2018 PENN HIGHLANDS ACCESS TO CARE IMPLEMENTATION STRATEGY PLAN

The Community Health Needs Assessment and Implementation Strategy Plan process undertaken by Penn Highlands Healthcare, with project management and consultation by Tripp Umbach, included input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of public health issues and representatives of vulnerable populations served by the hospital.

Produced by: Tripp Umbach

Section 1. Executive Summary

Introduction

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

With the four hospitals of Penn Highlands Healthcare - Penn Highlands Brookville, Penn Highlands Clearfield, Penn Highlands DuBois and Penn Highlands Elk - Penn Highlands strives to provide exceptional quality, safety and service.

Each facility is the largest employer in its hometown and is rooted deeply in both the popular and economic culture of their communities. The vision is to be an integrated health care delivery system that provides premier care with a personal touch, no matter where one lives in the region.

Important Note: In an effort to combat the following health issues in a unified approach, Penn Highlands Healthcare has chosen to identify system-level needs for the entire Penn Highlands service area. However, each hospital has created the following facility-specific strategies to combat those needs.

Objectives and Methodology

With the enactment of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, tax-exempt hospitals require community health needs assessments (CHNA) and implementation strategies to actively improve the health of communities served by health systems. These strategies provide hospitals and health systems with the necessary information to address the specific health needs of their communities. Coordination and management of strategies based upon the outcomes of a CHNA and implementing strategies can improve the impact of hospital community benefits.

To adhere to the requirements imposed by the IRS, tax-exempt hospitals and health systems must:

1. Conduct a CHNA every three years.
2. Adopt an implementation strategy to meet the community health needs identified through the assessment.
3. Report how they are addressing the needs identified in the CHNA.

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During the process, these individuals reviewed data related to the underserved and vulnerable populations in the service area. Tripp Umbach worked closely with leadership from Penn Highlands Healthcare to oversee and accomplish the assessment with the goal of gaining a better understanding of the health needs of the region.

Penn Highlands Healthcare will use CHNA findings to address local health care concerns via the Implementation Strategy Plan, as well as to function as a collaborator, working with regional agencies to help address medical solutions to broader socioeconomic and education issues in the service area.

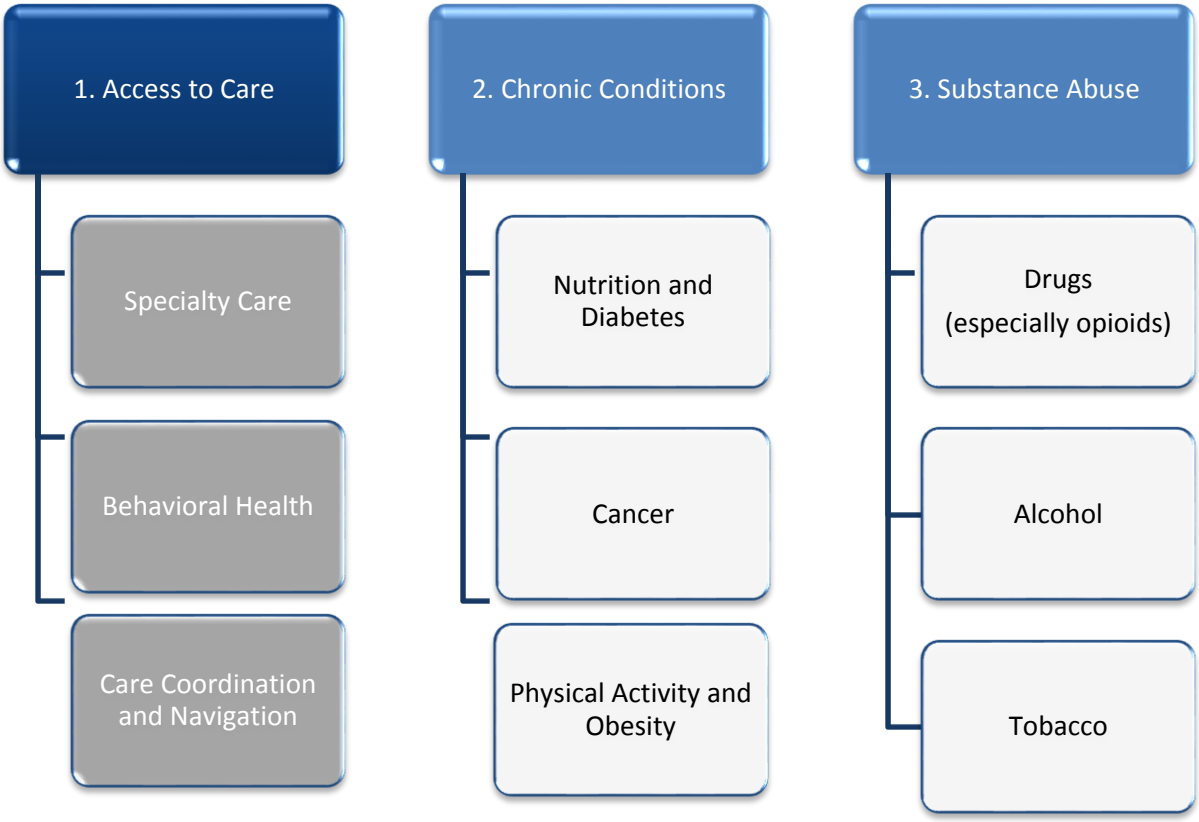
The project component pieces involved to determine the community health needs included:

- Public commentary on the 2015 CHNA and implementation plan (also conducted by Tripp Umbach)
- Evaluation of implementation strategies in 2015
- Secondary data analysis of health status and socioeconomic environmental factors related to health and well-being of residents
- Community leader interviews/public commentary
- Community forum at Penn Highlands DuBois
- Provider inventory of programs and services related to key prioritized needs

Key Prioritized Needs

Tripp Umbach and the project Steering Committee identified three prioritized community need areas for the Penn Highlands Healthcare system. The community health needs are based on qualitative and quantitative data, particularly from community forum feedback. Figure 1 (below) details the three prioritized need areas and key factors and considerations of each need.

Figure 1: Prioritized Community Health Needs for Penn Highlands Healthcare 2018 CHNA



Section 2. Implementation Plans for Each Facility

Access to care, which encompasses primary and specialty care, was identified as a need throughout the Penn Highlands service area during the CHNA project. It is important to note that access to care has been a priority for Penn Highlands for many years, including the previous CHNA and Implementation Plan. The following tables are each facilities' plan to address the issue of access to care in their service area.

Brookville

NEED: ACCESS TO CARE
Facility: PHB
Goal:
1. Provide Q care services to residents of Jefferson County.
2. Expand Primary Care Management of residents in Jefferson County.

Anticipated Impact:
1. Decrease ED visits for primary care problems
2. Increase screenings and primary prevention and management of chronic illness by continuity of care.
3. Increase the number of patients presenting to PHB Q Care with a primary provider of record.

