past 25 years in communities across the United States and internationally. Past community health projects have included: needs assessments, population health surveys, market analysis, program implementation plans, and processes for tracking, measuring, and evaluating community health programs. Today, more than one in four Americans lives in a community where Tripp Umbach has completed a community health assessment. Tripp Umbach:

- Has developed a deep understanding of the communities and health needs in the area through the CHNAs and implementation plans completed for all four Penn Highlands hospitals between 2011 and 2013, as well as the health system strategic planning and implementation process completed in 2013.

- Has established relationships with stakeholders and providers in the Penn Highlands primary service area: Cameron, Clearfield, Elk, and Jefferson County.

- Has a national perspective of best practices and community health improvement projects being used to improve population health.

Many of our projects are national pilots and have received statewide and national recognition. Tripp Umbach completed a series of 40 community health needs assessments in the 1990s in partnership with the Healthcare Association of Pennsylvania and has a longstanding consulting relationship with hospitals, medical schools, and research institutes throughout the Commonwealth. Tripp Umbach has completed a series of more than 50 community health needs assessments between 2011 and 2013, which met the industry standards and Internal Revenue Code § 501(r) requirements.

Internal Revenue Code § 501(r) mandates that non-profit hospitals conduct needs assessments every three years. Tripp Umbach, a national leader in conducting community health needs assessments has closely monitored 501(r) requirements, reflecting the most current information in this proposal.
Project Mission & Objectives

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

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

- Assuring that community members, including under-represented residents and those with a broad-based racial/ethnic/cultural and linguistic background are included in the needs assessment process. In addition, educators, health-related professionals, media representatives, local government, human service organizations, institutes of higher learning, religious institutions and the private sector will be engaged at some level in the process.
- Obtaining statistically valid information on the health status and socio-economic/environmental factors related to the health of residents in the community and supplement general population survey data that is currently available.
- Utilizing data obtained from the assessment to address the identified health needs of the service area.
- Providing recommendations for strategic decision-making regionally and locally to address the identified health needs within the region to use as a baseline tool for future assessments.
- Developing a CHNA document as required by the Patient Protection and Affordable Care Act (ACA).
Methodology

Tripp Umbach facilitated and managed a comprehensive community health needs assessment on behalf of Penn Highlands Healthcare. The assessment process included input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge and expertise of public health issues.

Key steps and data sources in the community health needs assessment included:

- **Community Health Assessment Planning** – A series of meetings was facilitated by the consultants and the CHNA oversight committee consisting of leadership from Penn Highlands Healthcare and other participating hospitals and organizations (i.e., Penn Highlands Brookville, Penn Highlands Clearfield, Penn Highlands DuBois, and Penn Highlands Elk). This process lasted from October 2014 until April 2015.

- **Public Commentary** – Tripp Umbach secured public commentary related to the previous community health needs assessments and implementation plans. This process lasted from December 2014 until January 2015.

- **Secondary Data Collection and Analysis** – Tripp Umbach managed and analyzed existing data sources to prepare a secondary data profile for each hospital service area, including state and national baseline data on relevant health measures using data from a variety of sources. This process lasted from February 2015 until March 2015.

- **Stakeholder Interviews** – Tripp Umbach completed interviews with key stakeholders (regionally), to secure insight and understanding of community health needs drawing upon past CHNAs and implementation plans. Stakeholders included persons with public health expertise, persons who represented agencies with access to relevant data, and who represented underserved populations and populations with chronic illnesses. This process lasted from December 2014 until January 2015.

- **Hand-Distributed Survey** – Tripp Umbach employed a hand-distribution methodology working closely with the Penn Highlands Healthcare working group to identify partners to capture the individual characteristics of the study area which included (but was not limited to): key populations such as underserved populations, chronically ill, specific barriers to accessing services, the types of services in greatest demand, health status and insight into health needs identified in previous CHNA. This process lasted from December 2014 until March 2015.

- **Implementation Plan Assessment** – Tripp Umbach reviewed the previous implementation plan and documented: efforts to implement, progress made, barriers to progress, and carry-over recommendations. This process lasted from March 2015 until April 2015.

- **Community Health Forum** – Tripp Umbach presented the study findings and facilitated a community health planning retreat resulting in the identification of significant community health needs and the development of community specific community health improvement strategies. This process lasted from March 2015 until April 2015.
• **Provider Inventory** – Tripp Umbach formulated a provider inventory in Excel format highlighting areas of deficits in specific categories related to identify community health needs. This process lasted from March 2015 until April 2015.

• **Implementation Planning** – Tripp Umbach facilitated a planning process that maximized system cohesion and synergies for leaders from each hospital. This process lasted from March 2015 until May 2015.

• **Final Report and Presentation** – Tripp Umbach provided a final community health needs assessment and implementation plan for each hospital in the Penn Highlands Healthcare system that meets the most recent industry and IRS standards and can be used to file Schedule H of the IRS 990 for FY-2016. This process lasted from April 2015 until May 2015.
Key Community Health Priorities

Community leaders reviewed and discussed existing data, in-depth interviews with community stakeholders representing a cross-section of agencies, and survey findings presented by Tripp Umbach in a forum setting, which resulted in the identification and prioritization of five community health priorities in the Penn Highlands Healthcare. Community leaders identified the following top community health needs that are supported by secondary and/or primary data: 1) drug and alcohol services 2) nutrition and wellness; 3) access to care 4) free clinics 5) navigation and coordination. A summary of the top five needs in the Penn Highlands Clearfield service area are as follows:

DRUG AND ALCOHOL

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. There are not enough providers to meet the demand among residents who are suffering through substance abuse problems.
2. The economy and socioeconomic status of the region is a major factor that leads people to abusing drugs and alcohol.
3. People are self-medicating and resorting to substances to deal with an array of other issues they are facing.
4. There is a lack of coordinated services and advocacy for individuals with substance abuse issues.

Addressing needs related to substance abuse is identified as the top health priority by community leaders at the community forum. It was also, by far, the most discussed health need among stakeholders during one-on-one interviews and survey respondents indicated that they are facing a drug and alcohol problem in their communities.

Secondary data, community leaders, stakeholders and survey respondents agree that substance abuse is a top health priority:

- Secondary data
  - A lower percentage of residents (35.2%) than the state average (38.2%) have the perception that having more than 5 drinks per week can be a great risk.
- Community Forum
  - Substance abuse services were the most discussed needs at the community forum.
Community leaders focused their discussions primarily on the limited number of services for drug and alcohol issues, the substance abuse problems of the area, and affordability of treatment and services.

Interview Key Findings

- Drug use is perceived as the biggest health risk of the region overall.
- Drug and alcohol abuse was mentioned 11 times as biggest health risk.
- The second biggest health risk (aging population) was mentioned only 6 times.
- There is a large perception that drug and alcohol abuse is a problem for the communities of Penn Highlands.

Survey Results

- Cameron County- 73.3% of respondents marking this as the #1 community priority.
- Clearfield County- 56.8% of respondents marking this as the #1 community priority.
- Elk County - 72.2% of respondents marking this as the #1 community priority.
- Jefferson County - 65.7% of respondents marking this as the #1 community priority.

Substance abuse is a great community concern and a top priority. During this previous CHNA, substance and drug abuse was only considered an emerging and growing problem—not as prevalent as it appears now. Community forum participants could not pinpoint the exact reasons why drug abuse was a problem in their community. Natural curiosity, boredom, peer pressure, and low self-esteem were a few reasons community leaders thought residents engaged in drug use. The groups’ collective experience however; did indicate that the problem is growing and has been present in their community for decades. One method to combat the increased use of drugs was through drug prevention education.

The proposed solutions included the following components:

1. Affect community change through the development of an active community anti-substance abuse coalition. Community coalitions were planned to hold community-wide meetings, develop public education campaigns, and attract sponsors for substance abuse prevention strategies. To strengthen the impact of these strategies on community substance abuse problems, coalitions were to focus on implementing research-tested programs and approaches.

2. Tracking data over time on substance abuse among students in school, rates of truancy, school suspensions, drug abuse arrests and drug-related emergency room admissions was another evaluation process. Data from community drug abuse assessments were proposed to serve as a baseline for measuring change.
NUTRITION AND WELLNESS

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Residents are not as active as they may need to be to remain healthy contributing to the rates of diabetes, obesity, and poor health outcomes.
2. People are not educated enough on the long-term effects of an unhealthy lifestyle.
3. The prevalence of diabetes contributes to poor health outcomes in the area.
4. Residents do not always have access to healthy nutrition and may need additional resources.
5. The poor socioeconomic status of the region leads to poor health choices.

Community leaders identified lifestyle-related health concerns as the second community health priority. Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes. It was discussed as a major health need among stakeholders during one-on-one interviews and survey respondents indicated that they are facing healthy lifestyle problems in their communities.

Secondary data, community leaders, stakeholders and survey respondents agree that substance abuse is a top health priority:

- Secondary Data
  - Only 51% of Jefferson County reports being able to access exercise opportunities.
  - Cameron, Clearfield, and Elk County all saw rises in the rates of adults who are sedentary; Elk County reports the highest rate for the study area at 30.9% in 2010.
  - More than one in every four children (under 18 years) in Cameron County lives in households that experienced food insecurity at some point in the past year.
• Community Forum
  ▪ Community leaders identified lifestyle-related health concerns as a top health priority.
  ▪ Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes.

• Interview Key Findings
  ▪ Obesity was mentioned third most when stakeholders listed their largest health concerns for the region.
  ▪ The low socioeconomic status of the region is a massive source for the health concerns and risks of the region. It is perceived that things like nutrition, a proper diet and lack of consistent exercise are all related to the low incomes and high unemployment of the region.

• Survey

  **Table 2: Survey Response- Top 5 Health Concerns Identified by County**

<table>
<thead>
<tr>
<th>Health Concern</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>31.1%</td>
<td>38.9%</td>
<td>36.5%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Obesity</td>
<td>37.4%</td>
<td>40.5%</td>
<td>35.7%</td>
<td>38.4%</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>33.3%</td>
<td>32.6%</td>
<td>26.2%</td>
<td>30.3%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>22.2%</td>
<td>36.3%</td>
<td>34.9%</td>
<td>34.9%</td>
</tr>
</tbody>
</table>

During the prior CHNA, preventative care and education was considered limited in the community. Forum attendees believed preventive care and education information may have decreased in the community due to reduced state and federal funding resources.

There was a perception that the health status of many residents is poor due to limited education and the lack of community promotion on healthy living.

Solutions were created on how to promote becoming healthy, getting healthy and remaining healthy. Diet and exercise information was considered important a component piece to preventive care and education. The planning group acknowledged the importance of having access to preventive care and education.
ACCESS TO CARE

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Residents do not always have access to care due to a lack of transportation. This is most often true for more rural residents that do not have reliable forms of transportation (because of financial instability or other reasons).

2. Health services (i.e., primary care, clinics) are not always readily available due to a shortage of providers, which can cause lengthy wait times to secure appointments.

3. Residents are not always able to afford behavioral health care when it is needed due to the lack of insurances and cost of care.

4. Substance abuse has remained a health concern in the area. The need for clinics who offer services for substance abuse is very high.

Increasing access to healthcare is identified as the third community health priority by community leaders. Access to health care is an ongoing health need in rural areas across the U.S. Apart from insurance issues, access to healthcare in the hospital services area is limited by provider to population ratios that cause lengthy wait times to secure appointments, location of providers, transportation issues, limited awareness of residents related to the location and eligibility of health programs as well as ways to be healthier. As the ACA has been implemented and the consolidation of health services has taken place across the country; this issue has worsened in many rural areas.

Access to care was identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

- Secondary Data
  - All four of the study area counties report lower PCP rates than seen across the state (80 per 100,000 population for the state).
    - Cameron = 60 per 100,000
    - Clearfield = 65 per 100,000
    - Elk = 47 per 100,000
    - Jefferson = 47 per 100,000

- Community Forum
  - Community leaders identified access to health care as a health priority.
  - Leaders focused their discussions primarily on the limited number of providers and transportation options.

- Stakeholder Interviews
Transportation is a barrier in people receiving the care that they need. However, attitudes seem to be shifting towards an acceptance that it is necessary to travel for specialized care.

There is a perception that many people in the community are uninsured and cannot afford the services they need.

Survey

- Twenty seven percent of all survey respondents did not have insurance, with “unable to afford” being the most common reason why (57.2%).
- Fifteen percent of all survey respondents say transportation is a barrier in receiving necessary healthcare.

In 2012, access to healthcare was identified as a need for the Penn Highlands Clearfield. Accessibility to needed primary care services, healthcare specialists, and emergency treatment were specific issues identified. Forum participants also reported other factors that prohibit patients from receiving healthcare services. These factors include: transportation, lack of health education, the inability to pay for health services, the health literacy level of the patient, and the lack of available physicians and/or sub-specialists in the community to address growing patient concerns.

Community forum participants, stakeholder interviews and focus groups agreed that residents’ access to healthcare and resources was an important community health priority. Specifically, participants believed the lack of adequate levels of health insurance causes some residents to avoid preventive care.

While stakeholders felt there were local healthcare facilities and institutions that provide healthcare services to their communities, they believed there was inadequate access to healthcare services due to the lack of health insurance coverage. Stakeholders believed the escalation in unemployment caused an increase in residents who are under/uninsured due to the loss of employment benefits such as health insurance.

In addition, community forum participants believed residents who live in a rural community are in greater need for a strong public transportation system than those who live in an urban setting. Residents who live in a rural environment are typically car owners, but rural people without access to a car are the most affected by the lack of available transportation options.

Public transportation may provide community residents who are low-income to obtain employment and training opportunities within and outside of the county.

Improving on the current transportation infrastructure in Clearfield County was identified as an important need for those in the community. Forum participants suggest utilizing a transportation voucher program where there is a coordination of a transportation system which consists of volunteer drivers in a rural area.
FREE CLINICS

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. While residents may have health insurance; they cannot always afford to use their health insurance due to unaffordable deductibles and copays.

2. The poor socioeconomic status of the region has created a lot of people who cannot afford services.

Individuals in the Penn Highlands Healthcare service area are struggling to pay the costs of the services and treatments they need. It is perceived that things like nutrition, family planning, drug use and alcohol use are all tied back to the low incomes and high unemployment of the region. With so many jobs leaving the area, individuals having a hard time keeping consistent employment, and many jobs being low quality, community leaders recognized the need for free clinics in the area.

The need for free clinics was identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

- Secondary Data
  - Elk County reports the highest rate for the study area of residents with inadequate social support at 21.2% of the population.
  - More than one in every 10 residents of Clearfield County are unable to see a doctor due to cost.
  - Jefferson and Elk County report higher uninsured rates as compared with the state (Jefferson = 14%, Elk = 13%, PA = 12%).
  - Secondary data shows that all four counties in the region report lower average household incomes (Cameron = $50,522, Clearfield = $51.133, Elk = $54,840, Jefferson = $50,827) as compared with the state of Pennsylvania ($71,088).
• Community Forum
  • There is a growing group of individuals – the “poor middle class” – who do not qualify for Medicaid but struggle to pay for the healthcare they need.

• Stakeholder Interviews:
  • The regional economy has stagnated. Following years of many quality jobs leaving the area, local communities are seeing many people struggle financially. This has created problems in the region, including a low number of living wage jobs, and a number of residents with limited or no health coverage.
  • Due to poor public transportation and the low socioeconomic status of the region, it can be difficult for some residents to access or afford the health care they need.

• Survey:
  • Twenty two percent of survey respondents receive their healthcare from free or reduced services.
  • Seventeen percent of survey respondents have Medicaid as their primary insurance.
  • Fifty seven percent of survey respondents who do not have any type of insurance are without it because they cannot afford it.
  • Forty three percent of survey respondents made less than $20,000 a year.

NAVIGATION AND COORDINATION

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Often times, many residents have several health problems they are dealing with and better coordination among providers could lead to better outcomes.

2. Residents without much education are sometimes overwhelmed and easily confused when attempting to navigate their healthcare options.

3. Care coordination and transitional care are not always available due to lack of funding for these activities, though it is a need among vulnerable residents.

Individuals struggle with coordinating their various healthcare services and providers. The poor economic landscape of the region causes, people to deal with inconsistent insurance, a blend of Medicaid and Medicare, and do not receive the needed amount of information to understand their options.

• Community Forum
  • Leaders acknowledged the need for more consistent coordination among services in the region as well as a need for trained, educated navigators to assist various populations in receiving the care they need. Community leaders feel
that people find the healthcare landscape confusing and sometimes overwhelming.

- **Stakeholder Interview**
  - A majority of respondents discussed the organizational changes in terms of health care in the Penn Highlands region. Almost all interviewees mentioned the reorganization and formation of the Penn Highlands network as a significant change. This had lead to a certain degree of unfamiliarity with the Penn Highlands Healthcare network and people are still not totally comfortable with the new network.

- **Survey**
  - Five percent of survey respondents say they do not know how to receive insurance.
  - Twelve percent of survey respondents say they are using multiple insurances.
  - Fifteen percent of survey respondents say they once had insurance, but have since lost it.
Community Health Needs Identification Forum

The following qualitative data was gathered during a regional community planning forum held on March 12, 2015 in DuBois, PA. The community planning forum was facilitated by Tripp Umbach with more than 25 community leaders from a four county region (Cameron, Clearfield, Elk and Jefferson) and lasted approximately four hours. Community leaders were identified by the community health needs assessment oversight committee for Penn Highlands Healthcare.

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

GROUP RECOMMENDATIONS

The group provided many recommendations to address community health needs and concerns for residents of the four counties. Below is a brief summary of the recommendations:

- Community leaders made the following recommendations related to substance abuse:
  - Create a larger menu of rehabilitation programs
  - Coordinate advocacy efforts for individuals struggling with substance abuse problems more effectively
  - Establish addiction medicine programs
  - Offer pain management solutions

- Community leaders made the following recommendations related to nutrition and wellness:
  - Provide education
  - Increase awareness on healthy choices

- Community leaders made the following recommendations related to access to care:
  - Create affiliations with larger health systems for specialty care
  - Utilize tele-healthcare
  - Rotate specialty physicians to make them more accessible
  - Increase the number and options for providers
• Community leaders made the following recommendations related to the need of more clinics:
  ▪ Formulate better partnerships with the free clinics in the area (such as the one happening at the Susquehanna Rural Free Clinic to handle issues with diabetes)
  ▪ Offer free or reduced services
  ▪ Adapt more effectively to the populations who need these services most
• Community leaders made the following recommendations related to navigation and coordination of services:
  ▪ Utilize (or create) healthcare navigators to break down the “silos”
  ▪ Create improved communication to effectively capitalize on the services already offered
  ▪ Support opportunities to obtain a degree for healthcare navigation

**PROBLEM IDENTIFICATION**

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

1. **Drug and Alcohol services/treatment**
2. **Nutrition and wellness**
3. **Access to care**
4. **Need for more free clinics**
5. **Navigation/Coordination**

The following summary represents the most important topic areas within the community discussed at the planning retreat in order of priority. Community leaders believe the following concerns are the most pressing problems and are identified as the most manageable to address and resolve.
1. Drug and Alcohol Services

Substance abuse services were most discussed at the community forum. Community leaders focused their discussions primarily on the limited number of services for drug and alcohol issues, the substance abuse problems of the area, and affordability of treatment and services.

