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Regional Health Assessment of Northeastern and North Central Pennsylvania: Findings from a qualitative study

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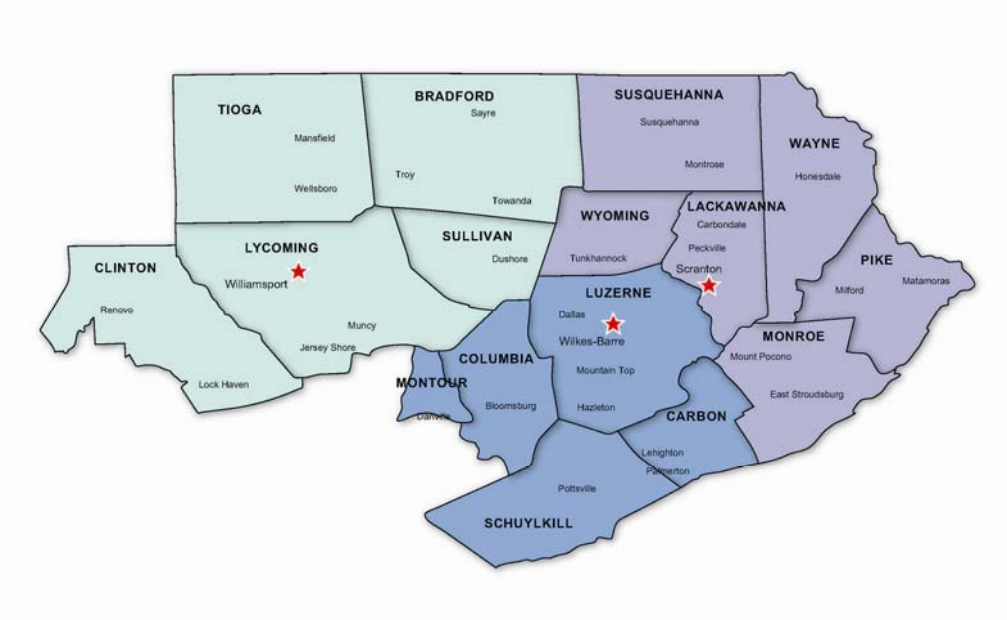

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EXECUTIVE SUMMARY

The Commonwealth Medical College (TCMC) carried out a regional health assessment of the 16 counties in its service area in 2009. The study utilized qualitative methods, the results of which will be combined with secondary quantitative data in the final reports. This report summarizes the preliminary findings from focus groups held in TCMC counties. The focus groups had two goals: 1) collect information about health needs, underserved populations, resources, and expectations for the new medical college and 2) begin to develop relationships with service providers and community leaders in the communities served by the medical college.

A regional community health advisory board was established to guide TCMC's work on this and other community based efforts. TCMC worked with this board, the Northeast PA Area Health Education Center (AHEC), and directors of county level State Health Improvement Plan (SHIP) partnerships to identify potential focus group participants representing a broad range of sectors, populations, and health issues in each county. One to four focus groups were held in each county, depending on population. To date TCMC staff has held 23 focus groups in 14 of 16 counties, with 6-14 participants each (average=10 participants). Half of the focus groups (12) were general and half had a specific population or issue focus. A total of 221 participants representing 195 agencies or entities participated. Immediately after each discussion TCMC representatives debriefed the session, creating an outline of the main themes discussed and the important ideas identified in each theme. Content analysis of the debriefing notes identified the main themes across focus groups.

The main themes fall into three broad areas: needs, strengths/resources, and expectations for TCMC. Under *needs*, 12 themes were identified in at least 75% of the focus groups. One theme is included because of regional importance even though it was only discussed in 50% of the focus groups. The main themes regarding needs are mental health, transportation, health insurance, lack of providers, lack of prevention and wellness, specific diseases/risk factors, drug and alcohol abuse, cultural and knowledge barriers to care, issues unique to seniors, lack of coordination of care, dental health, specific vulnerable populations, and regional demographic changes. Under *strengths and resources*, 5 themes were identified in at least 50% of the counties. The themes that emerged are interagency collaboration, the State Health Improvement Plan (SHIP) partnerships, volunteers, schools and churches as pillars of community, and descriptions of specific programs. Under *expectations for TCMC,* 4 themes were identified in at least 75% of the counties: the need for more physicians in the region, training a different kind of physician, efforts to improve regional healthcare, and ongoing connection to community.

