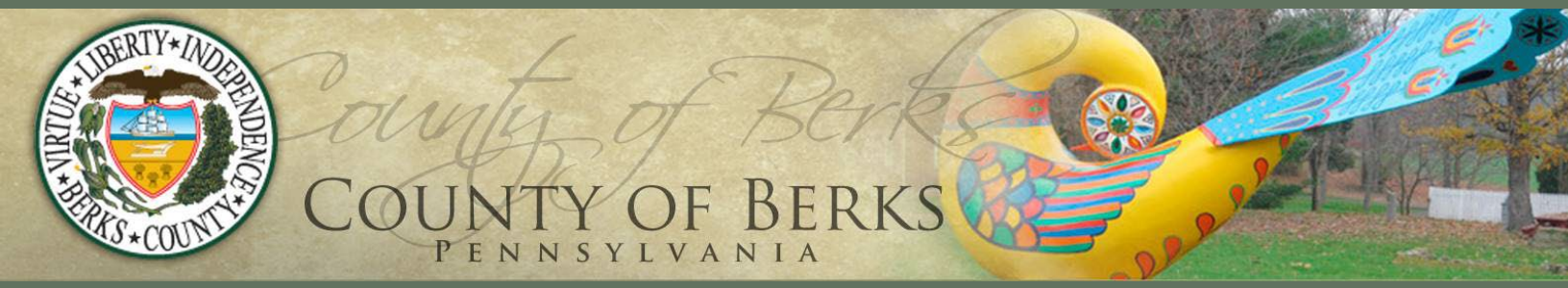

Berks County Final Report

Study of the Delivery of Health and Public Health Services in Berks County

HEALTH MANAGEMENT ASSOCIATES

We would like to acknowledge all who participated and contributed to this effort. Thank you very much for sharing your valuable insight and your time.

Berks County Commissioners

Christian Y. Leinbach, Commissioner, Chair
Michael S. Rivera, Commissioner, Vice-Chair
Lucine E. Sihelnik, Commissioner[1]

Berks County Core Team

Carolyn Bazik, CFO/Director of Co-County Wellness Services
Brian Gottschall, Director of Berks County Department of Emergency Services
Dr. Solomon Lausch, Retired Executive Director of the Berks Business Education Coalition
Pamela Seaman, Mental Health/Developmental Disabilities Program Administrator
Michael Toledo, President/CEO of Centro Hispano Daniel Torres Inc.

Interview Participating Organizations

Berks Alliance
Berks County Intermediate Unit
Penn State Health St. Joseph Medical Center
Tower Health
Twin Valley High School
United Way / 211

Focus Group Participating Organizations

Berks Community Health Center
Berks Counseling Center
Berks County Veterans Affairs
Berks County Department of Emergency Services
Centro Hispano Daniel Torres Inc.
Co-County Wellness Services
Community Care Behavioral Health
County EMS Working Group
County Fire Working Group
County Law Enforcement Working Group
Eastern PA EMS Council
Greater Reading Chamber Alliance
Habitat for Humanity
Hope Springs Clubhouse
Mary's Shelter
Mosaic House
Muhlenberg School District
NAI Keystone
New Castle Lawn & Landscaping
Opening Doors Program Participant
Pennsylvania Department of Health
Penske Trucking
Quantitative Evaluation and Sys-Tems (QEST)
Service Access and Management, Inc
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Tower Health
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[1] During the course of the study, there was a change in the composition of the Berks County Board of Commissioners. When this report was authorized, Commissioner Keven Barnhardt was on the Board. Commissioner Barnhardt resigned in January 2023. Commissioner Lucine E. Sihelnik was appointed by the Berks County Board of Judges as the new County Commissioner on February 14, 2023.

In addition to the above-named organizations, we would like to express appreciation to each Berks County community member who participated in focus group conversations or individual interviews. Thank you!

A. Executive Summary

The spread of COVID-19 created a public health crisis that this country has not experienced in the past century. This pandemic required local governments to act swiftly to limit the human cost of this public health threat. Three years later, many counties are considering how best to respond to changing community needs. Some counties are examining how they could leverage public health services and American Rescue Plan Act funding opportunities to develop infrastructure and systems with lasting impact on improving the lives of their residents.

The Berks County Commissioners requested that Health Management Associates, a research and consulting firm with public health, health care, and social service strategic planning expertise, conduct a study and receive guidance from a five-member core team of public health and health experts from County government, community-based organizations, and a private citizen with decades of leadership experience in the County.

This study assessed the health and public health services in Berks County to identify opportunities to ensure that all residents have resources and opportunities to pursue their highest level of health. Recognizing that a community's health is largely determined by conditions outside of health care settings, this study examined how the County coordinates and aligns cross-sector action tied to public health that engages county residents, businesses, schools, community organizations, and government sectors. The study goal was to ensure Berks County has community-informed information to assess how health care and public health services support its residents in improving health outcomes and health equity. In this way, the study aims to recommend steps the County can take to lead in public health emergencies as well as prevent avoidable health conditions and reduce health disparities.

We used a phased approach to assess public health service needs in Berks County. In phase one, we reviewed State and County health statistics to establish a baseline understanding of existing public health needs. We also geo-mapped data, reviewed recent Community Health Needs Assessments that two County Hospitals completed and compared the Berks County health profile to adjacent and similar counties. In phase two, we dug deeper into this landscape, convening focus groups with a total of 81 community members participating from across the county. These focus groups included individuals who interact with the health system in various ways, including service recipients, providers, and administrators. We also conducted key informant interviews with community leaders and healthcare stakeholders. The information on the approach other Pennsylvania counties use to meet public health needs also informed the study recommendations in phase three.

Berks County public health stakeholders resoundingly urged that the county consider an approach to public health that would provide resources to:

- Coordinate public health services already being implemented in the county (community-based organizations, hospitals, health plans, County, and City agencies), and support collective impact to target county resources to synergize existing efforts and needs not being addressed elsewhere.

- Provide one clear, trusted voice about public health threats, response, and concerns to guide County residents, businesses, schools, and private and public organizations in public health emergencies.
- Increase access to public health data to the public and key public health partners.
- Clarify roles and responsibilities for each public and private partner, and reduce duplication of County, City, and State efforts.
- Improve the health of county populations that exhibit the greatest disparities by supporting upstream factors that affect health like access to nutrition, housing, healthcare, and benefits, and ensure that prevention and wellness information and resources are accessible in English and Spanish.

Based on our analysis, we recommend that Berks County take the following actions:

1. Create a Berks County Health Director position to lead public health collective action and coordination and serve as a trusted communicator about public health information.
2. Establish a Public Health Advisory Panel to provide clinical and public health guidance for the County and the Health Director.
3. Support the establishment of a "Healthy Berks" Coalition to serve as a coordinating body for public health efforts in the county.
4. Create a Berks County health analyst position to improve Berks County specific public health data completeness and accuracy.

These recommendations will permit the county to have a **broad range of options** in enhancing its ability to meet public health needs in the future. By creating a Public Health Director position, Public Health Advisory Panel, a Healthy Berks Coalition, and a Health Data Analyst position, the county will be able to improve coordination of existing services and communicate with partners and the public as one authoritative voice about public health threats, emergencies, and risks. Simultaneously, these steps will provide a **glide path to establish a public health department** should the County decide to do so in the future.

B. What is Public Health?

Public health is what we do as a society to ensure the conditions in which everyone can be healthy. Public health is distinct from health care or social service delivery. For example, state and local public health departments monitor disease outbreaks, ranging from foodborne illnesses like E. Coli to communicable diseases like COVID-19 or measles, to identify the source of the outbreak, disseminate accurate information to the community, and prevent further spread. However, these departments do not typically provide medical treatment services for communicable diseases. Public health is often considered "invisible" because its focus is on preventing harmful outbreaks, disasters, injuries, and chronic illnesses from occurring. As evidenced by the COVID-19 pandemic, however, lack of a core public health infrastructure can mean that, when a public health emergency or disaster strikes, the response can be severely hampered without public health leadership to effectively communicate information, orchestrate

efforts, and coordinate partners, leaving communities woefully unprepared to quickly respond and implement surge capacity operations.

C. Approach to Understanding Public Health Needs and Opportunities in Berks County

This study of the delivery of health and public health services in Berks County was conducted June 2022 to March 2023. It assessed County health and public health services from the perspective of a cross section of community members and health stakeholders. This study considered Berks County public health needs and services more than two years after the start of the COVID-19 pandemic, an experience that shaped the views of stakeholders at all levels. Every step of the study was guided by a core team of public health and health experts from County government, community-based organizations, and a private citizen with decades of leadership experience in the County.

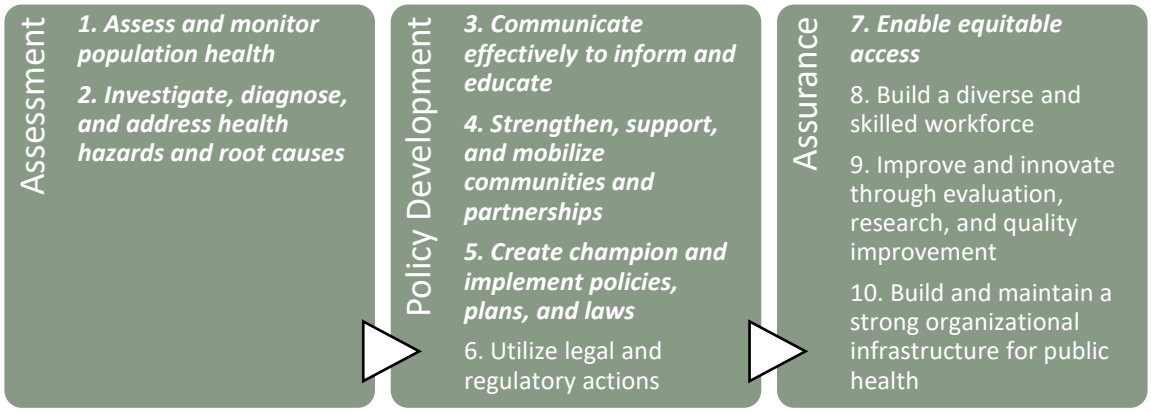
We began our study by reviewing two prior community health needs assessments (CHNAs) conducted in Berks County. Our study differed from a CHNA in that it looked at gaps, opportunities and strengths related to the provision of public health services. A CHNA is a systemic process to identify community needs and barriers, whereas this study was more focused on community priorities and solutions related to the coordination and delivery of public health services in Berks County.

We framed this study of the health and public health services in Berks County based on the National Standards for Public Health Essential Services. The 10 Essential Public Health Services fall into three domains, Assessment, Policy Development, and Assurance. Based on Berks County's needs identified in data and the recent CHNAs, we narrowed our focus to six of the 10 Public Health Essential Services:

- Assess and monitor population health;
- Investigate, diagnose, and address health hazards and root causes;
- Communicate effectively to inform and educate;
- Strengthen, support, and mobilize communities and partnerships;
- Create champion and implement policies, plans, and laws; and
- Enable equitable access.

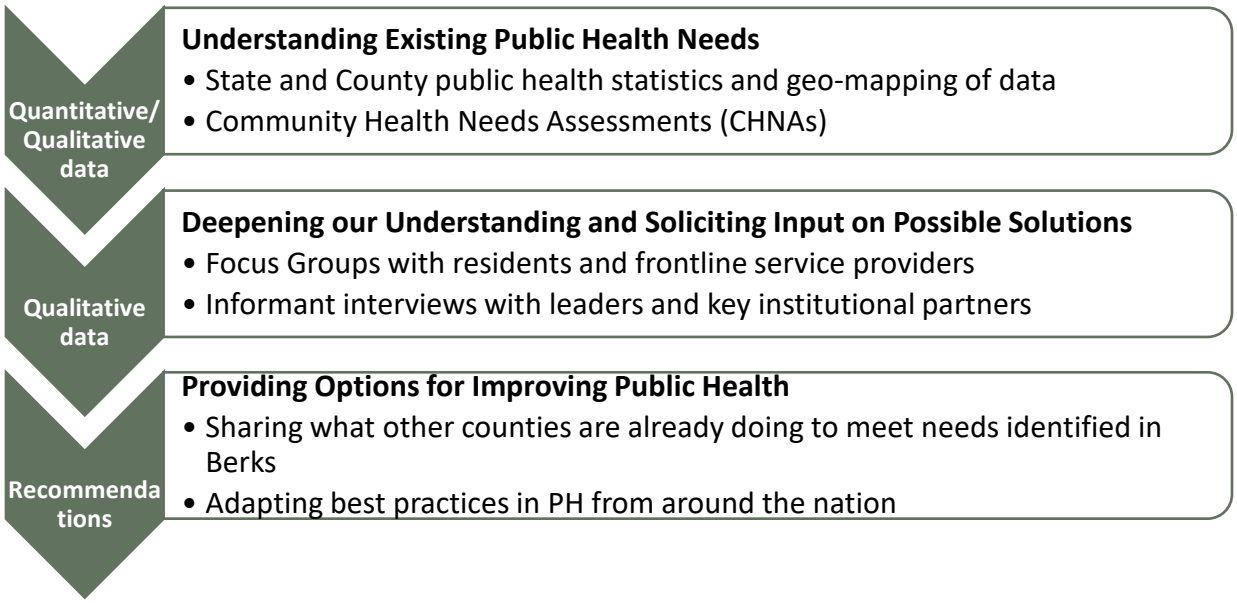
Our data analysis, document review, focus groups and interviews examined the current state of these six Essential Public Health Services in Berks County. **Figure 1** outlines the 10 Essential Public Health Services and the six (in bold) chosen to guide our study.

Figure 1. Essential Public Health Services



We implemented a three-phased approach to assessing public health service needs in Berks County. In phase one, we reviewed State and County health statistics to deepen our understanding of existing public health needs and we solicited input on possible solutions. We also analyzed State and County health statistics, geo-mapped data, and reviewed recent CHNAs. We compared Berks County's health profile to adjacent and similar counties (Chester, Lancaster, Lehigh, Montgomery, and York). In phase two, we dug deeper into this landscape, talking with community members from various county locations in focus groups. A total of 81 focus group participants were involved, drawn from residents, frontline healthcare workers, and health program staff. We also conducted 10 key informant interviews with community leaders and key stakeholders. Our conversations, which took place in both English and Spanish, provided the basis for our findings. Information on the approach that other counties use to meet needs like those in Berks County also informed the study recommendations in phase three. **Figure 2** illustrates our process.

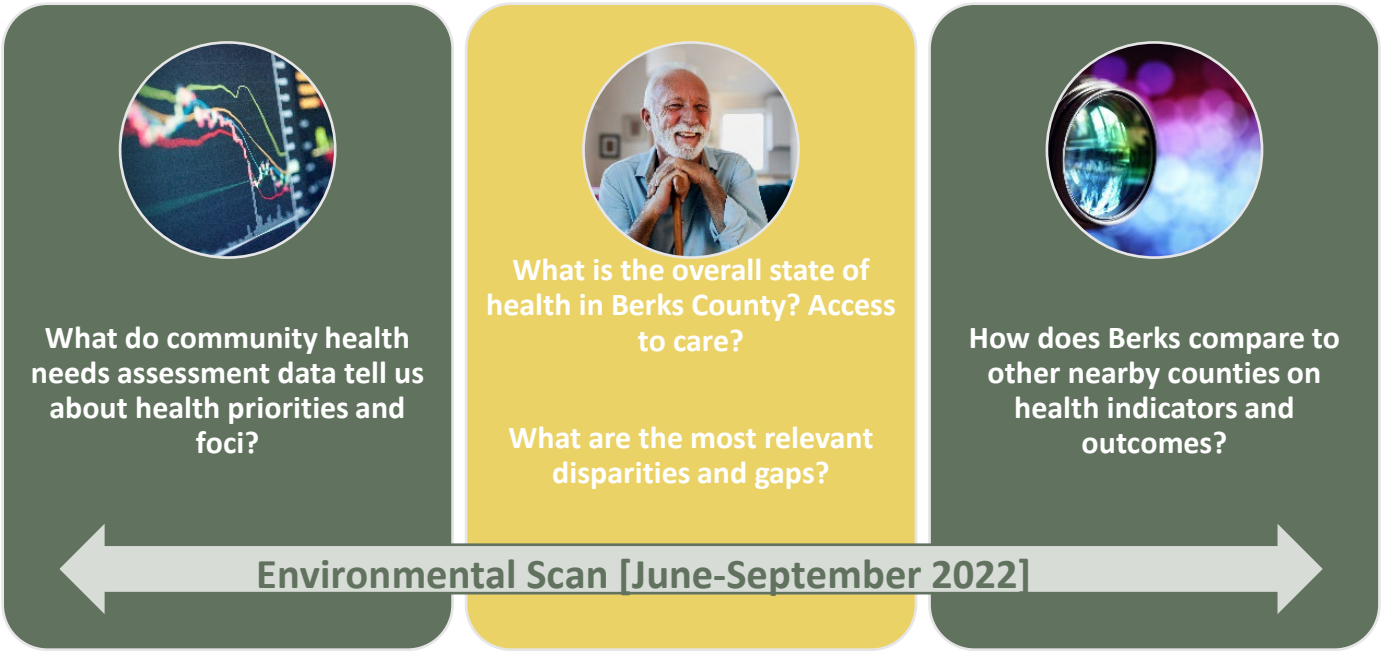
Figure 2. Process



D. We Started by Reviewing Recent Community Health Needs Assessments and Other Relevant Data and Information to Create a Berks County Health Profile

In the early stages of this project, HMA reviewed federal, state, and local data sources, as well existing reports, and documents to determine what Berks County health and social services organizations had already uncovered regarding the public health needs of individuals and families in the county. We framed our analysis around the following questions:

Figure 3. Analytic Questions



In answering these questions, HMA reviewed a host of existing State and County data including:

- Census and demographic data, including racial/ethnic composition, age distribution, socioeconomics, and special populations;
- Social and economic factors including income, poverty levels, education, unemployment, and homelessness in the four counties;
- Health outcomes across counties including, leading causes of death, health rankings, health factors and behaviors, and health conditions;
- Access to primary and preventive care, insurance coverage;
- Recent CHNAs conducted by Tower-Reading and Penn State-St. Joseph's Hospitals;

- National and state data dashboards including County Health Rankings,[2] CDC Places Data,[3] Reading City Health Dashboard,[4] Healthy People,[5] Data USA,[6] Word Population Review,[7] Future Ready PA,[8] and United States Census Bureau[9];
- Pennsylvania Department of Health and Department of Human Services data, including county health profiles and health disparities heat map; and
- United Way 211 Counts data on social services needs and service utilization.

Below we present key findings tied to the environmental scan questions above. Data sources and documents were examined systematically.

What We Learned from Prior Needs Assessments

HMA reviewed two recent Community Health Needs Assessments (CHNAs) covering Berks County prepared by Tower Health and Penn State Health. The Internal Revenue Service requires not-for-profit hospitals and health plans to conduct a community health needs assessment at least once every three years. For reference, both CHNAs are included in **Appendix A** and **Appendix B**, respectively.

The key health priorities identified in the two CHNAs were quite similar:

1. Improve access to equitable care, particularly for marginalized populations;
2. Provide behavioral/mental healthcare to both adults and youth;
3. Focus on health education and health literacy, especially resources and information tied to wellness and disease prevention; and
4. Address health disparities and increase the focus on health equity including SDOH.

Both CHNAs identified low rates of preventive care across all residents and disparities in preventive care among racial and ethnic minorities. For example, 18 percent of Latino residents and 17 percent of African American residents completed a colonoscopy compared to 35 percent of White residents and 30 percent of Asian residents. Further, the CHNAs recognized racial and ethnic disparities among seniors enrolled in Medicare. Compared to White Medicare enrollees, rates of several chronic health conditions were high among non-White seniors. Rates of diabetes were 7 percent higher among Hispanic, Black, and Asian people. In addition, both reports highlighted the health and social needs of the Hispanic and Latino populations including one third of Latinos living under the Federal Poverty Level and experiencing food

[2] County Health Rankings and Roadmap, 2022, https://www.countyhealthrankings.org/
[3] Centers for Disease Control and Prevention: Places, 2022, https://www.cdc.gov/places/index.html
[4] City Health Dashboard, Reading PA Overview, 2022 https://www.cityhealthdashboard.com/pa/reading/city-overview
[5] Healthy People 2023, 2022, https://health.gov/healthypeople
[6] DataUSA, Reading PA Profile, 2020 information, https://datausa.io/profile/geo/reading-pa/
[7] World Population Review, Reading PA Population, 2022, https://worldpopulationreview.com/us-cities/reading-pa-population
[8] Future Ready PA Index, 2022, https://futurereadypa.org/
[9] US Census Data, https://data.census.gov/

insecurity. Across race and ethnicity, Latinos in Berks County have the highest rate of being uninsured (11%) and the highest rates of emergency room visits, indicative of a lack of access to primary care. These findings indicate the need for increased attention to preventive care to address the disparities in health outcomes in Berks County.

The CHNAs also detail behavioral health needs including a lack of mental health and substance use disorder (SUD) services, a shortage of providers, insufficient inpatient beds and post-acute care resources, insufficient skilled-nursing facilities that admit people with serious mental illness, and a general lack of public awareness surrounding the existing behavioral health services.

Both CHNAs focused on the need for closing key health disparities, and linked these disparities to upstream, social factors outside of health care provision, including lack of awareness of available resources and services, food, and housing insecurity, lack of public transportation, and cultural and linguistic barriers. These assessments also noted a need for more focus on healthy literacy and preventive health, as well as the need for greater attention to behavioral health as a part of the promotion of community health and wellness.

What We Learned about the Socioeconomic Context for Health in Berks County

Drawing on data from the 2020 U.S. Census, Berks is similar to both Pennsylvania as a whole and the U.S. on many population metrics and demographic indicators (see **Table 1** below). Key ways in which Berks is different compared to statewide averages include:

- Racial/Ethnic Composition: Berks has a higher percentage of Hispanic/Latino residents, and lower percentages of Asian, Black/African American, and White residents.
- Language Diversity: Berks has higher percentage of households who speak a language other than English in their homes.
- Educational Attainment: Berks has lower percentages who have earned both a High School diploma and a 4-year college degree by age 26.

Table 1. Population Statistics, 2020

Indicator	*Berks County*	*Pennsylvania*	*United States*
Asian	2%	*4%*	*6%*
Black/African American	8%	*12%*	*14%*
Hispanic/Latino	24%	*8%*	*19%*
Multi-Racial	3%	*2%*	*3%*
Other	1%	*1%*	*2%*
White, Non-Hispanic	69%	*75%*	*59%*
Median Household income	$69,272	*$67,587*	*$69,021*
Percent in Poverty	13%	*12%*	*12%*
Percent with Disability (less than 65 years)	10%	*10%*	*9%*
Percent Under 18 years	22%	*21%*	*22%*
Percent Above 65 years	18%	*19%*	*17%*
High School Completion	88%	*91%*	*89%*

College Degree	*26%*	*33%*	*34%*
Language other than English Spoken at Home	*19%*	*12%*	*22%*

What We Learned about Health and Health Access in Berks County

Using data from the National Center for Health Statistics,[10] **Table 2** shows the leading cause of deaths in Berks County in comparison to both state and national averages. Causes of death are listed in rank order, apart from COVID-19 which represents a cumulative rate from 2020-2023. Across most indicators, Berks has lower rates of death compared to statewide averages. The two exceptions are Stroke and COVID-19 (indicated in red below). Berks has lower rates on four leading causes of death compared to national averages, and five that are higher (Heart Disease, Cancer, Stroke, Kidney Disease, and COVID).

Table 2. Leading Causes of Death (rate per 100,000), 2017

Indicator	*Berks County*	*Pennsylvania*	*United States*
Heart Disease	172.2	176.0	165.0
Cancer	156.9	161.0	152.5
Accidents	48.9	70.2	49.4
Stroke	**46.5**	**36.5**	**37.6**
Chronic Lower Respiratory Disease	33.9	37.1	40.9
Diabetes	19.3	21.0	21.5
Alzheimer's	16.7	21.7	31.0
Kidney Disease	14.6	15.9	13.0
COVID (all time since 2020)[11]	**412.9**	**387.6**	**327.3**

Using data from the 2022 County Health Profiles,[12] **Table 3** displays quality of life indicators. Berks ranks lower on self-reported health and number of poor physical health days (indicated in red).

Berks is similar to state and national averages on self-reported poor mental health and low birthweight.

Table 3. Quality of Life, 2020

Indicator	*Berks County*	*Pennsylvania*	*United States*
Poor or Fair Health	**20%**	**18%**	**17%**
Poor Physical Health Days	**4.2**	**3.9**	**3.9**
Poor Mental Health Days	4.6	4.6	4.5
Low Birthweight	8%	8%	8%

[10] Center for Disease Control and Prevention, National Center for Health Statistics, 2017 https://www.cdc.gov/nchs/pressroom/states/pennsylvania/pennsylvania.htm
[11] U.S. COVID-19 cases and deaths by state, https://usafacts.org/visualizations/coronavirus-covid-19-spread-map
[12] County Health Rankings and Roadmap, Berks County, 2022, https://www.countyhealthrankings.org/explore-health-rankings/pennsylvania/berks?year=2022

Table 4 shows various health factors and behaviors in Berks County. Compared with state and national data, Berks has slightly higher rates of adult smoking, physical inactivity, and obesity (indicated in red below). Berks also has higher rates of teen births and sexually transmitted infections. Other indicators were similar to state and national rates, or better in the case of access to healthy food.

Table 4. Health Factors and Behaviors, 2020

Indicator	*Berks County*	*Pennsylvania*	*United States*
Adult smokers	**19%**	**18%**	**16%**
Adult obesity	**34%**	**33%**	**32%**
Food environment index (10=best access to healthy food)	**8.7**	**8.4**	**7.8**
Physical inactivity	**28%**	**25%**	**26%**
Access to exercise opportunities	79%	78%	80%
Excessive drinking	19%	20%	20%
Sexually transmitted infections (rate per 100,000)	535.9	481.9	551.0
Teen births (rate per 100,00)	20	15	19

As shown in **Table 5,** Berks has lower access to primary care doctors, dentists, and mental health compared to state and national ratios (indicated in red below). Berks also has higher numbers of preventable hospital stays, and lower rates for mammography screenings than the state average. Berks does best on the percentage of residents with health insurance and propensity for flu vaccinations.

Table 5. Healthcare/Clinical Care Access, 2020

Indicator	*Berks County*	*Pennsylvania*	*United States*
Percent Uninsured	8%	7%	11%
Primary Care Physicians (ratio)	**1,590:1**	**1,220:1**	**1,310:1**
Dentists	**1,770:1**	**1,410:1**	**1,310:1**[13]
Mental Health Providers	**640:1**	**420:1**	**350:1**
Preventable Hospital Stays	**4,221**	**3,966**	**3,767**
Mammography Screening	45%	47%	43%
Flu Vaccinations	55%	54%	48%

Summarizing Berks in Relation to Other Nearby Counties

We examined key health data in Berks County in comparison with five nearby counties (Chester, Lancaster, Lehigh, Montgomery, and York). We ranked each county on selected indicators of health on scale of one to six (1=best rank/outcomes; 6=lowest rank or worst outcomes). **Table 5** below summarizes how Berks compared with other nearby counties.

[13] County Health Rankings and Roadmap, 2022, https://www.countyhealthrankings.org/
This website allows comparison of Berks to three other counties at a time.

Table 5. Summary of Health, Mortality, and Access (per capita) Rankings, County Comparison

Domain	Lowest outcomes (Berks 5 or 6)	Middle performing (Berks 3 or 4)	Best outcomes (Berks 1 or 2)
Leading Causes of Death	Heart disease (6) COVID death (6) Stroke (6) Chronic lower respiratory (6) Cancer (5) Kidney disease (5)	Accidents (4) Diabetes (4)	Alzheimer's (1)
Health Rankings	Poor or fair health (6) Poor physical health days (6) Premature death (5) Low birthweight (5)	Poor mental health days (4)	
Health Factors and Behaviors	Physical inactivity (6) Teen births (6) Adult smokers (5) Adult obesity (5) Sexually transmitted infection (5)	Food environment index (4) Excessive drinking (4) Access to exercise ops (3)	
Healthcare/Clinical Care Access	Primary Care Physician (6) Dentist (5) Mental Health Provider (5) Preventable Hospital Stays (6) Mammography Screening (5) Flu Vaccination (6)	% Uninsured (4)	

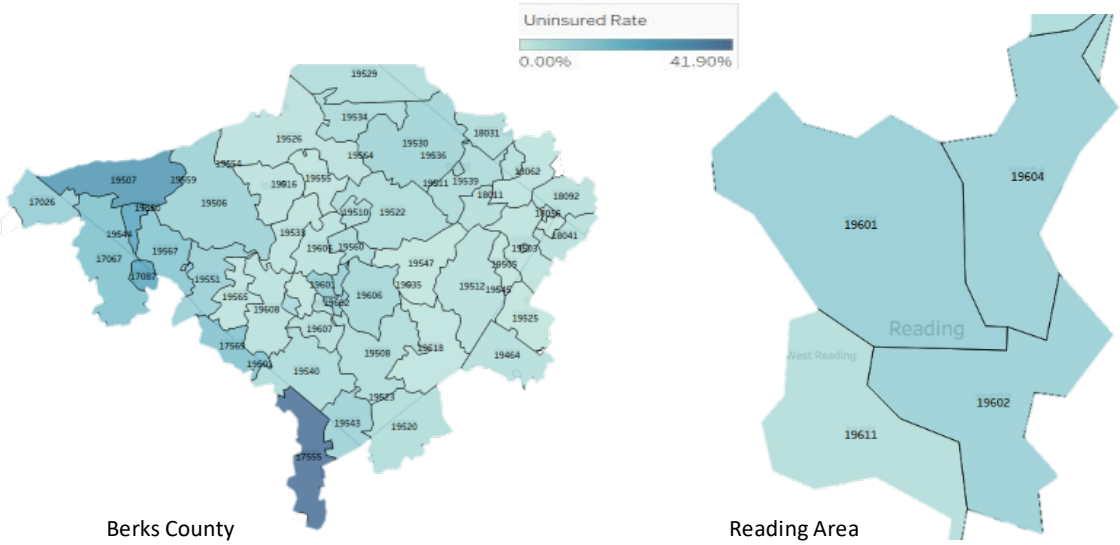
Geo Mapping Health Factors and Indicators

To examine the distribution of key health data and health-related factors within Berks County, we mapped Berks County's population at the zip code level across the following factors: uninsured rates, prevalence of cancer, obesity, chronic heart disease, diabetes, high cholesterol, smoking, asthma, and depression.

Using a federal mapping tool[14], we prepared geographic "heat maps" to illustrate the prevalence of a given condition or factor, drawing attention to the City of Reading in relation to the other portions of the County. Four zip codes (19601, 19602, 19604, and 19614) within the City of Reading have the highest Community Needs Index (CNI) scores.[15]

[14] Federal Berks County maps include zip codes that may fall largely outside of Berks County.
[15] A CNI score of 5.0 indicates the highest socioeconomic need. All these zip codes have CNI scores of 4.6-4.8.

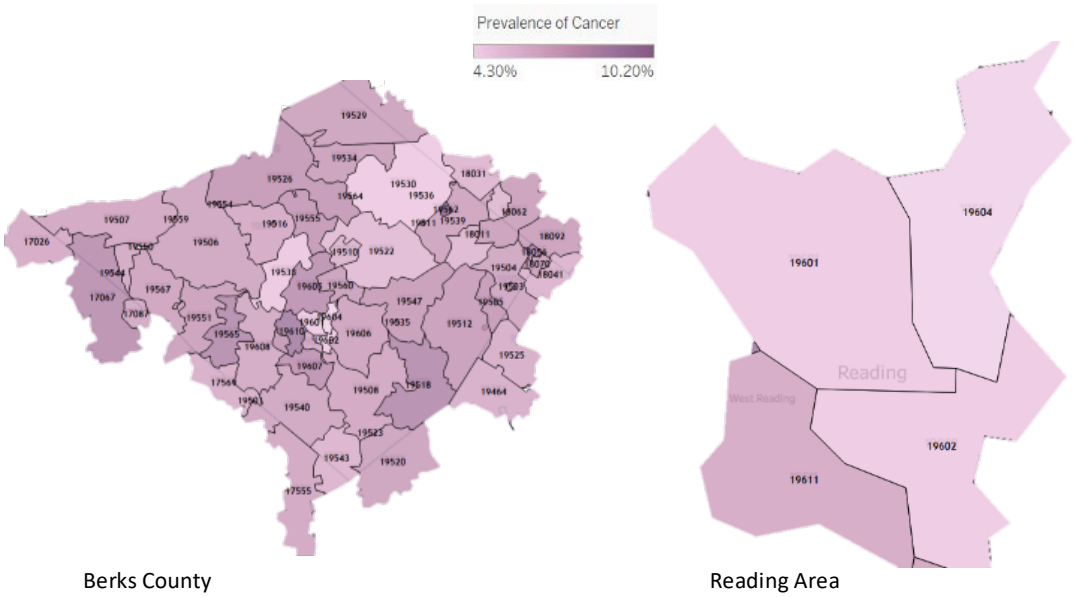
Figure 4. Uninsured Rates



Berks County Reading Area

Reading and the surrounding areas fall in the middle on the scale of uninsurance rates across Berks County. The highest rate of uninsured residents falls in the 19507-zip code furthest in the west of Berks County.

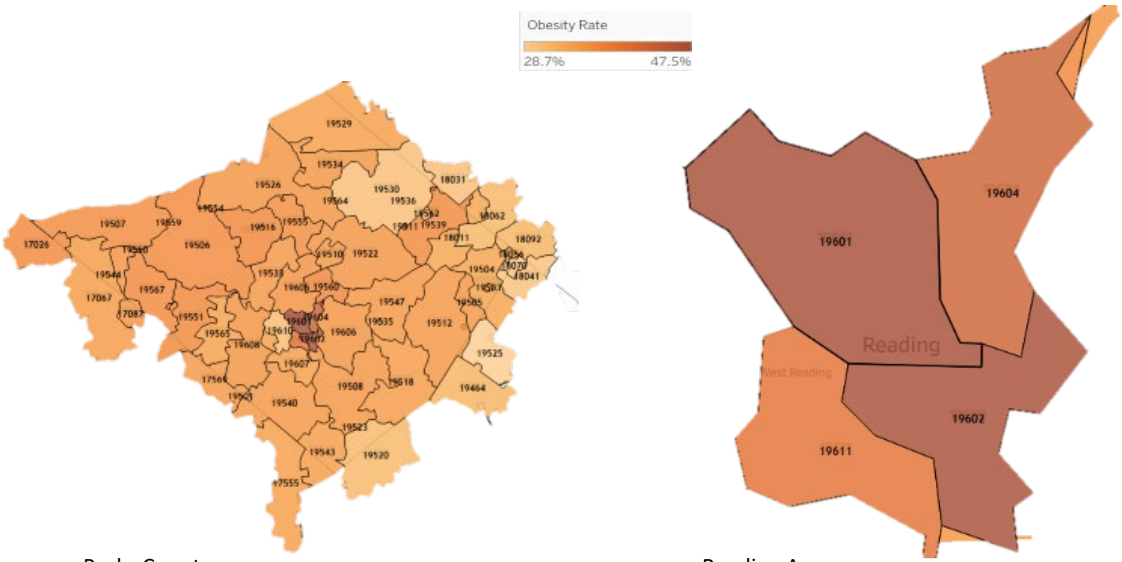
Figure 5. Prevalence of Cancer



Berks County Reading Area

Reading and the surrounding areas have a lower prevalence of cancer compared to other areas of Berks County. The highest rates of cancer are spread across Berks County in different zip codes (19565, 19610, 19518, and 19562).

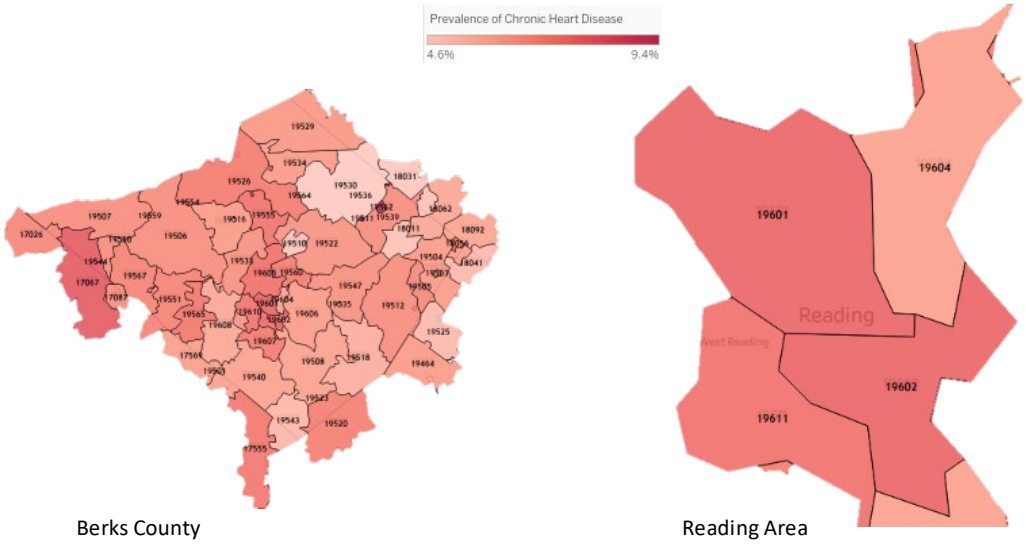
Figure 6. Prevalence of Obesity



Berks County Reading Area

Reading and the surrounding areas have a high prevalence of obesity compared with other areas of Berks County. The lowest prevalence of obesity in Berks County lies across the eastern side of the county.