Perceived Contributing Factors

- There are not enough providers to meet the demand among residents who are suffering through substance abuse problems.
- The economy and socioeconomic status of the region are major factors that lead people to abusing drugs and alcohol.
- People are self-medicating and resorting to substances to deal with an array of other issues they are facing.
- There is a lack of coordinated services and advocacy for individuals with substance abuse issues.

2. Nutrition and Wellness

Community leaders identified lifestyle-related health concerns as a top health priority. Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes.

Perceived Contributing Factors

- Residents are not as active as they may need to be to remain healthy, contributing to the rates of diabetes, obesity, and poor health outcomes.
- People are not educated enough on the long-term effects of an unhealthy lifestyle.
- The prevalence of diabetes contributes to poor health outcomes in the area.
- Residents do not always have access to healthy nutrition and may need additional resources.
- The poor socioeconomic status of the region leads to poor health choices.
3. Access to Care

Community leaders identified access to health care as a health priority. Community leaders focused their discussions primarily on the number of providers and limited transportation options.

*Perceived Contributing Factors*

- Residents do not always have access to care due to a lack of transportation. This is most often true for more rural residents that do not have reliable forms of transportation.
- Health services (i.e., primary care, clinics) are not always readily available due to a shortage of providers, which can cause lengthy wait times to secure appointments.
- There are not enough providers to meet the demand among residents. Where there are services, the wait times can be lengthy to secure an initial appointment.

4. Free Clinics

There is a growing group of individuals – the “poor middle class” – who do not qualify for Medicaid but struggle to pay for the healthcare they need.

*Perceived Contributing Factors*

- While residents may have health insurance; they cannot always afford to use their health insurance due to unaffordable deductibles and copays.
- The poor socioeconomic status of the region has created a population of people who cannot afford services.
- Residents are not always able to afford behavioral health care when it is needed due to the lack of insurances and cost of care.
- Substance abuse has remained a health concern in the area. The need is very high for clinics that offer services for substance abuse.
5. Navigation and Coordination

Leaders acknowledged the need for more consistent coordination among services in the region as well as a need for trained, educated navigators to assist various populations in receiving the care they need.

Perceived Contributing Factors

- Often times, many residents have several health problems they are dealing with and better coordination among providers could lead to better outcomes.
- Due to the poor socioeconomic status of the region, residents are overwhelmed and easily confused when attempting to navigate their healthcare options.
- Care coordination and transitional care are not always available due to lack of funding for these activities, though it is a need among vulnerable residents.
Tripp Umbach worked collaboratively with the Penn Highlands Healthcare community health needs assessment oversight committee to develop a secondary data process focused on three phases: collection, analysis and evaluation. Tripp Umbach obtained information on the demographics, health status and socio-economic and environmental factors related to the health and needs of residents from the multi-community service area of Penn Highlands Clearfield Hospital. The process developed accurate comparisons to the state baseline of health measures utilizing the most current validated data. In addition to demographic data, specific attention was focused on two key community health index factors: Community Need Index (CNI) and Prevention Quality Indicators Index (PQI). Tripp Umbach provided additional comparisons and trend analysis for County Health Rankings, Prevention Quality Indicators and CNI data from 2012 to present.

**DEMOGRAPHIC PROFILE**

The Penn Highlands Clearfield study area encompasses Clearfield County (as well as Centre—however Centre County is not part of the study area for this CHNA), and is defined as a zip code geographic area based on 80% of the hospital’s inpatient volumes. The Penn Highlands Clearfield community consists of 16 zip code areas.

**Key Findings**

- Of the four counties in the study area, Clearfield County reports the largest population at more than 81,500 residents.
- 17.9% of the Clearfield County population is age 65 and older; 15.9% are age 14 and younger.
- All four counties in the region report lower average household incomes ($51,133 for Cameron and $50,827 for Jefferson) as compared with the state of Pennsylvania ($71,088).
- Clearfield County reports the highest rate of households earning less than $15K per year (15.2%); this rate is higher than the rate seen for the state (12.5%).
- Three of the four study area counties (Cameron, Clearfield, and Jefferson) report higher rates of households earning less than $15K per year as compared with the state.
- Clearfield County reports a higher rate of residents with less than a high school education as compared with the state as well (3.9% for Clearfield County, 3.7% for PA).
- Clearfield County reports the most racial/ethnic diversity with 4.2% of the population identifying as a race/ethnicity other than ‘White, Non-Hispanic’.
- Jefferson County reports the highest rate for the study area of residents with no health insurance (12%).
Clearfield County reports 10.7% of the population not having health insurance.

COUNTY HEALTH RANKINGS

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

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

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

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

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

Pennsylvania has 67 counties; therefore, the rank scale for Pennsylvania is one to 67 (one being the healthiest county and 67 being the most unhealthy). The median rank is 34. Data for the
County Health Rankings is only defined as far as the county level, zip code level data is not available.

✓ Of the 8 County Health Rankings for the four counties in the study area:
  ▪ Clearfield County ranked the highest for:
    ✓ Physical Environment (52)
  ✓ Clearfield County saw a decline in adult obesity (29% to 31%). The state also saw a rise in adult obesity going from 28% of the population to 29%.
  ✓ All four of the study area counties (Cameron, Clearfield, Elk, and Jefferson) as well as the state saw declines or no change in uninsured rates.
  ✓ All four of the study area counties as well as the state saw declines in the rates of residents getting mammography screenings.
  ✓ Unemployment rates went down across the board.

PREVENTION QUALITY INDICATORS INDEX (PQI)

The Prevention Quality Indicators Index (PQI) was developed by the Agency for Healthcare Research and Quality (AHRQ). The AHRQ model was applied to quantify the PQI within the Penn Highlands markets and Pennsylvania. The PQI Index identifies potentially avoidable hospitalizations for the benefit of targeting priorities and overall community health.

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

From 2011 to 2014, there were a handful of data methodology changes. For each, Tripp Umbach went to past data and adjusted as necessary to make comparable. They are as follows:

- In the past, PQI data was presented as a value per 1,000 population. The AHRQ has revised this and the current data is presented as a value per 100,000 population. Tripp Umbach adjusted to match these as needed.
- PQI 2 changed from Perforated Appendix in Males 18+ for the past study to Perforated Appendix in Total 18+ population as a rate per 1,000 ICD-9 code admissions for appendicitis. This shift has changed the values for this measure drastically and therefore, Tripp Umbach did not adjust.
- PQI 5 changed from COPD in 18+ population to COPD or Asthma in “Older adults” 40+ population. Tripp Umbach did not adjust.
- Although not clearly explained by the AHRQ, it would seem that a definition of Newborn population has shifted for PQI 9 because the values are drastically lower in 2014 than in
previous years (2011). This has shifted PQI 9 values drastically. Tripp Umbach did not adjust.

- PQI 15 changed from Adult Asthma in 18+ population for past study to Asthma in Younger Adults 18-39 population. Tripp Umbach did not adjust.

**Overall**

- All four study area counties report higher PQI rates (indicating more preventable hospitalizations) than the state for:
  - Diabetes Short-Term Complications Admission Rate (PQI 1)
  - Perforated Appendix Admission Rate (PQI 2)
  - Congestive Heart Failure Admission Rate (PQI 8)
  - Bacterial Pneumonia Admission Rate (PQI 11)

- All four study area counties report lower PQI rates (indicating fewer preventable hospitalizations) than the state for:
  - Hypertension Admission Rate (PQI 7)
  - Low Birth Weight Rate Admission Rate (PQI 9)

- **Clearfield County** reports the highest PQI rates for the study area for 1 of the 14 measures: Diabetes Short-Term Complications (303.80 per 100,000 pop.).
Table 3: Prevention Quality Indicators – Clearfield Service Area Compared to Pennsylvania

<table>
<thead>
<tr>
<th>Prevention Quality Indicators (PQI)</th>
<th>Clearfield</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Short-Term Complications Admission Rate (PQI 1)</td>
<td>303.80</td>
<td>115.16</td>
</tr>
<tr>
<td>Perforated Appendix Admission Rate (PQI 2)</td>
<td>391.30</td>
<td>343.91</td>
</tr>
<tr>
<td>Diabetes Long-Term Complications Admission Rate (PQI 3)</td>
<td>64.64</td>
<td>119.79</td>
</tr>
<tr>
<td>COPD or Adult Asthma Admission Rate (PQI 5)</td>
<td>460.97</td>
<td>578.80</td>
</tr>
<tr>
<td>Hypertension Admission Rate (PQI 7)</td>
<td>33.94</td>
<td>53.99</td>
</tr>
<tr>
<td>Congestive Heart Failure Admission Rate (PQI 8)</td>
<td>528.42</td>
<td>418.29</td>
</tr>
<tr>
<td>Low Birth Weight Rate (PQI 9)</td>
<td>17.68</td>
<td>37.50</td>
</tr>
<tr>
<td>Dehydration Admission Rate (PQI 10)</td>
<td>53.33</td>
<td>61.90</td>
</tr>
<tr>
<td>Bacterial Pneumonia Admission Rate (PQI 11)</td>
<td>403.99</td>
<td>326.16</td>
</tr>
<tr>
<td>Urinary Tract Infection Admission Rate (PQI 12)</td>
<td>116.35</td>
<td>197.51</td>
</tr>
<tr>
<td>Angina Without Procedure Admission Rate (PQI 13)</td>
<td>14.54</td>
<td>11.80</td>
</tr>
<tr>
<td>Uncontrolled Diabetes Admission Rate (PQI 14)</td>
<td>4.85</td>
<td>14.20</td>
</tr>
<tr>
<td>Asthma in Younger Adults Admission Rate (PQI 15)</td>
<td>66.39</td>
<td>63.34</td>
</tr>
<tr>
<td>Lower Extremity Amputation Rate Among Diabetic Patients (PQI 16)</td>
<td>19.39</td>
<td>26.40</td>
</tr>
</tbody>
</table>
HEALTHY COMMUNITIES INSTITUTE (HCI) INDICATOR DATA

The Healthy Communities Institute (HCI) mission is to improve the health and environmental sustainability of cities, counties and communities worldwide.

The Healthy Communities Institute is a multi-disciplinary team comprising healthcare information technology veterans (professional internet-system developers and evaluators), academicians (health informatics experts, urban planners, and epidemiologists) and former senior government officials. The company is rooted in work started in 2002 in concert with the Healthy Cities Movement and the University of California at Berkeley. The management team from Harvard University, Cornell University and the University of California, Berkeley has expertise in informatics, public health, urban sustainability, community planning and high volume Internet sites.

- HCI Data includes:
  - Over 100 Health and Quality of Life Indicators
  - Healthy People 2020 Trackers
  - Performance Tracking
  - Database of Over 2,000 Proven Programs

Key findings

- Clearfield, Elk, and Jefferson County all report rises in Teen Obesity rates from 2009 to 2011; Cameron County is the only county to report a decline. Clearfield County reports the largest rise going from 19.3% to 20.0%, but Jefferson County reports the highest rates overall at 21.5% in 2009-2010 and 21.8% in 2010-2011.

- Clearfield County reports the highest rate of deaths due to drug-poisoning at 12.7 per 100,000 pop.

- Clearfield County reports the highest rate for the study area of residents unable to afford to see a doctor at 10.6% of the population (more than one in every 10 residents of Clearfield County are unable to see a doctor due to cost).

- All four counties (Cameron, Clearfield, Elk and Jefferson) are reporting declines in age-adjusted death rates due to coronary heart disease; men are more likely to die from coronary heart disease than women (across all four study area counties).

- In Clearfield and Jefferson County, Lyme disease has been on the rise between 2010 and 2011. Men and younger individuals (aged less than 15 years) are more likely to contract Lyme disease compared to their gender and age counterparts.

- Clearfield and Jefferson County report declines in their breast cancer incidence rates while Cameron and Elk County report rises.
Jefferson County reported a rise in colorectal cancer death rate; however, it is still the lowest in the region. Clearfield and Elk County reported declines in deaths due to colorectal cancer, however Clearfield still holds the highest rate for the region at 21.6 per 100,000 pop. Men are more likely to die as a result of colorectal cancer than women.

Clearfield and Elk County report rises in oral cavity and pharynx cancer incidence rates from 2005 to 2011. Clearfield County now reports the highest for the region at 11.8 per 100,000 pop.

Clearfield, Elk, and Jefferson County have all experienced declines in the age-adjusted death rates due to motor vehicle collisions.

Clearfield, Elk, and Jefferson County have all experienced rises in the age-adjusted death rates due to suicide; Elk County has the highest rate at 19.9 per 100,000 pop. in 2009-2011.

All four of the study area counties report raises in the rates of mothers who breast-feed their babies. Jefferson County still reports the lowest at 58.6%.

Clearfield County reports the highest rate for the study area region for low income households that are also more than 1 mile from a grocery store (4.9%).

In 2008-2012, 48.6% of the renters in Clearfield County spend more then 30% of their household income on rent.

Clearfield County is the only county to report a rise in the rate of Medicare population with diabetes; in 2012 it reached 28.8% (although Cameron County is still slightly higher at 28.9%).
Key Stakeholder Interviews

DATA COLLECTION

From January 5th to the 21st 2015, Tripp Umbach conducted interviews with eight key stakeholders in the Penn Highlands Clearfield service area. Tripp Umbach representatives conducted a 30-60 minute interview with each interviewee. All of the key stakeholders identified by Penn Highlands were willing to invest their time and provide information relating to the services of the hospital, the needs of the community county, and anything else pertaining to those topics. The key stakeholders work in community based organizations, private businesses, public positions, medical centers and typically are leaders in the community. The following table shows all of the individuals who completed an interview, along with their affiliation.

Table 4: Organizations that Participated in Stakeholder Interviews

<table>
<thead>
<tr>
<th>Participating Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>YMCA</td>
</tr>
<tr>
<td>PA CareerLink of Clearfield County</td>
</tr>
<tr>
<td>Pediatrician, Penn Highlands</td>
</tr>
<tr>
<td>Clearfield County CYS</td>
</tr>
<tr>
<td>Cen-Clear Services, Inc.</td>
</tr>
<tr>
<td>MoValley Economic Dev.</td>
</tr>
<tr>
<td>Philipsburg Osceola S.D.</td>
</tr>
<tr>
<td>Penn Highlands, Clearfield</td>
</tr>
</tbody>
</table>
Key Findings:

✓ The region has stagnated. Following years of regression, the community has a low socioeconomic status. This has created problems in the region, including limited transportation and housing options, a low number of lower wage jobs, and a number of residents with limited or no health coverage.

✓ Drug use/abuse is the most significant health issue in the region. Heroin is one of the most widely used drugs in the community. Mental health issues and drug addiction go hand in hand – if a person is struggling with one, they are struggling with the other, typically.

✓ Healthcare is accessible in the region, but transportation and insurance serve as the barriers to accessing health care. Due to poor public transportation and the low socioeconomic status of the region, it can be difficult for some residents to access the health care they need.

✓ There are a number of ways that the community could try to address issues and improve the health of the community. One of the best strategies for doing so is to have a more collaborative approach to health care and overcoming health issues. The community, Penn Highlands Clearfield, and local organizations need to all be involved in working toward reducing the drug and alcohol problem of the region and making sure that residents in the community have the care they need.

✓ It is critical to educate the people of the Clearfield community on health issues as a means to begin to address some of the major health problems in the community. Workshops and community forums, facilitated by hospitals and community organizations, can serve as places that people in the community can come to learn about health issues in the area and voice their opinions on the best ways to combat these issues.
Survey of Vulnerable Populations

Tripp Umbach worked closely with the CHNA oversight committee to assure that community members, including under-represented residents, were included in the needs assessment through a survey process.

DATA COLLECTION

Vulnerable populations were identified by the CHNA oversight committee and through stakeholder interviews. Vulnerable populations targeted by the surveys were seniors, low-income residents (including families), residents with behavioral health needs and residents that are uninsured.

A total of 484 surveys were collected in the Penn Highlands Healthcare hospital service area which provides a +/- 6.89 confidence interval for a 95% confidence level. Tripp Umbach worked with the oversight committee to design a 30 question health status survey. The survey was administered by community based organizations (i.e., CenClear, Free Medical Clinic, CCAAA, Clearfield CAL Center for Active Living, Susquehanna Rural Free Clinic, YMCA, etc.) that provide services to vulnerable populations in the hospital service area. Community based organizations were trained to administer the survey using hand-distribution.

- Surveys were administered onsite and securely mailed to Tripp Umbach for tabulation and analysis.
- Surveys were analyzed using SPSS software.

LIMITATIONS OF SURVEY COLLECTION

There are several inherent limitations to using a hand-distribution methodology when collecting surveys. The demographics of the population are not intended to match the general population of the counties surveyed. Often, the demographic characteristics of populations that are considered vulnerable populations are not the same as the demographic characteristics of a general population. For example, vulnerable populations by nature may have significantly less income than a general population. For this reason the findings of this survey are not relevant to the general populations of the counties they were collected in. Additionally, hand-distribution is limited by the locations where surveys are administered. In this case Tripp Umbach asked CBOs to self-select into the study and as a result there are several populations that have greater representation in raw data (i.e., seniors, low-income, etc.).

Demographics

- By March 4, 2015, Tripp Umbach received a total of 484 completed surveys
- Of the surveys gathered: 62.7% were female, 37.3% were male
The majority of the survey respondents reported their race as white (89.0%); the next largest racial group was multi-race at 5.1% of the survey population.

The household income level with the most responses was $10,000 to $19,999 with 22.6% of the respondents answering this.

**Table 5: Age Distribution of Survey Respondents**

<table>
<thead>
<tr>
<th>Age</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>41</td>
<td>8.7</td>
</tr>
<tr>
<td>26-35</td>
<td>76</td>
<td>16.1</td>
</tr>
<tr>
<td>36-45</td>
<td>83</td>
<td>17.6</td>
</tr>
<tr>
<td>46-55</td>
<td>102</td>
<td>21.7</td>
</tr>
<tr>
<td>56-65</td>
<td>90</td>
<td>19.1</td>
</tr>
<tr>
<td>66-75</td>
<td>43</td>
<td>9.1</td>
</tr>
<tr>
<td>76-85</td>
<td>23</td>
<td>4.9</td>
</tr>
<tr>
<td>86+</td>
<td>13</td>
<td>2.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>484</td>
<td></td>
</tr>
</tbody>
</table>

**Key Findings**

*Note: percentages are listed in order of Cameron, Clearfield, Elk, and Jefferson counties, respectively.*

**Table 6: Average Weight and Height**

<table>
<thead>
<tr>
<th>Weight &amp; BMI</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>Avg. Female (5’4”)*</th>
<th>Avg. Male (5’9”)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>189.6 lbs.</td>
<td>183.7 lbs.</td>
<td>188.8 lbs.</td>
<td>182.0</td>
<td>108-144 lbs.</td>
<td>121-163 lbs.</td>
</tr>
<tr>
<td>BMI</td>
<td>30.49</td>
<td>29.56</td>
<td>29.62</td>
<td>28.57</td>
<td>26.5</td>
<td>26.6</td>
</tr>
</tbody>
</table>
Table 7: Percentage of Survey Respondents Having Taken the Following Tests

<table>
<thead>
<tr>
<th>Test Received</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood test</td>
<td>73.5%</td>
<td>71.3%</td>
<td>72.1%</td>
<td>75.7%</td>
</tr>
<tr>
<td>Check up</td>
<td>61.2%</td>
<td>61.4%</td>
<td>63.6%</td>
<td>53.4%</td>
</tr>
<tr>
<td>Flu shot</td>
<td>42.9%</td>
<td>48.0%</td>
<td>38.8%</td>
<td>32.0%</td>
</tr>
<tr>
<td>Cholesterol test</td>
<td>40.8%</td>
<td>47.5%</td>
<td>41.9%</td>
<td>32.0%</td>
</tr>
</tbody>
</table>

Less common responses included: Colonoscopy, EKG, Urinalysis, Pneumonia vac., Mammogram, and Prostate test.

