Geisinger

2024 Community Health Needs Assessment
Geisinger Medical Center
Geisinger Shamokin Area Community Hospital
Geisinger Encompass Health Rehabilitation Hospital

About Geisinger

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

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

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

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

Our goals:

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

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

2024 CHNA Collaborative

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

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

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

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

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

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2024 CHNA Background

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

Advisory Committees

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

CHNA Planning Committee

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

Regional Advisory Committee

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

Our Research Partner

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

2024 CHNA Research Methods

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

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

Secondary Data Analysis

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

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

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

Primary Research and Community Engagement

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

Primary research and community engagement study methods included:

- An online Key Stakeholder Survey completed by 180 individuals serving the Central Region, who represent healthcare providers, social services professionals, educators, faith-based leaders, and community leaders, among others;
- Regional Community Forum bringing together 39 residents and diverse community representatives to review CHNA findings and collectively define challenges and co-develop meaningful strategies for health improvement; and
- Conversations with health system leaders to align community health planning with population health management and community engagement strategies.

Building Health Equity: Context for the Creation of this CHNA

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

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

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

Determining Community Health Priorities

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

Consistent Community Priorities and Contributing Factors

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

Focus on underlying Social Drivers of Health

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

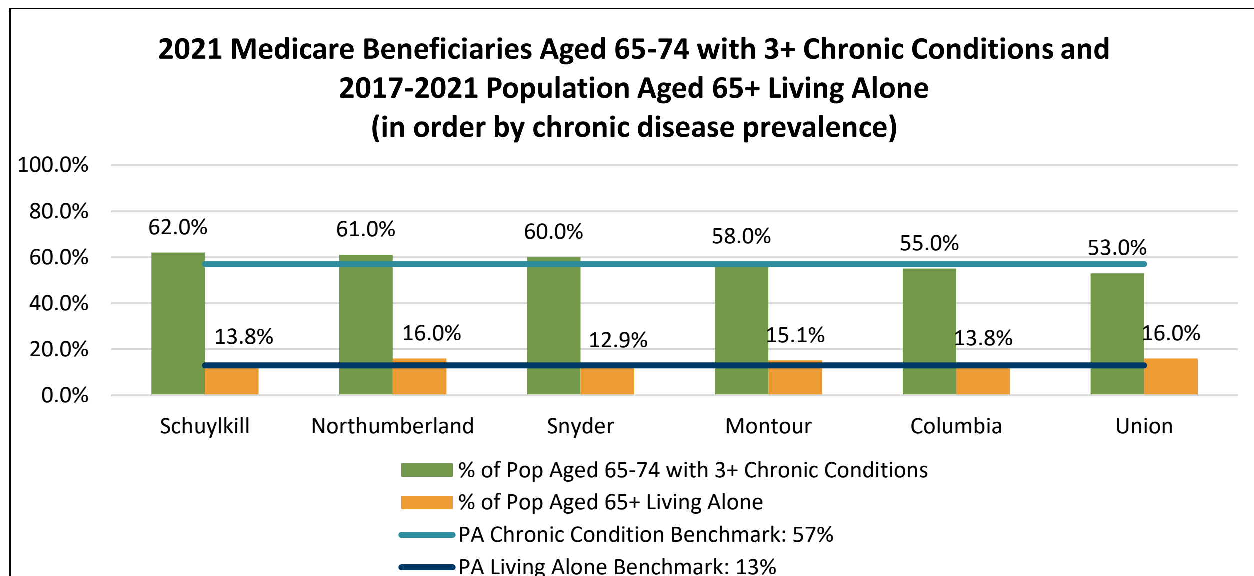
Executive Summary of CHNA Findings

Demographic and Priority Population Trends

The Central Region is comprised of six rural Pennsylvania counties: Columbia, Montour, Northumberland, Schuylkill, Snyder, and Union. The Center for Rural Pennsylvania defines a county as rural when population density, or the number of people per square mile within the county, is fewer than 291. Northumberland and Schuylkill counties are the most population dense (206 and 190, respectively) counties. Other Central Region counties have similar population density of 121 to 142.

Population growth over the past decade was stagnant in Montour and Snyder counties and declined in all other counties. Union County saw the largest population decline of -3.9% from 2010 to 2021. In contrast, the region saw significant growth in older adults. From 2010 to 2021, Snyder, Columbia, and Union counties saw 20%-28% growth in adults aged 65 or older.

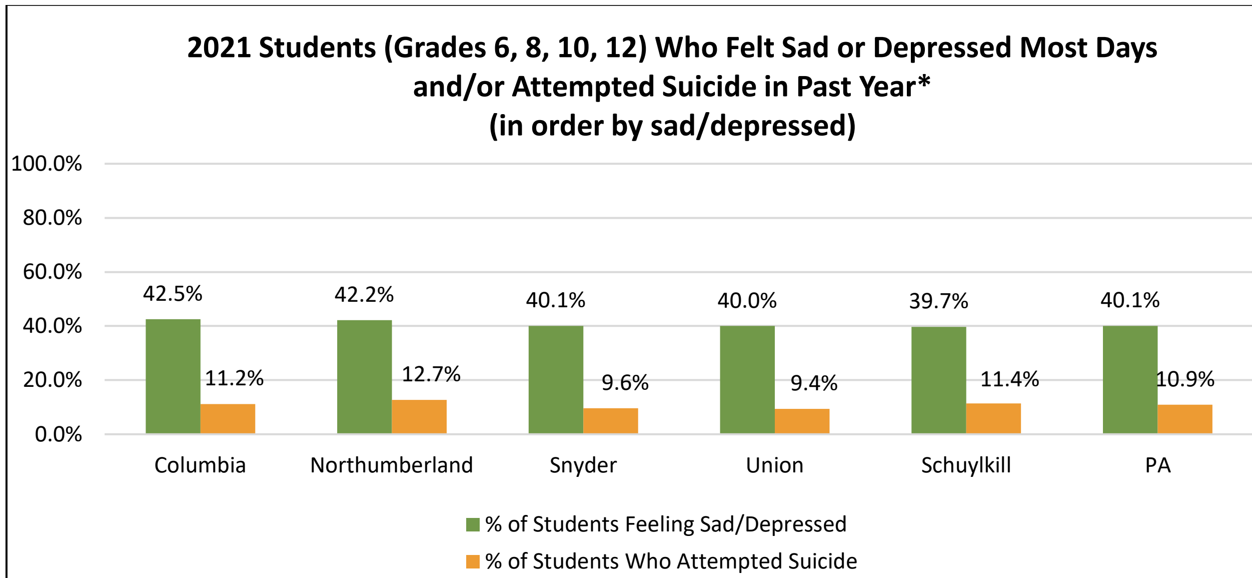
The growth of older adult populations will challenge communities to provide adequate support for aging residents, many of whom live alone and choose to age in place. Consistent with the state overall, approximately 50%-60% of Medicare beneficiaries aged 65-74 residing in the Central Region had three or more chronic conditions in 2021, and disease prevalence increased with older age groups 75+. Within the region, Northumberland County is an area of opportunity for improving older adult health and well-being. Approximately 21% of residents in the county are aged 65 or older, creating demand for services, and 16% of older adults live alone, potentially impeding wellness efforts.



Source: US Census Bureau, American Community Survey & CMS

Central Region counties are aging, but children comprise approximately 1 in 5 residents, reinforcing the potential for upstream, preventive action. Critical to these upstream efforts is addressing social drivers of health (SDoH) barriers that have historically disproportionately affected children. For example, while poverty levels generally declined across the region, approximately 18%-19% of children in Columbia, Schuylkill, and Northumberland counties experience poverty compared to 12%-15% of all residents.

Top health concerns for children in the Central Region, and statewide, include mental health issues. Child mental health was a growing concern before the pandemic, and the region continues to see a high, and often increasing, proportion of children who report poor mental health. Among counties with reportable data, approximately 2 in 5 students reported feeling consistently sad or depressed in 2021 and 1 in 10 students reported an attempted suicide.

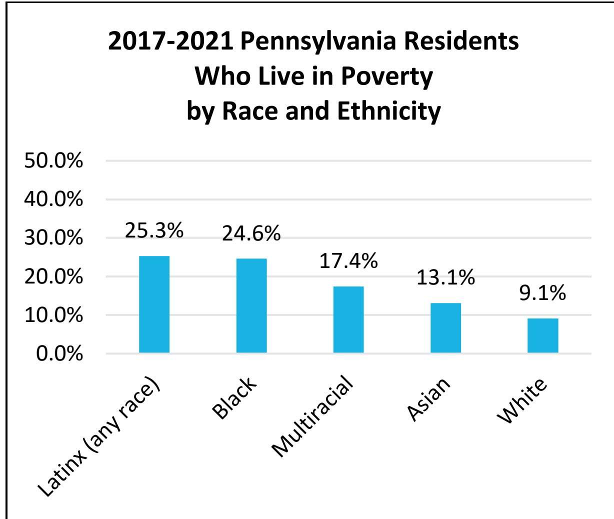


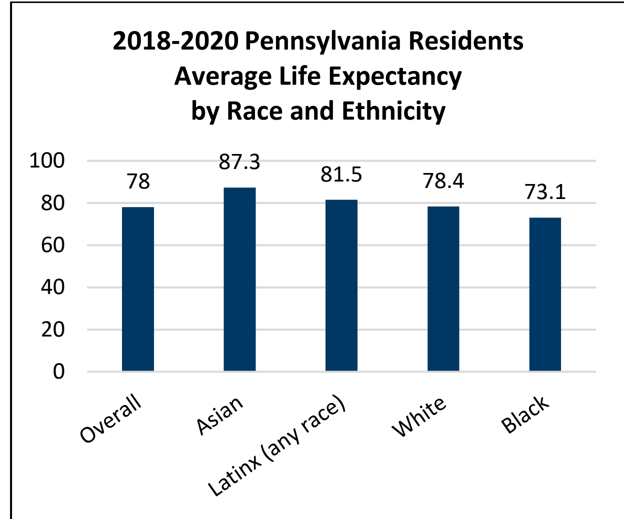
Source: Pennsylvania Youth Survey *Data are reported by county as available.

Commitment to school can be a protective factor for youth, reducing the likeliness of health concerns. School commitment indicators, like how important students feel school is to later life or how much they enjoy the experience, were declining even before the pandemic. Statewide, the percentage of youth who “feel school is going to be important for their later life” declined from 57.5% in 2017 to 41.8% in 2021. In the Central Region, Northumberland County students were the most likely to report an attempted suicide (13%) and were among the least likely to feel school is important (42%) or that they enjoy school (36%). Creating opportunities for youth engagement in schools and other settings and fostering future orientation is essential to improving their overall health and well-being.

The Central Region is a majority white community, but consistent with state and national trends, people of color are the only growing populations. This demographic shift is slow across counties, accounting for a 1-4 percentage point change over the last decade. Growth among populations of color was most evident for individuals who identify as multiracial and/or Latinx.

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





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

Social Drivers of Health Opportunities

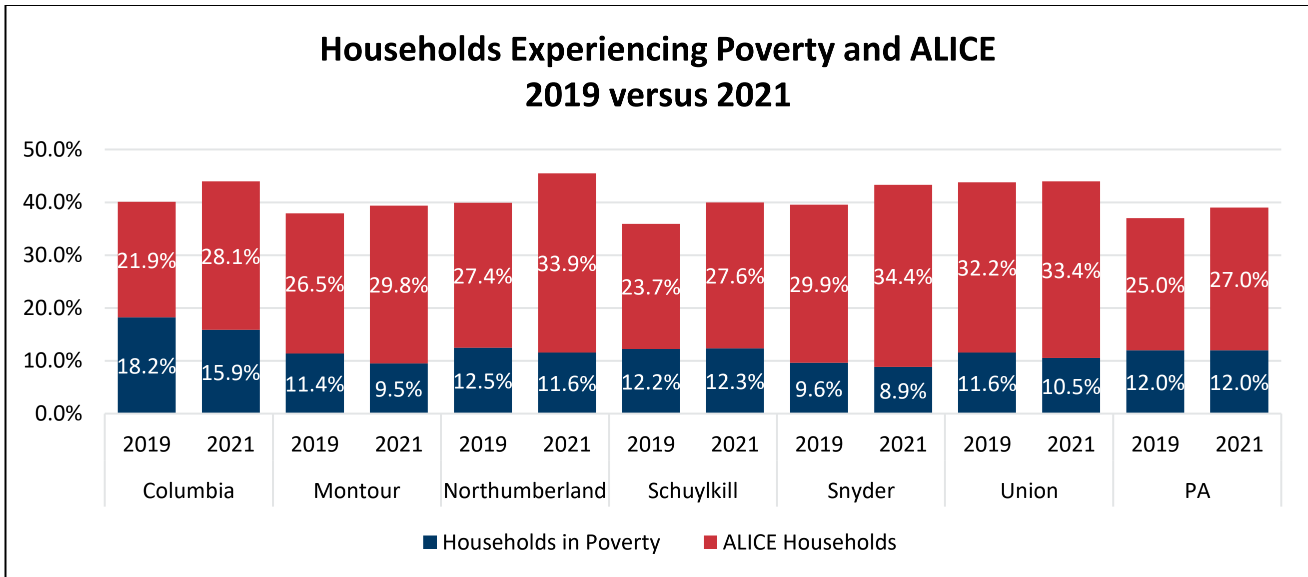
As part of the Key Stakeholder Survey, respondents were asked to share the top five priorities that their community should address to improve health and well-being of the populations they serve. While most respondents selected mental health conditions, the majority of the top five identified priorities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

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

Top Five Priority Responses	Percent of Responses
Mental health conditions	60.5%
Lack of transportation	46.1%
Housing (affordable, quality)	35.9%
Substance use disorder	35.3%
Childcare (affordable, quality)	34.7%

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

The opportunity to address financial hardship for ALICE households is demonstrated in Northumberland County. In 2021, 34% of Northumberland County households were ALICE, a nearly 7-point increase from 2019. Northumberland County households also struggled with basic needs like housing and childcare. Despite lower housing costs, 21.5% of homeowners and 42% of renters were cost burdened, spending 30% or more of their income on housing-related expenses. For households with children, the average cost of childcare for two children was 27% of median household income.



Source: United for ALICE

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

The Unmet Need Score (UNS) is a measure of access to primary and preventive healthcare services based on disparities in health status and SDoH. Scores range from 0 (least unmet need) to 100 (most unmet need). Central Region counties have similarly high UNSs of 61-65. When analyzed by zip code, these scores increase to 80-96 in select communities shown in the table below, indicating significant unmet need and disparities in health and well-being.

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

Relative to the hospital primary service areas, communities like Ashland, Coal Township, Mahanoy City, Mount Carmel, Pottsville, Shenandoah, and Sunbury in Northumberland and Schuylkill counties experience high social vulnerability and residents may live 72 years or less, as much as a 10-year difference compared to surrounding communities. The maps below display the SVI and average life expectancy by census tract within the hospital primary service areas.

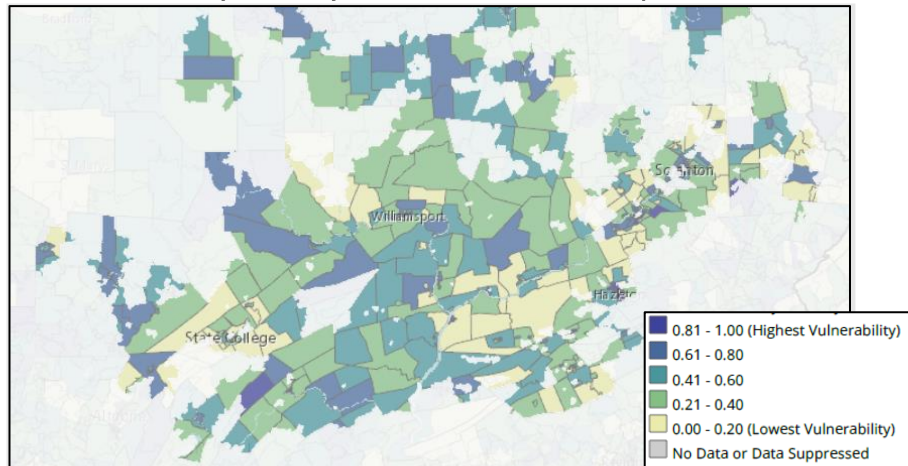
The hospitals largely serve the Central Region, but the combined primary service area spans communities across all CHNA study regions. Areas of social vulnerability within the service area are consistent with areas identified for other Geisinger hospitals, including Williamsport in the North Central Region and Hazleton, Scranton, and Wilkes-Barre in the Northeast Region.

2017-2021 Social Drivers of Health for Central Region Zip Codes with HRSA Unmet Need Score >80 out of 100

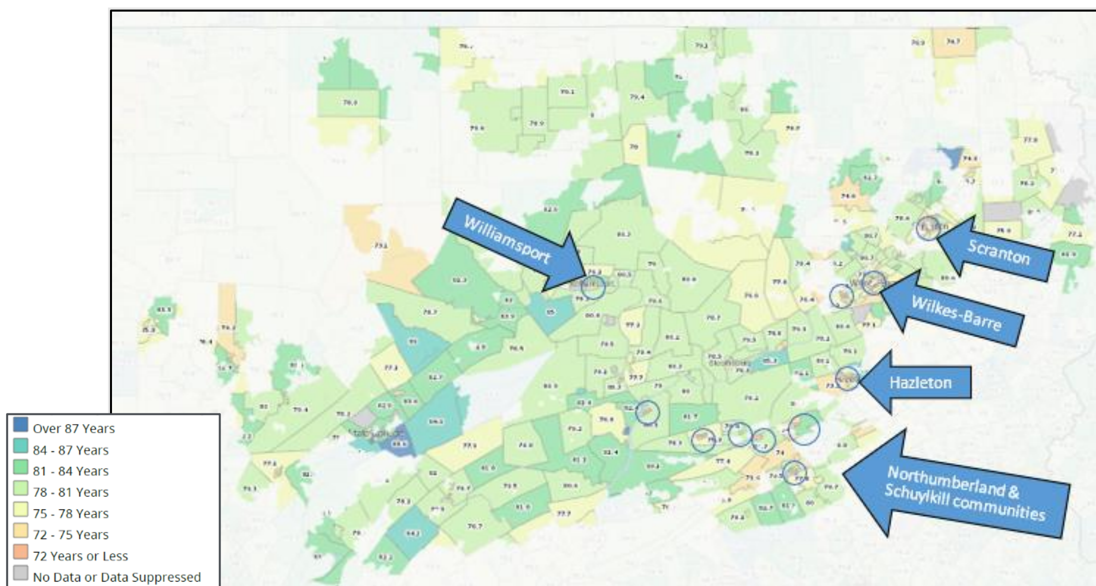
Zip Code (County)	Population in Poverty	Children in Poverty	No High School Diploma	No Health Insurance	UNS Score
17948, Mahanoy (Schuylkill)	27.9%	37.4%	10.8%	12.4%	95.7
17935, Girardville (Schuylkill)	26.1%	55.5%	15.8%	15.3%	87.7
17976, Shenandoah (Schuylkill)	29.1%	54.4%	15.8%	9.4%	86.7
17954, Minersville (Schuylkill)	24.3%	43.6%	12.0%	8.2%	83.4
17864, Port Trevorton (Snyder)	13.0%	23.3%	36.6%	39.9%	82.2
17810, Allenwood (Union)	36.6%	46.6%	16.1%	34.5%	81.4
17813, Beavertown (Snyder)	11.8%	22.4%	12.9%	11.9%	81.2
Pennsylvania	11.8%	16.4%	8.6%	5.6%	NA

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

Social Vulnerability Index by Census Tract within Hospital Service Areas



2010-2015 Life Expectancy by Census Tract within Hospital Service Areas*



*Highlighted communities have an average life expectancy of 72 years or less.

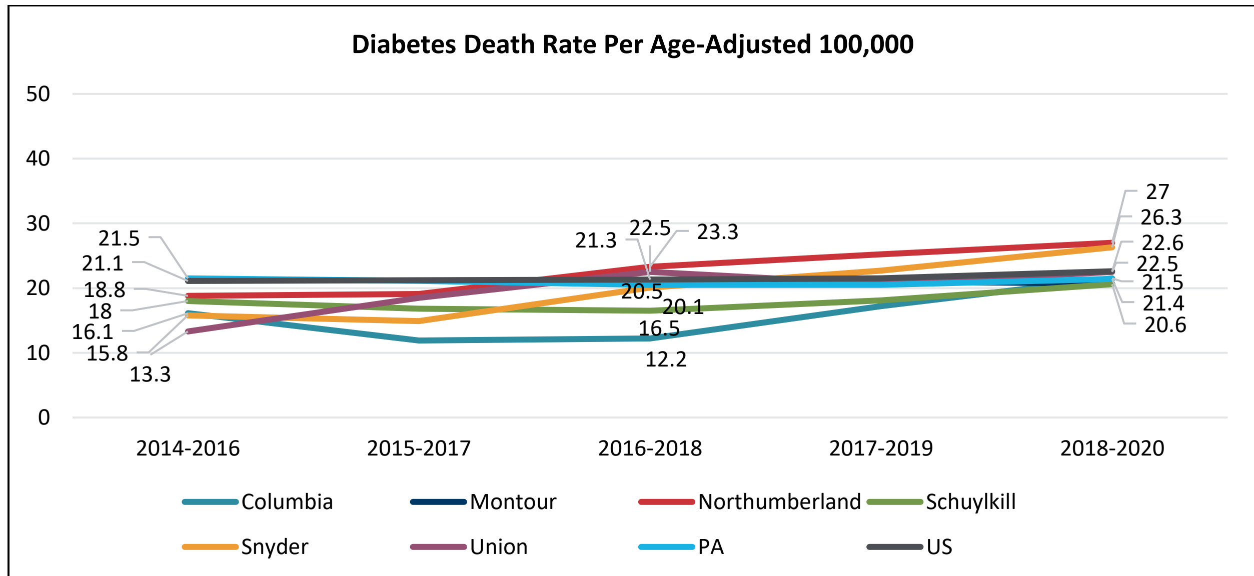
Priority Health Needs

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

Chronic conditions are the leading causes of morbidity and mortality statewide and nationally. In the Central Region, disease prevalence is generally comparable to state and national trends, but death rates due to conditions like heart disease, diabetes, and lower respiratory disease are disproportionately higher in Northumberland and Schuylkill counties. These findings are consistent with SDoH barriers experienced by residents of these communities.

Diabetes is among the fastest growing chronic conditions nationally, as well as one of the most expensive conditions to treat. Consistent with the state and nation, approximately 1 in 10 Central Region adults have been diagnosed with diabetes, and prevalence has increased.

Diabetes death rates also increased across the region, demonstrating access to care barriers. While the number of residents without health insurance declined and a similarly high percentage of adults report having an annual physical checkup (~75%), these factors alone do not ensure access to comprehensive healthcare when it is needed. Many other factors—like affordability, transportation, language, provider availability, and trust—can keep people from receiving the care they need.



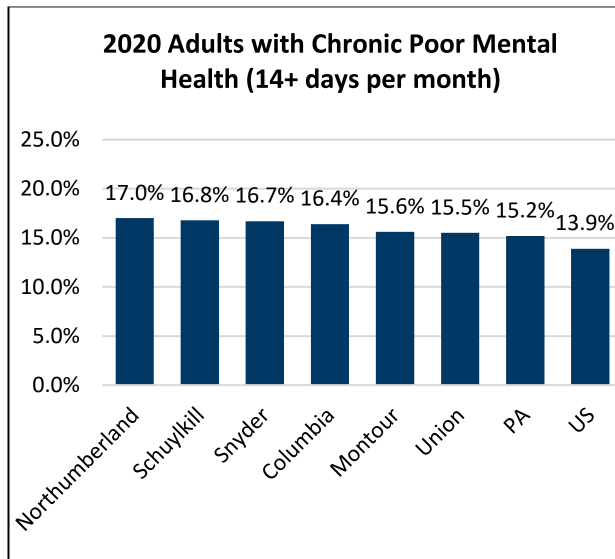
Source: Centers for Disease Control and Prevention

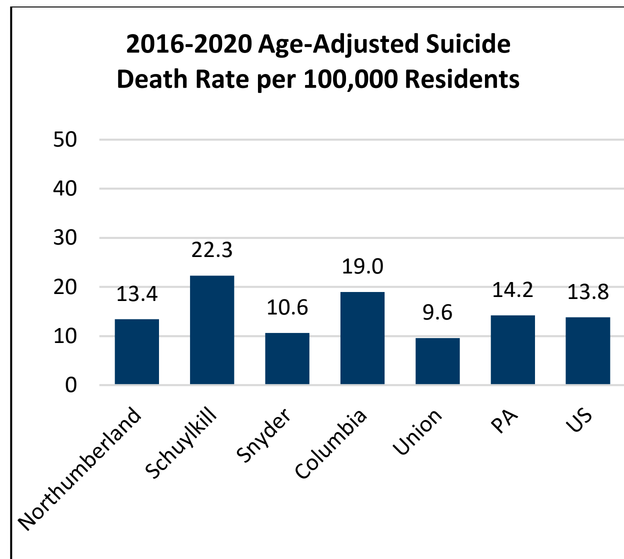
Note: Montour County data are not trended due to missing data (2018-2020 death rate = 20.7).

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

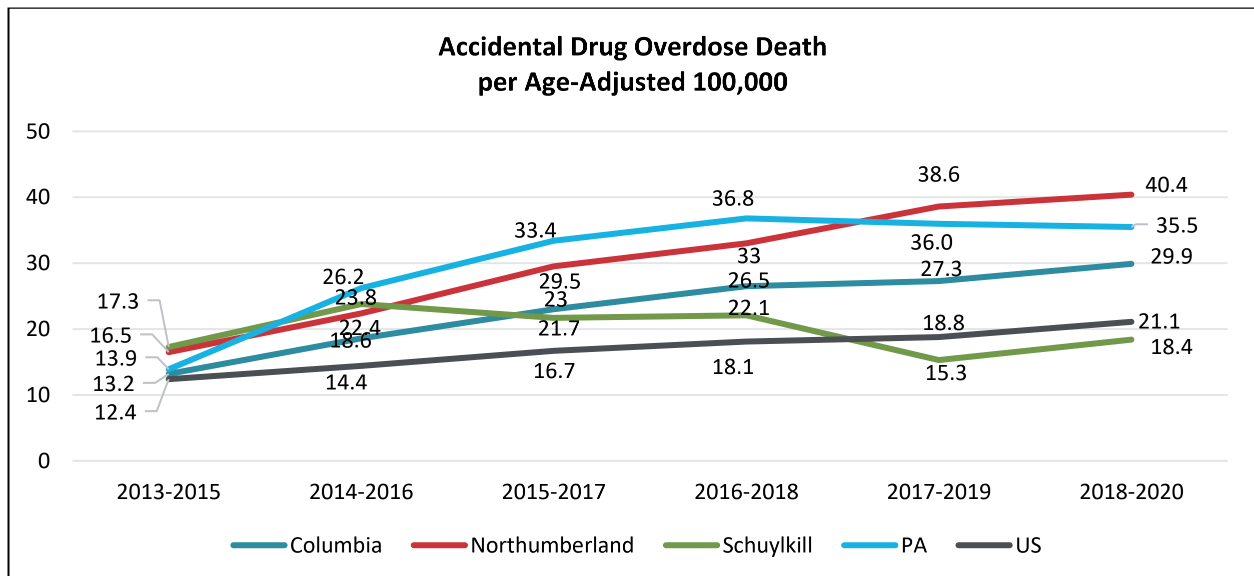
Opioid overdose hospitalizations generally declined, but accidental overdose deaths remain high and increased in Columbia and Northumberland counties. The use of amphetamines should also continue to be monitored within the region. Contrary to statewide trends, the rate of amphetamine use disorder hospitalizations in 2019 in Columbia, Montour, and Schuylkill counties outpaced those for opioids.

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





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



Source: Centers for Disease Control and Prevention
Note: Data are not reported for Montour, Snyder, and Union counties due to low counts.

Recommendations to Improve Health

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

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

Health Improvement Themes and Supporting Feeback by Community Representatives

Themes	Verbatim Comments by Community Representatives
Support multi-sector collaboration for better communication and non-competitive partnership, and to affect policy and funding	*"Connect with nontraditional service providers like community centers, senior centers. Advocate at the state and federal level for funding for sex education, and family resources as health care."* *"Perhaps a community collaboration committee that consists of Geisinger leadership and community-based organizations. This would allow for better conversations, collaboration, and ensure that everyone is working toward the same health outcomes."*
Go beyond addressing the immediate need, invest in upstream factors	*"The partnership at the Miller Center is a prime example of successful efforts to address Social Drivers of Health by collaborating on healthy food initiatives to ensure no one goes hungry."*
Bring services to the community, integrate/co-locate where residents naturally frequent	*"Bring health and wellness programs into the communities via church groups, schools and community centers to offer help in a neutral space – not clinic/doctor office."*
Address cultural biases with staff training	*"Relate to a variety of ethnic and cultural differences; provide public health screenings targeted to minorities, immigrants and refugees; help people navigate difficult and confusing public systems to qualify for assistance and healthcare; get out into the community – community health workers."* *"Keep resource lists for LGBTQ+ people of all ages, and their families and keep them updated. Make it easy for people to search and find gender affirmative care. Work with LGBTQ+ groups, family groups such as PFLAG and Trans Central PA. Make medical record gender affirming."*

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

Themes	Verbatim Comments by Community Representatives
Invest in supports for those historically placed at risk (youth, seniors, ALICE, etc.)	*"People with disabilities live in poverty due to the structure of the Medicaid SSI system. Our community offers no further education opportunities after High School to our population. Societal stigmas are a major community barrier for people with disabilities. Transportation continues to be a HUGE barrier for this population that most do not or are not able to drive. Distance to healthcare, options for specialists, medical community stigmas about the quality of life for people with disabilities and offering care based on that stigma."* *"Poverty is a cycle. Many of the young people I work with come from poverty and are desperately trying to get out. The odds are usually against them. Many lack family stability and support at home, especially when it comes to education. Without proper education, participants are left working entry-level jobs, struggling to make ends meet, and relying on assistance programs in order to survive; therefore, making it extremely difficult to end the cycle of poverty."*

Approval and Adoption of CHNA

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

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

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

A full summary of CHNA data findings for the Central Region and collective service areas for Geisinger Medical Center, Geisinger Shamokin Area Community Hospital, and Geisinger Encompass Health Rehabilitation Hospital service areas, with state and national comparisons, follows.

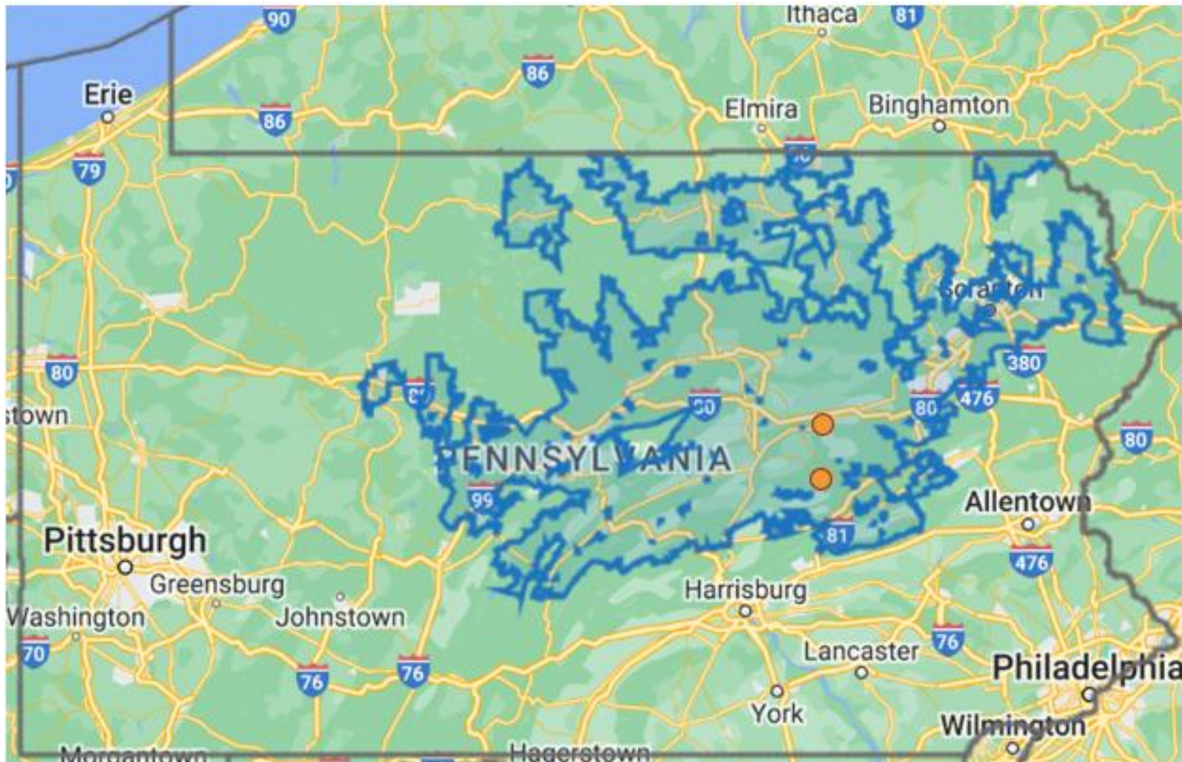
Geisinger Medical Center, Geisinger Shamokin Area Community Hospital, and Encompass Health Rehabilitation Hospital Service Area

Geisinger Medical Center (GMC) and Geisinger Shamokin Area Community Hospital (GSACH) operate under the same license, and as such are considered a single entity for purposes of the CHNA. Geisinger Encompass Health Rehabilitation Hospital is located on the campus of GMC and is operated as a partnership between GMC and Encompass Health Corporation. Collectively, the three hospitals have a primary service area comprising 173 zip codes across Pennsylvania. The service area was identified based on the patient zip codes of origin comprising 90% or more of hospital discharges in 2021.