Objectives	Annual Activity	Target Population	Evaluation Methods/ Metrics	Potential Partners	Planned Resource Commitment
Expand awareness and promotion of the presence of the PHB Q Care facility.	1.Distribute informational materials 2.Engage with community partners at health fairs and school district functions	Community/Jefferson County residents Jefferson County residents who do not have a primary care provider	Obtain baseline data/ PHB Q Care opened in 4/18. Increase by 1%in FY 19, 20 and 21 to equal a 3% increase over 3 years. Participation in community events/fairs and social media postings in FY18 and increase by 1% in FY 19, 20 and 21 to equal a 3% increase over 3 years.	Social Media PCPs and providers YMCA Community Agencies Brookville Chamber of Commerce/Victorian Days Brookville Area School District	.5 FTE of existing FTEs in the PHH system

Increase number of Jefferson County residents that receive care at PHB Q Care by 2% Per FY	Expand hours and location for PHB Q care according to use data	Residents of Jefferson County	Annualized stats = 2284 visits in FY 2018 Increase visits by 2% in FY 19, 20 and 21 to equal 6% increase/ 2421 visits in FY 2021		Existing FTEs at PHB Q care
Improve the number of Jefferson County residents who present with a PCP by 6% over 3 years	Monitor or track number of patients who do not have a PCP	Patients without a provider	Increase the number of patients referred and accepted by a provider FY 2018 = 75 patients FY 19, 20 and 21 increase by 2% per year to equal a total of 6% or 80 patients accepted by a provider	Penn Highlands Physician Network (PHPN) Penn Highlands Healthcare practice management DuBois Free Medical Clinic Private practice providers in Jefferson County	Existing FTEs in the PHB Q Care and within the PHH system

Clearfield

NEED: ACCESS TO CARE
Facility: PHC
Goal:
1. Expand physical therapy services at Moshannon Valley Community Medical Building.
2. Expand access to pulmonary services to Clearfield County residents.

Anticipated Impact:
1. Decrease in chronic problems that can be mitigated with physical therapy
2. Decrease in ED visits for chronic pulmonary problems

Objectives	Annual Activity	Target Population	Evaluation Methods/ Metrics	Potential Partners	Planned Resource Commitment
Expand physical therapy interventions by 2% per FY for a total of 6% in 3 years	Expand hours and flex staff according to demand	Clearfield, Phillipsburg, and west of St College communities on 322 that lack a local PT facility	To be determined Annualized interventions FY 2018= 292 Expand 2% per year to a total of 6% or 309 PT interventions in FY 2021	Rural Healthcare Clinic Free Clinic Frenchville AAA University Orthopedics-State College contact PCP in MVCMB	Facility PT staff Transportation Medical Staff education Marketing / Communications
Expand pulmonology services to Clearfield County residents by the placement of a pulmonologist to provide comprehensive / diagnostic services locally 2days / week.	Recruit a pulmonologist Dedicate 2 days to PHC office	Clearfield, Phillipsburg, and west of St College communities on 322	618 visits in FY 2017 1 day/week in Clearfield Expand service to 2 days/week Increase by 10% per FY to 30% in FY 2021 or 803 visits	Rural Healthcare Clinic Free Clinic Frenchville AAA University Orthopedics-State College contact PCP in MVCMB	Existing Facility Existing lung center staff 1 FTE physician PHH Transportation Medical Staff education Marketing / Communications

DuBois

NEED: ACCESS TO CARE
Facility: PHD
Goal:
1. Improve access to neurology services to Clearfield county.
2. Expand Lung and Breast screenings and awareness services.

Anticipated Impact:
1. Decrease in ED visits and readmissions for patients with neurological problems
2. Reduce morbidity and mortality for lung and breast cancer diagnosed patients

Objectives	Annual Activity	Target Population	Evaluation Methods/ Metrics	Potential Partners	Planned Resource Commitment
Expand access to neurology services by adding physician extenders in Satellite offices	PCP physician champion- Mandie Shaw CRNP- to serve as an advisor as barriers are identified and addressed regarding neurology service expansion Create and implement guidelines regarding new referrals and wait times for new appointments/ existing patients and wait times for follow up appointments	New referrals to neurology Existing neurology patients	PCP/Provider satisfaction Reduction in ED visits and readmissions under specific diagnoses Improve wait times by 2% per FY for new patient referrals to neurology FY 2018 patients currently waiting a minimum of 6 weeks and as much as 14 weeks for a new appointment. Improve wait times by 2% per FY to a total of 6% improvement or wait time of 3.5 to 8 weeks for a new pt appointment by FY 2021	PHH Practice Management Dr. Cameron – physician champion for Telemedicine Neurology staff	Providers Telemedicine Facilities Existing staff Possible addition of physician extenders

Provide breast navigation services to the PHD region for patients going through an abnormal breast imaging study and breast cancer diagnosis. Expand access to the Breast Navigator Role across PHH and the Community Education and Awareness Implement video chat with nurse navigator for patient breast education		Women who meet the screening criteria who are not currently being screened according to guidelines	Increase in number of new patients receiving screening mammograms Increase in number of early stage breast cancer by 2% each fiscal Current FY18 PHD= 9930 screening mammograms Increase mammograms over 3 years to equal 10228 mammograms in FY 2021	AGAPE Community Organizations Church Groups Health Fairs	2 FTE Nurse Navigators
Improve the number of baseline lung screenings by 3%.	Navigator visits to PCP's Education to health care providers and staff Distribution of information regarding lung cancer screening	Patients who meet the medical criteria for lung cancer screening and are not being screened	FY2017/2018 annualized baseline screenings= 459 Increase baseline screenings to 472 in 2021.	Private practices Area Agency on Aging Senior Center Public Housing Authority	PHH Practice Management Medical Staff

Elk

NEED: ACCESS TO CARE
Facility: PHE
Goal:
1. Improve access to neurology services to residents of Elk county.
2. Expand Lung and Breast screenings and awareness of services to Elk County residents.
3. Expand transportation services to the Elk County residents.

Anticipated Impact:
1. Decreased mortality from lung and breast cancer
2. Decrease ED visits for neurological problems.
3. Increase compliance with screenings/ follow up/ and specialty appointments.

Objectives	Annual Activity	Target Population	Evaluation Methods/ Metrics	Potential Partners	Planned Resource Commitment
Offer mobile CT scanning & mammography	Purchase scanner Hire staff Commit existing staff	Elderly and at-risk population without social support system-transportation	Increase # of LDCT and Mammograms in PHE market.	Area Agency on Aging Agape	Mobile CT unit Staff
Expand Neurology service to Elk County residents by offering consultation through Telemedicine. Expand breast cancer navigation through Videochat	Telemedicine commitment to PHE Work with IT to implement in existing equipment	At-risk without social support system/ transportation	Neurology telemedicine implementation Implement video chat for breast cancer navigation/ education	Area Agency on Aging Senior Centers Housing Authority	Telemedicine Neurology provider IT support
Improve the number of baseline lung screenings by 3% over 3years.	Distribution of information regarding screenings and transportation provided	Elk County residents who meet the medical criteria for lung cancer screening and have not been screened	156 annualized FY 18 Scans Increase to 161 baseline scans in FY 2021	Senior agencies	PHH transportation services PHH practice management Physician practices
Improve the number of baseline mammogram	2 FTE Breast Navigators	Patients in the Elk County who meet the criteria for a	4050 mammograms in FY 2017/ no information on	Community Groups Health Fairs	2 FTE Breast Navigators PHH transportation

screenings by 3 % over 3 years.		mammogram and have not had one	baseline numbers available Increase of 3% in FY 2021= 4172	Women's services	PHH Practice Management PHH Van Services
Improve utilization of PHH Van transportation services by 3% over 3 years	Distribute information regarding PHH Van Meet w/ PHH practice management to inform of service to pts	PHE patients without social supports and non- compliance with follow up	Make transportation available to pts in 70 mile one way radius from PHD. 0 pts transported in FY 2017 expand this to 10 in FY 2018 and to 3% or 30 patients in FY 2021	Senior Centers, Community Action, AAA Internal education with social workers for discharge planning	PHH vans and staff

Appendix A. Key Findings from CHNA for Access to Care

The health status of a community depends on many factors, including quality of health care, social and economic determinants, individual behaviors, heredity, education and the physical environment. Communities across the U.S. face numerous challenges and issues that negatively affect the overall health status of residents and hinder growth and development. In the Penn Highlands study area, three community health issues and needs were identified:

1. **Access to Health Care**
2. Chronic Conditions
3. Substance Abuse

Within each of the community health need areas, multiple factors must be considered. Health behaviors, education, and socioeconomic/environmental conditions greatly affect an individual's health status and ability to overcome health issues in the region. It is important for health providers and community-based organizations to understand the regional health issues and be aware of the most needed services and improvements.