- The most popular place for residents to seek care is a doctor’s office – 77.1%, 59.6%, 76.8%, and 49.5% respectively.
- The insurance category with the highest response rate was Private- 32.7%, 17.1%, and 28.9% respectively. Jefferson’s was Medicaid at 19.4%.
- The most common reason why individuals do not have health insurance is because they can’t afford it– 40%, 80.3%, 63.6%, and 51.9% respectively.
- Individuals report being examined by a medical doctor “1-2 times” in the past year for all four counties as the most popular choice- 34.7%, 38.9%, 33.6%, and 44.8% respectively.
- The most common response to “how is your health?” is “Good”-35.4%, 47.8%, 41.1%, and 38.8% respectively.
- And when people exercise, they most commonly do it “3-4 times per week” (45.8%, 37.2%, and 36.7% respectively) and Jefferson respondents most commonly did it 1-2 times (44.8%).
- The majority of respondents report they have been told they do not have a substance abuse problem (91.8%, 93.4%, 87.4%, and 66.0% respectively).
- The majority of respondents report “Yes” to having their children or grandchildren being up to date with immunizations (60.9%, 52.1%, 57.1%, and 55.6% respectively).
- The most popular form of finding out about services in the community is via “word-of-mouth” (76.6%, 64.6%, 75%, and 76.5% respectively).
- Their personal car is the most common form of transportation (73.5%, 70.9%, 65.1%, and 59.8% respectively).
- Only 4.1%, 9.2%, 11.6%, and 7.8% registered as taking public transportation.
- The majority of respondents report not consuming alcohol at all (58.3%, 64.4%, 68.0%, 75.2%).
Common Health Issues

### Table 8: Survey Responses – Health Issues Respondents Reported Ever Diagnosed

<table>
<thead>
<tr>
<th>Ever Diagnosed with</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>PA*</th>
<th>U.S.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>64.6%</td>
<td>37.2%</td>
<td>60.5%</td>
<td>62.1%</td>
<td>18.3%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>14.3%</td>
<td>13.6%</td>
<td>21.7%</td>
<td>10.7%</td>
<td>10.1%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Heart Problem</td>
<td>22.4%</td>
<td>19.9%</td>
<td>18.1%</td>
<td>15.5%</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Cancer</td>
<td>10.2%</td>
<td>9.6%</td>
<td>7.0%</td>
<td>2.9%</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

*Source: CDC

✓ 64.6%, 37.2%, 60.5%, and 62.1% respectively of individuals report being told by a doctor, nurse, or health professional that they have depression.

✓ 14.3, 13.6%, 21.7%, and 10.7% respectively of individuals report being told by a doctor, nurse, or health professional that they have diabetes.

✓ A majority of respondents report they have a heart problem (22.4, 19.9%, 18.1%, and 15.5% respectively).

✓ The majority of respondents report “No” to having been told they have cancer (89.8%, 90.4%, 93.0%, and 97.1% respectively).
Table 9: Survey Responses – Smoking Rates Reported by Respondents

<table>
<thead>
<tr>
<th>Smoking</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>PA*</th>
<th>U.S.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everyday</td>
<td>35.4%</td>
<td>24.4%</td>
<td>30.5%</td>
<td>59.6%</td>
<td>15.7%</td>
<td>13.4%</td>
</tr>
<tr>
<td>Not at all</td>
<td>60.4%</td>
<td>67%</td>
<td>64.1%</td>
<td>32.4%</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

*Source: CDC

✓ The majority of respondents report not smoking at all (60.4%, 67%, 64.1%, and 32.4% respectively); however, (35.4%, 24.4%, 30.5%, and 56.9%) smoke every day.

Table 10: Survey Responses – Physical Activity Rates Reported by Survey Respondents

<table>
<thead>
<tr>
<th>Physical Activities</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>PA*</th>
<th>U.S.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>49.0%</td>
<td>62%</td>
<td>62.7%</td>
<td>56.3%</td>
<td>73.7%</td>
<td>74.7%</td>
</tr>
<tr>
<td>No</td>
<td>51.0%</td>
<td>38%</td>
<td>37.3%</td>
<td>43.7%</td>
<td>26.3%</td>
<td>25.3%</td>
</tr>
</tbody>
</table>

*Source: CDC

✓ 49%, 62%, 62.7%, and 56.3% respectively of respondents claimed to have exercised in the last 30 days.
Conclusions and Recommended Next Steps

Penn Highlands Clearfield, working closely with community partners, understands that the community health needs assessment document is only a first step in an ongoing process. It is vital that ongoing communication and a strategic process follow the assessment process. With Penn Highlands Healthcare having such a large presence in the community, Penn Highlands Clearfield has access to many resources within Clearfield County and at the other three facilities. However, Penn Highlands Healthcare understands that accessing these services can be a major challenge for individuals living in the community. Residents of the Penn Highlands Clearfield service area have limited access to the healthcare resources in the region due to the need for an increase in healthcare providers and transportation to healthcare facilities, including free clinics. Collaboration and partnership are a strategy that Penn Highlands Healthcare must employ more so in order to affect the other needs facing the community—substance abuse and nutrition and wellness. It is important to create or expand existing partnerships with multiple community organizations when developing strategies to address the top identified needs. Implementation strategies will need to be considered the higher need areas in the poorest areas within Cameron, Clearfield, Elk and Jefferson County. Tripp Umbach recommends the following actions be taken by the hospital sponsors in close partnership with community organizations over the next six to nine months. Recommended Action Steps:

- Widely communicate the results of the community health needs assessment document to Penn Highlands Clearfield staff, providers, leadership and boards.

- Conduct an open community forum where the community health needs assessment results are presented widely to community residents, as well as through multiple outlets such as: local media, neighborhood associations, community-based organizations, faith-based organizations, schools, libraries and employers.

- Utilize the inventory of available resources in the community in order to explore further partnerships and collaborations.

- Implement a comprehensive “grass roots” community engagement strategy to build upon the resources that already exist in the community and the energy of and commitment of community leaders that have been engaged in the community health needs assessment process.

- Develop three “working groups” to focus on specific strategies to address the top identified needs of the facility. The working groups should meet for a period of four to six months to develop action plans and external funding requests.
Community Definition

The communities served by Penn Highlands DuBois include the following zip codes. The Penn Highlands DuBois primary service area includes 25 populated zip code areas (excluding zip codes for P.O. boxes and offices) where 80% of the hospital’s inpatient discharges originated.

Table 1: Penn Highlands DuBois Hospital Community Zip Codes

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>City</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>15834</td>
<td>Emporium</td>
<td>Cameron</td>
</tr>
<tr>
<td>16866</td>
<td>Philipsburg</td>
<td>Centre</td>
</tr>
<tr>
<td>15801</td>
<td>DuBois</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16830</td>
<td>Clearfield</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16833</td>
<td>Curwensville</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16838</td>
<td>Grampian</td>
<td>Clearfield</td>
</tr>
<tr>
<td>15849</td>
<td>Penfield</td>
<td>Clearfield</td>
</tr>
<tr>
<td>15848</td>
<td>Luthersburg</td>
<td>Clearfield</td>
</tr>
<tr>
<td>15757</td>
<td>McGees Mills</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16881</td>
<td>Woodland</td>
<td>Clearfield</td>
</tr>
<tr>
<td>16858</td>
<td>Morrisdale</td>
<td>Clearfield</td>
</tr>
<tr>
<td>15857</td>
<td>St Marys</td>
<td>Elk</td>
</tr>
<tr>
<td>15853</td>
<td>Ridgway</td>
<td>Elk</td>
</tr>
<tr>
<td>15846</td>
<td>Kersey</td>
<td>Elk</td>
</tr>
<tr>
<td>15823</td>
<td>Brockport</td>
<td>Elk</td>
</tr>
<tr>
<td>15845</td>
<td>Johnsonburg</td>
<td>Elk</td>
</tr>
<tr>
<td>15868</td>
<td>Weedville</td>
<td>Elk</td>
</tr>
<tr>
<td>15772</td>
<td>Rossiter</td>
<td>Indiana</td>
</tr>
<tr>
<td>15851</td>
<td>Reynoldsville</td>
<td>Jefferson</td>
</tr>
<tr>
<td>15767</td>
<td>Punxsutawney</td>
<td>Jefferson</td>
</tr>
<tr>
<td>15825</td>
<td>Brookville</td>
<td>Jefferson</td>
</tr>
<tr>
<td>15824</td>
<td>Brockway</td>
<td>Jefferson</td>
</tr>
<tr>
<td>15840</td>
<td>Falls Creek</td>
<td>Jefferson</td>
</tr>
<tr>
<td>15865</td>
<td>Sykesville</td>
<td>Jefferson</td>
</tr>
<tr>
<td>15864</td>
<td>Summerville</td>
<td>Jefferson</td>
</tr>
</tbody>
</table>
Consultant Qualifications

Tripp Umbach is a recognized national leader in community health research, economic analysis, feasibility studies, and market research, having conducted more than 500 projects over the past 25 years in communities across the United States and internationally. Past community health projects have included: needs assessments, population health surveys, market analysis, program implementation plans, and processes for tracking, measuring, and evaluating community health programs. Today, more than one in four Americans lives in a community where Tripp Umbach has completed a community health assessment. Tripp Umbach:

- Has developed a deep understanding of the communities and health needs in the area through the CHNAs and Implementation plans completed for all four Penn Highlands hospitals between 2011 and 2013, as well as the Health system strategic planning and implementation process completed in 2013.

- Has established relationships with stakeholders and providers in the Penn Highlands primary service area: Cameron, Clearfield, Elk, and Jefferson County.

- Has a national perspective of best practices and community health improvement projects being used to improve population health.

Many of our projects are national pilots and have received statewide and national recognition. Tripp Umbach completed a series of 40 community health needs assessments in the 1990s in partnership with the Healthcare Association of Pennsylvania and has a longstanding consulting relationship with hospitals, medical schools, and research institutes throughout the Commonwealth. Tripp Umbach has completed a series of more than 50 community health needs assessments between 2011 and 2013, which met the industry standards and Internal Revenue Code § 501(r) requirements.

Internal Revenue Code § 501(r) mandates that non profit hospitals conduct needs assessments every three years. Tripp Umbach, a national leader in conducting community health needs assessments has closely monitored 501(r) requirements, reflecting the most current information in this proposal.
Project Mission & Objectives

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

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

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

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

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

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

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

Tripp Umbach facilitated and managed a comprehensive community health needs assessment on behalf of Penn Highlands Healthcare. The assessment process included input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge and expertise of public health issues.

Key steps and data sources in the community health needs assessment included:

- **Community Health Assessment Planning** – A series of meetings was facilitated by the consultants and the CHNA oversight committee consisting of leadership from Penn Highlands Healthcare and other participating hospitals and organizations (i.e., Penn Highlands Brookville, Penn Highlands Clearfield, Penn Highlands DuBois, and Penn Highlands Elk). This process lasted from October 2014 until April 2015.

- **Public Commentary** – Tripp Umbach secured public commentary related to the previous community health needs assessments and implementation plans. This process lasted from December 2014 until January 2015.

- **Secondary Data Collection and Analysis** – Tripp Umbach managed and analyzed existing data sources to prepare a secondary data profile for each hospital service area, including state and national baseline data on relevant health measures using data from a variety of sources. This process lasted from February 2015 until March 2015.

- **Stakeholder Interviews** – Tripp Umbach completed interviews with key stakeholders (regionally), to secure insight and understanding of community health needs drawing upon past CHNAs and implementation plans. Stakeholders included persons with public health expertise, persons who represented agencies with access to relevant data, and who represented underserved populations and populations with chronic illnesses. This process lasted from December 2014 until January 2015.

- **Hand-Distributed Survey** – Tripp Umbach employed a hand-distribution methodology working closely with the Penn Highlands Healthcare working group to identify partners to capture the individual characteristics of the study area which included (but was not limited to): key populations such as underserved populations, chronically ill, specific barriers to accessing services, the types of services in greatest demand, and the health status and insight into health needs identified in previous CHNA. This process lasted from December 2014 until March 2015.

- **Implementation Plan Assessment** – Tripp Umbach reviewed the previous implementation plan and documented: efforts to implement, progress made, barriers to progress, and carry-over recommendations. This process lasted from March 2015 until April 2015.

- **Community Health Forum** – Tripp Umbach presented the study findings and facilitated a community health planning retreat resulting in the identification of significant community health needs and the development of community specific community health improvement strategies. This process lasted from March 2015 until April 2015.
• **Provider Inventory** – Tripp Umbach formulated a provider inventory in Excel format highlighting areas of deficits in specific categories related to identify community health needs. This process lasted from March 2015 until April 2015.

• **Implementation Planning** – Tripp Umbach facilitated a planning process that maximized system cohesion and synergies for leaders from each hospital. This process lasted from March 2015 until May 2015.

• **Final Report and Presentation** – Tripp Umbach provided a final community health needs assessment and implementation plan for each hospital in the Penn Highlands Healthcare system that meets the most recent industry and IRS standards and can be used to file Schedule H of the IRS 990 for FY-2016. This process lasted from April 2015 until May 2015.
Key Community Health Priorities

Community leaders reviewed and discussed existing data, in-depth interviews with community stakeholders representing a cross-section of agencies, and survey findings presented by Tripp Umbach in a forum setting, which resulted in the identification and prioritization of five community health priorities in the Penn Highlands Healthcare. Community leaders identified the following top community health needs that are supported by secondary and/or primary data: 1) drug and alcohol services 2) nutrition and wellness; 3) access to care 4) free clinics 5) navigation and coordination. A summary of the top five needs in the Penn Highlands DuBois service area are as follows:

**DRUG AND ALCOHOL**

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. There are not enough providers to meet the demand among residents who are suffering through substance abuse problems.
2. The economy and socioeconomic status of the region is a major factor that leads people to abusing drugs and alcohol.
3. People are self-medicating and resorting to substances to deal with an array of other issues they are facing.
4. There is a lack of coordinated services and advocacy for individuals with substance abuse issues.

Addressing needs related to substance abuse is identified as the top health priority by community leaders at the community forum. It was also, by far, the most discussed health need among stakeholders during one-on-one interviews and survey respondents indicated that they are facing a drug and alcohol problem in their communities.

Secondary data, community leaders, stakeholders and survey respondents agree that substance abuse is a top health priority:

- Secondary data
  - A lower percentage of residents (35.2%) than the state average (38.2%) have the perception that having more than 5 drinks per week can be a great risk.

- Community Forum
  - Substance abuse services were the most discussed needs at the community forum.
• Community leaders focused their discussions primarily on the limited number of services for drug and alcohol issues, the substance abuse problems of the area, and affordability of treatment and services.

• Interview Key Findings
  • Drug use is perceived as the biggest health risk of the region overall.
  • Drug and alcohol abuse were mentioned 11 times as biggest health risk.
  • The second biggest health risk (aging population) was mentioned only 6 times.
  • There is a large perception that drug and alcohol abuse is a problem for the communities of Penn Highlands.

• Survey Results
  • Cameron County- 73.3% of respondents marking this as the #1 community priority.
  • Clearfield County- 56.8% of respondents marking this as the #1 community priority.
  • Elk County - 72.2% of respondents marking this as the #1 community priority.
  • Jefferson County - 65.7% of respondents marking this as the #1 community priority.

That previous CHNA in 2012 identified substance abuse, whether alcoholism or drug abuse, as a community concern. The planning group identified this behavioral issue as a topic that is not readily discussed and is often ignored (at the time). In 2012, the Behavioral Health Risks Survey found 17% of Pennsylvania adults admitted to binge drinking (5 or more alcoholic drinks for men four or more alcoholic drinks for women).

The planning participants believed in strong community collaboration efforts as a remedy to the issue. The group was aware of existing resources that can be utilized and built upon for further prevention success.

In regards to action, the first step was planning an abuse prevention program to assess the type of problem and determine the level of risk factors affecting the problem.

Assessing the community’s readiness for prevention can help determine additional steps needed to educate the community before launching the prevention effort. A review of programs was needed to determine existing resources and gaps in addressing community needs, and to identify additional resources.

Lastly, the plan called to collect the expertise of community organizations that provide services.
NUTRITION AND WELLNESS

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Residents are not as active as they may need to be to remain healthy contributing to the rates of diabetes, obesity, and poor health outcomes.
2. People are not educated enough on the long-term effects of an unhealthy lifestyle.
3. The prevalence of diabetes contributes to poor health outcomes in the area.
4. Residents do not always have access to healthy nutrition and may need additional resources.
5. The poor socioeconomic status of the region leads to poor health choices.

Community leaders identified lifestyle-related health concerns as the second community health priority. Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes. It was discussed as a major health need among stakeholders during one-on-one interviews and survey respondents indicated that they are facing healthy lifestyle problem in their communities.

Secondary data, community leaders, stakeholders and survey respondents agree that substance abuse is a top health priority:

- Secondary Data
  - Only 51% of Jefferson County reports being able to access exercise opportunities.
  - Cameron, Clearfield, and Elk County all saw rises in the rates of adults who are sedentary; Elk County reports the highest rate for the study area at 30.9% in 2010.
  - More than one in every four children (under 18 years) in Cameron County lives in households that experienced food insecurity at some point in the past year.

The prior CHNA focused on increasing education and access to information—something that goes hand in hand with increasing one’s health and wellness. The planning group identified the need for a convenient method to assist community residents in obtaining existing information and the growing pool of community information. A community health education effort was identified as an important part of region becoming healthier.

In 2012, community leaders and focus group participants reported that exercise is not considered a priority. This was a consistent theme within the report. Factors such as self-motivation, financial difficulties, and the overexposure of information (overexposure of healthy diet information) are reasons why participants do not engage in regular physical activities.
• Community Forum
  ▪ Community leaders identified lifestyle-related health concerns as a top health priority.
  ▪ Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes.