Next steps in the study include a more in depth analysis of focus group transcripts and using secondary quantitative data to put the perspectives from focus group participants in the context of the demographics of the region and counties. These findings will be distributed to the community in 1-2 page briefs categorized by county and by major theme. The findings will also be used to guide development of the research, educational and clinical agendas of the new medical school.

INTRODUCTION

The Commonwealth Medical College is one of the nation's newest medical schools, welcoming charter classes of 65 medical students and 13 Masters in Biomedical Sciences students in August 2009. TCMC's mission is to "*educate aspiring physicians and scientists to serve society using a community based, patient centered, inter-professional and evidence based model of education that is committed to inclusion, promotes discovery and utilizes innovative techniques*." Northeastern Pennsylvania (NEPA) is home to TCMC, covering sixteen counties[1] and three regional campuses centered around the three main urban centers of Scranton, Wilkes-Barre and Williamsport. In addition to the medical education mission, TCMC is dedicated to engaging with communities in NEPA to improve health. TCMC envisions becoming an integral part of the community in Northeast Pennsylvania. Goals include:

1. Addressing access to care issues that may allow more patients to stay locally for care
2. Advancing biomedical discovery and achieving a positive economic impact locally and regionally
3. Creating a new national model for *community-based* medical education

In order to fulfill the mission of a community based model of medical education and the goal of becoming an active participant in the region, TCMC must develop an in-depth knowledge of the issues, organizations, and people in its new community. In early 2009, The medical college, embarked on a regional health needs assessment as part of a process of getting to know its new "neighborhood". Leadership for the project came from TCMC's Department of Family Medicine and Community Health.

The assessment is being conducted through a series of focus groups held in each of the 16 counties. As of November 1, 2009 23 of 25 focus groups in 14 of 16 counties have been completed. The last two focus groups (Montour and Columbia counties) were postponed to accommodate a concurrent and more detailed assessment being completed by Geisinger Health System. TCMC has worked with Geisinger research staff to choose a topic—drug and alcohol abuse—which was prioritized in both groups assessments. Focus groups on that topic will be held in Montour and Columbia counties in the coming months. This initial report summarizes the findings from the focus groups to date. These findings represent the experiences and observations of the participants involved in the focus groups. Whether or not every comment or issue is entirely supported by statistical data, these are the perceptions and beliefs of the participants. Final reports will include findings from these last two counties and the in-depth analysis of transcripts from all focus groups. Final reports will also include quantitative data from secondary sources.

This preliminary report includes a description of the methodology used, including information on the number and agency affiliations of participants. An overview of the main themes that emerged is followed by a paragraph description explaining the main concepts identified under each theme. Themes are listed in order of the frequency with which they were mentioned.

[1] Bradford, Carbon, Clinton, Columbia, Lackawanna, Luzerne, Lycoming, Monroe, Montour, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne, Wyoming

METHODS

Planning and Oversight

The regional health assessment staff recruited a group of 17 individuals representing diverse service sectors and the 16 counties in the TCMC service area to serve on a Community Health Advisory Board (CHAB) to guide the regional health assessment process. The Executive Director of the regional Area Health Education Center co-chaired this group with TCMC's principal investigator. The CHAB participated in several ways, including discussing study design, providing input to the initial question guide, identifying potential participants for the focus groups, serving as the pilot focus group, validating findings and meeting to formulate a strategy for dissemination of study findings, suggesting formats and outlets for communicating the results to various stakeholders in the communities of Northeast Pennsylvania. The group will also be meeting with TCMC leadership to discuss implications of study findings for the medical college's education, service and research missions and opportunities for future partnerships.

Participants

TCMC has completed 23 focus groups in 14 of the 16 counties in its service area (Table 1). The number of focus groups in each county was determined based on the total county population, with most counties (population < 100,000) having one focus group and the larger counties (>200,000) having up to four. The focus groups have ranged in size from 6 to 14 participants (average = 10). There have been a total of 221 participants representing 195 agencies. Participants represented varied and diverse agencies and sectors (Table 2).