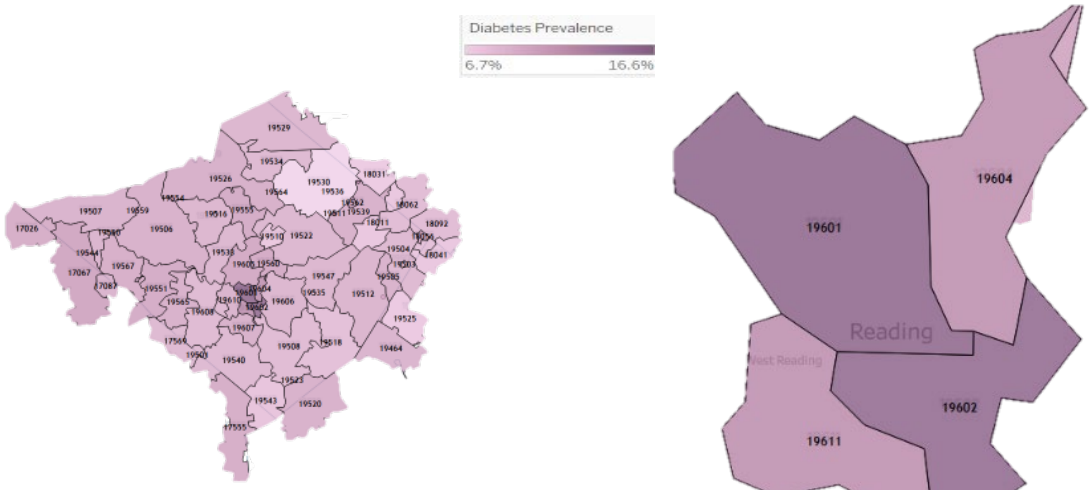
Figure 7. Prevalence of Chronic Heart Disease



Berks County Reading Area

Reading and the surrounding areas fall in the mid-to-high range for chronic heart disease prevalence compared with the rest of Berks County. Across Berks County are more zip codes with a mid-high range of chronic heart disease prevalence. Notably the zip code 19562 in the northeast has high rates of chronic heart disease.

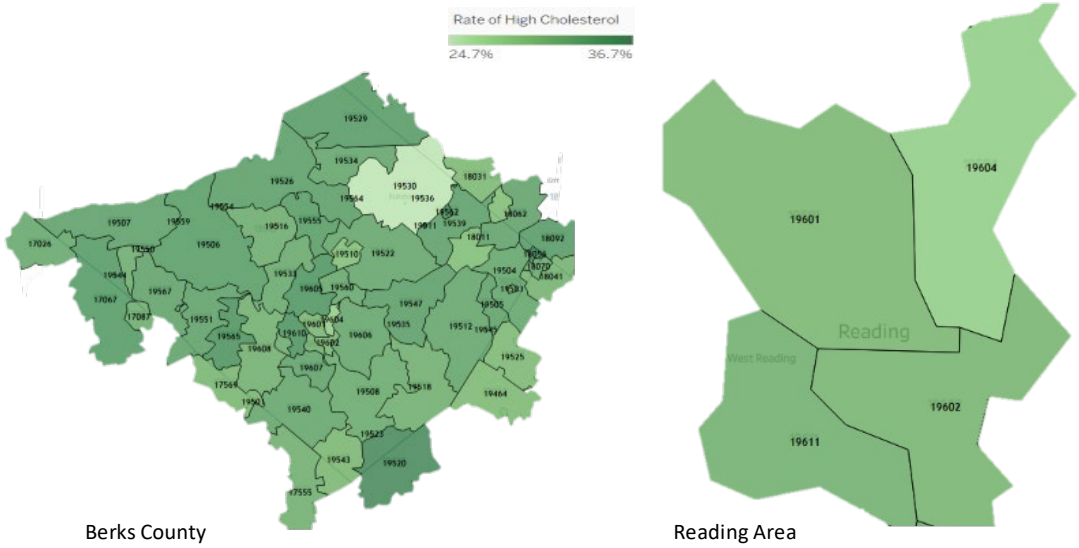
Figure 8. Prevalence of Diabetes



Berks County Reading Area

Reading and the surrounding areas experience high rates of diabetes compared with the rest of Berks County. The lowest rates of diabetes fall in the zip code 19530 in the northeast area of Berks County.

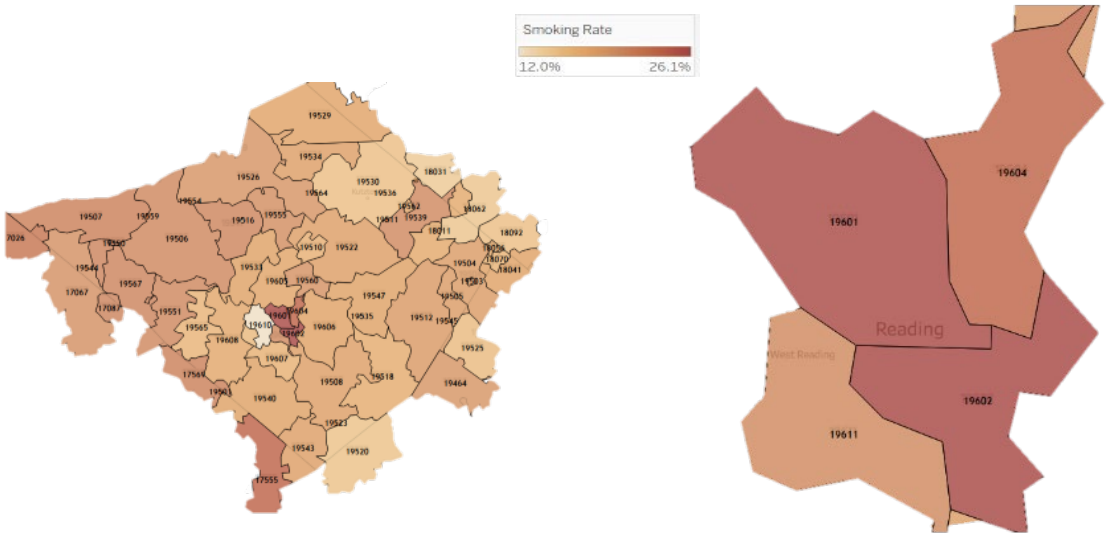
Figure 9. Prevalence of High Cholesterol



Berks County Reading Area

Reading and the surrounding areas experience low to medium rates of high cholesterol prevalence compared with the rest of Berks County. Most Berks County residents experience notably high rates of high cholesterol apart from one zip code in the northeast region (19530).

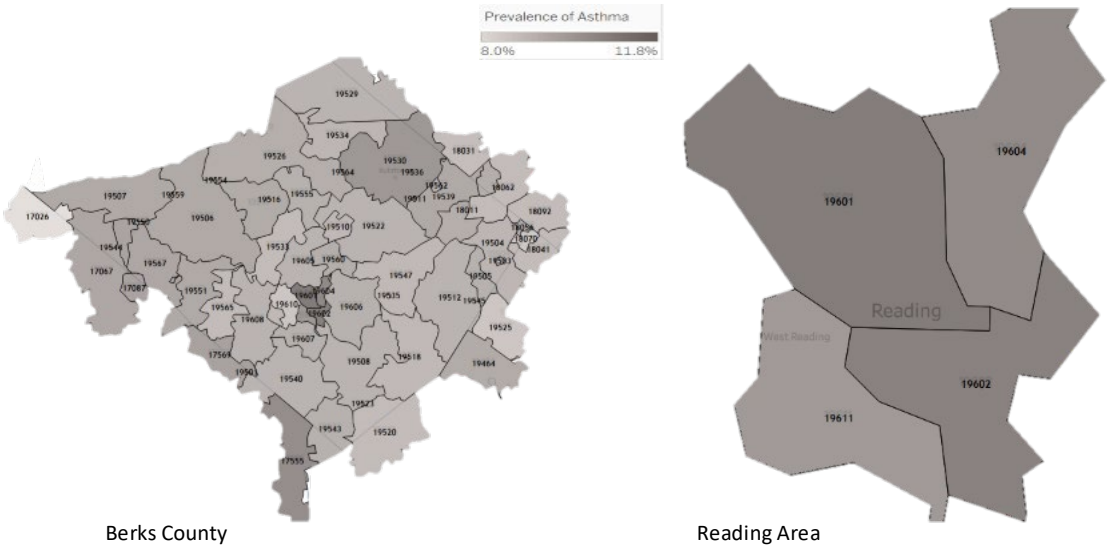
Figure 10. Smoking Rate



Berks County Reading Area

Reading and the surrounding areas have high rates of smoking compared with the rest of Berks County. These zip codes have some of the highest smoking rates in the county. Across Berks County smoking rates are similar with lower rates in the east and mid-range across the south and west sides of Berks County.

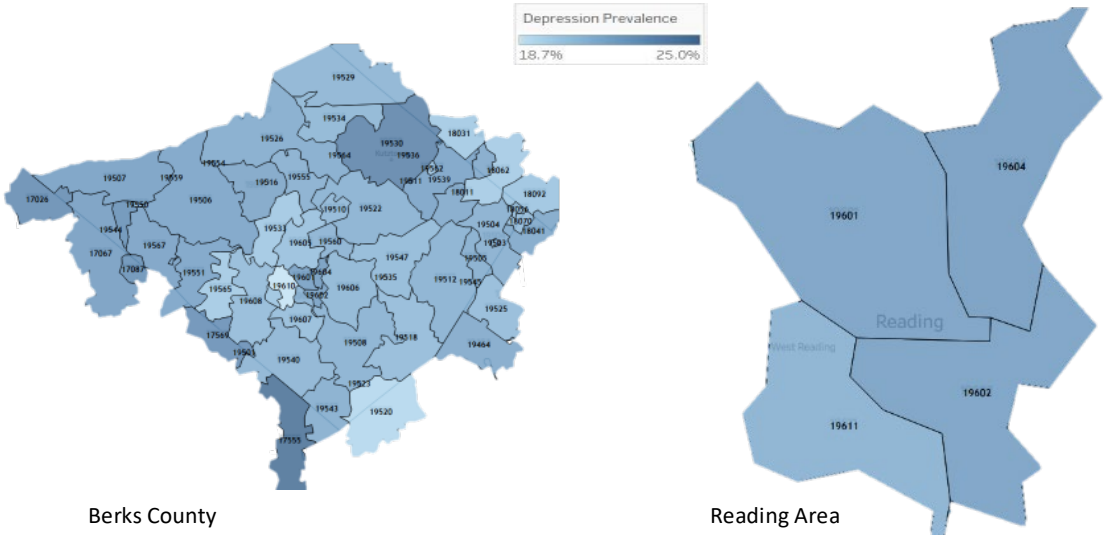
Figure 11. Asthma Rate



Berks County Reading Area

Reading and the surrounding areas have high rates of asthma compared to most other parts of Berks County. Medium rates of asthma are found across most of Berks County with the highest rates in zip code 19530.

Figure 12. Prevalence of Depression



Berks County Reading Area

Reading and the surrounding areas experience mid-range prevalence of depression among adults compared with the remainder of Berks County. High rates of depression in Berks County fall in the northeast region of the county (19530). The remaining areas of Berks County experience mid to low rates of depression.

Summary

Existing county-level health data show clear areas of need in Berks County. In comparison with state and national averages, as well as in relation to a subset of nearby Pennsylvania counties, Berks would appear to have a persistent pattern of poorer health behaviors and outcomes for most indicators when controlling for population. Compared to state and national data, Berks does best in terms of access to healthy food and lower rates of most of the leading causes of death. We also examined intra-county data by zip code. Looking at eight key health conditions, we detected no discernable pattern to suggest that health outcomes were worse or better in the City of Reading compared with other portions of the County. For three of eight conditions (smoking, asthma, and obesity), Reading has higher prevalence rates. However, Reading has lower prevalence of cancer, and is in the low- to mid-range for two other risk factors – high cholesterol and uninsurance**. In sum, public health is a countywide issue.**

E. We Deepened Our Understanding of Public Health Gaps and Racial, Ethnic and Geographic Health Disparities in Berks County through Focus Groups and Interviews

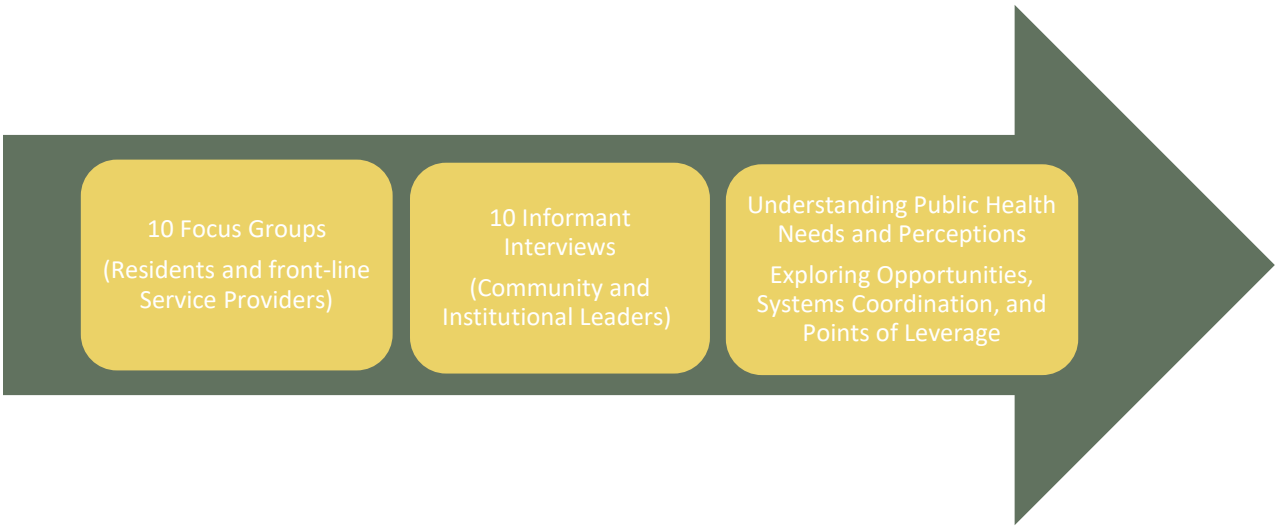
Overview and Methods

To better understand and contextualize data from extant sources, HMA conducted focus groups and interviews with Berks County stakeholders. The focus groups prioritized hearing input from Berks County residents as well as staff involved in the delivery of frontline services relevant to public health including:

- Older adults from rural communities
- Disabled adults and those who provide services to persons with disabilities
- Spanish-speaking adults from urban communities
- Representatives from local businesses and employers
- Individuals in transitional or emergency housing
- Volunteers involved in food delivery
- Community health center staff
- Emergency response staff
- Nurses and other school-based health staff
- Community-based organization (CBO) staff

As shown above, the focus groups included a variety of perspectives to represent a continuum of public health issue areas and constituencies. In this way, the focus groups aimed to solicit input about key issues and concerns from those directly impacted by public health decisions. **Appendix E** includes a detailed description of focus group methods.

Figure 13. Focus Group Methods



For the informant interviews, HMA focused on soliciting input from community and institutional leaders in Berks County. In particular, the informant interviews centered on gathering perspectives on the existing public health-related programs and systems coordination, as well as preferences for the redesign of the public health ecosystem in Berks County. We allocated time during interviews to discuss future

opportunities and points of leverage tied to enhance collaboration in public health. Key Berks County organizations and institutions represented in the interviews included:

- City and county government
- Community-based organizations (CBOs) and foundations
- Hospitals, managed care organizations, and other healthcare providers
- Public School Districts

Appendix F contains a detailed description of informant interview methods**.**

For both focus groups and interviews, our key questions and areas of inquiry centered on the six Core Public Health Services shown in **Figure 14** below. Input and feedback on public health in Berks County was filtered through the lens of how to enhance, develop, or leverage an existing system of public health to: a) respond to the public health needs of the people in Berks County, and b) address the core public health services and functions. A summary of key findings by each of these core functions and service areas follows.

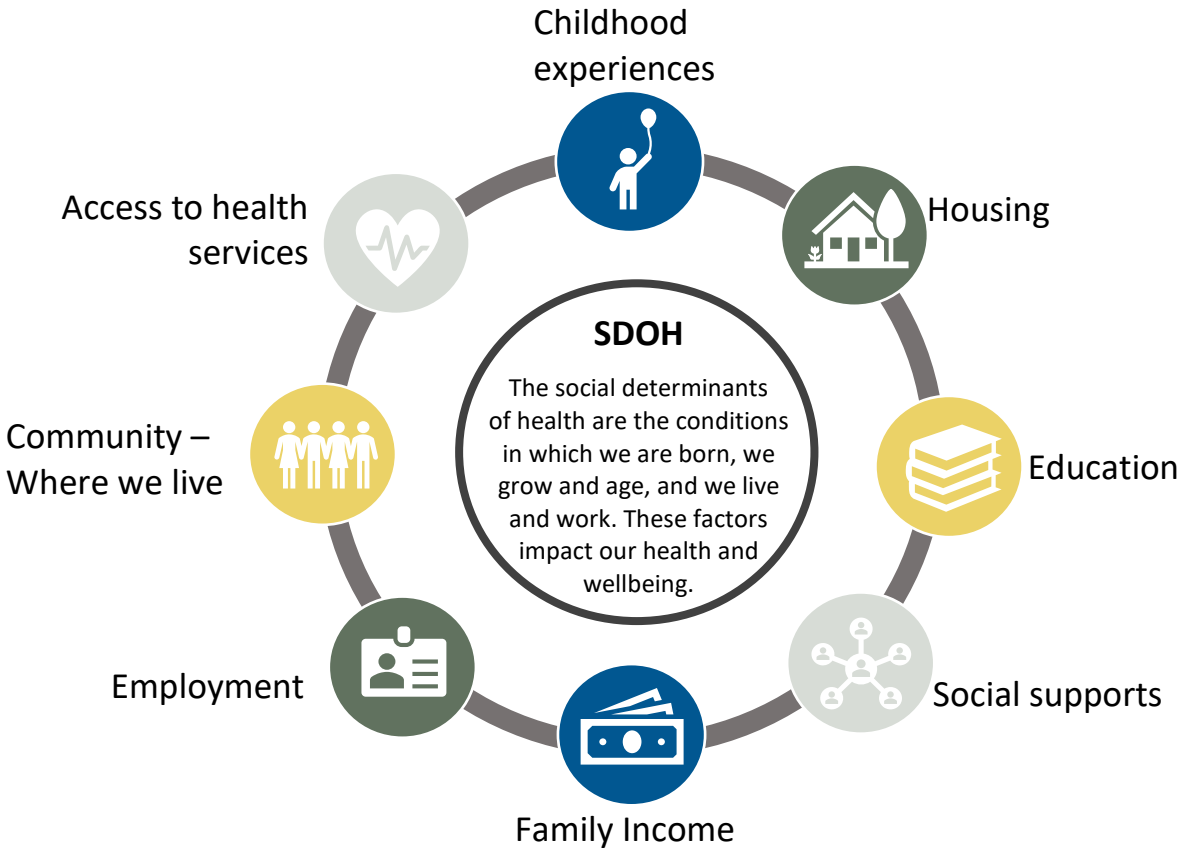
Figure 14. Key Questions by Core Public Health Service Area

Key Findings by Core Public Health Service Area

Across focus groups and interviews, one key theme was the need for Public Health to become more involved in upstream factors that impact health and wellness. Often termed the social determinants of health (SDOH), these are the factors that describe the interactivity of the conditions in which people are born, live, learn, work, play, and age that affect a wide range of health and quality-of-life outcomes and

risks. Each SDOH often intersects with the others to produce individual, family, and community effects (see **Figure 15**).

Figure 15. Social Determinants of Health



Interview respondents often mentioned the need for public health to pay closer more attention to basic needs (food, shelter, and safety) of Berks County residents. As such, they envisioned a public health system more attuned to issues of poverty, unemployment, affordable housing, food, and nutrition, etc., as considerable barriers to health and wellness.

> *"It is not always the issue of getting access to healthcare; they have health insurance. It is other things. It is the social determinants of health that are keeping them from actually having positive health outcomes." Service Provider*

Respondents cited a role for public health in **building awareness and acceptance of the role these upstream factors play as drivers of health disparities**. Similarly, they envisioned a role for public health in focusing health literacy and outreach on overcoming barriers to healthcare access especially

transportation, costs, lack of insurance, and undocumented status. Overall, they noted the need for public health to filter social issues (e.g., housing, transportation, education, etc.) though a health lens to highlight interdependence and need for preventive care.

A second clear theme centered on the need for more **focus on prevention and preventive health**. For example, respondents urged public health to focus education and social marketing on prevention of common chronic illnesses and diseases (e.g., asthma, diabetes, etc.). Similarly, participants expressed a clear consensus on the need to **promote awareness around healthy nutrition/dietary choices**, emphasizing the role of food and diet as health prevention strategies.

"Prioritize making access easier and equitable for preventive care." Service Provider

Lastly, respondents noted the need for **better access to primary care providers**. Indeed, they wanted the benefits of primary care to be messaged and reinforced continually, including the need for proactive care (e.g., routine wellness checks) and increased awareness of Medicare options and access.

Enable Equitable Access

What are the key barriers to more equitable access to healthcare that must be addressed and overcome?

During the focus groups, participants frequently point to issues related to improving equitable access to health and related services. **Language barriers often** were cited, with respondents noting the need for both more consistent and more accurate translations of public health messaging. Indeed, the participants expressed a clear consensus on the need for **more health literacy and promotion in Spanish** as the most commonly spoken language other than English in Berks County households.

"Promotoras that speak my language, are bilingual and have the patience to work with a person, answer questions, etc." Resident

"People need access to education and information in their language in the hospital." Resident

In a related aspect of health equity, respondents noted a need for public health to **provide culturally relevant and responsive care**. Multiple respondents noted the need for increasing cultural competence among both public and private service providers, including staff with bilingual and bicultural skills in engaging Spanish speaking residents.

Equity concerns also surfaced in relation to special populations, who participants said were getting insufficient attention. In particular, respondents noted that few health options were available to **uninsured and undocumented individuals.** Another group mentioned explicitly was the **population with disabilities**. Respondents felt that public health could do more to promote understanding of the needs of people with disabilities among clinicians and other providers. In addition, many respondents noted a need for more attention to the needs of **rural communities** that both lack healthcare access and are often reluctant to embrace public health messages about chronic disease and preventative care.

"People are avoiding accessing the health care system because they are undocumented." Resident

Another clear theme related to equitable access center on the need for **expanded access to mental health services**. Respondents noted a role for Public Health in promoting awareness of mental health services, reducing the stigma associated with mental illness, and continuing to push for **more integrated care** that links physical and mental health. In fact, respondents advocated a role for public health in helping advance coordination via one-stop delivery of health and human services, including mental healthcare. It is important to note that Berks County has made significant progress in integrated care, including establishing dedicated sites that support integrated care, as well as practice requirements for service providers.

To improve equitable access, focus group respondents and interviewees also offered a variety of suggestions centered on **greater flexibility and personalization** of health service delivery. Chief among these recommendations was expanding both **telehealth and mobile health** options. Other input included a desire for more patient navigation services, as well as a general need for more personalized attention and responsiveness of the healthcare and public health systems.

Communicate to Inform and Educate

How do differences in health literacy impact health access and outcomes?

The role of public health in communication and education, often captured by the term health literacy, was a major topic of discussion in the focus groups and interviews. Respondents agreed on the **need for** public

health **to tailor and segment communication**. Put another way, communication and outreach must become more tailored to meet the specific needs of different audiences and special populations.

"We have to be culturally aware of who we are talking to…we need to adjust to the different audiences for the same goal. The messaging has to be aware of the audience." Service Provider

"Many Spanish-speaking patients leave their medical appointments just as confused as they walked in due to culturally unfit information being presented." Service Provider

Akin to the findings on equitable access, respondents noted the need for public health to **adapt communication and outreach to become much more culturally sensitive and linguistically responsive**. Respondents noted that consistent translation into Spanish is lacking and needs to prioritization and Spanish language materials need to be disseminated more effectively. Moreover, respondents noted that public health should **disseminate information through trusted, local sources** such as community-based peer educators or health promoters (*promotoras*) who are most likely to have both cultural competence and the trust of communities.

"We can do more with schools, social services, radio, tv, to push messages. People are dying early for lack of education about self-management. More communication and education to patients about self-management and quality of life is needed." Resident

Focus group and interview participants advocated for **centering Health Literacy campaigns on the prevention of pervasive chronic illness and disease** (e.g., asthma, diabetes, etc.). Similarly, respondents noted the need to invest in messaging that highlights the linkages between health habits and health outcomes (e.g., link between sugary diet and diabetes or between obesity and heart disease), while also **raising the profile of preventive health services** and prevention education. Some respondents also noted the need to elevate issues not traditionally associated with public health (e.g., traffic safety and gun violence) as prevalent and preventable health crises in the county.

"We are lacking information and resource and we don't always have access to the computer." "People don't have the ability to navigate the internet and the tech to get the information they need." Resident

Another common theme was the need for public health to **make information and communication easier to understand and absorb**. Respondents suggested that future public health messaging employ infographics and other user-friendly formats. They also suggested that dissemination in multiple formats and media.

Most people consulted suggested a need for a **more centralized system to develop messaging** on health and then disseminate information through trusted local organizations. Interviewees described the current state of health messaging as "siloed" and "fragmented" as well as "conflicting" and "lacking in timeliness." In sum, the consensus was that the county needs clearer messaging and a centralized source of timely data-driven and culturally competent public health information. In this way, respondents anticipated that public health could **better engage communities, build trust, and articulate a clear role for public health** to advance community health and wellness.

"It goes back to having one voice and making sure we are all spreading the same information." Service Provider

Mobilize Communities and Partnerships

Which partnerships offer the best opportunities for encouraging community health and wellness?

A key theme of focus groups and interviews was the need for public health **to prioritize partnerships with organizations already working with underserved populations**. Respondents envision public health leading a coalition of agencies and organizations with a proven record of community engagement and support. In this respect, participants urged public health to leverage existing partnerships and support established collaborative structures.

At the same time, respondents want to **expand and strengthen additional partnerships** in Berks County. Chiefly, we heard a common call for **more coordination and partnership with schools**. Education was seen as a key lever for improving health; collaborating with schools to address the health of children and youth will enable public health to reach parents and families. In addition, many respondents noted opportunities to deepen existing partnerships that seek to **integrate physical and behavioral health** to address the needs of the whole person.

"I think each one of us understands where the disparities are, but the organizations are all working separately and not getting where we need to go." Service Provider

"An umbrella that can support every organization that is here today—" Service Provider

Respondents suggested identification of **a backbone organization, or the development of an independent** public health **entity,** charged with coordination across organizations involved in reducing the healthcare disparities evident in county-level data. They indicated that this body should function as a neutral party

that consistently **convenes and coordinates CBOs, hospitals, county agencies, etc., to address the interrelated factors affecting public health and coordinate countywide efforts**.

Nearly all participants stressed the importance of inclusive representation (e.g., City, County, CBOs, healthcare, etc.) in any new public health entity. They also agreed on the need for this body to support partnerships capable of working collaboratively to disseminate timely, quality data and public health information.

"If you had one single point of contact who was the authority and coordinator for health issues, health forums, health education. That is a role and would be a great service that would be afforded to Berks County." Service Provider

Assess and Monitor Population Health

What kinds of Public Health data and information need to be available and shared widely?

The central theme and desire of focus group and interview respondents was the need for public health to **better use existing data to highlight health equity gaps** and the role of SDOH in shaping health outcomes. They would like a greater focus on data-based treatment for chronic conditions (e.g., obesity and diet-related illness, asthma, hypertension), as well as data on SDOH that serve as barriers to access (e.g., access to healthy food, transportation, technology, etc.).

Another finding focused on the need for improving data accessibility. Respondents would like **more transparency and access to county-level data that can be analyzed** by zip code, race/ethnicity, primary language, etc. Armed with such data, they said that public health would be better positioned to transform health data into actionable priorities focused on reducing key health disparities.

Some respondents also noted that public health could play a beneficial role in building on and organizing conversations linked to existing data (e.g., CHNAs) to **promote greater public understanding of the context in which healthcare providers make their decisions**. In addition, nearly all participants agreed that a new public health entity would be better able to ensure data integrity and efficiency by functioning as a single point of contact and communication.

"In order to understand public health, we need data that feeds a big picture. We don't have this in this county. It's very fragmented…we need data that is consistent and consolidated on our entire population." Service Provider

Champion and Implement Policies and Laws

What can County organizations do to encourage health and wellness?

Focus group respondents and interviewees advanced multiple suggestions for how Public Health might play a greater role in either championing or implementing laws and policies that improve community health and wellness.

Many individuals with whom we consulted wanted public health to break down the silos and unhealthy competition within the existing system of health and human services in Berks County. They saw a role for public health in **leveraging relevant pilot projects and innovations** toward systems changes, such as:

- Investing in outreach and health literacy, especially community health workers and *promotoras*
- Improving access to county-level health data via State lobbying and influence
- Brokering payer-provider partnerships to address cost of healthcare
- Promoting the enforcement of existing laws relevant to public health (e.g., providing incentives to landlords who accept housing vouchers, bringing buildings up to habitable status, etc.)

In addition, multiple respondents envisioned a role for public health **in increasing access to mental health services**. They felt public health could further the integration of primary care and mental/behavioral health and lobby for commercial insurers to cover mental health services. Participants also called for increasing access to school-based mental health services, even though Student Assistance Programs (SAPs) that identify students with BH needs are available in every Berks County middle and high school. In short, respondent input reflects the need to increase awareness of what services already exist and target additional areas for expansion or scaling.

Lastly, participants expressed an overarching desire for public health to **advocate for funding that would augment staffing and resources** to better meet the needs of Berks County residents. For example, respondents identified increased funding for primary healthcare clinics, including school-based clinics, to extend hours of availability and provide greater access to community-based primary and preventive care.

F. We Examined How Other Counties in Pennsylvania Ensure the Health of the Public

Within Pennsylvania there are a variety of options available for addressing public health needs at the local level. Counties can, of course, rely upon the State for these services. They can develop their own county or municipal health departments to lead public health locally. Lastly, they can establish collaborative structures that pool efforts and resources to address some public health functions. All these models exist within the state.

Seven counties and four municipalities representing more than 45 percent of the state population have their own health departments.[16] The counties with health departments are Allegheny, Bucks, Chester, Delaware, Erie, Montgomery, and Philadelphia. In addition, Allentown, Bethlehem, Wilkes-Barre, and York, have municipal health departments.

In the absence of a public health department, several counties in Central Pennsylvania have adopted alternative models to promote public health through partnerships involving key health and social services providers, funders, academic institutions, and local officials. These models focus on improving access to healthcare, effectively sharing health information and resources, and maximizing resources and fiscal investments.

Below are some examples of public health collaboratives in place in York, Lebanon, and Adams counties. Though each model varies in structure and vision, these groups tend to work together to assess and prioritize the needs of county residents through shared data and assessments, identify public health priorities, partner to address priorities and maximize resources, implement mutually agreed upon strategies, increase visibility of issues, and foster communication among key stakeholders.

Table 6: Public Health Collaboratives

Healthy York County Coalition: Founded in 1994	
Membership: Approximately 45 organizations have representation on the Leadership Council.	
Steering Committee • Family First Health • York Traditions Bank • Two Retired Physicians • York County Human Services Department • York City Health Bureau (official public health entity under the Pennsylvania Department of Health) • York County Community Foundation • WellSpan Health Management Associates UPMC Pinnacle • Central PA Transportation Authority • United Way of York County	**Task Forces & Committees** • **Access & Empowerment:** Identifies needs, conducts research, and seeks solutions to address issues related to healthcare access, health insurance, and related challenges. • **Advocacy & Public Policy:** Identifies community health opportunities; educates lawmakers, community leaders, and others; and engages stakeholders to take action and advocate for progress. • **Alliance for Low Income Personal Care Home (ALPHA):** A major initiative of the coalition ALPHA is

[16] US Census Data, QuickFacts Table PA, 2022, https://www.census.gov/quickfacts/fact/table/PA/PST045222

<table>
<tr><td>Funders
York County Community Foundation
United Way of York County
WellSpan Health
AARP
City of York – Bureau of Health (official public health entity under the PA DOH)
Glatfelter Insurance Group
Hospice and Community Care
OSS Health
UPMC Pinnacle
Vising Nurse Association- Hanover & Spring Grove
York Area Housing Group
York County Economic Alliance
York County Literacy Council</td><td>a public-private partnership with a cross-section of housing, health and human services stakeholders created to identify and implement sustainable solutions for the ALPHA homes.
Community Engagement: Assists with communications, event planning, and strategic relationship building.
Prevention & Wellness: Oversees the York County Walks initiative, which is working to promote walking and improve walkability of communities.
Your Life: Conducts educational sessions to help residents understand advanced care options, encourage family conversations, and the sharing of advance directives. Coalition volunteers are available to assist residents with advance directive documents.
Website
http://www.healthyyork.org</td></tr>
<tr><td colspan="2">Community Health Council of Lebanon County: Founded in 1994</td></tr>
<tr><td colspan="2">Membership: The Council is a not-for-profit organization and consists of more than 25 committees, task forces, and events involving more than 400 community volunteers.</td></tr>
<tr><td>Current Committees and Taskforces
Age Wave
Communities That Care
Healthy Lifestyles
Lebanon County Coalition to End Homelessness
Mentor a Mother
Teen Pregnancy Prevention & Support Network
Tobacco Prevention and Cessation
Suicide Prevention Task Force</td><td>Partners
Lebanon County Council of Human Services Agencies
REACH Project
Stronger Together Heroin Task Force
Website
http://communityhealthcouncil.com/about-us/</td></tr>
<tr><td colspan="2">Board of Directors – Representatives from:
Penn State College of Medicine
Area Agency on Aging
Lebanon Family Health Services (Board President)
UPMC (1st VP)
Lebanon County Drug and Alcohol
Lancaster General/Penn Medicine
Family First Health
WellSpan Philhaven
Youth Advocate Program (2nd VP)
Chamber of Commerce
WellSpan Health
Child & Adolescent Service System Prog. (Secretary)
Lebanon County Children and Youth
VA Medical Center
Union Community Care
Domestic Violence Intervention
Health system physician
Lebanon Family Health Services (Treasurer)
Luthercare for Kids
YMCA
Better Together Lebanon (ex-officio)
Lebanon County Commissioner (ex-officio)</td></tr>
</table>

<table>
<tr><td>

- Lebanon County MH/ID/EI

</td><td>

- Lebanon County District Attorney's Office (ex-officio)
- Superintendent of Record (ex-officio)
- Community Volunteer

</td></tr>
<tr><td colspan="2">Healthy Adams County: Founded in 1996</td></tr>
<tr><td colspan="2">Membership: Approximately 300 members serve on a variety of committees and taskforces.</td></tr>
<tr><td colspan="2">Sponsors

- Wellspan Health. Houses the Executive Director and Administrative Assistant
- Franklin & Marshall's College, Center for Opinion Research. Complete health assessments.

</td></tr>
<tr><td>

Leadership

- Adams County Office for Aging, Inc.
- Community Representative
- Gettysburg Area Recreation Authority
- United Way of Adams County
- YWCA Gettysburg & Adams County
- Adams County Housing Authority
- PA Interfaith Community Programs
- Adams Economic Alliance
- Communications Specialist
- WellSpan System Communications
- SCCAP, Inc. (Community Action Agency)
- Gettysburg College Center for Public Service
- TrueNorth Wellness Services

Visit: https://www.healthyadamscounty.org/

</td><td>

Task Forces & Initiatives

These committees address the priority health and human service needs, and many were formed as a direct result of needs identified through CHNAs:

- Adams County Women's Cancer Coalition
- Adams County Food Policy Council
- Behavioral Health Task Force & Suicide Prevention Sub-Committee
- Children's Health & Nutrition Task Force
- Domestic Violence Task Force
- End of Life Committee
- Health Literacy Task Force
- Latino Services Task Force
- Physical Fitness Task Force
- Community Wellness Connections (CWC)

</td></tr>
</table>

As the examples demonstrate, these county public health collaboratives share several key features:

- They are inclusive and typically involve multiple organizations and stakeholders in a broadly conceived conception of public health and wellness.
- They are anchored by a smaller set of key partner organizations that take a leadership role, often through a steering committee.
- They use smaller issue-oriented committees and taskforces to organize their initiatives and provide opportunities for members to get involved in different public health issues. These committees and taskforces include key issue areas, represent targeted populations, and often focus on health equity and/or the SDOH.
- They use public and private sponsors and funders to support their efforts aimed at advancing community health and wellness.
- They have a public presence and website to communicate and inform residents and other constituents.

G. We Developed Guiding Principles and Goals for a Berks County Public Health Model

Berks County public health stakeholders recommended the following principles and goals in developing an approach to public health in Berks County. Future efforts should focus on:

- Coordinating public health services already being implemented in the county (CBOs, hospitals, County, and City agencies) and supporting collective action so that county resources are targeted at needs not addressed elsewhere so county funds can have the greatest impact.
- Providing one clear, trusted voice about public health threats, response, and concerns to guide county residents, businesses, schools, and private and public organizations in public health emergencies.
- Increasing access to public health data to the public and key public health partners.
- Identifying clear roles and responsibilities for each public and private partner and reducing duplication of county, city, and state efforts. For example, the County will not assume roles where the State has jurisdiction but will establish a mechanism to collaborate with the State to ensure that public health analytics, emergency response and communications roles meet the needs of county residents, and public and private sector organizations.
- Improving the health of county populations that exhibit the greatest disparities by supporting upstream factors that affect health, such as access to nutrition, housing, healthcare, and benefits, and ensuring that prevention and wellness information and resources are accessible both in English and in Spanish.

H. Recommendations

At the outset, the HMA team was neutral in terms of whether a health department would be the best approach for Berks County to meet public health needs, as seven other Pennsylvania counties have done, or whether another model would be most responsive. As described above, we solicited input from a range of public health stakeholders. Although we did not speak with everyone working to meet the health needs of Berks County residents, we heard from leaders, demographically diverse community members, service providers, businesses, and faith-based and cultural groups. We learned that those individuals and groups closest to healthcare delivery strongly favored establishing a health department. Others were concerned about the costs of adhering to outdated state requirements for public health departments, including the necessity to provide clinical services and conduct certain health and safety inspections not currently required in the county (See **Appendix G**).

Based on this feedback, we recommend four steps to improve coordination of existing services, analyze health at the census tract and/or zip code level, and communicate to partners and the public in one authoritative voice about public health threats, emergencies, and risks. These steps will prepare the county to have a strong response to any future public health threats and will benefit Berks County

communities in the short term and over time. They will also create a glide path for establishing a Berks County Health Department should that be desired in the future.