• Interview Key Findings
  ▪ Obesity was mentioned third most when stakeholders listed their largest health concerns for the region.
  ▪ The low socioeconomic status of the region is a massive source for the health concerns and risks of the region. It is perceived that things like nutrition, a proper diet and lack of consistent exercise are all related to the low incomes and high unemployment of the region.

• Survey

  Table 2: Survey Response- Top 5 Health Concerns Identified by County

<table>
<thead>
<tr>
<th>Health Concern</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>31.1%</td>
<td>38.9%</td>
<td>36.5%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Obesity</td>
<td>37.4%</td>
<td>40.5%</td>
<td>35.7%</td>
<td>38.4%</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>33.3%</td>
<td>32.6%</td>
<td>26.2%</td>
<td>30.3%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>22.2%</td>
<td>36.3%</td>
<td>34.9%</td>
<td>34.9%</td>
</tr>
</tbody>
</table>
ACCESS TO CARE

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Residents do not always have access to care due to a lack of transportation. This is most often true for more rural residents that do not have reliable forms of transportation (because of financial instability or other reasons).

2. Health services (i.e., primary care, clinics) are not always readily available due to a shortage of providers, which can cause lengthy wait times to secure appointments.

3. Residents are not always able to afford behavioral health care when it is needed due to the lack of insurances and cost of care.

4. Substance abuse has remained a health concern in the area. The need for clinics who offer services for substance abuse is very high.

Increasing access to healthcare is identified as the third community health priority by community leaders. Access to health care is an ongoing health need in rural areas across the U.S. Apart from insurance issues, access to healthcare in the hospital services area is limited by provider to population ratios that cause lengthy wait times to secure appointments, location of providers, transportation issues, limited awareness of residents related to the location and eligibility of health programs as well as ways to be healthier. As the ACA has been implemented and the consolidation of health services has taken place across the country; this issue has worsened in many rural areas.

Access to care was identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

- **Secondary Data**
  - All four of the study area counties report lower PCP rates than seen across the state (80 per 100,000 pop. for the state).
    - Cameron = 60 per 100,000
    - Clearfield = 65 per 100,000
    - Elk = 47 per 100,000
    - Jefferson = 47 per 100,000

- **Community Forum**
  - Community leaders identified access to health care as a health priority.
  - Leaders focused their discussions primarily on the limited number of providers and transportation options.

- **Stakeholder Interviews**
Transportation is a barrier in people receiving the care that they need. However, attitudes seem to be shifting towards an acceptance that it is necessary to travel for specialized care.

There is a perception that many people in the community are uninsured and cannot afford the services they need.

- **Survey**
  - Twenty seven percent of all survey respondents did not have insurance, with “unable to afford” being the most common reason why (57.2%).
  - Fifteen percent of all survey respondents say transportation is a barrier in receiving necessary healthcare.

In 2012, the planning retreat bred a one-stop shop idea (a central location for public and professional health education information to be accessed, obtained and readily available for the community). It was important to the group that available resources of information bridge the gap between service providers and end users. Community leaders felt that making healthcare information more readily available to the public was vital to strengthening the knowledge of the community and its residents. Access to healthcare information had to be organized, communicated, and preserved for current and future use.

The prior plan called for a formal strategic plan or system created by the hospitals and other partnering community organizations which would create a strong partnership and a team approach. It was theorized that the creation of this partnership would allow the hospitals and the organizations to dismantle organizations who are not contributing positively to the partnership effort.

Penn Highlands Brookville has been successful in creating a systematic, centralized location of information—both through the formation of the Penn Highlands network and the formation of the Penn Highlands Healthcare website.
FREE CLINICS

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. While residents may have health insurance; they cannot always afford to use their health insurance due to unaffordable deductibles and copays.

2. The poor socioeconomic status of the region has created a lot of people who cannot afford services.

Individuals in the Penn Highlands Healthcare service area are struggling to pay the costs of the services and treatments they need. It is perceived that things like nutrition, family planning, drug use and alcohol use are all tied back to the low incomes and high unemployment of the region. With so many jobs leaving the area, individuals having a hard time keeping consistent employment, and many jobs being low quality, community leaders recognized the need for free clinics in the area.

The need for free clinics was identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

- Secondary Data
  - Elk County reports the highest rate for the study area of residents with inadequate social support at 21.2% of the population.
  - More than one in every 10 residents of Clearfield County are unable to see a doctor due to cost.
  - Jefferson and Elk County report higher uninsured rates as compared with the state (Jefferson = 14%, Elk = 13%, PA = 12%).
  - Secondary data shows that all four counties in the region report lower average household incomes (Cameron = $50,522, Clearfield = $51,133, Elk = $54,840, Jefferson = $50,827) as compared with the state of Pennsylvania ($71,088).
• Community Forum
  • There is a growing group of individuals – the “poor middle class” – who do not qualify for Medicaid but struggle to pay for the healthcare they need.

• Stakeholder Interviews:
  • The regional economy has stagnated. Following years of many quality jobs leaving the area, local communities are seeing many people struggle financially. This has created problems in the region, including a low number of lower wage jobs, and a number of residents with limited or no health coverage.
  • Due to poor public transportation and the low socioeconomic status of the region, it can be difficult for some residents to access or afford the health care they need.

• Survey:
  • Twenty two percent of survey respondents receive their healthcare from free or reduced services.
  • Seventeen percent of survey respondents have Medicaid as their primary insurance.
  • Fifty seven percent of survey respondents who do not have any type of insurance are without it because they cannot afford it.
  • Forty three percent of survey respondents made less than $20,000 a year.

NAVIGATION AND COORDINATION

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Often times, many residents have several health problems they are dealing with and better coordination among providers could lead to better outcomes.
2. Residents without much education are sometimes overwhelmed and easily confused when attempting to navigate their healthcare options.
3. Care coordination and transitional care are not always available due to lack of funding for these activities, though it is a need among vulnerable residents.

Individuals struggle with coordinating their various healthcare services and providers. The poor economic landscape of the region causes, people to deal with inconsistent insurance, a blend of Medicaid and Medicare, and do not receive the needed amount of information to understand their options.
• Community Forum
  • Leaders acknowledged the need for more consistent coordination among services in the region as well as a need for trained, educated navigators to assist various populations in receiving the care they need. Community leaders feel that people find the healthcare landscape confusing and sometimes overwhelming.

• Stakeholder Interview
  • A majority of respondents discussed the organizational changes in terms of health care in the Penn Highlands region. Almost all interviewees mentioned the reorganization and formation of the Penn Highlands network as a significant change. This had lead to a certain degree of unfamiliarity with the Penn Highlands Healthcare network and people are still not totally comfortable with the new network.

• Survey
  • Five percent of survey respondents say they do not know how to receive insurance.
  • Twelve percent of survey respondents say they are using multiple insurances.
  • Fifteen percent of survey respondents say they once had insurance but have since lost it.
Community Health Needs Identification Forum

The following qualitative data was gathered during a regional community planning forum held on March 12, 2015 in DuBois, PA. The community planning forum was facilitated by Tripp Umbach with more than 25 community leaders from a four county region (Cameron, Clearfield, Elk and Jefferson) and lasted approximately four hours. Community leaders were identified by the community health needs assessment oversight committee for Penn Highlands Healthcare.

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

GROUP RECOMMENDATIONS

The group provided many recommendations to address community health needs and concerns for residents of the four counties. Below is a brief summary of the recommendations:

- Community leaders made the following recommendations related to substance abuse:
  - Create a larger menu of rehabilitation programs
  - Coordinate advocacy efforts for individuals struggling with substance abuse problems more effectively
  - Establish addiction medicine programs
  - Offer pain management solutions
- Community leaders made the following recommendations related to nutrition and wellness:
  - Provide education
  - Increase awareness on healthy choices
- Community leaders made the following recommendations related to access to care:
  - Create affiliations with larger health systems for specialty care
  - Utilize tele-healthcare
  - Rotate specialty physicians to make them more accessible
  - Increase the number and options for providers
Community leaders made the following recommendations related to the need of more clinics:
  - Formulate better partnerships with the free clinics in the area (such as the one happening at the Susquehanna Rural Free Clinic to handle issues with diabetes)
  - Offer free or reduced services
  - Adapt more effectively to the populations who need these services most

Community leaders made the following recommendations related to navigation and coordination of services:
  - Utilize (or create) healthcare navigators to break down the “silos”
  - Create improved communication to effectively capitalize on the services already offered
  - Support opportunities to obtain a degree for healthcare navigation

PROBLEM IDENTIFICATION

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

1. Drug and Alcohol services/treatment
2. Nutrition and wellness
3. Access to care
4. Need for more free clinics
5. Navigation/Coordination

The following summary represents the most important topic areas within the community discussed at the planning retreat in order of priority. Community leaders believe the following concerns are the most pressing problems and are identified as the most manageable to address and resolve.
1. Drug and Alcohol Services

Substance abuse services were most discussed at the community forum. Community leaders focused their discussions primarily on the limited number of services for drug and alcohol issues, the substance abuse problems of the area, and affordability of treatment and services.

Perceived Contributing Factors

- There are not enough providers to meet the demand among residents who are suffering through substance abuse problems.
- The economy and socioeconomic status of the region are major factors that lead people to abusing drug and alcohol.
- People are self-medicating and resorting to substances to deal with an array of other issues they are facing.
- There is a lack of coordinated services and advocacy for individuals with substance abuse issues.

2. Nutrition and Wellness

Community leaders identified lifestyle-related health concerns as a top health priority. Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes.

Perceived Contributing Factors

- Residents are not as active as they may need to be to remain healthy contributing to the rates of diabetes, obesity, and poor health outcomes.
- People are not educated enough on the long-term effects of an unhealthy lifestyle.
- The prevalence of diabetes contributes to poor health outcomes in the area.
- Residents do not always have access to healthy nutrition and may need additional resources.
- The poor socioeconomic status of the region leads to poor health choices.
3. Access to Care

Community leaders identified access to health care as a health priority. Community leaders focused their discussions primarily on the number of providers and limited transportation options.

**Perceived Contributing Factors**

- Residents do not always have access to care due to a lack of transportation. This is most often true for more rural residents that do not have reliable forms of transportation.
- Health services (i.e., primary care, clinics) are not always readily available due to a shortage of providers, which can cause lengthy wait times to secure appointments.
- There are not enough providers to meet the demand among residents. Where there are services, the wait times can be lengthy to secure an initial appointment.

4. Free Clinics

There is a growing group of individuals – the “poor middle class” – who do not qualify for Medicaid but struggle to pay for the healthcare they need.

**Perceived Contributing Factors**

- While residents may have health insurance; they cannot always afford to use their health insurance due to unaffordable deductibles and copays.
- The poor socioeconomic status of the region has created a population of people who cannot afford services.
- Residents are not always able to afford behavioral health care when it is needed due to the lack of insurances and cost of care.
- Substance abuse has remained a health concern in the area. The need is very high for clinics that offer services for substance abuse.

5. Navigation and Coordination

Leaders acknowledged the need for more consistent coordination among services in the region as well as a need for trained, educated navigators to assist various populations in receiving the care they need.
Perceived Contributing Factors

- Often times, many residents have several health problems they are dealing with and better coordination among providers could lead to better outcomes.
- Due to the poor socioeconomic status of the region, residents are overwhelmed and easily confused when attempting to navigate their healthcare options.
- Care coordination and transitional care are not always available due to lack of funding for these activities, though it is a need among vulnerable residents.
Secondary Data

Tripp Umbach worked collaboratively with the Penn Highlands Healthcare community health needs assessment oversight committee to develop a secondary data process focused on three phases: collection, analysis and evaluation. Tripp Umbach obtained information on the demographics, health status and socio-economic and environmental factors related to the health and needs of residents from the multi-community service area of Penn Highlands DuBois Hospital. The process developed accurate comparisons to the state baseline of health measures utilizing the most current validated data. In addition to demographic data, specific attention was focused on two key community health index factors: Community Need Index (CNI) and Prevention Quality Indicators Index (PQI). Tripp Umbach provided additional comparisons and trend analysis for County Health Rankings, Prevention Quality Indicators and CNI data from 2012 to present.

DEMOGRAPHIC PROFILE

The Penn Highlands DuBois study area encompasses Cameron, Clearfield, Elk and Jefferson counties (as well as Centre and Indiana—however Centre and Indiana counties are not part of the study area for this CHNA), and is defined as a zip code geographic area based on 80% of the hospital’s inpatient volumes. The Penn Highlands DuBois community consists of 16 zip code areas.

Key Findings:

- Cameron County reports the highest rate of residents age 65 and older (21.8%); this is higher than the state (15.8%).
- 17.9% of the Clearfield County population is age 65 and older; 15.9% are age 14 and younger.
- 19.3% of the Elk County population is age 65 and older; 16.3% are age14 and younger.
- Jefferson County reports the highest rate of residents age0-14 (17.7%); this is equal to that of the state.
- Elk County reports the highest average annual household income ($54,840) as compared with the other counties in the region.
- Cameron County reports the lowest average annual household income ($50,522) for the study region.
- All four counties in the region report lower average household incomes as compared with the state of Pennsylvania ($71,088).
- Cameron County reports the lowest rate of households earning more than $100K (7.9%); the state rate being 21.8%.
- Clearfield County reports the highest rate of households earning less than $15K per year (15.2%); this rate is higher than the rate seen for the state (12.5%).
11% of the households in Elk County report earning less than $15K per year; this is lower than the rate seen for the state (12.5%).

3 of the 4 study area counties (Cameron, Clearfield, and Jefferson) report higher rates of households earning less than $15K per year as compared with the state.

Cameron and Jefferson County report the highest rates of residents with less than a high school education (4.2% each); this is higher than the state rate of 3.7%.

Clearfield County reports a higher rate of residents with less than a high school education as compared with the state as well (3.9% for Clearfield County, 3.7% for PA).

All four of the study area counties report lower rates of residents with some college education or degree as compared with the state.

Elk County reports the most homogenous racial/ethnic population with only 1.7% of the population reporting a race/ethnicity other than ‘White, Non-Hispanic.’

Clearfield County reports the most racial/ethnic diversity with 4.2% of the population identifying as a race/ethnicity other than ‘White, Non-Hispanic.’

All four of the study area counties report less diversity than the state which has 17.8% of the population identifying as a race/ethnicity other than ‘White, Non-Hispanic.’

Jefferson County reports the highest rate for the study area of residents with no health insurance (12%).

Clearfield County reports 10.7% of the population not having health insurance.

Cameron and Elk County see lower rates of residents without health insurance (8.8% and 7.0%) as compared with the state (9.8%).
COUNTY HEALTH RANKINGS

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

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

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

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

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

Pennsylvania has 67 counties; therefore, the rank scale for Pennsylvania is one to 67 (one being the healthiest county and 67 being the most unhealthy). The median rank is 34. Data for the County Health Rankings is only defined as far as the county level, zip code level data is not available.
Of the 8 County Health Rankings for the four counties in the study area:

✓ Cameron County ranked the highest for:
  ▪ Health Behaviors (66 – second worst in the state)
  ▪ Health Factors (64 – fourth worst in the state)
  ▪ Social and Economic Factors (64 – fourth worst in the state)

✓ Elk County ranked the highest for:
  ▪ Morbidity (67 – worst in the state)
  ▪ Health Outcomes (62 – sixth worst in the state)

✓ Jefferson County ranked the highest for:
  ▪ Mortality (61 – seventh worst in the state)
  ▪ Clinical Care (61 – seventh worst in the state)

✓ Clearfield County ranked the highest for:
  ▪ Physical Environment (52)
Key Findings

- Cameron County reports the highest adult smoking rate at 39%; higher than the state rate of 20%.
- Elk County reports the only rate of adult obesity higher than the state rate for the study area (Elk = 31%, PA = 29%).
- Elk County reports the highest excessive drinking rate at 24%; higher than the state rate of 21%.
- All four of the study area counties report lower STD rates than seen across the state (415 per 100,000 pop. for the state).
- Jefferson and Elk counties report higher uninsured rates as compared with the state (Jefferson = 14%, Elk = 13%, PA = 12%).
- All four of the study area counties report lower PCP rates than seen across the state (80 per 100,000 pop. for the state).
- Elk and Jefferson County report higher rates of diabetic residents as compared with the state (13% for both Elk and Jefferson County, 10% for PA).
- All four of the study area counties report higher rates of mammography screening as compared with the state.
- All four of the study area counties report lower violent crime rates than seen across the state (367 per 100,000 pop. for the state).
- Clearfield County saw a decline in adult obesity (29% to 31%); while Elk and Jefferson County saw rises (29% to 31% for Elk, 28% to 29% for Jefferson). The state also saw a rise in adult obesity going from 28% of the population to 29%.
- All four of the study area counties as well as the state saw rises in the PCP rate; however, all four counties still report lower PCP rates than the state.
- All four of the study area counties as well as the state saw declines in the rates of residents getting mammography screenings.
- Unemployment rates went down across the board.
PREVENTION QUALITY INDICATORS INDEX (PQI)

The Prevention Quality Indicators Index (PQI) was developed by the Agency for Healthcare Research and Quality (AHRQ). The AHRQ model was applied to quantify the PQI within the Penn Highlands markets and Pennsylvania. The PQI Index identifies potentially avoidable hospitalizations for the benefit of targeting priorities and overall community health.

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

From 2011 to 2014, there were a handful of data methodology changes. For each, Tripp Umbach went to past data and adjusted as necessary to make comparable. They are as follows:

- In the past, PQI data was presented as a value per 1,000/population. The AHRQ has revised this and the current data is presented as a value per 100,000/population. Tripp Umbach adjusted to match these as needed.
- PQI 2 changed from Perforated Appendix in Males 18+ for the past study to Perforated Appendix in Total 18+ population as a rate per 1,000 ICD-9 code admissions for appendicitis. This shift has changed the values for this measure drastically and therefore, Tripp Umbach did not adjust.
- PQI 5 changed from COPD in 18+ population to COPD or Asthma in “Older adults” 40+ population. Tripp Umbach did not adjust.
- Although not clearly explained by the AHRQ, it would seem that a definition of Newborn population has shifted for PQI 9 because the values are drastically lower in 2014 than in previous years (2011). This has shifted PQI 9 values drastically. Tripp Umbach did not adjust.
- PQI 15 changed from Adult Asthma in 18+ population for past study to Asthma in Younger Adults 18-39 population. Tripp Umbach did not adjust.

Overall:

- All four study area counties report higher PQI rates (indicating more preventable hospitalizations) than the state for:
  - Diabetes Short-Term Complications Admission Rate (PQI 1)
  - Perforated Appendix Admission Rate (PQI 2)
  - Congestive Heart Failure Admission Rate (PQI 8)
  - Bacterial Pneumonia Admission Rate (PQI 11)
- All four study area counties report lower PQI rates (indicating fewer preventable hospitalizations) than the state for:
  - Hypertension Admission Rate (PQI 7)
- Low Birth Weight Rate Admission Rate (PQI 9)

- **Cameron County** reports the highest PQI rates for the study area for 5 of the 14 measures: COPD or Adult Asthma (725.35 per 100,000 pop.), Diabetes Long-Term Complications (172.29 per 100,000 pop.), Lower Extremity Amputation Rate among Diabetic Patients (49.22 per 100,000 pop.), Perforated Appendix (725 per 100,000 pop.), and Bacterial Pneumonia (615.31 per 100,000 pop.).
  - Two of the four diabetes measures.