Focus Groups

The following questions were asked at every focus group (with slight modifications for the specialized focus groups):

1. What health issues are currently the biggest burdens on (youth, adults, seniors) in your county?
2. What are the significant health issues, not currently problematic, that you see on the horizon?
3. What populations are most overlooked or underserved by health and social services in the county?
4. What programs or services are having the biggest positive impact on the health of (youth, adults, seniors) in your county?
5. What do medical providers in your county need?
6. What do you want to see from TCMC?

Focus groups were facilitated by the principal investigators (two individuals) and lasted 60-90 minutes. Participants were offered reimbursement for travel expenses. The study was supported financially by the medical college.

Table 1. The Commonwealth Medical College Regional Health Assessment County Focus Groups

County	# Participants	Focus	County population (2008)
Bradford	7	General	61,233
Carbon	14	General	63,558
Clinton	12	General	37,038
Columbia**	Not yet held	Drug and Alcohol	65,004
Lackawanna	12	Youth	209,408
Lackawanna	9	Seniors	
Lackawanna	8	Minorities	
Lackawanna	8	Minorities	
Luzerne	11	Youth	311,983
Luzerne	9	Seniors	
Luzerne	11	Minorities	
Luzerne	11*	General	
Lycoming	9	Youth	116,670
Lycoming	9	Seniors	
Monroe 1	9	General	165,058
Monroe 2	8	General	
Montour**	Not yet held	Drug and Alcohol	17,705
Pike**	7	Mental Health	59,664
Schuylkill 1	6	General	147,254
Schuylkill 2	8	General	
Sullivan	9	General	6,124
Susquehanna	11	General	40,831
Tioga	12	General	40,574
Wayne**	11	Mental Health	52,016
Wyoming	10	General	27,759

*Focus group made up of representatives of perspectives underrepresented in previous focus groups: higher education, media, government, and business.

** Counties with community assessments recently completed or in process. Specific health issue identified jointly with those assessment investigators.

Table 2. Agencies and Sectors that participated in Focus Groups

County and state government	K-12 schools
County human services	Colleges and universities
County assistance offices	Non-profit and community based organizations
County children and youth services and Head Start	Hospitals
Area agency on the aging and other senior services	Health systems/health insurers
County and private mental health services	Heath Centers and clinicians
County and private substance abuse services	Legal and justice system
County coroners	Faith organizations
Public health	Community leaders
Businesses	

Data Analysis

Immediately after every focus group, 2-4 TCMC employees and interns debriefed the discussion and created an outline of the main themes and important issues for that county. A total of 16 people were involved in this stage of analysis. Content analysis of these debriefing notes generated the main themes across all focus groups. The current report comes from this stage of analysis.

The percentage reported for themes was calculated for completed focus groups in which each need was discussed. The questions about strengths and expectations for the medical school were not asked in every focus group; percentages only include those groups where the question was asked. Themes pertaining to needs and expectations were included if discussed in at least 75% of the focus groups. One theme, demographic changes, is included because it was very important regionally, even though it was only discussed in 50% of the focus groups. Themes about positives and resources were included if discussed in at least 50% of the counties. Due to the depth of discussion regarding needs, much less time was available in each discussion for the positives (Question 4) and there was more variation in how participants interpreted the question; less consistency across focus groups and counties necessitated this lower threshold for inclusion. Also, some of the positive themes were more county specific and thus very influenced by the greater number of focus groups in the larger counties. (For example, the SHIP partnerships are specific to a single county or a small group of counties. The SHIPs were mentioned in 50% of the counties, but only 35% of the focus groups.) Calculating the frequencies by county instead of by focus group gave a better indication of the importance of these themes.

Each focus group was audio recorded and transcribed. Qualitative data software (Atlas.ti) will be used to do a more in-depth content analysis of the discussions.