1. Create a Berks County Health Director position to lead public health collective action and coordination and serve as a trusted communicator about public health information. This position requires a visionary leader and excellent communicator with proven expertise in public health and healthcare. For two examples of public health director positions see **Appendix H**.
    - Option 1: This position will be an employee of the County of Berks and will be accountable to the County Commissioners.
    - Option 2: This position will be housed in a trusted non-governmental public health-focused organization, which will be accountable to the County Commissioners.
2. Create a Public Health Advisory Panel

    We recommend that the County commissioners create a Public Health Advisory Panel to advise the Health Director and guide public health assessment, policy, and assurance activities. Panel members should collectively bring strong expertise in medicine, public health, behavioral health, and the factors that shape health. Establishing a Public Health Advisory Panel now, will help prepare Berks County to meet State requirement of a Board of Health should the County decided to establish County Health Department in the future. (State requirements regarding the Board of Health make-up and obligations under an established County Health Department are detailed in **Appendix G**).
3. Support the establishment of a "Healthy Berks" Coalition[17] to serve as a coordinating body for public health efforts in the county. The Public Health Director will coordinate or cofacilitate the coalition's activities. This coalition also may include leadership from the following entities:
    - Federally qualified health center and community health centers
    - Tower-Reading and Penn State St. Joseph's hospitals
    - United Way and community-based organizations, including the Hispanic Center and Berks County Community Foundation
    - Faith-based groups that providing health and social services
    - Co-County Wellness Services and other County public health organizations
    - County mental health, disabilities, emergency response, data, and environmental health organizations
    - Public, parochial, and private school systems

[17] Other counties in Pennsylvania coordinate public health efforts through a coalition structure.

4. Create a Berks County health analyst position to improve Berks County-specific public health data completeness and accuracy, who will report to the Health Director. This position will provide critical support for the Public Health Director—identifying data gaps, providing census tract-level monitoring of the health of Berks County residents, and supporting a strong response to pandemics or other public health emergencies. This position could be a County employee or subcontractor.

Establishing public health leadership positions, a Public Health Advisory Panel, and a "Healthy Berks Coalition" will address needs identified in this assessment. Immediate benefits will include improved coordination of existing services, better understanding of public health needs and threats through improved hyper local analytics, and a mechanism to communicate with partners and the public in one authoritative voice about public health threats, emergencies, and risks. These steps also will create a glide path to establish a Berks County Health Department, which is an 18–24-month process. At this time, a County Health Department is subject to a number of Pennsylvania laws and regulations (clinical services, certain inspections) that were not identified as needs. This situation could change if Pennsylvania modernizes its regulations to conform with national Public Health 3.0[18] standards.

At present, Pennsylvania requires a Board of Health and Public Health Director to establish a Health Department. It also requires County matching funds to draw down state funds for the Health Department. County investments in these positions would be a significant step toward providing this funding match. Dedicated public health positions also will enable the County to engage the state in discussions about public health regulation modernization to focus less on requirements that were common decades ago and more on the nimble local public health leadership states and counties are evolving into today that focus on assessing the public's health, developing policies, partnerships, and communications that address health needs and responding to public health emergencies, such as COVID-19.

I. Summary

In summary, we recommend that Berks County:

1. Create a Berks County Health Director position to lead public health collective action and coordination and serve as a trusted communicator about public health information.
2. Establish a Public Health Advisory Panel and appoint members who can advise on public health assessment, assurance and policy activities.
3. Support the establishment of a "Healthy Berks" Coalition to serve as a coordinating body for public health efforts in the county.
4. Create a Berks County Health Data Analyst position to improve Berks County-specific public health data completeness and accuracy.

[18] Centers for Disease Control and Prevention, Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century, 2017, https://www.cdc.gov/pcd/issues/2017/17_0017.htm

These recommendations will permit the county to have a **broad range of options** in enhancing its ability to meet public health needs in the future. With a Public Health Director, Public Health Advisory Panel, Healthy Berks Coalition, and Health Data Analyst in place, the county will be able to improve coordination of existing services, analyze health at the census tract and/or zip code level, and communicate to partners and the public in one authoritative voice about public health threats, emergencies, and risks. Simultaneously, these steps will provide a glide path for the **option of establishing a public health department** should that be desired in the future.

APPENDICES

Appendix A: 2022 Tower Health Community Health Needs Assessment

Full CHNA on next page.

COMMUNITY HEALTH NEEDS

2022 ASSESSMENT

HEALTH IS WHERE WE LIVE, LEARN AND WORK

Reading Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

Reading.TowerHealth.org

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LETTER FROM THE CEO

OUR MESSAGE TO THE COMMUNITY

Charles Barbera,
MD, MBA, MPH, FACEP

President and Chief Executive Officer,
Reading Hospital

Reading Hospital is committed to meeting the changing health needs of our communities while working to develop programs and services that provide our region with high-quality care close to home.

To achieve this goal, we must first identify the community's evolving health needs. Reading Hospital - in collaboration with all Tower Health facilities and our community partners - completed the 2022 Community Health Needs Assessment (CHNA), which identifies our region's health priorities and determines our collective path forward.

Hospitals are required to conduct a CHNA every three years to retain their nonprofit status. The data for this CHNA was collected regionally and reported for our hospital service area. Working with our strategic and community partners, Reading Hospital will use the results of this assessment as a foundation to develop tactics to address each of the identified regional health priorities: Access to equitable care, behavioral health, health education and prevention, and health equity.

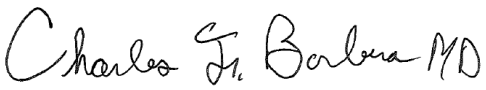
Reading Hospital is committed to advancing health and transforming lives throughout Berks County. As a leading health care provider, we strive to positively impact the health and well-being of our patients, as well as the broader communities we serve. Many of our programs and services have been developed to address specific regional health needs or overcome barriers to care. These efforts continue to make a difference in the lives of individuals and families. We are grateful for our community partners who worked to help make these programs possible.

The most important aspect of the CHNA process is community partnership and engagement. Resident feedback about the health status of the community is integral to planning and executing interventions, programs, and activities. Each of our community partners brings significant and unique expertise. We look forward to an ongoing partnership to ensure that vulnerable individuals receive the care and services they need. We are much stronger together than we would be individually, and the community benefits from our collaboration.

I would like to offer my sincere thanks to the citizens and stakeholder participants throughout all the Reading Hospital communities who generously volunteered their time and valuable insights during the comprehensive CHNA process.

I am beyond thankful for your ongoing support and continued involvement in the well-being of our communities. By working together, we can continue to change lives across our region.

Sincerely,



Charles Barbera,
MD, MBA, MPH, FACEP

President and Chief Executive Officer,
Reading Hospital

Questions or comments regarding the CHNA can be sent via email to communitywellness@towerhealth.org or by calling 1-833-34-TOWER

ABOUT
THIS REPORT

COMMUNITY HEALTH NEEDS ASSESSMENT INTRODUCTION

A Community Health Needs Assessment (CHNA) is an organized process involving the community to identify and analyze community health needs. The process provides a pathway for communities to identify and prioritize health and social needs and to plan and act upon unmet and prioritized community health needs. The CHNA process undertaken by Reading Hospital included input from those who represent the broad interests of the community. Representatives served by the hospital facilities, mainly those knowledgeable of public health issues, information related to the vulnerable, underserved, disenfranchised, hard-to-reach, and representatives of those populations served by each hospital. The CHNA documented what and where the need is, along with who is most affected.

In the fall of 2022, Reading Hospital will release our Implementation Strategy Plan (ISP), which includes goals and strategies to address how to solve key findings from the CHNA.

IRS MANDATE

The CHNA report is a complete review of primary and secondary data analyzing demographic, health, and socioeconomic data at the local, state, and national levels. This report fulfills the requirements of the Internal Revenue Code 501(r)(3), established within the Patient Protection and Affordable Care Act (PPACA), requiring that nonprofit hospitals conduct CHNAs every three years. Reading Hospital's CHNA report aligns with the parameters and guidelines established by the Affordable Care Act and complies with IRS requirements.

Reading Hospital is proud to present its 2022 CHNA report and its findings to the community.

CONSULTANT INFORMATION

Tower Health contracted with Tripp Umbach, a private health care consulting firm, to complete a CHNA. Tripp Umbach has conducted more than 400 CHNAs and has worked with more than 800 hospitals. Changes introduced by the PPACA have placed an increased level of importance on population health and well-being and on collaborative efforts among providers, public health agencies, and community organizations to improve the communities' overall health and ensure access to essential services.

CHNA PROCESS – COMMUNITY ENGAGEMENT

The CHNA process began in February 2021, and collection of quantitative and qualitative data concluded in September 2021. As part of this needs assessment, a vast number of residents, educators, government, health care professionals, and health and human services leaders in Reading Hospital's service area participated in the study. Information collected from leaders provided a deeper understanding of community matters, health equity factors, and community needs. See Figure 1. Reading Hospital collected community and key informant surveys, community stakeholder interviews, and focus group data to engage and capture the community's perspective.

Various types of data, such as county demographics and chronic disease prevalence, were gathered from local, state, and federal databases to compile secondary data. Community surveys, key informant surveys, and community stakeholder interviews were dispersed community-wide to garner participation from all members residing or working in the primary service area. The data collected identified the needs, high-risk behaviors, barriers, societal issues, and concerns of the underserved and vulnerable populations. Information from focus groups with hospital leadership and community partners who provide services and care to the region was also included in the collection phase.

While multiple steps made up the overall CHNA process, Tripp Umbach worked closely with members of the working group[1] to collect, analyze, and identify the results to complete the hospital's assessment.

Figure 1: Community Engagement

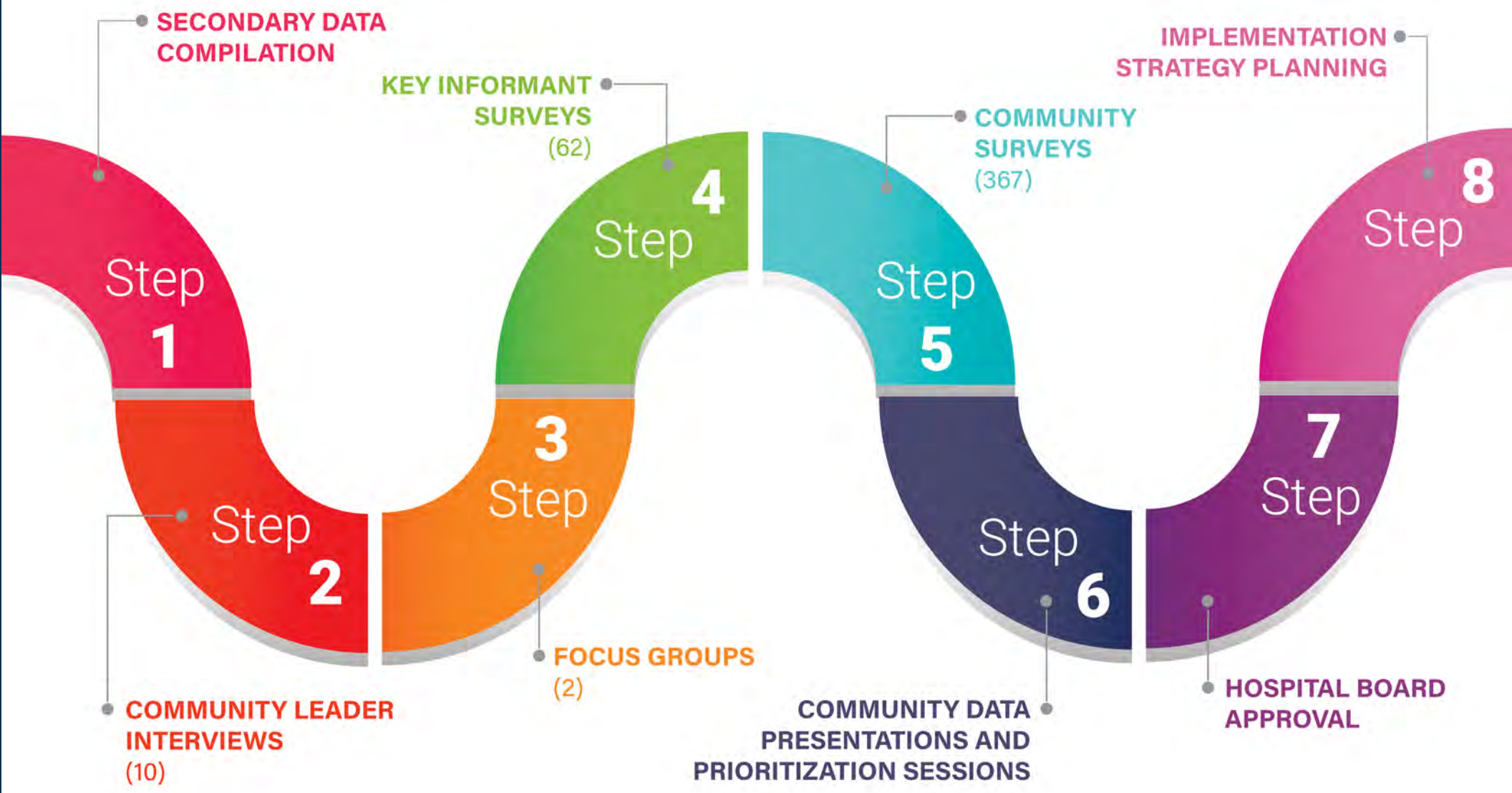
[1] Members of the working group consisted of Desha Dickson, Associate Vice President Community Wellness, Reading Hospital; Tanieka Mason, Senior Manager SDOH & Analytics, Reading Hospital; Courtney Powers, Program Manager, Community Wellness, Reading Hospital; Ha T. Pham, Senior Principal, Tripp Umbach; Barbara Terry, Senior Advisor, Tripp Umbach; and Julia Muchow, Project Assistant, Tripp Umbach.

2021-2023 COMMUNITY HEALTH REGIONAL PRIORITIES

The CHNA roadmap was designed to engage all aspects of the community, from community residents to community-based organizations, health and business leaders, educators, policymakers, and health care payers, to identify health care needs and recommend possible solutions to address health issues identified.

Numerous secondary and quantitative data sources were gathered from noted public health sources to establish current health status of the population. Primary data was collected specifically from community stakeholder interviews, key informant surveys, focus groups with health care leaders and community leaders, and a broad-based community survey in English and in Spanish. The primary and secondary data created a framework of current health status as outlined in the CHNA roadmap in Figure 2.

Figure 2: Roadmap for Community Health Needs Assessment at Reading Hospital[2]



[2] It is important to note that data collected for the 2022 CHNA has limitations in information. Secondary data utilized for the report is not specific to the hospital's primary service area but rather provides a scope or picture to a larger geographic region. Data was also limited to the most recent publicly available data years. Primary data obtained through interviews and surveys is also limited in representation of the hospital's service area as information was collected through convenience sampling

READING HOSPITAL

WHO ARE WE?

Reading Hospital is a nationally recognized institution that has served the local community since 1867, and in its current location since 1926. With a tradition of clinical excellence and a commitment to low patient costs, we perform nearly 19,000 surgical procedures a year. Reading Hospital is home to many of our top-tier specialty care centers, including:

- McGlinn Cancer Institute
- Miller Regional Heart Center
- Reading HealthPlex for Advanced Surgical & Patient Care
- Emergency Services
- Level I Trauma Center
- Beginnings Maternity Center, housing the region's only Level III Neonatal Intensive Care Unit (NICU)

At Reading Hospital, advancing your health and wellness is our mission. When you enter our facilities, you can expect the highest quality health care in the region, as well as access to cutting-edge technology and experienced, caring medical professionals. More than 1,000 physicians and providers across 46 locations offer comprehensive care ranging from prevention, screenings, and education to the latest clinical services and treatments. Our community health programs provide essential resources to residents of Berks County and surrounding areas. Whatever your health care needs, we are committed to meeting them.

MISSION

The mission of Reading Hospital is to provide compassionate, accessible, high-quality, cost-effective health care to the community; to promote health; to educate health care professionals; and to participate in appropriate clinical research.

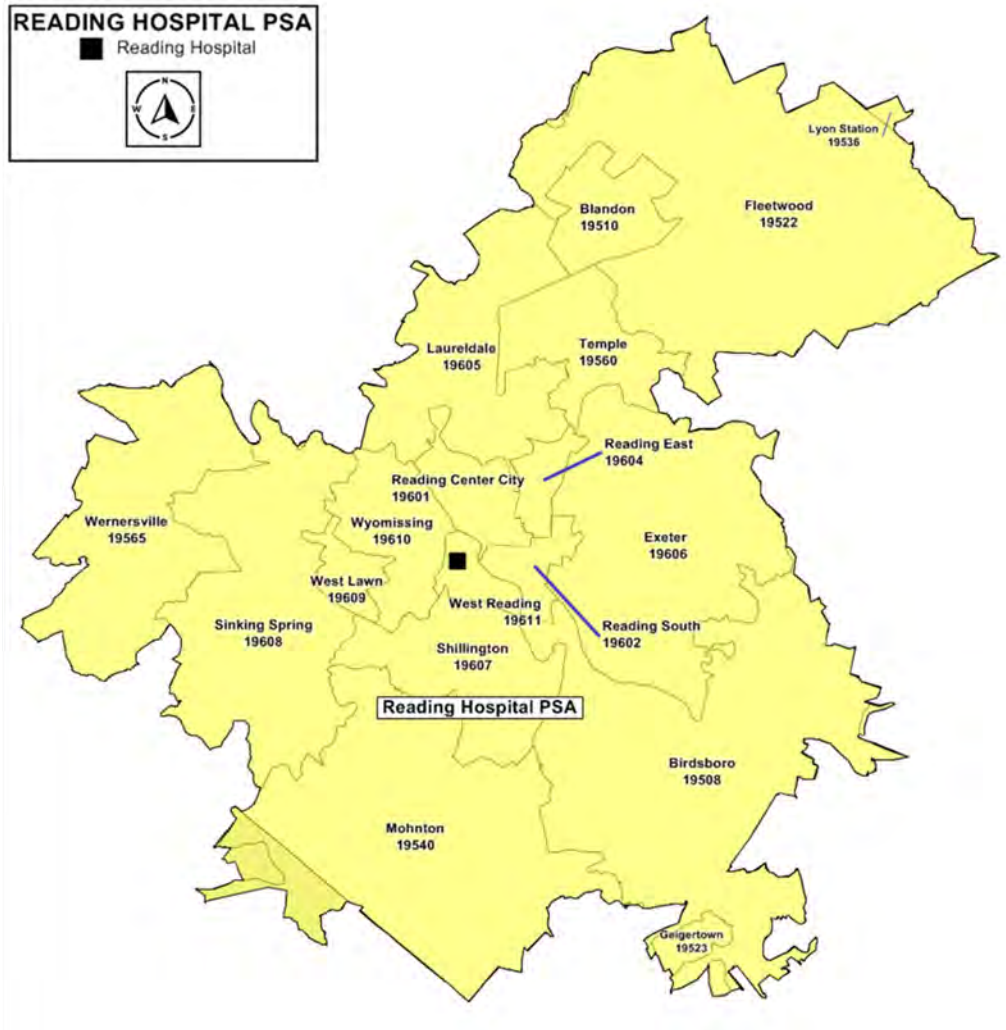
VISION

Reading Hospital will be an innovative, leading regional health system dedicated to advancing the health and transforming the lives of the people we serve through excellent clinical quality, accessible, patient-centered, caring service and unmatched physician and employee commitment.

REPORT SERVICE AREA

A community is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. While the CHNA considers other types of health care providers, the hospital is the single largest provider of acute care services. For this reason, the utilization of hospital services provides the clearest definition of the community. Reading Hospital's primary service area (PSA) includes 21 ZIP codes within Berks County.[3]

Reading Hospital PSA	
ZIP Codes	**Town/Neighborhood**
19508	Birdsboro
19510	Blandon
19522	Fleetwood
19523	Geigertown
19536	Lyon Station
19540	Mohnton
19560	Temple
19565	Wernersville
19601	Reading Center City
19602	Reading South
19603	Reading (NS)
19604	Reading East
19605	Laureldale
19606	Exeter
19607	Shillington
19608	Sinking Spring
19609	West Lawn
19610	Wyomissing
19611	West Reading
19612	Reading (NS)
19542	Monocacy Station (NS)



[3] Note: NS ZIP codes are non-spatial ZIP codes with no population. They are often P.O. boxes.

EVALUATION OF
2019 CHNA IMPLEMENTATION STRATEGY

Reading Hospital has worked over the last three years to develop and implement strategies to address the health needs in the study area and evaluate the effectiveness of the strategy created in terms of meeting goals and combatting health problems in the community.

The evaluation process is to determine the effectiveness of the previous plan. The working group tackled the problem statements for each past priority and strategy and developed ways to address its effectiveness. The self-assessments on each of the strategies are internal markers to denote how to improve and track each of the goals and strategies within the next three years. The following tables reflect highlights and accomplishments from Reading Hospital. Specific metric information/measurable indicators can be obtained from the hospital's administrative department.

1 HEALTH PRIORITY: ACCESS TO HEALTH CARE

Goal: Increase access to healthcare services by community members, particularly those considered vulnerable and/or living in underserved areas.

STRATEGIES	ACTION STEPS
Increased cultural awareness	Conducted diversity and inclusion and cultural competency trainings
	Created a Diversity and Inclusion Council
Expanded/Promoted programs that educate students about careers in health care	Implemented and/or expanded career exploration programs, such as, medical explorers, shadowing and college and high school internships.
Streamlined access to care facilities	Opened an advanced access center across ambulatory and specialty care service lines.
Supported programs that provide care to vulnerable populations	Street Medicine program opened a telemedicine kiosk.
Enhanced the use of remote patient monitoring	Increased remote monitoring of patients.

2 HEALTH PRIORITY: SOCIAL DETERMINANTS OF HEALTH (SDOH)

Goal: Identify and address Social Determinants of Health (SDOH)

STRATEGIES	ACTION STEPS
Identified and addressed SDOH in the clinical environment	Completed 137,949 (December 15, 2021) SDOH screenings
Medical-Legal Partnership Program	Identified and resolved legal issues that had the potential of negatively impacting health.
Identified and removed transportation barriers	Implemented Ride Health. A complimentary transportation program to assist patients get to and from medical appointments.
Implemented community-based intervention initiatives	Implemented a Community Health Worker Program to work with vulnerable patients and close care gaps.

3 HEALTH PRIORITY: DISEASE PREVENTION AND MANAGEMENT

Goal: Implement chronic disease prevention and management programs in the primary service area, specifically targeting vulnerable populations.

STRATEGIES	ACTION STEPS
Encouraged community members to engage in physical activity	Promoted Bike Share Program to encourage bike riding as a form of exercise.
	Promoted Berks Trail Challenge to encourage community members to walk as a form of exercise.
Educated community on the importance of early disease detection	Provided free cancer screenings

4 HEALTH PRIORITY: ACCESS TO BEHAVIORAL HEALTH SERVICES

Goal: Improve access to screening, assessment, treatment, and support for behavioral health and reduce stigma related to treatment.

STRATEGIES	ACTION STEPS
Center of Excellence	Screened patients for opioid use disorder (OUD) and provide care coordination to remove barriers for patients seeking treatment.
Increased access to behavioral health	Construction on Tower Behavioral Health completed.
	Integrated therapists into primary care practices to screen for depression.
Promoted mental health screenings and training	Promoted Mindkare Kiosk and online mental health screenings.
	Provided Mental Health First Aid training.

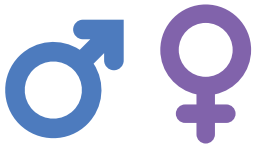
COMMUNITY AT A GLANCE

THE COMMUNITY WE SERVE

POPULATION

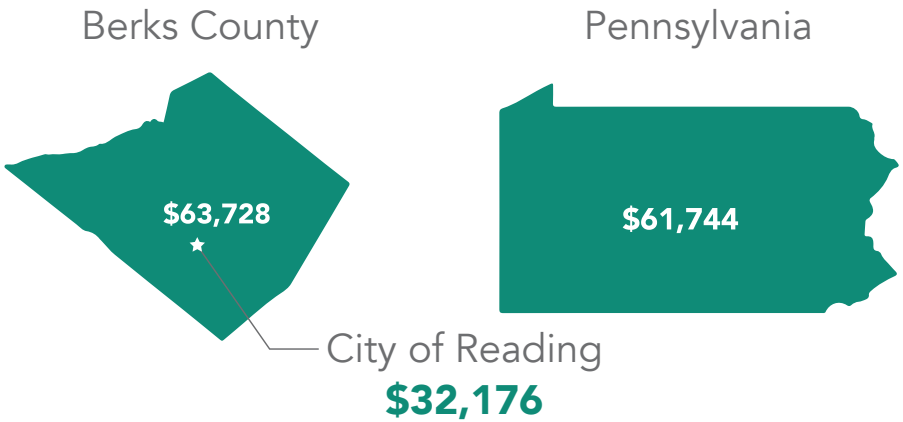
Source: U.S. Census Bureau 2020

GENDER



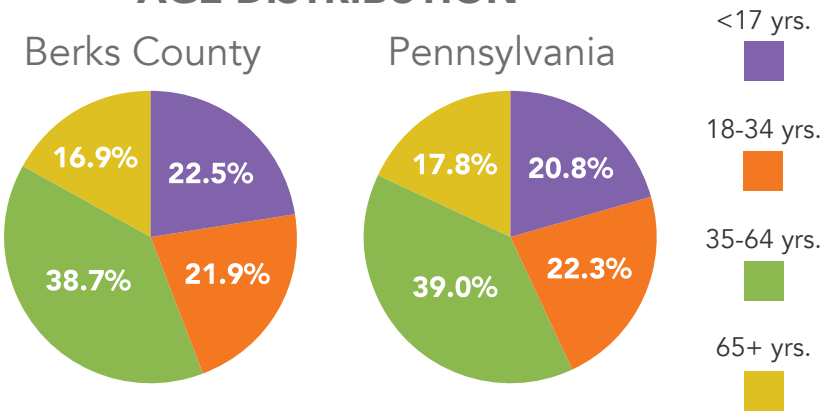
Source: U.S. Census Bureau 2019

MEDIAN HOUSEHOLD INCOME



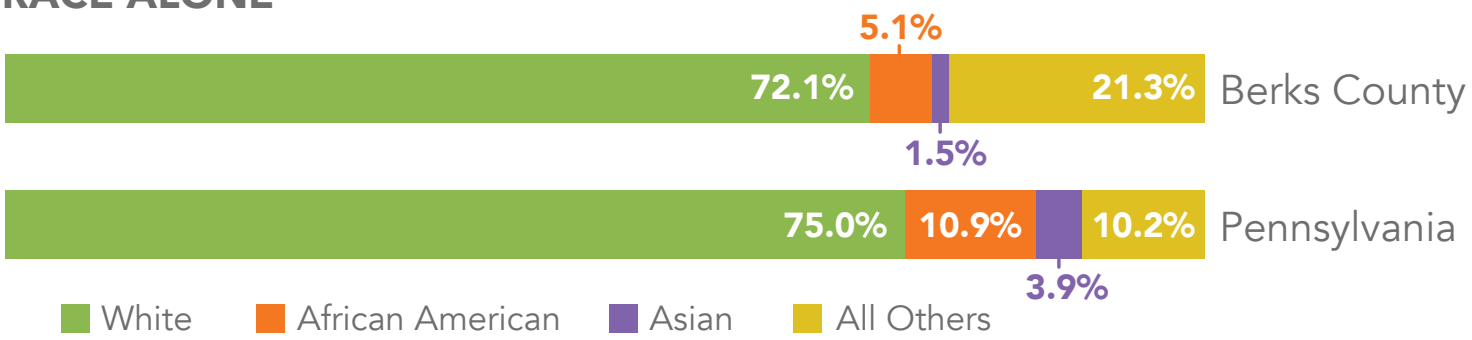
Source: U.S. Census Bureau 2019

AGE DISTRIBUTION



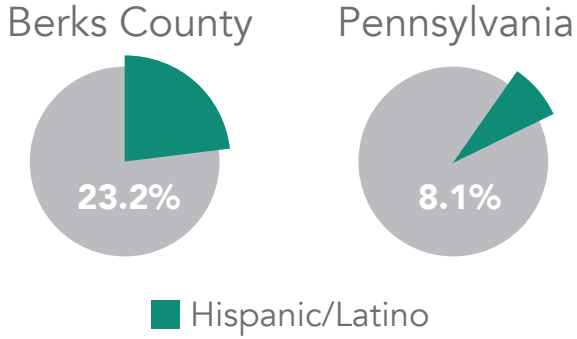
Source: U.S. Census Bureau 2019

RACE ALONE



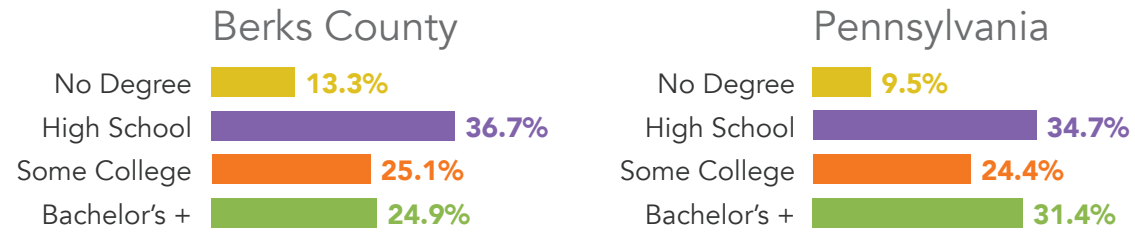
Source: U.S. Census Bureau 2020

ETHNICITY



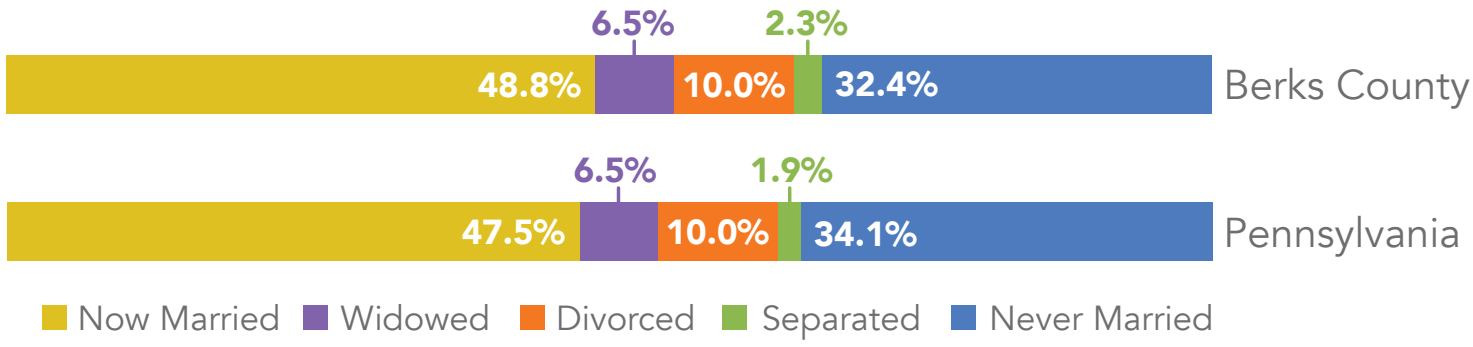
Source: U.S. Census Bureau 2020

EDUCATION



Source: U.S. Census Bureau. American Community Survey 2015-2019

MARITAL STATUS



Source: American Community Survey 2019

OUR ENVIRONMENT

VIOLENT CRIME

(per 100,000 population)

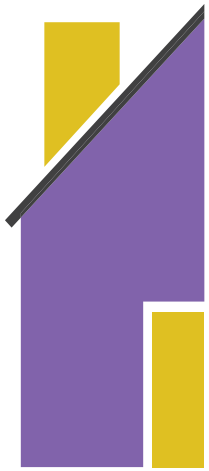
Berks County

299.9

Pennsylvania

315.6

Source: FBI Uniform Crime Reports 2020



HOUSING COST BURDEN

(Households where housing costs are 30% or more of total household income)

Berks County

29.5%

Pennsylvania

28.1%

SUBSTANDARD HOUSING

(Units having 1. lack complete plumbing, 2. lack complete kitchen, 3. 1+ occupants per room, 4. percentage of household income greater than 30%, and 5. gross rent of household income greater than 30%.)

Berks County

29.4%

Pennsylvania

28.1%

Source: U.S. Census Bureau 2019

HOUSING OCCUPANCY BY RACE

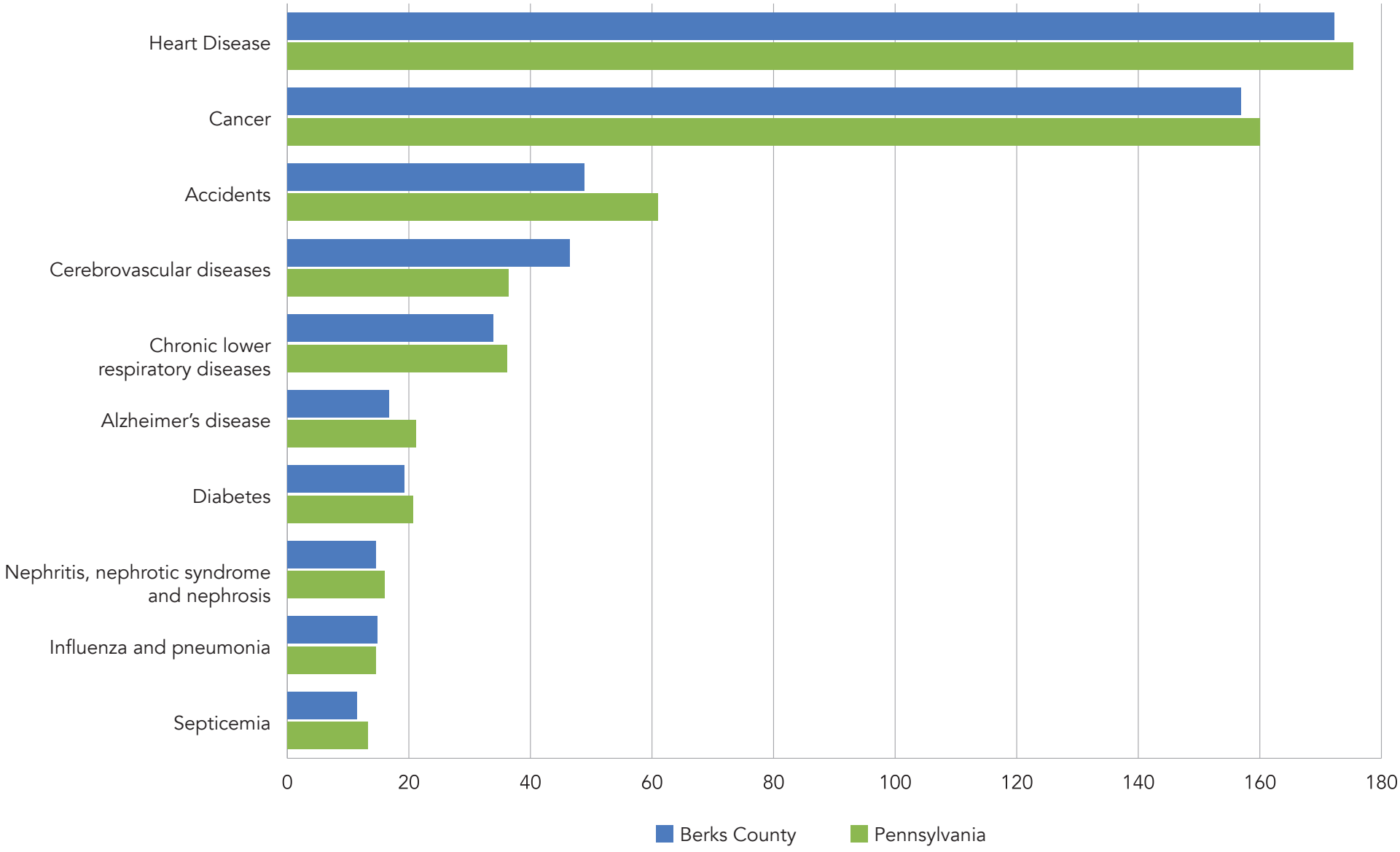
	Owner-Occupied Housing			Renter-Occupied Housing		
	Berks County	**Pennsylvania**	**U.S.**	**Berks County**	**Pennsylvania**	**U.S.**
White	75.6	73.3	69.5	24.4	26.7	30.5
Black	41.7	43.2	41.8	58.3	56.8	58.2
Asian	71.3	58.4	59.6	28.7	41.6	40.4
Native American or Alaska Native	40.1	52.3	54.3	59.9	47.7	45.7
Some other race	43.2	39.4	39.9	56.9	60.6	60.1
Multiple race	40.8	45.0	49.0	59.2	55.0	51.0

Source: U.S. Census Bureau 2019

KEY HEALTH FINDINGS

TOP CAUSES OF DEATH

(per 100,000 population)



Source: Pennsylvania Department of Health 2014-2019

OVERALL DISEASE DEATHS BY RACE/ETHNICITY IN BERKS COUNTY

(ages 35 years+ per 100,000 population)

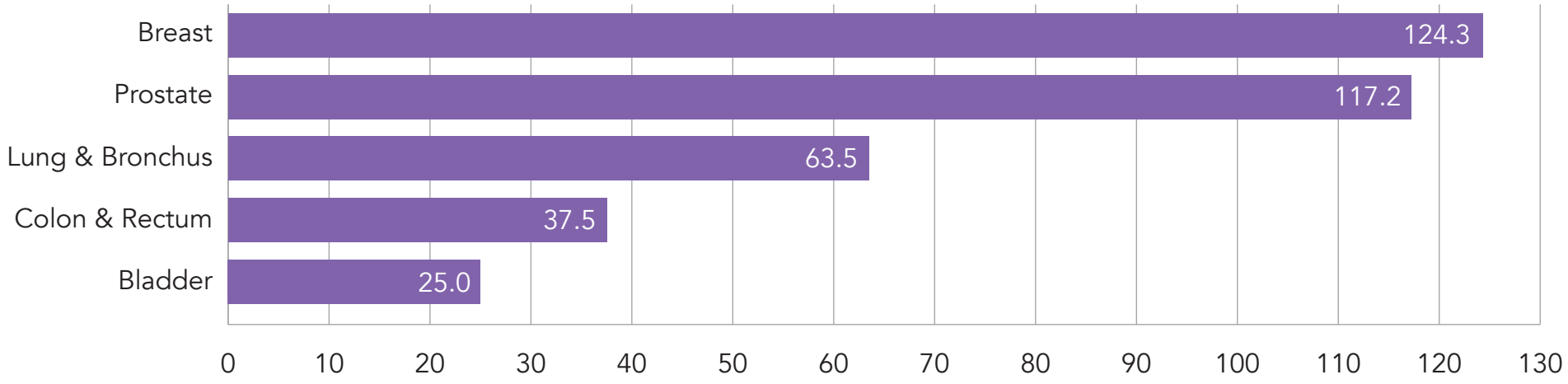
	Heart Disease	Stroke
White	336.0	105.0
Black	445.0	80.0
Asian/Pacific Islander	121.0	67.0
Hispanic	226.0	77.0