GMC and Geisinger Encompass Health are located in Danville, Montour County. Danville is situated on the North Branch of the Susquehanna River. Conveniently located within Central Pennsylvania, Danville Borough describes itself as offering endless opportunities for outdoor recreation, shopping, entertainment, education, and for creating a life that's all your own. GMC and its affiliated institutions are one of the largest employers in the region.

GSACH is located in Coal Township, Northumberland County, just outside the City of Shamokin. Coal Township was established from the original Township of Coal which included all coal lands in Northumberland County. Shamokin was once the most populous area and the largest trading center within a 60-mile radius.

Collective Hospital Service Areas and Locations



Social Drivers of Health & Health Equity:
Where we live impacts the choices available to us

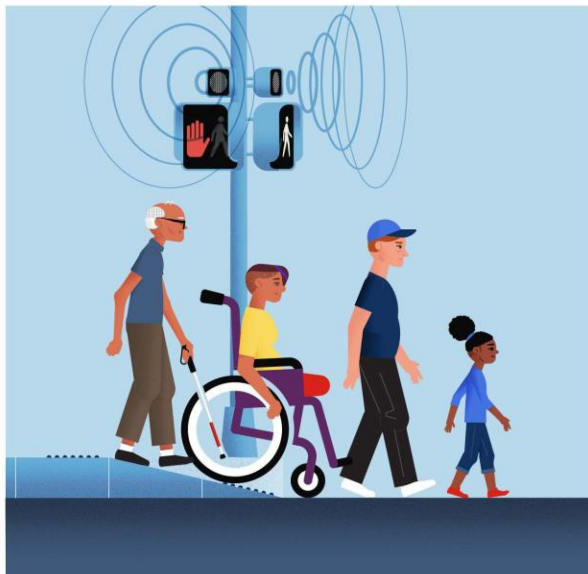
Social drivers of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health risks and outcomes. Healthy People 2030, the nation's benchmark for health, recognizes SDoH as central to its framework, naming "social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

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

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

EQUALITY:
Everyone gets the same – regardless if it's needed or right for them.

EQUITY:
Everyone gets what they need – understanding the barriers, circumstances, and conditions.



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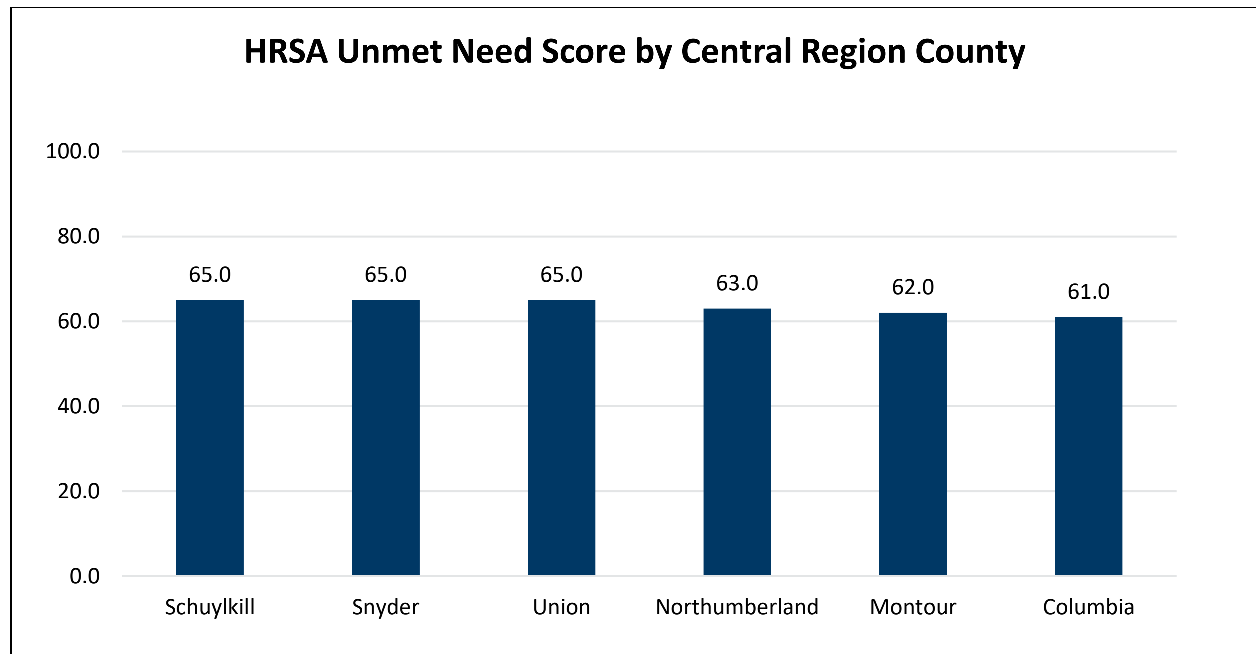
A host of indexes and tools are available to illustrate the potential for health disparities and inequities at the community-level based on SDoH. A description of each index is provided below followed by data visualizations of each tool that show how well the hospital service areas fare compared to state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

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

Unmet Need Score and Social Vulnerability Index

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

Central Region counties have similarly high unmet need scores of 61-65. This finding is reflective of both upstream social drivers of health like availability of care providers, educational attainment, and transportation, and downstream health outcomes like chronic disease prevalence and overall life expectancy. **Residents of Northumberland and Schuylkill counties have historically experienced more social drivers of health barriers and have the lowest overall life expectancy within the region of 75-76 years, a 3–7-year difference from surrounding counties.**



Source: Health Resources and Services Administration

2018-2020 Life Expectancy by Race and Ethnicity

	Overall Life Expectancy	Asian	Black	White	Latinx Origin (any race)
Columbia	78.3	NA	NA	78.3	88.7
Montour	78.0	NA	NA	NA	NA
Northumberland	76.1	NA	72.2	76.2	78.8
Schuylkill	75.0	NA	71.8	74.7	104.7
Snyder	80.8	NA	NA	NA	NA
Union	82.1	NA	86.3	81.4	97.0
Pennsylvania	78.0	87.3	73.1	78.4	81.5

Source: National Vital Statistics System

When analyzed by zip code, areas within the Central Region with an UNS of 75 or higher, indicating more unmet need, are predominantly in Northumberland and Schuylkill counties. **Notably, the communities of Mahanoy City, Girardville, and Shenandoah in Schuylkill County have UNSs exceeding 85 out of a maximum score of 100.** Residents of these communities, as demonstrated throughout this report, experience more poverty, receive fewer preventive care services, and experience more negative physical and mental health outcomes. While areas underserved by primary and preventive healthcare are concentrated in Northumberland and Schuylkill counties, it is also worth noting disparities affecting Snyder and Union county communities, noted in the table below.

2017-2021 Social Drivers of Health for Central Region Zip Codes with Unmet Need Score of >75 out of 100 in Descending Order by Unmet Need Score

Zip Code (County)	Population in Poverty	Children in Poverty	No High School Diploma	No Health Insurance	UNS Score
17948, Mahanoy City (Schuylkill)	27.9%	37.4%	10.8%	12.4%	95.7
17935, Girardville (Schuylkill)	26.1%	55.5%	15.8%	15.3%	87.7
17976, Shenandoah (Schuylkill)	29.1%	54.4%	15.8%	9.4%	86.7
17954, Minersville (Schuylkill)	24.3%	43.6%	12.0%	8.2%	83.4
17864, Port Trevorton (Snyder)	13.0%	23.3%	36.6%	39.9%	82.2
17810, Allenwood (Union)	36.6%	46.6%	16.1%	34.5%	81.4
17813, Beavertown (Snyder)	11.8%	22.4%	12.9%	11.9%	81.2
17886, West Milton (Union)	49.4%	78.5%	12.4%	35.4%	79.8
17845, Millmont City (Union)	16.3%	29.6%	23.1%	25.4%	79.6
17853, Mount Pleasant Mills (Snyder)	4.6%	8.9%	17.9%	13.5%	78.6
17851, Mount Carmel (Northumberland)	17.3%	35.6%	12.9%	3.9%	78.3
17872, Shamokin (Northumberland)	27.4%	46.4%	15.2%	3.6%	77.4
17964, Pitman (Schuylkill)	10.1%	10.5%	19.9%	14.5%	77.1
17901, Pottsville (Schuylkill)	15.9%	20.9%	9.9%	5.5%	76.9
17801, Sunbury (Northumberland)	13.4%	16.1%	9.5%	4.0%	76.5
17981, Tremont (Schuylkill)	9.5%	8.9%	14.9%	6.4%	75.7
17866, Coal Township (Northumberland)	10.6%	5.1%	15.4%	3.5%	75.1
Pennsylvania	11.8%	16.4%	8.6%	5.6%	NA

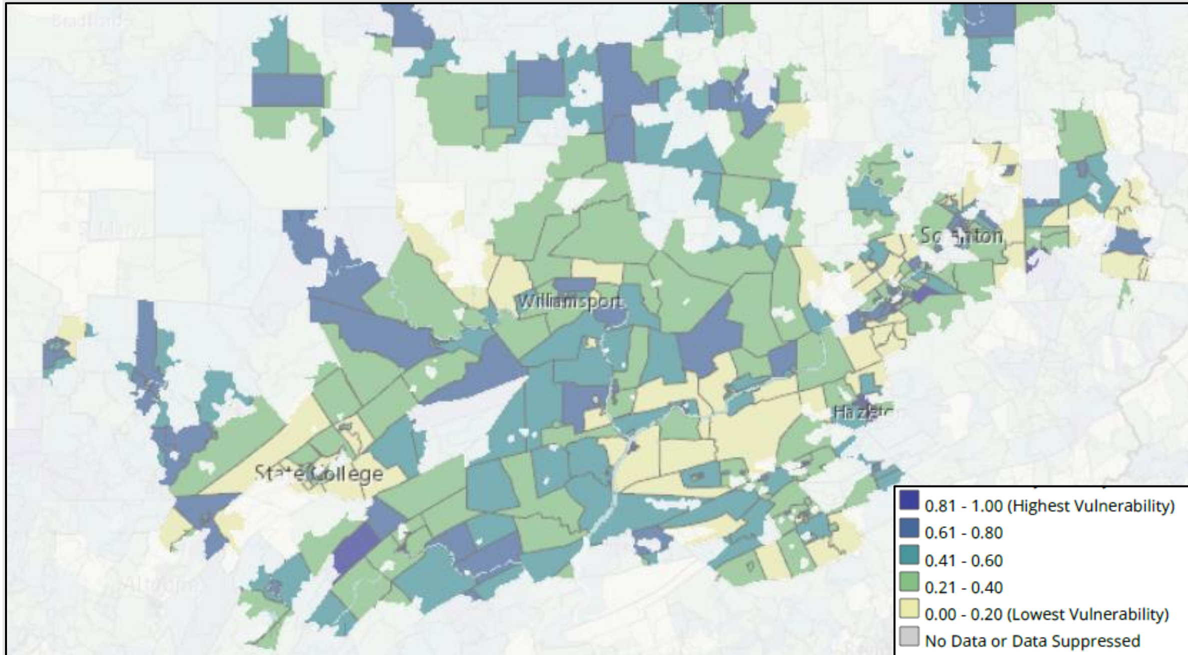
Source: US Census Bureau, American Community Survey

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

The hospitals largely serve the Central Region, but the combined primary service area spans communities across all CHNA study regions. Areas of social vulnerability within the primary service area are consistent with areas identified for other Geisinger hospitals and are associated with significant health disparities. Many areas of vulnerability are located within Northumberland and Schuylkill counties, including Ashland, Coal Township, Mahanoy City, Mount Carmel, Pottsville, Shenandoah, and

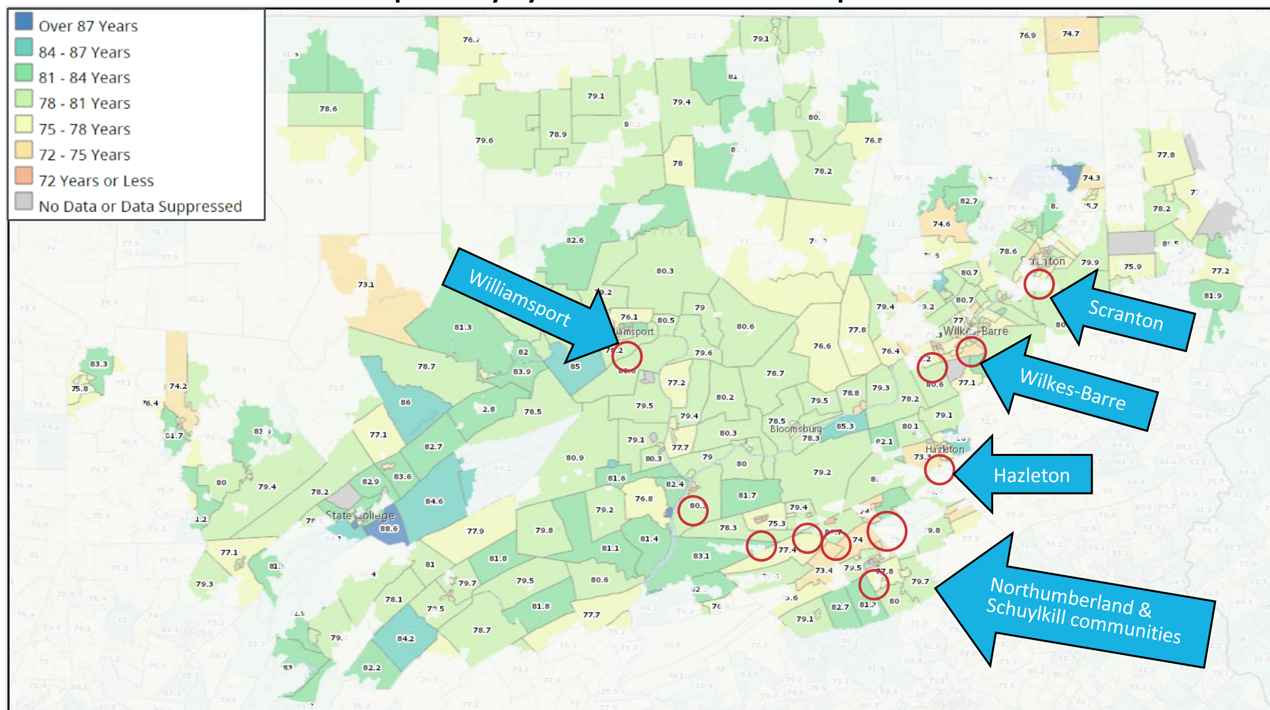
Sunbury. Others are in Northeast Region urban areas, including Hazleton, Scranton, and Wilkes-Barre. Within these communities, residents may live 72 years or less.

Social Vulnerability Index by Census Tract within Hospital Service Areas



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

2010-2015 Life Expectancy by Census Tract within Hospital Service Areas*



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

*Residents of communities highlighted in red have an average life expectancy of 72 years or less.

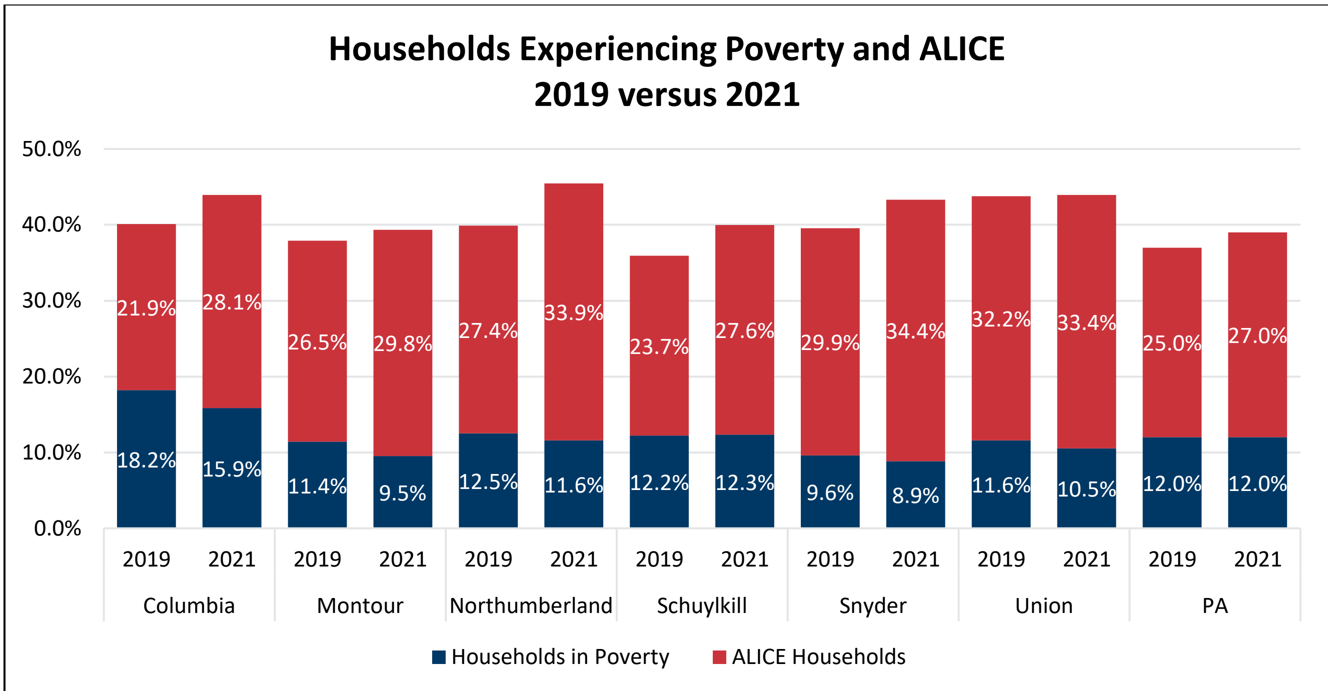
Asset Limited Income Constrained Employed (ALICE)

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

Across Central Region counties in 2021, at least one-quarter of households were ALICE. **In Northumberland, Snyder, and Union counties, more than one-third of households were ALICE; when combined with households living in poverty, nearly half of all households in these counties may have experienced financial hardship.**

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

The percentage of people in the region experiencing poverty continued to slowly decrease, but ALICE households increased, as people's personal financial statuses experienced little change, or returned to pre-pandemic statuses, but the world around them grew more expensive. **In Columbia and Northumberland counties, the proportion of ALICE households increased more than 6 percentage points from 2019 to 2021.** People's *experience* of financial hardship feels more acute than ever.



Source: United for ALICE

Geisinger Urgent Social Needs Screening

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

The following table provides a summary of urgent social needs screening results for Geisinger patients residing in the Central Region. **It is worth noting consistent food insecurity concerns among adults in nearly every county, and the need for clothing affecting approximately 1 in 10 households with children in all counties.** It is also worth noting the need for childcare services among older adults in Snyder and Union counties. Snyder and Union counties have the lowest availability of childcare services in the region, based on the rate of childcare centers per 1,000 children under the age of 5, and this identified need may speak to the use of grandparents and other elders as caregivers, beyond their capacity.

Geisinger Universal Health Risk Assessment Central Region Patient Results

Top Identified Social Needs	Columbia	Montour	Northum berland	Schuylkill	Snyder	Union
Top Need (All Adults)	Food Worry (6.5%, n=547)	Food Worry (4.3%, n=128)	Food Worry (5.4%, n=980)	Employment (5.2%, n=960)	Food Worry (4.9%, n=296)	Employment (3.8%, n=211)
Adults aged 18-64	Food Worry (7.9%, n=501)	Food Worry (5.5%, n=117)	Employment (7.5%, n=904)	Employment (7%, n=911)	Food Worry (7.4%, n=257)	Employment (5.4%, n=197)
Adults aged 65 or older	Transportation (3.5%, n=71)	Clothing (3.4%, n=29)	Clothing (3.1%, n=191)	Clothing (2.5%, n=136)	Childcare (2.3%, n=60)	Childcare (2.1%, n=41)
Top Need (All Households)	Clothing (12.5%, n=188)	Clothing (11.5%, n=194)	Clothing (11.9%, n=773)	Clothing (7.7%, n=256)	Clothing (11.4%, n=220)	Clothing (10.6%, n=233)
Households with children under 18 years	Clothing (12.4%, n=182)	Clothing (11.3%, n=188)	Clothing (11.8%, n=759)	Clothing (7.7%, n=251)	Clothing (11.4%, n=220)	Clothing (10.6%, n=233)

Source: Geisinger Universal Health Risk Assessment, Oct .1, 2022 to Jul. 31, 2023

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

Demographics: Who Lives in the Central Region?

Our Community and Residents

Consistent with Pennsylvania overall, the Central Region is aging, with a significant increase in the number of older adults from 2010 to 2021 in all counties. In contrast, the youth population declined across all counties by an average of approximately 7% from 2010 to 2021. Montour and Snyder counties were the only counties to see population growth, although growth was modest at an estimated <2%.

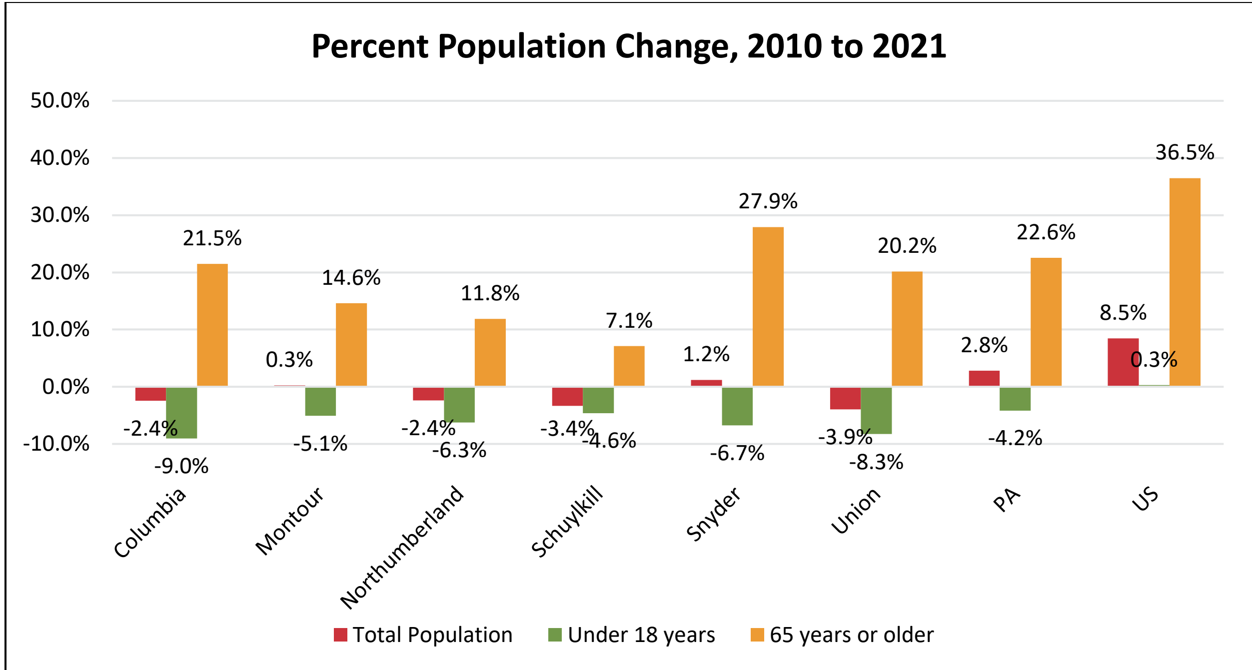
Montour, Northumberland, and Schuylkill are among the oldest counties in the region; approximately one in five residents are aged 65 or older and median ages are nearly three years older than the state median. **It is worth noting that the population of residents aged 65 or older outpaces the national estimate of 16% in nearly all zip codes across the region.**

Central Region Communities

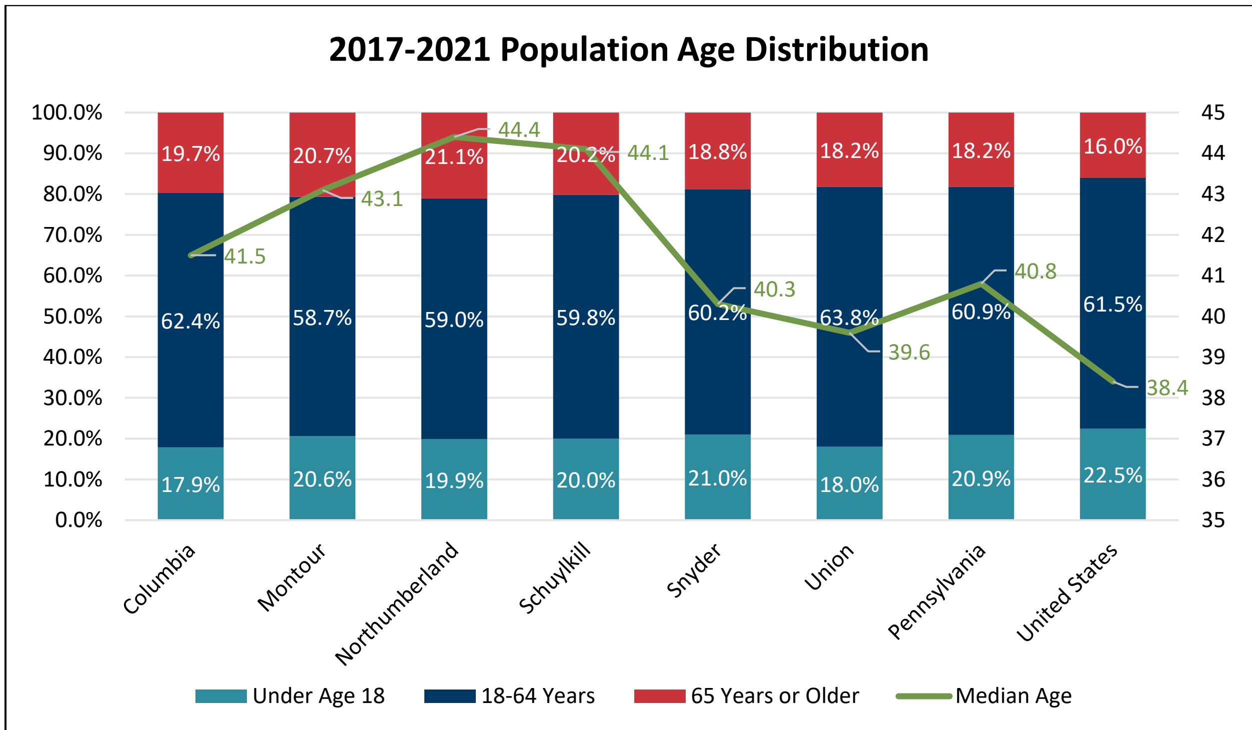
2017-2021 Total Population

	Total Population
Columbia	65,013
Montour	18,198
Northumberland	91,853
Schuylkill	143,308
Snyder	39,877
Union	43,094
Pennsylvania	12,970,650
United States	329,725,481

Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

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

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

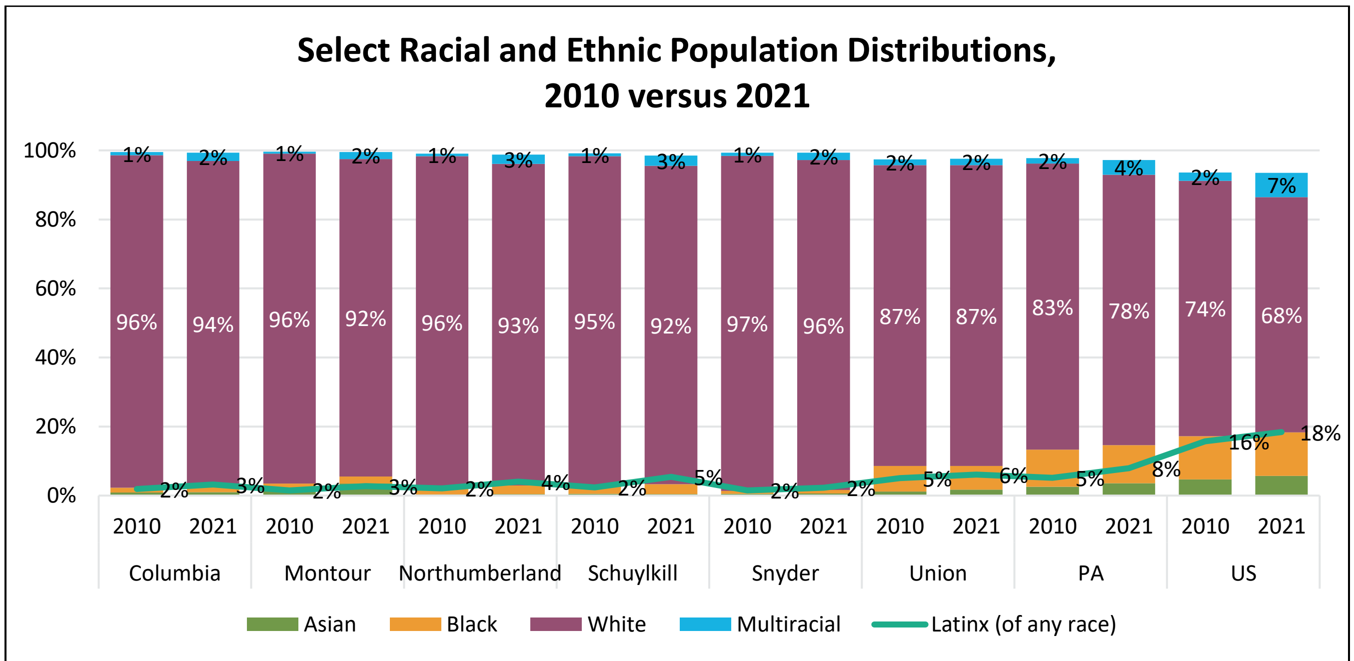
Central Region counties are majority white communities with less racial diversity than state and national benchmarks. Union County benefits from the most population diversity with 13% of residents identifying with a race other than white and 6% identifying as Latinx (any race). **Union County is home to the Lewisburg Penitentiary, a federal facility with an estimated inmate population of 1,284. Population diversity and socioeconomic disparities between racial groups in Union County reflect, in part, deeper institutional inequities.** Available data provided by The Sentencing Project reveal that Black Americans are imprisoned at a rate that is roughly five times the rate of white Americans. Latinx individuals are incarcerated in state prisons at a rate that is 1.3 times the incarceration rate of whites.

Consistent with state and national trends, population diversity is increasing within the region, though only marginally. Montour County experienced a four-percentage point decline in the white population from 2010 to 2021, the largest of any county in the region.