THEMES: OVERVIEW

I. Needs (in rank order)

- Mental health
- Access to healthcare: transportation
- Access to healthcare: insurance
- Access to healthcare: lack of providers
- Prevention and wellness
- Specific diseases, injuries, risk factors
- Drug & alcohol
- Access to healthcare: knowledge and culture
- Seniors
- Coordination of care
- Dental health
- Vulnerable populations
- Demographic changes

II. Strengths and Resources (in rank order)

- Interagency collaboration
- Schools and Churches
- Volunteers and volunteerism
- State Health Improvement Plan (SHIP) partnerships
- Specific Programs

II. Expectations from TCMC (in rank order)

- More physicians
- A different kind of physician
- Better healthcare in the region
- Connection with community

THEMES: DESCRIPTIONS

I. Needs

1. Mental Health (100% of focus groups)

Mental Health is the one theme that was mentioned in every single focus group. It was such a big issue that, when looking for a specific issue to probe in more depth in Wayne and Pike counties (where a broad community assessment had just been completed), it was chosen. There is a dire lack of mental health providers, especially psychiatrists; in particular, participants noted a lack of psychiatrists who treat children and patients on medical assistance. The lack of coordination between mental health services and physical health services leads to inconsistent and lower quality of care for patients in both areas. Mental health issues seem to either overwhelm primary care provider (one nurse practitioner said that 25-30% of her patients have mental health problems such that she rarely gets to address their physical health) or are left untreated because the provider just doesn't have time to address them. There is a lack of both in-patient and out-patient mental health facilities, especially those that serve children. Our schools are bearing the brunt of the scale of untreated mental health issues in our children. One participant from a school district said that there are so many "hurting kids in our guidance office" (1/4 of students in the high school are in a therapy group) that they have added an additional crisis counselor to every building in the school district. Finally, the issue of stigma around mental health cannot be avoided. While some think it is getting better among youth ("everyone has a counselor"), it is still a very hard issue to overcome in the general public and especially among seniors.

Patients with mental retardation have such a hard time finding a physician that they often go to Philadelphia for care. The growing incidence of children diagnosed with autism spectrum disorders, combined with the limited number of providers who understand it, leave parents of children with ASD in an extremely hard place. The services after the child turns 18 years old are even more limited.

2. Access to Healthcare: Transportation (91% of focus groups)

Transportation is a timeless and big issue in access to healthcare. In rural areas the combination of long distances, lack of specialists (so one has to travel even further to get to them) and a lack of public transportation is very challenging. One focus group participant told us to "Write down transportation, underline it 3 times, put it all in caps, and star it". There are limited public "shared ride" transportation options in every county, which are time consuming and cumbersome to use; many will not cross county lines, although residents of some counties have to go out of the county for most or all of their care (especially specialty care). The economic downturn and rise in fuel costs have exacerbated this situation as people and agencies have less money for gas. Lack of transportation is especially hard on seniors and youth, who often rely on others for their mobility.

2. Access to Healthcare: Insurance and Cost (91% of focus groups)

The problem of the working poor being uninsured is especially great in this region where much of the employment (farming, lumber, mining, tourism, retail) does not offer benefits. The groups most often discussed as being especially vulnerable are single adults who are "post- Medicaid" (18-25 yrs) and "pre-Medicare" (55-64), and the newly unemployed who don't know how to access the system of safety net care/insurance (See theme on vulnerable populations). The strain on our emergency departments from caring for this large population of uninsured was widely discussed. Emergency department clinicians and school nurses provide primary care for many in our region, and these patients receive little or no preventive care. There is a high rate of coverage by public entitlement or safety net insurance. In one focus group a hospital representative shared that their hospital patients are "1/3 Medicaid, 1/3 Medicare, and 1/3 a mix of private insurance and uninsured". The two main problems with public insurance were that many providers do not accept Medical Assistance and that the paper work for all programs is prohibitively confusing, especially in areas of low literacy (one county reported a 40% functional literacy). With or without insurance the cost of health care is too high. One service provider quoted a client who said "I'd rather be dead than sick" because being sick is too much of an economic burden on the family.

2. Access to Healthcare: Lack of Providers (91% of focus groups)

The lack of providers was wide spread. All primary care providers, and especially pediatricians, are scarce. Specialty care is even worse. The following specialties were mentioned in most or all of the counties where lack of providers were discussed: psychiatry, dental, geriatrics, obstetrics and gynecology, orthopedics, and oncology. The recruitment and retention of physicians is really challenging for both social and economic reasons; isolation, lack of career options for professional spouses, and low reimbursement rates from a population with low rates of private insurance make starting a practice here a hard sell. There is a lack of facilities as well, especially low income clinics, urgent care, STD clinics, and facilities for seniors. The challenge of scheduling is also a barrier to care. Many physician office hours do not accommodate those who can't afford to leave work during the day, and long waits at offices compound this problem. Participants understand that this is often out of the control of physician, who are overworked and asked to do "18 hours of work in a 10 hour day".