Source: Pennsylvania Department of Health 2019

OVERALL COMMON CANCERS IN BERKS COUNTY

MOST COMMONS CANCERS IN BERKS COUNTY

(per 100,000 population)

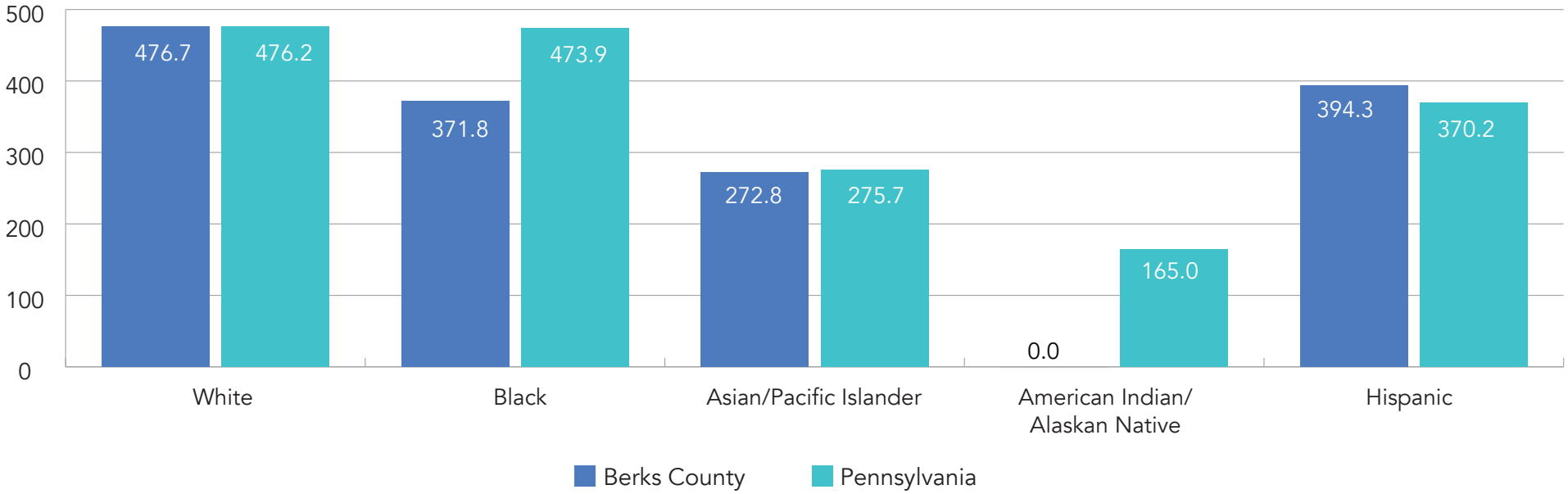


Source: Pennsylvania State Cancer Profiles 2014-2018

OVERALL CANCER INCIDENCE

CANCER INCIDENCE RATES BY RACE

(per 100,000 population)



CANCER INCIDENCE RATES IN BERKS COUNTY BY RACE

(per 100,000 population)

	Lung & Bronchus	Colon & Rectum Cancer	Breast Cancer (Females only)	Prostate Cancer (Men only)	Bladder
White	64.4	36.7	125.5	110.1	25.5
Black	46.3	30.3	82.6	172.3	-
Asian/Pacific Islander	-	-	88.3	-	-

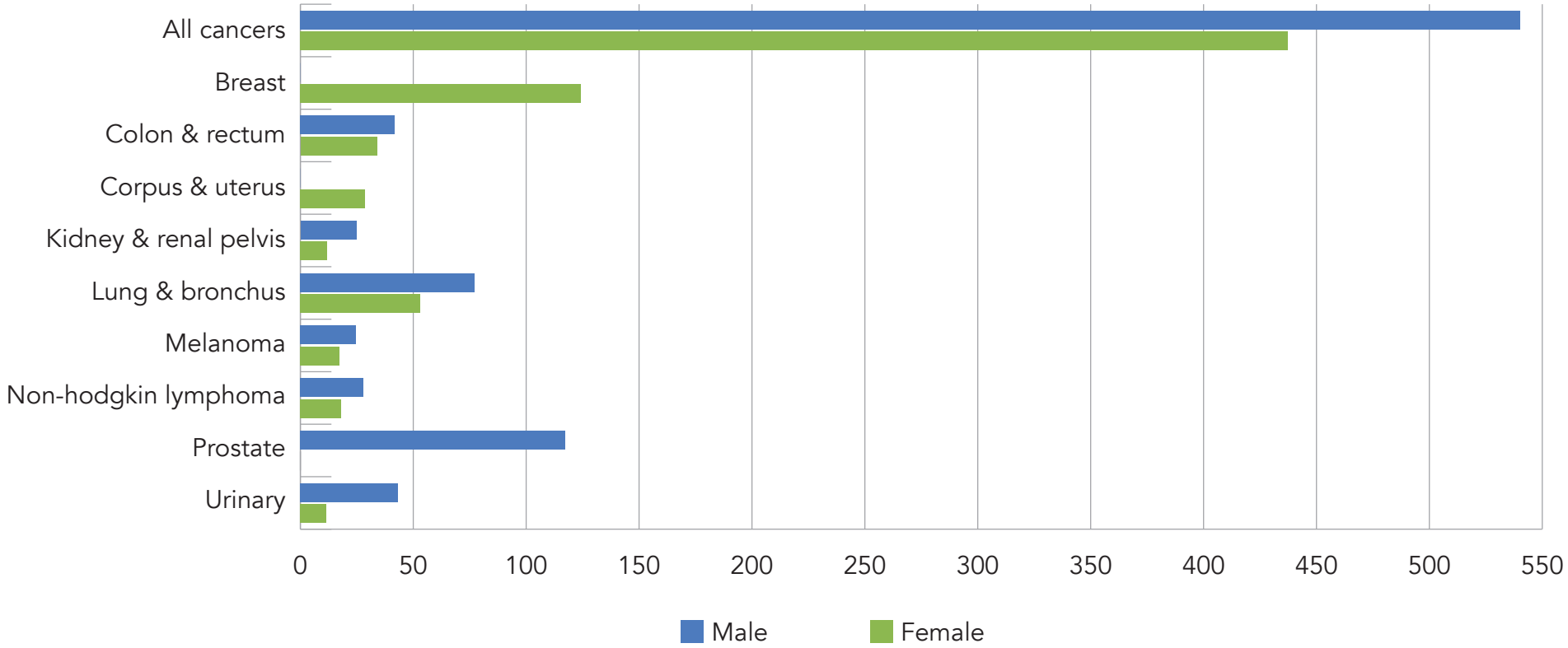
Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.

Source: Pennsylvania State Cancer Profiles 2014-2018

CANCER BY GENDER

CANCERS BY GENDER IN BERKS COUNTY

(per 100,000 population)



Source: Pennsylvania State Cancer Profiles 2014-2018

CANCER INCIDENCE RATES AND DEATH BY RACE AND ETHNICITY

(per 100,000 population)

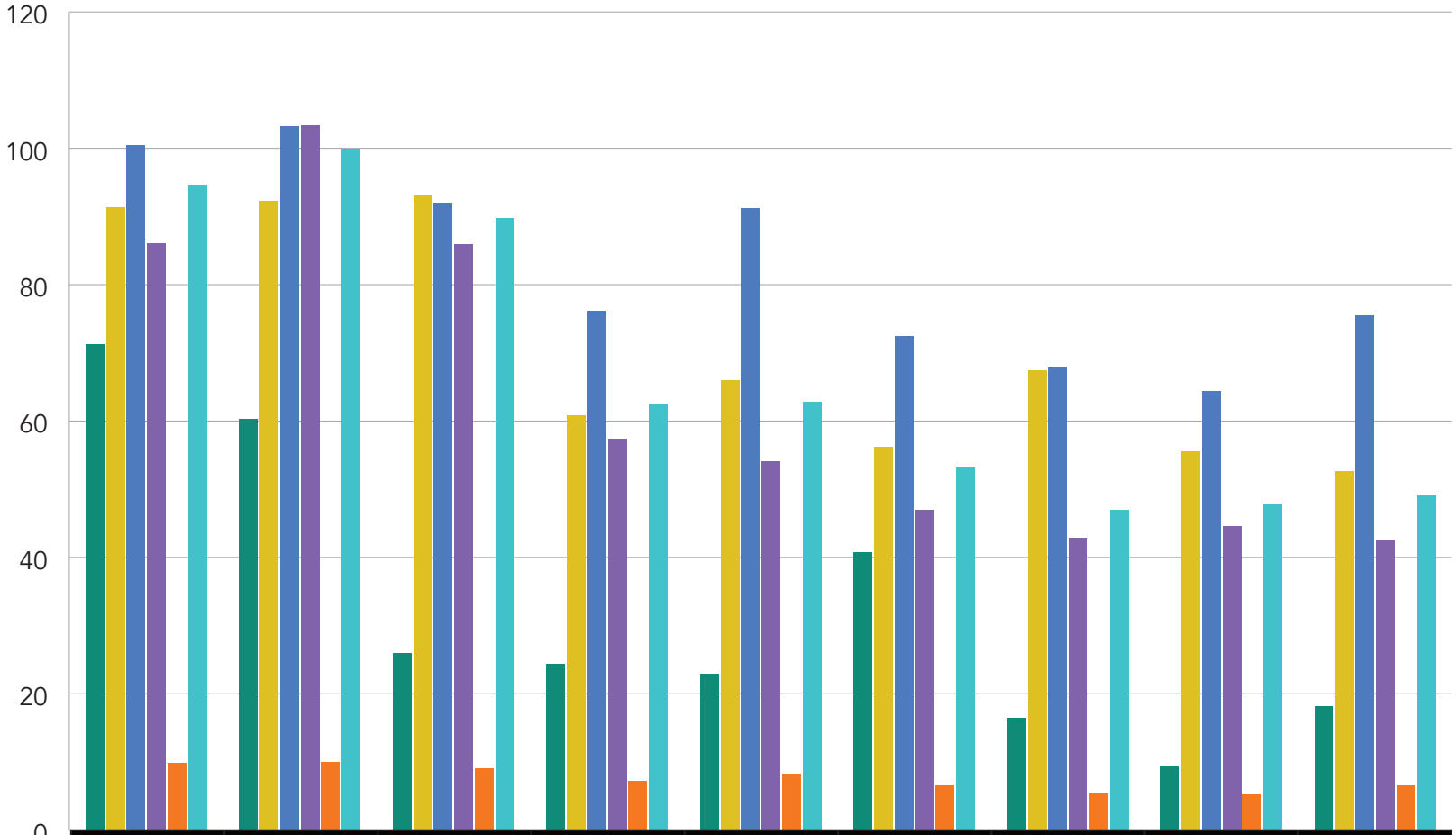
All Cancer Incidence by Race/Ethnicity			
	Berks County	Pennsylvania	U.S.
White	476.7	476.2	451.0
Black	371.8	473.9	444.9
Asian/Pacific Islander	272.8	275.7	291.7
American Indian/Alaskan Native	-	165.0	285.8
Hispanic	394.3	370.2	345.0

All Cancer Deaths by Race/Ethnicity			
	Berks County	Pennsylvania	U.S.
White	158.0	159.3	153.4
Black	173.0	190.5	173.6
Asian/Pacific Islander	82.5	90.2	95.6
American Indian/Alaskan Native	-	44.9	101.2
Hispanic	123.8	107.2	109.7

Note: Dash in the cell indicates that there is no data. Race categories include Hispanic. For example, white rate figures include Hispanic data.

Source: Pennsylvania State Cancer Profiles. Death data 2015-2019; incidence data 2014-2018.

ADULT EMERGENCY ROOM VISITS PER 1,000/MONTHS ZIP CODE SUMMARY



	19601	19602	19604	19605	19606	19607	19608	19609	19610
Asian	71.3	60.3	25.9	24.4	22.9	40.7	16.4	9.5	18.2
Black	91.3	92.3	**93.1**	60.8	**66.0**	**56.2**	**67.4**	**55.6**	**52.6**
Hispanic	**100.5**	**103.2**	**92.0**	**76.1**	**91.2**	**72.5**	**67.9**	**64.4**	**75.5**
White	86.1	**103.3**	85.9	57.4	54.1	46.9	42.8	44.6	42.5
Other Race	9.9	10.0	9.1	7.2	8.2	6.7	5.5	5.4	6.6
All Adults	**94.7**	**99.9**	**89.7**	**62.6**	**62.8**	**53.2**	**47.0**	**47.9**	**49.1**

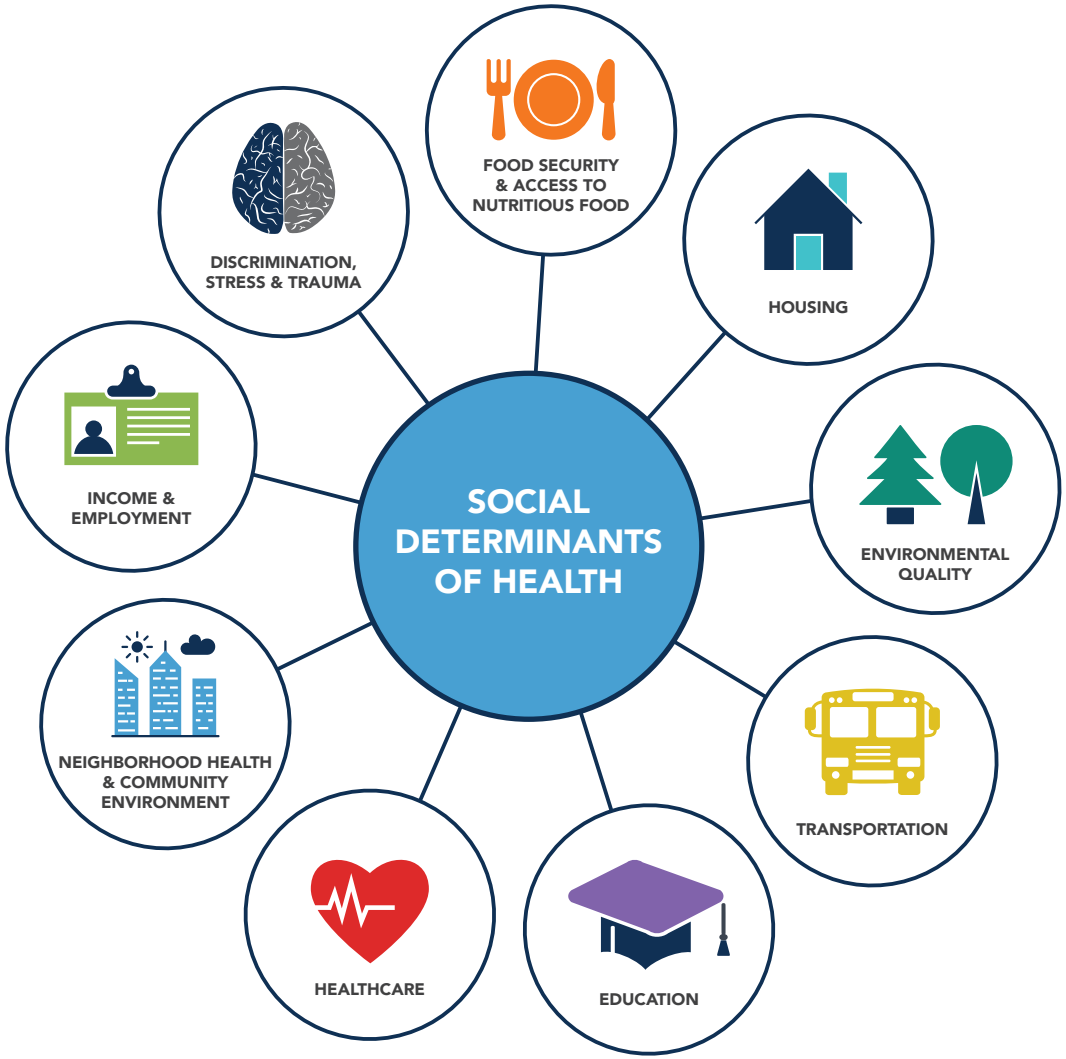
Note: The figures in red indicate high emergency room visits when compared to the benchmarked data of all adults within the specific ZIP code.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services


EMERGENCY

WHERE WE LIVE, LEARN, WORK, AND PLAY
AND HOW IT AFFECTS OUR LIVES

Figure 3: Influential Factors



The World Health Organization (WHO) defines social determinants of health (SDOH) as the economic and social conditions that influence individual and group differences in health status. Where we live, learn, work, and play are important factors that shape one's overall health standing. Communities with access to healthy foods, livable-affordable homes, quality education, and a safe/clean environment are healthier than their counterparts. Our social and physical environment have strong impacts on our overall health aside from our traditional health care settings. Social and environmental factors include our race, income, education level, and livable home environment (i.e., community), etc.

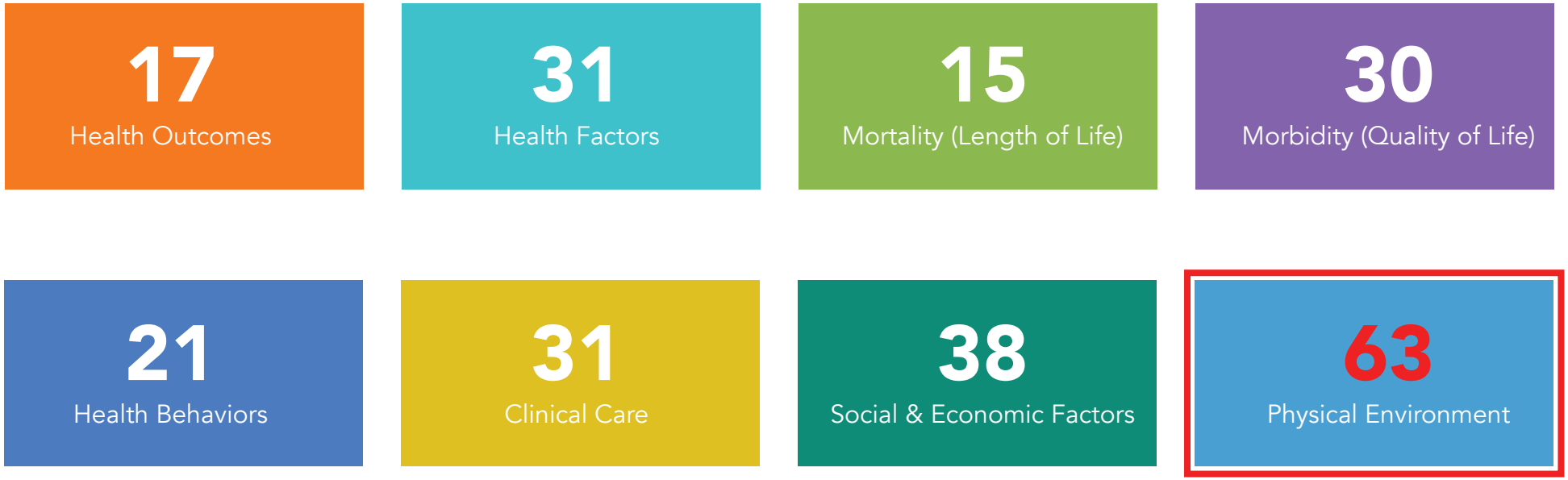
According to the Robert Wood Johnson Foundation, social inequalities such as poverty are linked to unhealthy behaviors like smoking, poor diet, and lack of exercise. However, community investments in proven programs and policy changes can reduce disparities, allowing residents to make it easier to make better healthier choices and reducing illnesses.

FACTORS THAT INFLUENCE OUR HEALTH

SDOH and individual choices play a vital role in one's overall health and well-being; however, those choices must be made available to yield a good outcome. SDOH plays a substantial role in providing residents with choices as everyone does not have access to the same options. Providing health equity provides an equal opportunity for individuals to live healthy lives.

According to County Health Rankings & Roadmaps, Figure 4 shows Berks County is ranked poorly in Physical Environment (63/67 counties) and above the median in Social and Economic Factors in 2021 (38/67 counties). Social and economic factors, such as income, education, employment, community safety, injury and death, social support, and children in poverty, can significantly affect how well and how long we live. Pennsylvania has 67 counties; a score of 1 indicates the "healthiest" county for the state in a specific measure.

Figure 4: County Health Rankings: Berks County
(1-67) (1=Healthiest)



Source: County Health Rankings and Roadmaps 2021

ADDRESSING SOCIAL DETERMINANTS OF HEALTH
COMMUNITY CONNECTION PROJECT (CCP)[4]

The following data represents a project that is under way at Reading Hospital to address SDOH.

HEALTH RELATED SOCIAL NEEDS

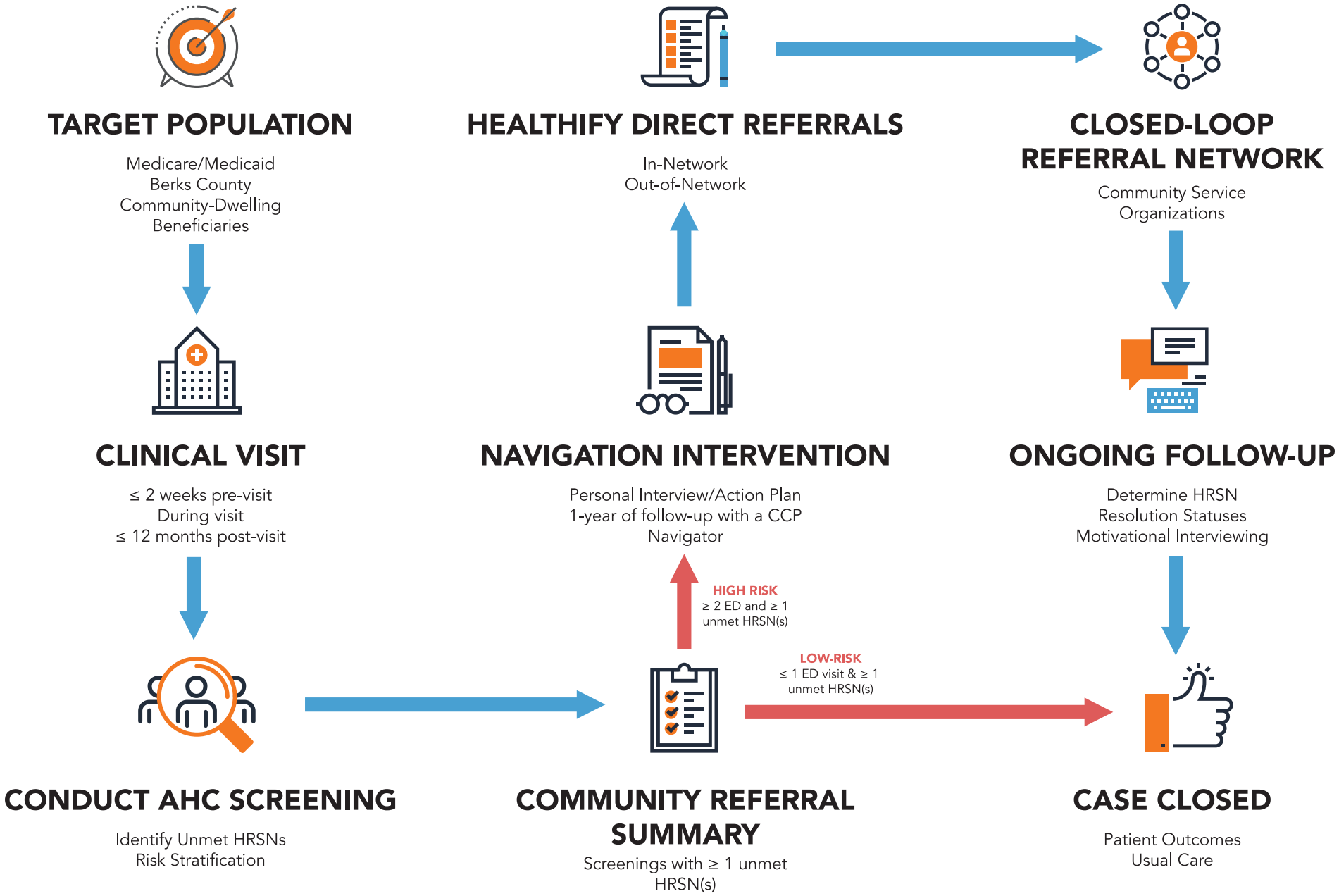
In past CHNA cycles at Reading Hospital, the community has identified barriers such as SDOH impeding their access to health care. As a response, Reading Hospital began to address SDOH through the CCP. The CCP is funded by the Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities (AHC) model cooperative agreement, which seeks to address housing instability, food insecurity, transportation, utilities, and interpersonal violence (safety) health-related social needs (HRSNs).

The project features a consortium comprising of leadership from clinical teams, community service organizations, managed care organizations, and the Pennsylvania State Medicaid Office. The CCP consortium works to build, maintain, and strengthen the community's capacity to address Medicare and Medicaid beneficiary needs. Reading Hospital provides screening, referral, and navigation services for Berks County beneficiaries utilizing an integration between Healthify Inc. and EPIC electronic health records. Healthify creates direct referrals and communicates important information amongst other community service partners, thus creating a closed-loop referral system. The integration also provides Reading Hospital with a wealth of data that can be leveraged to inform more equitable health practicing for our communities.

[4] The project described is supported by Funding Opportunity Number CMS-1P1-17-001 from the Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

CCP OVERVIEW

Figure 5: CCP Screening, Referral, Navigation Workflow

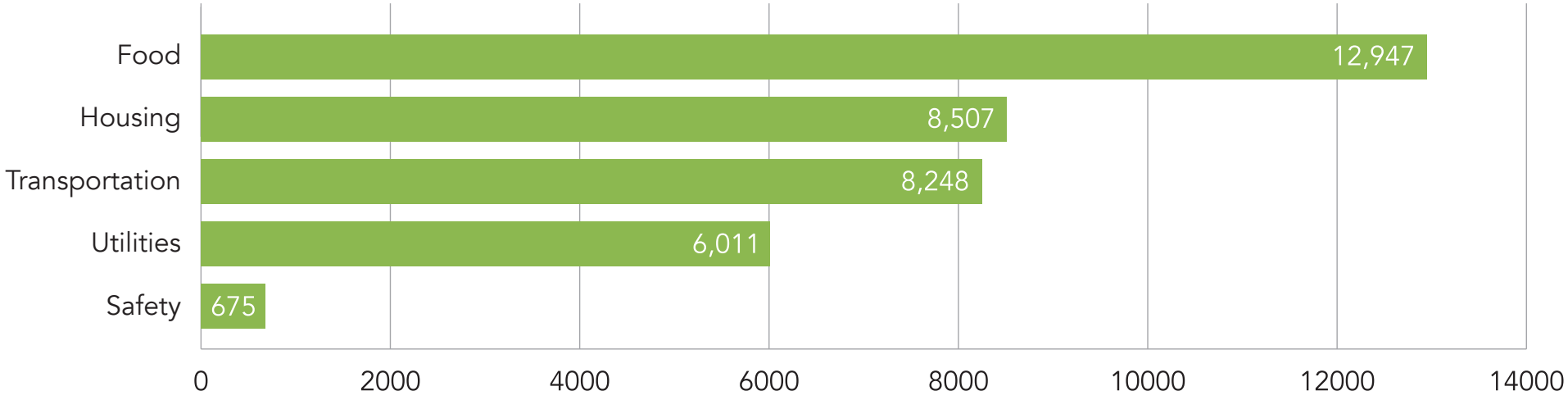


IMPLEMENTATION OUTCOMES/IMPACT

Since September 24, 2018, screenings, referrals, and navigation have been implemented across more than 22 clinical delivery sites such as the emergency department, inpatient units, hospital-outpatient based sites, ambulatory locations, and Berks Community Health Center (local federally qualified health center). More than 30 community service partners (CSP) such as food banks, a transportation municipality, housing/homeless shelters, and community action agencies are receiving referrals via Healthify. There is at least one CSP for each HRSN.

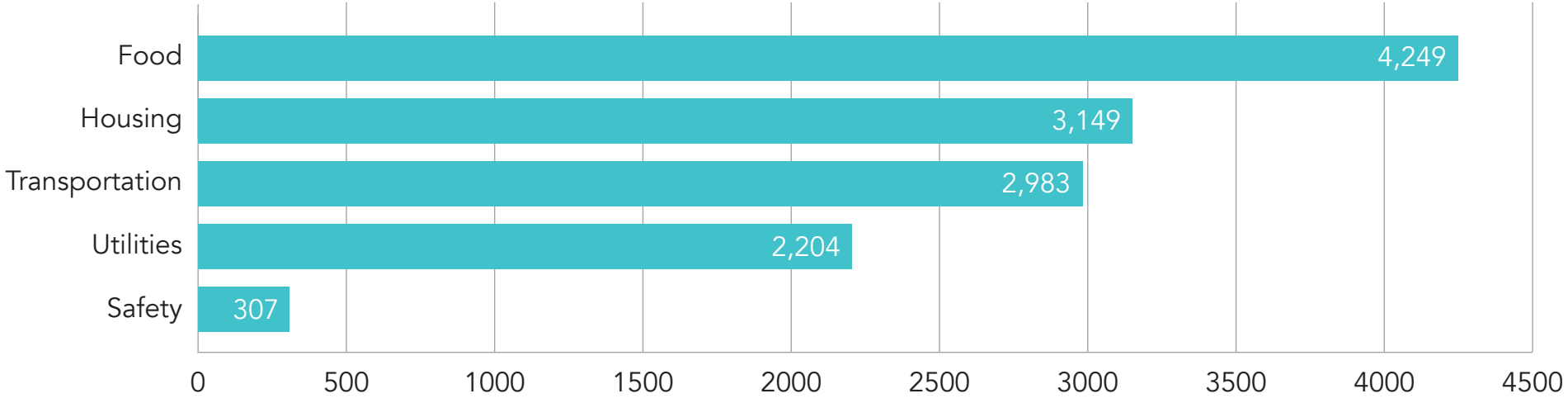
As of June 2021, Reading Hospital has completed 130,215 screenings for 49,221 beneficiaries. Figure 6 shows a breakdown of positive completed screenings by the HRSN identified. A third (n=42,646) of these screenings were high-risk, resulting in 6,184 unique navigation cases. HRSNs identified by unique navigation cases are shown in Figure 7.

Figure 6: Number of Screenings by HRSN May 2018-June 2021



Source: CMS AHC Data System

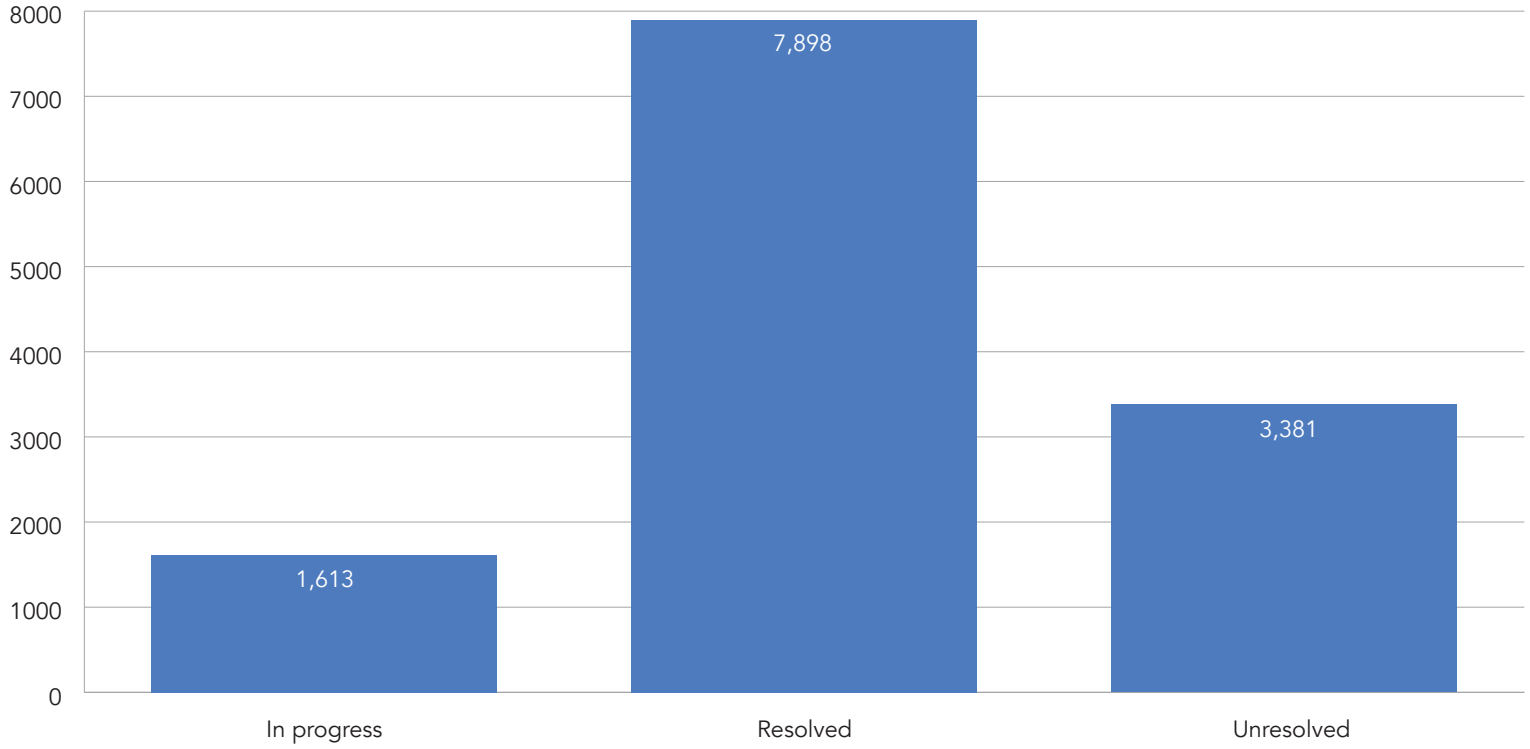
Figure 7: Number of Navigation Cases by HRSN May 2018-June 2021



Source: CMS AHC Data System

Community navigators provide up to one year of ongoing follow-up for beneficiary navigation cases to determine a resolution status for identified HRSNs. Needs left in progress are still pending a resolved or unresolved status. The beneficiary must state their need as resolved; however, a successful connection to a CSP who may resolve their needs may also determine a resolved status. As of September 14, 2021, 10,564 referrals were created for a variety of services. Unresolved statuses occur when beneficiaries opt out of services, are lost-to-follow-up, or have no available resources to resolve their needs.

Figure 8: Number of HRSNs by Resolution Status May 2018-June 2021



Source: CMS AHC Data System

As of June 30, 2021, Reading Hospital resolved 61% (n=7,898) of all HRSNs identified by navigation cases (Figure 8). Resolved cases are attributable to navigation follow-up and referral response. At least 64% of Healthify referrals were sent to CBOs who partner with CCP to receive referrals through Healthify's closed-loop referral system. This system reduces many communication barriers, helping all teams resolve needs effectively and efficiently. The CBO partnership and collaboration has positively impacted the opportunity to resolve beneficiary HRSNs whereas, beneficiaries who receive these services commonly express their gratitude for our clinical-community linkages.

EQUITY LENS: DEMOGRAPHICS SUMMARY

Demographic data such as education, race, ethnicity, sex, and age group was analyzed for 49,638 unique beneficiaries in which 131,589 completed screenings were conducted from May 2018 to July 2021. Table 9 displays data associated with unique beneficiaries with a completed screening and Table 10 displays data related to unique beneficiaries who accepted navigation. Note, beneficiaries who accepted navigation must also complete a screening.

Table 9: Number of Unique Beneficiaries with a Completed Screening

Number of Unique beneficiaries with a COMPLETED SCREENING (N=49,638) N (%)	
EDUCATION (N=40,497)	
LESS THAN HIGH SCHOOL GRADUATE	9966 (24.6)
HIGH SCHOOL GRADUATE	16708 (41.3)
SOME COLLEGE OR TWO-YEAR DEGREE	8821 (21.8)
FOUR-YEAR DEGREE	5002 (12.4)
RACE (N=36,169)	
BLACK OR AFRICAN AMERICAN	2683 (7.4)
WHITE	23015 (63.6)
MULTIPLE RACES	661 (1.8)
OTHER	9810 (27.1)
ETHNICITY (N=41,247)	
NOT HISPANIC, LATINX, OR SPANISH ORIGIN	24431 (59.2)
ANOTHER HISPANIC, LATINX, OR SPANISH ORIGIN	16816 (40.8)
SEX (N=48,784)	
FEMALES	30617 (62.8)
MALES	18167 (37.2)
AGE (IN YEARS)	
≤ 17	8781 (17.7)
18 – 64	19730 (39.7)
≥ 65	21127 (42.6)

Table 10: Number of Unique Beneficiaries Who Accepted Navigation

Number of Unique beneficiaries who ACCEPTED NAVIGATION (N=5,898) N (%)	
EDUCATION (N=5,350)	
LESS THAN HIGH SCHOOL GRADUATE	1667 (31.2)
HIGH SCHOOL GRADUATE	2197 (41.1)
SOME COLLEGE OR TWO-YEAR DEGREE	1165 (21.8)
FOUR-YEAR DEGREE	321 (6.0)
RACE (N=4,588)	
BLACK OR AFRICAN AMERICAN	547 (11.9)
WHITE	2077 (45.3)
MULTIPLE RACES	108 (2.4)
OTHER	1856 (40.5)
ETHNICITY (N=5,429)	
NOT HISPANIC, LATINX, OR SPANISH ORIGIN	2391 (44.0)
ANOTHER HISPANIC, LATINX, OR SPANISH ORIGIN	3038 (56.0)
SEX (N=5,710)	
FEMALES	3803 (66.6)
MALES	1907 (33.4)
AGE (IN YEARS)	
≤ 17	672 (11.4)
18 – 64	4214 (71.4)
≥ 65	1012 (17.2)

Source: AHC Monthly Monitoring Dashboard Report July 2021

Notable disparities were identified between the navigation and screening beneficiary population for some demographic characteristics (Table 11). The beneficiaries in the navigation population generally reported attaining education level of less than a high school graduate, Hispanic ethnicity, and age 18-to-64-years. These disparities highlight key characteristics of the most vulnerable beneficiaries who are accepting navigation.