2017-2021 Population by Race and Ethnicity

	American Indian / Alaska Native	Asian	Black or African American	Native Hawaiian / Pacific Islander	White	Other Race	Two or More Races	Latinx Origin (any race)
Columbia	0.0%	1.0%	1.7%	0.3%	94.2%	0.4%	2.4%	3.2%
Montour	0.1%	3.5%	2.0%	0.0%	92.0%	0.4%	2.0%	2.7%
Northumberland	0.1%	0.4%	2.5%	0.0%	93.2%	1.2%	2.7%	4.0%
Schuylkill	0.1%	0.4%	2.9%	0.0%	92.2%	1.2%	3.0%	5.4%
Snyder	0.0%	0.6%	1.0%	0.0%	95.6%	0.7%	2.1%	2.3%
Union	0.3%	1.7%	6.9%	0.0%	87.1%	2.1%	1.9%	6.1%
Pennsylvania	0.2%	3.6%	11.0%	0.0%	78.3%	2.7%	4.3%	7.9%
United States	0.8%	5.7%	12.6%	0.2%	68.2%	5.6%	7.0%	18.4%

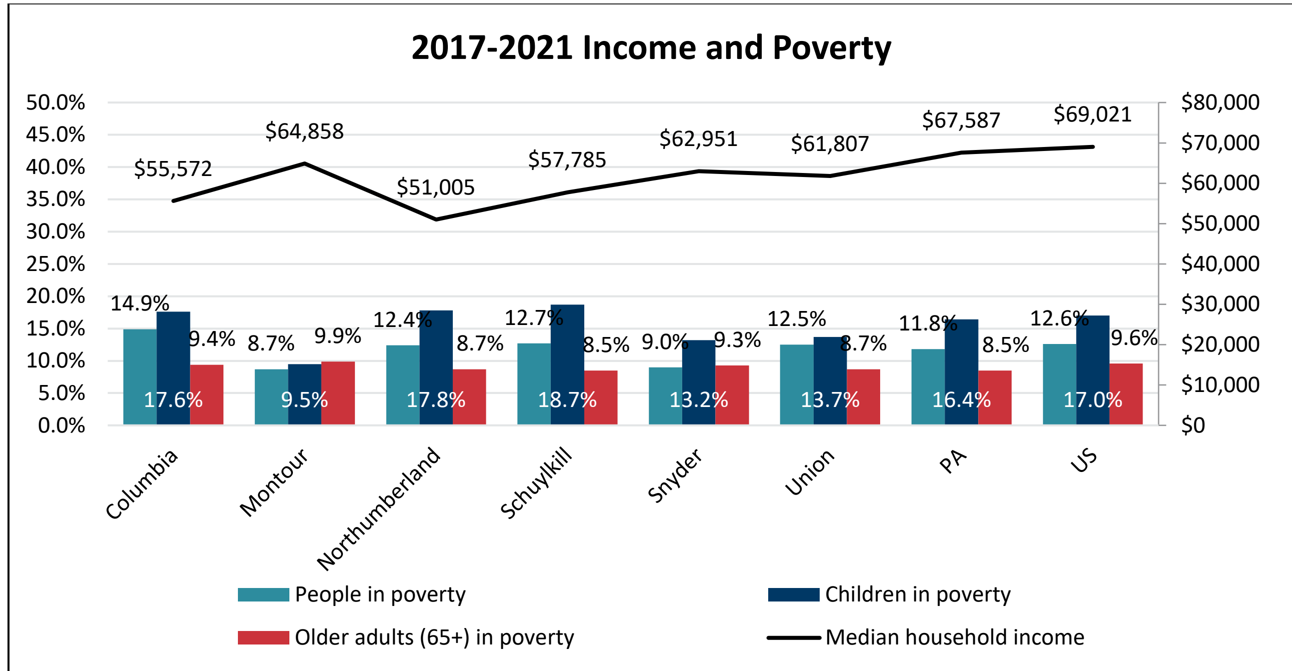
Source: US Census Bureau, American Community Survey



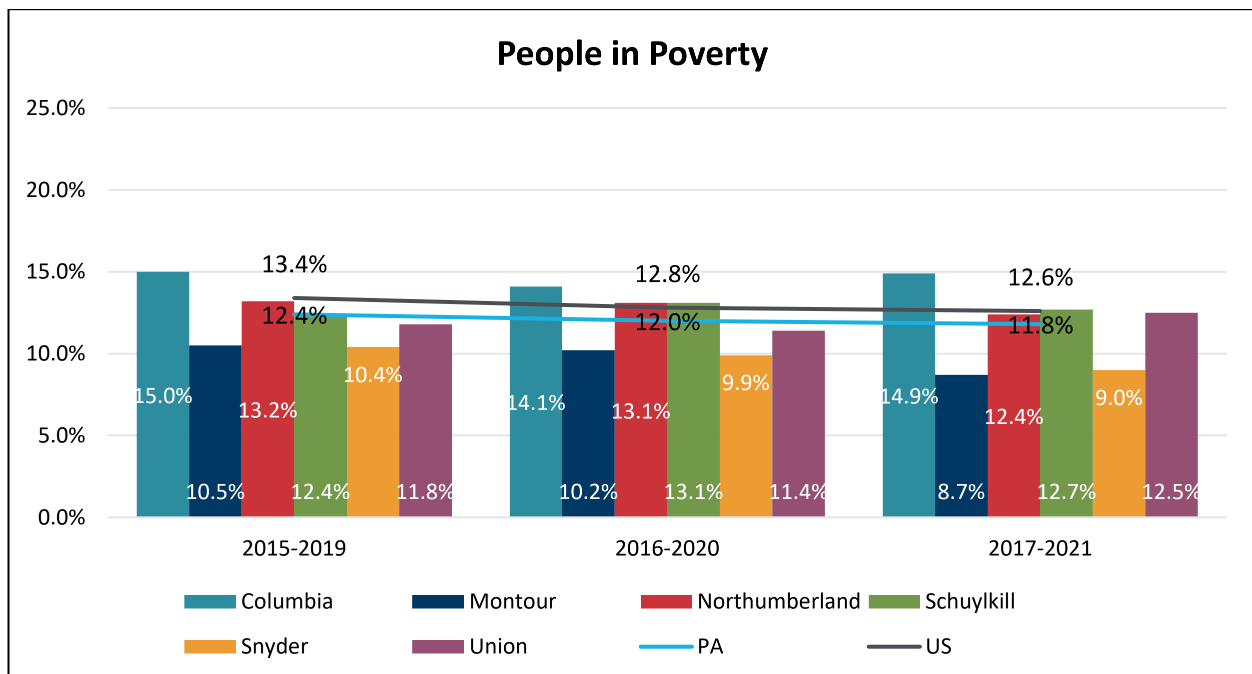
Source: US Census Bureau, American Community Survey

Income and Work

All Central Region counties have lower median household incomes than state and national medians, although county-wide poverty levels are only elevated in Columbia (15% compared to 12% and 13% respectively). **Columbia and Schuylkill counties have the highest percentages of children in poverty, outpacing the state and the nation, at 18% and 19% respectively.**

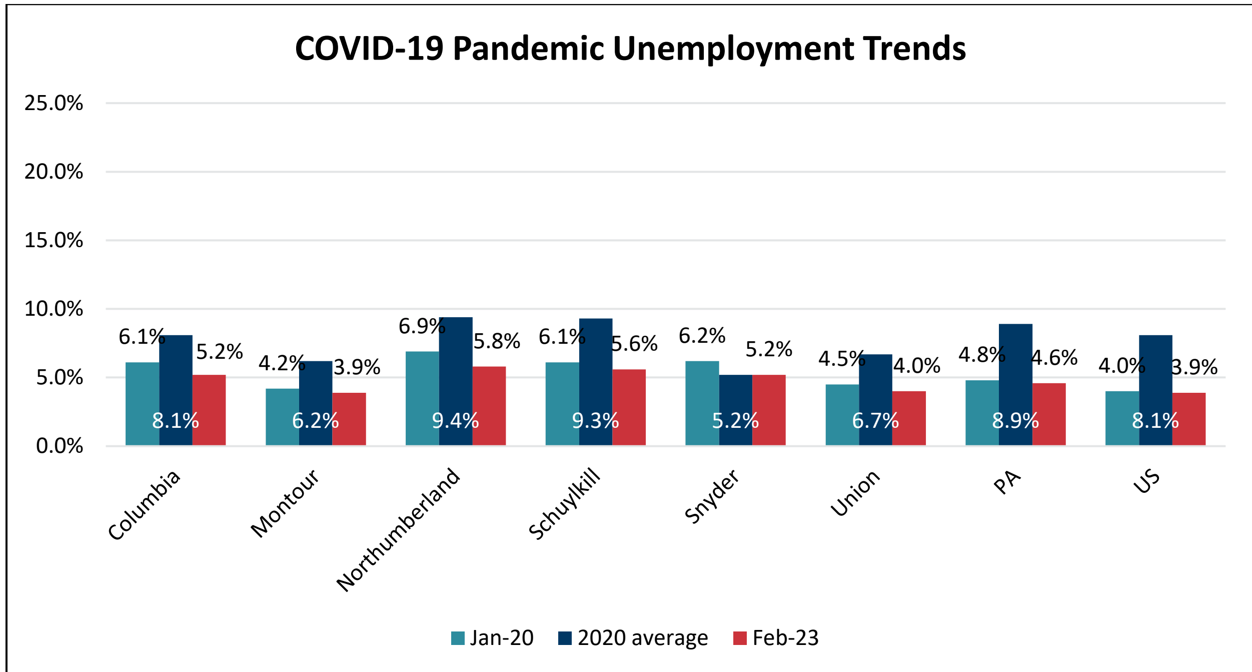


Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

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



Source: US Bureau of Labor Statistics

When analyzed by zip code, pockets of high poverty are largely seen within Northumberland and Schuylkill counties. **Children are historically disproportionately affected by poverty, and within communities including Shamokin, Mount Carmel, Mahanoy City, Shenandoah, and Girardville, approximately one-third to nearly half of children live in poverty.**

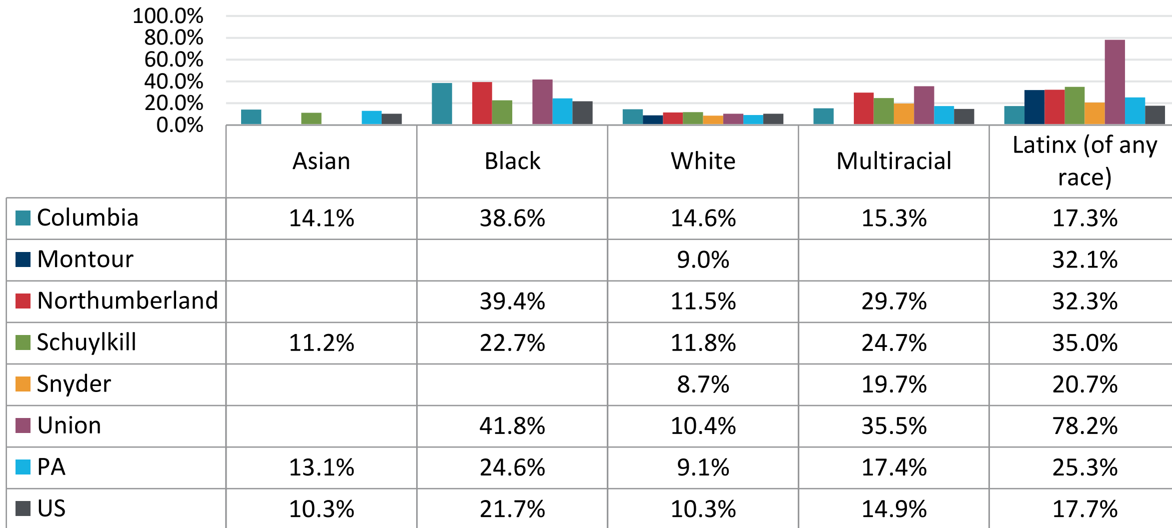
Poverty is not experienced by every community equally and contributes to further inequalities such as access to safe living and working conditions, health services, and basic needs, among other things. Union County has the most significant socioeconomic disparities between racial groups; only 10% of white residents live in poverty compared to 42% of Black residents and a staggering 78% of Latinx residents. This disparity reflects, in part, the inmate population at the Lewisburg Penitentiary.

2017-2021 Population in Poverty by Central Region Zip Code

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

2017-2021 Children in Poverty by Central Region Zip Code

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

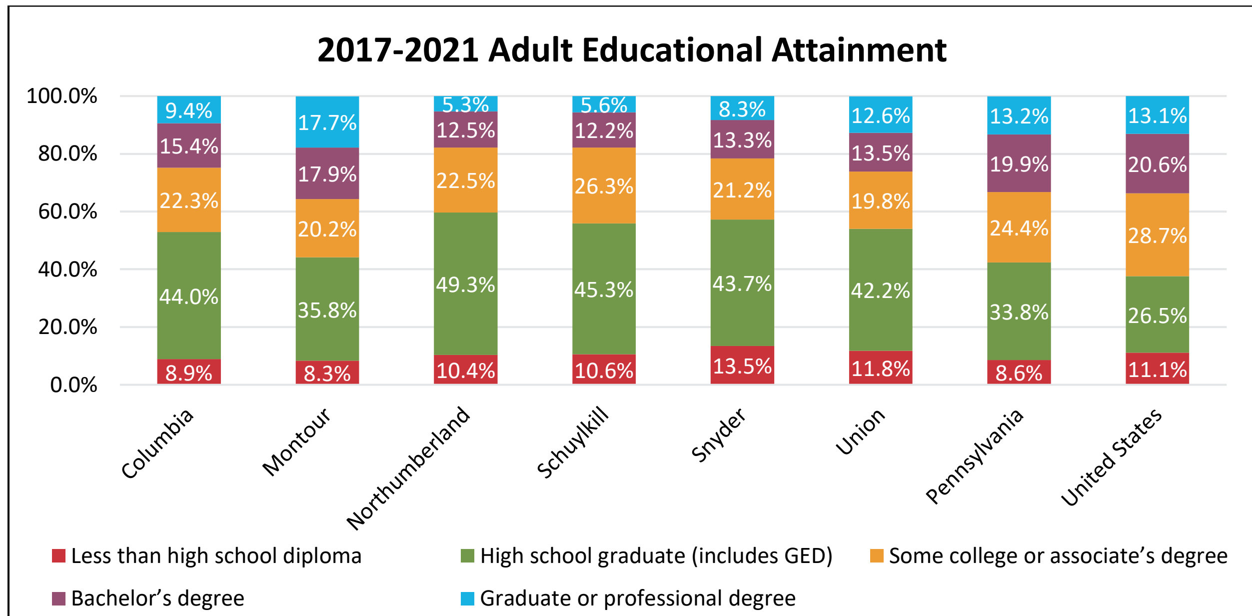


	Asian	Black	White	Multiracial	Latinx (of any race)
Columbia	14.1%	38.6%	14.6%	15.3%	17.3%
Montour			9.0%		32.1%
Northumberland		39.4%	11.5%	29.7%	32.3%
Schuylkill	11.2%	22.7%	11.8%	24.7%	35.0%
Snyder			8.7%	19.7%	20.7%
Union		41.8%	10.4%	35.5%	78.2%
PA	13.1%	24.6%	9.1%	17.4%	25.3%
US	10.3%	21.7%	10.3%	14.9%	17.7%

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

Education

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



Source: US Census Bureau, American Community Survey

Our Homes and Where We Live

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

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

In general, Central Region residents are more likely to own their home when compared to state and national benchmarks. Homeownership increases in more rural communities.

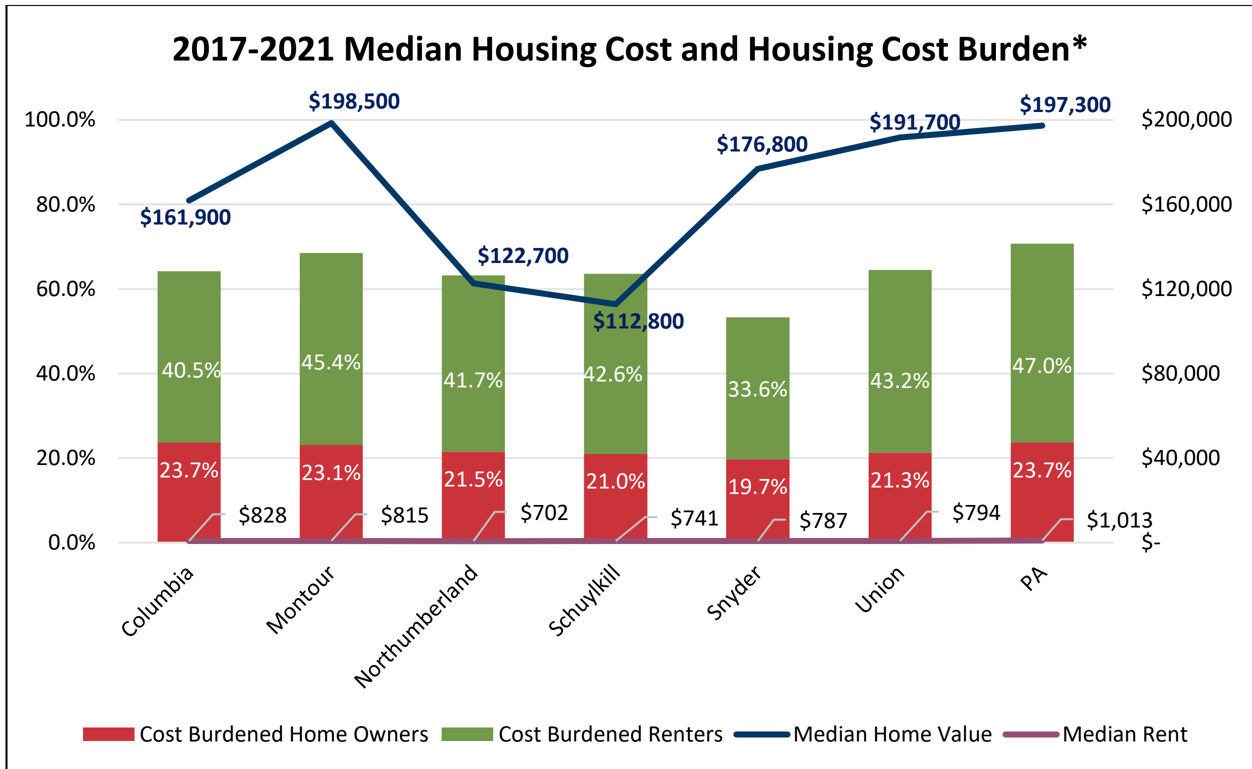
2017-2021 Housing Occupancy

	Owner Occupied Units	Renter Occupied Units
Columbia	70.3%	29.7%
Montour	67.9%	32.1%
Northumberland	72.7%	27.3%
Schuylkill	75.9%	24.1%
Snyder	74.9%	25.1%
Union	71.6%	28.4%
Pennsylvania	69.2%	30.8%
United States	64.6%	35.4%

Source: US Census Bureau, American Community Survey

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

The graph below demonstrates that renters, who may already experience the stresses that accompany less stability as compared to homeowners, are also, on average, more cost-burdened than the homeowners in their communities. **Rental costs have ballooned across the country since COVID-19, leaving many to struggle to continue to afford their current rent, while also having less and less opportunity to save money to make future home ownership possible.** The Central Region is no exception to these trends. Schuylkill and Snyder counties have the highest percentage of homeowners and boast the lowest percentages of cost-burdened homeowners, meaning that housing costs are relatively affordable; however, approximately 20% of homeowners and one-third or more of renters in these counties *still* meet the criteria of being cost-burdened.



Source: US Census Bureau, American Community Survey

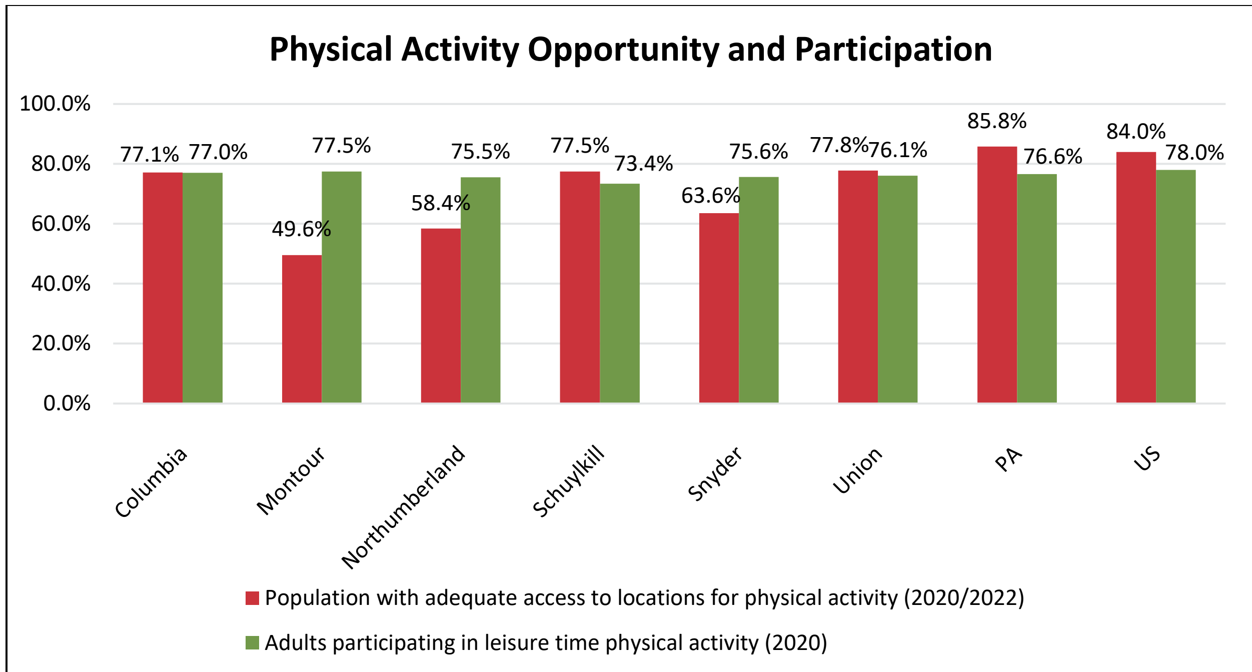
*Defined as spending 30% or more of household income on rent or mortgage expenses.

Neighborhood and Built Environment

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

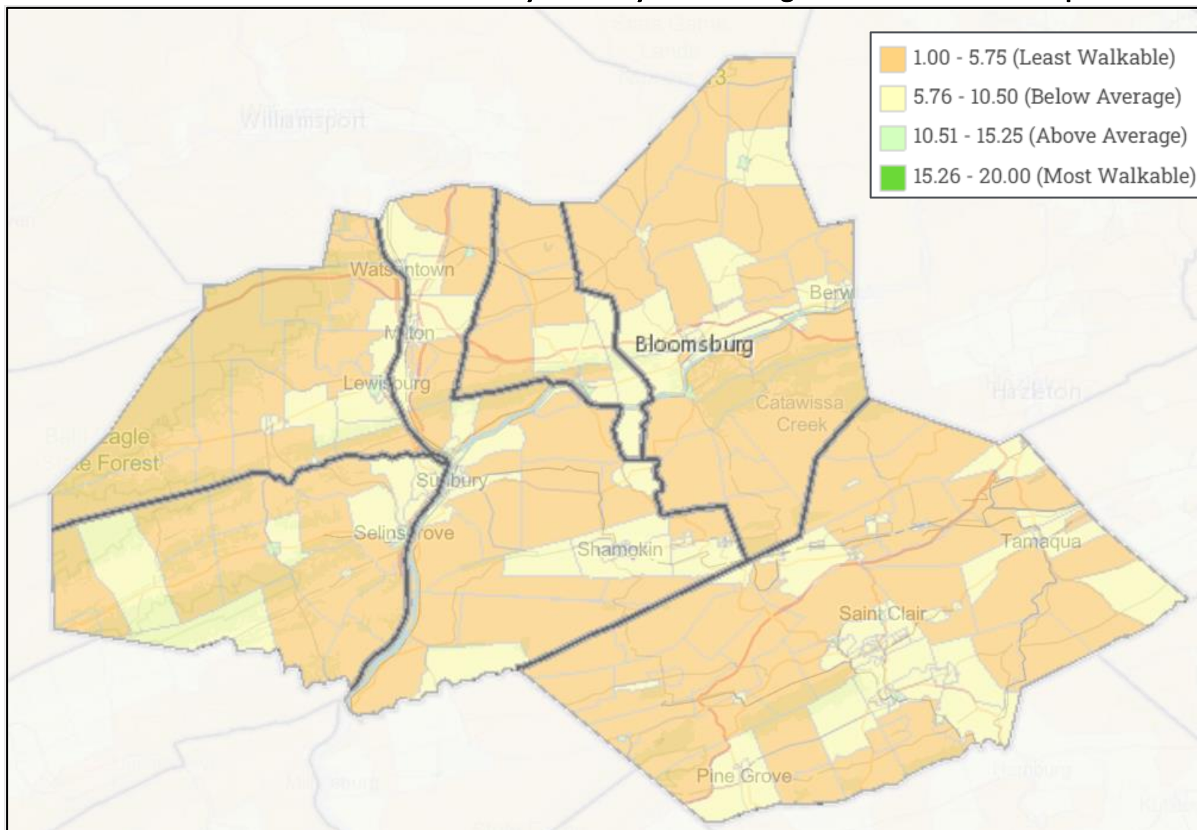
Feedback from Key Stakeholder Survey participants centered around the scarcity of reliable and affordable public transportation options available to residents. Combined with a region that is, on the whole, "below average" in its walkability rating, as well as a rapidly aging population, it can be difficult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

Despite these concerns, residents of the Central Region have demonstrated resilience in prioritizing physical activity. Montour, Northumberland, and Snyder counties are far below Columbia and Union counties, as well as the state and nation, in the percentage of the population with adequate access to locations for physical activity. Yet, in all three of these places, the percentage of adults who participate in leisure time physical activity is on par with their counterparts, and far outpaces what would be expected given the reported lack of access.



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

2021 National Walkability Index by Central Region Census Block Group



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

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

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

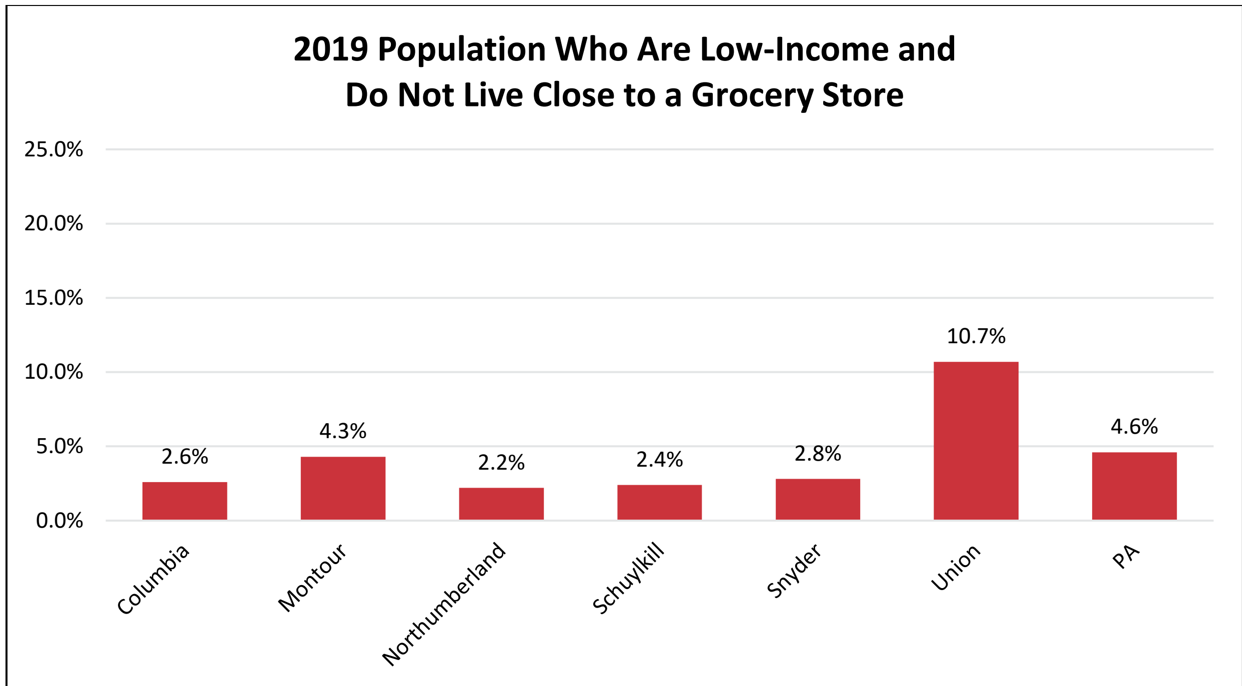
Across the Central Region in 2021, approximately 1 in 10 residents were estimated to be food insecure. **The percentage of children who experience food insecurity outpaces that for adults, but the percentage of children experiencing food insecurity declined *more rapidly* in recent years than the percentage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

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

Food Insecurity

	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Food Insecure Residents								
2021	10.6%	8.3%	10.9%	11.0%	8.6%	8.9%	9.4%	10.4%
2020	11.3%	9.6%	12.4%	12.3%	9.9%	9.4%	8.9%	11.8%
2019	11.7%	10.5%	12.7%	12.0%	10.9%	10.1%	10.6%	10.9%
Food Insecure Children								
2021	11.4%	8.6%	13.4%	13.5%	9.3%	8.9%	12.2%	12.8%
2020	14.2%	12.5%	17.8%	17.4%	13.6%	11.4%	13.1%	16.1%
2019	15.6%	13.4%	17.7%	16.6%	15.4%	12.7%	14.7%	14.6%

Source: Feeding America & USDA Food Environment Atlas



Source: Health Resources and Services Administration

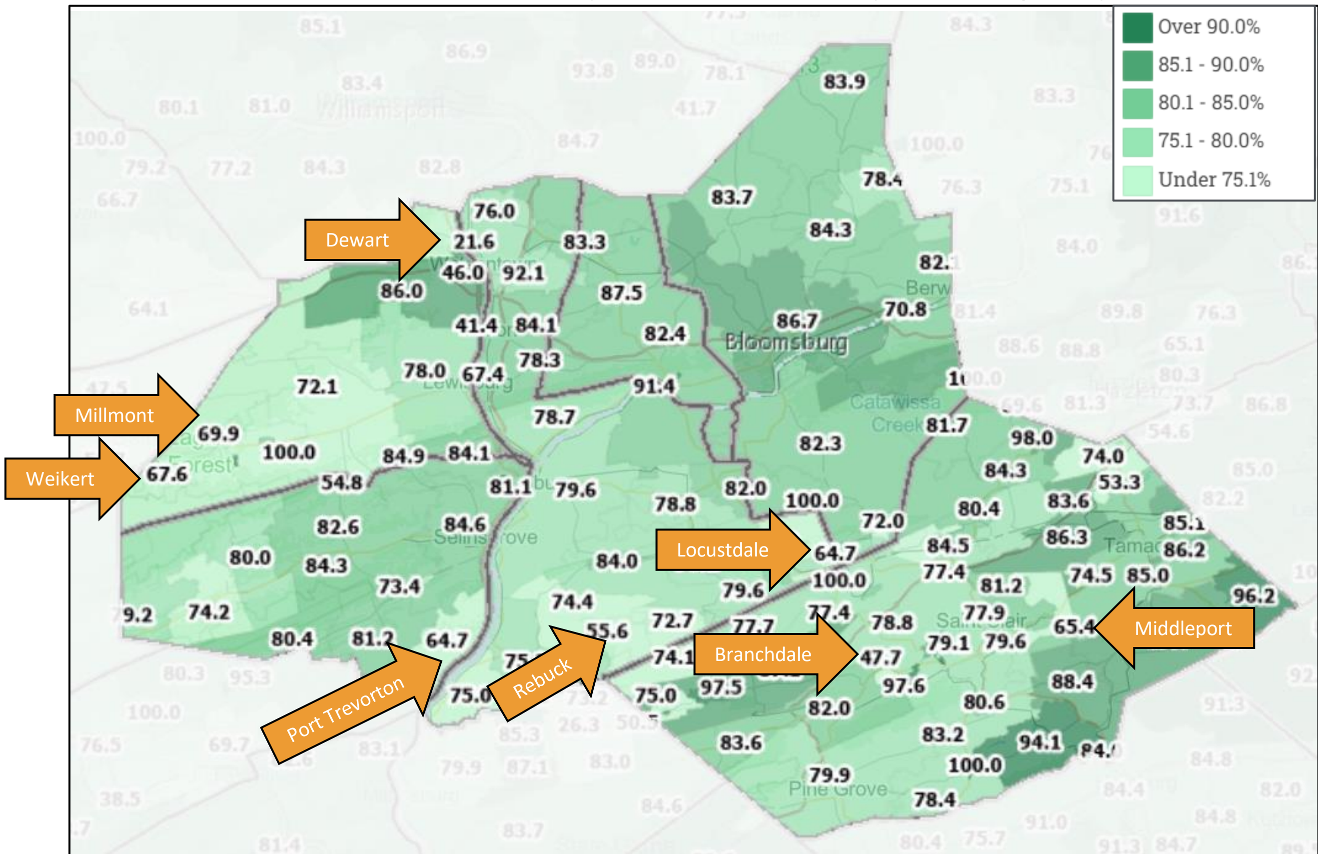
During the COVID pandemic, we were able to use technology to bring services to people in their homes, but not uniformly. We need to bridge the wide digital divide within our communities to effectively reach all residents. Residents of the Central Region generally have slightly lower digital access as compared to state and national benchmarks. **However, deeper analysis reveals that in some smaller communities, highlighted on the map below, fewer than 65% of residents have reliable internet access.** In Dewart in Delaware Township, Northumberland County, *only 22%* of residents have reliable internet access.