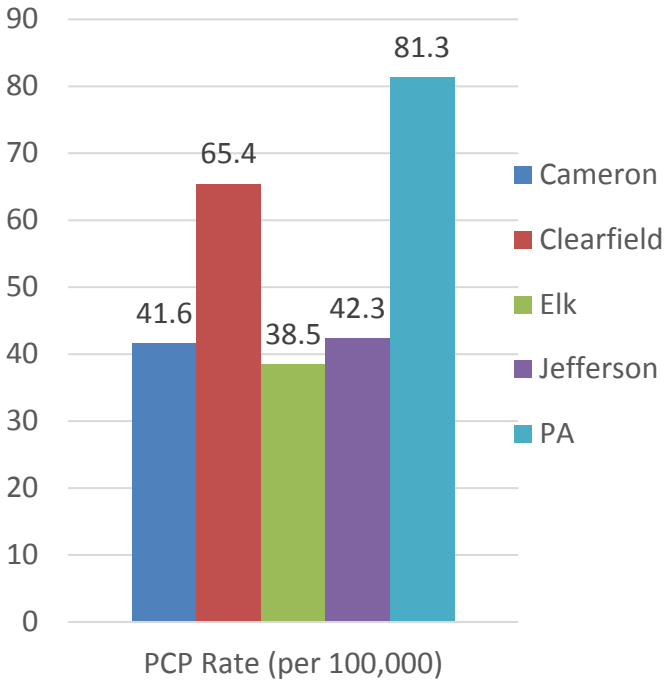
Access to Health Care

Access to health care is perhaps the most important segment of the care continuum. The ability for an individual to access health care is key to having a healthy life. Typically, access to care refers to the opportunity (and ease) in which people can obtain health care, but it can also refer to having or utilizing health care coverage. Disparities in health service access can significantly affect an individual's and a community's quality of life in a negative way. A lack of available health resources, the high cost of services, and being uninsured can serve as some of the top barriers to accessing health care services. Across the U.S., a predicted shortage of as many as 90,000 physicians by 2025 will serve as an access issue.[1]

While Pennsylvania scores fairly well at access and affordability (15th best in the country), access issues are typically more prominent in rural areas, such as the counties that make up the largest portion of the Penn Highlands service area.[2] As shown in Figure 2 below, the Penn Highlands service area is significantly behind on PCP rates per 100,000 population.[3] Disparities in health and health access exist across the geographic regions of the state, with Pennsylvanians living in rural communities more likely to have unmet heath needs and have poor access to health care than those in urban communities. A 2012 report from the Pennsylvania Department of Health found that individuals living in rural communities had higher rates for cancer, obesity, heart disease, and diabetes. According to the same report, children and nonelderly adults living in rural communities were also more likely to be uninsured.[4]

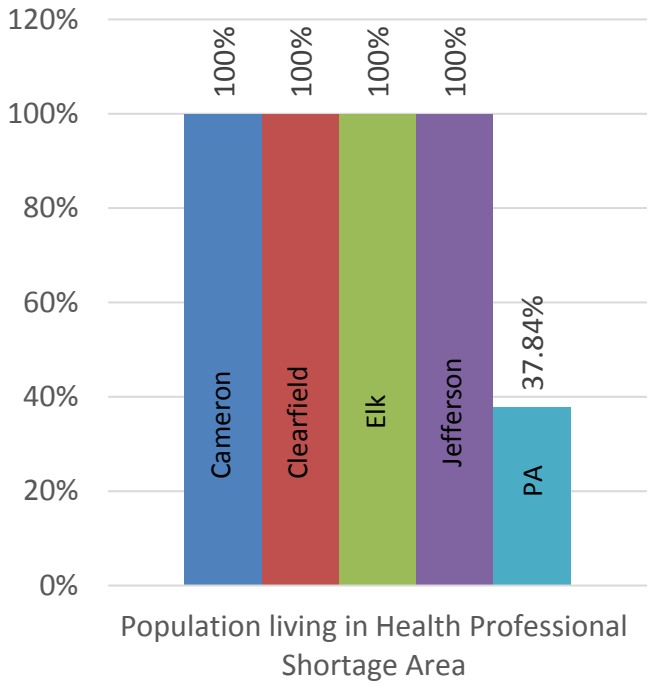
[1] Berstein, Lenny. "U.S. faces 90,000 doctor shortage by 2025, medical association warns." The Washington Post.
[2] Health System Data Center. The Commonwealth Fund.
[3] 2017 County Health Rankings.
[4] The Henry J. Kaiser Family Foundation, The Pennsylvania Health Care Landscape Fact Sheet

Figure 2: PCP Rate per 100,000 Population



As illustrated in Figure 3 below, the majority of the Penn Highlands service area is living within a health professional shortage area. Health Professional Shortage Areas (HPSAs) are designated as having shortages of primary care, dental care, or mental health providers and may be geographic (a county or service area), population (e.g., low income or Medicaid eligible) or facilities based (e.g., federally qualified health centers, or state or federal prisons).

Figure 3: Population Living in a HPSA



While an overall predicted physician shortage is anticipated by 2025, this especially is true for specialty physicians in the U.S. By 2025, there is predicted to be a shortfall of 28,200 to 63,700 non-primary physicians, including up to 12,300 medical specialists, up to 31,600 surgical specialists, and up to 20,200 other specialists.[5]

Mental health is a growing issue across the U.S. Approximately one in five adults in the U.S. – or 43.8 million residents – experiences mental illness in a given year. 21.5 percent of youth age 13 through 18 experiences a severe mental disorder at some point during their lives.[6] In many instances, mental illness and substance abuse go hand-in-hand; among the 20.2 million adults in the U.S. with a substance abuse issue, approximately 10.2 million have a co-occurring mental health issue.[7]

With high rates of mental illness and substance abuse across the nation and in the state of Pennsylvania, it is increasingly important for residents to be able to seek and obtain quality care and treatments in order to manage their conditions. However, many struggling with mental and behavioral health issues are unable to access treatment. 56.5% of adults with mental illness did not receive treatment in the past year, and for those seeking treatment, 20.1% continue to report unmet treatment needs.[8]

As seen in Table 2, while Clearfield County (222.9) is well above the state average for mental health providers per 100,000 population, Jefferson and Elk County lags well behind, with only 69.4 providers.

Table 2: Mental Health Providers per 100,000 Population

Geography	Mental Health Providers per 100,000 Population
Cameron County	n/a
Clearfield County	222.9
Elk County	64.1
Jefferson County	69.4
PA	171.5

Accessing behavioral health care is pertinent as behavioral health issues can have detrimental effects on the health of individuals and communities. For example, those living with serious mental illness face an increased risk of developing a chronic medical condition. An adult with a serious mental illness dies on average 25 years sooner than someone without a serious mental illness; the deaths typically stem from a treatable chronic condition.[9] In addition, untreated mental health conditions prevent individuals from leading everyday lives. Mental illness may prevent individuals from obtaining an education and having a stable job, both which are important to an individual's well-being, as well as the overall health of a community. Improved access to behavioral health care services for all residents will help those dealing with mental illness and substance abuse to receive the treatment they need.