Table 11: Demographic Disparities of Unique Beneficiaries in CCP

Demographics	Completed a Screening, n=49,638 N (%)	Accepted Navigation, n=5,898 N (%)
Less than high school graduate	9,966 (24.6)	1,667 (31.2)
Hispanic, Latinx, or Spanish origin	16,816 (40.8)	3,038 (56.0)
Age 18-64 years	19,730 (39.7)	4,214 (71.4)

IMPACT ON THE PATIENT

To determine how SDOH impacts health outcomes and utilization, McKinsey and Company conducted a Consumer SDOH Survey of 2,010 individuals in 2019. Survey results found that "respondents reporting higher inpatient or E.R. utilization were more likely to report unmet social needs." The positive impacts of addressing SDOH by the health care system and payer are benefiting patients in other ways. "Eighty-five percent of respondents reporting multiple unmet social needs indicated they would use a social program offered by their health insurer." (McKinsey & Company)

In 2021, a patient was screened by the CCP and determined to have an unmet food and transportation need. Through navigation services, she was referred to Helping Harvest and BARTA. It was also identified that the patient needed some additional assistance for infant care essentials therefore, she was connected to Hannah's Hope Ministries. All community-based organizations were able to provide her with services to meet her needs. During follow-up with a CCP Community Navigator, the patient stated that she is using one of Helping Harvest's food pantries, receving BARTA transportation services, and had received baby supplies through Hannah's Hope Ministries. She reported that all her needs were now resolved and there were no additional concerns to be addressed.

PULLING IT TOGETHER

Building on the vital work that has been underway, Reading Hospital places an unrelenting focus on actions required to continually improve health and quality of life for its residents. Focus groups with community members and hospital leadership drew similarities in top community health needs.

Figure 12 shows the top community health needs identified by focus group.

Participants of the CHNA across the various data collection methods emphasized the need to improve access to equitable care and behavioral health and to expand health education and prevention. Inequities such as demographical differences highlight the importance of weaving an equity focus within all areas of health. We can conclude that plans to improve health can be achieved through the following areas of focus:

A) Access to Equitable Care
B) Behavioral Health
C) Health Education and Prevention
D) Health Equity

A) ACCESS TO EQUITABLE CARE

Facing the challenges of COVID-19, Reading Hospital used lessons learned to better understand the impact of the pandemic on the plethora of previously identified health needs and issues. The post-pandemic CHNA further helped the health system to realize the even wider gaps that resulted as related to accessing care; a lack of education and awareness of available health services and programs; an even greater digital divide and lack of access to technology; the increased demand for behavioral health services; and the limited capacity to provide quality and appropriate care due to limited language services.

Figure 13 delineates the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.

WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 13: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the contributors and barriers to people accessing equitable care?"

- Economic disparity
- Community fear and distrust
- Language barriers
- Shortage of diverse, ethnic providers
- Limited insurance coverage
- Lack of transportation
- Convenience of appointment
- Unconscious bias and stigmas

"Why are People Treated Differently?"

- Race/ethnicity – 54%
- Insurance coverage – 23%
- Non-English speaking – 23%

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the perceived barriers to accessing care and services?"

- Affordability
- Health literacy
- Lack of transportation
- Lack of insurance
- Cultural barriers

"What are the Barriers to a Quality Life"

- Economic disparities
- Cost of care/meds
- Lack of insurance
- Health literacy
- Mental illness

KEY INFORMANT SURVEYS

"What are the Perceived Barriers To Accessing Care and Services?"

- Affordability
- Lack of transportation
- No insurance
- Health literacy

"What are the Barriers to a Quality Life?"

- High costs of care/meds
- Economic disparities
- Mental illness

COMMUNITY SURVEYS

"What are the Contributors and Barriers to Accessing Care?"

- Lack of access to health care/PCPs
- Inconvenience/appointment scheduling
- Lack of jobs
- Lack of exercise

"What are the Most Important Health Issues?"

- Behavioral health/mental health
- Drug/alcohol use
- Lack of exercise
- Aging Issues (Arthritis, hearing/vision loss)
- Access to healthy foods

"What are the Barriers to a Quality Life?"

- Ease in accessing health care, doctors
- Low crime, safe neighborhoods
- Good jobs, a healthy economy
- Good schools
- Healthy behaviors and lifestyles

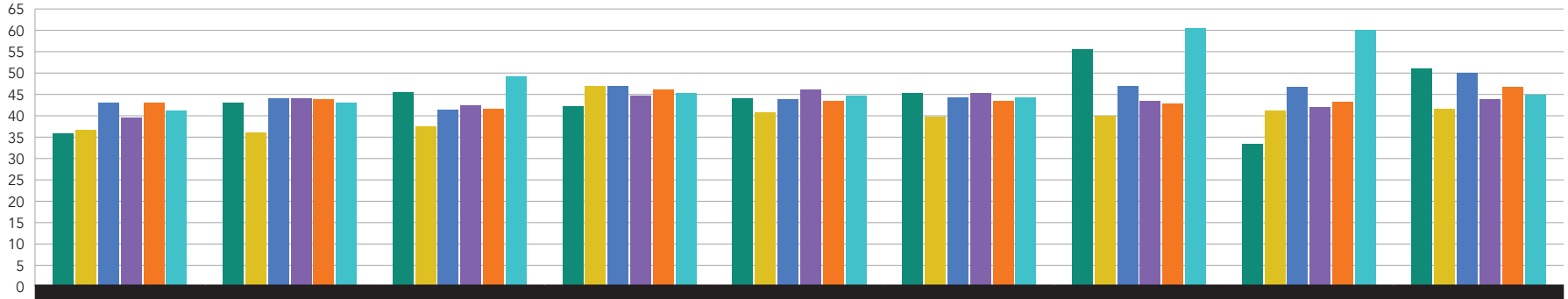
Figure 14 shows Berks County residents who have no health insurance coverage or coverage via Medicare. Over the last few CHNA cycles, we have seen the percentage of insured people steadily rise; however, efforts to improve access to care must continue.

Figure 14: Percentage of Population with No Health Insurance Coverage

Source: The Agency for Healthcare Research and Quality (AHRQ) 2018

The PA Health Equity Analysis Tool (HEAT) provides a geographic perspective at the granular level to areas that have opportunities to improve equity.[5] The below figure depicts ZIP codes within the City of Reading related to adults who obtain primary care visits by ZIP code.

Figure 15: Percentage of Adults with Primary Care Physician Visits by ZIP Code Summary



	19601	19602	19604	19605	19606	19607	19608	19609	19610
Asian	35.9	42.9	45.5	42.2	44.1	45.2	55.5	33.3	51.0
Black	36.6	36.0	37.5	46.8	40.7	39.8	40.0	41.2	41.6
Hispanic	42.9	44.0	41.3	46.9	43.9	44.3	46.8	46.6	50.0
White	39.5	44.1	42.3	44.7	46.0	45.2	43.5	41.9	43.9
Other Race	42.9	43.9	41.6	46.1	43.3	43.5	42.8	43.2	46.6
All Adults	41.2	43.0	59.1	45.3	44.7	44.2	60.4	60.1	44.8

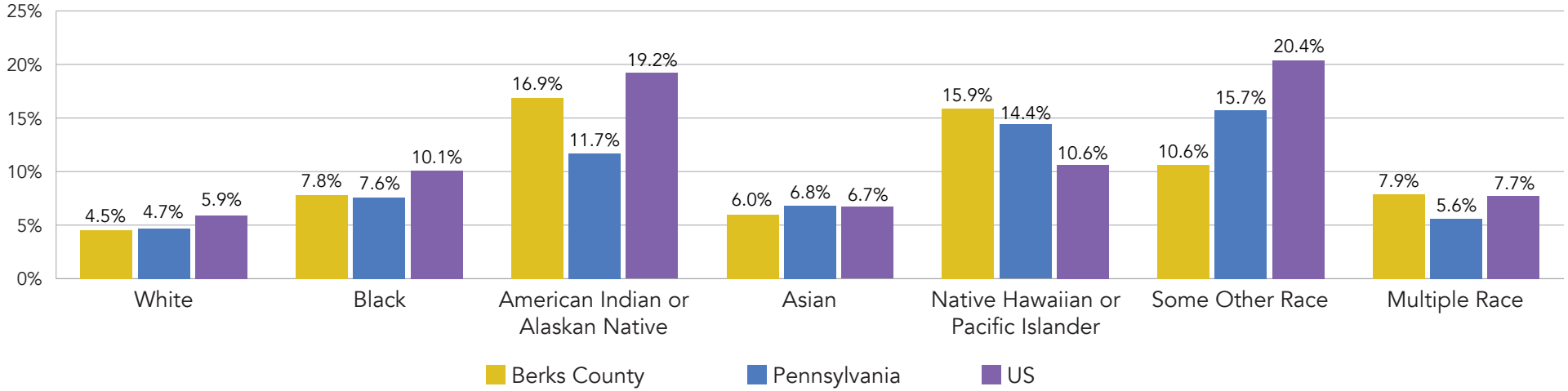
Note: The figures in red indicate low percentages of adults with primary care physician visits when compared to the benchmarked data of all adults within the specific ZIP code.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

[5] The Department of Human Services (DHS) in collaboration with the Department of Health (DOH) has launched the PA Health Equity Analysis Tool (HEAT). The PA HEAT dashboard is designed to illustrate variation in a variety of health and social determinants of health indicators at the regional, county, ZIP code, and census tract levels.

Although the percentage of uninsured has increased over the past several years, Figure 16 shows more uninsured Blacks, Native Americans or Alaska Natives, Native Hawaiians or Pacific Islanders, and residents of multiple races as compared to the state.

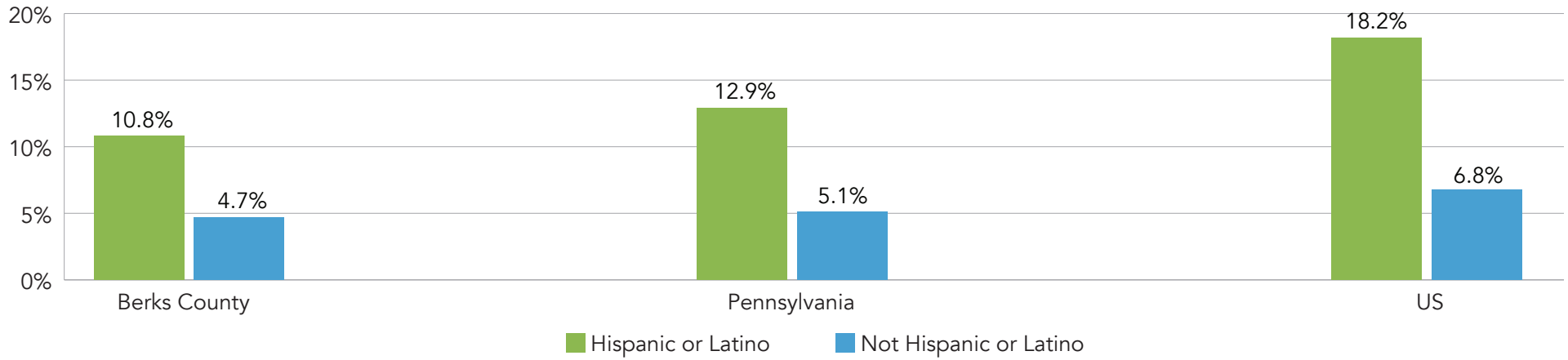
Figure 16: Percentage of Uninsured Population by Race



Source: U.S. Census Bureau, American Community Survey 2019

Figure 17 shows more uninsured Hispanic or Latinos when compared to the state and the nation.

Figure 17: Percentage of Uninsured Population by Ethnicity

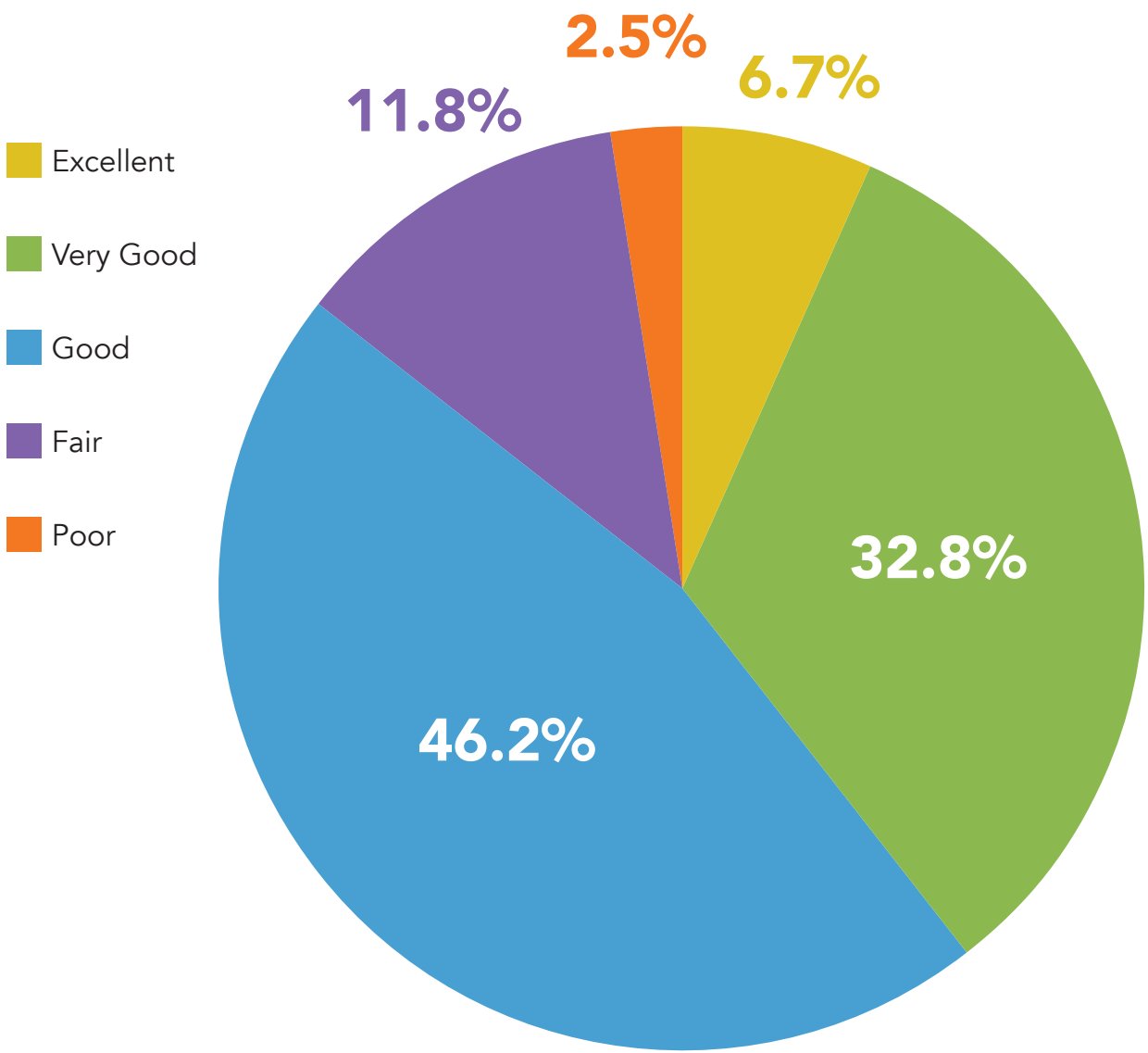


Source: U.S. Census Bureau, American Community Survey 2019

When asked to rate their health status, 86% (n=204) of community health survey respondents stated good, very good, or excellent health. 50% (n=124) noted the need for blood pressure screenings, and 40% (n=94) cited the need for cholesterol screenings for chronic disease management.

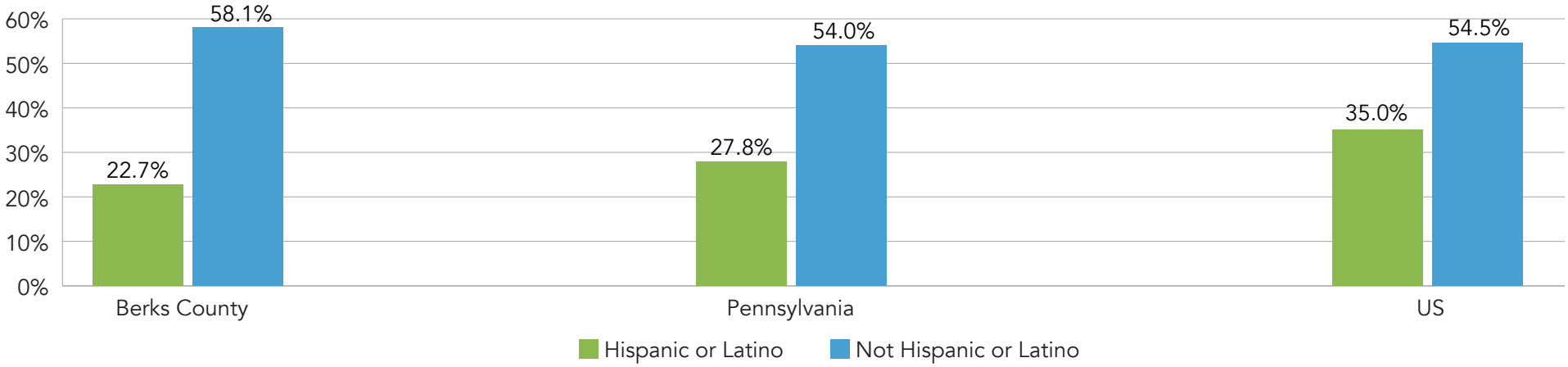
Figure 18 reported how respondents described their overall health.

Figure 18: Description of Overall Health



Economic status and income are strongly associated with morbidity and mortality. Income directly influences health and longevity and may perpetuate or exacerbate health disparities. It is noted that income inequality has grown substantially over recent decades.

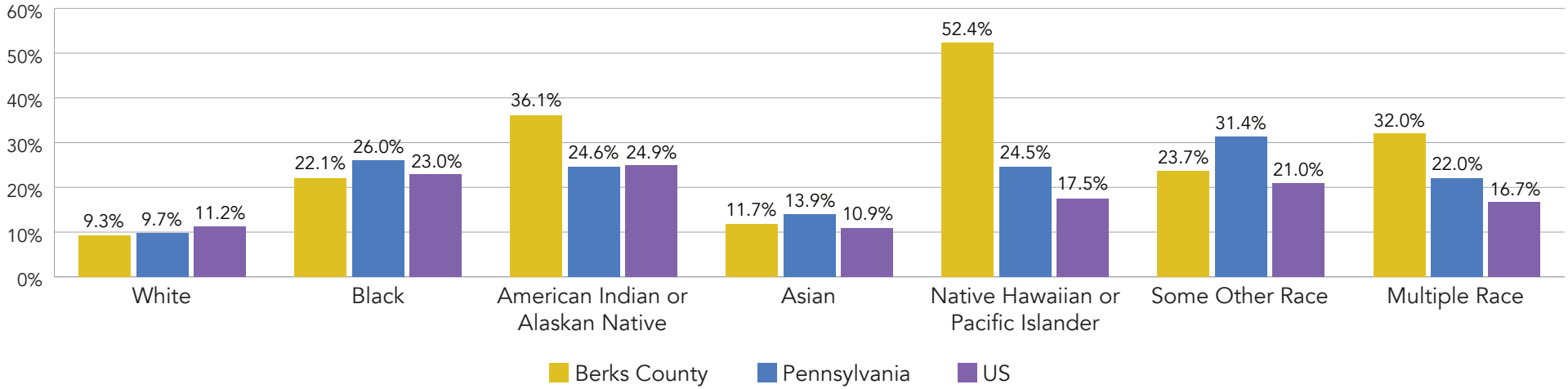
Figure 19: Families Earning More Than $75,000 by Ethnicity



Source: U.S. Census Bureau, American Community Survey 2019

Figure 20 reported the percentage of the population below 100% of the federal poverty line (FPL) by race.[6]

Figure 20: Population Below 100% FPL by Race

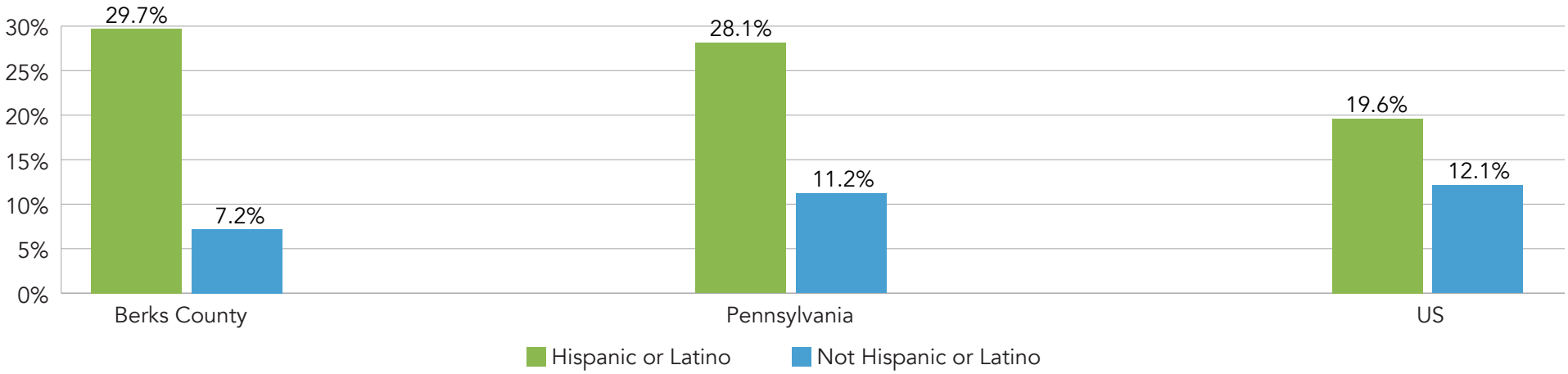


Source: U.S. Census Bureau, American Community Survey 2019

[6] Federal poverty levels (FPL) are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid, and CHIP coverage. For a family or household of 4 living in one of the 48 contiguous states or the District of Columbia, the poverty guideline for 2021 is $26,500.

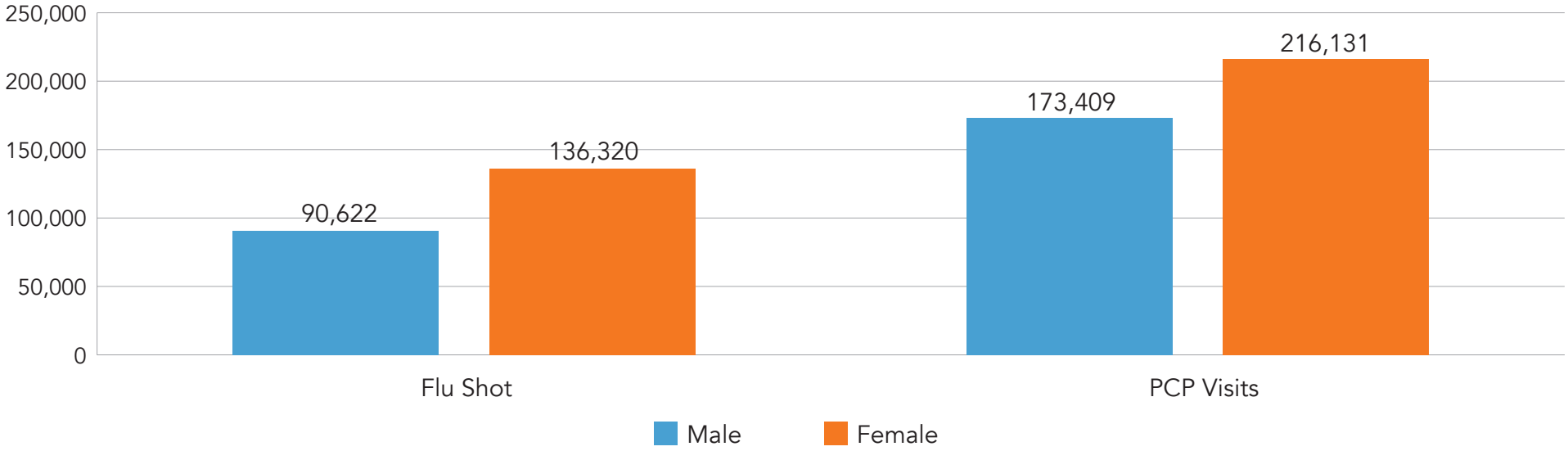
Figure 21 reports the percentage of the population below 100% of the federal poverty line by ethnicity.

Figure 21: Population Below 100% FPL by Ethnicity



Source: U.S. Census Bureau, American Community Survey 2019

Figure 22: Reading Hospital with Completed Health Screenings and Preventative Health Measures by Gender 2018-2020



Source: Epic Clarity

Table 23 shows patients who are potentially eligible for a mammography screening and were seen at Reading Hospital between 2018 and 2020. During this time, a 49% mammography screening rate has been achieved. Nearly half (n=174,766) of patients who are potentially eligible for a mammography screening and were seen at Reading Hospital between 2018 and 2020, had a completed screening. About 23% (n=40,607) of patients without a completed screening reside in the following top 5 ZIP codes: 19606, 19601, 19607, 19605, 19604.

Table 23: Overall Mammography Screenings 2018- 2020

	Mammography Complete	Mammography Eligible	Completion Rate
2018	47,326	96,479	49%
2019	60,548	119,218	51%
2020	66,892	138,795	48%

Source: Epic Clarity. The following information on race and ethnicity screening analysis was provided by Tanieka Mason, MPH Sr. Manager SDOH & Analytics, Community Wellness, Reading Hospital.

Table 24 highlights in red the various race categories where the mammography screening rate is less than the overall screening rate of 51.3%*

Table 24: Mammography Screenings by Race 2018 – 2020

	Mammography Complete	Mammography Eligible	Completion Rate
American Indian or Alaska Native	141	325	43.4%
Asian Indian, or Other Asian	1,658	3,176	52.2%
Black or African American	11,956	25,667	46.6%
Native Hawaiian or Other Pacific Islander	206	452	45.6%
White or Caucasian	146,583	278,388	52.7%
Other	11,579	27,806	41.6%
TOTAL	**172,123**	**335,814**	**51.3%**

*Total excludes 18,678 records of data marked as the patient refused, unknown, or missing.

Source: Epic Clarity

Table 25 highlights in red the ethnicity category where the mammography screening rate is less than the overall screening rate of 51.6%*

Table 25: Mammography Screenings by Ethnicity 2018 – 2020

	Mammography Complete	Mammography Eligible	Completion Rate
Hispanic or Latino	15,292	35,532	43.0%
Not Hispanic or Latino	153,453	291,464	52.6%
TOTAL	**168,745**	**326,996**	**51.6%**

*Total excludes 27,496 records of data marked as the patient refused, unknown, or missing

Source: Epic Clarity

Table 26 shows patients who are potentially eligible for a colonoscopy screening and were seen at Reading Hospital between 2018 and 2020 and completed a screening. During this time, a 31% colonoscopy screening rate has been achieved. About 22% (n=81,086) of patients without a completed screening reside in the following top 5 zip codes: 19606, 19601, 19607, 19608, 19605.

Table 26: Colonoscopy Screenings 2018- 2020

	Colonoscopy Completed	Colonoscopy Eligible	Completion Rate
2018	53,015	150,870	35.1%
2019	55,848	180,974	30.9%
2020	57,438	209,113	27.5%

Source: Epic Clarity.

Table 27 highlights in red the various race categories where the colonoscopy screening rate is less than the overall screening rate of 32%*

Table 27: Colonoscopy Screenings by Race 2018 – 2020

	Colonoscopy Completed	Colonoscopy Eligible	Completion Rate
American Indian or Alaska Native	103	454	22.7%
Asian Indian, or Other Asian	1,295	4,333	29.9%
Black or African American	5,976	35,427	16.9%
Native Hawaiian or Other Pacific Islander	81	601	13.5%
White or Caucasian	148,905	429,874	34.6%
Other	6,822	38,996	17.5%
TOTAL	**163,182**	**509,685**	**32.0%**

*Total excludes 31,272 records of data marked as the patient refused, unknown, or missing.

Source: Epic Clarity

Table 28 highlights in red the ethnicity category where the colonoscopy screening rate is less than the overall screening rate of 31.9%*

Table 28: Colonoscopy Screenings by Ethnicity 2018 – 2020

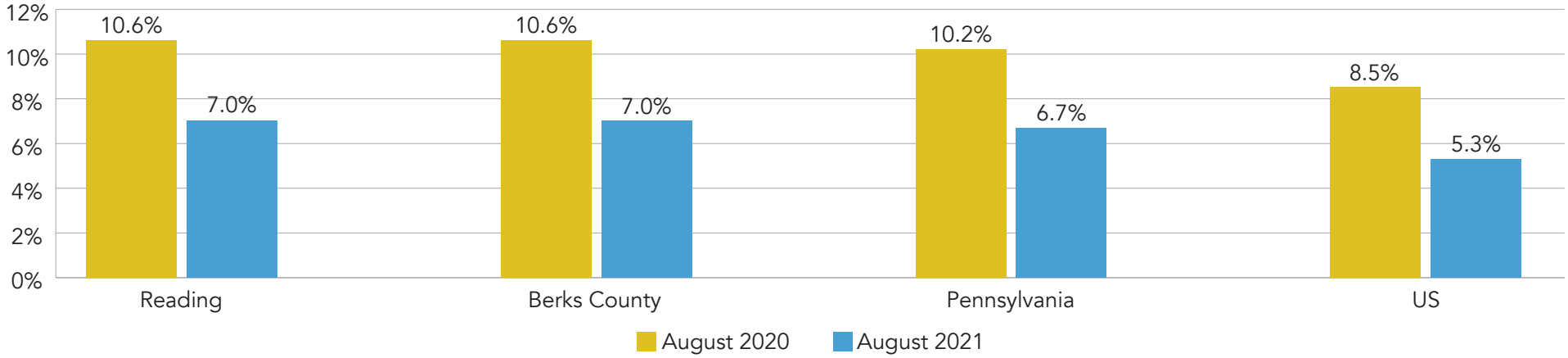
	Colonoscopy Completed	Colonoscopy Eligible	Completion Rate
Hispanic or Latino	8,980	49,371	18.2%
Not Hispanic or Latino	149,084	445,401	33.5%
TOTAL	**158,064**	**494,772**	**31.9%**

*Total excludes 46,185 records of data marked as the patient refused, unknown, or missing.

Source: Epic Clarity

Figure 29 illustrates the unemployment rate in Reading, Berks County, the state, and the nation.

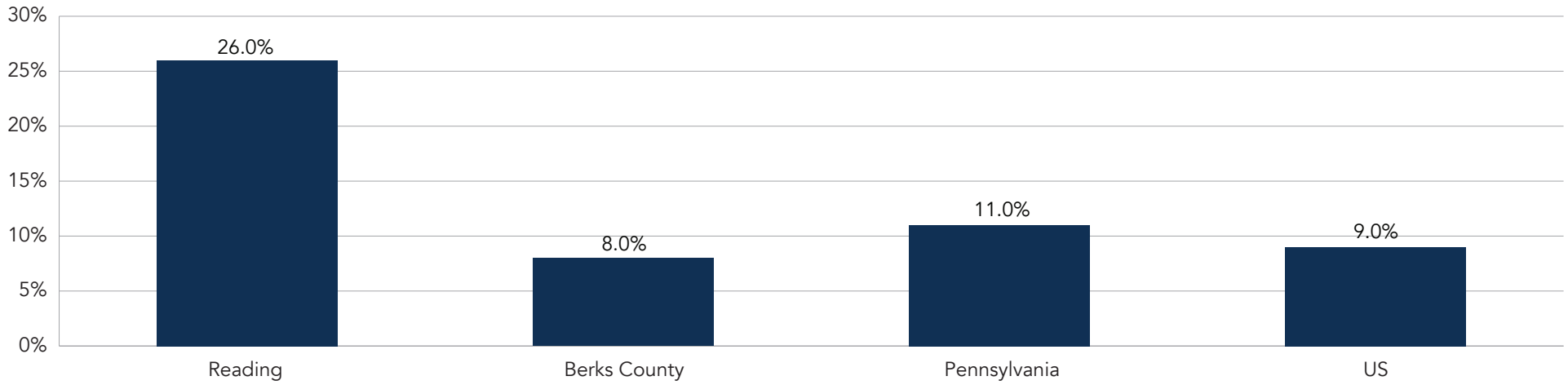
Figure 29: Unemployment Rates



Source: U.S. Department of Labor, Bureau of Labor Statistics 2020-2021

Figure 30 shows a higher rate of Reading residents not having a motor vehicle when compared to those in Berks County, Pennsylvania, and the state for the years 2015-2019. Lack of reliable transportation can hinder one's ability to get to and from medical appointments, meetings, work, or things needed for daily living.

Figure 30: Households with No Motor Vehicle



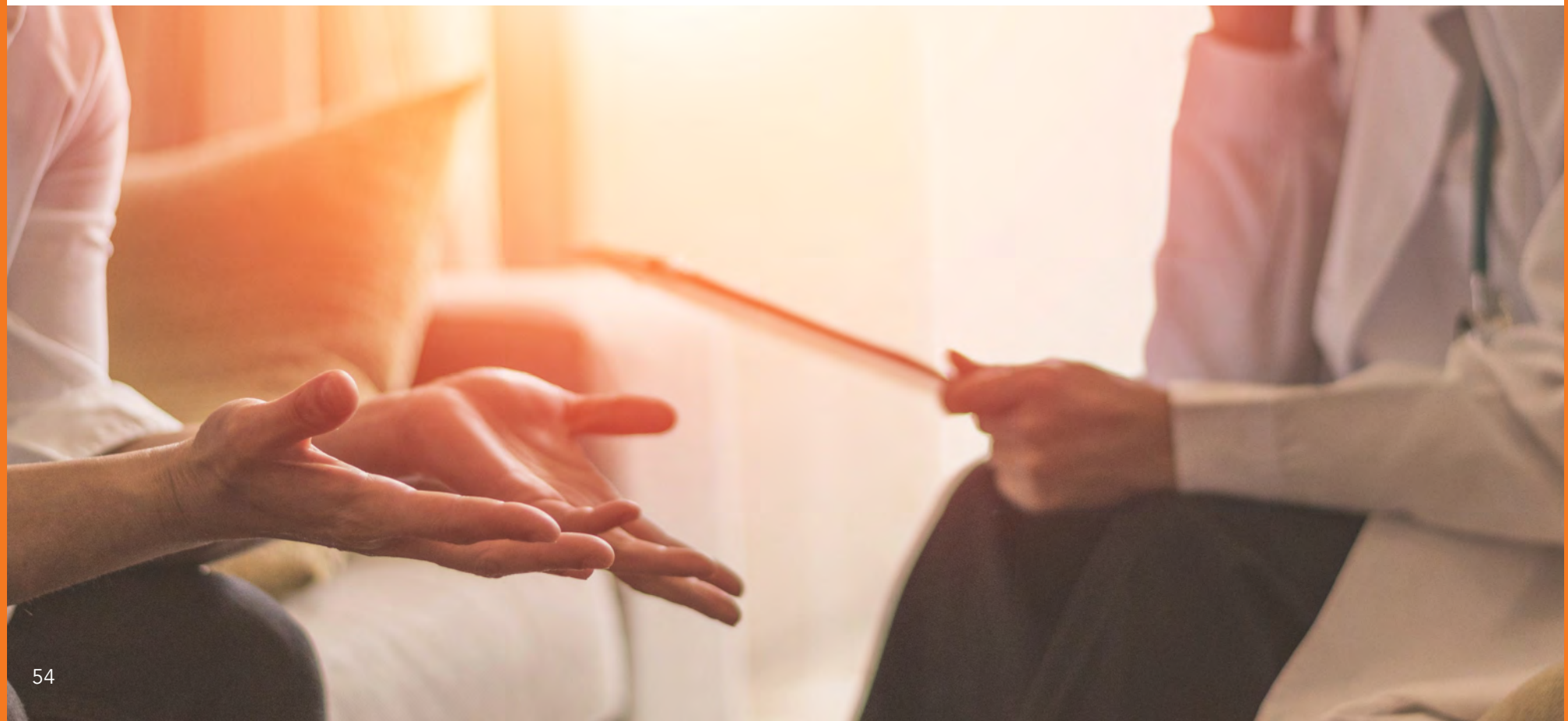
Source: Berks Vital Signs 2015-2019

B) BEHAVIORAL HEALTH

Improving access and adequacy of behavioral health services and programs has become a high priority for Reading Hospital's communities in the past several years as more than 60% of community survey respondents noted behavioral health as having the greatest impact on overall community health. The COVID-19 pandemic, social distancing policies, mandatory lockdowns, isolation, and the fear of getting sick made the need for access to behavioral health services even more evident.

Mental health and drug and alcohol use have increased significantly as employers and employees worried about the suspension of productive activity, loss of income, and an ever-present "fear of the future" (National Institutes of Health). The impact of COVID-19 on the workplace further resulted in mental health issues such as anxiety, depression, post-traumatic stress disorder (PTSD), and sleep disorders. This impact was especially noted among health care workers, especially those on the front line; migrant workers; and workers in contact with the public.

Figure 31 delineates the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.



WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 31: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the contributors and barriers to people receiving behavioral health services?

- Lack of behavioral health/mental health services
- Lack of awareness of available services
- Shortage of behavioral health providers and services

KEY INFORMANT SURVEYS

"What are the perceived barriers to accessing behavioral health services?"

- Drug/alcohol use
- Lack of access to behavioral health/mental health services
- Awareness of available behavioral health services
- Lack of behavioral health care coordination

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the Perceived Barriers to Behavioral Health Services?"