2017-2021 Households by Digital Access

	With Computer Access			With Internet Access	
	Computer Device	Desktop / Laptop	Smartphone	Internet Subscription	Broadband Internet
Columbia	89.3%	73.2%	78.5%	84.1%	83.6%
Montour	86.3%	73.2%	77.6%	82.7%	82.3%
Northumberland	85.0%	68.0%	72.9%	80.1%	79.4%
Schuylkill	87.9%	72.3%	76.5%	82.2%	81.7%
Snyder	85.5%	73.6%	75.6%	81.3%	80.7%
Union	84.7%	72.9%	69.8%	76.9%	75.9%
Pennsylvania	90.9%	77.3%	82.0%	86.1%	85.8%
United States	93.1%	78.9%	86.5%	87.2%	87.0%

Source: US Census Bureau, American Community Survey

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



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

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

Central to concerns around economic recovery for residents is the lack of *any* childcare options for children who are younger than school-aged (3.7 per 1,000 children under age 5 in Snyder County), as well as the prohibitive cost. **In Columbia County, residents with small children may spend one-third of their income on just childcare.**

Childcare Availability and Affordability

	Number of Childcare Centers per 1,000 Population Under 5 Years Old	Childcare Costs for a Household with Two Children as a Percent of Median Household Income
Columbia	6.0	33.7%
Montour	6.0	26.8%
Northumberland	4.1	26.8%
Schuylkill	5.2	27.0%
Snyder	3.7	22.2%
Union	4.1	20.7%
Pennsylvania	5.2	27.2%
United States	7.0	27.0%

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

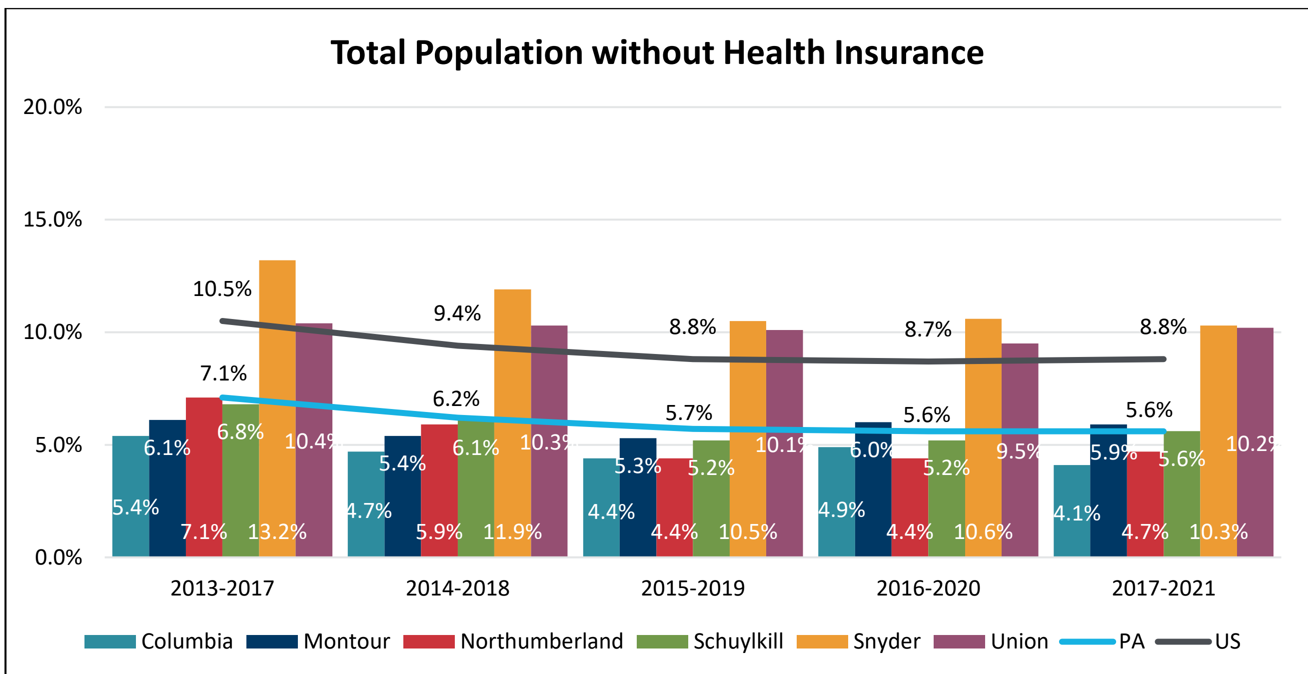
Our Health Status as a Community

Access to Care

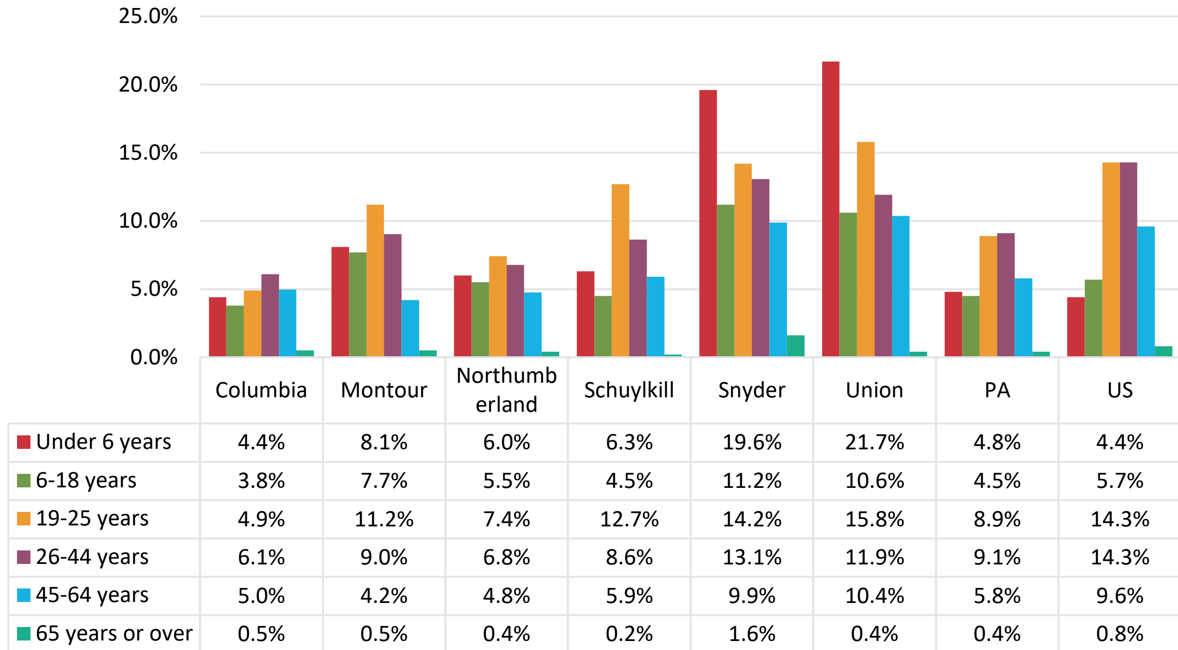
Lack of health insurance is a barrier to accessing healthcare. Without health insurance, residents face high costs for care when they need it, and they are less likely to receive preventive care. Preventive care, such as well visits and screenings, can detect small problems that can be treated more easily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

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

Snyder and Union counties have a high percentage of children ages six and under who are without health insurance, estimated at approximately 20%. This proportion far outpaces the percentage of children living in poverty and the percentage of children who experience food insecurity. This finding may reflect several factors including Plain Community members who are less likely to participate in health insurance programs, or a gap in eligibility awareness for PA Children's Health Insurance Program (CHIP). **No family makes too much for CHIP, presenting an opportunity to increase community awareness and education around what options *are* available for the region's children.**

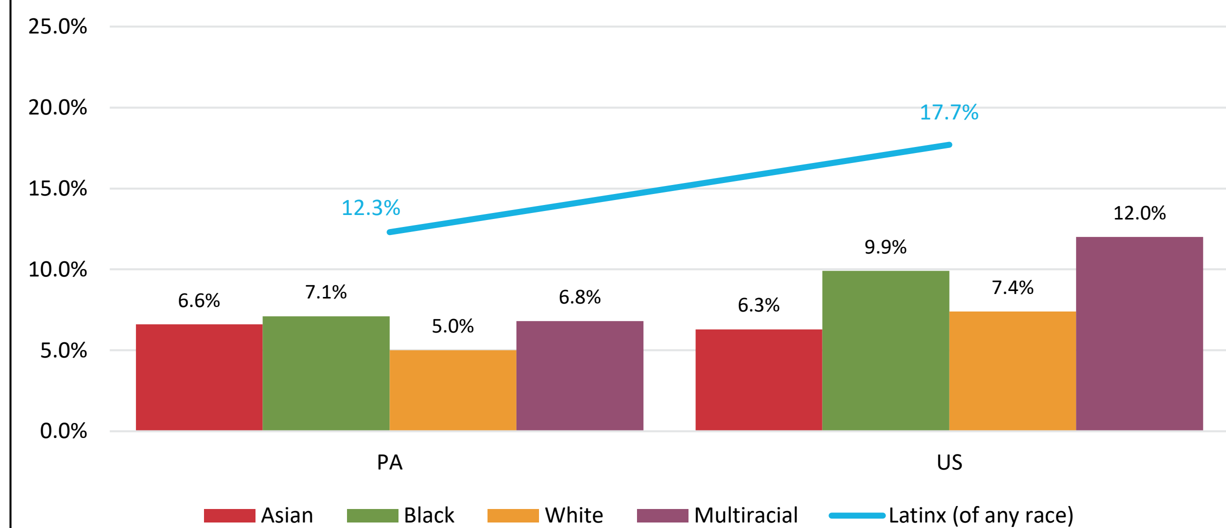


Source: US Census Bureau, American Community Survey

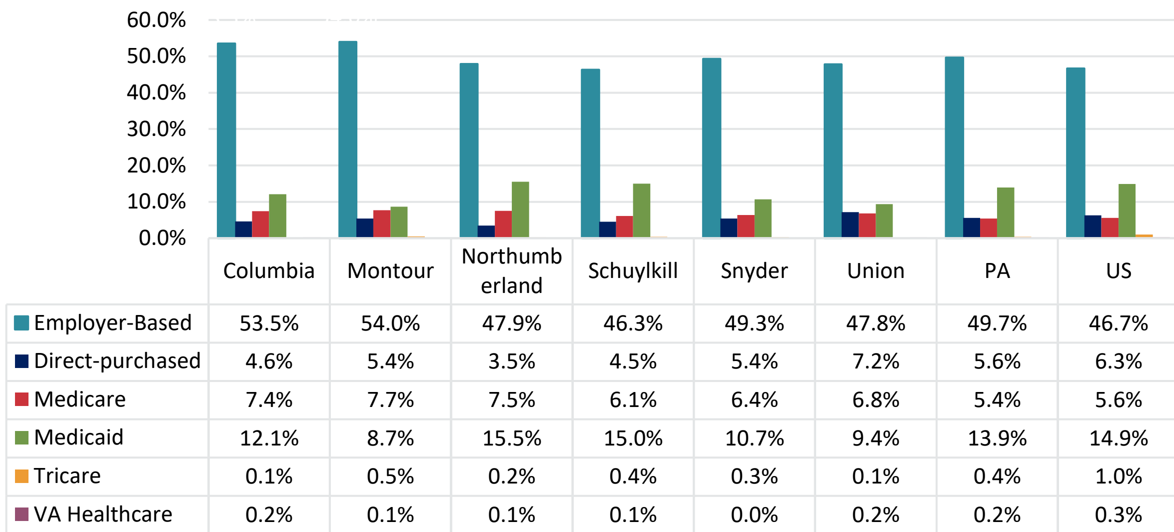


	Columbia	Montour	Northumb erland	Schuylkill	Snyder	Union	PA	US
Under 6 years	4.4%	8.1%	6.0%	6.3%	19.6%	21.7%	4.8%	4.4%
6-18 years	3.8%	7.7%	5.5%	4.5%	11.2%	10.6%	4.5%	5.7%
19-25 years	4.9%	11.2%	7.4%	12.7%	14.2%	15.8%	8.9%	14.3%
26-44 years	6.1%	9.0%	6.8%	8.6%	13.1%	11.9%	9.1%	14.3%
45-64 years	5.0%	4.2%	4.8%	5.9%	9.9%	10.4%	5.8%	9.6%
65 years or over	0.5%	0.5%	0.4%	0.2%	1.6%	0.4%	0.4%	0.8%

Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey



	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Employer-Based	53.5%	54.0%	47.9%	46.3%	49.3%	47.8%	49.7%	46.7%
Direct-purchased	4.6%	5.4%	3.5%	4.5%	5.4%	7.2%	5.6%	6.3%
Medicare	7.4%	7.7%	7.5%	6.1%	6.4%	6.8%	5.4%	5.6%
Medicaid	12.1%	8.7%	15.5%	15.0%	10.7%	9.4%	13.9%	14.9%
Tricare	0.1%	0.5%	0.2%	0.4%	0.3%	0.1%	0.4%	1.0%
VA Healthcare	0.2%	0.1%	0.1%	0.1%	0.0%	0.2%	0.2%	0.3%

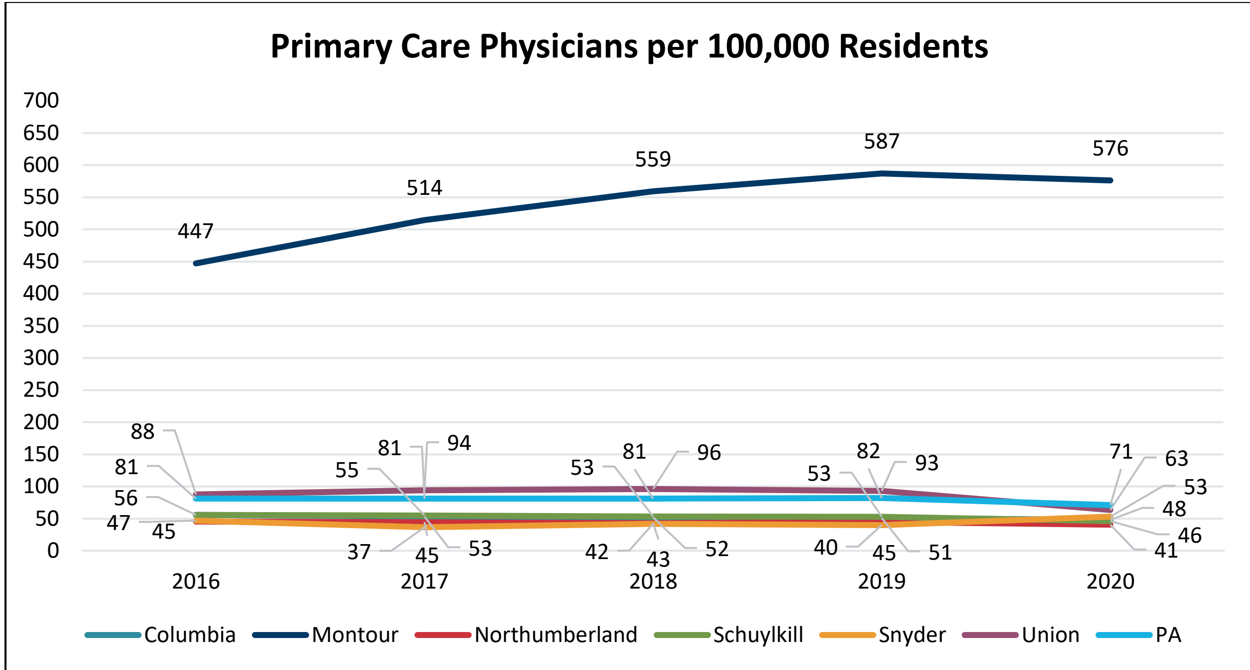
Source: US Census Bureau, American Community Survey

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

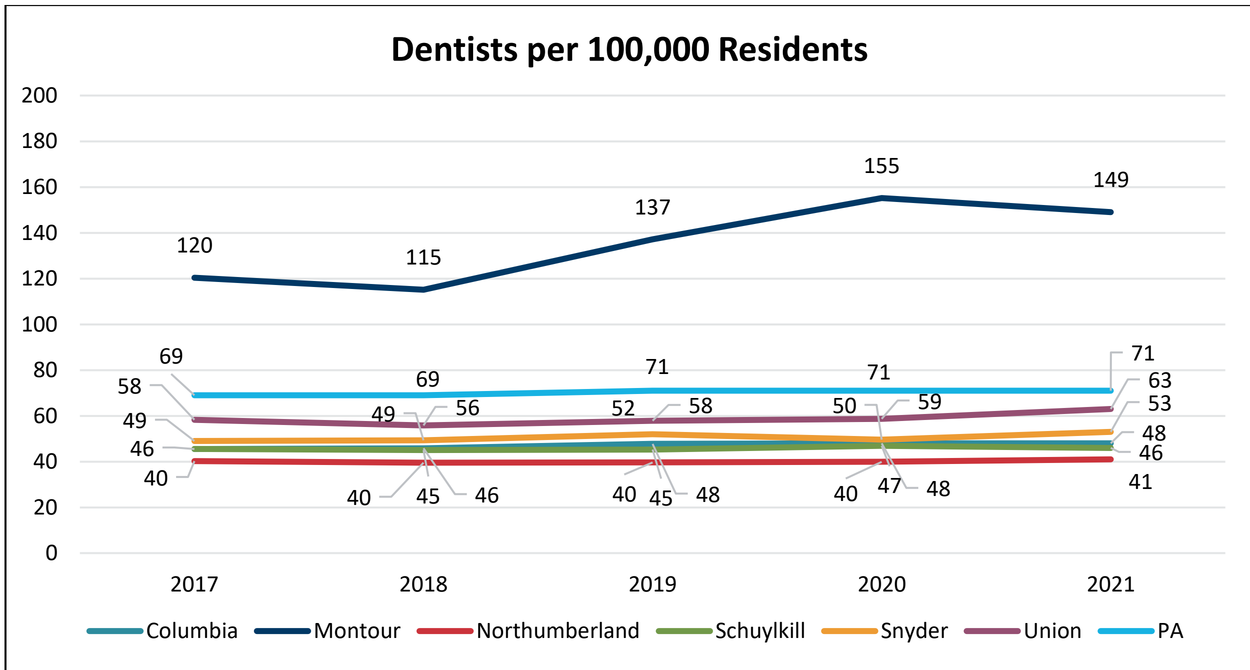
There is an opportunity to grow primary and preventive care services within the Central Region, outside of Montour County. All other counties have fewer physicians and dentists than the state average, and **the entire region, excluding the southeastern portion of Union County, is a Health Professional Shortage Area (HPSA) for dental care for individuals with low income.**

Despite a lack of doctors, adult residents of the Central Region report preventive visits within the last year on par with state and national benchmarks – about three-quarters of adults. They report regular dental checkups with slightly less frequency, 59%-64% of adults, compared to 68% across Pennsylvania.

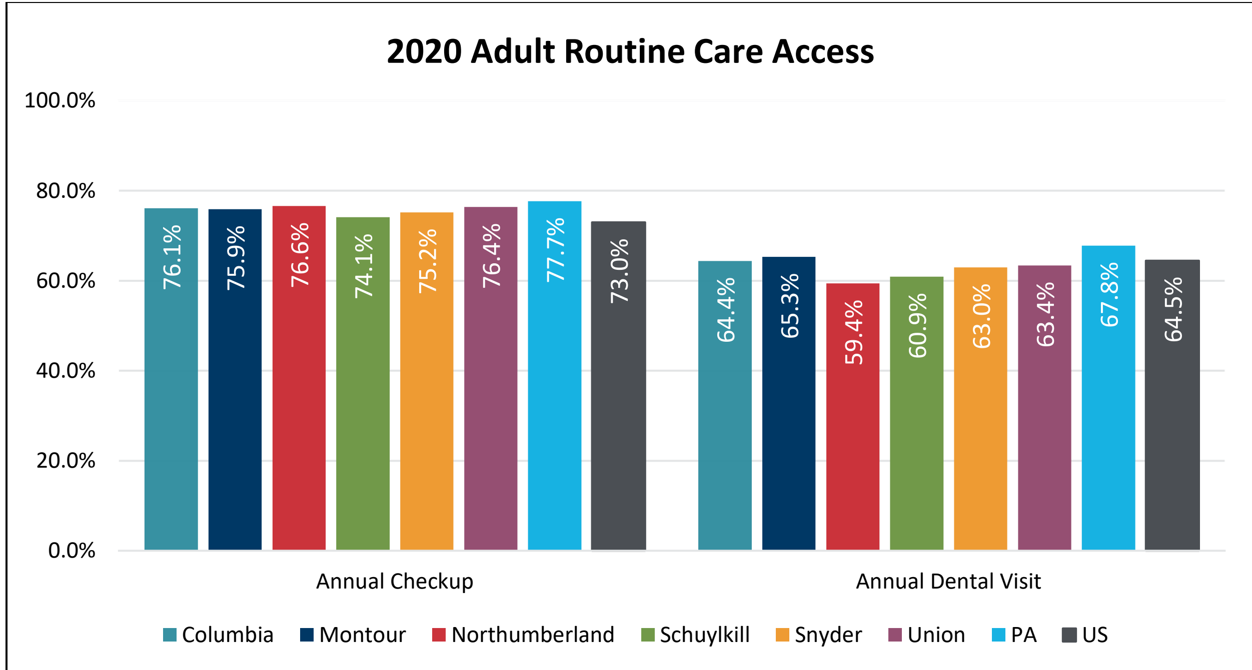
When analyzed by zip code, the proportion of adults receiving preventive visits is generally consistent across the region, but receipt of regular dental care is more varied. In Northumberland and Schuylkill counties, the proportion of adults with regular dental care falls to approximately 53% in Shamokin, Coal Township, and Mahanoy City.



Source: Health Resources & Services Administration
Note: Montour County is the home county for Geisinger Medical Center in Danville, contributing to higher reported provider rates.

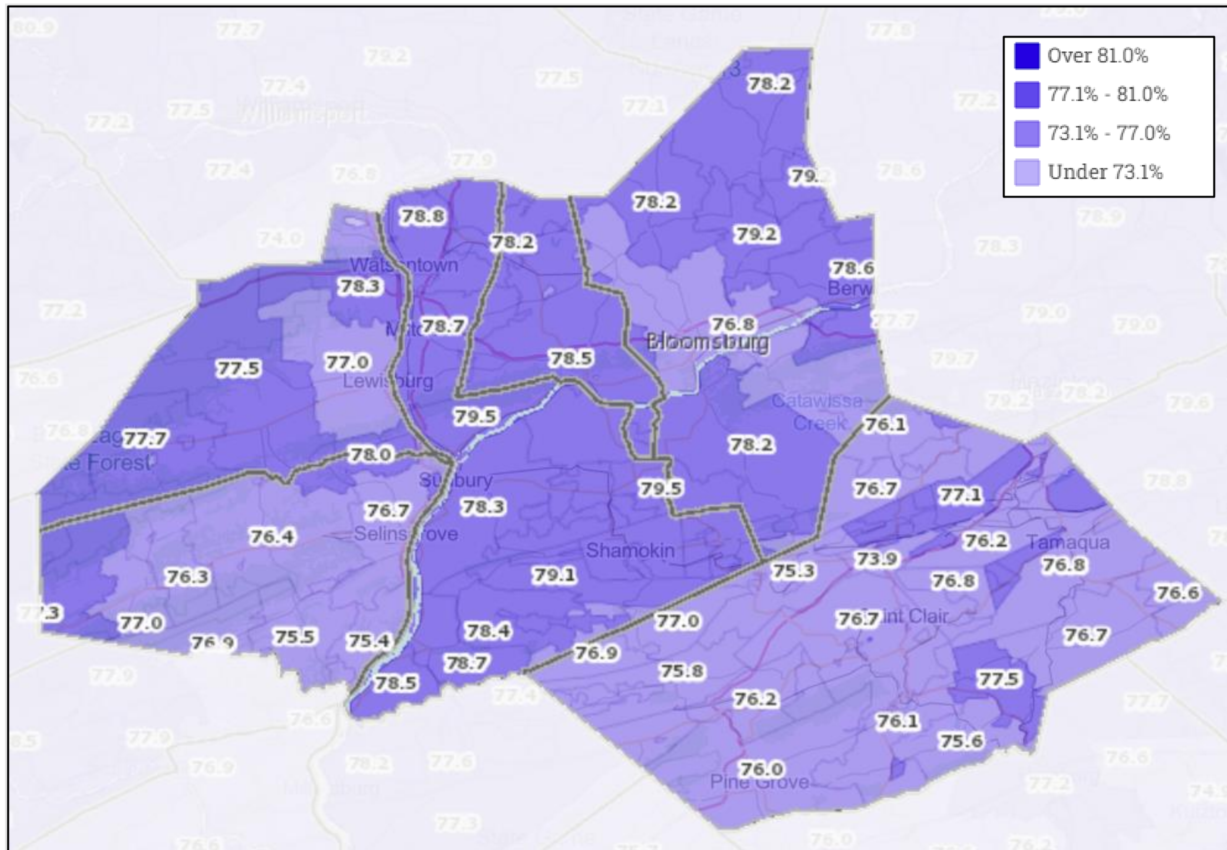


Source: Health Resources & Services Administration
Note: Montour County is the home county for Geisinger Medical Center in Danville, contributing to higher reported provider rates.



Source: Centers for Disease Control and Prevention

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



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

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

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

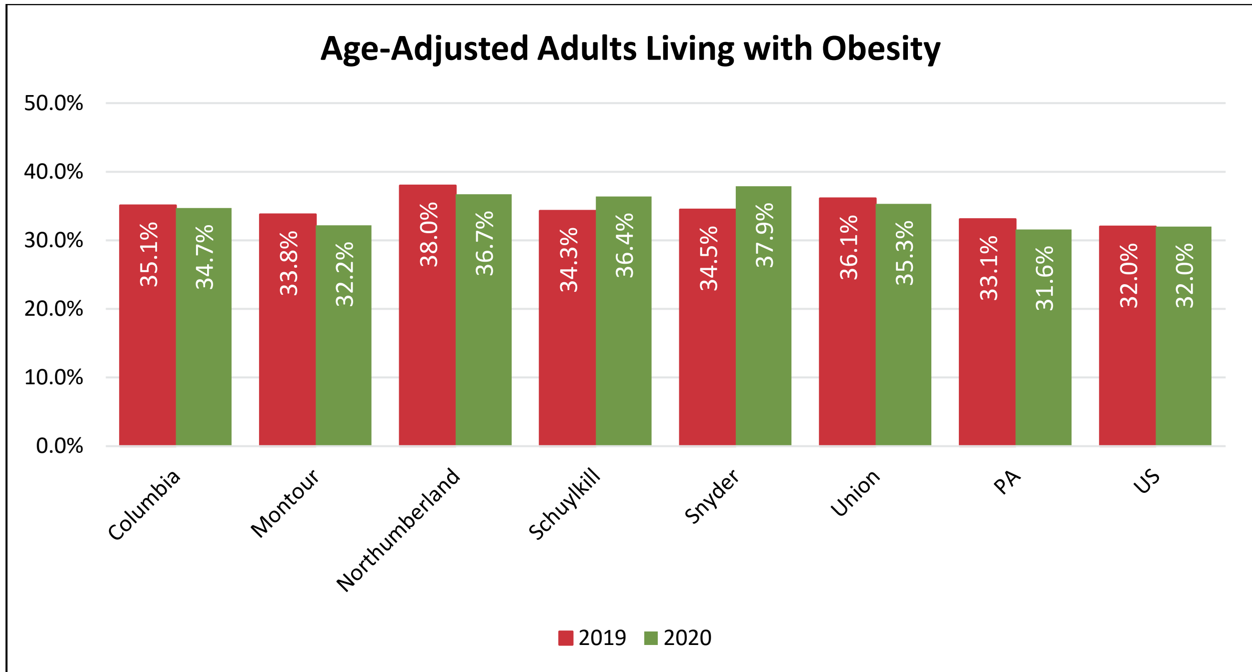
Health Risk Factors and Chronic Disease

Prior to COVID-19, the top leading causes of death for Pennsylvania and US residents were chronic diseases. **Across the Central Region, diabetes and heart disease incidence are comparable to the state and nation, but death rates due to these conditions are higher in Northumberland, Schuylkill, and/or Snyder counties, potentially indicating barriers to diagnosis, treatment, and/or care management.**

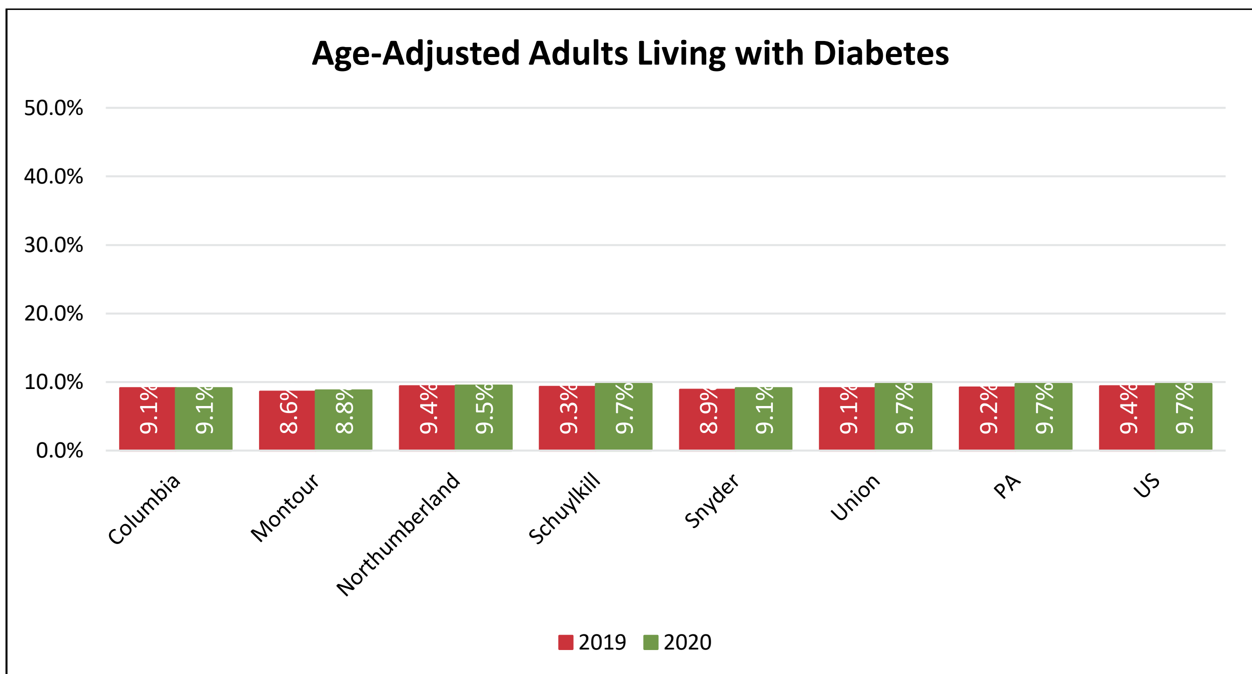
It is interesting to note that despite more smokers and a higher incidence of COPD in the region compared to state and national benchmarks, diagnoses of asthma and incidence and death rates due to lung cancer are comparable. **Snyder and Union counties, despite having a relatively large smoking population, have lung-related death rates at nearly half that of their neighbors, and the state and nation. This finding is worth exploring for other protective factors.**

The region generally has a relatively high overall incidence of cancer; cancer incidence in Montour County is 20% higher than across the state of Pennsylvania. However, excluding Schuylkill County, overall cancer death rates are consistent with state and national benchmarks. This finding may indicate better cancer screening practices and earlier detection and treatment.