[5] AAMC
[6] "Mental Health by the Numbers" National Alliance on Mental Illness. 2016.
[7] "Mental Health by the Numbers" National Alliance on Mental Illness. 2016.
[8] Mental Health America. 2018.
[9] "Mental Health by the Numbers" National Alliance on Mental Illness. 2016.

2018 PENN HIGHLANDS CHRONIC CONDITIONS IMPLEMENTATION STRATEGY PLAN

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- Community forum at Penn Highlands DuBois
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Key Prioritized Needs

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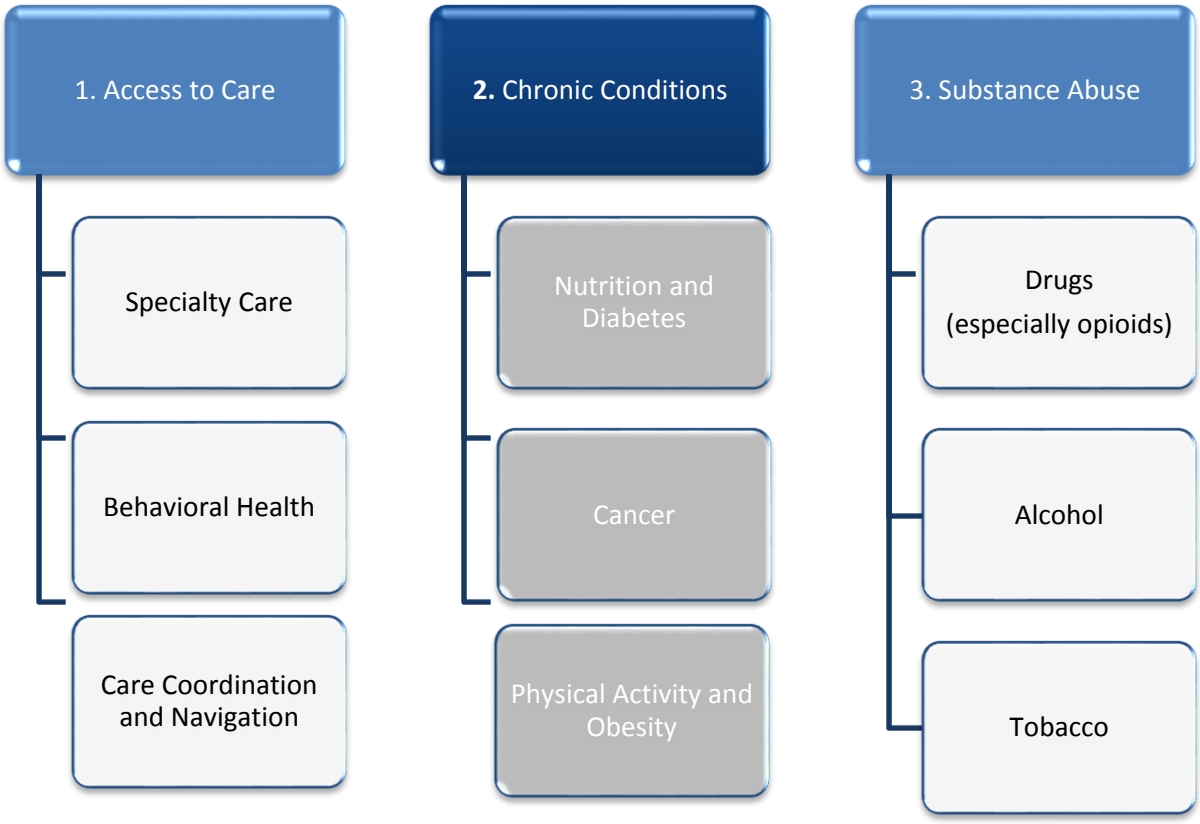


Section 2. Implementation Plans for Chronic Conditions

Chronic Conditions (nutrition, diabetes, cancer, physical activity, and obesity) was identified as a need throughout the Penn Highlands service area. It is important to note that these conditions have been a priority for Penn Highlands for many years, including the previous CHNA and Implementation Plan. The following tables are each facilities' plan to address the issue of chronic conditions in their service area.

PH DuBois and PH Brookville: Diabetes and Nutrition

NEED: Chronic Conditions: Nutrition and Diabetes, Cancer and Physical Activity and Obesity
Facility: PH DuBois, PH Brookville
Goal: Expand Diabetes and Nutrition Education Services within the PHH service area
Anticipated Impact: Increased number of patients seen for diabetes, obesity and nutrition education and early detection

Objectives	Annual Activity	Target Population	Evaluation Methods/ Metrics	Potential Partners	Planned Resource Commitment
1) Expand diabetes and nutrition education services within the PH Service area.	1. Open satellite sites of the Diabetes & Nutrition Wellness Center in Brookville & Clarion and provide diabetes/nutrition education on a bimonthly basis at each location. 2. Expand an additional 2 days per month in Clearfield beyond the once weekly current service.	1. All provider referred patients living in the Brookville/Clarion and surrounding areas with nutrition and/or diabetes diagnoses. 2. All providers referring patients in the Clearfield and surrounding areas.	Comparison of the number of patients seen in the zip codes for these areas before and after implementation. FY2017-18 visits: Dubois/Brookville: 1,092	Providers in these geographical areas.	RD/CDE staffing 2. Starting 9/5/18.
2) Achieve enrollment with Center for Medicare and Medicaid Services for Diabetes Prevention Program	Offer Diabetes Prevention Programming throughout the PHH Service area by beginning two cohorts per year	Patients with pre-diabetes within the PHH service area	Required Data Entry for CMS.	CMS Providers CDC Diabetes Prevention Support Center-University of Pittsburgh ($750 for training per trainer)	RD/ RN/ RDT, Data Analyst

3)Decrease diagnosis rate of Type 2 Diabetes post Gestational Diabetes	Develop Handouts and provide monthly or quarterly group sessions for Life's Journey patients: Getting Back into Your Blue Jeans	Patients with Gestational Diabetes	Blood Glucose/Hemoglobin A1c assessments Achieve A1C below 6.5 for patients with gestational diabetes	Life's Journey Staff/Providers	RD/RN Diabetes Educator Cost of printing materials
4) Provide community nutrition education for chronic disease prevention.	Offer programming twice yearly in all PHH service areas for the public to include: 1. My Plate 2. Food Label Math 3. How to Measure/ Portions 4. Healthy Shopping at the Dollar Store 5. Compare Your Drinks 6. How to Buy/Use Fresh Fruits & Vegetables	1.Customers of local dollar stores 2. Residents of low income housing 3. Food bank recipients 4. People who come to churches for free meals. 5. Parents of children attending daycares	Pre/post knowledge test Number of People Participating	Dollar Store owners Area Agency on Aging Managers of Low Income Housing Units Food Banks/Churches Farmers Markets Penn State Extension	Dietitians or Diabetes Nurse Educators, Diet Technicians Cost of printing materials
5) Provide nutrition education to Daycare Providers on Meal & Snack Planning	Offer an annual nutrition education program	Daycare owners/providers	Number attended Pre and Post Test results for daycare providers	Penn State Extension Dept. of Health	RDs, RDTs, CDMs Cost of printing education materials
6)Promote healthy selections in the cafeterias for visitors and employees	Expand on Monthly Healthy Super-Foods tables in the cafeteria to include a chef's table once per quarter featuring some ingredients	Patient families/employees/local residents	Number of patients, families, employees, and residents served Annual Retail survey results on healthy selections	Food Vendors	Chef, Food Service Staff, Possibly RDs