- Inadequate behavioral health/mental health services
- Lack of awareness of available behavioral health/mental health services
- Poor integration and coordination of behavioral health services

COMMUNITY SURVEYS

"What are the Contributors and Barriers to Overall Health?"

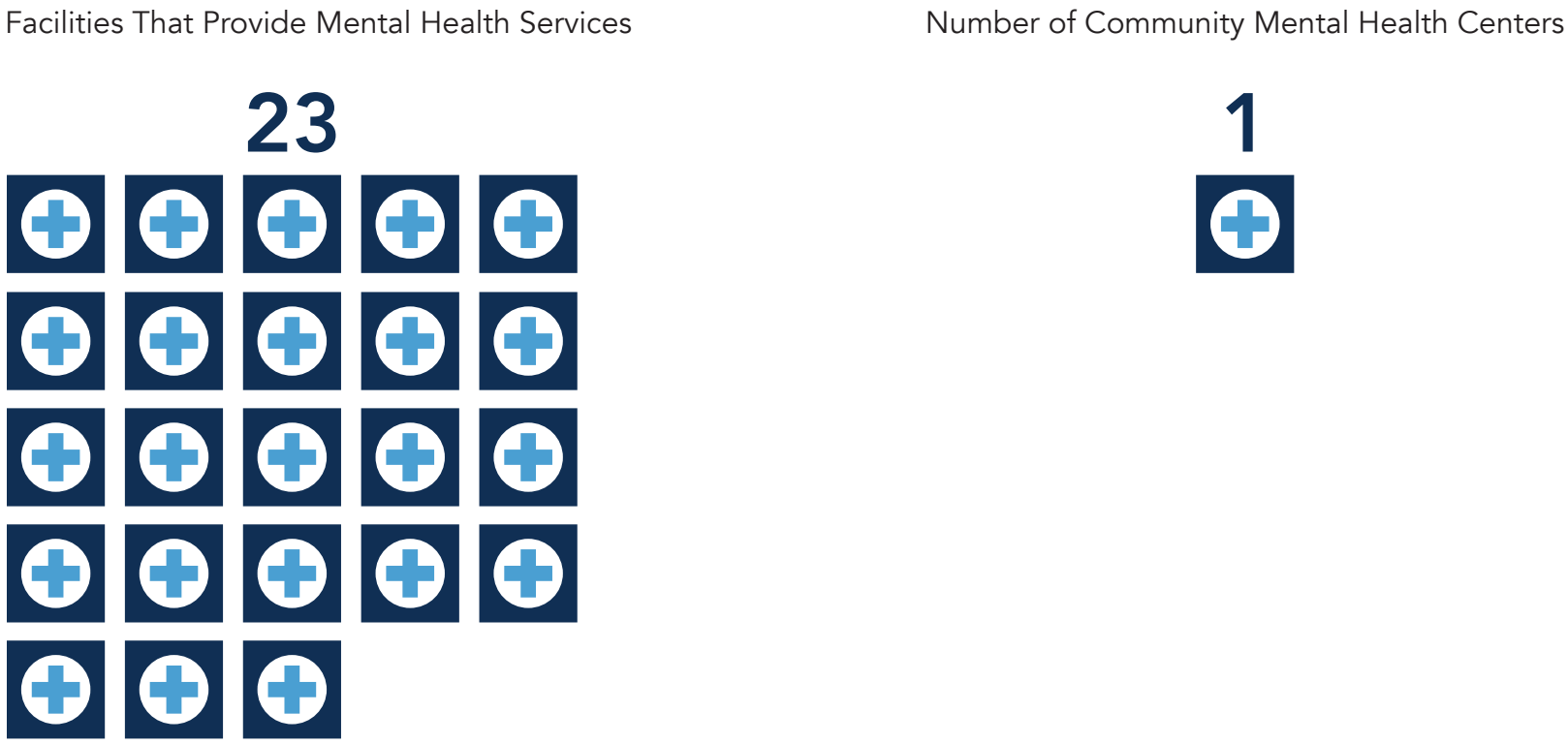
- Lack of access to behavioral health/mental health services
- Drug/alcohol use
- Awareness of available behavioral health/mental health services

Figure 32 illustrates the number of facilities that provide mental health services and the number of community mental health centers in Berks County.

Community mental health centers (CMHC) fill the need for mental health treatment and services throughout the country. CMHCs are community-based organizations providing mental health services, sometimes as an alternative to the care that mental hospitals provide. CMHC represents a basic change in social acceptance and attitudes related to mental health. CMHCs were designed to move mental health care from the traditional hospital or state "custodial" care to the community where holistic programs, family-centered care, and therapeutic services enhance recovery and restoration.

Community mental health facilities are specific to mental health illnesses. Children, adults, and individuals who are chronically mentally ill or have been discharged from an inpatient mental health facility can be treated at a community mental health center.

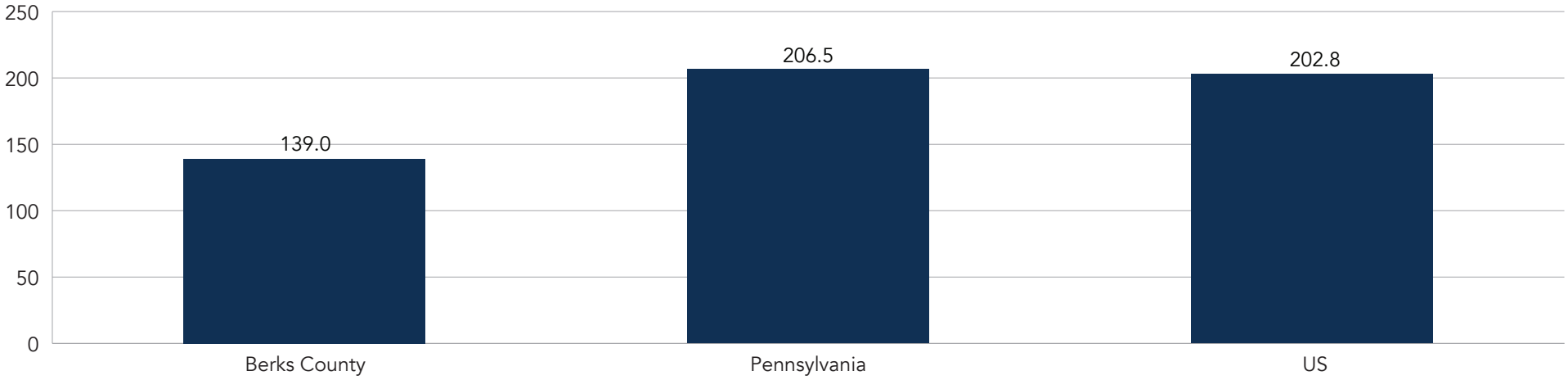
Figure 32: Mental Health Facilities and Centers in Berks County



Source: The Agency for Healthcare Research and Quality (AHRQ) 2018

Figure 33 illustrates the shortage in the number of mental health providers (per 100,000 population) in Berks County when compared to the state and the nation.

Figure 33: Mental Health Providers

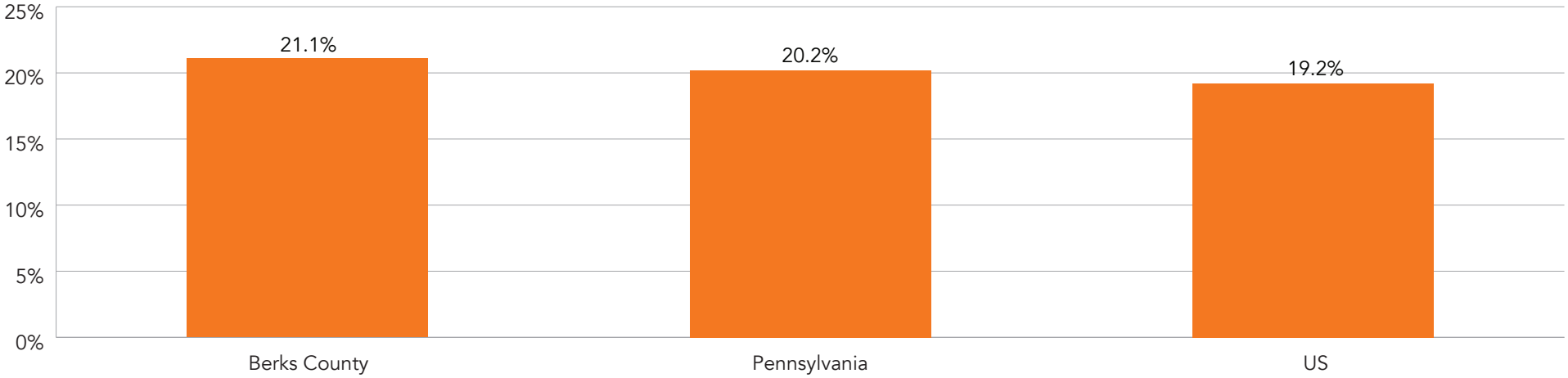


Source: County Health Rankings & Roadmaps 2019

Alcohol and tobacco use are root causes and can further exacerbate behavioral health conditions. In Pennsylvania, both alcohol and tobacco use pose a significant health risk when compared to the United States. When analyzing alcohol consumption, rates are worse or the same in Berks County when compared to the state.

Figure 34 illustrates the percent of adults who are heavy drinkers in Berks County, the state, and the nation.

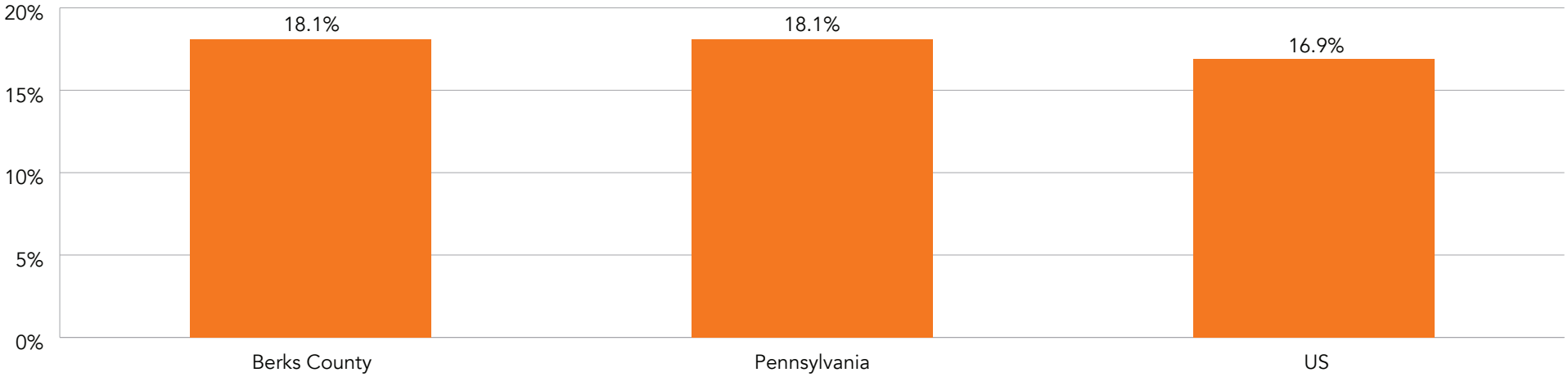
Figure 34: Alcohol Consumption (18 years and older who are Heavy Drinkers)[7]



Source: County Health Rankings & Roadmaps 2018

Figure 35 illustrates the percentage of adults who are binge drinkers in Berks County, the state, and the nation.

Figure 35: Alcohol Consumption (18 years and Older Who Are Binge Drinkers)[8]

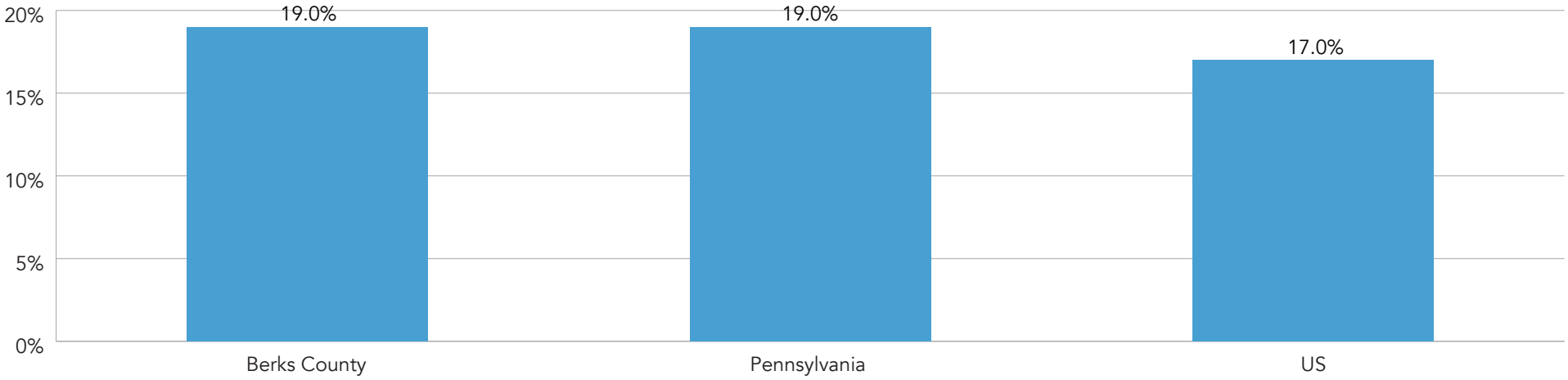


Source: CDC, Behavioral Risk Factor Surveillance System 2018

[7] Heavy drinking is defined as having more than two drinks per day for men and more than one per day for women, over the past 30 days.
[8] A binge drinker is an adult age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Figure 36 shows adults 18 and older who smoke every day or some days in Berks County, the state, and the nation.

Figure 36: Tobacco Usage - Current Smokers[9]



Source: CDC, Behavioral Risk Factor Surveillance System 2018

[9] Smokers or current smokers are adults age 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

C) HEALTH EDUCATION AND PREVENTION

Having access to health education programs that help people better understand how to manage an existing health condition and prevent further illness is paramount to good health. Health education and health literacy play a vital role in accessing care as knowledge empowers individuals to make informed health decisions and helps them effectively navigate today's complex health care delivery system.

Providing health education and understanding of health issues enables patients and families to successfully implement treatment plans as essential to managing chronic conditions and preventing complications or hospitalizations. By improving health literacy and education to the broad community on how to address and prevent chronic diseases and illness, the health organization's paradigm shifts from treating disease to a focus on wellness, healthy behaviors, and positive health outcomes.

Figure 37 delineates the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.

WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 37: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

Discussions related to Health Education

- Lack of awareness of available resources/services
- Where/how to access services
- Inconvenience of services
- Resources available in multi-languages
- Cultural practices

KEY INFORMANT SURVEYS

"What are the Perceived Barriers to Accessing Care and Services?"

- Lack of education on available resources
- Limited services available
- Lack of prevention education

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the perceived barriers to accessing care and services?"

- Cultural barriers
- Language barriers
- Lack of knowledge of available education resources

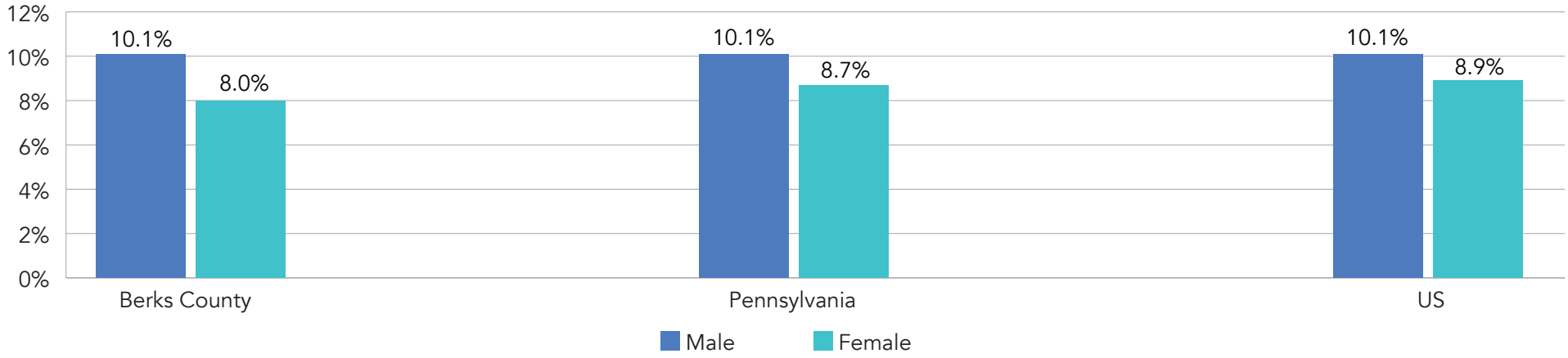
COMMUNITY SURVEYS

"What are the Contributors and Barriers to Accessing Care?"

- Unhealthy lifestyles and behaviors
- Poor nutrition and eating behaviors
- Lack of exercise
- Lack of access to healthy foods
- More chronic disease education/information needed

Figure 38 shows the percentage of adults aged 20 and older, by gender, who have ever been told by a doctor that they have diabetes.

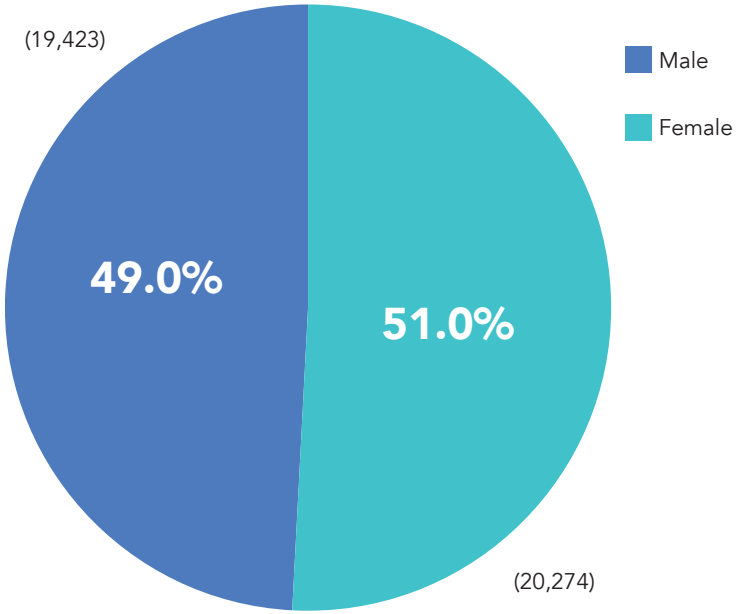
Figure 38: Diabetes by Gender



Source: U.S. Census Bureau 2017

Figure 39 shows the 2021 diabetes registry of patients at Reading Hospital by gender.

Figure 39: Diabetes Registry Patients by Gender



Source: EPIC Clarity

Table 40: 2021 Diabetes Registry Patients at Reading Hospital by Ethnicity

Ethnicity	Diabetes Registry Patients
Hispanic or Latino	6,056
Not Hispanic or Latino	31,780
Patient Refused	556
Unknown	1,291
Total	**39,683**

Source: Epic Clarity

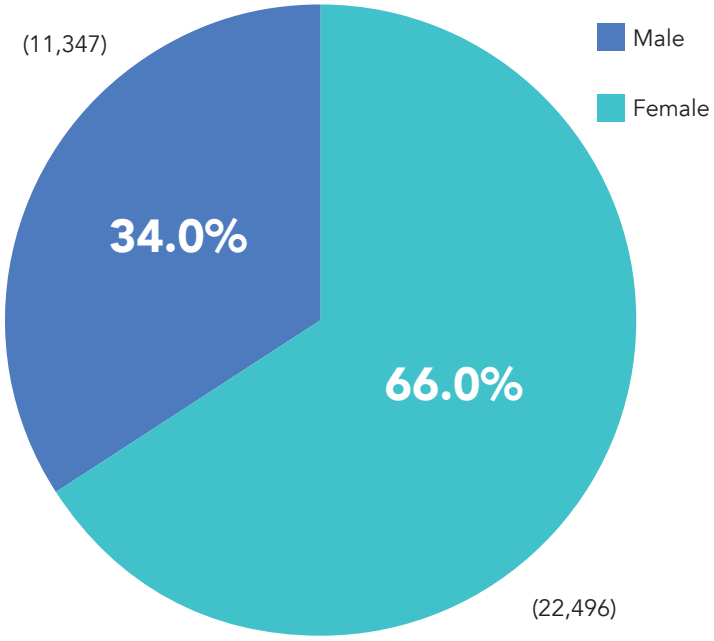
Table 41: 2021 Diabetes Registry Patients at Reading Hospital by Race

Race	Diabetes Registry Patients
American Indian or Alaska Native	51
Black or African American	4,444
Hispanic	8
Native Hawaiian or Other Pacific Islander	51
Other	4,779
Other Asian	392
Patient Refused	297
Unknown	699
Vietnamese	1
White or Caucasian	28,961
Total	**39,683**

Source: Epic Clarity

Figure 42 shows the 2021 asthma registry of patients at Reading Hospital by gender.

Figure 42: Asthma Registry Patients by Gender



Source: EPIC Clarity

Table 43: 2021 Asthma Registry Data at Reading Hospital by Ethnicity

Ethnicity	Asthma Registry Patients
Hispanic or Latino	7,774
Not Hispanic or Latino	24,252
Patient Refused	405
Unknown	1,408
Total	**33,839**

Source: Epic Clarity

Table 44: 2021 Asthma Registry Data at Reading Hospital by Race

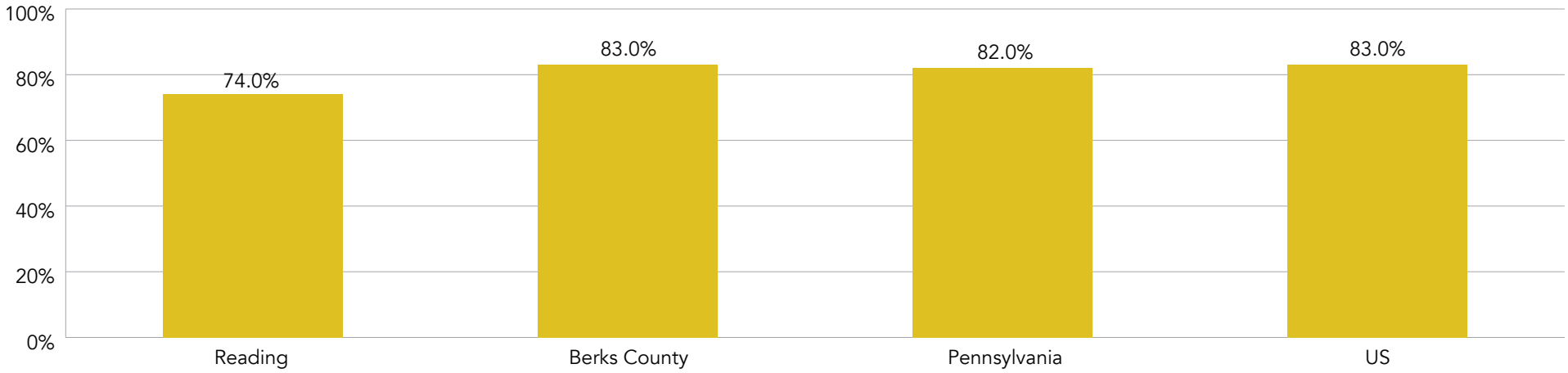
Race	Asthma Registry Patients
American Indian or Alaska Native	42
Black or African American	3,650
Hispanic	3
Native Hawaiian or Other Pacific Islander	37
Other	6,182
Other Asian	190
Patient Refused	316
Unknown	813
White or Caucasian	22,604
Total	**33,837**

Source: Epic Clarity


Patient Prescription Information

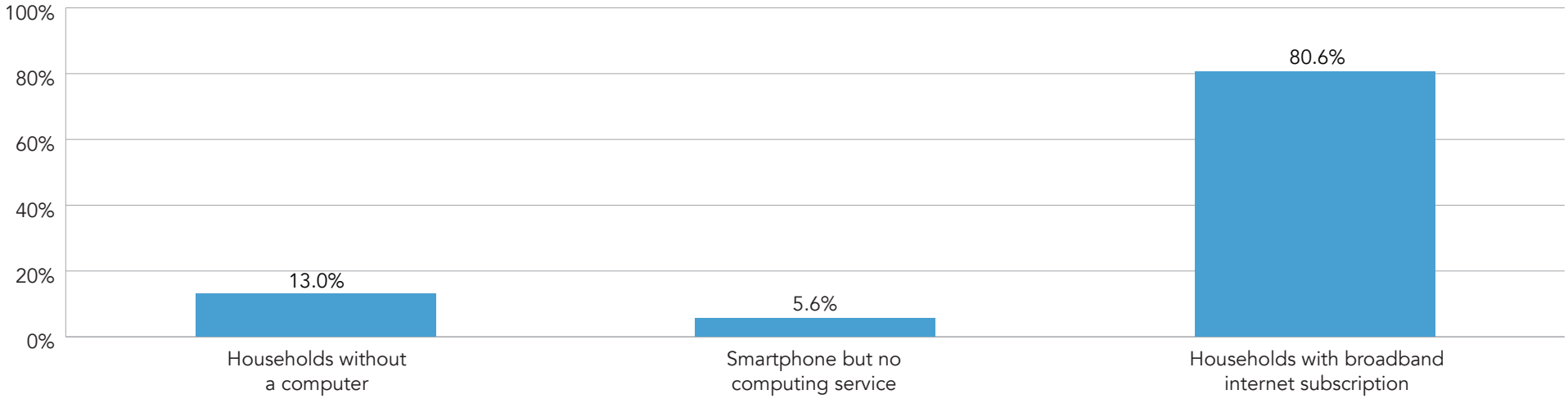
Figure 45 illustrates the percentage of residents in Berks County with/without internet or a computing device. Primary data indicated a lack of access to the internet among minorities and seniors. With the advent of virtual applications and programs, more health centers and professionals are utilizing the internet as a means of reaching targeted audiences. This avenue allows underserved or disenfranchised populations connection to obtain health education.

Figure 45: Percentage of Households in Berks County with Internet Connection



Source: Berks Vital Signs 2015-2019

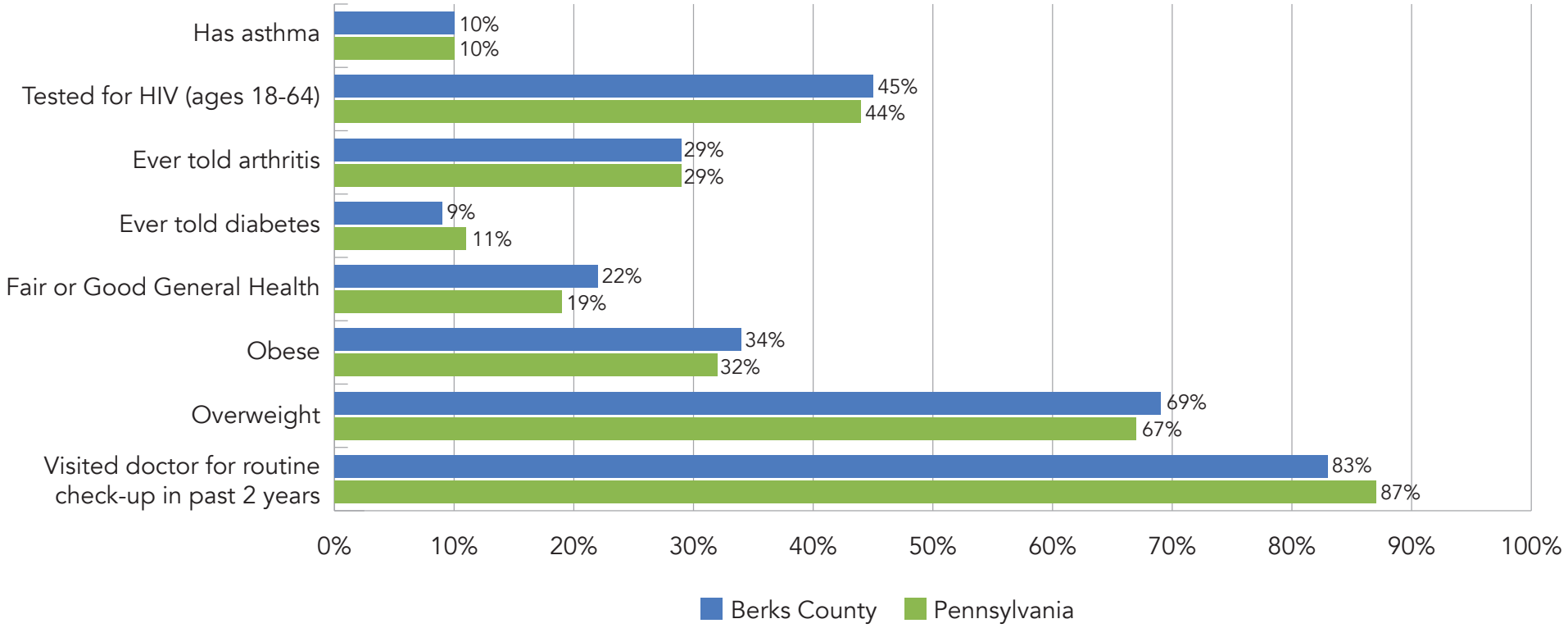
Figure 46: Percentage of Households in Berks County with Limited Technology



Source: The Agency for Healthcare Research and Quality (AHRQ) 2018

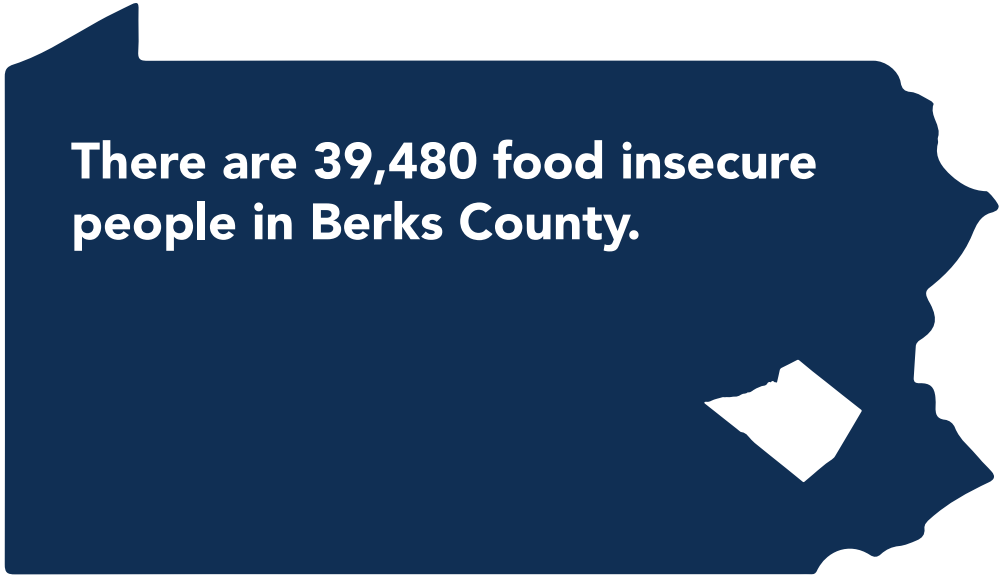
Figure 47 shows adult health risk behaviors, health outcomes, and general health in Berks County and Pennsylvania. Specifically, the graph depicts the obesity/overweight rate of individuals in Berks County exceeding the state rate.

Figure 47: Overall Adult Health Risks



Source: Pennsylvania Department of Health 2017-2019

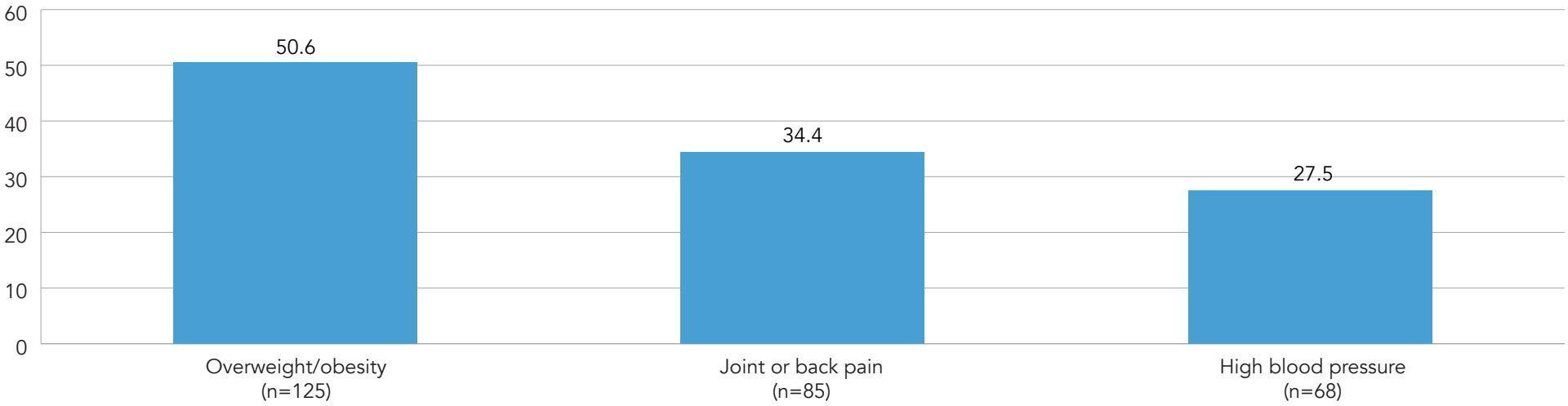
The USDA refers to food insecurity as the lack of access (periodically) to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food insecurity may reflect a household's need to make trade-offs between important basic needs, such as housing or medical bills and purchasing nutritionally adequate foods. Lack of access to healthy foods impacts chronic diseases such as obesity/ overweight, diabetes, and high blood pressure.



Source: Feeding America 2019

Community health respondents in the Reading Hospital service area, when asked about the top challenges faced, reported overweight/obesity, joint or back pain, and high blood pressure.

Figure 48: Top Three Challenges Currently Faced



SM SNAP Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP)[10] reported the following in Berks County:

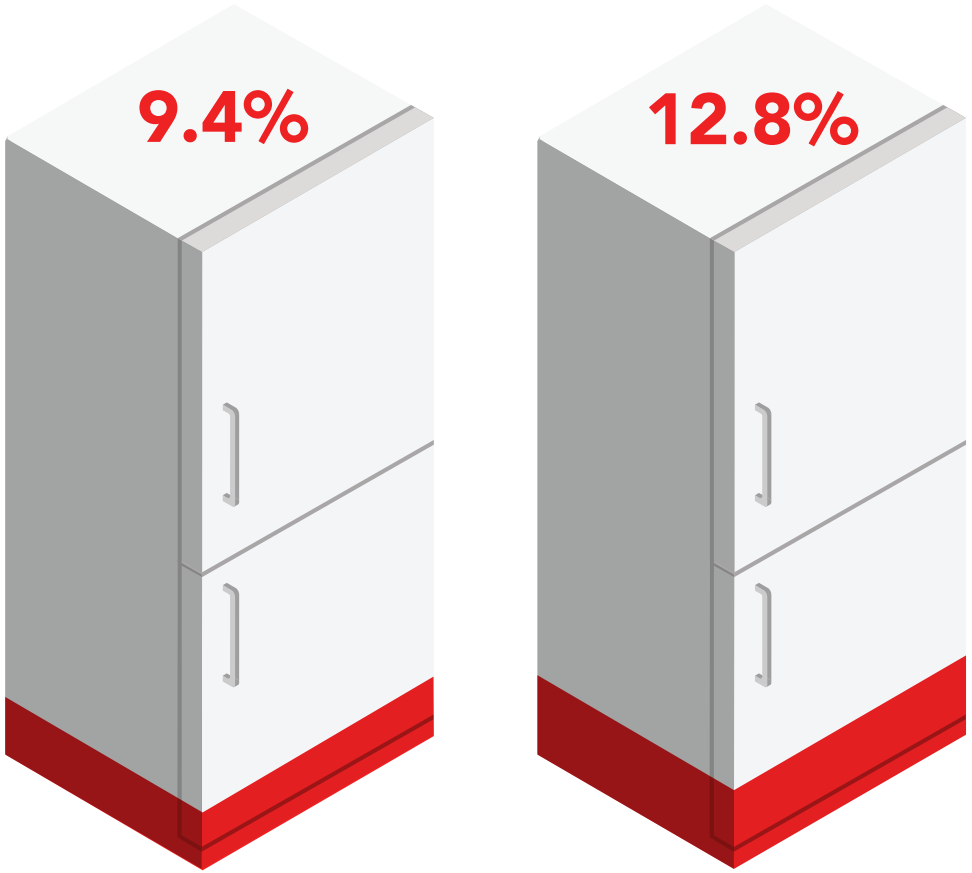
- 59,288 Berks County residents received $7,163,720 in SNAP benefits to help make ends meet in December 2018.
- 66% of those receiving SNAP are children, seniors, and persons with disabilities.
- 97% of benefits are redeemed by the end of the month.
- Low-income SNAP participants spend $1,400, or nearly 25%, less in annual medical costs than low-income adults who don't participate in SNAP
- SNAP boosts wages for workers who do not earn enough to afford a basic diet and is also there to help those who are between jobs while they search for work

[10] SNAP provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move toward self-sufficiency.

COVID-19 AND THE IMPACT ON FOOD INSECURITY

In early 2020, COVID-19 spread across the United States, creating an economic recession. The pandemic has negatively impacted millions of people for the first time who are experiencing food insecurity along with those who experienced food insecurity before the COVID-19 crisis.

Figure 49: Food Insecurity in Berks County



Source: Feeding America 2019

"Helping Harvest Fresh Food Bank distributed **5.4 million pounds** of food valued at **$7.2 million** in Berks County in 2019. In 2020, those numbers rose dramatically to **9.1 million pounds** valued at **$12 million**."

Jay Worrall

President
Helping Harvest

Figure 50 from the community survey shows health behaviors for which people in the community need more information.