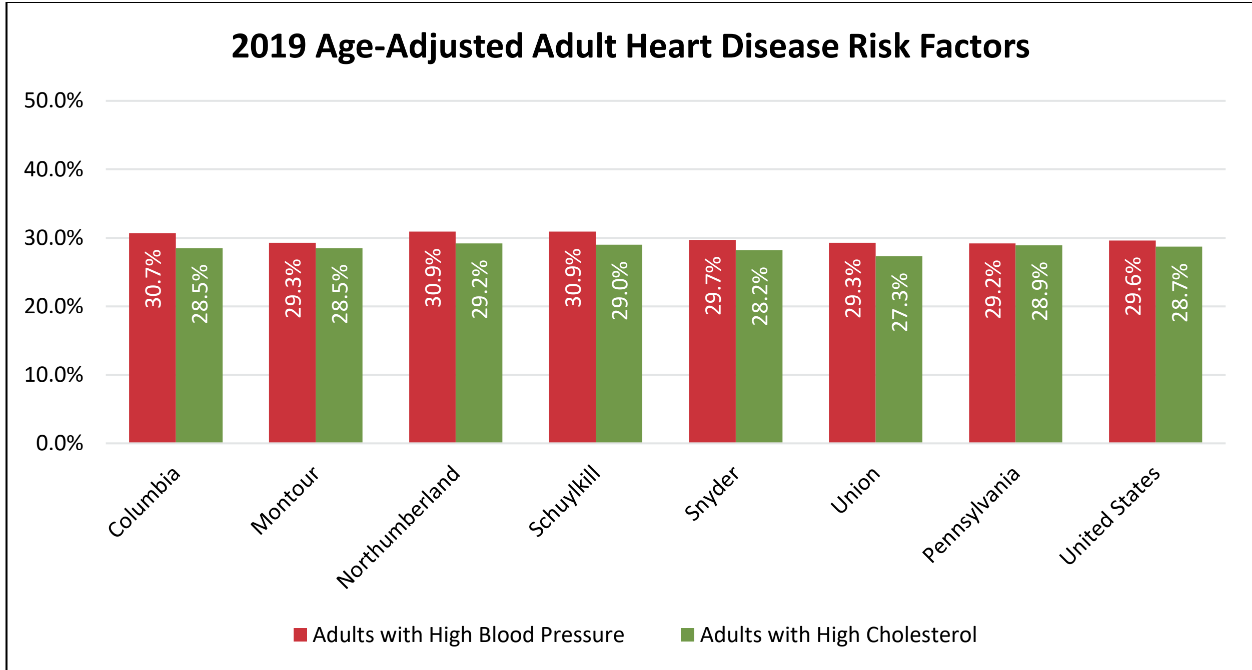
It is clear that social drivers of health directly impact health risk factors and ultimately chronic disease, resulting in inequities in quality of life and life expectancy. Across the state of Pennsylvania, death rates for Black residents attributed to diabetes and heart disease far outpace death rates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



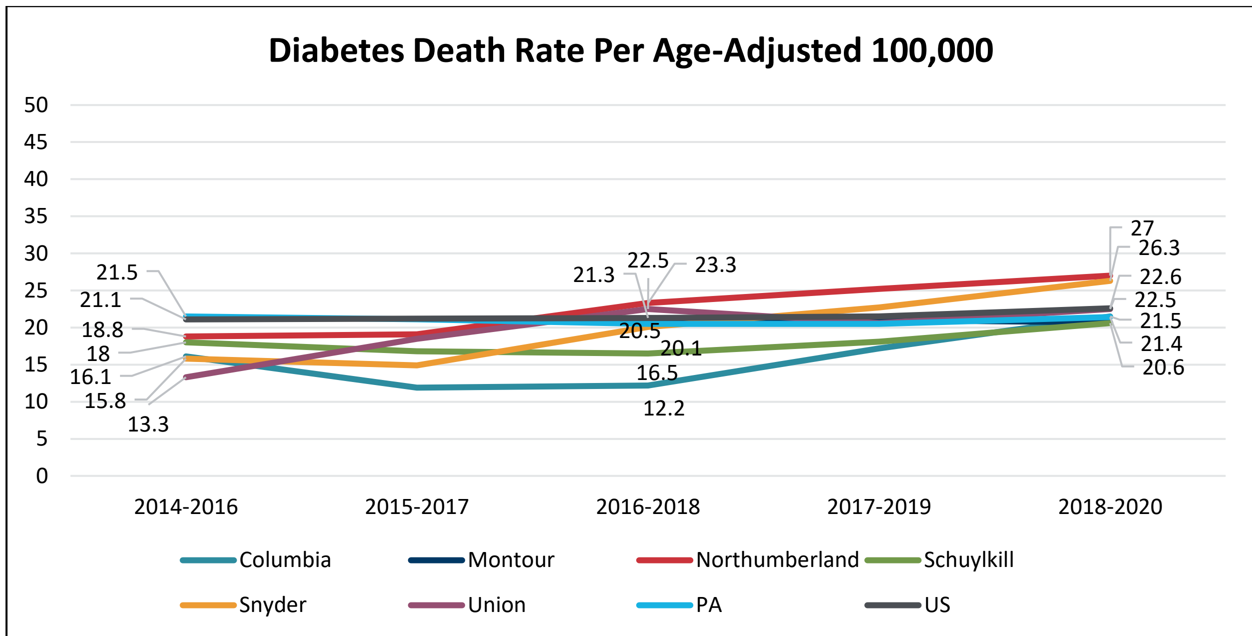
Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention

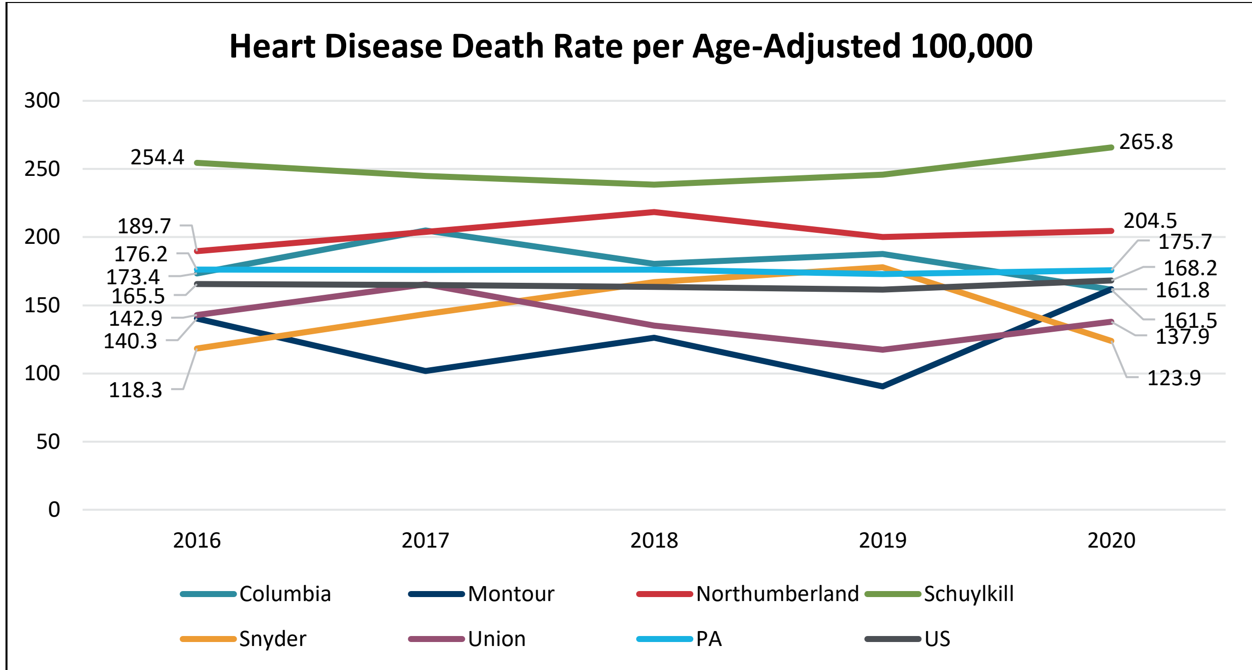


Source: Centers for Disease Control and Prevention



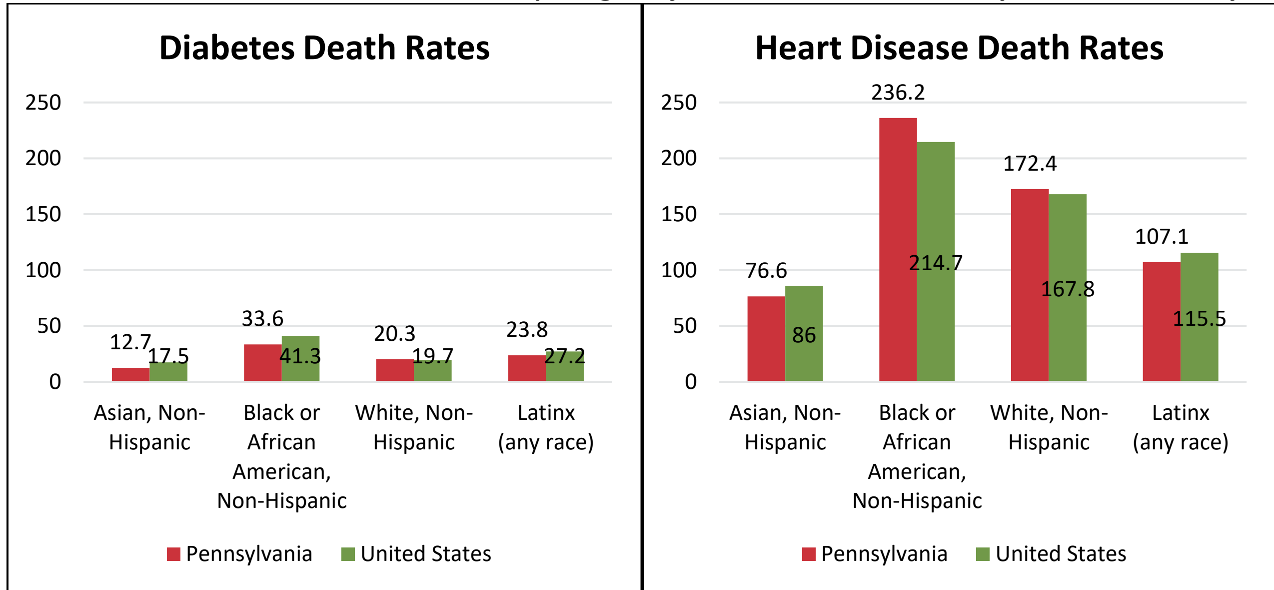
Source: Centers for Disease Control and Prevention

Note: Montour County data are not trended due to missing data. The 2018-2020 diabetes death rate for Montour County was 20.7.

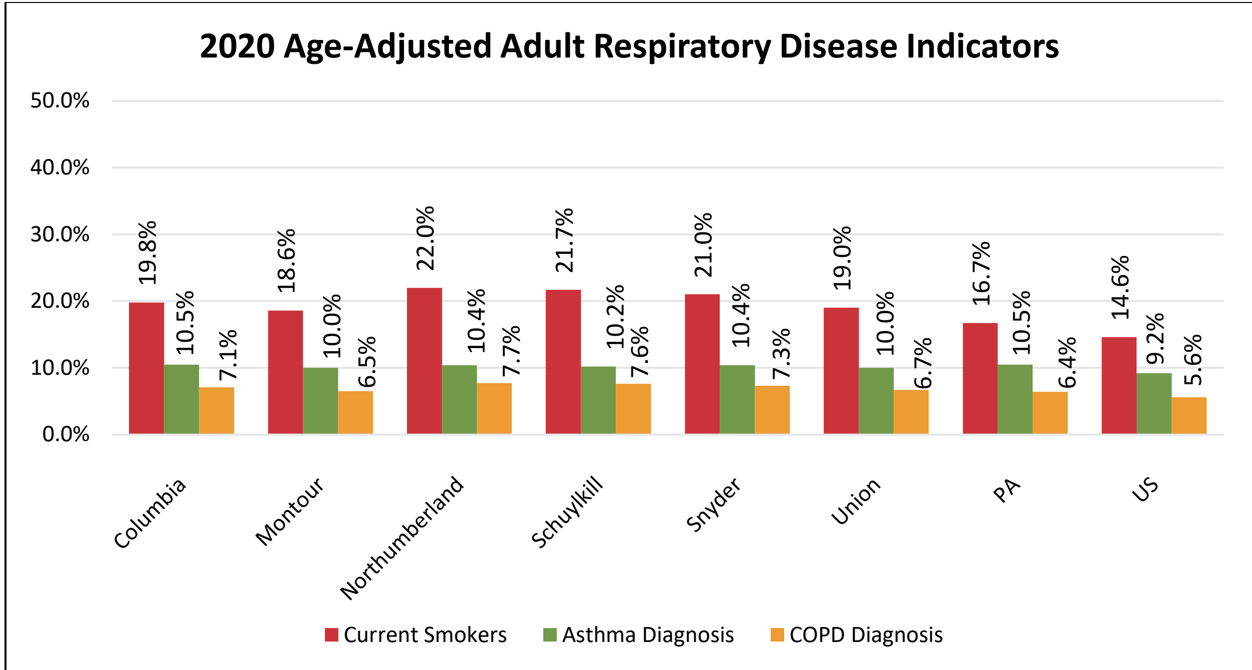


Source: Centers for Disease Control and Prevention

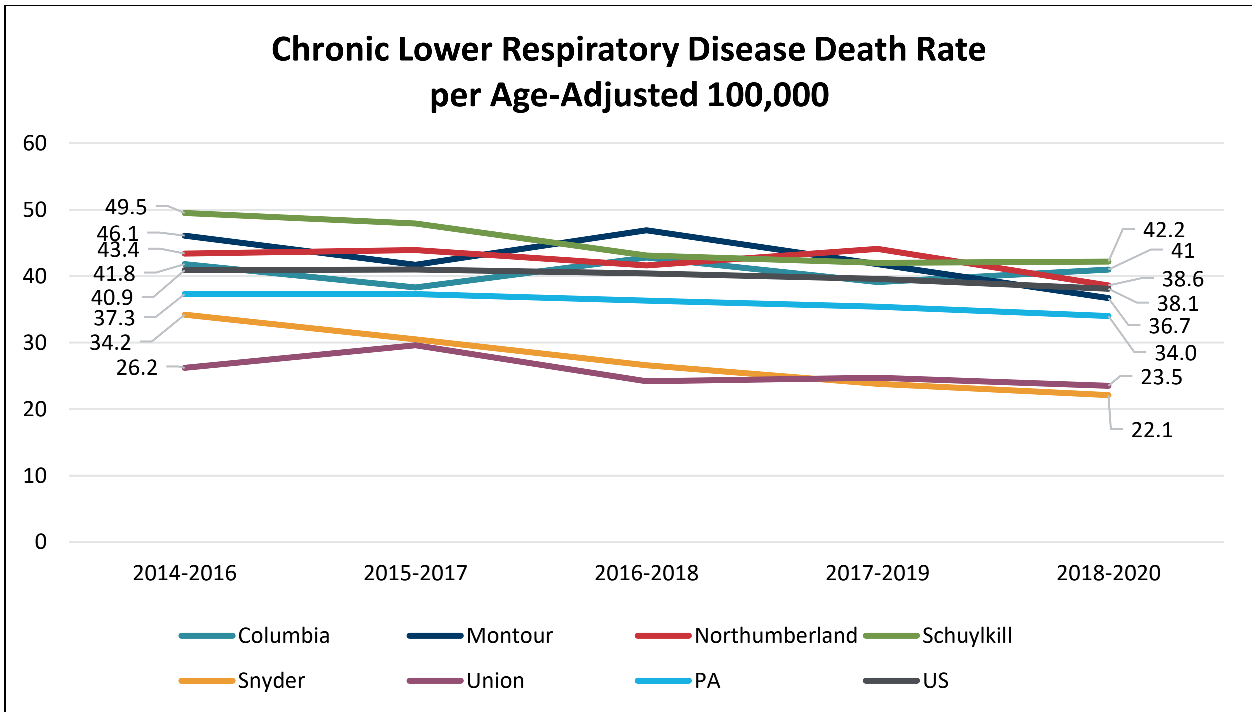
2018-2020 Chronic Disease Death Rates per Age-Adjusted 100,000 Residents by Race and Ethnicity



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



Source: Centers for Disease Control and Prevention



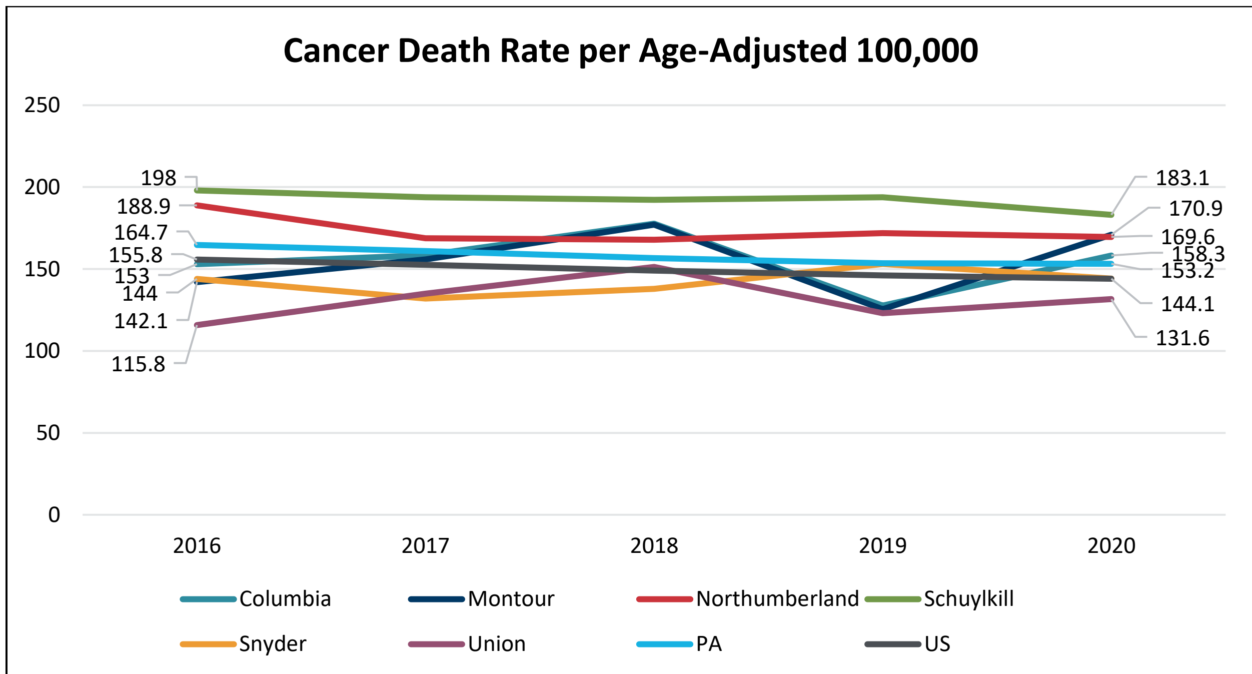
Source: Centers for Disease Control and Prevention

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

	Cancer Incidence Rate
Columbia	492.9
Montour	534.0
Northumberland	491.6
Schuylkill	506.4
Snyder	451.0
Union	447.7
Pennsylvania	448.4

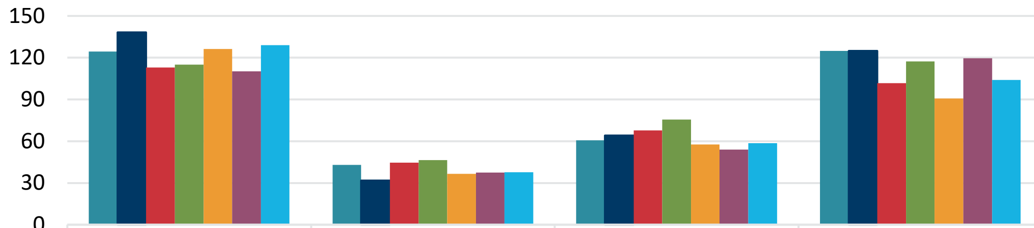
Source: Pennsylvania Department of Health

Note: Data are not available for the United States for 2016-2020.



Source: Centers for Disease Control and Prevention

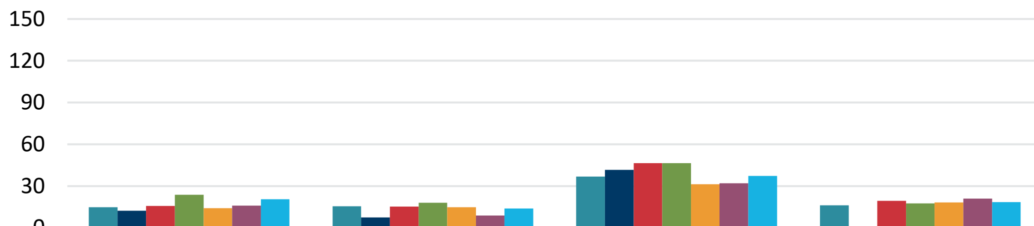
2016-2020 Cancer Incidence per Age-Adjusted 100,000 for Most Common Cancer Types



	Female Breast	Colorectal	Lung and Bronchus	Prostate
Columbia	124.4	42.9	60.7	124.8
Montour	138.1	31.7	64.1	124.9
Northumberland	112.9	44.6	67.8	101.6
Schuylkill	114.9	46.4	75.5	117.3
Snyder	126.2	36.5	57.7	90.7
Union	110.2	37.5	53.9	119.6
PA	129	37.8	58.6	104.1

Source: Pennsylvania Department of Health

2016-2020 Cancer Death per Age-Adjusted 100,000 for Most Common Cancer Types



	Female Breast	Colorectal	Lung and Bronchus	Prostate
Columbia	14.8	15.4	36.8	16.1
Montour	12.3	7.5	41.5	0
Northumberland	15.7	15.3	46.4	19.3
Schuylkill	23.8	18	46.4	17.5
Snyder	14	14.8	31.3	18.2
Union	15.9	8.8	31.9	21
PA	20.4	13.8	37.3	18.4

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

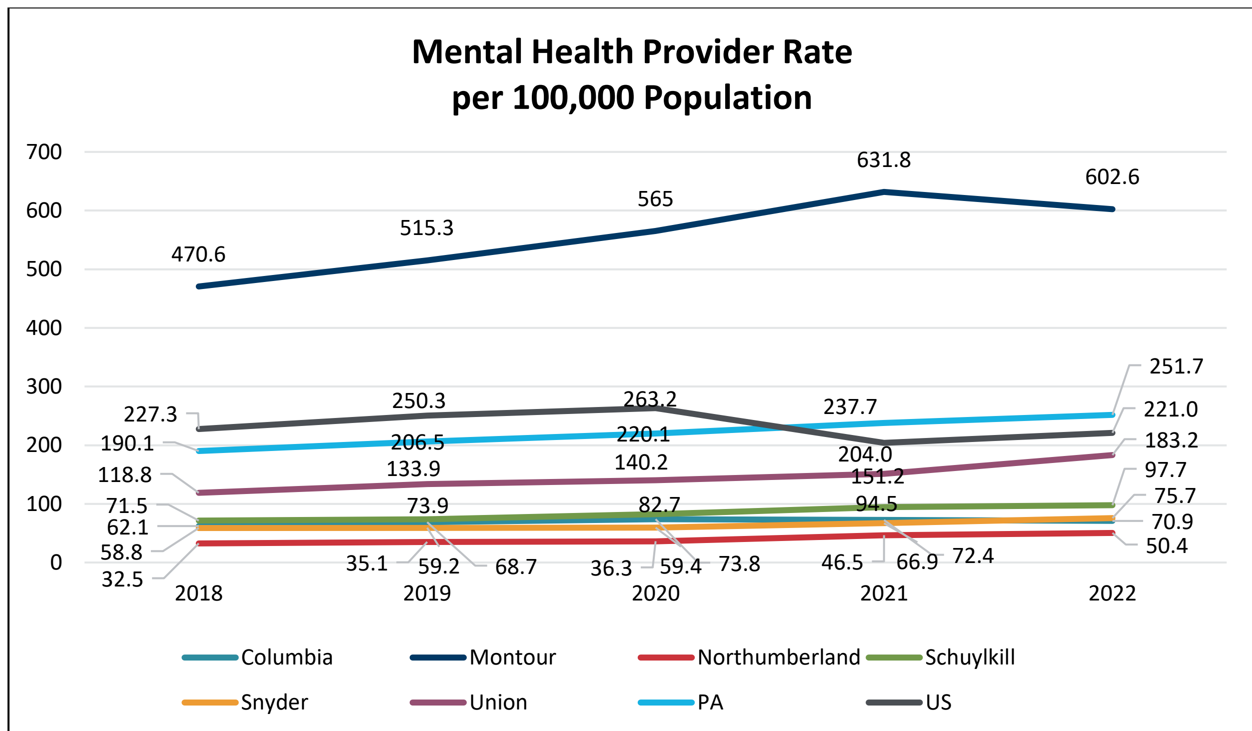
Mental Health and Substance Use Disorder

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

Social service and healthcare agencies are consistently reporting difficulty hiring and retaining mental health providers since COVID-19, a problem that is especially exacerbated in more rural communities. Outside of Montour County, Central Region counties have fewer mental health providers than the state or nation overall. Northumberland County has only one-fifth the number of providers per 100,000 residents compared to the rest of Pennsylvania.

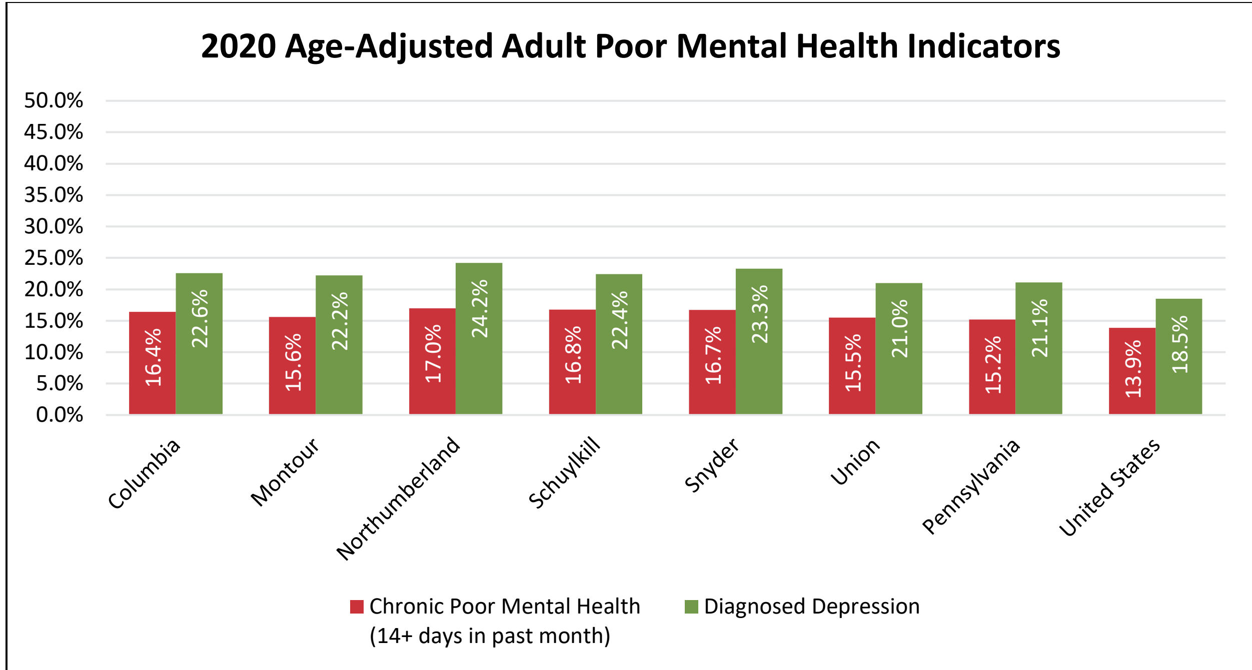
At the other end of the spectrum, community residents suffer disproportionately poor mental health. **In Schuylkill County, the death rate by suicide is 58% higher than state and national rates. Across all counties, more than one in five adults report a diagnosis of depression.** These findings, when considered with underlying social drivers, isolation due to the COVID-19 pandemic and a more rural setting, and limited access to mental healthcare, point to a growing mental health crisis in the region.

When analyzed by zip code, the proportion of adults reporting mental distress is generally consistent across the region, with few areas of notable disparity. Areas of disparity include communities with previously identified health barriers, including poverty and lack of healthcare access (e.g., Shamokin, Mahanoy City, Shenandoah). **Bloomsburg is also an area of disparity, reporting the highest proportion of adults with mental distress in the region at 18.3%.**



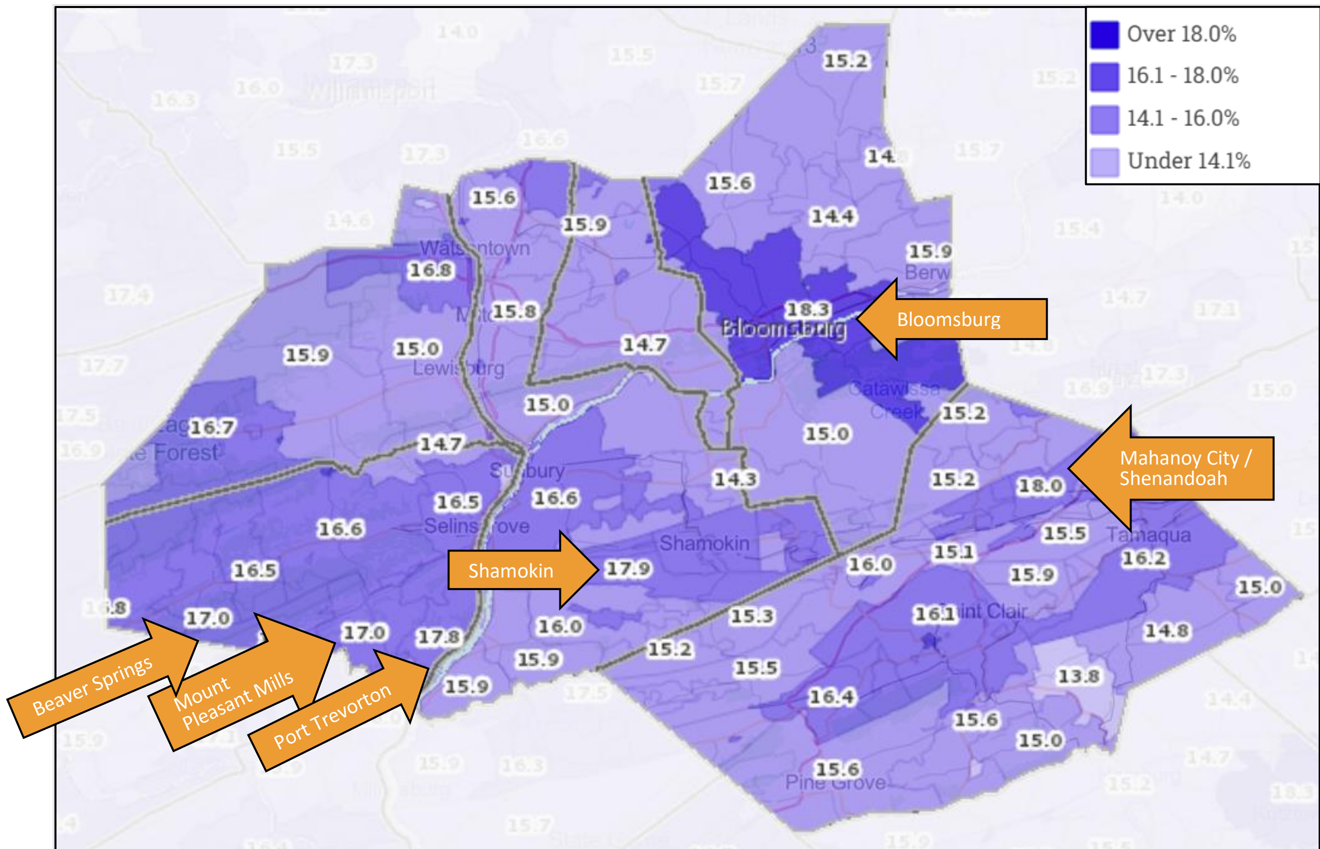
Source: Centers for Medicare and Medicaid Services

Note: Montour County is the home county for Geisinger Medical Center in Danville, contributing to higher reported provider rates.

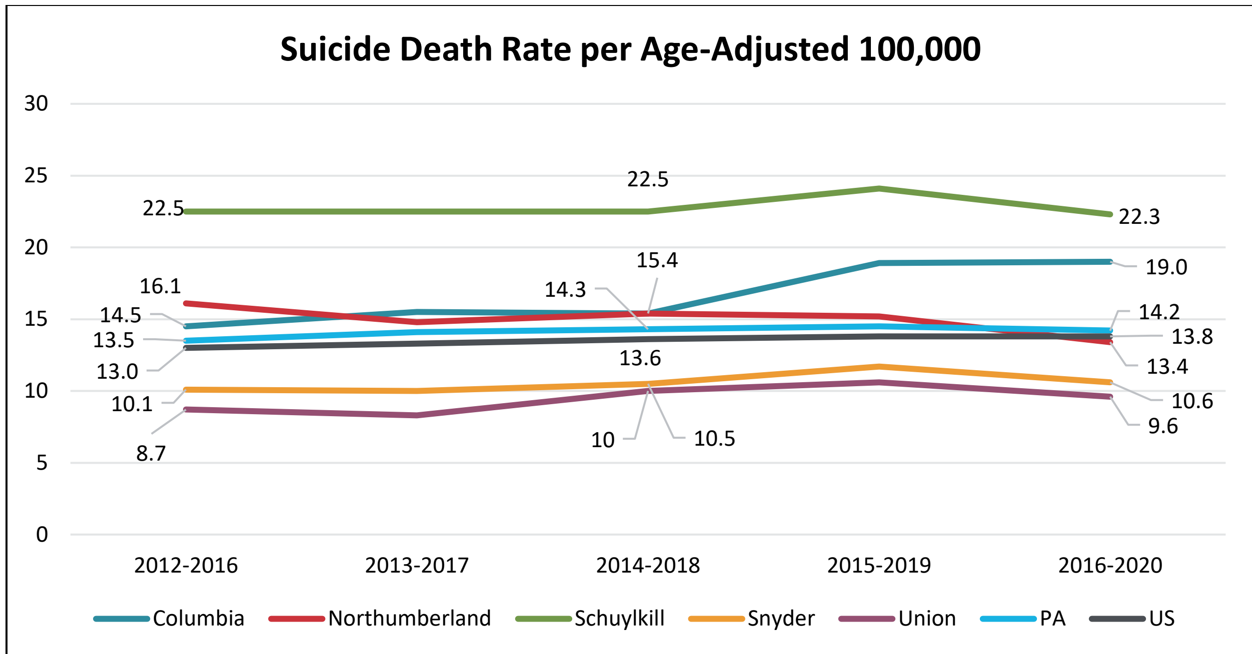


Source: Centers for Disease Control and Prevention

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



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



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

Substance use concerns are still prevalent in the region and recent trends indicate the need to evaluate health improvement and treatment efforts. For example, while hospitalizations from the use of drugs such as opioids have generally declined, death rates due to accidental overdose remain high and increased in communities likely Columbia and Northumberland counties.