- **Elk County** reports the highest PQI rates for the study area for 4 of the 14 measures: Asthma in Younger Adults (73.21 per 100,000 pop.), Uncontrolled Diabetes (31.96 per 100,000 pop.), Hypertension (55.93 per 100,000 pop.), and Congestive Heart Failure (791.02 per 100,000 pop.).
  - Two of the three heart measures.

- **Jefferson County** reports the highest PQI rates for the study area for 3 of the 14 measures: Angina without Procedure (33.33 per 100,000 pop.), Dehydration (91.66 per 100,000 pop.), and Urinary Tract Infections (336.07 per 100,000 pop.).

- **Clearfield County** reports the highest PQI rates for the study area for 1 of the 14 measures: Diabetes Short-Term Complications (303.80 per 100,000 pop.).
<table>
<thead>
<tr>
<th>Prevention Quality Indicators (PQI)</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>PA</th>
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<tr>
<td>Diabetes Short-Term Complications Admission Rate (PQI 1)</td>
<td>246.12</td>
<td>303.80</td>
<td>291.64</td>
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<td>Perforated Appendix Admission Rate (PQI 2)</td>
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<td>460.97</td>
<td>609.86</td>
<td>555.65</td>
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<td>Congestive Heart Failure Admission Rate (PQI 8)</td>
<td>762.98</td>
<td>528.42</td>
<td>791.02</td>
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<td>Low Birth Weight Rate (PQI 9)</td>
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<td>Bacterial Pneumonia Admission Rate (PQI 11)</td>
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<td>Urinary Tract Infection Admission Rate (PQI 12)</td>
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<td>Angina Without Procedure Admission Rate (PQI 13)</td>
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<td>Uncontrolled Diabetes Admission Rate (PQI 14)</td>
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<td>Asthma in Younger Adults Admission Rate (PQI 15)</td>
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<td>73.21</td>
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<td>Lower Extremity Amputation Rate Among Diabetic Patients (PQI 16)</td>
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<td>26.40</td>
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</table>
HEALTHY COMMUNITIES INSTITUTE (HCI) INDICATOR DATA

The Healthy Communities Institute (HCI) mission is to improve the health and environmental sustainability of cities, counties and communities worldwide.

The Healthy Communities Institute is a multi-disciplinary team comprising healthcare information technology veterans (professional internet-system developers and evaluators), academicians (health informatics experts, urban planners, and epidemiologists) and former senior government officials. The company is rooted in work started in 2002 in concert with the Healthy Cities Movement and the University of California at Berkeley. The management team from Harvard University, Cornell University and the University of California, Berkeley has expertise in informatics, public health, urban sustainability, community planning and high volume Internet sites.

- HCI Data includes:
  - Over 100 Health and Quality of Life Indicators
  - Healthy People 2020 Trackers
  - Performance Tracking
  - Database of Over 2,000 Proven Programs

Key findings

Health and Risk Behaviors:

- Jefferson County reports the lowest rate of residents being able to access exercise opportunities as compared with the other counties in the study area with only 51% of the population having access.
- All four of the study area counties report slight declines or steady adult obesity rates between 2009 and 2010.
- Clearfield, Elk, and Jefferson County all report rises in Teen Obesity rates from 2009 to 2011; Cameron County is the only county to report a decline. Clearfield reports the largest rise going from 19.3% to 20.0%, but Jefferson reports the highest rates overall at 21.5% in 2009-2010 and 21.8% in 2010-2011.
- Cameron County is the only county in the study area to report a rise in the rate of children who are overweight or obese from 2009 to 2011 (37.4% to 41.5%); Cameron County also has the highest rates of overweight or obese children for the study area.
- Cameron, Clearfield, and Elk County all saw rises in the rates of adults who are sedentary; Elk County reports the highest rate for the study area at 30.9% in 2010.
- Jefferson County saw a rise in the rates of adults who drink excessively from 18.5% in 2005-2011 to 21.1% in 2006-2012. Even though Elk County reported a decline it still reports the highest rate for the study area with 24.1% of adults drinking excessively.
Jefferson County reports the highest rate of alcohol-impaired driving deaths at 52.9%.

Cameron County reports the highest rate of adults who smoke (38.5%) for the study area.

Clearfield County reports the highest rate of deaths due to drug-poisoning at 12.7 per 100,000 pop.

Health Access and Health Concerns:

The rates of residents with health insurance have risen across all four counties; women report having health insurance at a higher rate than men. Children with health insurance have also risen for all four counties.

Elk County reports the highest rate for the study area of residents with inadequate social support at 21.2% of the population.

Clearfield County reports the highest rate for the study area of residents unable to afford to see a doctor at 10.6% of the population (more than one in every 10 residents of Clearfield County are unable to see a doctor due to cost).

For most of the study area, children’s asthma rates were steadily rising from 2007 to 2011; this trend has taken a turn the other way and for all four counties between 2012 and 2013 childhood asthma rates are declining.

All four counties are reporting declines in age-adjusted death rates due to coronary heart disease; men are more likely to die from coronary heart disease than women (across all four study area counties).

In Cameron, Clearfield, and Jefferson County, Lyme disease has been on the rise between 2010 and 2011. Men and younger individuals (ages less than 15 years) are more likely to contract Lyme disease compared to the gender and age counterparts.

Cameron, Elk, and Jefferson County all report rises in the rates of residents with diabetes from 2009 to 2010. (In 2010, Jefferson = 13.0%, Elk = 12.7%, Cameron = 12.0%). Men are more likely than women to die as a result of diabetes.

Cameron County is the only county of the four in the study area to report a rise in the age-adjusted death rate due to stroke going from 38.4 per 100,000 pop. in 2008-2010 to 48.9 in 2009-2011.
Cancer

- Cameron, Elk, and Jefferson County have all seen rises in all cancer incidence rates between the years of 2005 and 2011. Clearfield County, however, has seen a steady decline in all cancer incidence rates from 2005 to 2011.

- Across all of the cancers, men are more likely to contract cancer than women.

- Elk and Jefferson County have seen declines in the age-adjusted death rates due to breast cancer among residents while Clearfield County has seen a rise in age-adjusted death rates due to breast cancer (going from 19 per 100,000 pop. in 2006-2010 to 23.7 - the highest for the study area in 2007-2011).

- Clearfield and Jefferson County report declines in their breast cancer incidence rates while Cameron and Elk County report rises.

- Jefferson County reported a rise in colorectal cancer death rate; however, it is still the lowest in the region. Clearfield and Elk County reported declines in deaths due to colorectal cancer; however Clearfield still holds the highest rate for the region at 21.6 per 100,000 pop. Men are more likely to die as a result of colorectal cancer than women.

- Jefferson has been reporting a steady rise in age-adjusted deaths due to prostate cancer from 2005 to 2011; while it is still currently the lowest at 20.4 per 100,000 pop., at the current trajectory, it will soon be the highest for the study area.

- Clearfield and Elk County report rises in oral cavity and pharynx cancer incidence rates from 2005 to 2011. Clearfield County now reports the highest for the region at 11.8 per 100,000 pop.

- Elk County reports a rise in the age-adjusted death rate due to lung cancer; going from 49.6 per 100,000 pop. in 2005-2009 to 53.3 in 2007-2011; now the highest for the study area.

Accidents, Maternal, and Child Care:

- Elk County has seen a rise and is the highest in the region for deaths due to firearms (going from 15.3 per 100,000 pop. in 2008-2010 to 20 in 2009-2011).

- Clearfield, Elk, and Jefferson County have all experienced declines in the age-adjusted death rates due to motor vehicle collisions.

- Clearfield, Elk, and Jefferson County have all experienced rises in the age-adjusted death rates due to suicide; Elk County has the highest rate at 19.9 per 100,000 population in 2009-2011.

- Cameron, Elk, and Jefferson County all report declines in the rates of mothers who receive adequate pre-natal care from 2010 to 2011. Jefferson County reports the lowest at 56.7%.

- All four of the study area counties report raises in the rates of mothers who breast-feed their babies. Jefferson County still reports the lowest at 58.6%. 
Elk County experienced a rise in low birth weight babies going from 8.9% in 2010 to 9.5% in 2011.

Jefferson County reports an infant mortality rate of 8 per 1,000 births; this is nearly double the rate seen for Clearfield County.

From 2011 to 2012, all four of the study area counties reported rises in the child food insecurity rates; Cameron County reporting the highest for the region at 25.4% - more than one in every four children (under 18 years) in Cameron County live in households that experienced food insecurity at some point in the past year.

Elk and Clearfield County reported rises in the rates of children with Type II Diabetes. Elk County reports the highest rate for the region at 0.18% in 2008-2009.

Environment and Poverty:

93.1% of the Cameron County population is getting water from a public water system that has received at least one health-based violation in FY12-13. The other three counties in the study area report rates in the range of 4% - 9%.

Both Cameron and Clearfield County report the highest rates for the study area for residents age 65 and older with low access to a grocery store (2.3%).

On the other hand, Elk and Jefferson County report the highest rates for the study area of households without a car and low access to a grocery store (3.1%).

Cameron, Clearfield, and Jefferson County all saw rises in the child abuse rates between 2011 and 2012. Clearfield County reports the highest rate in 2012 at 14.8 cases per 1,000 children.

Jefferson County (the only of the four counties) saw a rise in the rate of people living below the poverty level going from 14.1% in 2007-2011 to 14.5% in 2008-2012; it is now the highest rate for the study area. Women and children are more likely than their counterparts to live below the poverty level.

Jefferson County is also the only county (of the four) to see a rise in children living below the poverty level.

Per Capita income levels rose for Cameron, Elk, and Jefferson County from 2007-2011 to 2008-2012, but declined for Clearfield County from $21,365 to $20,693 – now the lowest for the study area.

All four of the study area counties reported declines in the rates of residents age 65 and older living below the poverty level between 2007-2011 and 2008-2012.

Cameron and Jefferson County saw rises in the rates of households receiving cash public assistance income from 2007-2011 to 2008-2012; Cameron County reports the highest rate at 3.8%.

Clearfield County reports the highest rate for the study area region for low income households that are also more than 1 mile from a grocery store (4.9%).
In 2008-2012, 48.6% of the renters in Clearfield County spend more than 30% of their household income on rent.

Even though the number of single-parent households declined for Elk County, they still report the highest rate for the study area (going from 38.3% in 2007-2011 to 36.6% in 2008-2012).

Clearfield County reports the highest rate of solo drivers with a long commute for the study area at 28.4% in 2008-2012.

Both Clearfield and Jefferson County have seen raises in the rates of students eligible for free school lunches from 2008 to 2012. Clearfield reports the highest rate in 2012 at 38.9%.

Clearfield, Elk, and Jefferson County all report declines in school drop-out rates; Cameron County, on the other hand saw a rise from 0.9% in 2011-2012 to 1.4% in 2012-2013.

Elk and Jefferson County saw rises in the rates of residents age 25 and older with a Bachelor’s degree or higher from 2007 to 2012; Cameron and Clearfield County on the other hand, saw declines.

**Medicare Population:**

All four of the study area counties reported declines in Alzheimer’s disease or dementia in the Medicare population from 2011 to 2012. Clearfield County reports the highest rate for the region in 2012 at 10.1%.

Cameron, Clearfield and Jefferson County report rises in the Medicare population with asthma from 2011 to 2012. Clearfield County reports the highest rate for the region in 2012 at 5.2%. For Cameron, Clearfield, and Elk County, those under 65 report higher rates of asthma; for Jefferson County those 65 and older report higher rates of asthma.

Clearfield County is the only county in the region that reported a rise in the Medicare population that was treated for atrial fibrillation from 2011 to 2012. However, Elk County reports the highest rate for the region with 9.2%.

**Medicare Population:**

Even though Elk County is the only county to report a decline in the cancer rate for the Medicare population, it is still the highest rate in the study area at 9.7%. Those 65 and older are much more likely to be treated for cancer across all of the study area counties as compared with residents under 65 years old.

Clearfield, Elk, and Jefferson County all saw rises in the rate of Medicare population being treated for chronic kidney disease from 2011 to 2012. Cameron County is the only county to experience a decline, but still holds the highest rate for the region at 17.1%.

From 2011 to 2012 Cameron County reported the highest rates of Medicare population with COPD and in this time this rate rose from 15% to 16.3%.

**Medicare Population (cont’d):**
All four of the study area counties reported rises in the depression rates of the Medicare population; Cameron with the highest of 21.1% in 2012. Depression is more common in those younger than 65 as opposed to those ages 65 and older.

Clearfield is the only county to report a rise in the rate of Medicare population with diabetes; in 2012 it reached 28.8% (although Cameron is still slightly higher at 28.9%).

All four study area counties reported declines in the rates of all of the following heart conditions in the Medicare population from 2011 to 2012:

- Heart failure - Jefferson reports the highest at 19.5%
- Hyperlipidemia (high lipid levels) – Clearfield reports the highest at 50.2%
- Hypertension - Jefferson County reports the highest at 59.7%
- Ischemic Heart Disease - Jefferson reports the highest at 33.2%

All four of the study area counties reported declines in the rates of the Medicare population getting mammography screening; - Jefferson County reports the lowest rate at 64.3%.

Cameron County reports a rise in the rate of Osteoporosis in the Medicare population (going from 5.8% to 7.1%) while the three other counties report declines from 2011 to 2012.

in the Medicare population from 2011 to 2012; Elk County reports the highest rate for the region at 33.2%.
Key Stakeholder Interviews

DATA COLLECTION

From January 5th to the 21st 2015, Tripp Umbach conducted interviews with nine key stakeholders in the Penn Highlands Dubois service area. Tripp Umbach representatives conducted a 30-60 minute interview with each interviewee. All of the key stakeholders identified by Penn Highlands were willing to invest their time and provide information relating to the services of the hospital, the needs of the community, and anything else pertaining to those topics. The key stakeholders work in community based organizations, private businesses, public positions, medical centers and typically are leaders in the community. The following table shows all of the individuals who completed an interview, along with their affiliation.

**Table 4: Organizations Participating in Stakeholder Interviews**

<table>
<thead>
<tr>
<th>Participating Organizations</th>
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<tr>
<td>YMCA</td>
</tr>
<tr>
<td>Clearfield and Jefferson Drug &amp; Alcohol Commission</td>
</tr>
<tr>
<td>DuBois Area School District</td>
</tr>
<tr>
<td>Swift Kennedy Group</td>
</tr>
<tr>
<td>Behavioral Health Alliance of Rural PA</td>
</tr>
<tr>
<td>DuBois Area Chamber of Commerce</td>
</tr>
<tr>
<td>DuBois Regional Airport</td>
</tr>
<tr>
<td>Coldwell Banker</td>
</tr>
<tr>
<td>DuFAST Transit</td>
</tr>
</tbody>
</table>
Key Findings

✓ Stakeholders identify Penn Highlands as the health care leader in the region. Penn Highlands has a strong reputation, and stakeholders think that PH is in the best position to address health issues in the community.

✓ An aging population and drug use are the most significant health issues in the community. Both require specific health services and both have an effect on the overall well-being of the community.

✓ With the mergers in the Penn Highlands network, health care is accessible in the PH Dubois service area. Transportation, though, can serve as a barrier to accessing necessary health care services.

✓ As PH Dubois works to address community health issues, it will be important for the hospital to collaborate with other organizations in the region. This will help the hospital better educate the community and expand its reach.
Survey of Vulnerable Populations

Tripp Umbach worked closely with the CHNA oversight committee to assure that community members, including under-represented residents, were included in the needs assessment through a survey process.

DATA COLLECTION:

Vulnerable populations were identified by the CHNA oversight committee and through stakeholder interviews. Vulnerable populations targeted by the surveys were seniors, low-income residents (including families), residents with behavioral health needs and residents that are uninsured.

A total of 484 surveys were collected in the Penn Highlands Healthcare hospital service area which provides a +/- 4.45 confidence interval for a 95% confidence level. Tripp Umbach worked with the oversight committee to design a 30 question health status survey. The survey was administered by community based organizations (i.e., CenClear, Free Medical Clinic, CCAAA, Clearfield CAL Center for Active Living, Susquehanna Rural Free Clinic, YMCA, etc.) that provide services to vulnerable populations in the hospital service area. Community based organizations were trained to administer the survey using hand-distribution.

- Surveys were administered onsite and securely mailed to Tripp Umbach for tabulation and analysis.
- Surveys were analyzed using SPSS software.

Limitations of Survey Collection:

There are several inherent limitations to using a hand-distribution methodology when collecting surveys. The demographics of the population are not intended to match the general population of the counties surveyed. Often, the demographic characteristics of populations that are considered vulnerable populations are not the same as the demographic characteristics of a general population. For example, vulnerable populations by nature may have significantly less income than a general population. For this reason, the findings of this survey are not relevant to the general populations of the counties they were collected in. Additionally, hand-distribution is limited by the locations where surveys are administered. In this case, Tripp Umbach asked CBOs to self-select into the study and as a result there are several populations that have greater representation in raw data (i.e., seniors, low-income, etc.).
Demographics
- By March 4, 2015, Tripp Umbach received a total of 484 completed surveys
- Of the surveys gathered: 62.7% were female, 37.3% were male

Table 5: Age Breakdown of Survey Respondents

<table>
<thead>
<tr>
<th>Age</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>41</td>
<td>8.7</td>
</tr>
<tr>
<td>26-35</td>
<td>76</td>
<td>16.1</td>
</tr>
<tr>
<td>36-45</td>
<td>83</td>
<td>17.6</td>
</tr>
<tr>
<td>46-55</td>
<td>102</td>
<td>21.7</td>
</tr>
<tr>
<td>56-65</td>
<td>90</td>
<td>19.1</td>
</tr>
<tr>
<td>66-75</td>
<td>43</td>
<td>9.1</td>
</tr>
<tr>
<td>76-85</td>
<td>23</td>
<td>4.9</td>
</tr>
<tr>
<td>86+</td>
<td>13</td>
<td>2.8</td>
</tr>
<tr>
<td>SUBTOTAL</td>
<td>471</td>
<td>100</td>
</tr>
<tr>
<td>MISSING</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>484</td>
<td></td>
</tr>
</tbody>
</table>

- The majority of the survey respondents reported their race as white (89.0%); the next largest racial group was multi-race at 5.1% of the survey population.
- The household income level with the most responses was $10,000 to $19,999 with 22.6% of the respondents answering this.

Key Findings
*Note: percentages are listed in order of Cameron, Clearfield, Elk, and Jefferson County, respectively.