2. Prevention and Wellness (91% of focus groups)

Participants were very concerned by the lack of preventive care and healthy behaviors in the region. They attribute this lack to many factors. One is low levels of literacy (both basic and health related). Basic reading and math skills in many counties are quite low; understanding of medical terminology and issues is likewise low. These each interfere with people's ability to understand and follow health messages from healthcare providers and in the popular media. The lack of a "culture of prevention" was discussed widely. There is a social norm in many communities (especially discussed in rural and minority communities) that you do not go to the doctor unless it is an emergency, even if you do have insurance. Another factor is that providers often don't have time for (or don't sufficiently prioritize) prevention messages. (e.g. "How can a physician see that a patient gained 25 pounds since the last visit and not say anything about it?") Finally, participants discussed the lack of healthy behaviors in the general public and the lack of effective health education to change those behaviors. Issues around healthy diet, adequate exercise, basic hygiene and sleep for children, and sexual/reproductive health for youth were all discussed; many in the public think they understand these issues but either don't really understand or don't/can't act on that knowledge. Social service providers struggle to reach people with health education messages early enough and in ways that might actually change behavior.

2. Specific Disease, Injury and Risk Factors (91% of focus groups)

The way that the first question was asked ("What are the health issues that are the greatest burden on X age group?") didn't necessarily provoke in depth discussion on specific medical *conditions*. Still, there were some conditions that surfaced repeatedly. Almost every group brought up diabetes. There was concern about the increasing incidence, especially among youth. Cancer (different specific cancers in different counties), cardiovascular disease, and asthma were the other chronic diseases frequently discussed. Among infectious diseases, sexually transmitted diseases including HIV/AIDS were the most often mentioned. Injuries and violence came up as well: motor vehicle crash injuries among teens and family violence (including intimate partner violence, child abuse and neglect, elder abuse) are issues of significant concern. Behavioral risk factors were discussed in almost every group. Substance abuse was discussed so frequently that it is its own theme. Tobacco use, unsafe sexual behavior among adolescents, and obesity from a sedentary lifestyle were all discussed widely.

3. Drug and Alcohol Abuse (87% of focus groups)

Substance abuse is both a significant health and social issue on its own and a risk factor for many other issues that were raised in these focus groups (e.g. mental health, violence, injury etc.). Alcohol abuse is the most prevalent, causes the most problems and is a gateway to other drugs. It is being abused very early by youth and is largely socially accepted: "The parental problems are an issue because it is accepted, this is what you do. You win the softball game; everybody goes out and has a beer." The drugs most often mentioned were heroin and prescription drugs. Heroin is a big issue and growing in most counties. Abuse of prescription drugs, especially narcotics, is a huge problem in most counties. They are cheap and abundant in homes and communities, and are popular among youth. One participant shared that in Wayne County prescription drugs are the number one reason for referral to inpatient drug and alcohol treatment. Use of methamphetamines is decreasing across the region. Participants expressed concern over treatment options for people suffering from addiction. There are insufficient rehabilitation facilities in most counties, especially for youth. There are not enough medication assisted drug rehab facilities (e.g. methadone or suboxone) in the region. Finally many physicians don't sufficiently understand addiction or how to refer patients with it.

4. Access to Healthcare: Knowledge and Culture (83% of focus groups)

Knowledge and culture are significant barriers to care for many. Not knowing about services, and low health literacy keep some away. The problems for the non-English speaking communities come from a lack of interpreters (populations are often large enough to need significant interpreter services but too small to support professional linguistic support). While Spanish is the most widely spoken language, many other populations live here and need language support to access health care. The challenge of navigating the system is huge for everyone, but especially hard for immigrants and seniors. Racism and discrimination were discussed in depth in our focus groups that targeted minority communities and mentioned in most others. Latinos, African Americans, the poor, gays and lesbians, and women all shared stories of discrimination in our healthcare system that create barriers. Discrimination can make people not want to return (e.g. a married African American professional woman was enraged by being treated as an irresponsible, single, poor mother when she took her son to the emergency room) and can also keep people from being able to get care (e.g. a Latino advocate shared that physicians refused to negotiate lower rates for her clients when they pay for services with cash while the white woman next to her in the focus group regularly negotiates lower rates when she pays out of pocket).