Surpassing opioids in the Central Region are amphetamines. Across Pennsylvania in 2019, the rate of amphetamine use disorder hospitalizations was *78% lower* than the rate of opioid hospitalizations; however, in Columbia, Montour, and Schuylkill counties, amphetamine hospitalizations *outpaced* those for opioids. It is worth noting a similarly high rate of hospitalizations for both opioids and amphetamines in Northumberland and Schuylkill counties.

Of most pressing concern are rates of alcohol misuse by residents. Approximately 1 in 5 adults in Central Region counties report binge drinking, a slightly higher proportion than the state and nation overall. in all counties, the rate of alcohol-related hospitalizations far outpaces the rate for other reported substances.

Alcohol Use Disorder Indicators

	2020 Adults (age-adjusted) Reporting Binge Drinking	2016-2020 Driving Deaths due to Alcohol Impairment
Columbia	20.2%	20.5%
Montour	19.7%	6.2%
Northumberland	20.2%	22.8%
Schuylkill	20.5%	24.7%
Snyder	20.2%	29.1%
Union	19.7%	37.5%
Pennsylvania	18.5%	25.3%
United States	16.7%	27.0%

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

2019 Substance Use Disorder Hospitalizations per 100,000 by Substance

	Alcohol	Opioid	Amphetamine	Cocaine
Columbia	411.5	42.0	129.4	27.0
Montour	507.6	112.1	204.4	NA
Northumberland	477.4	242.7	191.5	44.6
Schuylkill	502.0	285.5	311.6	19.4
Snyder	273.9	62.5	32.7	NA
Union	244.0	64.9	54.5	NA
Pennsylvania	568.4	293.2	63.7	164.1

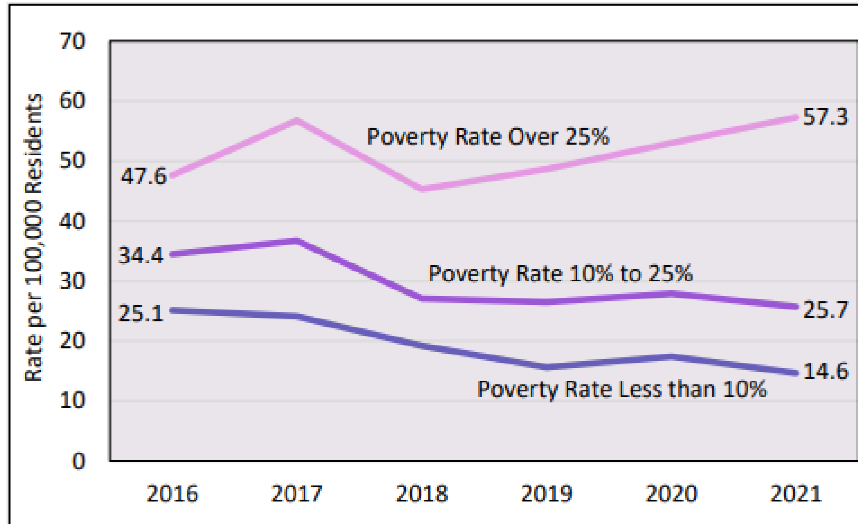
Source: Pennsylvania Health Care Cost Containment Council (PHC4)

Opioid Overdose Hospitalization Rates per 100,000 Central Region Residents

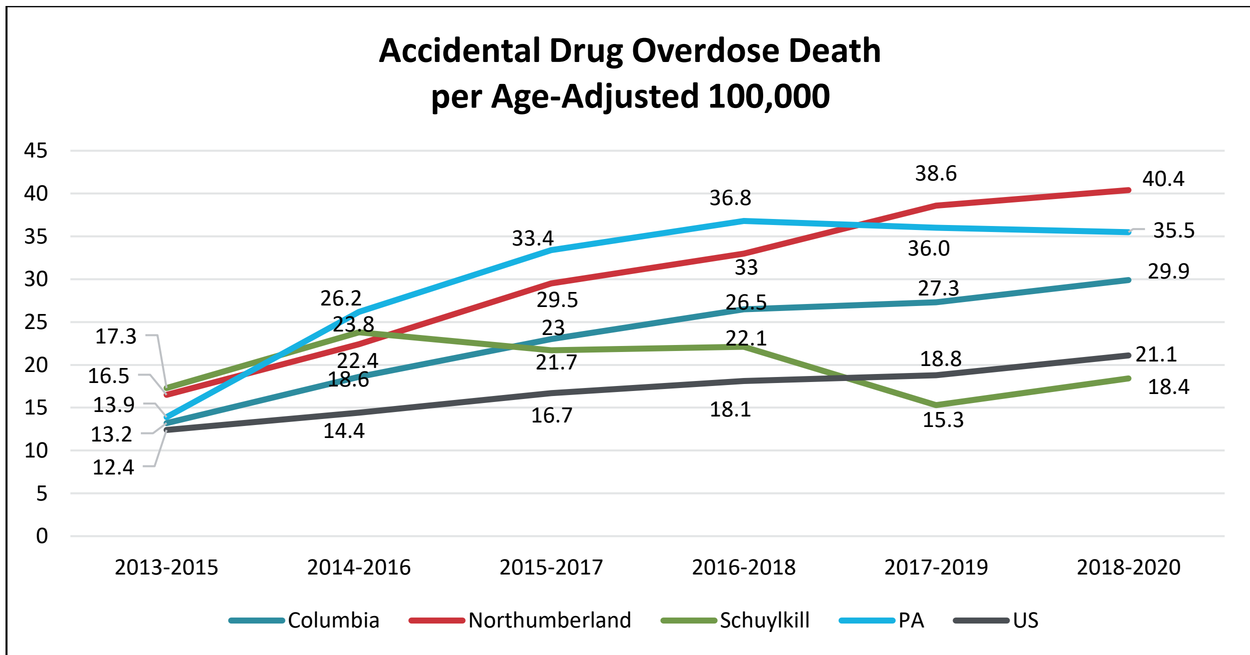
	2016	2017	2018	2019	2020	2021
Columbia	37.2	44.6	NA	28.7	NA	19.8
Montour	NA	NA	NA	NA	NA	NA
Northumberland	36.2	20.8	28.8	22.4	30.3	15.8
Schuylkill	25.0	27.6	22.7	24.5	16.1	18.6
Snyder	NA	NA	NA	NA	NA	NA
Union	NA	NA	NA	NA	NA	NA
Pennsylvania	31.6	33.0	25.1	23.2	24.8	22.9

Source: Pennsylvania Health Care Cost Containment Council (PHC4)

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



Source: Pennsylvania Health Care Cost Containment Council (PHC4)
*Rates are calculated using PHC4 hospital discharge data and US Census Bureau 2020 population estimates.



Source: Centers for Disease Control and Prevention
Note: Data are not available for Montour, Snyder, and Union counties due to low death counts.

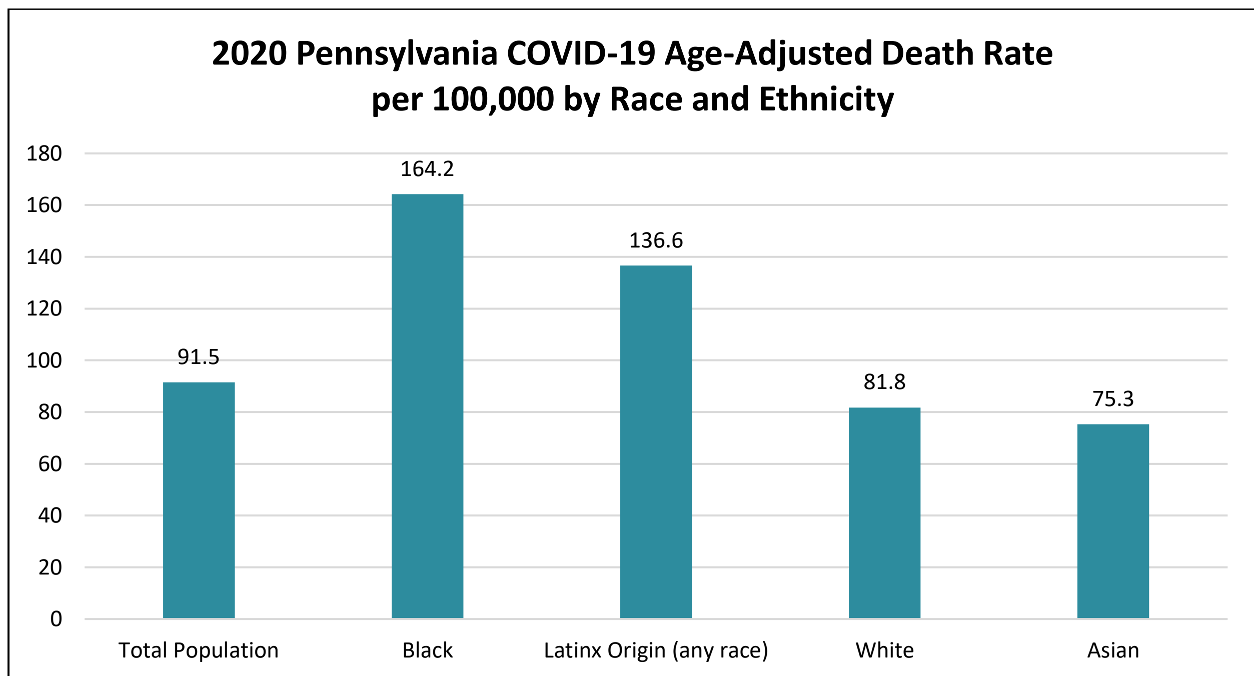
COVID-19

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

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

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

COVID-19 was the leading cause of death (by death count) for Pennsylvania residents who identified as Latinx and Asian/Pacific Islander in 2020. While COVID-19 was the third leading cause of death for Black residents – who also suffer the highest rates of co-morbid conditions that would exacerbate or be exacerbated by COVID-19 – the death rate for Black residents was the highest of any group, followed by residents who identify as Latinx. **Black and Latinx groups experienced the largest decline (5%) in life expectancy due to COVID-19, but Black people have the lowest overall life expectancy at now 71.5 years, 5.5 years below the average for all citizens, and closer to 6 years below any other single group.**

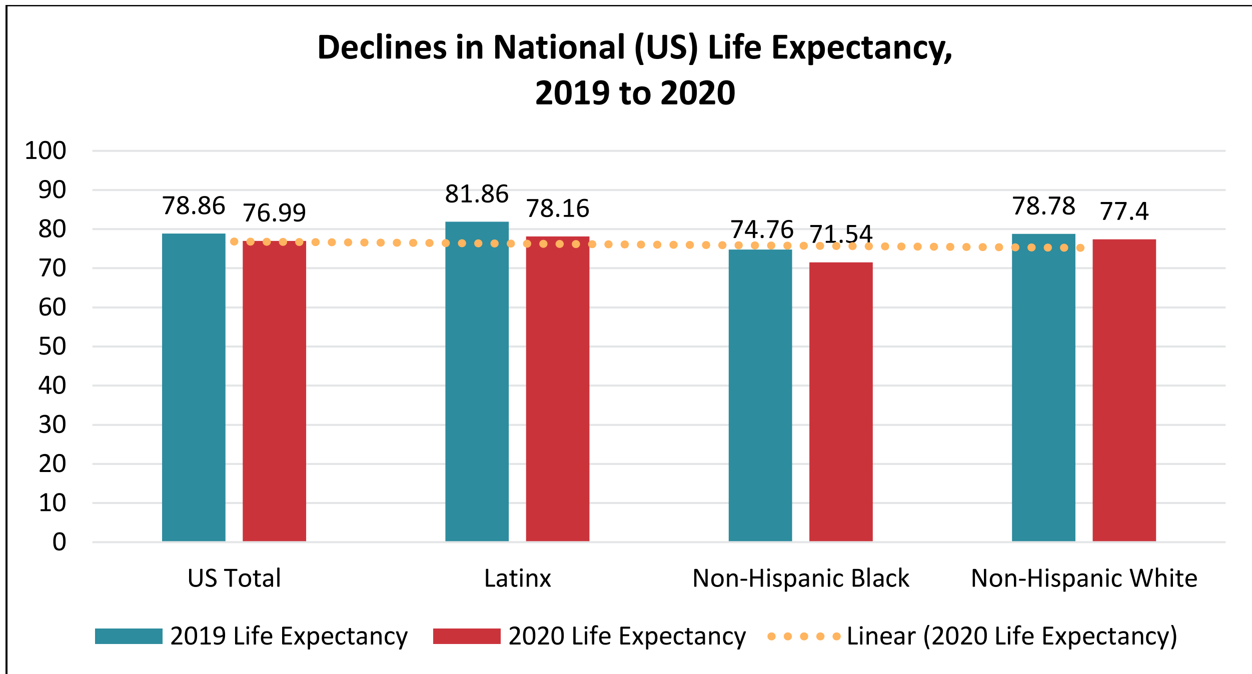


Source: Pennsylvania Department of Health

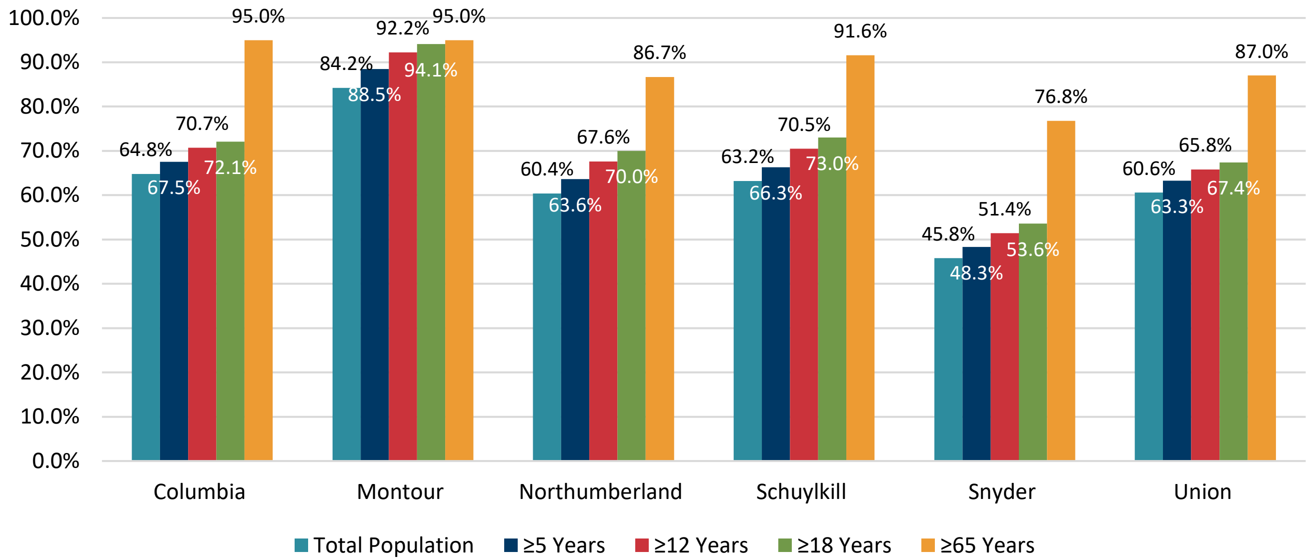
Leading Causes of Death among Pennsylvania Residents by Race and Ethnicity in 2020

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

Source: Pennsylvania Department of Health



Source: Centers for Disease Control and Prevention



Source: Centers for Disease Control and Prevention

Populations of Special Interest

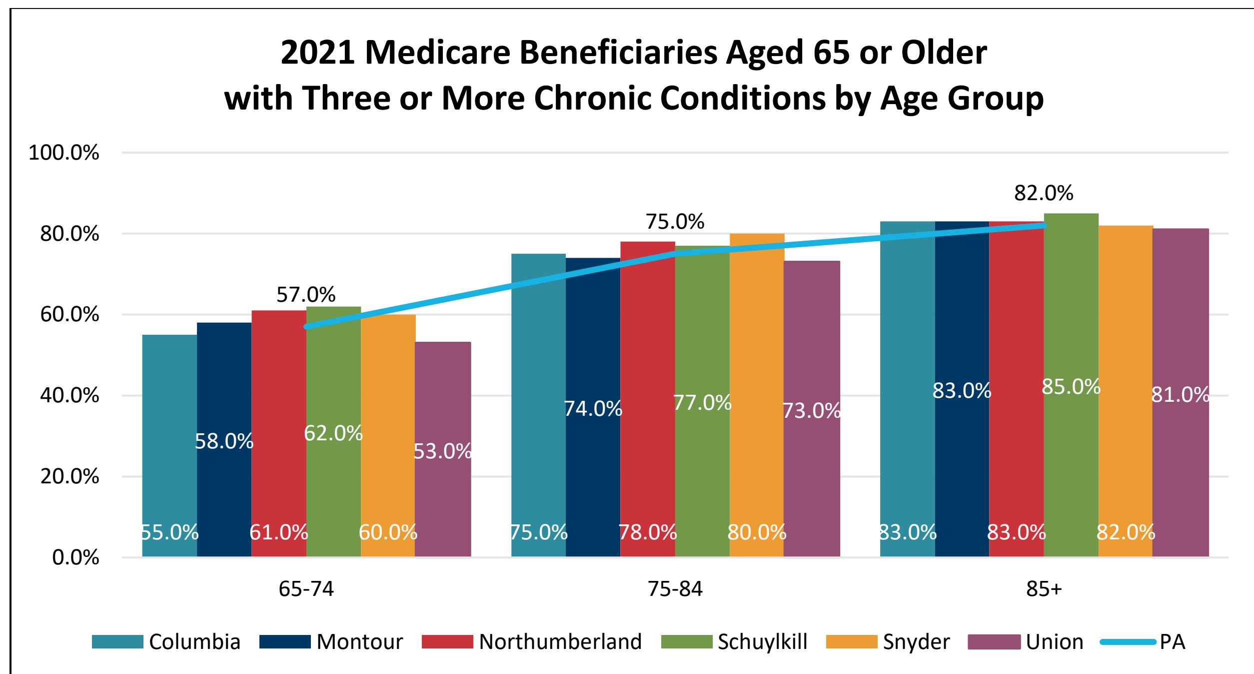
Aging Population

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

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

Healthcare utilization and care costs increase significantly with a higher number of reported chronic diseases, due in part to increased emergency department (ED) visits and hospital readmissions. **Across the region in 2021, between 53% (in Union County) and 62% (in Schuylkill County) of Medicare beneficiaries aged 65-74 reported three or more chronic conditions. Disease prevalence increased to between 81% and 85% at age 85+.**

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



Source: Centers for Medicare & Medicaid Services

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

	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Alzheimer's disease, related disorders, senile dementia	2%	2%	2%	2%	2%	2%	2%	2%
Cancer (breast, lung, colorectal, prostate)	10%	10%	10%	10%	10%	9%	10%	9%
Depression	16%	18%	19%	16%	18%	15%	16%	15%
Diabetes	25%	24%	27%	25%	25%	22%	24%	24%
High cholesterol	61%	64%	67%	69%	72%	67%	65%	58%
Hypertension	59%	59%	62%	64%	61%	57%	60%	59%
Obesity	31%	26%	29%	39%	29%	21%	27%	21%
Rheumatoid arthritis	28%	30%	31%	32%	32%	30%	31%	30%

Source: Centers for Medicare & Medicaid Services

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

	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Alzheimer's disease, related disorders, senile dementia	9%	10%	9%	8%	9%	9%	9%	9%
Cancer (breast, lung, colorectal, prostate)	16%	16%	15%	14%	14%	16%	15%	14%
Depression	17%	19%	21%	18%	20%	19%	18%	17%
Diabetes	29%	29%	34%	31%	34%	28%	30%	29%
High cholesterol	74%	75%	78%	78%	82%	78%	76%	72%
Hypertension	76%	76%	78%	80%	78%	76%	78%	75%
Obesity	31%	26%	26%	32%	33%	23%	25%	19%
Rheumatoid arthritis	38%	38%	41%	41%	42%	40%	41%	39%

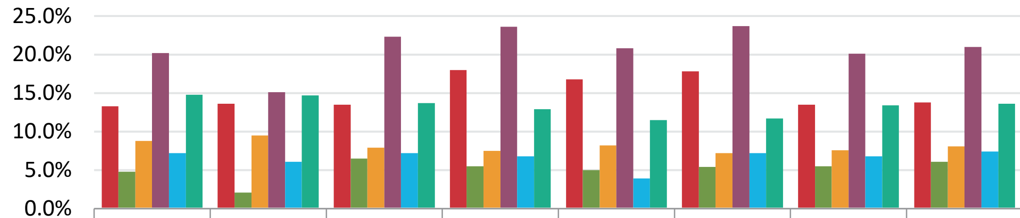
Source: Centers for Medicare & Medicaid Services

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

	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Alzheimer's disease, related disorders, senile dementia	26%	27%	27%	26%	25%	25%	26%	25%
Cancer (breast, lung, colorectal, prostate)	16%	14%	14%	15%	15%	15%	15%	14%
Depression	23%	23%	27%	24%	24%	26%	23%	21%
Diabetes	27%	27%	27%	29%	27%	27%	27%	27%
High cholesterol	69%	73%	74%	75%	78%	74%	71%	67%
Hypertension	86%	86%	85%	87%	84%	84%	85%	83%
Obesity	17%	13%	14%	18%	15%	14%	14%	11%
Rheumatoid arthritis	46%	48%	50%	47%	48%	47%	48%	45%

Source: Centers for Medicare & Medicaid Services

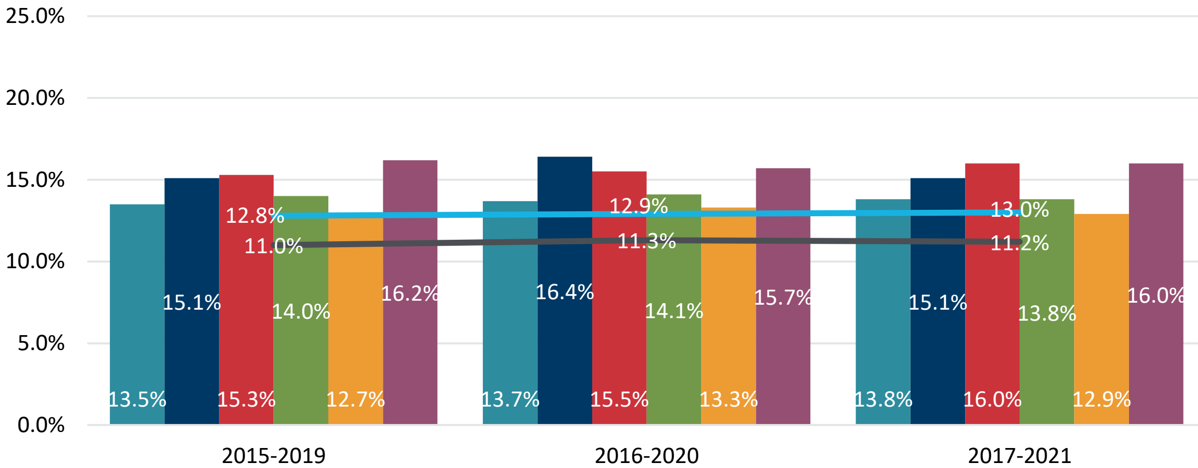
2017-2021 Prevalence of Disabilty Type among Older Adults (65+)



	Columbia	Montour	Northumberland	Schuylkill	Snyder	Union	PA	US
Hearing difficulty	13.3%	13.6%	13.5%	18.0%	16.8%	17.8%	13.5%	13.8%
Vision difficulty	4.8%	2.1%	6.5%	5.5%	5.0%	5.4%	5.5%	6.1%
Cognitive difficulty	8.8%	9.5%	7.9%	7.5%	8.2%	7.2%	7.6%	8.1%
Ambulatory difficulty	20.2%	15.1%	22.3%	23.6%	20.8%	23.7%	20.1%	21.0%
Self-care difficulty	7.2%	6.1%	7.2%	6.8%	3.9%	7.2%	6.8%	7.4%
Independent living difficulty	14.8%	14.7%	13.7%	12.9%	11.5%	11.7%	13.4%	13.6%

Source: US Census Bureau, American Community Survey

Older Adults Aged 65 or Older Living Alone



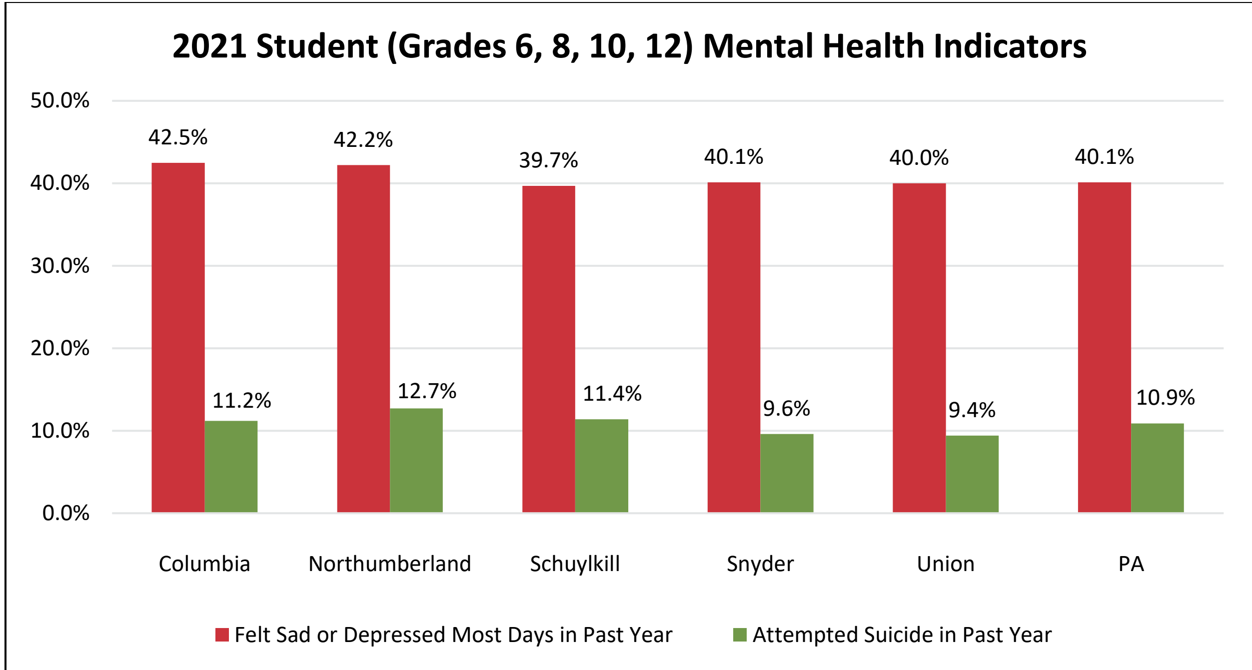
Source: US Census Bureau, American Community Survey

Youth

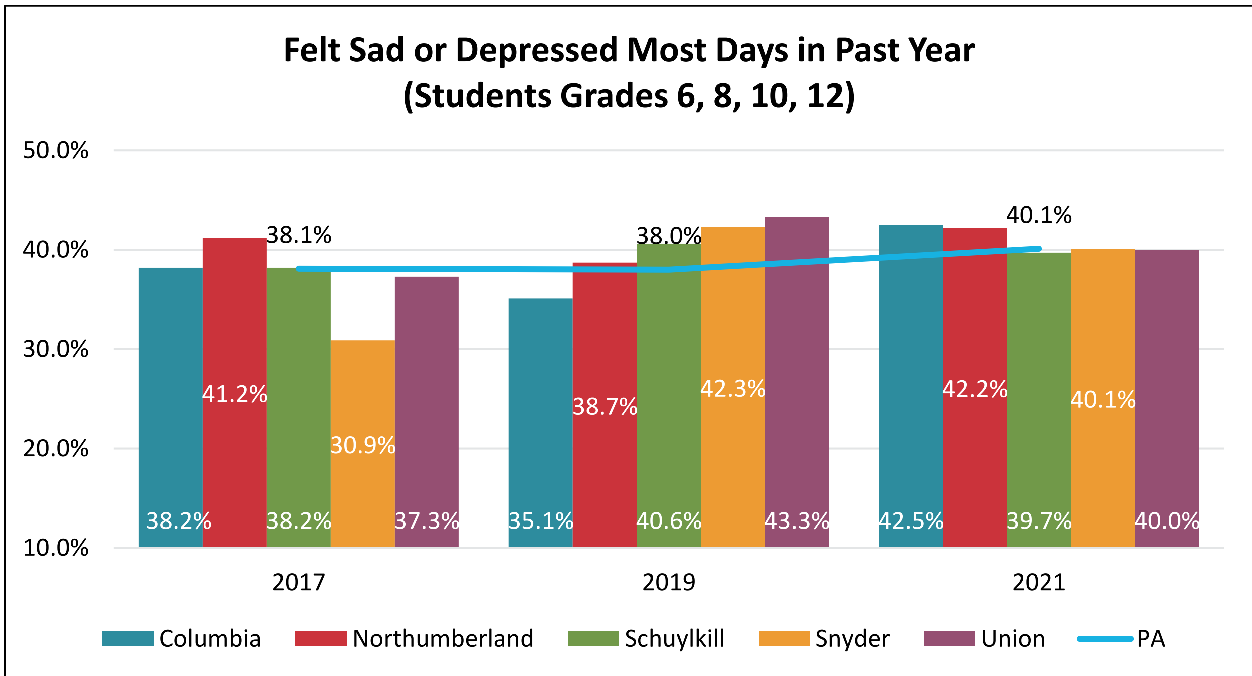
The COVID-19 pandemic has made unprecedented changes to the lives and experiences of young people worldwide. These concerns represent Adverse Childhood Experiences (ACEs), defined as traumatic or stressful events that occur before the age of 18. ACEs can have lifelong impacts on economic, educational,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

Mental and behavioral health disorders can be both the result of and the cause of ACEs. Students across Pennsylvania, including the Central Region, are showing a steady decline in substance use of all kinds, and reported use within the region is generally on par with or lower than elsewhere in the state. **The decline in substance use is an especially helpful measure given the ongoing rise in mental health concerns.** Mental health challenges among youth were proportionately high prior to the COVID-19 pandemic and are higher still in recent years.