Table 6: Average Weight and Height of Survey Respondents

<table>
<thead>
<tr>
<th>Weight &amp; BMI</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>Avg. Female (5'4'')*</th>
<th>Avg. Male (5'9'')*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>189.6 lbs.</td>
<td>183.7 lbs.</td>
<td>188.8 lbs.</td>
<td>182.0</td>
<td>108-144 lbs.</td>
<td>121-163 lbs.</td>
</tr>
<tr>
<td>BMI</td>
<td>30.49</td>
<td>29.56</td>
<td>29.62</td>
<td>28.57</td>
<td>26.5</td>
<td>26.6</td>
</tr>
</tbody>
</table>
Table 7: Percentage of Survey Respondents Having Taken the Following Tests

<table>
<thead>
<tr>
<th>Test Received</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood test</td>
<td>73.5%</td>
<td>71.3%</td>
<td>72.1%</td>
<td>75.7%</td>
</tr>
<tr>
<td>Check up</td>
<td>61.2%</td>
<td>61.4%</td>
<td>63.6%</td>
<td>53.4%</td>
</tr>
<tr>
<td>Flu shot</td>
<td>42.9%</td>
<td>48.0%</td>
<td>38.8%</td>
<td>32.0%</td>
</tr>
<tr>
<td>Cholesterol test</td>
<td>40.8%</td>
<td>47.5%</td>
<td>41.9%</td>
<td>32.0%</td>
</tr>
</tbody>
</table>

Less common responses included: Colonoscopy, EKG, Urinalysis, Pneumonia vac., Mammogram, and Prostate test.

- The most popular place for residents to seek care is a doctor’s office – 77.1%, 59.6%, 76.8%, and 49.5% respectively.
- The insurance category with the highest response rate was Private- 32.7%, 17.1%, and 28.9% respectively. Jefferson’s was Medicaid at 19.4%.
- The most common reason why individuals do not have health insurance is because they can’t afford it– 40%, 80.3%, 63.6%, and 51.9% respectively.
- Individuals report being examined by a medical doctor “1-2 times” in the past year for all four counties as the most popular choice- 34.7%, 38.9%, 33.6%, and 44.8% respectively.
- The most common response to “how is your health?” is “Good”-35.4%, 47.8%, 41.1%, and 38.8% respectively.
- And when people exercise, they most commonly do it “3-4 times per week” (45.8%, 37.2%, and 36.7% respectively) and Jefferson respondents most commonly did it 1-2 times (44.8%).
- The majority of respondents reported they have been told they do not have a substance abuse problem (91.8%, 93.4%, 87.4%, and 66.0% respectively).
- The majority of respondents report “Yes” to having their children or grandchildren being up to date with immunizations (60.9%, 52.1%, 57.1%, and 55.6% respectively).
- 19.6%, 31.1%, 28.6%, and 35.4% respectively of respondents answered “Doesn’t apply to me.”
- Their personal car is the most common form of transportation (73.5%, 70.9%, 65.1%, and 59.8% respectively).
- Only 4.1%, 9.2%, 11.6%, and 7.8% registered as taking public transportation
- The majority of respondents report not consuming alcohol at all (58.3%, 64.4%, 68.0%, and 75.2%).
## Common Health Issues

**Table 8: Survey Responses – Health Issues Respondents Reported Ever Diagnosed With**

<table>
<thead>
<tr>
<th>Ever Diagnosed with</th>
<th>Cameron County</th>
<th>Clearfield County</th>
<th>Elk County</th>
<th>Jefferson County</th>
<th>PA*</th>
<th>U.S.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>64.6%</td>
<td>37.2%</td>
<td>60.5%</td>
<td>62.1%</td>
<td>18.3%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>14.3%</td>
<td>13.6%</td>
<td>21.7%</td>
<td>10.7%</td>
<td>10.1%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Heart Problem</td>
<td>22.4%</td>
<td>19.9%</td>
<td>18.1%</td>
<td>15.5%</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Cancer</td>
<td>10.2%</td>
<td>9.6%</td>
<td>7.0%</td>
<td>2.9%</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

*Source: CDC

✓ 64.6%, 37.2%, 60.5%, and 62.1% respectively of individuals report being told by a doctor, nurse, or health professional that they have depression.

✓ 14.3, 13.6%, 21.7%, and 10.7% respectively of individuals report being told by a doctor, nurse, or health professional that they have diabetes.

✓ A majority of respondents report being told they have a heart problem (22.4%, 19.9%, 18.1%, and 15.5% respectively).

✓ The majority of respondents report “No” to having been told they have cancer (89.8%, 90.4%, 93.0%, and 97.1% respectively).
Table 9: Survey Responses – Smoking Rates Reported By Respondents

<table>
<thead>
<tr>
<th>Smoking</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>PA*</th>
<th>U.S.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everyday</td>
<td>35.4%</td>
<td>24.4%</td>
<td>30.5%</td>
<td>59.6%</td>
<td>15.7%</td>
<td>13.4%</td>
</tr>
<tr>
<td>Not at all</td>
<td>60.4%</td>
<td>67%</td>
<td>64.1%</td>
<td>32.4%</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

*Source: CDC

The majority of respondents report not smoking at all (60.4%, 67%, 64.1%, and 32.4% respectively); however, (35.4%, 24.4%, 30.5%, and 56.9%) smoke every day.

Table 10: Survey Responses – Physical Activity Rates Reported By Survey Respondents

<table>
<thead>
<tr>
<th>Physical Activities</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>PA*</th>
<th>U.S.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>49.0%</td>
<td>62%</td>
<td>62.7%</td>
<td>56.3%</td>
<td>73.7%</td>
<td>74.7%</td>
</tr>
<tr>
<td>No</td>
<td>51.0%</td>
<td>38%</td>
<td>37.3%</td>
<td>43.7%</td>
<td>26.3%</td>
<td>25.3%</td>
</tr>
</tbody>
</table>

*Source: CDC

49%, 62%, 62.7%, and 56.3% respectively of respondents claimed to have exercised in the last 30 days.
Conclusions and Recommended Next Steps

Penn Highlands DuBois, working closely with community partners, understands that the community health needs assessment document is only a first step in an ongoing process. It is vital that ongoing communication and a strategic process follow the assessment process. With Penn Highlands Healthcare having such a large presence in the community, DuBois has access to many resources within DuBois and at the other three facilities. However, Penn Highlands Healthcare understands that accessing these services can be a major challenge for individuals living in the community. Residents of the Penn Highlands DuBois service area have limited access to the healthcare resources in the region due to the need for an increase in healthcare providers and transportation to healthcare facilities, including free clinics. Collaboration and partnership are a strategy that Penn Highlands Healthcare must employ more so in order to affect the other needs facing the community—substance abuse and nutrition and wellness. It is important to create or expand existing partnerships with multiple community organizations when developing strategies to address the top identified needs. Implementation strategies will need to consider the higher need areas in the poorest areas within Cameron, Clearfield, Elk and Jefferson County. Tripp Umbach recommends the following actions be taken by the hospital sponsors in close partnership with community organizations over the next six to nine months.

Recommended Action Steps:

- Widely communicate the results of the community health needs assessment document to Penn Highlands DuBois staff, providers, leadership and boards.

- Conduct an open community forum where the community health needs assessment results are presented widely to community residents, as well as through multiple outlets such as: local media, neighborhood associations, community-based organizations, faith-based organizations, schools, libraries and employers.

- Utilize the inventory of available resources in the community in order to explore further partnerships and collaborations.

- Implement a comprehensive “grass roots” community engagement strategy to build upon the resources that already exist in the community and the energy of and commitment of community leaders that have been engaged in the community health needs assessment process.

- Develop three “working groups” to focus on specific strategies to address the top identified needs of the facility. The working groups should meet for a period of four to six months to develop action plans and external funding requests.
Community Definition

The communities served by Penn Highlands Elk include the following zip codes. The Penn Highlands Elk primary service area includes 5 populated zip code areas (excluding zip codes for P.O. boxes and offices) where 80% of the hospital’s inpatient discharges originated.

Table 1: Penn Highlands Elk Hospital Community Zip Codes

<table>
<thead>
<tr>
<th>Zip</th>
<th>City</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>15834</td>
<td>Emporium</td>
<td>Cameron</td>
</tr>
<tr>
<td>15845</td>
<td>Johnsonburg</td>
<td>Elk</td>
</tr>
<tr>
<td>15846</td>
<td>Kersey</td>
<td>Elk</td>
</tr>
<tr>
<td>15853</td>
<td>Ridgway</td>
<td>Elk</td>
</tr>
<tr>
<td>15857</td>
<td>St. Marys</td>
<td>Elk</td>
</tr>
</tbody>
</table>
Consultant Qualifications

Tripp Umbach is a recognized national leader in community health research, economic analysis, feasibility studies, and market research, having conducted more than 500 projects over the past 25 years in communities across the United States and internationally. Past community health projects have included: needs assessments, population health surveys, market analysis, program implementation plans, and processes for tracking, measuring, and evaluating community health programs. Today, more than one in four Americans lives in a community where Tripp Umbach has completed a community health assessment. Tripp Umbach:

- Has developed a deep understanding of the communities and health needs in the area through the CHNA and implementation plans completed for all four Penn Highlands hospitals between 2011 and 2013, as well as the health system strategic planning and implementation process completed in 2013.

- Has established relationships with stakeholders and providers in the Penn Highlands primary service area: Cameron, Clearfield, Elk, and Jefferson County.

- Has a national perspective of best practices and community health improvement projects being used to improve population health.

Many of our projects are national pilots and have received statewide and national recognition. Tripp Umbach completed a series of 40 community health needs assessments in the 1990s in partnership with the Healthcare Association of Pennsylvania and has a longstanding consulting relationship with hospitals, medical schools, and research institutes throughout the Commonwealth. Tripp Umbach has completed a series of more than 50 community health needs assessments between 2011 and 2013, which met the industry standards and Internal Revenue Code § 501(r) requirements.

Internal Revenue Code § 501(r) mandates that nonprofit hospitals conduct needs assessments every three years. Tripp Umbach, a national leader in conducting community health needs assessments has closely monitored 501(r) requirements, reflecting the most current information in this proposal.
Project Mission & Objectives

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

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

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

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

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

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

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

Tripp Umbach facilitated and managed a comprehensive community health needs assessment on behalf of Penn Highlands Healthcare. The assessment process included input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge and expertise of public health issues.

Key steps and data sources in the community health needs assessment included:

- **Community Health Assessment Planning** – A series of meetings was facilitated by the consultants and the CHNA oversight committee consisting of leadership from Penn Highlands Healthcare and other participating hospitals and organizations (i.e., Penn Highlands Brookville, Penn Highlands Clearfield, Penn Highlands DuBois, and Penn Highlands Elk). This process lasted from October 2014 until April 2015.

- **Public Commentary** – Tripp Umbach secured public commentary related to the previous community health needs assessments and implementation plans. This process lasted from December 2014 until January 2015.

- **Secondary Data Collection and Analysis** – Tripp Umbach managed and analyzed existing data sources to prepare a secondary data profile for each hospital service area, including state and national baseline data on relevant health measures using data from a variety of sources. This process lasted from February 2015 until March 2015.

- **Stakeholder Interviews** – Tripp Umbach completed interviews with key stakeholders (regionally), to secure insight and understanding of community health needs drawing upon past CHNA’s and implementation plans. Stakeholders included persons with public health expertise, persons who represented agencies with access to relevant data, and who represented underserved populations and populations with chronic illnesses. This process lasted from December 2014 until January 2015.

- **Hand-Distributed Survey** – Tripp Umbach employed a hand-distribution methodology working closely with the Penn Highlands Healthcare working group to identify partners to capture the individual characteristics of the study area which included (but was not limited to): key populations such as underserved populations, chronically ill, etc.; specific barriers to accessing services; the types of services in greatest demand; health status and insight into health needs identified in previous CHNA. This process lasted from December 2014 until March 2015.

- **Implementation Plan Assessment** – Tripp Umbach reviewed the previous implementation plan and documented: efforts to implement, progress made, barriers to progress, and carry-over recommendations. This process lasted from March 2015 until April 2015.

- **Community Health Forum** – Tripp Umbach presented the study findings and facilitated a community health planning retreat resulting in the identification of significant community health needs and the development of community specific community health improvement strategies. This process lasted from March 2015 until April 2015.
- **Provider Inventory** – Tripp Umbach formulated a provider inventory in Excel format highlighting areas of deficits in specific categories related to identify community health needs. This process lasted from March 2015 until April 2015.

- **Implementation Planning** – Tripp Umbach facilitated a planning process that maximized system cohesion and synergies for leaders from each hospital. This process lasted from March 2015 until May 2015.

- **Final Report and Presentation** – Tripp Umbach provided a final community health needs assessment and implementation plan for each hospital in the Penn Highlands Healthcare system that meets the most recent industry and IRS standards and can be used to file Schedule H of the IRS 990 for FY-2016. This process lasted from April 2015 until May 2015.
Key Community Health Priorities

Community leaders reviewed and discussed existing data, in-depth interviews with community stakeholders representing a cross-section of agencies, and survey findings presented by Tripp Umbach in a forum setting, which resulted in the identification and prioritization of five community health priorities in the Penn Highlands Healthcare. Community leaders identified the following top community health needs that are supported by secondary and/or primary data: 1) drug and alcohol services 2) nutrition and wellness; 3) access to care 4) free clinics 5) navigation and coordination. A summary of the top five needs in the Penn Highlands Elk service area are as follows:

**DRUG AND ALCOHOL**

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. There are not enough providers to meet the demand among residents who are suffering through substance abuse problems.
2. The economy and socioeconomic status of the region is a major factor that leads people to abusing drugs and alcohol.
3. People are self-medicating and resorting to substances to deal with an array of other issues they are facing.
4. There is a lack of coordinated services and advocacy for individuals with substance abuse issues.

Addressing needs related to substance abuse is identified as the top health priority by community leaders at the community forum. It was also, by far, the most discussed health need among stakeholders during one-on-one interviews and survey respondents indicated that they are facing a drug and alcohol problem in their communities.

Secondary data, community leaders, stakeholders and survey respondents agree that substance abuse is a top health priority:

- **Secondary data**
  - A lower percentage of residents (35.2%) than the state average (38.2%) have the perception that having more than 5 drinks per week can be a great risk.
- **Community Forum**
  - Substance abuse services were the most discussed needs at the community forum.
• Community leaders focused their discussions primarily on the limited number of services for drug and alcohol issues, the substance abuse problems of the area, and affordability of treatment and services.

• Interview Key Findings
  • Drug use is perceived as the biggest health risk of the region overall.
  • Drug and alcohol abuse was mentioned 11 times as the biggest health risk.
  • The second biggest health risk (aging population) was mentioned only 6 times.
  • There is a large perception that drug and alcohol abuse is a problem for the communities of Penn Highlands.

• Survey Results
  • Cameron County- 73.3% of respondents marking this as the #1 community priority.
  • Clearfield County- 56.8% of respondents marking this as the #1 community priority.
  • Elk County - 72.2% of respondents marking this as the #1 community priority.
  • Jefferson County - 65.7% of respondents marking this as the #1 community priority.
NUTRITION AND WELLNESS

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Residents are not as active as they may need to be to remain healthy contributing to the rates of diabetes, obesity, and poor health outcomes.
2. People are not educated enough on the long-term effects of an unhealthy lifestyle.
3. The prevalence of diabetes contributes to poor health outcomes in the area.
4. Residents do not always have access to healthy nutrition and may need additional resources.
5. The poor socioeconomic status of the region leads to poor health choices.

Community leaders identified lifestyle-related health concerns as the second community health priority. Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes. It was discussed as a major health need among stakeholders during one-on-one interviews and survey respondents indicated that they are facing healthy lifestyle problems in their communities.

Secondary data, community leaders, stakeholders and survey respondents agree that substance abuse is a top health priority:

- **Secondary Data**
  - Only 51% of Jefferson County reports being able to access exercise opportunities.
  - Cameron, Clearfield, and Elk County all saw rises in the rates of adults who are sedentary; Elk County reports the highest rate for the study area at 30.9% in 2010.
  - More than one in every four children (under 18 years) in Cameron County live in households that experienced food insecurity at some point in the past year.

- **Community Forum**
  - Community leaders identified lifestyle-related health concerns as a top health priority.
  - Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes.

- **Interview Key Findings**
  - Obesity was mentioned third most when stakeholders listed their largest health concerns for the region.
  - The low socioeconomic status of the region is a massive source for the health concerns and risks of the region. It is perceived that things like nutrition, a
proper diet and lack of consistent exercise are all related to the low incomes and high unemployment of the region.

- Survey

**Table 2: Survey Response - Top 5 Health Concerns Identified by County**

<table>
<thead>
<tr>
<th>Health Concern</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>31.1%</td>
<td>38.9%</td>
<td>36.5%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Obesity</td>
<td>37.4%</td>
<td>40.5%</td>
<td>35.7%</td>
<td>38.4%</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>33.3%</td>
<td>32.6%</td>
<td>26.2%</td>
<td>30.3%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>22.2%</td>
<td>36.3%</td>
<td>34.9%</td>
<td>34.9%</td>
</tr>
</tbody>
</table>

The 2012 community health needs assessment identified that preventive healthcare and wellness relates to the lack of available community physicians to address health concerns and the inability of patients to acquire information.

Community forum participants and focus group participants all agreed that accessing information needs to be readily available for residents. Access to healthcare information must be organized, communicated, easy-to-understand and up-to-date. Resources must be made available in order to bridge the gap between service providers and end-users. A centralized place for information (one-stop shop) was discussed (e.g., establishing a central location for public and professional health education information to be accessed, downloaded and readily available for the community).

Accessing information was considered challenging and time-consuming for adults who are unfamiliar with navigating through the vast amount of available public information on health care. If information on services is available, the opportunity to obtain treatment exists, and residents may have access to these services.

Thus, it was deemed important to establish community organizations and large health care providers that can leverage their strengths to create and implement an access point for residents to obtain information. A formal plan or system created by large health care providers and other partnering community organizations would create a strong partnership and team approach to creating an infrastructure of health and social information.

The formation of Penn Highlands Healthcare since the previous CHNA has created access to healthcare and wellness information through the formation of the Penn Highlands Healthcare website.
ACCESS TO CARE

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Residents do not always have access to care due to a lack of transportation. This is most often true for more rural residents that do not have reliable forms of transportation (because of financial instability or other reasons).

2. Health services (i.e., primary care, clinics) are not always readily available due to a shortage of providers, which can cause lengthy wait times to secure appointments.

3. Residents are not always able to afford behavioral health care when it is needed due to the lack of insurances and cost of care.

4. Substance abuse has remained a health concern in the area. The need for clinics who offer services for substance abuse is very high.

Increasing access to healthcare is identified as the third community health priority by community leaders. Access to health care is an ongoing health need in rural areas across the U.S. Apart from insurance issues, access to healthcare in the hospital services area is limited by provider to population ratios that cause lengthy wait times to secure appointments, location of providers, transportation issues, limited awareness of residents related to the location and eligibility of health programs as well as ways to be healthier. As the ACA has been implemented and the consolidation of health services has taken place across the country; this issue has worsened in many rural areas.