PH Elk: Diabetes and Nutrition

NEED: Chronic Conditions: Nutrition and Diabetes, Cancer and Physical Activity and Obesity
Facility: PH Elk
Goal: Expand Diabetes and Nutrition Education Services within the PHH service area
Anticipated Impact: Increased number of patients seen for diabetes, obesity and nutrition education

Objectives	Annual Activity	Target Population	Evaluation Methods/ Metrics	Potential Partners	Planned Resource Commitment
1)Decrease number people diagnosed with type 2 DM	Start new cohort for PreventT2	People with prediabetes	Average % weight loss, decreased DM diagnoses Look at lab results to see a decrease in A1c	Elk County Department of Health	Grant-funded
2) Provide community nutrition education for chronic disease prevention.	Offer programming twice yearly in all PHH service areas for the public to include: • My Plate • Food Label Math • How to Measure/ Portions • Healthy Shopping at the Dollar Store • Compare Your Drinks • How to Buy/Use Fresh Fruits and Vegetables	1.Customers of local dollar stores 2. Residents of low income housing 3. Food bank recipients 4. People who come to churches for free meals. 5. Parents of children attending daycares	Pre/post knowledge test Number of People Participating	Dollar Store owners Area Agency on Aging Managers of Low Income Housing Units Food Banks/Churches Farmers Markets Penn State Extension	Dietitians or Diabetes Nurse Educators, Diet Technicians Cost of printing materials
3) Promote healthy selections in the cafeterias for visitors and employees	Expand on Monthly Healthy Super-Foods tables in the cafeteria to include a chef's table once per quarter featuring some ingredients	Patient families/employees/local residents	Number of patients, families, employees, and residents served Annual Retail survey results on healthy selections	Food Vendors	Chef, Food Service Staff, Possibly RDs

PH Clearfield: Diabetes and Nutrition

NEED: Chronic Conditions: Nutrition and Diabetes, Cancer and Physical Activity and Obesity
Facility: PH Clearfield
Goal: Expand Diabetes and Nutrition Education Services within the PHH service area
Anticipated Impact: Increased number of patients seen for diabetes, obesity and nutrition education

Objectives	Annual Activity	Target Population	Evaluation Methods/Metrics	Potential Partners	Planned Resource Commitment
1) Increase healthy weight loss	Biggest Loser Competition	All Employees	Number of employees participating % Weight Loss among participants	Rehab	
2) Expand nutrition and health info to schools	Host mini-nutrition/health fair during Open House focusing on healthy lunch and snack choices	School students	Number attended Number of events provided Pre and Post Test Results	School Food Service	
3) Provide nutrition and health info to employees and community	Emails, café table exhibits; Can look at offering class at Hospital or Community Facility Oct 8, 2018 – Wellness Fair at Clearfield School District (reviewing food safety, nutrition, hand hygiene)	All employees/ Interested community Members	Number of employees attended Pre and Post Test results	Morrison Websites, CenClear, PSU Coop Extension	Morrison Websites
4) Promote healthy selections in the cafeterias for visitors and employees	Expand on Monthly Healthy Super-Foods tables in the cafeteria to include a chef's table once per quarter featuring some of the ingredients	Patient families/employees/local residents	Number of patients, families, employees, and residents served Annual Retail survey results on healthy selections	Food Vendors	Chef, Food Service Staff, Possibly RDs

All Penn Highlands Facilities: Cancer

NEED: Chronic Conditions (Cancer)
Facility: All
Goal: Early Detection and Prevention
Anticipated Impact: Increase number of people being screened

Objectives	Annual Activity	Target Population	Evaluation Methods/ Metrics	Potential Partners	Planned Resource Commitment
Increase Community awareness regarding cancer prevention and screening	Seek opportunities for public speaking engagements Progressively expand advocacy groups including community volunteers and patient groups to cover all regions	Adults Elderly and at-risk population Residents with suspected cancer conditions	Number of Public speaking events Pre and Post Test results	Physicians APP's RN's	
Feature monthly awareness campaigns to the community regarding specific cancer month Example: • March Colon • October Breast	Tri County Sunday Education Articles for the community Radio Education Spots	Elderly and at-risk population Residents with suspected cancer conditions	Increase the number of colonoscopies conducted across PHH Increase the number if mammograms across PHH	Pharm companies GI Lab physician leaders GI Lad admin leaders Area Agency on Aging Practice Management	
Increase cancer awareness among influential groups and the public	Monthly Social Committee Meetings		Number of presentations made Number of participants reached		
Engage and mobilize key stakeholders	Develop relationships with	Community partners in the cancer community	Increase the number of partnerships with	Stakeholders in the cancer community	

within the cancer community who will champion the development and implementation of an awareness plan for cancer prevention	stakeholders within the cancer community		stakeholders in the cancer community		

NOTE: If levels of cancer awareness are low, and fear and stigma are high, it may well be necessary, at least initially, to focus on the education and empowerment of influential individuals or groups who can then act as societal models, mobilize communities and resources, and influence the demand for change. In certain communities, trained community leaders, real-life testimonies from patients, family members and caregivers, can often play a vital role in raising cancer awareness and reducing the stigma and fear of cancer.

PH DuBois and PH Clearfield: Physical Activity and Obesity

NEED: Chronic Conditions: Physical Activity and Obesity
Facility: PH DuBois and PH Clearfield
Goal: Expand Awareness and services to promote physical activity to reduce obesity and support chronic conditions
Anticipated Impact: Increased number of people participating in physical activities and support groups

Objectives	Annual Activity	Target Population	Evaluation Methods/ Metrics	Potential Partners	Planned Resource Commitment
1) Expand support for Parkinson's Disease	Continue to expand speakers at the Parkinson's Support Group throughout the year	Those diagnosed with Parkinson's disease, family members, caregivers	Number of presentation made Number of people attending	Marketing, Rehab	
2)Reduce Osteoporosis among adult female patients	Continue to support "Strong Woman Program" taught by Cardiac Rehab	Adult females	Number of presentations made Number of People Attending	Penn State Dubois, Cardiac Rehab	

			Reduced rate of osteoporosis diagnosis among adult females in service area		

PH DuBois and PH Elk: Physical Activity and Obesity

NEED: Chronic Conditions: Physical Activity and Obesity
Facility: PH Dubois and PH Elk
Goal: Expand Awareness and services to promote physical activity to reduce obesity and support chronic conditions
Anticipated Impact: Increased number of people participating in physical activities and support groups

Objectives	Annual Activity	Target Population	Evaluation Methods/ Metrics	Potential Partners	Planned Resource Commitment
1) Promote Physical activity throughout community	Yoga and Pilates Class – 2 days a week	Adults	Number of physical activity sessions conducted Number of people attending	Marketing, Rehab	
2) Reduce number of falls in patients at hospital	TBD – Implement a balance assessment to look at risk for falls	Adults	Identification of number of people identified at risk Work with Risk Management to track number of falls	Rehab, inpatient units, Risk Management	

Appendix A. Key Findings from the CHNA for Chronic Conditions

The health status of a community depends on many factors, including quality of health care, social and economic determinants, individual behaviors, heredity, education and the physical environment. Communities across the U.S. face numerous challenges and issues that negatively affect the overall health status of residents and hinder growth and development. In the Penn Highlands study area, three community health issues and needs were identified:

1. Access to Health Care
2. **Chronic Conditions**
3. Substance Abuse

Within each of the community health need areas, multiple factors must be considered. Health behaviors, education, and socioeconomic/environmental conditions greatly affect an individual's health status and ability to overcome health issues in the region. It is important for health providers and community-based organizations to understand the regional health issues and be aware of the most needed services and improvements.