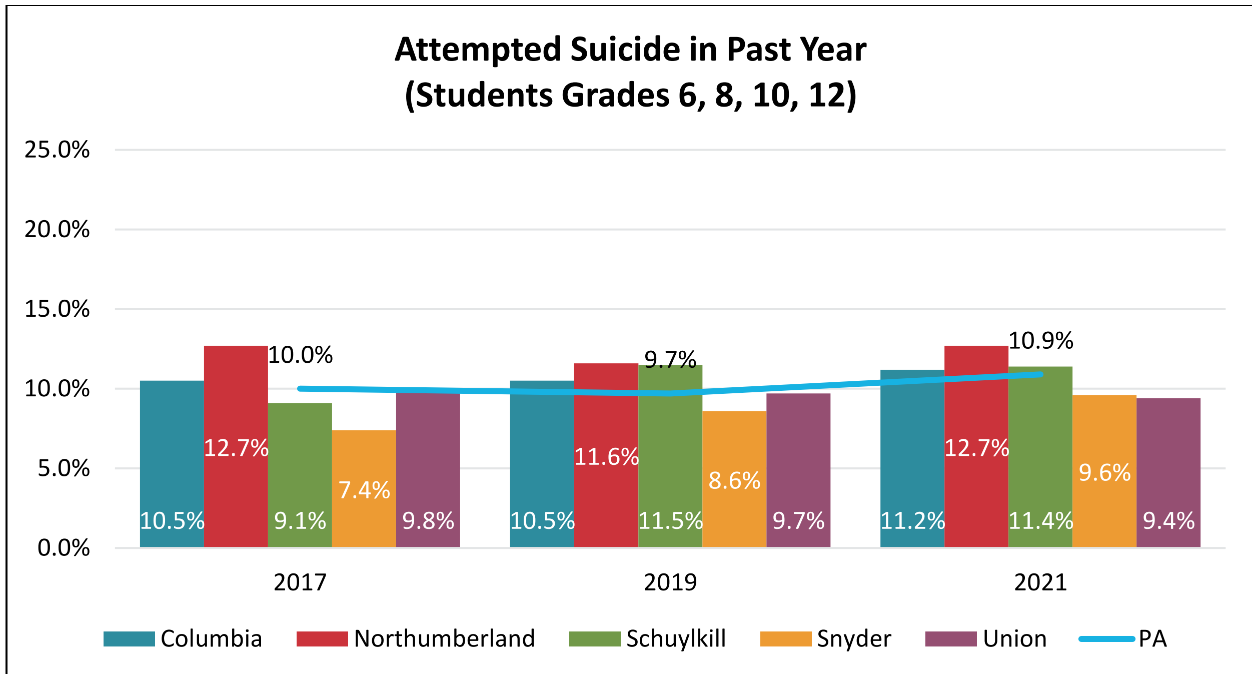
Schools, as they have finally re-opened to "normal" capacity in the last year are feeling the impact of these numbers in tangible ways. **Young people are struggling. In particular, fewer than half of students across the region "feel that school is going to be important for their later life."** Despite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



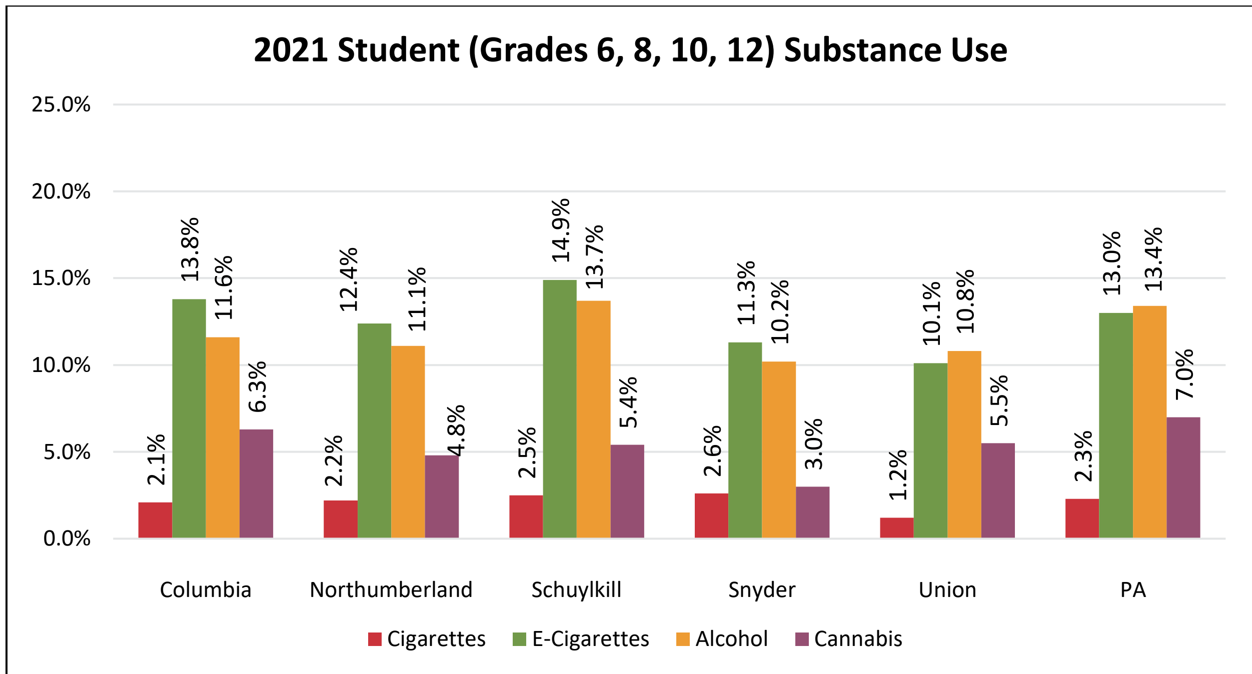
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



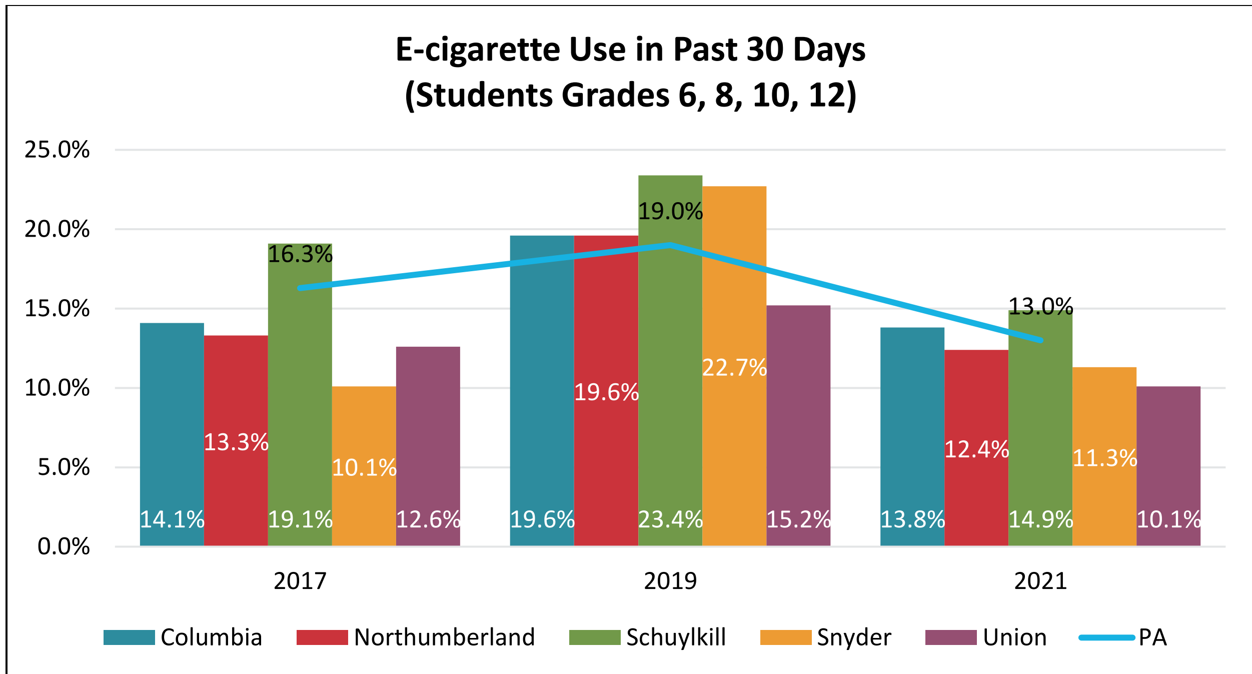
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



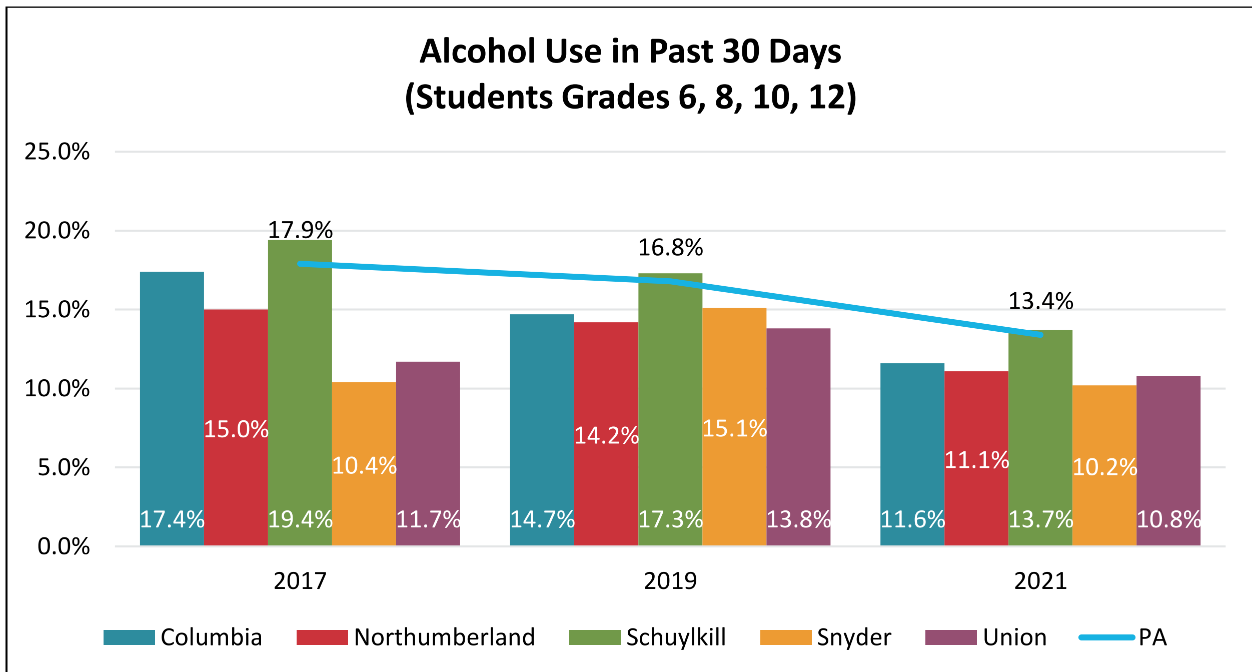
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



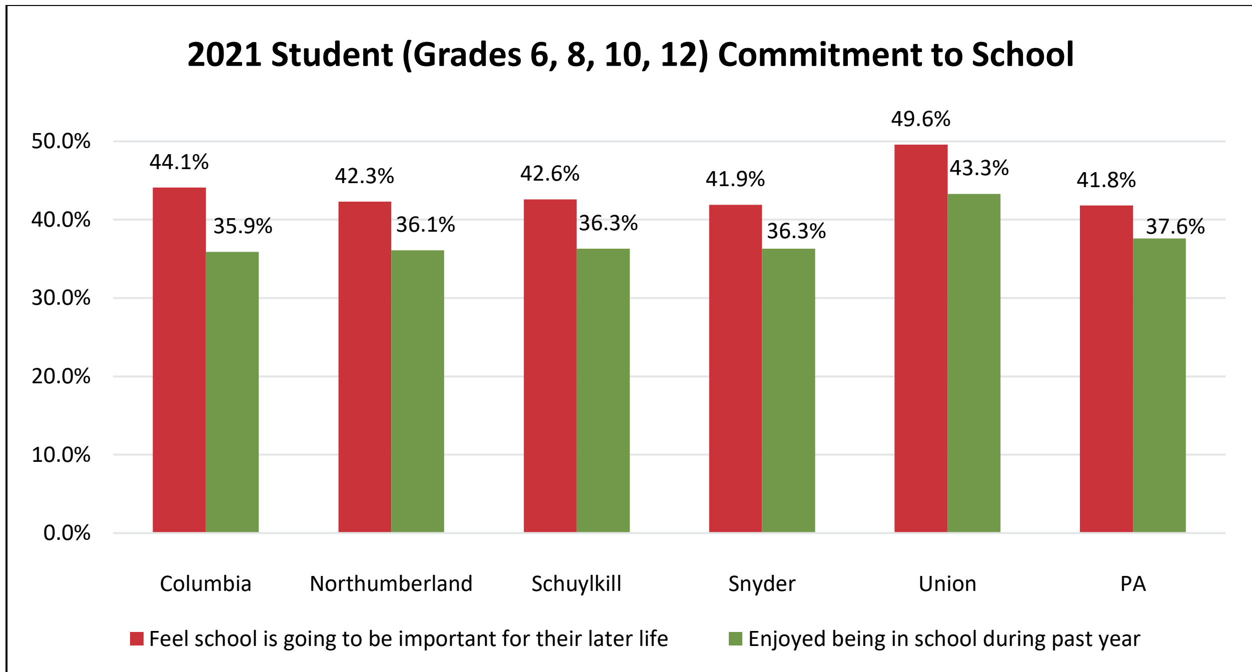
Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.



Source: Pennsylvania Commission on Crime and Delinquency
Note: Data are not reported for Montour County.

LGBTQIA+

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

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

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

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

General Health

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

Healthcare

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

Discrimination

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

Basic Needs

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

Mental Health & Substance Use Disorder

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

Sexual Health

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

Pregnancy, Birth, and Babies

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

Across the region, there is an opportunity for improvement in pregnancy outcomes, notably around prenatal care access and smoking during pregnancy. No county meets the national benchmark or Healthy People 2030 (HP2030) goal for first trimester prenatal care access. **Smoking prevalence among adults in the region is higher than across the rest of the state and the nation, a trend that continues among pregnant people in most counties. Outside of Montour and Union counties, between 10% and 18% of people reportedly continued to smoke during pregnancy, compared to 9% across the state and only 5% nationwide.**

However, it doesn’t appear that any one factor, whether the timing of the onset of prenatal care or smoking status during pregnancy, has a consistent impact on birth outcomes, such as prematurity or low-birth weight, within the region. All counties, excluding Northumberland, experience these outcomes at a similar rate as the state and nation.

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

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

	All Births		White Birth %	Black/African American Birth %	Latinx (any race) Birth %
	Count	Birth Rate per 1,000			
Columbia	544	16.4	91.2%	1.5%	5.0%
Montour	220	23.8	90.0%	1.4%	3.2%
Northumberland	877	19.5	90.9%	2.6%	7.4%
Schuylkill	1,280	18.5	86.3%	2.3%	14.1%
Snyder	377	18.9	96.8%	1.3%	1.6%
Union	406	20.9	91.9%	2.7%	2.2%
Pennsylvania	130,730	19.9	69.4%	14.2%	12.8%
United States	3,613,647	11.0	51.0%	14.7%	24.0%

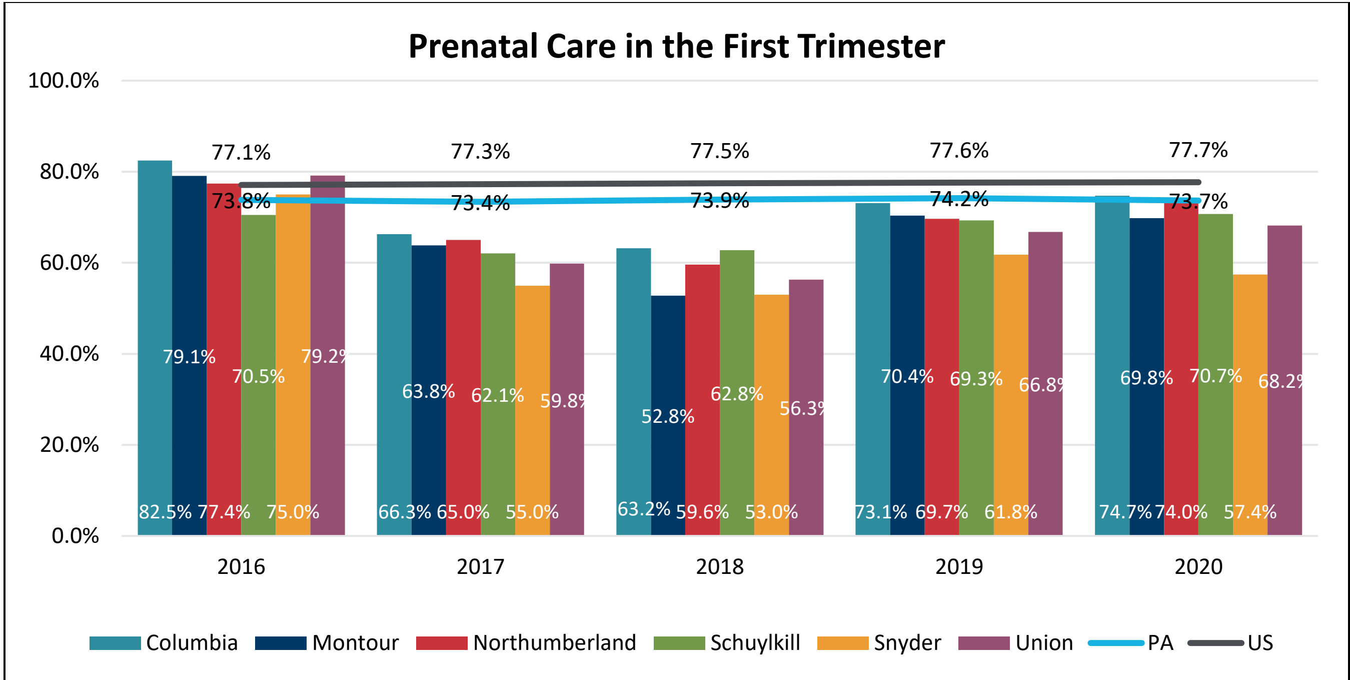
Source: Pennsylvania Department of Health & Centers for Disease Control and Prevention

2020 Maternal and Infant Health Indicators

Opportunities for improvement based on HP2030 goals are highlighted

	Teen (15-19) Births	First Trimester Prenatal Care	Premature Births	Low Birth Weight Births	Non-Smoking during Pregnancy
Columbia	3.3%	74.7%	9.0%	7.2%	86.5%
Montour	NA	69.8%	9.1%	5.0%	94.0%
Northumberland	5.8%	74.0%	10.9%	10.1%	81.5%
Schuylkill	4.8%	70.7%	10.1%	7.3%	81.6%
Snyder	4.0%	57.4%	7.7%	6.1%	89.7%
Union	2.5%	68.2%	4.0%	4.2%	93.3%
Pennsylvania	3.7%	73.7%	9.6%	8.3%	91.3%
Black/African American	6.8%	64.8%	14.0%	14.5%	93.1%
White	2.6%	77.2%	8.6%	6.8%	90.1%
Latinx (any race)	8.5%	65.3%	10.2%	8.5%	95.5%
United States	4.4%	77.7%	10.0%	8.2%	94.5%
Black/African American	6.4%	68.4%	14.3%	14.1%	95.5%
White	3.0%	82.8%	9.1%	6.8%	91.9%
Latinx (any race)	6.8%	72.3%	9.8%	7.4%	98.6%
HP2030 Goal	NA	80.5%	9.4%	NA	95.7%

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



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

2016-2020 Infant Death per 1,000 Live Births

	Infant Deaths
Columbia	5.1 (n=2,738)
Montour	NA (n=1,087)
Northumberland	6.6 (n=4,565)
Schuylkill	8.5 (n=6,589)
Snyder	NA (n=2,099)
Union	NA (n=2,010)
Pennsylvania	5.9 (n=4,012)
Black/African American	13.0
White	4.6
Latinx (any race)	6.5
HP2030 Goal	5.0

Source: Pennsylvania Department of Health

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

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

Source: Pennsylvania Department of Health

Key Stakeholder Survey

Background

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

A total of 180 individuals representing the Central Region responded to the survey. A list of the represented community organizations and the participants' respective titles is included in Appendix B.

Many of the stakeholders' organizations served residents of more than one Pennsylvania county, and a few provided statewide, or even nationwide, services. In total, stakeholder organizations served more than 40 Pennsylvania counties. More than 60% of respondents worked with organizations serving Northumberland, Snyder, and Union counties within the Central Region. Most considered their services to be open to all populations, regardless of age, race, religion, health needs, or income. Beyond that, the populations most served were people or families with low incomes or in poverty, children (age 0-11 years), and older adults/seniors.

Populations Served by Key Stakeholder Survey Participants

	Number of Participants	Percent of Total
No specific focus-serve all populations	111	61.7%
People or families with low incomes or in poverty	38	21.1%
Children (age 0-11)	36	20.0%
Older adults/Seniors	31	17.2%
Adolescents (age 12-18)	28	15.6%
Young adults (age 19-24)	28	15.6%
People with behavioral health concerns	23	12.8%
Other	23	12.8%
People or families experiencing homelessness	22	12.2%
People or families without health insurance or who are underinsured	20	11.1%
People with disabilities (physical, intellectual, developmental, etc.)	18	10.0%
LGBTQ+ community	13	7.2%
Veterans	12	6.7%
African American/Black	8	4.4%
Pregnant or postpartum people	8	4.4%
Asian/South Asian	5	2.8%
Hispanic/Latinx	5	2.8%
American Indian/Alaska Native	4	2.2%
People with memory care (Alzheimer's disease, dementia) concerns	4	2.2%
Faith-based community	3	1.7%
Pacific Islander/Native Hawaiian	3	1.7%
New Americans/Immigrants/Refugees	2	1.1%
Undocumented citizens	2	1.1%

Survey Findings

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

While most stakeholders described the overall quality of life of the people they serve as average (54%), about one in seven respondents described the quality of life as “above average” or “excellent,” and all stakeholders identified numerous strengths within the community. These strengths, listed below, can be drawn upon to improve the quality of life for all people in the Central Region.

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

	Number of Participants	Percent of Total
Access to healthcare services	64	38.3%
Good schools	61	36.5%
Safe neighborhoods	51	30.5%
Available social services	32	19.1%
Community connectedness	31	18.6%
Access to crisis support services (e.g., Neighborly, United Way 211, 988 National Suicide Hotline)	24	14.4%
Clean environment	23	13.8%
Employment opportunities	23	13.8%
Strong family life	21	12.6%
Resources for seniors	19	11.4%

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

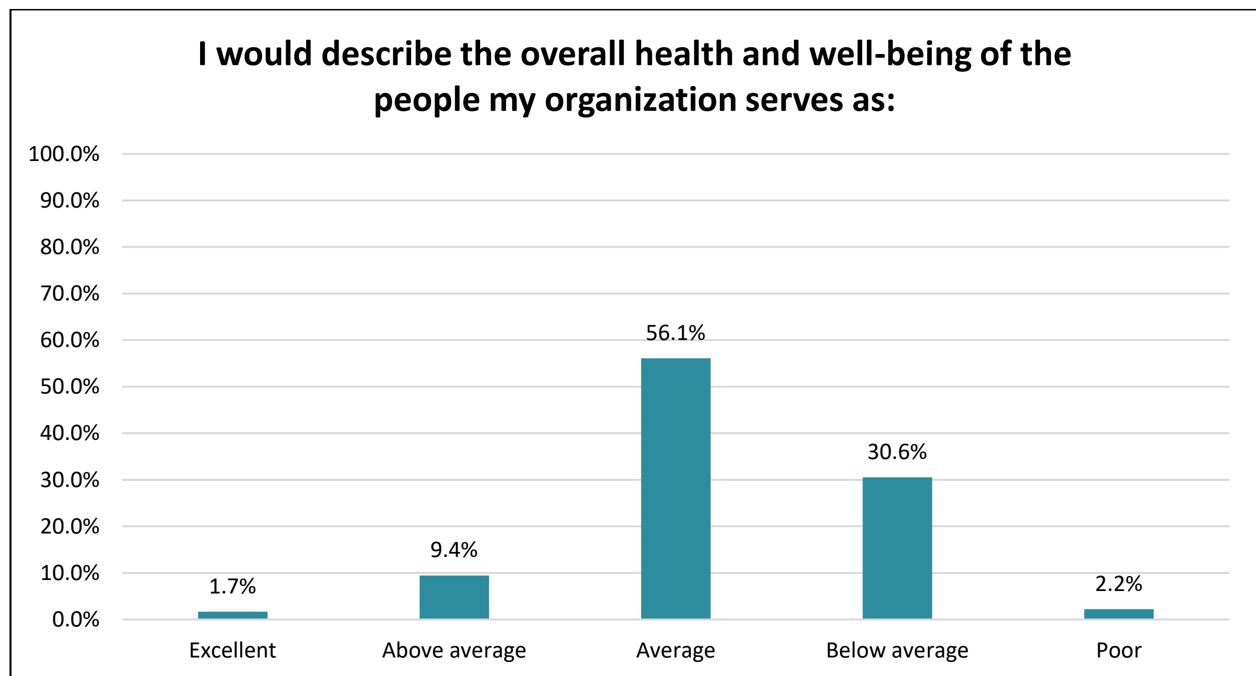
Additionally, stakeholders identified feelings of safety within the community, both from violence and within interpersonal relationships, as well as *some* opportunities for social mobility such as good schools, employment opportunities, and available stop-gap resources for those who fall on hard times,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

Thinking about the people their organization serves, key stakeholders were asked to describe the overall health and well-being of individuals and the most pressing concerns affecting them. Approximately 56% of stakeholders described overall health and well-being as “average” and 31% described it as “below average” or “poor,” indicating opportunity for health improvement.

When asked to identify the top five most pressing concerns affecting the people their organization serves, an overwhelming 61% of respondents selected mental health conditions, and almost half (46%) identified lack of transportation. Childcare (affordable, quality), housing (affordable, quality), and substance use disorder were all selected by more than one-third of respondents as top five concerns among constituents.

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

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



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

	Number of Participants	Percent of Total
Mental health conditions	101	60.5%
Lack of transportation	77	46.1%
Housing (affordable, quality)	60	35.9%
Substance use disorder (dependence/ misuse of opiates, heroin, etc.)	59	35.3%
Childcare (affordable, quality)	58	34.7%
Ability to afford healthcare	55	32.9%
Economic stability (employment, poverty, cost of living)	54	32.3%
Ability to afford health foods	44	26.4%
Overweight/Obesity	31	18.6%
Stress (work, family, school, etc.)	25	15.0%
Older adult health concerns	23	13.8%
Health literacy (ability to understand health information)	21	12.6%
Limited healthcare capacity (appointments, convenient time/location, etc.)	18	10.8%
Child/Adolescent health concerns	16	9.6%
Limited healthcare providers	15	9.0%

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

- *“Continue to focus on social determinants; people can’t focus on health issues if basic housing/food/job needs are not met.”*
- *“I believe investment in building out community resources for behavioral health resources, housing and transportation specifically for members who are transitioning from one level of care to another needs to be priority. We often struggle to transition a member safely from an acute or post-acute facility back into the community because they do not have appropriate housing or transportation for their follow up appts.”*
- *“Offer childcare for their employee’s families.”*
- *“…the cost of nutritious foods is too exorbitant. Individuals with lower incomes cannot afford healthy choices and therefore choose prepackaged, economical foods. It would benefit the community at large to find a way to provide some sort of local transportation for those who cannot afford vehicles to make appointments, go grocery shopping, etc. Many of the local universities have a ‘communal’ bus that takes students to stores for shopping purposes and it seems the community should be able to provide something like that for its members.”*

- *"Provide health literacy (physical, chronic, and above all, mental wellness) workshops out in the community. In general, more people need to understand that mental health needs to be regarded on par with physical health. With stigma reduction, there will be more community support for the intersection of mental health, substance abuse, and poverty. Here at the Bloomsburg Public Library we provide a stopping place for vulnerable, 'unseen' individuals. On the other hand, we have other patrons who are stuck in a mindset that people who live with addiction, poverty, or mental illness should continue to be criminalized or pushed to the margins."*
- *"Incentivize caregivers with better pay, benefits to encourage applicants and as well as to retain employed caregivers, provide housing for those who don't qualify for skilled care."*
- *"Training and technical assistance to ensure providers are educated and comfortable addressing intimate partner violence, sexual assault, human trafficking and other traumas and improve partnership with local victim service organization."*
- *"Educational programs/partnerships to build the healthcare workforce pipeline while elevating educational attainment."*
- *"Work more collaboratively with nonprofits and agencies whose missions align with solving these challenges. Move beyond ownership to a greater good model. Too much competition over limited resources and with the excuse of we are doing it for the greater good."*
- *"Continuum of care and referrals to partnering organizations. Collaborative funding applications to address systemic issues."*
- *"Bring health and wellness programs into the communities via church groups, schools and community centers to offer help in a neutral space – not clinic/doctor office."*
- *"Connect with nontraditional service providers like community centers, senior centers. Advocate at the state and federal level for funding for sex education, and family resources as health care."*
- *"Be more visible and accessible in the community. Make health care less complicated. Talk to people in lay terms."*
- *"More mobile clinics. Preventative clinics, irrespective of insurance availability. Insurance is a big problem."*

Social Drivers of Health

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

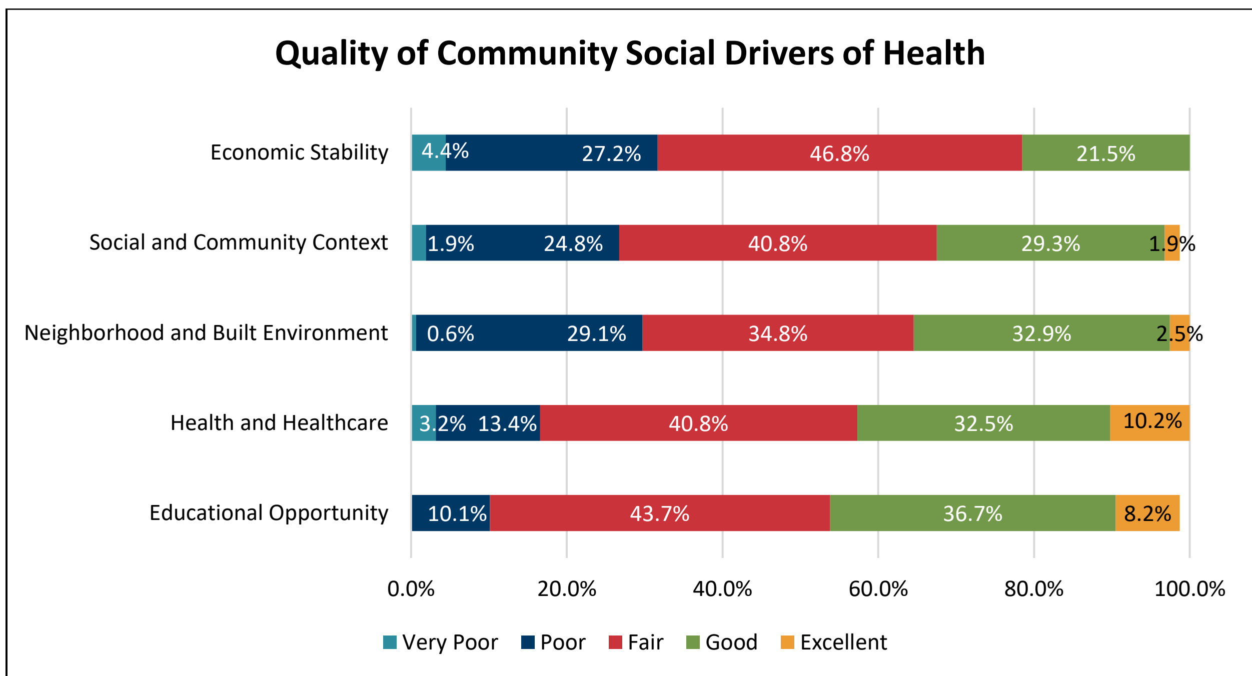
The mean score for each SDoH domain is listed in the table below in rank order, followed by a graph showing the scoring frequency. Educational opportunity was seen as the strongest community SDoH with 45% of stakeholders rating it as "good" or "excellent." Economic stability was seen as the weakest SDoH with 47% rating it as "fair" and 32% rating it as "poor" or "very poor." There was greater variability

in stakeholders' perceptions of health and healthcare, with the highest percentage of "excellent" ratings, but also the second highest percentage of "very poor" ratings.

Approximately 56% (n= 89) of stakeholders stated that their organization currently screens the people their organization serves for needs related to SDoH.

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

	Mean Score
Educational Opportunity (Consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)	3.44
Health and Healthcare (Consider access to healthcare, access to primary care, health literacy)	3.33
Neighborhood and Built Environment (Consider access to healthy foods, quality of housing, crime and violence, environmental conditions, transportation)	3.08
Social and Community Context (Consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	3.05
Economic Stability (Consider poverty, employment, food security, housing stability)	2.85



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

- *"Hard to retain workforce and pay living wage. Limited healthcare workforce pipeline. Many rural areas face critical issues with transportation, health care access, healthy food, childcare, etc."*
- *"Economic Stability: food security is a real concern in our communities. Local organizations are being leveraged more than ever…Social and Community Context: There is a major cultural divide in our communities. There are negative perceptions of minoritized populations as well as a sense that*

these populations should leave the area. Perceptions of cultural diversity is that it is a threat to the area versus enrichment…Neighborhood: crime is truly out of control. There has been an uptick in violence against women."