4. Seniors (83% of focus groups)

This region has an unusually high percentage of senior citizens. The numbers keep growing due to three factors: 1) The population bubble of "baby boomers" are reaching retirement age and everyone is living longer, 2) Many seniors who are not from here choose to retire here because of the low cost of living, and 3) The "brain drain" of youth leaving the area from a lack of jobs means that seniors make up an even larger percentage of the population. Some of the issues for seniors are present in all age groups (e.g. mental health problems, coordination of care, and access to healthcare issues); however they can have unique aspects. For example mental health problems for seniors often go undiagnosed when they are confused with dementia, which is seen as a "normal part of aging". Likewise, depression often comes with the loneliness and isolation people can experience when friends and spouses die or physical mobility limitations decrease social opportunities. Medication issues were commonly discussed—both over-medication caused by increasing health problems crossed with poor coordination of care between providers and under-medication from the high cost of prescription drugs on Medicare. One of the big problems is a lack of facilities across the continuum of care (senior centers, adult day care, assisted living, nursing homes). Almost every county has a shortage in some part of this continuum. There is a statewide transition to community based care with the concept of "aging in place"; however, the infrastructure to support this change isn't in place yet (insufficient in-home care) which creates gaps in services. The senior centers that are in the region were quite universally mentioned as great resources, even though almost everyone wants more of them. Unfortunately many seniors are not accessing them; sometime this is a transportation issue but there is also stigma with being seen as old. Multiple participants shared stories of people in their 80s saying "I'm not old enough for a senior center. That's for *old* people."

5. Coordination of Care (78% of focus groups)

Issues of coordination of care were identified between physicians (between primary care and specialty care providers and among specialists), between social services and medical services, and between school and medical services. Lack of communication between different parts of the healthcare system was very concerning for participants. The example of overmedication of seniors who are seeing multiple specialists, but who may lack the strong anchor of a primary care physician was mentioned many times. Participants, who were mostly non-medical providers (only 7% of participants were medical clinicians or represented a hospital or health system), experience a distinct lack of coordination between medical and social services. Many physicians don't know about the full range of social services that are available in their communities nor do they refer patients to those services appropriately. One social service provider complained that "We need an avenue to get to physicians [because] the Medical Society is closed to us." Struggles coordinating between schools and medical services came up several times. The coordination of medical services with both social services and schools was seen as being especially poor around mental health issues. With schools, the challenge of sharing information with the overlay of both medical privacy and school privacy regulations was also mentioned.

6. Dental Health (74% of focus groups)

Dental health came up in most counties. It is an issue which cuts across all age groups. There are not enough dentists, and few accept medical assistance. Participants discussed the low reimbursement for dental services by Medicaid and the fact that patients with MA have a higher rate of missing appointment, but are still frustrated by the paucity of dental health options for recipients of medical assistance. There is also a "generational lack of dental hygiene and education". Poor diet and poor brushing/hygiene compound to create very big dental health needs. People with "bad teeth" can have trouble getting a job or end up in the emergency room with abscesses. The good news is that some low income dental clinics have opened in several counties and there are more on the way; however, the process of starting one is challenging. The new clinics can struggle to find providers to hire and may be immediately overwhelmed with patients when they do open.

6. Vulnerable Populations (74% of focus groups)

When asked who the most overlooked or underserved populations are, the most common answer across all counties was the working poor. They have too much income to qualify for Medicaid, but don't get health insurance through work and cannot afford it on their own. They can also be hard to reach with health care and social services. (See theme on access to care: insurance) Age groups frequently mentioned included young adults (18 to 25 years) and young seniors (55 to 64). The young adult group is too old to be covered by their parent's insurance and often feel invincible. The young seniors may be starting to have increased health issues, but do not yet qualify for Medicare; and the older women no longer get the regular care they received during their reproductive years. Minorities were also often discussed among the vulnerable populations (See theme on access to care: Knowledge and Culture). Caregivers are another vulnerable group that focus group participants identified. Two kinds of caregivers were discussed: 1) the sandwich generation that is simultaneously caring for their children and their parents while often ignoring caring for themselves, and 2) grandparents who are caring for grandchildren when parents are absent (often due to addiction). These caregivers can become vulnerable themselves as they focus on others' needs at the expense of their own health and healthcare. They can also be hard to reach with traditional social services.