Chronic Conditions

Chronic conditions are medical conditions are typically described as long in duration and slow in progression, and usually include the following conditions:

- Alzheimer's
- Heart Failure
- Arthritis
- Hepatitis
- Asthma
- HIV/AIDS
- Atrial Fibrillation
- Hyperlipidemia (High cholesterol)
- Autism Spectrum Disorders
- Hypertension (High blood pressure)
- Cancer
- Ischemic Heart Disease
- Chronic Kidney Disease
- Osteoporosis
- COPD
- Schizophrenia
- Depression
- Stroke
- Diabetes

Obesity and Physical Activity

Obesity is a major issue across the United States affecting all demographics. More than one-third (36.5%) of adults in the U.S. are currently obese, and that number has continues to rise.[1] Data from 2015-2016 show that

[1] "Adult Obesity Facts." Center for Disease Control and Prevention.

nearly 1 in 5 school age children and young people (6 to 19 years) in the United States has obesity.[2] Obesity is particularly prevalent across the Southern and Appalachian portions of the U.S. Pennsylvania experiences high rates of obesity, as the state had the 25th highest obesity rate in the nation in 2017.[3]

Table 1: Adult Obesity Percentages and Recreation Facilities per 100,000 Population

Geography	Adult Obesity %	Recreation & Fitness Facility Access per 100,000
Cameron County	28%	n/a
Clearfield County	37%	6.12
Elk County	29%	9.39
Jefferson County	32%	4.42
PA	30%	11.07

As illustrated in Table 1, the entire Penn Highlands Healthcare system shows above average rates of obesity, minus Cameron County.[4] Further, the entire study area of Penn Highlands Healthcare shows lower than average rates for recreation and fitness facilities.[5] Obesity is one of the largest contributing factors of preventable chronic conditions, including diabetes, hypertension, and stroke. Adults who are overweight are more likely to have high blood pressure and high cholesterol, both of which can lead to major health issues such as heart disease and stroke. As obesity rates are on the rise, so are chronic diseases. The toll and the overall health care costs associated with obesity and chronic diseases are staggering. The CDC estimates that health care costs due to obesity and the chronic diseases that stem from obesity are estimated to be anywhere between $147 billion to $210 billion per year.[6]

Pennsylvania has the 25th highest adult obesity rate in the nation, according to *The State of Obesity: Better Policies for a Healthier America*. Pennsylvania's adult obesity rate is currently 30.3%, up from 20.3% in 2000 and from 13.7% in 1990.[7]

While Penn Highlands scores poorly for access to recreation and fitness facilities, it should be noted that the study area does score very well for the ranking of Physical Environment within the 2017 County Health Rankings. Specifically, Cameron and Elk Counties rank 1st and 3rd overall, respectively, out of 60 counties in Pennsylvania. Physical environment includes components such as air and water quality, housing and transportation, and available green space.

[2] Hales CM, Carroll MD, Fryar CD, Ogden CL. Prevalence of obesity among adults and youth: United States, 2015–2016. NCHS Data Brief.
[3] The State of Obesity http://stateofobesity.org
[4] County Health Rankings 2017
[5] County Health Rankings 2017
[6] "The Healthcare Costs of Obesity." The State of Obesity.
[7] The State of Obesity, Pennsylvania, https://stateofobesity.org/states/pa

In addition to a healthy diet, physical activity and fitness also is important to leading a healthy lifestyle and preventing obesity and chronic disease. Physical inactivity is responsible for one in 10 deaths among U.S. adults.[8]

Interview respondents felt that the lack of gyms in the area, cost of gym membership, and the rising cost of team sports, are among the reasons why individuals (both young and old) are not exercising as much as they need to.

Nutrition and Diabetes

Poor nutrition is a top reason for obesity rates in the region. Community leaders interviewed for the CHNA cite that poor nutrition and unhealthy diets consisting of fried and processed foods are contributing factors. A balanced diet consisting of fruit and vegetables is important for having good nutrition.

While nutritious food consumption can help prevent obesity and chronic conditions, socioeconomic and environmental factors serve as barriers to an individual's ability to lead a healthier lifestyle. During the community forum and interviews, community leaders revealed that healthy food options are not always available in the study area; they expressed the need for more supermarkets and healthy food options for residents. In addition, poor public transportation makes it difficult for residents to travel to access grocery stores that sell healthy food options.

Income levels also play a role in a person's ability to afford fresh fruits and vegetables. Residents struggling to make a living are not able to make healthy eating a priority. Fresh fruits and vegetables can be expensive; residents with lower incomes turn to cheaper processed foods to feed their families. With all four counties in the Penn Highlands Health region earning about $20,000 less than the average Pennsylvanian, access and ability to purchasing healthy foods may be limited.[9]

Diabetes was identified as a top concern in the 2015 CHNA. To combat this issue, Penn Highlands Healthcare has provided numerous diabetes and nutrition/wellness outreach programs in conjunction with community partners and events.

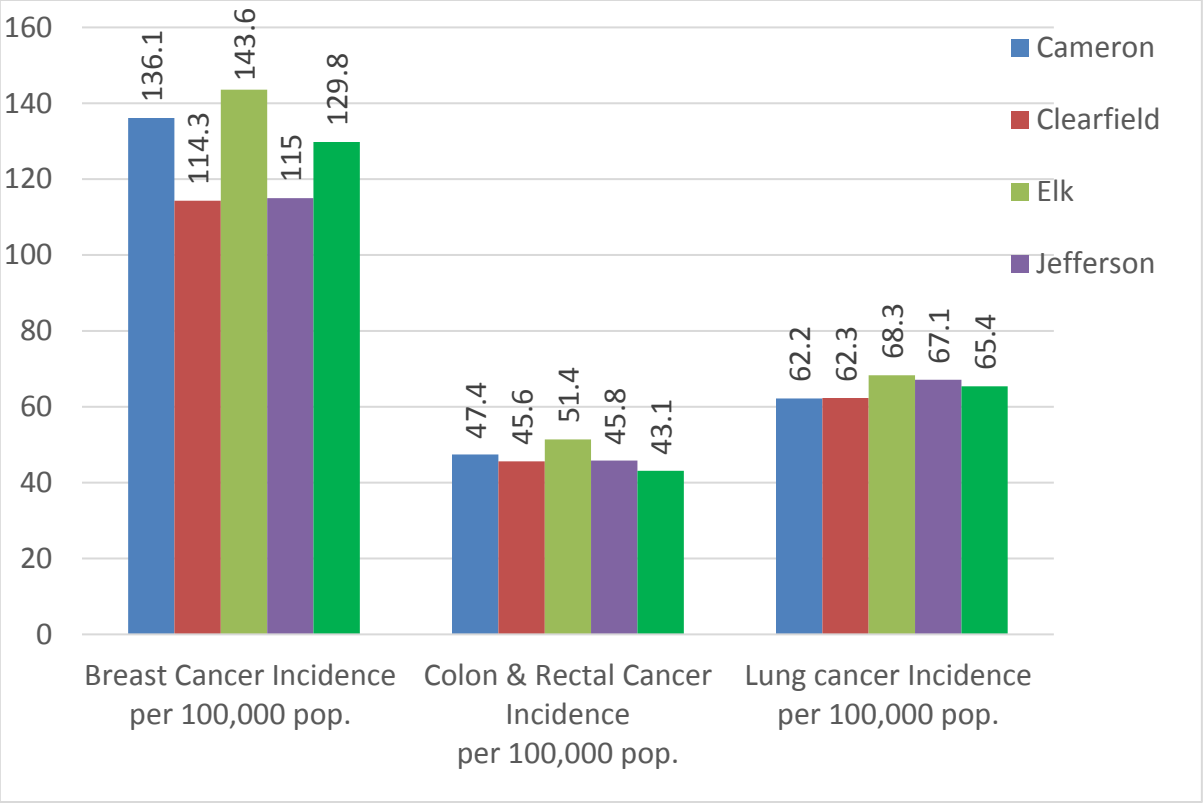
[8] Danaei G, Ding EL, Mozaffarian D, et al. The Preventable Causes of Death in the United States: Comparative Risk Assessment of Dietary, Lifestyle, and Metabolic Risk Factors.
[9] 2012-2016 American Community Survey