- *"Poor – urgent referrals often take months to be seen. A lot of homelessness as well as drug addiction and overdose in the area although I see a community that fights any movement with homeless shelters or treatment facilities."*
- *"There are no medical or mental health facilities in the towns within our school district. There is also no public transportation in the area."*
- *"Schools, most houses of worship and social institutions not LGBTQ+ supportive in general and some are hostile. Same for families. No LGBTQ Center in the immediate area. Very few GSA clubs or LGBTQ+ youth groups."*
- *"Working in social services for over 30 years and in multiple different fields, I recognize that we live in a very poor county with families that have had multigenerational trauma which affects all areas of their lives as noted above. It takes a lot of time and energy to build trusting relationships to help people move out of the intergenerational problems they have experienced. People who work in human services are not compensated enough to do the hard work that is required to build healthy communities. They too are often living in poverty unable to meet their own basic needs."*
- *"Poverty is a cycle. Many of the young people I work with come from poverty and are desperately trying to get out. The odds are usually against them. Many lack family stability and support at home, especially when it comes to education. Without proper education, participants are left working entry-level jobs, struggling to make ends meet, and relying on assistance programs in order to survive; therefore, making it extremely difficult to end the cycle of poverty."*
- *"The justice involved population are often limited in access to self-sustaining employment. They have issues making enough money to meet their basic needs. Transportation is consistently a barrier due to loss of license. This limits their ability to participate in community activities that give them a sense of belonging. Crime and criminal behavior also limit their ability to reintegrate into society successfully. There is a lack of cognitive behavior interventions, mental health treatment and substance abuse treatment that could help overcome some of the barriers noted that greatly limit the quality of life available to justice involved individuals."*
- *"People with disabilities live in poverty due to the structure of the Medicaid SSI system. Our community offers no further education opportunities after High School to our population. Societal stigmas are a major community barrier for people with disabilities. Transportation continues to be a HUGE barrier for this population that most do not or are not able to drive. Distance to healthcare, options for specialists, medical community stigmas about the quality of life for people with disabilities and offering care based on that stigma."*

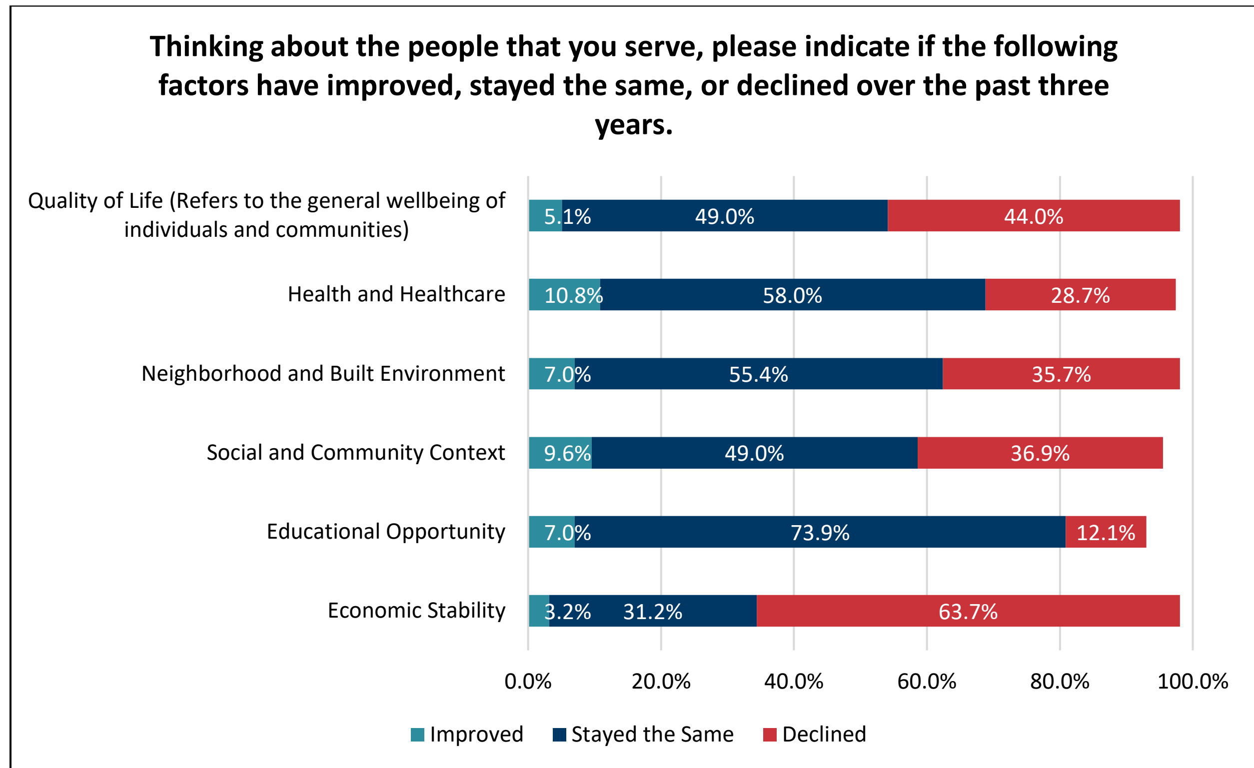
COVID-19 Insights and Perspectives

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

Key stakeholders were also asked how SDoH have fared over the last three years, compared to before the pandemic. On four of six SDoH measures, most respondents perceived conditions to be the same as,

if not improved, from the start of the pandemic. However, stakeholders cited a perceived precipitous decline in overall economic stability, including poverty, employment, food security, and housing.

Conversely, more stakeholders perceived improvement in health and healthcare than in any other measure (11%), influenced by lessons learned and skills acquired throughout the pandemic, such as telehealth. Feedback to this effect includes stakeholder reflections such as, *"Online support works and is very important and should continue even now that we can also meet physically."*



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

- *"Relate to a variety of ethnic and cultural differences; provide public health screenings targeted to minorities, immigrants and refugees; help people navigate difficult and confusing public systems to qualify for assistance and healthcare; get out into the community – community health workers."*
- *"Work together to efficiently and effectively deploy resources. Reduce duplication of efforts."*
- *"Make an individual's 'total health' the top priority – building systems that incent outcomes based on performance and leverage/coordinate the full suite of community programs and services needed to attain better health."*
- *"Our families do not always know how to advocate for their children. When they cannot get into appointments for illness or injury, they make use of urgent care and become reliant on urgent care, even sometimes for physicals. A primary pediatrician would more likely be able to guide ongoing healthcare of the child and pick up on things that the parents are not."*

- *"Less stigma, offer harm reduction strategies (needle exchanges, methadone clinics, etc.)"*
- *Support and employ more support staff positions – health navigators, CHWs, etc. who can bridge the gaps between those in need and the healthcare and social services providers."*
- *"Routine screenings (colorectal, mammograms, pap), childhood immunizations, and depression screening took a back seat during the COVID-19 pandemic. Organizations need to take stronger initiatives to get back on track."*
- *"By continuing to ride the wave of technology used to increase and improve connectivity with members."*
- *"Transportation is a huge issue in our area. There are many elderly that do not drive and a lot of people that cannot afford cars or gas and cannot get to their appointments because we do not have bus transportation and taxis/Ubers are too expensive."*
- *"Fight for lower insurance rates, focus on hiring and retaining staff and making them happy. Focus a lot less on the bottom line and acquiring more and more and more and more property."*

In closing, key stakeholders were asked to leave any parting or summary thoughts regarding the COVID-19 pandemic. A total of 102 stakeholders responded, and their responses are grouped thematically below.

COVID-19 Pandemic Feedback Themes	Number of Responses
Necessity of teamwork and partnerships (between community-based organizations, among healthcare providers, and between and amongst members of the community in "big" and "small" ways)	24
Mental health (the ongoing impact on people's mental health and the need for increased services, especially for youth)	22
Health education (the necessity of providing consistent, accurate, and accessible health information to members of the community to promote health)	18
Importance of prevention and preparedness, and implementing lessons learned	17
Necessity of addressing mistrust (in the government, in the healthcare system, between diverse community members)	13
Current economic crisis (disparate impact of all factors on the poor, need to address SDoH)	9
More support solutions for vulnerable populations (elderly, people with disabilities)	6
Address ongoing barriers to accessing healthcare (transportation, insurance concerns, etc.)	4
Strengthening capacity of healthcare and social services organization (hiring and retention, training, availability)	3

Next Steps and Future Collaboration

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

- *"Better data sharing and seeing the big picture/connectedness of all resources."*
- *"Childcare options for all income levels and additional opportunities for low-to-moderate income families."*
- *"Ensure vulnerable populations are connected with a healthcare based social worker or medical advocate."*
- *"Use 211/Help Line and Warm Line as a resource more to reduce crisis and access to services."*
- *"By financially supporting organizations in their quest to build stronger communities of mutual interest."*
- *"Come out into the community and provide free workshops, talks, screenings in the locations where people already come for information – for example, the Bloomsburg Public Library."*
- *"Keep resource lists for LGBTQ+ people of all ages, and their families and keep them updated. Make it easy for people to search and find gender affirmative care. Work with LGBTQ+ groups, family groups such as PFLAG and Trans Central PA. Make medical record gender affirming."*
- *"Reach out to county BH/ID/ Aging offices for transitioning impaired individuals to supportive communities to reduce revolving door of admission/discharge and to ensure least restrictive housing opportunities with necessary services."*
- *"Perhaps a community collaboration committee that consists of Geisinger leadership and community-based organizations. This would allow for better conversations, collaboration, and ensure that everyone is working toward the same health outcomes."*
- *"If a foster child is a 'no show,' make repeated calls to C&Y caseworkers, CASA volunteers, foster parents, bio parents, and other family members until the child is evaluated."*
- *"More mobile health services would be beneficial."*
- *"The COVID vaccine delivery to vulnerable citizens Task Force was excellent."*
- *"The partnership at the Miller Center is a prime example of successful efforts to address Social Drivers of Health by collaborating on healthy food initiatives to ensure no one goes hungry."*
- *"Partnerships like Healthy Kids Day at the Miller Center where families can learn about healthy lifestyles and receive free information about healthy food, bike helmets for kids, be active together, etc. are fantastic! I'd love to see more of that, partnering with the downtown groups/Chambers/Visitors Bureaus in every community."*
- *"Continue to offer subject matter experts to other organizations."*

Central Region Community Forum

Background

Geisinger, Allied Services, and Evangelical Community Hospital hosted a Community Forum on September 13, 2022, at the Pine Barn Inn in Danville. The forum convened 39 representatives of health and social service agencies, education sectors, senior services, local government, and civic organizations, among others. The objective of the forum was to share data from the CHNA and garner feedback on community health priorities and opportunities for collaboration among partner agencies.

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

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

Common Themes

- The region benefits from robust health and social services to improve access to care, behavioral health, and chronic disease. Participants identified a number of services, many addressing SDoH barriers (e.g., transportation, cost assistance, care for uninsured/underinsured), bringing care directly to the community (e.g., mobile or in-home), and/or facilitating inter-agency referrals.

Identified Community Assets

Access to Care	Behavioral Health	Chronic Disease
▪ Aging Office ▪ Berwick Urgent Care ▪ Central Susquehanna Sight Services ▪ Community Action Agencies ▪ Family Health - WIC/SNAP ▪ Geisinger at Home, Life Geisinger, 65 Forward ▪ Head Start ▪ Mobile health units (Evangelical/Geisinger) ▪ Penn College/Luzerne County Community College ▪ Penn State Extension (educational programs) ▪ Rabbit Transit ▪ SEDA-COG (broadband and transportation planning) ▪ Susquehanna Valley United Way ▪ Transitions of PA	▪ Gaudenzia ▪ Geisinger: EMRLink, Free2BMom, Medication Assisted Treatment (MAT), Outpatient Pharmacy Program ▪ School-based health education programs ▪ LPN Career Center ▪ Mental health telehealth services for patients with low income ▪ SEARCH Academy	▪ Geisinger 65 Forward ▪ Berwick Teen Center ▪ Danville Area Community College ▪ School-based health education programs ▪ Question Persuade Refer (QPR) Training ▪ SEARCH Academy ▪ YMCAs

- Sustained, collective impact will require broad-based and multi-sector collaboration. Success factors for collaboration include:
  - Consistent inter-agency communication to share available resources and conduct joint outreach efforts;
  - Non-competitive forums to foster collaboration and address duplication of services;
  - Government and elected official involvement to impact policy and funding; and
  - Collective investment for community revitalization and efforts to retain and attract young families and working age residents.
- Community childcare options are limited and increasingly expensive, affecting family work-life balance and financial security, as well as community economic potential.
  - The region (and nation) is experiencing a childcare staffing crisis with fewer people entering the workforce due to low wages.
  - Childcare related call-offs by employees are hindering employer operations.
  - Employers are exploring creative solutions to childcare challenges. Examples include Evangelical Community Hospital's pilot onsite childcare center for employees with emergency care needs. The center is available on a sliding scale based on income and in partnership with Patch Caregiving.
- Individuals with special needs, non-English speakers, transient families, and the unhoused individuals are often missing from community conversations, and therefore the opportunity to share their lived experience and address service delivery gaps.

Access to Care and Chronic Disease

- Rural communities are underserved by healthcare services and would benefit from mobile services, better public transportation, and support for rural clinics.
  - Urgent care centers are partners in meeting care gaps, but services are often limited and wait times can be long.
  - The region may benefit from community member training and education to assist in medical emergencies while waiting for medical services.
- Affordable healthcare and childcare are needed to support financially burdened populations, like ALICE households, and make available the opportunity to prioritize their health. Advocacy for policies like universal health coverage (Healthcare for All) is needed.
- Populations living in isolation and/or experiencing socioeconomic barriers (e.g., unhoused, older adults, individuals with low-income or low technology access, and caregivers) are consistently not benefiting from available community resources. Primary barriers continue to be access issues like transportation, lack of awareness of services, and lack of knowledge of eligibility.
  - Community action agencies, faith-based organizations, and human services agencies can better collaborate to reach these populations and identify strategic partnerships to provide holistic service.

- Communities that have lost their local hospital and/or have limited access to care providers are at risk for worse health outcomes due to unmanaged chronic diseases. The region can learn from other organizations and collaboratives working to address health disparities, including:
    - Jewish Healthcare Foundation (Pittsburgh), an activist and grantmaking foundation working to test new models of care, new public health initiatives, and new collaboratives to improve coordination and manage population health.
    - Pennsylvania Perinatal Quality Collaborative, a partnership of birth sites, NICUs, and health plans to review processes and adopt strategies to improve maternal outcomes.
- The community would benefit from integrated, more inclusive injury prevention initiatives. Injury or trauma is a disease process, and the only disease process that is 100% preventable. At Geisinger Medical Center, the leading mechanism of injury is falls, across all age groups, but especially in older adults. Older adults in rural communities are particularly vulnerable as many of those who sustain injuries do not return to their homes. The second cause of injury is motor vehicle crashes, affecting both young and mature drivers.

Behavioral Health

- Access to behavioral healthcare has improved, but certain populations (listed below) continue to be underserved for a variety of reasons like stigma and poverty. Essential community champions or connectors to underserved populations must be identified to better serve these individuals.
    - Individuals who are unhoused
    - Individuals with co-occurring mental health disorders
    - LGBTQIA+
    - Single mothers living in poverty
    - Youth
- The region can learn from best practice behavioral healthcare models in other communities, including screening for mental health at client encounters and individualized treatment plans that keep patients at home and meet them where they are at. Example models include:
    - Behavioral Health Rehabilitation Services (BHRS), providing individualized care and treatment primarily in community settings
    - Lifestyle medicine options for coordinated, team-based care that prioritizes preventive healthcare and self-care
    - UPMC's Health Access Initiative for Recovery (HAIR) training Allegheny County-based Black barbers and stylists on how to talk to their clientele about substance use, anxiety, depression, suicide prevention, and how to properly refer them to resources and help
    - Walk-in mobile crisis centers

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

Evaluation of Health Impact

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

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

Our goals:

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

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

Priority – Access to Care

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

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

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

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

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

Surveys conducted by the Junior Achievement event organizers found that:

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

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

Priority – Behavioral Health

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

- Opened a 96-bed facility providing care for adult, pediatric, and adolescent patients who struggle with acute symptoms of behavioral health disorders such as anxiety, depression, bipolar disorder, psychosis, and posttraumatic stress disorder in Moosic, PA. Development plans for a second, 96-bed hospital – Geisinger Behavioral Health Center Danville – are underway, and the facility is expected to open in 2025.
- Implemented follow-up care for pediatric behavioral health patients seen in the emergency department in crisis, including help to navigate psychiatric crises and connections with appropriate behavioral health specialists.
- Embedded a behavioral health specialist in the pediatric infusion center to assist pediatric patients with inflammatory bowel disease, including Crohn's disease and ulcerative colitis.
- Continued to provide Narcan overdose reversal kits in the community and partnered with community agencies to increase distribution.
- Offered Free2BMom program specifically designed to treat pregnant women addicted to opioids or with a history of or current opioid use disorder.
- Provided medication disposal boxes at GMC, GSACH, and area retailers as part of the Medication Take Back Program to prevent misuse and/or harm to the environment.
- Implemented standard postpartum depression screenings for new mothers.

Program and Strategy Highlights:

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

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

The Geisinger Bridge Clinic received funding from the Susan W. McDowell Pediatric Behavioral Health Catalyst Fund to address the need for follow-up care for pediatric behavioral health patients who come

to the emergency department in crisis. Since the beginning of the COVID-19 pandemic, there has been a national rise in suicidal thoughts and suicide attempts among school-age children, according to the American Academy of Pediatrics. The clinic will alleviate strain on our emergency medicine colleagues and provide interventions for children and families with professionals helping to navigate psychiatric crises. The program will also ensure long-term access for patients with appropriate behavioral health specialists.

The prevalence of inflammatory bowel disease, including Crohn's disease and ulcerative colitis, has increased more than 130% in the past 10 years. The diseases can cause loss of appetite, fatigue, diarrhea, rectal bleeding, delayed growth, and the need for possible surgery, and require infusion therapy to help manage them. Youth dealing with these illnesses are at greater risk for depression, anxiety, social difficulties, and poorer quality of life, according to the Crohn's and Colitis Foundation. An embedded behavioral health specialist in the pediatric infusion center provides patient assessment and offers coping and management skills for gastrointestinal disorders for young patients and families.

Priority – Chronic Disease Prevention and Management

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

- Conducted screening and referral practices to identify and respond to social drivers of health needs for patients.
- Provided Geisinger Mobile Care Gap bus to reach individuals with diabetes who have a care gap in their preventive health and require critical screenings and services.
- Provided Geisinger Fresh Food Farmacy at GSACH, offering diabetes education and management resources as well as nutritious foods for individuals identified as having A1C levels greater than 8.0 and food insecurity.
- Implemented the ZING543210 online website and program for community-based healthy lifestyle education.
- Supported and sponsored community-based programs, trainings, and events to promote community wellness and prevention.
- Implemented Walk with a Doc, pairing discussions on timely health topics and wellness walks.
- Offered free culinary medicine classes to community members and Geisinger employees at Geisinger Selinsgrove. The classes included nutrition education, food safety, and smart shopping lessons and live cooking demonstrations based on the Mediterranean diet.
- Dr. Ruiz, Chair of Cardiology, attended 28 community events in 2023 to educate the community on topics such as stress in the workplace, heart health and prevention, and heart disease.
- Dr. Cybele Pacheco and Dr. Anne Marie Morse attended the Representative Joanne Stehr and Senator Lynda Schelgel Culver Senior Expo in Elysburg to discuss 65 Forward and Sleep Disorders.

- Dr. Sandra Culbertson spoke at the Greater Susquehanna Valley Chamber Women's Leadership Luncheon & Learn about Pelvic Floor Disorders.
- Implemented best practices in cancer detection, including low-dose CT scans for lung cancer and machine-learning algorithm to identify and conduct outreach for patients with high-risk for colorectal cancer.
- Updated and expanded the GSACH emergency room to better serve the Shamokin area and surrounding region. Improvements include a technologically advanced, aesthetically pleasing environment conducive to providing the highest-quality emergent care, 19 private care areas, and a five-bed rapid evaluation unit for treatment of less severe injury and illness.
- Opened a new Geisinger 65 Forward Health Center in Coal Township in 2021 to better meet the care needs of people aged 65 or older.
- Opened a ConvenientCare walk-in clinic in Mount Carmel for minor health concerns.

Program and Strategy Highlights:
Geisinger's Mobile Care Gap bus offers care to individuals with diabetes who have a care gap in their preventive health. It offers critical services and screenings to help patients with diabetes manage their health. The bus stops every Monday, Wednesday, and Friday at different locations in the Geisinger footprint. Patients with care gap misses are contacted and scheduled for appointments on the bus — no walk-ins are taken. Staff members also assist in scheduling mammography and colorectal screening services. Three nurses on the bus each see up to 20 patients. Services provided include height, weight and blood pressure checks, foot exams, diabetic retinopathy eye exams, nephropathy screening (urine collection) and any overdue lab work including phlebotomy services (A1C). Patients can also be vaccinated against pneumonia and flu, when needed.

The Mobile Care Gap bus was established in response to the COVID-19 pandemic and resulting care gaps for diabetic patients. Patients were missing critical yearly eye exams, kidney checks, and blood tests used to monitor how well people are managing blood sugar levels. The bus continues to operate and during the fall and winter months, when the bus may not be appropriate, the mobile nurses will go into clinics to continue closing diabetic care gaps.

In partnership with community philanthropists, the Fresh Food Farmacy was launched in July 2016 at GSACH. The program is available for patients with diagnosed diabetes and facing food insecurity. Patients receive more than 20 hours of diabetes education with clinical staff and access to the Fresh Food Farmacy app, which includes healthy recipes and nutrition information. Patients receive enough food to prepare healthy, nutritious meals for their whole family, twice a day for five days (10 meals per week). Patients attend an evidence-based weekly diabetes or chronic disease self-management program and have access to other no-cost classroom education offered by dietitians and team members. The program now serves more than 200 patients and their families and has expanded to serve three locations: Shamokin, Scranton, and Lewistown.

Geisinger's COVD-19 Response

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

Vaccine Distribution

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

Contact Tracing

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

Community

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

Next Steps

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

Appendix A: Public Health Secondary Data References

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Appendix B: Key Stakeholder Survey Participants

AIDS Resource, Executive Director
Allied In-Home Services, AVP
Allied Services-Behavioral Health Division, Director, Behavioral Health Division
American Rescue Workers, Director of Development and Community Engagement
B.I.D.A., Executive Director
BARRASSE LAW, owner
Berwick Teen Center, Director
Bloomsburg Food Cupboard, Coordinator
Bloomsburg Public Library, Library Director
Bloomsburg Public Library, Board Member
Busy Little Beavers, CEO
Center for Breast Health, RN
Center for Community Resources, Case Management Program Manager
Central Susquehanna Intermediate Unit, Adult Education Program Manager
Central Susquehanna Intermediate Unit, SYNCH Project and Data Collection Manager, CSIU Nurse Aide Training Program Coordinator
Central Susquehanna Intermediate Unit, Career Coach
Central Susquehanna Opportunities, Inc., Project Coordinator
Central Susquehanna Sight Services, Life Skills Director
Central Susquehanna Sight Services, Prevention of Blindness Specialist
Central Susquehanna Sight Services, President/CEO
Child & Family Support Services, Clinical Director of our Pottsville Office
Columbia Child Development Program, Coordinator
Columbia Child Development Program, Executive Director
Columbia County Family Center, Director
Columbia County Volunteers in Medicine, Executive Director
Commonwealth of Pennsylvania, Commonwealth of Pennsylvania
Community Giving Foundation, Program Officer
Concerned Citizens for Child Care, Inc., Executive Director
County of Snyder, Commissioner
CSIU, Career Counselor
CSIU Early Childhood, Director of Early Childhood
DACC, Director of Operations
Danville Head Start, Family and Health Services Manager
Degenstein Community Library, Director
Donald L. Heiter Community Center, Inc., Executive Director
Evangelical Community Hospital, HR
Evangelical Community Hospital, EVP/COO
Evangelical Community Hospital, AVP Revenue Cycle
Evangelical Community Hospital, Manager
Evangelical Community Hospital, Vice President
Evangelical Community Hospital, VPMA
Evangelical Community Hospital, Vice President Patient Care/CNO
Evangelical Community Hospital, Associate Vice President

Evangelical Community Hospital, Operations Manager - EVS
Evangelical Community Hospital, HIPAA Compliance Coordinator
Evangelical Community Hospital, Director Cardiopulmonary Services
Evangelical Community Hospital, Director of Imaging Services
Evangelical Community Hospital, Director, Project Management
Evangelical Community Hospital, President & CEO
Evangelical Community Hospital, Controller
Evangelical Community Hospital, Director
Evangelical Community Hospital, Vascular Access Coordinator
Evangelical Community Hospital, Associate Vice President, Medicine Practices
Evangelical Community Hospital, Chief of EMS Services
Evangelical Community Hospital, Director Care Coordination
Evangelical Community Hospital, Director, Women's Health and Cancer Services
Evangelical Community Hospital, Director/RN
Evangelical Community Hospital, Office Supervisor
Evangelical Community Hospital, Vice President, Clinical Operations
Evangelical Community Hospital, RN Practice Manager
Evangelical Community Hospital, AVP of Surgical Services
Evangelical Community Hospital, OB Nurse Manager
Evangelical Community Hospital, Real Estate Manager
Evangelical Community Hospital, Employee & Public Safety Supervisor
Evangelical Community Hospital, IT Training Manager
Evangelical Community Hospital, Manager
Evangelical Community Hospital, Director, Miller Center and Community Health Initiatives
Evangelical Community Hospital, Director Quality, Patient Safety & Risk Management
Evangelical Medical Services Organization, Office Manager
Family Service Association of Northeastern Pennsylvania, CEO
First Order Painting, Owner
Foster Grandparent Program of Central PA, Program Coordinator
Foster Grandparent Program of Central PA, Director
Geisinger, Inpatient Social Work Care Manager
Geisinger, Community Engagement Strategist, Senior
Geisinger, VP, Strategy & Market Advancement
Geisinger, CAO
Geisinger, Community Benefit Coordinator
Geisinger, Director
Geisinger, Director
Geisinger, Director
Geisinger, Nursing Director
Geisinger, CMO
Geisinger Bloomsburg Hospital, Operations Manager
Geisinger Encompass Health Rehabilitation Hospital, Business Development Director
Geisinger Health Plan, Chief Administrative Officer, Geisinger Clinic
Geisinger Health Plan, Director
Geisinger Health System, Program Director, DEI
Geisinger Henry Cancer Center, Social worker
Geisinger Home Infusion, Director

Geisinger Hospice, Chaplain/Bereavement Coordinator
Geisinger Medical Center, Breast and Cervical Cancer Early Detection Program Navigator
Geisinger Medical Center, Outreach/Injury Prevention Coordinator for Adult Trauma
Girls on the Run Mid State PA, Executive Director
Greater Susquehanna Valley Chamber of Commerce, Membership & Workforce Development Director
Greater Susquehanna Valley YMCA, CEO
Greater Susquehanna Valley YMCA, Mifflinburg Branch, Director
Hospice of Evangelical, Director
Innovative Manufacturers Center (IMC), Manager, Outreach & Special Projects
L&I BWPO, L&I BWPO
Lewisburg Borough - Lewisburg, PA, Mayor
Lewisburg Children's Museum, Executive Director
Lewisburg YMCA, Associate Executive Director
LIFE Geisinger, LIFE Geisinger
Luzerne County Community College- Berwick Center, Director
Middlecreek Area Community Center, Executive Director
Mifflinburg YMCA, Youth Coordinator
Montgomery House Library, Library Director
Montour Area Recreation Commission, Director
Montour County Children and Youth, Executive Director
Montour County PA Board of Commissioners, Chairman Montour County PA Board of Commissioners
Moses Taylor Foundation, President and CEO
Mount Carmel Area Public Library, Librarian
N4CS, Executive Director
Northern Montour Recreation Association (Exchange Pool), Board Secretary
Northumberland County Aging Office, Center Supervisor
Northumberland County BHIDS, Program Specialist/Outpatient Clinic Director
Northumberland County CYS, Administrator
Office of PA Senator Lynda Schlegel Culver, Constituent Relationship Specialist
PA Department of Health, PA Department of Health
PA Education for Children & Youth Experiencing Homelessness, Consultant
PA State Police- Selinsgrove, Station Commander- Sergeant
Pennsylvania Department of Health, Community Health Nurse Snyder County
Pennsylvania State Police, Trooper - Community Service Officer
PFLAG Danville / Central Susquehanna Valley, President
Regional Engagement Center, President
Schuylkill Intermediate Unit 29, School Social Worker/Interagency Coordinator
Schuylkill MH/DS, Deputy Administrator
Selinsgrove Area Meals on Wheels, President - Board of Directors
Shamokin Area School District, Curriculum Coordinator
Shikellamy School District, Superintendent
Shikellamy School District, School Psychologist
Shiloh United Church of Christ, Senior Pastor
Snyder County Children and Youth Services, CYS Administrator
Snyder County DA's Office, District Attorney
Sunbury's Revitalization, Inc., Executive Director
Susquehanna Council, BSA, Seven Bridges District Executive

Susquehanna University, Chief of Staff
Susquehanna Valley CASA - Voices for Children, Board Vice President and CASA Volunteer
Susquehanna Valley CASA, Susquehanna Valley Mediation, Board Member and Volunteer
Susquehanna Valley Ethical Society, Founder/Board President
Susquehanna Valley Mediation, Executive Director
Susquehanna Valley Mediation Center, Crisis/Rapid Response Coordinator
Susquehanna Valley Sight Services, Board Member
Susquehanna Valley United Way, President/CEO
Susquehanna Valley United Way, Northumberland County Safe Care Manager
Susquehanna Valley United Way, Recovery Engagement Project Coordinator
Tapestry of Health, Director
THACC The Gate House, Program Director
The Arc Susquehanna Valley, Executive Director
The Bloomsburg Children's Museum, Director
The Foundation of the Columbia Montour Chamber of Commerce, Director
The Good Samaritan Mission, Executive Director
The Miller Center, Marketing & Communications
The Ronald McDonald House of Scranton, Executive Director
The Wright Center for Community Health, Assistant Director of Clinical Compliance & Reporting
The Wright Center for Community Health, Project Manager
TIME – The Improved Milton Experience, Executive Director
Town of Bloomsburg, Mayor
Town of Bloomsburg Human Relations Commission, Chair
Transitions of PA, CEO
Trinity Reformed United Church of Christ-Bloomsburg, Pastor
Union County Government, County Commissioner
Union County Housing Authority, Executive Director
Union County Prison, Deputy Warden
Union County Probation Department, Chief Probation Officer
Union Snyder Agency on Aging, Inc., Long Term Care Manager
Union-Snyder Agency on Aging, Inc., Retired Health & Wellness Coordinator; member of Advisory Council
Union-Snyder Agency on Aging, Inc., Community Services Manager
Union-Snyder Community Action Agency, Executive Director
Union-Snyder Community Action Agency, Food Security Director
Union-Snyder Community Action Agency, Community Impact Director
Union-Snyder Community Action Agency, Administrator
Veterans Multi-Service Center, Homeless Veterans Reintegration Program- Case Manager
VNA Health System, Community Liaison, Events Coordinator
Weis Center Bucknell University, Artist Liaison
Weis Center for the Performing Arts, Marketing Director
Williams Valley Schools, Social Worker

Appendix C: Central Region Community Forum Participants

Sue Auman, Union-Snyder Community Action Agency
Matt Beagle, First Columbia Bank & Trust Co.
Chris Berleth, Columbia Montour Chamber of Commerce
Ashlee Bower, Central Susquehanna Intermediate Unit
Kelly Braun, Pennsylvania Office of Rural Health
Taryn Crayton, Columbia Montour Chamber of Commerce
Darcy Decker, PFLAG
Tyler Dombroski, SEDA-Council of Governments
Cathy Esworthy, Trinity Learning Center
Kelly Everitt, Evangelical Community Hospital
Jada Fasold, Geisinger Health Plan
Regina Graham, Geisinger
Ashley Hackenberg, Danville Head Start
Angela Haines, Greater Susquehanna Valley YMCA
Steve Herman, SEDA-Council of Governments
Dana Hotra, Family Health Council of Central PA
Ethan Howard, Penn State Extension
Denika Keefer, Geisinger Health Plan
Dave Kovach, Columbia County Commissioner
Betsy Kramer, SEDA-Council of Governments
Adrienne Mael, United Way
Linda Marshall, Danville Area School District
Bonita McDowell, Greater Susquehanna Valley YMCA
Ryan McNally, Evangelical Community Hospital
Alyssa Meyers-Sanonu, Community Giving Foundation
Tessa Moore, The Arc Susquehanna Valley
Kim Olszewski, Commonwealth University
Sheila Packer, Evangelical Community Hospital
Jessica Probst, Central Susquehanna Intermediate Unit
Stacy Richards, Union County Commissioner
Kara Seesholtz, Community Giving Foundation
Heather Shnyder, Transitions of PA
Amy Shortlidge, Berwick Industrial Development Association
Ayrin Shortlidge, Berwick Area United Way
Jen Sullivan, Evangelical Community Hospital
Lacy Temple, Columbia-Montour Aging Office
Katherine Vastine, Central Susquehanna Intermediate Unit
Danielle Velkoff, Susquehanna Valley United Way
Amy Wright, Geisinger