Figure 50: Top Health Behaviors for Which People Need More Information

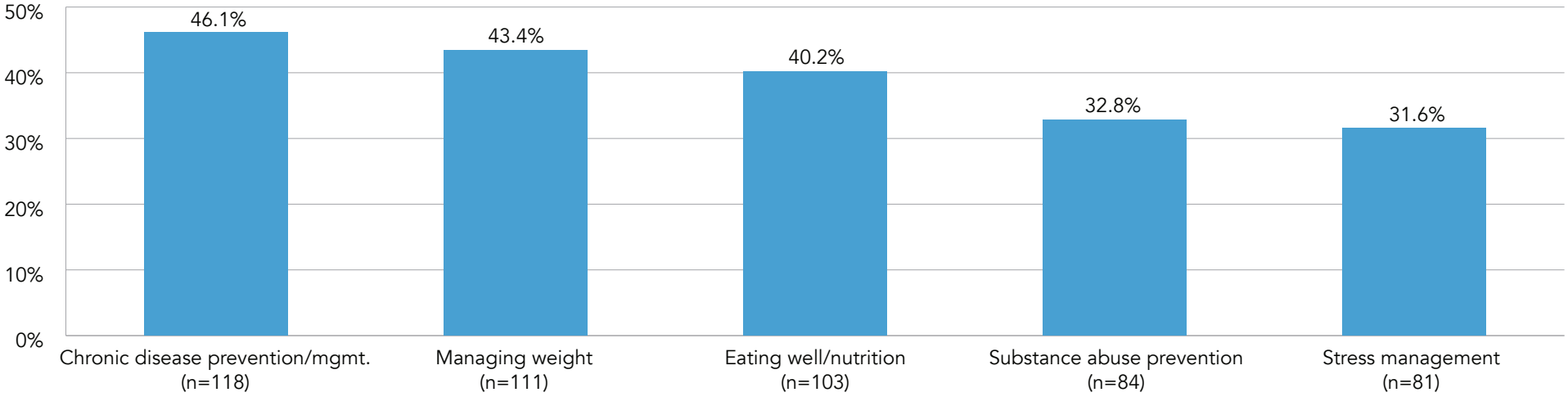
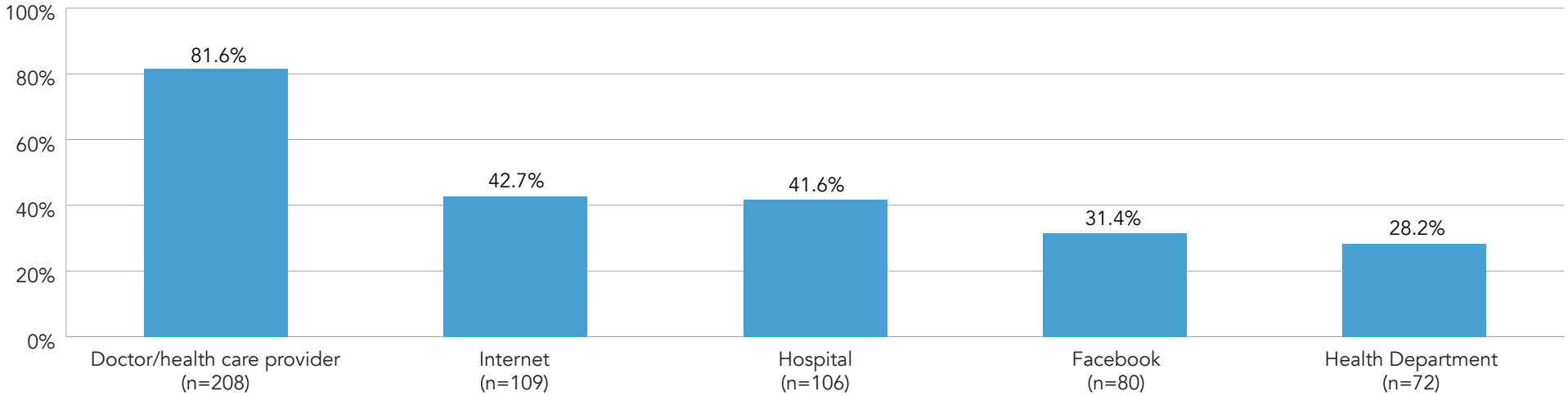


Figure 51 from the community survey reports how the community wants to receive health information.

Figure 51: Top Ways Community Wants to Receive Information



D) HEALTH EQUITY

Understanding and addressing the needs of diverse and disparate populations is a significant challenge for health care organizations. As a critical aspect of improving health equity and decreasing health disparities, there is a continued effort to enhance the provision of culturally competent and linguistically appropriate care to a very diverse service area as defined by racial and ethnic communities with various cultural beliefs and perceptions, health practices, and behaviors as well as a distrust of the health delivery system.

When assessing the diverse and disparate population, many SDOH and barriers to health care access and services were uncovered. Barriers such as a lack of transportation, inadequacy of language and interpretation services, lack of insurance coverage, and cultural bias and discrimination, to name a few, have a very dramatic impact on the capacity to provide quality health care and the quality of life for Reading Hospital communities. Interventions such as CCP that improve health equity and reduce disparities must be systematic as an organization gains greater understanding and appreciation for diverse cultures and enhances the organization's ability to serve all patients effectively and efficiently.

SYSTEM POLICIES

Health equity is impacted by policies and systems that serve as barriers to equitable care. These policies and systems may favor one group over another, negatively impacting health and quality of life.

LANGUAGE/CULTURE

Meeting the needs of diverse populations through culturally and linguistically appropriate care and patient specific services such as language, literacy, accessibility to interpretation services and targeted outreach to disenfranchised populations can provide health equity.

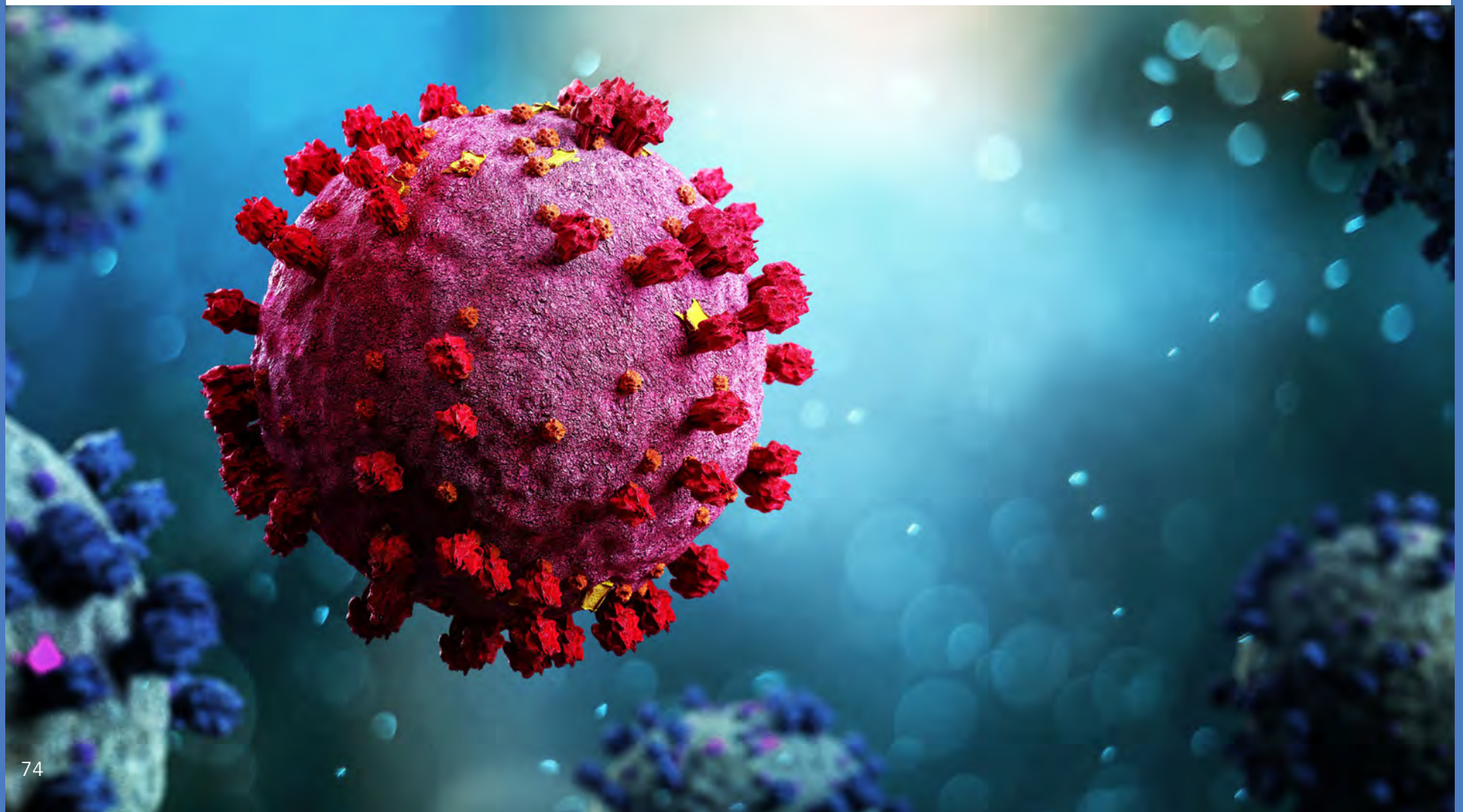
SOCIAL DETERMINANTS OF HEALTH

Health equity demands a multi-sectoral approach to engage and mobilize the broad community to address social, economic, educational and environmental factors that influence health, defined as SDOH.

LESSONS LEARNED FROM COVID-19 AND HEALTH EQUITY

The effects of COVID-19 are far-reaching and long-lasting. The Centers for Diseases Control and Prevention (CDC) reported that essential employees (those in health care, food services, and transportation) were much more likely to die than other workers. Hispanics are nearly two times more likely to contract the disease as whites. Blacks have been hospitalized at three times the rate of whites, and American Indian/Alaska Natives have lost loved ones at more than double the rate of whites.

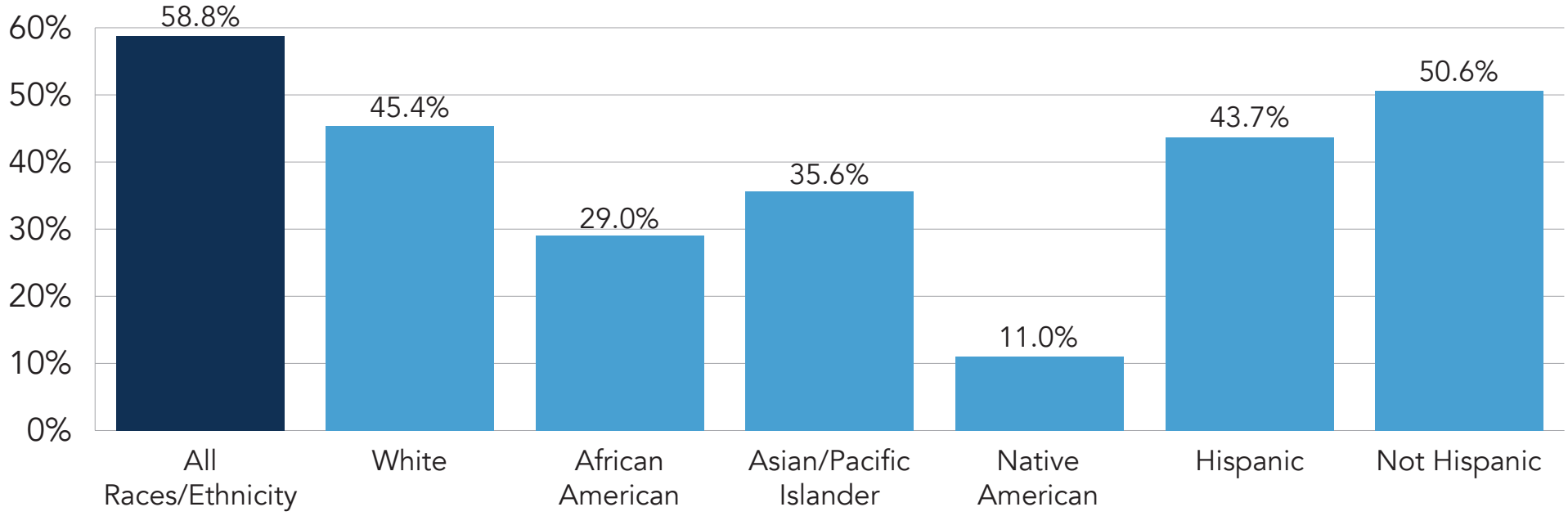
Race and ethnicity are markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC).



The effects of COVID-19 are far-reaching, long-lasting, and certainly have a global impact. In the United States, The Centers for Diseases Control and Prevention (CDC) reported that essential employees (those in health care, food services, and transportation) were much more likely to die than other workers. Hispanics are nearly two times more likely to contract the disease than whites. Blacks have been hospitalized at three times the rate of whites, and American Indian/Alaska Natives have lost loved ones at more than double the rate of whites.

In Pennsylvania, non-Hispanic whites experienced 83.2% of all COVID-19 deaths. However, the impact of looking at the data by age determined multiple, age-specific disparities for Hispanics and non-Hispanic Blacks compared to non-Hispanic whites. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC).

Figure 52: Full Vaccination Coverage for Race/Ethnicity in Berks County



Source: The PA Department of Health

Reviewing data by demographics such as age, gender, race, and ethnicity are markers for other underlying conditions that affect health. Additional factors such as socioeconomic status, access to health care, and exposure to the virus related to occupation are relevant to uncovering the challenges around vaccination access and acceptance, as well as understanding the impact and providing opportunities to develop mitigation solutions.

DRIVERS OF DISEASE INEQUITIES

Unfortunately, the COVID-19 pandemic has further exacerbated existing inequalities, with many people suffering from chronic illnesses and other conditions that increase their risk of severe illness. Underserved communities continue to feel the brunt, and the lack of investment in addressing barriers to healthy and productive lives in marginalized communities leads to many other health and social consequences.

It was reported that independent drivers of disease inequalities and a multi-sectorial approach are needed to reduce the impact of COVID-19 and other health issues among marginalized, disenfranchised, vulnerable, and underserved communities.

DISCRIMINATORY POLICIES

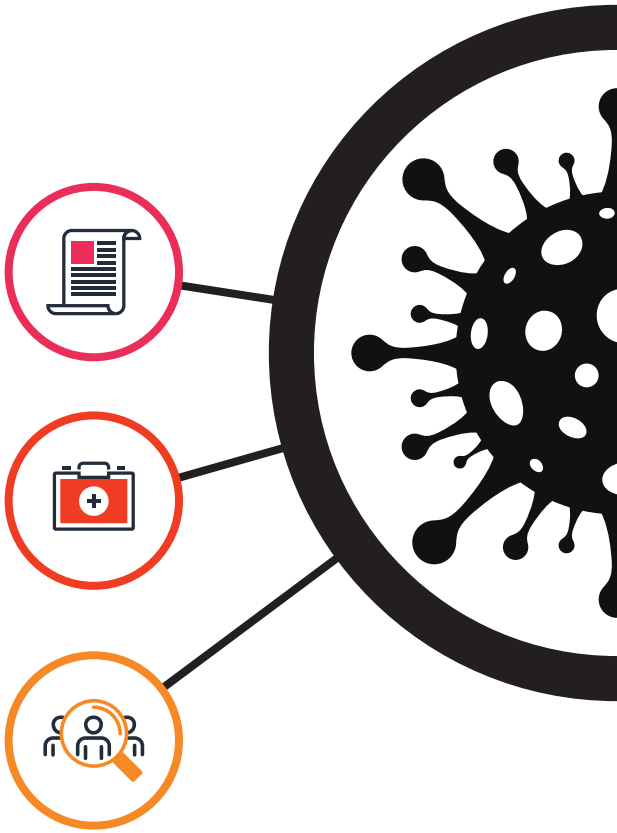
Policies impacting healthcare, education, finance, criminal justice, and other formative systems which should serve to protect communities can lead to stress as well as act as barriers towards proper healthcare.[11]

LIMITED ACCESS TO ESSENTIAL SERVICES AND RESOURCES

Barriers towards health insurance, childcare, sick leave, paid leave, or access to PPE, make some demographics more prone to COVID-19 inequities.[12]

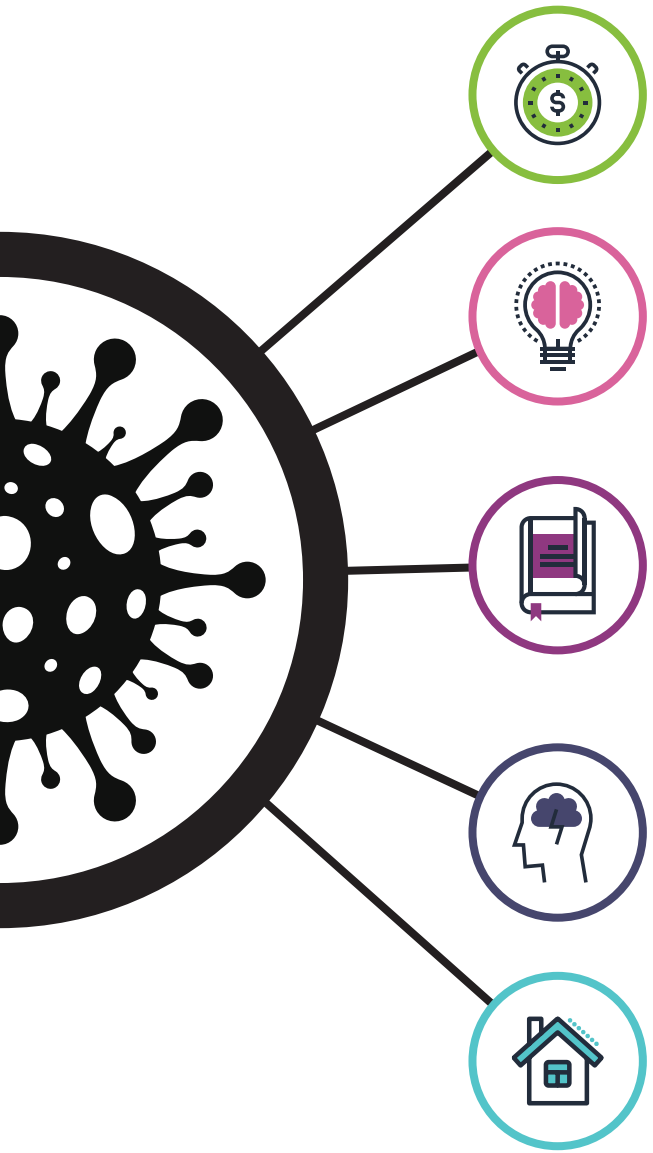
HISTORY OF RACISM & SOCIAL DISCRIMINATION

Systemic racism and other forms of social discrimination have contributed to discriminatory policies, limited investment in community well-being, lack of access to quality healthcare, and a poor sense of trust between communities and health and social systems.[11,13]



[11] CDC, 2020
[12] Pew Research Center, 2020
[13] Health Affairs, 2020
[14] NY Times, 2020
[15] NIMH, 2020
[16] Harvard, 2020
[17] L.C. Cooper and D.C. Crews, 2020
[18] J. Jaiswal, C. LoSchiavo, and D. C. Perlman, 2020
[19] CDC, 2020

Figure 53: COVID-19 is a Health Equity Issue: Key Drivers of Disease Inequities (The Health Equality Initiative)



POVERTY

Living in poverty, health is one of many priorities.[19]

MISTRUST

Insufficient community engagement, combined with misinformation or a lack of consistent information as well as a history of discrimination, causes many marginalized communities to lack trust towards health and social services.[17,18]

LOW HEALTH LITERACY & MISINFORMATION

People from ethnically and racially diverse communities didn't have the opportunity to develop skills to identify credible news sources, which has been shown to correlate with low health statuses.[16]

CHRONIC STRESS

Stress can impact physical health, inducing conditions such as heart disease or high blood pressure, which could lead to COVID-19 complications.[15]

OVERCROWDED LIVING CONDITIONS

Many groups live in overcrowded conditions such as multi-generational homes or nursing homes, prisons, homeless shelters, or other kinds of group "homes." This can make it difficult to social distance and increase the risk for COVID-19. Factors such as unemployment can lead to homelessness, and therefore increased vulnerability to COVID-19.[11,14]

Source: The Health Equality Initiative 2020

WHAT DID WE LEARN FROM THE COMMUNITY?

Capturing the perspectives and insights from the focus groups, stakeholder interviews, key informants, and community survey respondents, "What we heard from the community on equitable care" is portrayed as follows:

Figure 54: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the contributors and barriers to health equity?"

- Lack of awareness of available resources/services
- Where/how to access services
- Inconvenience of services
- Resources available in multi-languages
- Cultural practices

KEY INFORMANT SURVEYS

"What are the Perceived Barriers to Accessing Care and Services?"

- Lack of education on available resources
- Limited services available
- Lack of prevention education

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the perceived barriers to accessing care and services?"

- Cultural barriers
- Language barriers
- Lack of knowledge of available education resources

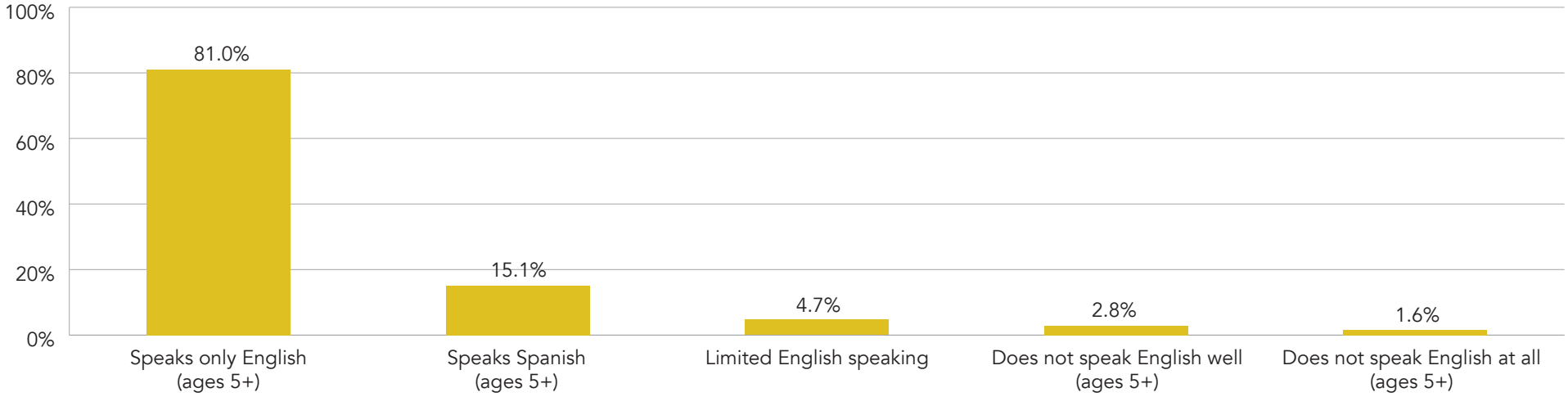
COMMUNITY SURVEYS

"What are the Barriers to Overall Health"

- Unhealthy lifestyles and behaviors
- Poor nutrition and eating behaviors
- Lack of exercise
- Lack of access to healthy foods
- More chronic disease education/information needed

Figure 55 reveals the percentages of residents who speak only English and Spanish and residents who are limited in English speaking.

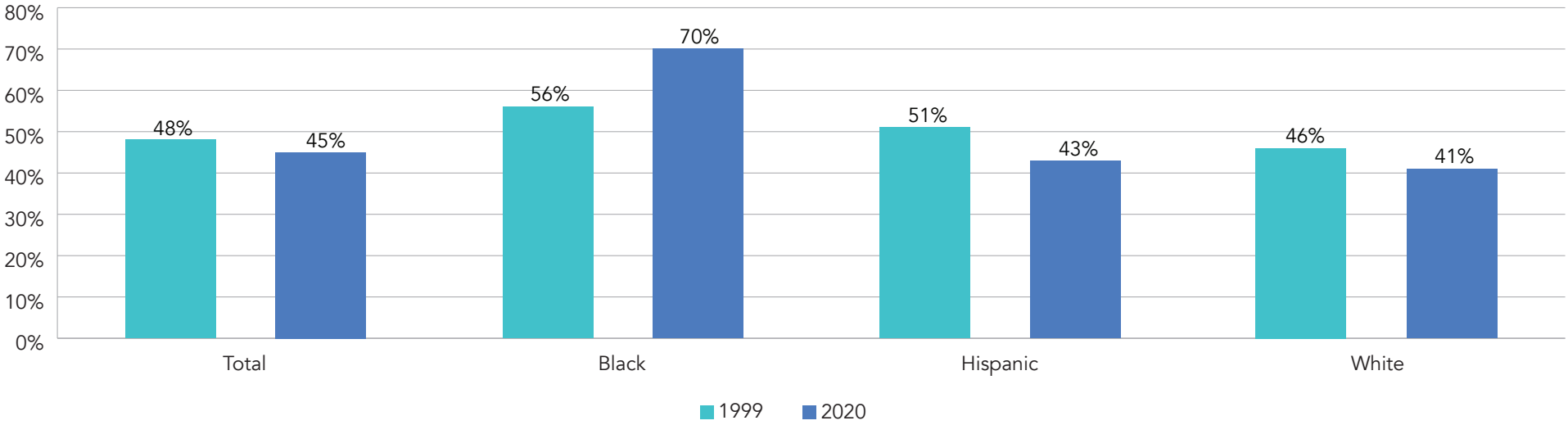
Figure 55: Households with Residents Speaking English Only, Spanish, and Limited English



Source: U.S. Census Bureau, American Community Survey 2018

Figure 56 reveals health care treatment in the years 1999 and 2020. This data highlights disparities in demographics that should be considered when providing health care services. Please click here for additional data related to the study conducted by KFF's The Undefeated Survey on Race and Health 2020.

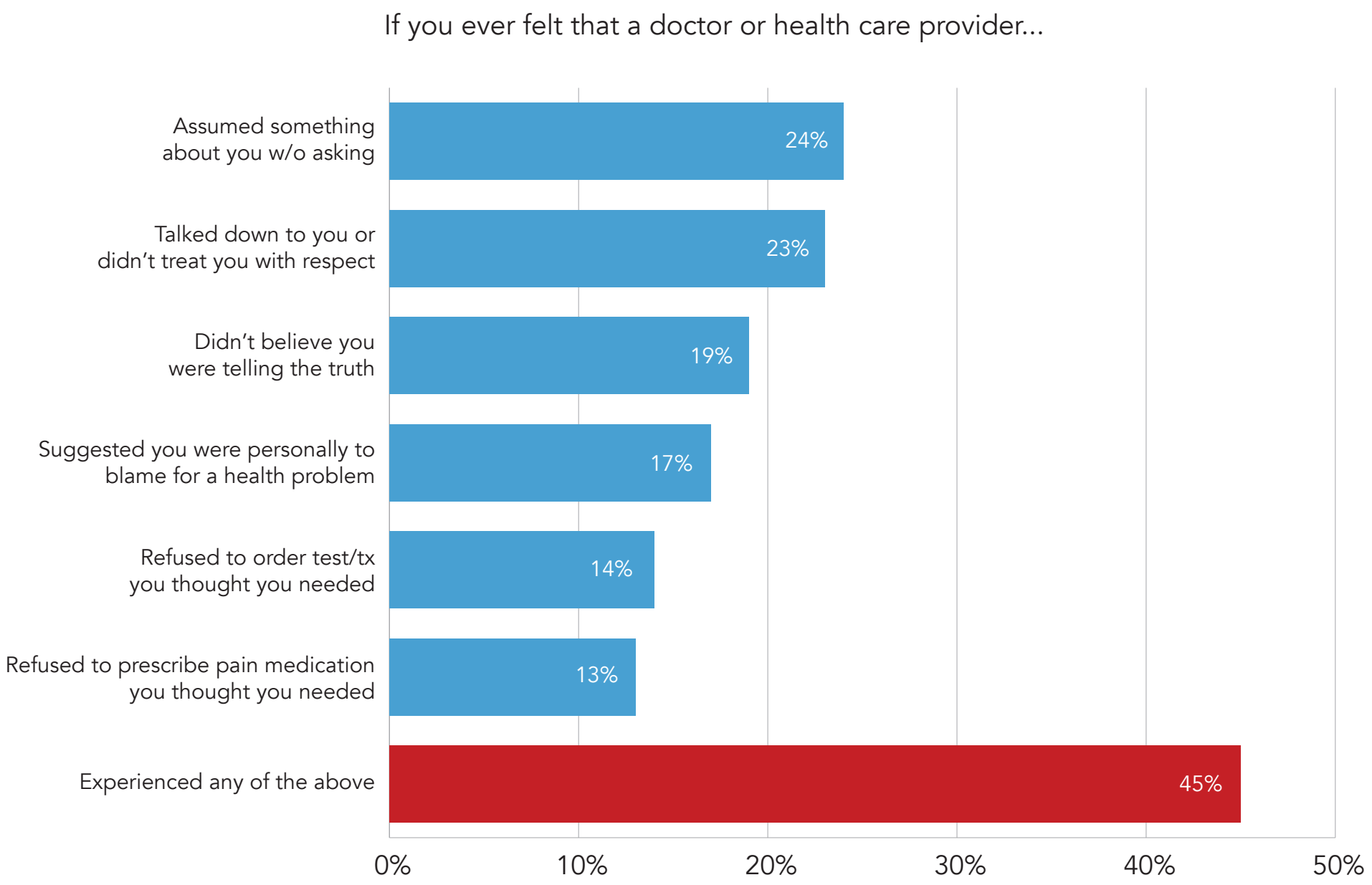
Figure 56: Percentage That Thinks the Health Care System Mistreats People Based on Race/Ethnic Background Very Often or Somewhat Often



Source: KFF/The Undefeated Survey on Race and Health 2020

Figure 57 reports that nearly half of adults reported one of six negative experiences with health care providers in the last three years.

Figure 57: Percentage Reporting Yes to Negative Experiences With a Doctor or Health Care Provider

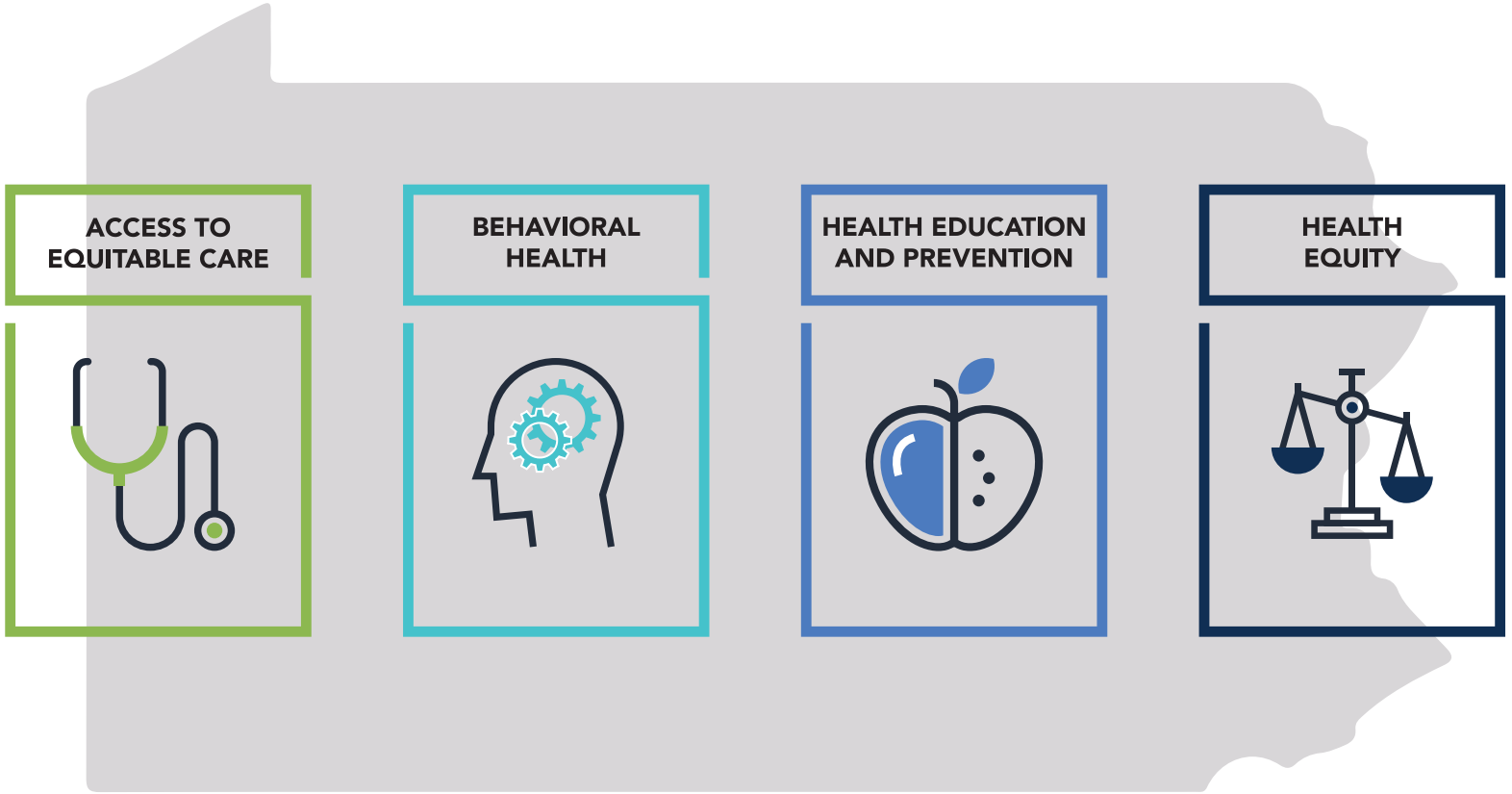


Source: KFF/The Undefeated Survey on Race and Health 2020

CHNA FOCUS AREAS FOR
READING HOSPITAL 2022

In 2021, key need areas were identified during the CHNA process through the gathering of primary and secondary data such as community stakeholder interviews, leadership and health equity focus groups, key informant surveys, a community survey, and a health provider inventory, which highlights organizations and agencies that serve the community.

Equitable care means delivering care that does not differ in quality according to characteristics of the patient or patient group such as age, gender, geographic location, cultural background, ethnicity, religion, and socioeconomic status. With health equity as an ongoing focus, "access to care" transformed to "access to equitable care" and was strongly emphasized through all aspects of primary data collection. The four identified areas of focus were:



CONCLUSION

WHAT'S NEXT … IT'S COMPLICATED

One of the most challenging aspects of providing quality health care is the difficulty that populations and individuals experience in navigating the health care system. Access to equitable health care becomes more complicated and complex based on geographic factors – where people were born, live, work, and play – and economic, cultural, educational, and social factors. The health system may provide a plethora of recognized physicians, best practice services, and special programs, but access is complicated if residents lack transportation and insurance. There is a direct correlation between the ease of accessing health care and the overall health of a community.

Access is complicated for vulnerable populations such as the elderly, unemployed/underemployed, and low-income. Those factors serve as barriers to care and limit their ability to seek care early, often resulting in a health crisis, emergency visit, or hospitalization for illness and conditions that could be prevented. Access is complicated for ethnic patients with language barriers, limited English-speaking skills, and low levels of education. Culturally competent and appropriate care and treatment are essential to improving health and ensuring good outcomes. Just because we built it does not mean they will come.

Improving health equity is a daunting task as it extends well beyond the walls of the health system, reaches deep into the community sectors, and travels toward local and state government where health policies and protocols are developed. There has been increased recognition across the health care environment that improving health and achieving health equity demands a multi-sectoral approach. This approach requires the health system to engage and mobilize the broad community to address social, economic, and environmental factors that influence health. For example, the lack of access and availability of public transportation impacts not only access to health care but affects employment, access to affordable healthy food, and many other important drivers of health and wellness.

As the next step, Reading Hospital will advance efforts to align and integrate the many voices and ideas offered from the community as received through the focus groups, a community survey, community stakeholder interviews, and provider interview processes. Reading Hospital will engage and collaborate with our community partners on the development of the CHNA Implementation Strategy Plan.

CONTACT//

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Phone: 484-628-8000

E-mail: communitywellness@towerhealth.org

www.**towerhealth**.org

Reading Hospital

TOWER HEALTH

Advancing Health. Transforming Lives.

Appendix B: 2021 PennState Health Community Health Needs Assessment

Full CHNA and CHNA Findings presentation on next page

PennState Health

A SIX-COUNTY

Berks | Cumberland | Dauphin | Lancaster | Lebanon | Perry

COMMUNITY HEALTH NEEDS ASSESSMENT

FULL REPORT

Conducted on behalf of:

Penn State Health Milton S. Hershey Medical Center

Penn State Health Holy Spirit Medical Center

Penn State Health St. Joseph Medical Center

Penn State Health Hampden Medical Center

Pennsylvania Psychiatric Institute

Penn State Health Rehabilitation Hospital

2021

Table of Contents

Overview

Introduction – Our Commitment to Community Health

Penn State Health is committed to understanding and addressing the health needs of the communities it serves. In order to best do that, the health system completed its 2021 Community Health Needs Assessment (CHNA).

For this fourth assessment cycle, Penn State Health formed a collective workgroup that included Penn State Health Milton S. Hershey Medical Center, Penn State Health Holy Spirit Medical Center, Penn State Health St. Joseph Medical Center, Penn State Health Hampden Medical Center, Pennsylvania Psychiatric Institute, Penn State Health Rehabilitation Hospital and key community stakeholders to identify and address the needs of residents living in Berks, Cumberland, Dauphin, Lancaster, Lebanon and Perry counties. Because Penn State Health Lancaster Medical Center was under construction during this assessment, this community was also included. The Department of Public Health Sciences at Penn State College of Medicine coordinated the CHNA efforts. By taking a systemwide approach to data collection and community health planning, Penn State Health will leverage system assets across the service area to address prioritized health needs.

The following pages describe the process and methods used in the 2021 CHNA and our findings on the health status of the communities we serve. We thank all of our community partners who joined us in these efforts. Our next step will be to develop our Implementation Plan to foster a collective impact to improve health across the region and reduce health disparities. We look forward to continued partnership to strengthen our community together.