Cancer

It is no secret that cancer is a local, national, and worldwide chronic disease that has affected millions of people. In Pennsylvania, there are projected to be 80,960 estimated new cases in 2018 and 28,620 estimated deaths in 2018 alone.[10] The most common cancer diagnoses in Pennsylvania are breast (female), lung, prostate, and colon.[11]

Locally, in the Penn Highlands Healthcare service area, there are higher rates of these cancers.

Figure 2: Cancer Screenings in Region



As observed in Figure 2 above, the Penn Highlands Healthcare service area sees higher level of cancer rates in some counties for breast, colon and rectal, and lung compared to the state average[12].

Penn Highlands, like health systems across the county, are dealing with the rising numbers of cancer diagnoses. Consider the scope of cancer on a national level[13]:

- In 2018, an estimated 1,735,350 new cases of cancer will be diagnosed in the United States and 609,640 people will die from the disease.

[10] American Cancer Society
[11] American Cancer Society
[12] Community Commons
[13] Cancer.gov

- The most common cancers (listed in descending order according to estimated new cases in 2018) are breast cancer, lung and bronchus cancer, prostate cancer, colon and rectum cancer, melanoma of the skin, bladder cancer, non-Hodgkin lymphoma, kidney and renal pelvis cancer, endometrial cancer, leukemia, pancreatic cancer, thyroid cancer, and liver cancer.
- The number of new cases of cancer (cancer incidence) is 439.2 per 100,000 men and women per year (based on 2011–2015 cases).
- Cancer mortality is higher among men than women (196.8 per 100,000 men and 139.6 per 100,000 women).
- When comparing groups based on race/ethnicity and sex, cancer mortality is highest in African American men (239.9 per 100,000) and lowest in Asian/Pacific Islander women (88.3 per 100,000).
- Approximately 38.4% of men and women will be diagnosed with cancer at some point during their lifetimes (based on 2013–2015 data).

2018 PENN HIGHLANDS SUBSTANCE ABUSE IMPLEMENTATION STRATEGY PLAN

The Community Health Needs Assessment and Implementation Strategy Plan process undertaken by Penn Highlands Healthcare, with project management and consultation by Tripp Umbach, included input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of public health issues and representatives of vulnerable populations served by the hospital.

Produced by: Tripp Umbach

Section 1. Executive Summary

Introduction

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

With the four hospitals of Penn Highlands Healthcare - Penn Highlands Brookville, Penn Highlands Clearfield, Penn Highlands DuBois and Penn Highlands Elk - Penn Highlands strives to provide exceptional quality, safety and service.

Each facility is the largest employer in its hometown and is rooted deeply in both the popular and economic culture of their communities. The vision is to be an integrated health care delivery system that provides premier care with a personal touch, no matter where one lives in the region.

Important Note: In an effort to combat the following health issues in a unified approach, Penn Highlands Healthcare has chosen to identify system-level needs for the entire Penn Highlands service area. However, each hospital has created the following facility-specific strategies to combat those needs.

Objectives and Methodology

With the enactment of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, tax-exempt hospitals require community health needs assessments (CHNA) and implementation strategies to improve the health of communities served by health systems. These strategies provide hospitals and health systems with the necessary information to address the specific health needs of their communities. Coordination and management of strategies based upon the outcomes of a CHNA and implementing strategies can improve the impact of hospital community benefits.

To adhere to the requirements imposed by the IRS, tax-exempt hospitals and health systems must:

1. Conduct a CHNA every three years.
2. Adopt an implementation strategy to meet the community health needs identified through the assessment.
3. Report how they are addressing the needs identified in the CHNA.

The CHNA and Implementation Plan process undertaken by Penn Highlands Healthcare, with project management and consultation by Tripp Umbach, included input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of public health issues and representatives of vulnerable populations served by the hospital.

During the process, these individuals reviewed data related to the underserved and vulnerable populations in the service area. Tripp Umbach worked closely with leadership from Penn Highlands Healthcare to oversee and accomplish the assessment with the goal of gaining a better understanding of the health needs of the region.

Penn Highlands Healthcare will use CHNA findings to address local health care concerns via the Implementation Strategy Plan, as well as to function as a collaborator, working with regional agencies to help address medical solutions to broader socioeconomic and education issues in the service area.

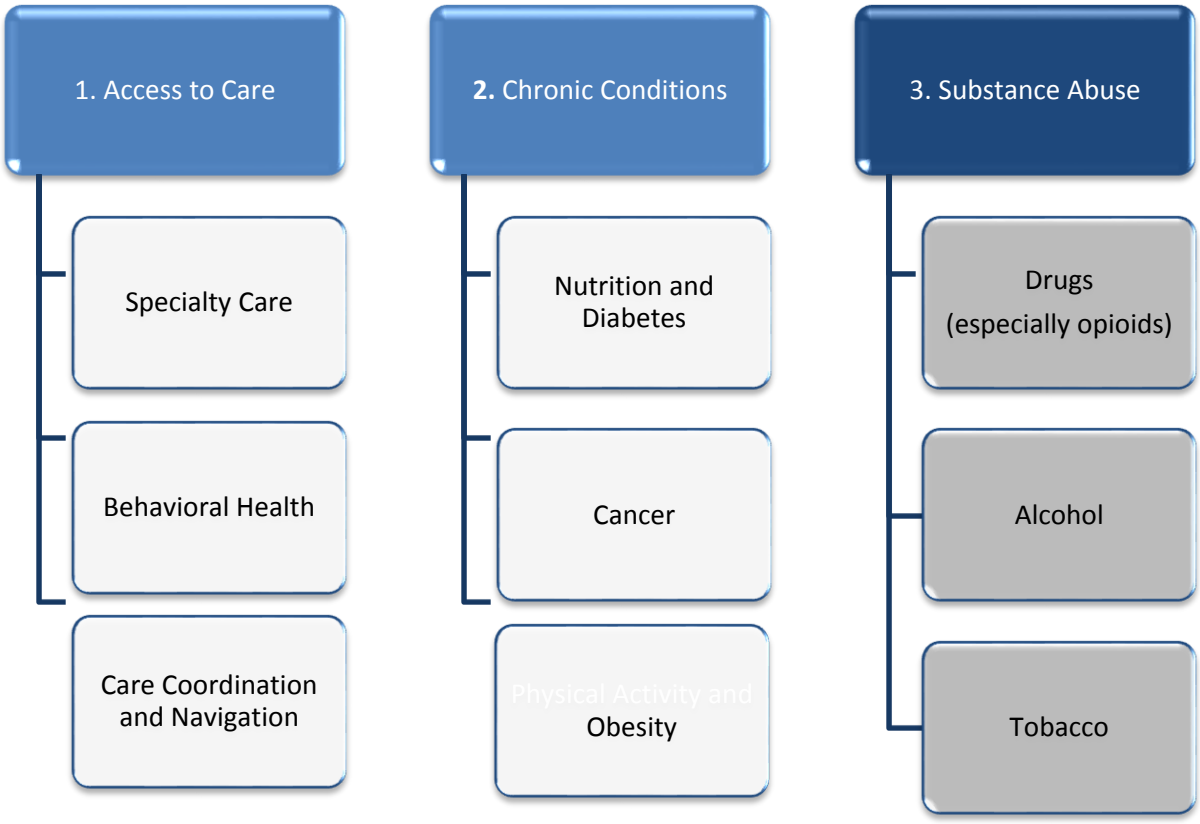
The project component pieces involved to determine the community health needs included:

- Public commentary on the 2015 CHNA and implementation plan (also conducted by Tripp Umbach)
- Evaluation of implementation strategies in 2015
- Secondary data analysis of health status and socioeconomic environmental factors related to health and well-being of residents
- Community leader interviews/public commentary
- Community forum at Penn Highlands DuBois
- Provider inventory of programs and services related to key prioritized needs

Key Prioritized Needs

Tripp Umbach and the internal Steering Committee identified three prioritized community need areas for the Penn Highlands Healthcare system. The community health needs are based on qualitative and quantitative data, particularly from community forum feedback. Figure 1 (below) details the three prioritized need areas and key factors and considerations of each need.

Figure 1: Prioritized Community Health Needs for Penn Highlands Healthcare 2018 CHNA



Section 2. Implementation Plans for Substance Abuse

Substance Abuse (drugs, alcohol and tobacco) was identified as a need throughout the Penn Highlands service area. It is important to note that these conditions have been a priority for Penn Highlands for many years, including the previous CHNA and Implementation Plan. Due to Penn Highlands Healthcare having its own dedicated behavioral health department, the following Implementation Plan is not categorized by each facility, but rather from an overall system perspective.

NEED: Substance Abuse
Facility: DuBois Penn Highlands Behavioral Health Department.
This department provides substance abuse services to Dubois, Elk, Brookville and Clearfield hospitals.
Goal: Collaborate with community Substance Abuse Providers to reduce substance abuse.
Anticipated Impact: Tri County Area to include Clearfield, Jefferson and Elk counties.

Objectives	Annual Activity	Target Population	Evaluation Methods/ Metrics	Potential Partners	Planned Resource Commitment
Address barriers that impede the ability to meet the assessment and treatment demand.	Support the local Single County Authority (SCA) Continue attending SCA meetings. Visit the Free Clinic Support the Housing Specialist meeting	Schools At-Risk youth Justice Department Homelessness Free Clinic	Collaborate with the education system three times per year. Attend outreach meetings two times per month - Clearfield Jefferson D&A and LHOT-Housing meeting Visit the Free Clinic once per month Participate in Housing Specialist meeting once a month. Visit local homeless shelters two times per year.	Cen Clear Drug and Alcohol. Clearfield Jefferson Drug and Alcohol Commission Pyramid Healthcare	Staff time Community partnerships

Identify available transportation to treatment.	Secure transportation from local providers	People presenting at the local emergency room. Patients at the free clinic	Develop four partnerships with local transportation providers, Constable, Uber, D&A & Pyramid Health Care	Constables Uber Drug and Alcohol treatment providers.	Staff time Local transportation providers
Develop a list of hospital detox beds and rehabs in the area.	Compile list of beds at various facilities: Warren General, Pyramid Health Care, Butler Hospital, Spirit Life Indiana	Free Clinic Patients Clearfield Jefferson Drug and Alcohol referrals Emergency room referrals	Up to date list of detox and rehab beds for hospital staff to reference.	Cen Clear Drug and Alcohol. Clearfield Jefferson Drug and Alcohol Commission. Pyramid Healthcare.	Staff time Local detox and rehab providers
Educate the staff on drug trends and treatment	Present at quarterly staff meetings	Healthcare staff, emergency room, physicians and nurses.	Two education sessions per year.	Staff	Staff
Participate on the Clearfield Jefferson Opioid Task Force.	Provide support at Consortium meetings. Provide education to local community churches and senior center.	Youth 18-21 Adults 22-65	Monthly Updates to the Free Clinic. County housing meeting	SCA Single County Authority Clearfield Jefferson Drug and Alcohol Commission Cen Clear Drug and Alcohol Managed Care	Staff time

Appendix A. Key Findings from the CHNA for Substance Abuse

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol, tobacco, and illicit drugs. Substance abuse also does not discriminate – all genders, races, religions and both the rich and poor are susceptible to substance abuse. Repeated use of these substances use can lead to dependence syndrome - a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

Policies which influence the levels and patterns of substance use and related harm can significantly reduce the public health problems attributable to substance use, and interventions at the health care system level can work towards the restoration of health in affected individuals.[1]

When speaking with members of the Penn Highlands community, many were concerned about three particular substances – drugs (especially opioids), alcohol, and tobacco.

Drugs (with emphasis on opioids)

Every day, more than 115 people in the United States die after overdosing on opioids. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.[2]

In 2016, there were 2,235 opioid-related overdose deaths--- in Pennsylvania a rate of 18.5 deaths per 100,000 persons—compared to the national rate of 13.3 deaths per 100,000 persons. Since 2010, opioid-related overdose deaths have increased in all categories. Heroin overdose deaths have increased from 131 to 926; synthetic opioid overdose deaths have increased from 98 to 1,309; and prescription opioid overdose deaths have increased from 411 to 729 deaths.[3]

In the study area, the opioid epidemic was a health issue that was discussed very frequently – many residents were concerned about the perceived growing levels of opioid abuse in the Penn Highlands Healthcare service area. Communities which are both rural and economically depressed are typically very susceptible to opioid abuse. It was a topic that was discussed heavily at the Penn Highlands Healthcare Community Forum.

[1] World Health Organization
[2] National Institute on Drug Abuse
[3] National Institute on Drug Abuse, *Pennsylvania Opioid Summary*

Alcohol and Tobacco Use

Another lingering community health issue that was been discussed during the last CHNA was prevalent alcohol and tobacco use. Stakeholders often discussed during interviews that alcohol and tobacco use are "generational" issues that passed down from adults to their children. Many said that dependence and abuse are engrained in the culture of the region and that it will take years – if not decades – of education to change the habits of residents.

Table 1: Alcohol and Tobacco Access Consumption

Geography	Liquor Store Access per 100,000 population	Alcohol Consumption (%)	Tobacco Usage (current smokers, %)
Cameron County	19.6	n/a	44.6%
Clearfield County	20.8	18.9%	21.1%
Elk County	34.4	27.2%	35.5%
Jefferson County	26.5	24.3%	28.8%
PA	14.3	18.7%	20.8%

As illustrated in Table 1, the entire Penn Highlands Healthcare service area higher rates in all major alcohol and tobacco measures compared to the state. This data shows that interviewees are correct in their perception that residents of the region are consuming alcohol and tobacco at a higher rate than the Pennsylvania averages.