7. Regional Demographic Changes (52% of focus groups)

These issues were mentioned in about half of the focus groups, mostly in the counties near the NY/NJ border (Schuylkill, Carbon, Monroe, Pike), the urban centers (Lackawanna and Luzerne), and the north central region (Bradford, Tioga). In the border counties there is a huge population explosion as people move west to escape the sprawl and high housing costs of New York City (especially Monroe and Pike counties). The health and social service infrastructure is stretched to the limit, and the population continues to grow. There is also a large commuter population that works in New Jersey or New York City coming home late in the evening or only on the weekends. This is especially hard for families with children, who are sometimes left as young as 13 for the week to care for themselves and younger siblings. The influx of a more metropolitan population is also hard as they leave their social supports behind and clash with a different culture. The increasing diversity has enflamed racism. The participants in Schuylkill Co discussed the recent, high-profile, racially motivated murder as indicative of this problem.

The urban centers in Lackawanna and Luzerne counties discussed issues of especially high increase in senior populations (See theme on seniors) and the growth in minority populations. There is concern that many residents in these counties are ignorant of the rapidly increasing communities of color and any unique needs they may have. There was also discussion of the fact that the flip side of very tightly knit and supportive communities is that it is hard to break in as an "outsider" or new comer. In Scranton and Wilkes-Barre there is increasing gang activity.

In the north central region the demographic changes have to do with the gas drilling for the natural gas found in the Marcellus Shale. Along with the gas companies comes a sudden influx of employees. This is a challenge due to the numbers of new residents and a cultural shift. In Bradford county one participant shared, "we are expecting a population explosion in this county by the end of the summer. We know that we are going to have eighteen hundred drillers in here by the end of this month and once the schools in Oklahoma close and the families move up we are going to have a real problem. Now we are going to have a cultural shift. They are going to be totally different from us." In small counties the arrival of 1000 to 3000 people all at once can create a real burden on the infrastructure.

II. Strengths and Resources

1. Specific Programs (93% of counties)

Many *specific programs* in every community were mentioned as standing out in serving the public. Several kinds of programs were repeatedly mentioned: early childhood intervention and home visitation programs for new families (the Nurse Family Partnership was mentioned where it exists), Meals on Wheels, YMCAs, and senior centers.

2. Interagency Collaboration (86% of counties)

Many participants discussed variations on the theme of *interagency collaboration*. While the coordination between the medical community and social services may be challenging, the collaboration among social services was commonly mentioned. Especially in the smaller counties, the lack of "turfism" was appreciated. Many of the service providers are lifelong residents of the county and know each other well. People wear many hats and can refer clients in need to the resources in the community. Residents and local providers care a lot about their communities and are working above and beyond to meet needs because of a genuine love of their community (it was frequently pointed out that they aren't being paid very much). The following sentiment was echoed repeatedly across counties: "Notwithstanding all of these challenges and concerns we've just heard. We have wonderful organizations, wonderful people...And there's not a whole lot of turf battles like some counties may suffer from…people really truly worked together as much as possible. We have to. We're all in this together. This is our community, our county. And it's up to us to make a good quality of life out of it."

3. Schools and churches (79% of counties)

Schools and *churches* are pillars of connection in many communities. The wellness programs that are required if schools receive federal monies for free/reduced lunch programs were mentioned as a positive development in many schools. Schools are a center of social life in communities ("I think the schools…forms some kind of mini-communities and it gets people to at least have some kind of interaction… like everybody goes to the [high school] graduation, whether you have children there or not.") They are also increasingly a central place to provide services as a way to overcome the transportation issues in rural counties. Services (probation officers, drug and alcohol counseling, after school programs, safety education, mental health services, and physical health services/clinics) come to the school so students do not need to go to them. As with schools, churches are an important center of community life. They are a big support for many seniors in particular, and provide diverse services (food pantries, programs for youth, homeless shelters/support etc.).

4. Volunteers and Informal Supports (57% of counties)

The work of *volunteers*, and especially senior volunteers, was discussed as an important way that limited resources are stretched to meet needs. Organizations like Kiwanis and the Lions help to fill holes and volunteer EMS services are often doing much for the community both in terms of meeting health needs and in bringing people together for social gatherings. In small communities where "everyone knows each other" there are strong informal supports and much generosity.