Access to care was identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

- Secondary Data
  - All four of the study area counties report lower PCP rates than seen across the state (80 per 100,000 pop. for the state).
    - Cameron = 60 per 100,000
    - Clearfield = 65 per 100,000
    - Elk = 47 per 100,000
    - Jefferson = 47 per 100,000

- Community Forum
  - Community leaders identified access to health care as a health priority.
  - Leaders focused their discussions primarily on the limited number of providers and transportation options.

- Stakeholder Interviews
- Transportation is a barrier in people receiving the care that they need. However, attitudes seem to be shifting towards an acceptance that it is necessary to travel for specialized care.
- There is a perception that many people in the community are uninsured and cannot afford the services they need.

Survey

- Twenty seven percent of all survey respondents did not have insurance, with “unable to afford” being the most common reason why (57.2%).
- Fifteen percent of all survey respondents say transportation is a barrier in receiving necessary healthcare.

In 2012, there was a rise in the number of uninsured and underinsured Americans amidst a slow economy and a decline in employer-sponsored coverage -- elk county was no different. At the time (but still holding true today), low-income workers were at the greatest risk of being uninsured because they are less likely to be offered health coverage, and less able to afford their share of the premiums. Medicaid covers many low-income children, but coverage for adults is limited.

Community health committee members and focus group participants reported other factors that prohibit patients from receiving healthcare services. These factors include:

- the lack of available physicians in the community to address growing patient concerns
- transportation
- lack of health education
- payment options and
- the literacy level of patients

The qualitative data illustrated that uninsured and underinsured patients do not seek medical care for many of these reasons. Adults who do not address their health conditions and ailments typically have a poorer health status. Committee members, stakeholder interviews and focus groups support the concept that residents’ access to healthcare and resources is an important community health priority.
FREE CLINICS

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. While residents may have health insurance; they cannot always afford to use their health insurance due to unaffordable deductibles and copays.
2. The poor socioeconomic status of the region has created a lot of people who cannot afford services.

Individuals in the Penn Highlands Healthcare service area are struggling to pay the costs of the services and treatments they need. It is perceived that things like nutrition, family planning, drug use and alcohol use are all tied back to the low incomes and high unemployment of the region. With so many jobs leaving the area, individuals having a hard time keeping consistent employment, and many jobs being low quality, community leaders recognized the need for free clinics in the area.

The need for free clinics was identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

• Secondary Data

  • Elk County reports the highest rate for the study area of residents with inadequate social support at 21.2% of the population.
  • More than one in every 10 residents of Clearfield County are unable to see a doctor due to cost.
  • Jefferson and Elk County report higher uninsured rates as compared with the state (Jefferson = 14%, Elk = 13%, PA = 12%).
  • Secondary data shows that all four counties in the region report lower average household incomes (Cameron = $50,522, Clearfield = $51,133, Elk = $54,840, Jefferson = $50,827) as compared with the state of Pennsylvania ($71,088).
Community Forum

- There is a growing group of individuals – the “poor middle class” – who do not qualify for Medicaid but struggle to pay for the healthcare they need.

Stakeholder Interviews:

- The regional economy has stagnated. Following years of many quality jobs leaving the area, local communities are seeing many people struggle financially. This has created problems in the region, including a low number of lower wage jobs, and a number of residents with limited or no health coverage.
- Due to poor public transportation and the low socioeconomic status of the region, it can be difficult for some residents to access or afford the health care they need.

Survey:

- Twenty two percent of survey respondents receive their healthcare from free or reduced services.
- Seventeen percent of survey respondents have Medicaid as their primary insurance.
- Fifty seven percent of survey respondents who do not have any type of insurance are without it because they cannot afford it.
- Forty three percent of survey respondents made less than $20,000 a year.

NAVIGATION AND COORDINATION

Underlying factors identified by secondary data and primary input from community leaders, community stakeholders and resident survey respondents:

1. Often times, many residents have several health problems they are dealing with and better coordination among providers could lead to better outcomes.
2. Residents without much education are sometimes overwhelmed and easily confused when attempting to navigate their healthcare options.
3. Care coordination and transitional care are not always available due to lack of funding for these activities, though it is a need among vulnerable residents.

Individuals struggle with coordinating their various healthcare services and providers. The poor economic landscape of the region causes people to deal with inconsistent insurance, a blend of Medicaid and Medicare, and do not receive the needed amount of information to understand their options.
• Community Forum
  • Leaders acknowledged the need for more consistent coordination among services in the region as well as a need for trained, educated navigators to assist various populations in receiving the care they need. Community leaders feel that people find the healthcare landscape confusing and sometimes overwhelming.

• Stakeholder Interview
  • A majority of respondents discussed the organizational changes in terms of health care in the Penn Highlands region. Almost all interviewees mentioned the reorganization and formation of the Penn Highlands network as a significant change. This had lead to a certain degree of unfamiliarity with the Penn Highlands Healthcare network and people are still not totally comfortable with the new network.

• Survey
  • Five percent of survey respondents say they do not know how to receive insurance.
  • Twelve percent of survey respondents say they are using multiple insurances.
  • Fifteen percent of survey respondents say they once had insurance, but have since lost it.
The following qualitative data was gathered during a regional community planning forum held on March 12, 2015 in DuBois, PA. The community planning forum was facilitated by Tripp Umbach with more than 25 community leaders from a four county region (Cameron, Clearfield, Elk and Jefferson) and lasted approximately four hours. Community leaders were identified by the community health needs assessment oversight committee for Penn Highlands Healthcare.

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

GROUP RECOMMENDATIONS

The group provided many recommendations to address community health needs and concerns for residents of the four counties. Below is a brief summary of the recommendations:

- Community leaders made the following recommendations related to substance abuse:
  - Create a larger menu of rehabilitation programs.
  - Coordinate advocacy efforts for individuals struggling with substance abuse problems more effectively.
  - Establish addiction medicine programs.
  - Offer pain management solutions.

- Community leaders made the following recommendations related to nutrition and wellness:
  - Provide education.
  - Increase awareness on healthy choices.

- Community leaders made the following recommendations related to access to care:
  - Create affiliations with larger health systems for specialty care.
  - Utilize tele-healthcare.
  - Rotate specialty physicians to make them more accessible.
  - Increase the number and options for providers.
Community leaders made the following recommendations related to the need of more clinics:

- Formulate better partnerships with the free clinics in the area (such as the one happening at the Susquehanna Rural Free Clinic to handle issues with diabetes).
- Offer free or reduced services.
- Adapt more effectively to the populations who need these services most.

Community leaders made the following recommendations related to navigation and coordination of services:

- Utilize (or create) healthcare navigators to break down the “silos”.
- Create improved communication to effectively capitalize on the services already offered.
- Support opportunities to obtain a degree for healthcare navigation.

PROBLEM IDENTIFICATION

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

1. Drug and Alcohol services/treatment
2. Nutrition and wellness
3. Access to care
4. Need for more free clinics
5. Navigation/Coordination

The following summary represents the most important topic areas within the community discussed at the planning retreat in order of priority. Community leaders believe the following concerns are the most pressing problems and are identified as the most manageable to address and resolve.
1. Drug and Alcohol Services

Substance abuse services were most discussed at the community forum. Community leaders focused their discussions primarily on the limited number of services for drug and alcohol issues, the substance abuse problems of the area, and affordability of treatment and services.

Perceived Contributing Factors

- There are not enough providers to meet the demand among residents who are suffering through substance abuse problems.
- The economy and socioeconomic status of the region are major factors that lead people to abusing drug and alcohol.
- People are self-medicating and resorting to substances to deal with an array of other issues they are facing.
- There is a lack of coordinated services and advocacy for individuals with substance abuse issues.

2. Nutrition and Wellness

Community leaders identified lifestyle-related health concerns as a top health priority. Leaders focused discussions around the access residents have to healthy options as well as the impact to health outcomes.

Perceived Contributing Factors

- Residents are not as active as they may need to be to remain healthy contributing to the rates of diabetes, obesity, and poor health outcomes.
- People are not educated enough on the long-term effects of an unhealthy lifestyle.
- The prevalence of diabetes contributes to poor health outcomes in the area.
- Residents do not always have access to healthy nutrition and may need additional resources.
- The poor socioeconomic status of the region leads to poor health choices.
3. Access to Care

Community leaders identified access to health care as a health priority. Community leaders focused their discussions primarily on the number of providers and limited transportation options.

**Perceived Contributing Factors**

- Residents do not always have access to care due to a lack of transportation. This is most often true for more rural residents that do not have reliable forms of transportation.
- Health services (i.e., primary care, clinics) are not always readily available due to a shortage of providers, which can cause lengthy wait times to secure appointments.
- There are not enough providers to meet the demand among residents. Where there are services, the wait times can be lengthy to secure an initial appointment.

4. Free Clinics

There is a growing group of individuals – the “poor middle class” – who do not qualify for Medicaid, but struggle to pay for the healthcare they need.

**Perceived Contributing Factors**

- While residents may have health insurance; they cannot always afford to use their health insurance due to unaffordable deductibles and copays.
- The poor socioeconomic status of the region has created a population of people who cannot afford services.
- Residents are not always able to afford behavioral health care when it is needed due to the lack of insurances and cost of care.
- Substance abuse has remained a health concern in the area. The need is very high for clinics that offer services for substance abuse.

5. Navigation and Coordination

Leaders acknowledged the need for more consistent coordination among services in the region as well as a need for trained, educated navigators to assist various populations in receiving the care they need.
Perceived Contributing Factors

- Often times, many residents have several health problems they are dealing with and better coordination among providers could lead to better outcomes.
- Due to the poor socioeconomic status of the region, residents are overwhelmed and easily confused when attempting to navigate their healthcare options.
- Care coordination and transitional care are not always available due to lack of funding for these activities, though it is a need among vulnerable residents.
Secondary Data

Tripp Umbach worked collaboratively with the Penn Highlands Healthcare community health needs assessment oversight committee to develop a secondary data process focused on three phases: collection, analysis and evaluation. Tripp Umbach obtained information on the demographics, health status, socio-economic and environmental factors related to the health and needs of residents from the multi-community service area of Penn Highlands Elk Hospital. The process developed accurate comparisons to the state baseline of health measures utilizing the most current validated data. In addition to demographic data, specific attention was focused on two key community health index factors: Community Need Index (CNI) and Prevention Quality Indicators Index (PQI). Tripp Umbach provided additional comparisons and trend analysis for County Health Rankings, Prevention Quality Indicators and CNI data from 2012 to present.

DEMOGRAPHIC PROFILE

The Penn Highlands Elk study area encompasses Cameron and Elk County and is defined as a zip code geographic area based on 80% of the hospital’s inpatient volumes. The Penn Highlands Elk community consists of 5 zip code areas.

Key Findings:

- Cameron County reports the highest rate of residents ages 65 and older (21.8%); this is higher than the state (15.8%).
- 19.3% of the Elk County population is 65 and older; 16.3% are ages 14 and younger.
- Elk County reports the highest average annual household income ($54,840) as compared with the other counties in the region.
- Cameron County reports the lowest average annual household income ($50,522) for the study region.
- All four counties in the region report lower average household incomes as compared with the state of Pennsylvania ($71,088).
- Cameron County reports the lowest rate of households earning more than $100K (7.9%); the state rate being 21.8%.
- Clearfield County reports the highest rate of households earning less than $15K per year (15.2%); this rate is higher than the rate seen for the state (12.5%).
- 11% of the households in Elk County report earning less than $15K per year; this is lower than the rate seen for the state (12.5%).
- Cameron and Jefferson County report the highest rates of residents with less than a high school education (4.2% each); this is higher than the state rate of 3.7%.
- All four of the study area counties report lower rates of residents with some college education or degree as compared with the state.
Elk County reports the most homogenous racial/ethnic population with only 1.7% of the population reporting a race/ethnicity other than ‘White, Non-Hispanic.’

All four of the study area counties report less diversity than the state which has 17.8% of the population identifying as a race/ethnicity other than ‘White, Non-Hispanic.’

Cameron and Elk County see lower rates of residents without health insurance (8.8% and 7.0%) as compared with the state (9.8%).

COUNTY HEALTH RANKINGS

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

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

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

- Health Outcomes — Two types of health outcomes are measured to represent the health of each county: how long people live (mortality) and how healthy people feel (morbidity). These outcomes are the result of a collection of health factors and are influenced by existing programs and policies at the local, state and federal levels.
- Health Factors — A number of different health factors shape a community’s health outcomes. The County Health Rankings are based on weighted scores of four types of
factors: Health behaviors (six measures), Clinical care (five measures), Social and economic (seven measures), Physical environment (four measures).

Pennsylvania has 67 counties; therefore, the rank scale for Pennsylvania is one to 67 (one being the healthiest county and 67 being the most unhealthy). The median rank is 34. Data for the County Health Rankings is only defined as far as the county level, zip code level data is not available.

✔ Of the 8 County Health Rankings for the four counties in the study area:
✔ Cameron County ranked the highest for:
  - Health Behaviors (66 – second worst in the state)
  - Health Factors (64 – fourth worst in the state)
  - Social and Economic Factors (64 – fourth worst in the state)
✔ Elk County ranked the highest for:
  - Morbidity (67 – worst in the state)
  - Health Outcomes (62 – sixth worst in the state)
Key Findings

✓ Cameron County reports the highest adult smoking rate at 39%; higher than the state rate of 20%.
✓ Elk County reports the only rate of adult obesity higher than the state rate for the study area (Elk = 31%, PA = 29%).
✓ Elk County reports the highest excessive drinking rate at 24%; higher than the state rate of 21%.
✓ All four of the study area counties report lower STD rates than seen across the state (415 per 100,000 pop. for the state).
✓ Jefferson and Elk County report higher uninsured rates as compared with the state (Jefferson = 14%, Elk = 13%, PA = 12%).
✓ All four of the study area counties report lower PCP rates than seen across the state (80 per 100,000 pop. for the state).
✓ Elk and Jefferson County report higher rates of diabetic residents as compared with the state (13% for both Elk and Jefferson County, 10% for PA).
✓ All four of the study area counties report higher rates of mammography screening as compared with the state.
✓ All four of the study area counties report lower violent crime rates than seen across the state (367 per 100,000 population for the state).
✓ All four of the study area counties as well as the state saw rises in the PCP rate; however, all four counties still report lower PCP rates than the state.
✓ All four of the study area counties, as well as the state saw declines in the rates of residents getting mammography screenings.
✓ Unemployment rates went down across the board.
PREVENTION QUALITY INDICATORS INDEX (PQI)

The Prevention Quality Indicators Index (PQI) was developed by the Agency for Healthcare Research and Quality (AHRQ). The AHRQ model was applied to quantify the PQI within the Penn Highlands markets and Pennsylvania. The PQI Index identifies potentially avoidable hospitalizations for the benefit of targeting priorities and overall community health.

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

From 2011 to 2014, there were a handful of data methodology changes. For each, Tripp Umbach went to past data and adjusted as necessary to make comparable. They are as follows:

- In the past, PQI data was presented as a value per 1,000 population. The AHRQ has revised this and the current data is presented as a value per 100,000 population. Tripp Umbach adjusted to match these as needed.
- PQI 2 changed from Perforated Appendix in Males 18+ for the past study to Perforated Appendix in Total 18+ population as a rate per 1,000 ICD-9 code admissions for appendicitis. This shift has changed the values for this measure drastically and therefore, Tripp Umbach did not adjust.
- PQI 5 changed from COPD in the 18+ population to COPD or Asthma in “Older adults” 40+ population. Tripp Umbach did not adjust.
- Although not clearly explained by the AHRQ, it would seem that a definition of Newborn population has shifted for PQI 9 because the values are drastically lower in 2014 than in previous years (2011). This has shifted PQI 9 values drastically. Tripp Umbach did not adjust.
- PQI 15 changed from Adult Asthma in the 18+ population for past study to Asthma in Younger Adults 18-39 population. Tripp Umbach did not adjust.

Overall:

- All four study area counties report higher PQI rates (indicating more preventable hospitalizations) than the state for:
  - Diabetes Short-Term Complications Admission Rate (PQI 1)
  - Perforated Appendix Admission Rate (PQI 2)
  - Congestive Heart Failure Admission Rate (PQI 8)
  - Bacterial Pneumonia Admission Rate (PQI 11)
- All four study area counties report lower PQI rates (indicating fewer preventable hospitalizations) than the state for:
  - Hypertension Admission Rate (PQI 7)
  - Low Birth Weight Rate Admission Rate (PQI 9)
- Cameron County reports the highest PQI rates for the study area for 5 of the 14 measures: COPD or Adult Asthma (725.35 per 100,000 pop.), Diabetes Long-Term
Complications (172.29 per 100,000 pop.), Lower Extremity Amputation Rate among Diabetic Patients (49.22 per 100,000 pop.), Perforated Appendix (725 per 100,000 pop.), and Bacterial Pneumonia (615.31 per 100,000 pop.).

- Two of the four diabetes measures.

- **Elk County** reports the highest PQI rates for the study area for 4 of the 14 measures: Asthma in Younger Adults (73.21 per 100,000 pop.), Uncontrolled Diabetes (31.96 per 100,000 pop.), Hypertension (55.93 per 100,000 pop.), and Congestive Heart Failure (791.02 per 100,000 pop.).

  - Two of the three heart measures.
<table>
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<tr>
<th>Prevention Quality Indicators (PQI)</th>
<th>Cameron</th>
<th>Elk</th>
<th>PA</th>
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<td>Diabetes Short-Term Complications Admission Rate (PQI 1)</td>
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<td>Perforated Appendix Admission Rate (PQI 2)</td>
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<td>COPD or Adult Asthma Admission Rate (PQI 5)</td>
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<td>Lower Extremity Amputation Rate Among Diabetic Patients (PQI 16)</td>
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HEALTHY COMMUNITIES INSTITUTE (HCI) INDICATOR DATA

The Healthy Communities Institute (HCI) mission is to improve the health and environmental sustainability of cities, counties and communities worldwide.

The Healthy Communities Institute is a multi-disciplinary team comprising healthcare information technology veterans (professional internet-system developers and evaluators), academicians (health informatics experts, urban planners, and epidemiologists) and former senior government officials. The company is rooted in work started in 2002 in concert with the Healthy Cities Movement and the University of California at Berkeley. The management team from Harvard University, Cornell University and the University of California, Berkeley has expertise in informatics, public health, urban sustainability, community planning and high volume Internet sites.

- HCI Data includes:
  - Over 100 Health and Quality of Life Indicators
  - Healthy People 2020 Trackers
  - Performance Tracking
  - Database of Over 2,000 Proven Programs

Key findings

**Health and Risk Behaviors:**

☑ All four of the study area counties report slight declines or steady adult obesity rates between 2009 and 2010.

☑ Clearfield, Elk, and Jefferson County all report rises in Teen Obesity rates from 2009 to 2011; Cameron County is the only county to report a decline. Clearfield reports the largest rise going from 19.3% to 20.0%, but Jefferson reports the highest rates overall at 21.5% in 2009-2010 and 21.8% in 2010-2011.