5. State Health Improvement Plan (SHIP) partnerships (50% of counties[2])

The work of the *SHIP partnerships* (State Health Improvement Plan) was mentioned in many counties. Some of the counties have extremely active and well respected SHIP partnerships that are seen as having a large and positive impact on the community.

[2] The SHIPs are by definition broad based. If you just look at the counties that had a general, county wide focus group (versus the ones that were population or issue specific), the frequency goes up to 66%.

III. Expectations of The Commonwealth Medical College

1. More Physicians (93% of counties)

When asked what they wanted from the medical college, not surprisingly the most common response was *more physicians in the region*. Participants hope that TCMC will increase the number of physicians in the area in both primary care and specialty care (especially psychiatry and geriatrics). They want physicians who are from here and who represent the diversity of the region. They want TCMC to encourage local students to pursue medicine and to offer regional scholarships.

2. Different kind of Physician (77% of counties)

Participants also want TCMC to train a *different kind of physician*. They want physicians who

1. work well and communicate well with other physicians and with allied health providers
2. have a multicultural perspective and can care for diverse populations
3. have a good bedside manner—communicate well with and empower patients
4. use a medical home model
5. focus on community health as well as individual health
6. understand seniors
7. understand addiction

3. Better regional healthcare (77% of counties)

The focus group participants expect TCMC to work to improve the quality of *healthcare in the region*. They see the medical school as having a role in improving coordination and communication within the healthcare system and in improving access to care (especially for minorities and the uninsured). This role ties in with the desire to have the school personalize healthcare so patients do not feel like a cog in a healthcare factory. They want the school to work to change the culture around healthcare so that more people go to the doctor before the crisis in their health occurs; and they want TCMC to work to improve health and wellness, not just healthcare. They think efforts to start a dental school should be considered.

4. Connection to Community (77% of counties)

Finally, participants want TCMC to continue and expand a *connection to the community*. What this means to them is that the school will collaborate with existing educational and healthcare entities, recognizing the good work that is currently being done by physicians in the region. They want to see students and residents in the community in clinics, hospitals, agencies, and especially to see students get out to the rural communities in this region. Participants would like the presence of the medical school help to break down geographic barriers within the region (e.g. Lackawanna-Luzerne, rural-urban).

DISSEMINATION OF FINDINGS

One of the main goals of this regional health assessment was for TCMC to initiate relationships with the many service providers and citizens of its 16 county service area to begin a conversation about how to improve the health status of the region. To that end, the Community Health Advisory Board (CHAB) has been instrumental in assisting in the initial validation of the focus group data and in suggesting formats and strategies for sharing the findings and for making the data available for others to use. In August 2009, the TCMC health assessment research staff held a meeting with members of the CHAB and presented the preliminary findings. The group thought that the themes identified and the specific examples offered by focus group participants resonated with their own experience as service providers and health advocates. An in-depth discussion of dissemination options resulted in a plan that includes:

- This written preliminary report, which will be sent to all focus group participants, to the TCMC Board of Trustees, to local legislators, and posted on the TCMC website
- A meeting with a local congressman and his staff regarding the findings for counties in his district
- A working meeting in December in which members of the CHAB, the research staff and TCMC leadership will discuss the findings and implications for TCMC's educational, research, clinical, and service activities, and for future partnerships
- A briefing of the TCMC Board of Trustees and legislative staff, also scheduled for December, 2009
- Drafting of county specific and theme specific one-two page briefs for use by community based organizations and agencies in planning health services or writing grant proposals
- A poster presentation at an NIH sponsored conference on health equity (New York Academy of Medicine, October 1-2, 2009)
- Poster and seminar presentations ("Regional Health Assessment in Rural PA-Building Community Partnerships" and "Community Engaged Research: Building Partnerships with Communities in a New Medical School" poster and seminar accepted at annual meeting of Society of Teachers of Family Medicine)
- Drafting of several papers to be submitted to academic journals, once the detailed qualitative analysis is complete.

TCMC's intention is that this health assessment will serve as a beginning of its partnership with communities in Northeast Pennsylvania, in working together toward improved health for NEPA residents and that the data and perspectives that the focus groups participants so generously shared will be accessible to all who wish to use it to build on our understanding of the health of the region.