☑ Cameron County is the only county in the study area to report a rise in the rate of children who are overweight or obese from 2009 to 2011 (37.4% to 41.5%); Cameron County also has the highest rates of overweight or obese children for the study area.

☑ Cameron, Clearfield, and Elk County all saw rises in the rates of adults who are sedentary; Elk County reports the highest rate for the study area at 30.9% in 2010.

☑ Even though Elk County reported a decline it still reports the highest rate for the study area with 24.1% of adults drinking excessively.

☑ Cameron County reports the highest rate of adults who smoke (38.5%) for the study area.
Health Access and Health Concerns:

- Elk County reports the highest rate for the study area of residents with inadequate social support at 21.2% of the population.

- For most of the study area, children's asthma rates were steadily rising from 2007 to 2011; this trend has taken a turn the other way and for all four counties between 2012 and 2013 childhood asthma rates are declining.

- All four counties are reporting declines in age-adjusted death rates due to coronary heart disease; men are more likely to die from coronary heart disease than women (across all four study area counties).

- Cameron, Elk, and Jefferson County all report rises in the rates of residents with diabetes from 2009 to 2010. (In 2010, Jefferson = 13.0%, Elk = 12.7%, Cameron = 12.0%). Men are more likely than women to die as a result of diabetes.

- Cameron County is the only county of the four in the study area to report a rise in the age-adjusted death rate due to stroke going from 38.4 per 100,000 pop. in 2008-2010 to 48.9 in 2009-2011.

Cancer

- Cameron, Elk, and Jefferson Counties have all seen rises in all cancer incidence rates between the years of 2005 and 2011. Clearfield County, however, has seen a steady decline in all cancer incidence rates from 2005 to 2011.

- Across all of the cancers, men are more likely to contract cancer than women.

- Elk and Jefferson Counties have seen declines in the age-adjusted death rates due to breast cancer among residents while Clearfield County has seen a rise in age-adjusted death rates due to breast cancer (going from 19 per 100,000 pop. in 2006-2010 to 23.7 - the highest for the study area in 2007-2011).

- Clearfield and Jefferson County report declines in their breast cancer incidence rates while Cameron and Elk Counties report rises.

- Clearfield and Elk County report rises in oral cavity and pharynx cancer incidence rates from 2005 to 2011. Clearfield County now reports the highest for the region at 11.8 per 100,000 pop.

- Elk County reports a rise in the age-adjusted death rate due to lung cancer; going from 49.6 per 100,000 pop. in 2005-2009 to 53.3 in 2007-2011; now the highest for the study area.

Accidents, Maternal, and Child Care:

- Elk County has seen a rise and is the highest in the region for deaths due to firearms (going from 15.3 per 100,000 pop. in 2008-2010 to 20 in 2009-2011).
Clearfield, Elk, and Jefferson County have all experienced declines in the age-adjusted death rates due to motor vehicle collisions.

Clearfield, Elk, and Jefferson County have all experienced rises in the age-adjusted death rates due to suicide; Elk County has the highest rate at 19.9 per 100,000 pop. in 2009-2011.

Cameron, Elk, and Jefferson County all report declines in the rates of mothers who receive adequate pre-natal care from 2010 to 2011. Jefferson County reports the lowest at 56.7%.

All four of the study area counties report raises in the rates of mothers who breast-feed their babies. Jefferson County still reports the lowest at 58.6%.

Elk County experienced a rise in low birth weight babies going from 8.9% in 2010 to 9.5% in 2011.

From 2011 to 2012, all four of the study area counties reported rises in the child food insecurity rates; Cameron County reporting the highest for the region at 25.4% - more than one in every four children (under 18 years) in Cameron County live in households that experienced food insecurity at some point in the past year.

Elk and Clearfield County reported rises in the rates of children with Type II Diabetes. Elk County reports the highest rate for the region at 0.18% in 2008-2009.

Environment and Poverty:

93.1% of the Cameron County population is getting water from a public water system that has received at least one health-based violation in FY12-13. The other three counties in the study area report rates in the range of 4% - 9%.

Both Cameron and Clearfield County report the highest rates for the study area for residents ages 65 and older with low access to a grocery store (2.3%).

On the other hand, Elk and Jefferson County report the highest rates for the study area of households without a car and low access to a grocery store (3.1%).

Cameron, Clearfield, and Jefferson County all saw rises in the child abuse rates between 2011 and 2012. Clearfield County reports the highest rate in 2012 at 14.8 cases per 1,000 children.

Per Capita income levels rose for Cameron, Elk, and Jefferson County from 2007-2011 to 2008-2012, but declined for Clearfield County from $21,365 to $20,693 – now the lowest for the study area.

All four of the study area counties reported declines in the rates of residents ages 65 and older living below the poverty level between 2007-2011 and 2008-2012.

Income and Education:
Cameron and Jefferson County saw rises in the rates of households receiving cash public assistance income from 2007-2011 to 008-2012; Cameron County reports the highest rate at 3.8%.

Even though the number of single-parent households declined for Elk County, they still report the highest rate for the study area (going from 38.3% in 2007-2011 to 36.6% in 2008-2012).

Clearfield, Elk, and Jefferson County all report declines in school drop-out rates; Cameron County, on the other hand saw a rise from 0.9% in 2011-2012 to 1.4% in 2012-2013.

Elk and Jefferson County saw rises in the rates of residents ages 25 and older with a Bachelor’s degree or higher from 2007 to 2012; Cameron and Clearfield County on the other hand, saw declines.

**Medicare Population:**

Cameron, Clearfield and Jefferson County report rises in the Medicare population with asthma from 2011 to 2012. Clearfield County reports the highest rate for the region in 2012 at 5.2%. For Cameron, Clearfield, and Elk County, those under 65 years of age report higher rates of asthma; for Jefferson County those 65 and older report higher rates of asthma.

Clearfield County is the only county in the region that reported a rise in the Medicare population that was treated for atrial fibrillation from 2011 to 2012. However, Elk County reports the highest rate for the region with 9.2%.

**Medicare Population:**

Even though Elk County is the only county to report a decline in the cancer rate for the Medicare population, it is still the highest rate in the study area at 9.7%. Those 65 and older are much more likely to be treated for cancer across all of the study area counties as compared with residents under 65 years old.

Clearfield, Elk, and Jefferson County all saw rises in the rate of Medicare population being treated for chronic kidney disease from 2011 to 2012. Cameron County is the only county to experience a decline, but still holds the highest rate for the region at 17.1%.

From 2011 to 2012 Cameron County reported the highest rates of Medicare population with COPD, and in this time this rate rose from 15% to 16.3%.

All four of the study area counties reported rises in the depression rates of the Medicare population; Cameron with the highest of 21.1% in 2012. Depression is more common in those younger than 65 as opposed to those ages 65 and older.

Clearfield is the only county to report a rise in the rate of Medicare population with diabetes; in 2012 it reached 28.8% (although Cameron is still slightly higher at 28.9%).
All four study area counties reported declines in the rates of all of the following heart conditions in the Medicare population from 2011 to 2012.

Cameron County reports a rise in the rate of Osteoporosis in the Medicare population (going from 5.8% to 7.1%) while the three other counties report declines from 2011 to 2012.

Cameron and Elk County reported rises in Rheumatoid arthritis in the Medicare population from 2011 to 2012; Elk County reports the highest rate for the region at 33.2%.

All four of the counties saw declines or steady rates for the Medicare population being treated for stroke between 2011 and 2012.
Key Stakeholder Interviews

DATA COLLECTION

From January 5th to the 21st 2015, Tripp Umbach conducted interviews with eight key stakeholders in the Penn Highlands Elk service area. Tripp Umbach representatives conducted a 30-60 minute interview with each interviewee. All of the key stakeholders identified by Penn Highlands were willing to invest their time and provide information relating to the services of the hospital, the needs of the community, and anything else pertaining to those topics. The key stakeholders work in community based organizations, private businesses, public positions, medical centers and typically are leaders in the community. The following table shows all of the individuals who completed an interview along with their affiliation.

<table>
<thead>
<tr>
<th>Participating Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>YMCA</td>
</tr>
<tr>
<td>Stackpole Hall Foundation</td>
</tr>
<tr>
<td>Dickinson Center</td>
</tr>
<tr>
<td>United Way</td>
</tr>
<tr>
<td>PA Department of Health</td>
</tr>
<tr>
<td>Elk Co. Catholic School System</td>
</tr>
<tr>
<td>Office of Human Services</td>
</tr>
<tr>
<td>CAPSEA</td>
</tr>
</tbody>
</table>

Key Findings

✔ The rural nature and low socioeconomic status of the region is a source of health concerns in the Penn Highlands Elk service area. It is perceived that drug and alcohol use, lower education levels, fewer specialty physicians, and an aging population tie back to the downward economic trends of the community.

✔ Drug and alcohol use/abuse is cited as the leading issue in the PH Elk service area. Educators and organizations need to continue to communicate the dangers of drug and alcohol use to both adults and youth in the region, and especially work to break down the perceived cultural acceptance of alcohol use.

✔ Penn Highlands should further collaborate with local organizations and agencies that focus on the health and wellness of the community. Respondents think these facilities
and organizations are well suited to educate residents and address issues facing the community.

- While primary care is accessible in the PH Elk service area, specialty care is less accessible. Residents’ attitudes seem to be shifting toward an acceptance that it is necessary to travel for specialized care.
Survey of Vulnerable Populations

Tripp Umbach worked closely with the CHNA oversight committee to assure that community members, including under-represented residents, were included in the needs assessment through a survey process.

DATA COLLECTION:

Vulnerable populations were identified by the CHNA oversight committee and through stakeholder interviews. Vulnerable populations targeted by the surveys were seniors, low-income residents (including families), residents with behavioral health needs and residents that are uninsured.

A total of 484 surveys were collected in the Penn Highlands Healthcare hospital service area which provides a +/- 7.5 confidence interval for a 95% confidence level. Tripp Umbach worked with the oversight committee to design a 30 question health status survey. The survey was administered by community based organizations (i.e., CenClear, Free Medical Clinic, CCAAA, Clearfield CAL Center for Active Living, Susquehanna Rural Free Clinic, YMCA, etc.) that provide services to vulnerable populations in the hospital service area. Community based organizations were trained to administer the survey using hand-distribution.

- Surveys were administered onsite and securely mailed to Tripp Umbach for tabulation and analysis.
- Surveys were analyzed using SPSS software.

LIMITATIONS OF SURVEY COLLECTION:

There are several inherent limitations to using a hand-distribution methodology when collecting surveys. The demographics of the population are not intended to match the general population of the counties surveyed. Often, the demographic characteristics of populations that are considered vulnerable populations are not the same as the demographic characteristics of a general population. For example vulnerable populations by nature may have significantly less income than a general population. For this reason, the findings of this survey are not relevant to the general populations of the counties they were collected in. Additionally, hand-distribution is limited by the locations where surveys are administered. In this case, Tripp Umbach asked CBOs to self-select into the study and as a result there are several populations that have greater representation in raw data (i.e., seniors, low-income, etc.).
Demographics:
- By March 4, 2015, Tripp Umbach received a total of 484 completed surveys
- Of the surveys gathered: 62.7% were female, 37.3% were male

### Table 5: Age Breakout of Survey Respondents

<table>
<thead>
<tr>
<th>Age</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>41</td>
<td>8.7</td>
</tr>
<tr>
<td>26-35</td>
<td>76</td>
<td>16.1</td>
</tr>
<tr>
<td>36-45</td>
<td>83</td>
<td>17.6</td>
</tr>
<tr>
<td>46-55</td>
<td>102</td>
<td>21.7</td>
</tr>
<tr>
<td>56-65</td>
<td>90</td>
<td>19.1</td>
</tr>
<tr>
<td>66-75</td>
<td>43</td>
<td>9.1</td>
</tr>
<tr>
<td>76-85</td>
<td>23</td>
<td>4.9</td>
</tr>
<tr>
<td>86+</td>
<td>13</td>
<td>2.8</td>
</tr>
<tr>
<td><strong>SUBTOTAL</strong></td>
<td><strong>471</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td><strong>MISSING</strong></td>
<td><strong>13</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>484</strong></td>
<td></td>
</tr>
</tbody>
</table>

- The majority of the survey respondents reported their race as white (89.0%); the next largest racial group was multi-race at 5.1% of the survey population.
- The household income level with the most responses was $10,000 to $19,999 with 22.6% of the respondents answering this.

**Key Findings**

*Note: percentages are listed in order of Cameron, Clearfield, Elk, and Jefferson Counties, respectively.*

### Table 6: Average Weight and Height of Survey Respondents

<table>
<thead>
<tr>
<th>Weight &amp; BMI</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>Avg. Female (5’4”)*</th>
<th>Avg. Male (5’9”)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>189.6 lbs.</td>
<td>183.7 lbs.</td>
<td>188.8 lbs.</td>
<td>182.0</td>
<td>108-144 lbs.</td>
<td>121-163 lbs.</td>
</tr>
<tr>
<td>BMI</td>
<td>30.49</td>
<td>29.56</td>
<td>29.62</td>
<td>28.57</td>
<td>26.5</td>
<td>26.6</td>
</tr>
</tbody>
</table>
Table 7: Percentage of Survey Respondents Having Taken the Following Tests

<table>
<thead>
<tr>
<th>Test Received</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood test</td>
<td>73.5%</td>
<td>71.3%</td>
<td>72.1%</td>
<td>75.7%</td>
</tr>
<tr>
<td>Check up</td>
<td>61.2%</td>
<td>61.4%</td>
<td>63.6%</td>
<td>53.4%</td>
</tr>
<tr>
<td>Flu shot</td>
<td>42.9%</td>
<td>48.0%</td>
<td>38.8%</td>
<td>32.0%</td>
</tr>
<tr>
<td>Cholesterol test</td>
<td>40.8%</td>
<td>47.5%</td>
<td>41.9%</td>
<td>32.0%</td>
</tr>
</tbody>
</table>

Less common responses included: Colonoscopy, EKG, Urinalysis, Pneumonia vac., Mammogram, and Prostate test.

- The most popular place for residents to seek care is a doctor’s office – 77.1%, 59.6%, 76.8%, and 49.5% respectively.
- The insurance category with the highest response rate was Private- 32.7%, 17.1%, and 28.9% respectively. Jefferson's was Medicaid at 19.4%.
- The most common reason why individuals do not have health insurance is because they can’t afford it– 40%, 80.3%, 63.6%, and 51.9% respectively.
- Individuals report being examined by a medical doctor “1-2 times” in the past year for all four counties as the most popular choice- 34.7%, 38.9%, 33.6%, and 44.8% respectively.
- The most common response to “how is your health?” is “Good”-35.4%, 47.8%, 41.1%, and 38.8% respectively.
- And when people exercise, they most commonly do it “3-4 times per week” (45.8%, 37.2%, and 36.7% respectively) and Jefferson respondents most commonly did it 1-2 times (44.8%).
- The majority of reported respondents have been told they do not have a substance abuse problem (91.8%, 93.4%, 87.4%, and 66.0% respectively).
- The majority of respondents report “Yes” to having their children or grandchildren being up to date with immunizations (60.9%, 52.1%, 57.1%, and 55.6% respectively).
- The most popular form of finding out about services in the community is via “word-of-mouth” (76.6%, 64.6%, 75%, and 76.5% respectively).
- Their personal car is the most common form of transportation (73.5%, 70.9%, 65.1%, and 59.8% respectively).
- Only 4.1%, 9.2%, 11.6%, and 7.8% registered as taking public transportation.
- The majority of respondents report not consuming alcohol at all (58.3%, 64.4%, 68.0%, 75.2%).
Common Health Issues

Table 8: Survey Responses – Health Issues Respondents Reported Ever Diagnosed With

<table>
<thead>
<tr>
<th>Ever Diagnosed with</th>
<th>Cameron</th>
<th>Clearfield</th>
<th>Elk</th>
<th>Jefferson</th>
<th>PA*</th>
<th>U.S.*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>64.6%</td>
<td>37.2%</td>
<td>60.5%</td>
<td>62.1%</td>
<td>18.3%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>14.3%</td>
<td>13.6%</td>
<td>21.7%</td>
<td>10.7%</td>
<td>10.1%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Heart Problem</td>
<td>22.4%</td>
<td>19.9%</td>
<td>18.1%</td>
<td>15.5%</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Cancer</td>
<td>10.2%</td>
<td>9.6%</td>
<td>7.0%</td>
<td>2.9%</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

*Source: CDC

✓ 64.6%, 37.2%, 60.5%, and 62.1% respectively of individuals report being told by a doctor, nurse, or health professional that they have depression.

✓ 14.3, 13.6%, 21.7%, and 10.7% respectively of individuals report being told by a doctor, nurse, or health professional that they have diabetes.

✓ A majority of respondents report being told they have a heart problem (22.4%, 19.9%, 18.1%, and 15.5% respectively).

✓ The majority of respondents report “No” to having been told they have cancer (89.8%, 90.4%, 93.0%, and 97.1% respectively).
The majority of respondents report not smoking at all (60.4%, 67%, 64.1%, and 32.4% respectively); however, (35.4%, 24.4%, 30.5%, and 56.9%) smoke every day.

49%, 62%, 62.7%, and 56.3% respectively of respondents claimed to have exercised in the last 30 days.
Conclusions and Recommended Next Steps

Penn Highlands Elk, working closely with community partners, understands that the community health needs assessment document is only a first step in an ongoing process. It is vital that ongoing communication and a strategic process follow the assessment process. With Penn Highlands Healthcare having such a large presence in the community, Penn Highlands Elk has access to many resources within their community and at the other three facilities. However, Penn Highlands Healthcare understands that accessing these services can be a major challenge for individuals living in the community. Residents of the Penn Highlands Elk service area have limited access to the healthcare resources in the region due to the need for an increase in healthcare providers and transportation to healthcare facilities, including free clinics. Collaboration and partnership are a strategy that Penn Highlands Healthcare must employ more so in order to affect the other needs facing the community—substance abuse and nutrition and wellness. It is important to create or expand existing partnerships with multiple community organizations when developing strategies to address the top identified needs. Implementation strategies will need to consider the higher need areas in the poorest areas within Cameron, Clearfield, Elk and Jefferson County. Tripp Umbach recommends the following actions be taken by the hospital sponsors in close partnership with community organizations over the next six to nine months.

Recommended Action Steps:

- Widely communicate the results of the community health needs assessment document to Penn Highlands Elk staff, providers, leadership and boards.
- Conduct an open community forum where the community health needs assessment results are presented widely to community residents, as well as through multiple outlets such as: local media, neighborhood associations, community-based organizations, faith-based organizations, schools, libraries and employers.
- Utilize the inventory of available resources in the community in order to explore further partnerships and collaborations.
- Implement a comprehensive “grass roots” community engagement strategy to build upon the resources that already exist in the community and the energy of and commitment of community leaders that have been engaged in the community health needs assessment process.
- Develop three “working groups” to focus on specific strategies to address the top identified needs of the facility. The working groups should meet for a period of four to six months to develop action plans and external funding requests.