Thank you,

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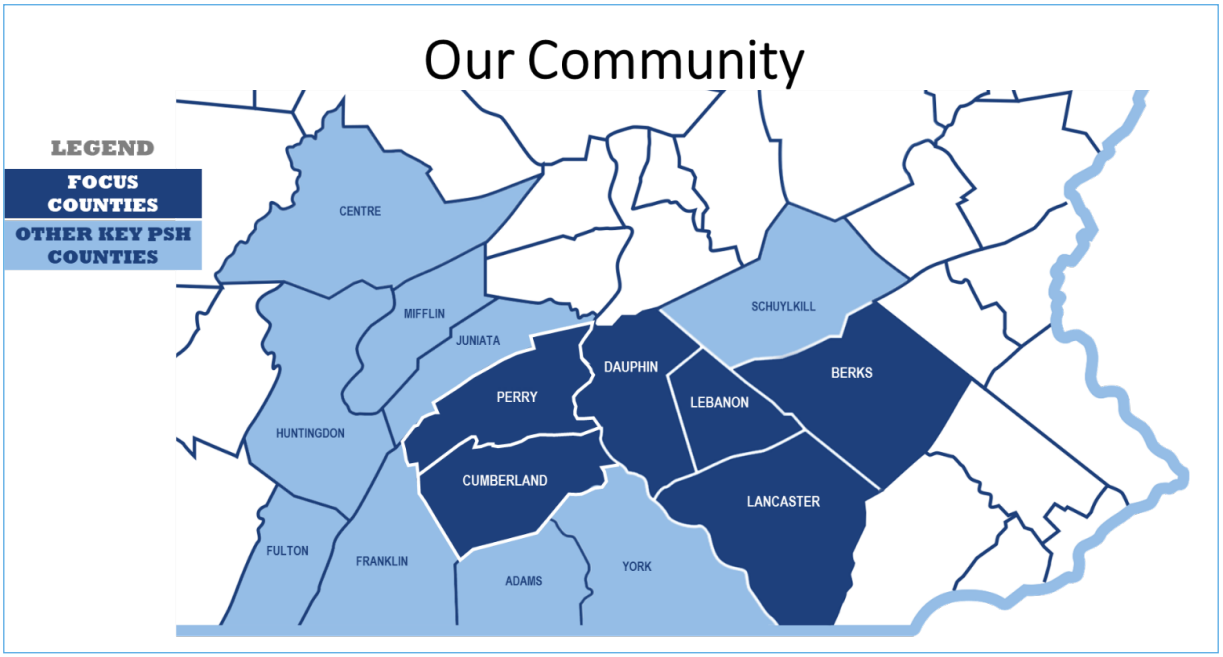
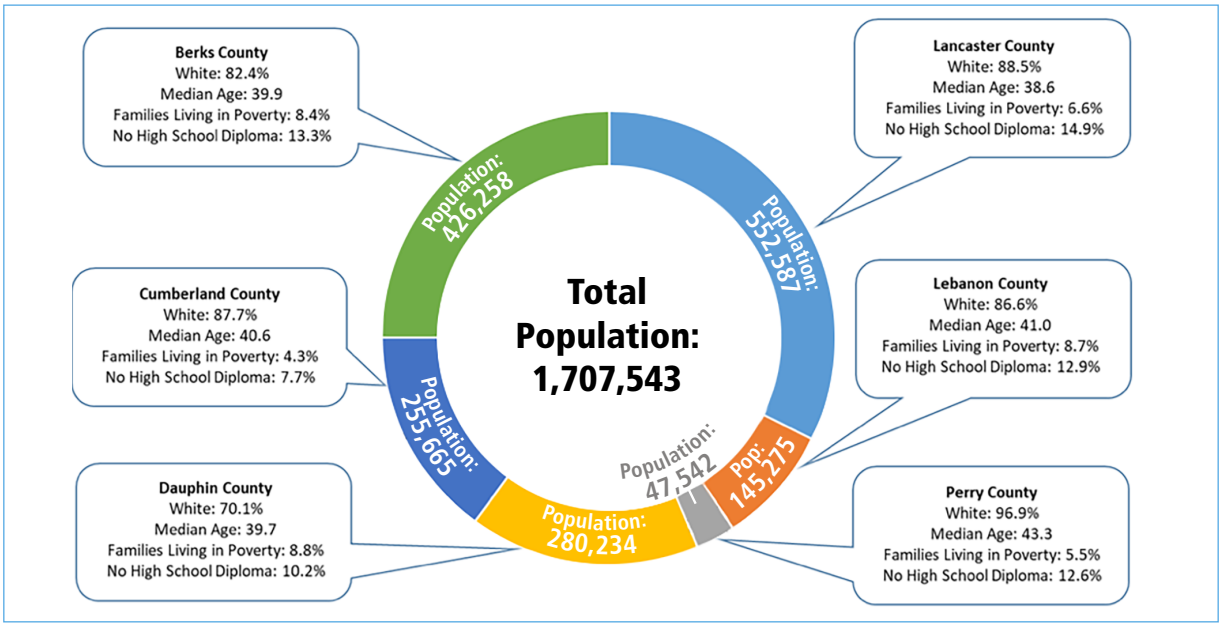
Community Description

The service area defined for purposes of the CHNA encompasses 225 ZIP codes in six Pennsylvania counties: Berks, Cumberland, Dauphin, Lancaster, Lebanon and Perry. These six focus counties represent the community where health care resources are available and provided by the partnering Penn State Health organizations. The counties are also home to the majority of Penn State Health's patient population.





CHNA Process

The 2021 CHNA used both primary and secondary methods to solicit community input and compare health trends and disparities across the six-county service area. The CHNA timeline complied with IRS Tax Code 501(r) requirements to conduct a CHNA every three years, as set forth by the Affordable Care Act.

Specific CHNA steps included:

- *Kickoff meeting to announce the start of the CHNA process and host all internal community-minded staff members. They provided input on community partners to engage based on high-need areas, as defined by Community Need Index (CNI) scores*
- *Monthly leadership meetings, including all hospitals, to review progress and provide feedback*
- *A Key Informant Survey with 317 community leaders and stakeholders representing the broad interests of the community, including experts in public health and individuals representing medically underserved, low-income and minority populations*
- *A Community Member Survey (CMS) completed by 2,778 individuals, with 2,532 responses able to be used based upon county of residence and age*
- *An analysis of existing secondary data sources, including public health statistics, demographic and social measures and health care utilization*
- *Two Partner Forums, with representatives from diverse community-based and public health organizations, to gather insight on community health needs and foster collaboration toward community health improvement – the first forum hosted 112 participants and the second 103 participants*
- *Review of the current CHNA Implementation Plan and available resources*
- *Prioritization of identified community health needs to determine the most pressing issues on which to focus community health improvement efforts*

Appendix B contains a list of community partner organizations that participated in any aspect of the assessment process. Please note this list may not be all-inclusive since participants could remain anonymous.

Prioritized Community Health Needs

Through multiple methods of community engagement, facilitated dialogue with community health experts and a series of criteria-based voting exercises, the most significant issues to focus systemwide health improvement efforts over the three-year cycle from July 1, 2022, to June 30, 2025, are **1) Mental Health 2) Health Equity** and **3) Wellness and Disease Prevention.**

Mental Health includes a focus on community groups, such as the LGBTQ+ community, people of color and youth. Substance use disorder will also be addressed under this priority. Health Equity covers concerns that include access to care, elder issues with access, social determinants of health, racism, diversity, transportation and housing. Wellness and Disease Prevention encompasses food access and nutrition, substance use prevention, chronic disease prevention, health education and physical activity. Everyone agreed that these priorities, and focus areas within, represent all six ranked health concerns, that all of these areas are very interrelated and one cannot be addressed without the other.

Additional Information and Feedback

For additional information about the CHNA and opportunities for collaboration, please contact us at CHNA@pennstatehealth.psu.edu.

To provide feedback on this CHNA at any time, please link or scan:
Link: redcap.link/34eua53p

Scan:

CHNA Summary of Findings Per Priority

Partnering hospitals will focus systemwide health improvement efforts over the next three-year cycle on the identified priority areas of 1) Mental Health 2) Health Equity and 3) Wellness and Disease Prevention. The following section summarizes key CHNA findings, community health needs and comments related to the priority areas.

Priority 1 – Mental Health

Within the six-county service area, the average number of mentally and physically unhealthy days reported in the past 30 days has continued to increase, with more mentally unhealthy days being reported than physically unhealthy days (CHR, 2021). **Fifty-seven percent** of adult community member survey respondents had at least one poor mental health day in the past month (up from 54% in the 2018 survey), and **1 in 10** respondents reported 15 or more days of poor mental health.

Among the LGBTQ+ population, **63%** said depression was a top three health concern (LGBTQ Health Needs Assessment, 2020). **Eighteen percent** of community member survey respondents needed and received mental health services, while **1 in 11** respondents needed, but did not receive, mental health services. Furthermore, **40%** of children in the service area reported feeling sad or depressed most days in the past year, and **1 in 6** reported considering suicide one or more times in the past year (PAYS, 2019).

One community member commented, *"I think that our largest community health issue, which is of epidemic proportions, is childhood trauma/adverse childhood experiences."*

Priority 2 – Health Equity

While **8%** of community member respondents were unemployed, **11%** of Black/African American respondents were unemployed, compared to only **3%** of white/Caucasian respondents. **Twenty-seven percent** of households in the service area earn above the poverty level but below the cost of living (United Way, 2018). One community member stated, *"Many of the supports offered regarding food or health care are aimed at those who are eligible for free government programs, but there are many of us who are in the 'working poor' category who qualify for nothing."*

For respondents who were uninsured, **almost half** indicated that they cannot afford insurance, while **one-quarter** indicated they are ineligible for employer-paid insurance. Hispanic/Latino individuals and Black/African American individuals were more likely to report being uninsured compared to white individuals. Even though many individuals do have health insurance, **1 in 11** still did not receive care in the past year due to cost. One key informant mentioned, *"Most people are forced to travel outside of an hour to get to doctors who accept Medicaid or Medicare."* However, many individuals don't seek care at all due to a lack of transportation.

Fifty-four percent of Key Informant Survey respondents indicated that residents may not have transportation to medical appointments. In particular, **1 in 15** community respondents indicated that they or their family needed transportation services but were not able to access them.

Priority 3 – Wellness and Disease Prevention

Unfortunately, **44%** of CMS respondents reported being told they're overweight or obese (up from 41% in 2018), and **1 in 5** children in grades 7-12 were found to be obese during the 2017-2018 school year (School Health Statistics, 2017-18). Two large contributors to obesity include lack of exercise and poor diet. Access to exercise opportunities has been decreasing among all counties in the service area, and approximately **1 in 5** community member respondents reported no days of physical activity in the past month.

While **98%** of respondents said they're able to have fresh/healthy foods when they want them, **1 in 8** respondents reported being worried about running out of food before having money to buy more, and **1 in 14** children reported having skipped a meal due to family finances (PAYS, 2019). Poor eating habits, lack of exercise and obesity can result in many negative health outcomes. **Forty-two percent** of CMS respondents reported having been told they have high blood pressure and **39%** had high cholesterol. Overall, **16%** of respondents had diabetes; however, **22%** of Hispanic/Latino respondents had diabetes compared to **16%** of non-Hispanics/Latinos.

Further exacerbating these negative health outcomes, about **1 in 7** respondents age 50 or older had never received a colonoscopy, and approximately **1 in 15** women respondents aged 40+ had not received a mammogram. Unfortunately, there are more cases of melanoma within our service area compared to Pennsylvania overall and, as one community member stated, *"Dermatologist appointments are not available in a reasonable time frame or at all."*

Board Approvals

The 2021 CHNA final report was reviewed and approved by the hospitals' boards of directors and made available to the public via each hospital's website:

Penn State Health Milton S. Hershey Medical Center
Penn State Health Holy Spirit Medical Center
Penn State Health St. Joseph Medical Center
Penn State Health Hampden Medical Center
pennstatehealth.org/community

Pennsylvania Psychiatric Institute
ppimhs.org/about-us/community-programs

Penn State Health Rehabilitation Hospital
psh-rehab.com/patients-and-caregivers/admissions/community-health-needs-assessment/

Key Informant Survey

Background

A Key Informant Survey was conducted electronically to solicit information about community health needs. A total of 317 individuals responded to the survey, including health and social service providers; community and statewide public health experts; civic, religious and social leaders; community planners, policymakers and elected officials; and others representing diverse populations, including minority, low-income, LGBTQ+ and other underserved or vulnerable populations.

The survey was available in English and Spanish and included a disability and language accommodation statement. It was open for a longer period of time compared to past CHNA cycles, from November 2020 to March 2021, due to the COVID-19 pandemic. QR codes and links to the survey were shared multiple times via email, as well as at virtual meetings and professional education sessions.

Survey Participants

Key informants were asked a series of questions about their perceptions of community health, including health drivers, barriers to care, community infrastructure and recommendations for community health improvement. Respondents represented excellent geographic balance across the six county area, as follows: Berks County (124, 39.1%), Cumberland County (123, 38.8%), Dauphin County (167, 52.7%), Lancaster County (97, 30.6%), Lebanon County (97, 30.6%), Perry County (100, 31.6%) and Other (67, 21.1%). Respondents were able to select multiple counties, so percentages do not add up to 100%.

Populations Served

About 40% of respondents provided services to all residents. Of those organizations that focused primarily on a special population, most served low-income/poor (35%), families (27%) or children/youth (27%). “Other” populations served, as indicated by 5% of respondents, included Arabic, Nepalese, veterans, pregnant women, single parents, college students and individuals affected by specific issues, including HIV/AIDS, mental health, intellectual disabilities, epilepsy or substance use.

Populations Served by Key Informants

	Percentage of Informants*	Number of Informants
Not Applicable (Serve All Populations)	39.8%	126
Low-Income/Poor	35.3%	112
Families	27.4%	87
Children/Youth	27.1%	86
Seniors/Elderly	25.9%	82
Hispanic/Latino	23.3%	74
Uninsured/Underinsured	22.4%	71
Black/African American	21.5%	68
Women	21.1%	67
Disabled	20.8%	66
LGBTQ+ Community	20.2%	64
Homeless	20.2%	64
Men	15.8%	50
Immigrant/Refugee	13.3%	42
Asian/Pacific Islander	7.9%	25
Migrant Workers/Families	6.6%	21
American Indian/Alaska Native	6.6%	21
Other**	5.1%	16

*Key informants were able to select multiple populations. Percentages do not add up to 100%.

Health Perceptions

Choosing from a list of 24 specified health issues, respondents were asked to select the top three health conditions impacting the populations they serve. An option for "other" was also provided. The respondents were then asked a second question to similarly select what they saw as the top three contributing factors to those health conditions. The top 10 responses (percentage and count) for each question are depicted in the tables that follow.

Top 10 Health Conditions Affecting Residents

Ranking	Condition	Informants Selecting as a Top 3 Health Concern	
		Percent	Count
1	Mental Health Conditions	61.8%	196
2	Substance Use Disorder	43.9%	139
3	Overweight/Obesity	30.9%	98
4	Diabetes	26.5%	84
5	Heart Disease and Stroke	19.6%	62
6	Infectious Disease	16.7%	53
7	Disability	12.9%	41
8	Cancers	11.4%	36
9	Domestic Violence	9.5%	30
10	Alzheimer's Disease/Dementia	7.3%	23

Approximately two-thirds of respondents (61.8%) saw mental health conditions as a top three health concern in the community; 43.9% of respondents selected substance use disorder as a top three health concern; and 30.9% of respondents selected overweight/obesity.

Key informants' responses were more divided on their perceptions of factors that most contributed to the health conditions they chose in the previous question. This variation in perception suggests less consensus among respondents about what factors most contribute to community health conditions.

Nearly 30% of respondents considered poverty as a top three contributing factor to health conditions, followed by ability to afford health care (28.7%) and drug/alcohol use (27.1%).

Top 10 Contributing Factors to Health Conditions Affecting Residents

Ranking	Contributing Factor	Informants Selecting as a Top 3 Contributor	
		Percent	Count
1	Poverty	30.0%	95
2	Ability to Afford Health Care	28.7%	91
3	Drug/Alcohol Use	27.1%	86
4	Health Habits	26.8%	85
5	Inadequate or No Health Insurance	17.7%	56
6	Stress	16.7%	53
7	Food Insecurity	15.1%	48
8	Availability of Health and Wellness Programs	13.9%	44
9	Health Literacy	12.6%	40
10	Availability of Healthy Food Options	12.3%	39

To expand upon their quantitative responses, respondents were asked to provide comments about their selections. Comments are included below.

Health Perceptions – Comments by Key Informants

Ability to Afford Health Care/Poverty

- *"Even with insurance, health care is often still unaffordable due to copays, deductibles, etc."*
- *"We have an inaccessible, unaffordable and complex health care system that is difficult to navigate."*

Health Habits & Overweight/Obesity

- *"Go where the people live, work and play/relax – get close to all residents; offer programs on dangers/benefits of being overweight, eating well and exercise; ensure such programs are in schools."*

Mental Health/Substance Abuse

- *"For mental health and Substance Use Disorder, there are services available, but not always enough. Barriers include type of insurance and not having the right insurance."*
- *"Improve competency working with marginalized populations; increase communication between medical, mental health and social support services."*

Health Care Access

Key informants were asked to rate their agreement with statements pertaining to health of the community and access to care using a scale of (1) "strongly disagree" to (4) "strongly agree."

Approximately 51% of informants "somewhat disagreed" or "strongly disagreed" that their community is healthy. Access to adequate and timely health services is a key contributor to the health of a community. Yet, primary care services were not considered to be widely available across the community. Approximately 42% of respondents "somewhat disagreed" or "strongly disagreed" that residents have a regular primary care doctor that they go to for care. Approximately 54% of informants indicated that there is a sufficient number of providers who accept Medicaid/Medical Assistance. Although, approximately 54% of informants "somewhat disagreed" or "strongly disagreed" that residents have access to transportation to services.

Perceptions were divided on cultural sensitivities and competencies among providers. Cultural sensitivity received the highest mean score (2.76), while sufficient number of bilingual providers received the lowest mean score (2.00).

2021

Resident Health Care Access

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
I would describe my community as healthy.	11.1%	40.0%	43.2%	5.7%
Residents have a regular primary care provider/doctor/ practitioner that they go to for health care.	5.2%	36.8%	47.7%	10.3%
Residents have available transportation (public, personal or other service) for medical appointments and other services.	19.1%	35.0%	37.9%	8.0%
Providers in the community are culturally sensitive to race, ethnicity, cultural preferences, etc., of patients.	6.1%	26.6%	52.2%	15.1%
There is a sufficient number of providers that accept Medicaid/Medical Assistance in the community.	17.6%	28.7%	39.4%	14.3%
There is a sufficient number of bilingual providers in the community.	32.8%	40.2%	21.2%	5.8%

Key informants were asked to rate their agreement to statements pertaining to the availability and accessibility of primary and specialty care providers using scale of (1) "strongly disagree" to (4) "strongly agree."

Mental health and substance abuse services were identified by informants as the least available and accessible resources to residents. Around 70% of informants "somewhat disagreed" or "strongly disagreed" that residents receive mental health care when they need it and that there is a sufficient number of providers in the community. More than 60% of informants "somewhat disagreed" or "strongly disagreed" that residents receive substance abuse care when they need it and that there is a sufficient number of providers in the community.

Health Care Provider Availability

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
Primary Care				
Residents can receive care when they need it.	4.5%	31.7%	48.5%	15.2%
There is a sufficient number of providers in the community.	7.6%	21.6%	50.8%	20.0%
Vision Care Services				
Residents can receive care when they need it.	16.5%	35.5%	37.2%	10.9%
There is a sufficient number of providers in the community.	14.7%	21.7%	46.3%	17.3%
Specialty Care Services				
Residents can receive care when they need it.	9.5%	32.9%	43.7%	14.0%
There is a sufficient number of providers in the community.	12.8%	29.7%	40.9%	16.7%
Dental Care Services				
Residents can receive care when they need it.	25.0%	32.8%	32.1%	10.1%
There is a sufficient number of providers in the community.	19.5%	25.0%	38.3%	17.2%
Substance Abuse Services				
Residents can receive care when they need it.	21.8%	38.6%	31.4%	8.3%
There is a sufficient number of providers in the community.	25.0%	37.7%	29.0%	8.3%
Mental Health Care Services				
Residents can receive care when they need it.	30.5%	37.0%	25.3%	7.1%
There is a sufficient number of providers in the community.	33.2%	36.5%	21.9%	8.4%

Inability to afford care, challenges of navigating the health care system, lack of transportation, feeling healthy and lack of awareness/emphasis on preventive health were most chosen within respondents' top three selections as why residents who have health insurance do not receive regular care.

Primary Reason Individuals With Health Insurance Do Not Receive Regular Care

Ranking	Reason	Informants Selecting as a Top 3 Reason	
		Percent	Count
1	Unable to afford care (copays, deductibles, prescriptions, etc.)	48.9%	155
2	Challenges of navigating the health care system	48.0%	152
3	Lack of transportation to access health care services	35.3%	112
4	Feel healthy ("Don't need to go to the doctor.")	34.4%	109
5	Awareness/emphasis of preventive health measures	30.9%	98
6	Fear of diagnosis, treatment	24.0%	76
7	Providers not accepting insurance/new patients	18.0%	57
8	Limited office hours of providers (no weeknight/weekend office hours)	14.8%	47
9	Lack of providers available in the community	13.9%	44
10	Providers do not speak their language	7.6%	24
11	Personal beliefs or community biases related to religion, spirituality, culture, gender/sexual orientation, etc.	7.3%	23
12	Other*	3.2%	10

*Other responses include insurance policy limitations, poor treatment in the past, a negative perspective of care and a lack of personal motivation.

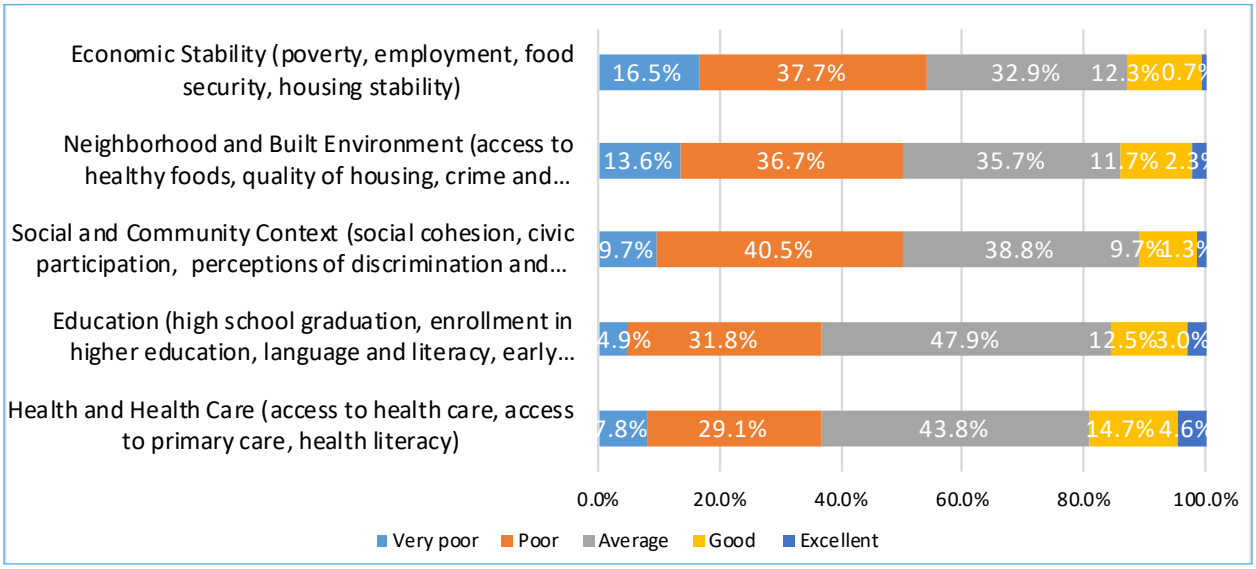
Social Determinants of Health

Healthy People 2030 defines social determinants of health as conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, function and quality of life outcomes and risks. Based on comments made throughout the survey, key informants recognized the impact that social determinants had upon residents' health. A section within the survey asked respondents to rate social determinants of health across five different dimensions: economic stability; education; health and health care; neighborhood and built environment; and social and community context, using a scale of (1) "very poor" to (5) "excellent."

The mean scores for each dimension are listed in the table below in rank order, followed by a table showing the scoring frequency. Mean scores fell between 2.79 to 2.43, with most respondents rating the listed social determinants as "poor" or "average."

Ranking	Social Determinant of Health	Mean Score
1	Health and Health Care	2.79
2	Education	2.77
3	Social and Community Context	2.52
4	Neighborhood and Built Environment	2.52
5	Economic Stability	2.43

Social Determinants of Health Impacting the Community



Impact of Social Determinants on Health

Key informants acknowledged the impact of social determinants—particularly poverty—as key underlying factors of health issues within the community. Key informants' specific comments related to poverty and health impact are included below.

- *"Social determinants of health are a main driver for mental health and physical health."*
- *"I feel that food insecurity and poverty lead to a lot of the other factors listed. Poverty causes health disparities and issues obtaining healthy foods that lead to unhealthy eating habits."*
- *"Affordable, safe housing is the number one social determinant for a healthy life."*
- *"Education, social support, unemployment, poverty, health literacy, availability of healthy and affordable food and other factors certainly have an impact on health concerns."*
- *"A collaborative approach with community organizations, especially for underserved, low-income families (food pantries, cultural groups), and community context can be improved by more positive perception on discrimination and equity."*
- *"Build language accessibility; maybe consider mobile service options; effectively screen for trauma, domestic violence and social determinants of health in patient-care settings."*

Community Resources

Key informants were asked what resources are missing in the community that would help residents optimize their health. Respondents could choose as many options as they thought applied. Approximately 60% of informants chose mental health services as a missing resource within the community, and just over half included transportation. Just under 40% checked health and wellness programs, followed by multicultural or bilingual health care providers, housing and substance abuse services.

Missing Resources Within the Community to Optimize Health

Ranking	Resource	Percentage of Informants	Number of Informants
1	Mental Health Services	59.9%	190
2	Transportation Options	51.4%	163
3	Health and Wellness Education and Programs	39.8%	126
4	Multicultural or Bilingual Health Care Providers	36.9%	117
5	Housing	34.7%	110
6	Substance Abuse Services	34.7%	110
7	Dental Care	30.9%	98
8	Healthy Food Options	30.6%	97
9	Child Care Providers	30.0%	95
10	Community Clinics/Federally Qualified Health Centers	28.1%	89

Community Member Survey

Background

A Community Member Survey was conducted with residents across the six-county community to gather insights into health status, risk behaviors, barriers to accessing health services and the health and social needs of vulnerable community members. The survey was conducted with adults age 18 or over and included low-income, underserved or minority populations.

Due to the COVID-19 pandemic limiting in-person opportunities, the survey was conducted over a longer period, from September 2020 to April 2021, than past CHNA cycles. Electronic and paper versions of the survey were available in English and Spanish, and they included a disability and language accommodation statement. Paper surveys were collected at 29 community partner physical locations, primarily focused on underserved communities. Advertising cards, including QR codes and links, were shared at community events where in-person surveying could not be accommodated due to COVID-19. Paper and virtual advertising materials were shared extensively by our community partners via their virtual events and educational sessions, with support groups, in community and professional newsletters, with former patient/client email lists, via press release cycles, from September 2020 to April 2021, and through social media articles.

The survey was not intended to be a representative sample of the greater community, but rather provide general insights into respondents' perceptions and health status. The survey data were analyzed by county and race/ethnicity. (Note: Racial/ethnic data was not analyzed for groups with fewer than 10 respondents.)

Demographics

A total of 2,778 individuals completed the survey across the six-county service area, and 2,532 responses were able to be used based upon county of residence and age. The largest percentages of respondents resided in Dauphin County (43%) and Berks County (19%), which are the home counties of the Milton S. Hershey Medical Center, Penn State Health St. Joseph Medical Center, Pennsylvania Psychiatric Institute and Penn State Health Rehabilitation Hospital. The largest percentages of respondents were female (67.5%) and white (87.4%). Nine percent of respondents identified as Hispanic or Latino and 5% of respondents identified as Black or African American.

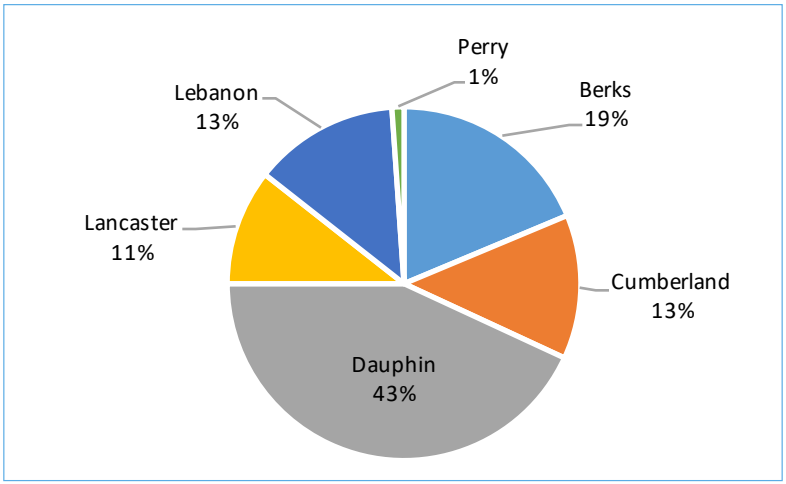
The most represented age groups were 65 to 74 (23.4%) and 55 to 64 (22.6%). Approximately 19% of respondents reported a household income of $34,999 or less. About 2.8% did not complete high school, while 15.6% graduated high school or earned a GED. Seventy-seven percent of respondents have some college experience, including earning an associate, bachelor's or master's degree. About half of the respondents were employed, while the other half was not working due to being retired (32.7%), unemployed (4.4%), unable to work (4.1%) or for other reasons. Demographic data for all survey respondents is shown in the charts that follow.

2021

NOTE: Data from the 2021 survey questions are included in some of the following charts, but should not be used for comparison given the use of convenience sampling, rather than generalizable samples.

2021 Community Survey Respondents

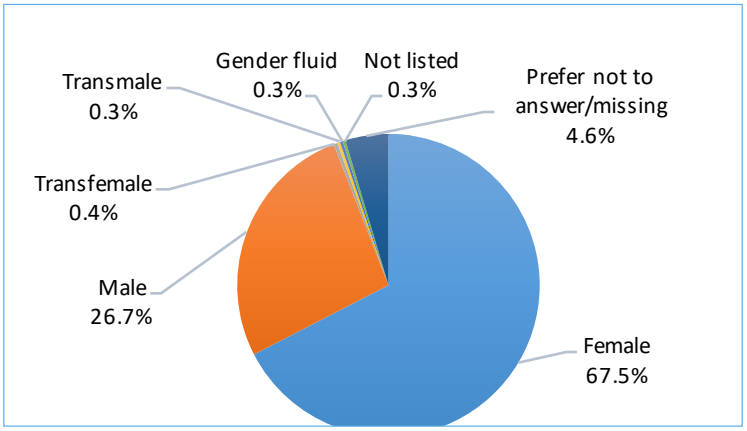
County of Residence



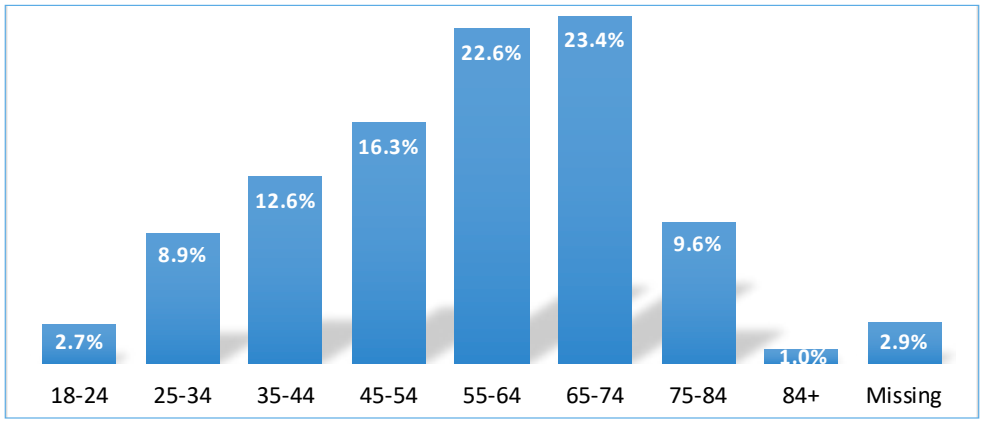
2021 Top Three ZIP Codes of Respondent Residence, by County

Berks	Cumberland	Dauphin	Lancaster	Lebanon	Perry
19601 Reading (10.7%)	17050 Mechanicsburg (23.1%)	17036 Hummelstown (28.5%)	17022 Elizabethtown (22.4%)	17078 Palmyra (34.4%)	17053 Marysville (20.8%) 17068 New Bloomfield (20.8%)
19606 Reading (9.4%)	17055 Mechanicsburg (20.3%)	17033 Hershey (25.5%)	17603 Lancaster (14.8%)	17042 Lebanon (27.8%)	17020 Duncannon (12.5%) 17074 Newport (12.5%)
19604 Reading (8.1%)	17011 Camp Hill (17.5%)	17112 Harrisburg (7.7%)	17602 Lancaster (11.2%)	17046 Lebanon (13.6%)	17090 Shermans Dale (8.3%)

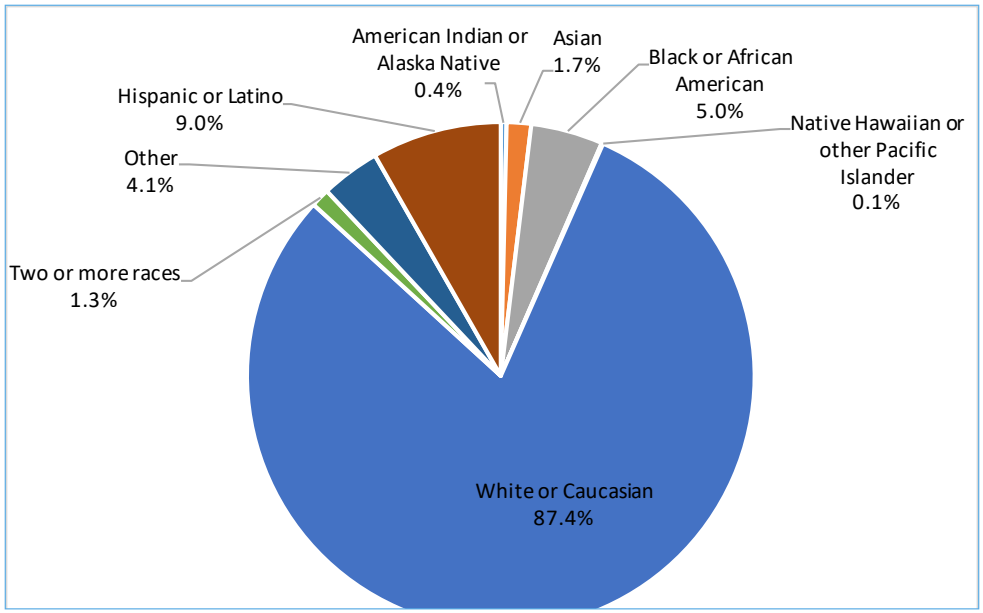
Gender of Respondents



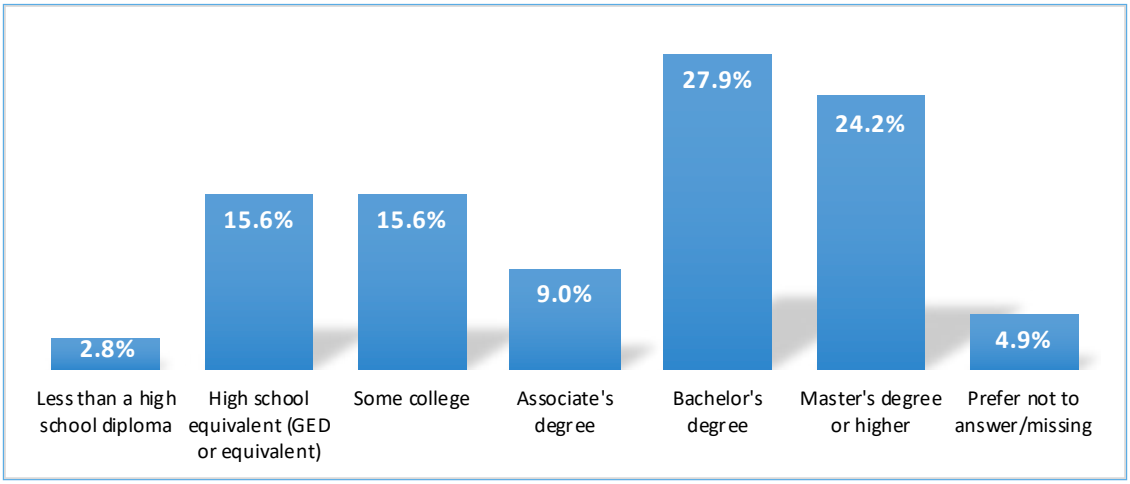
Age of Respondents



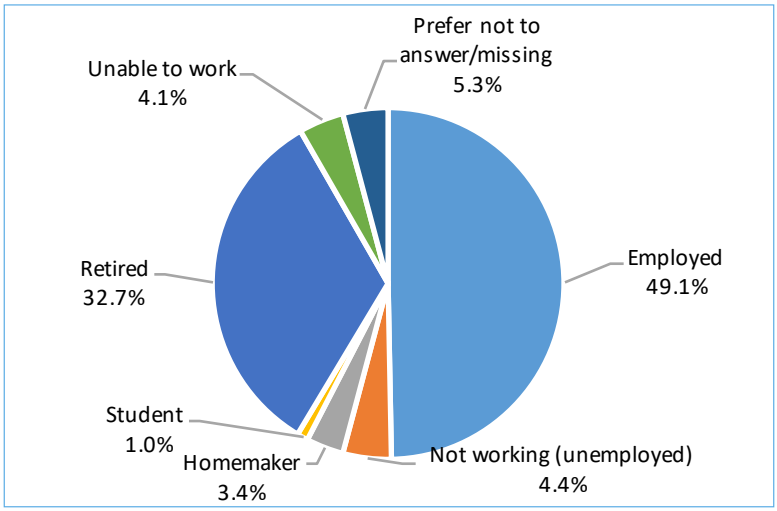
Race and Ethnicity of Respondents



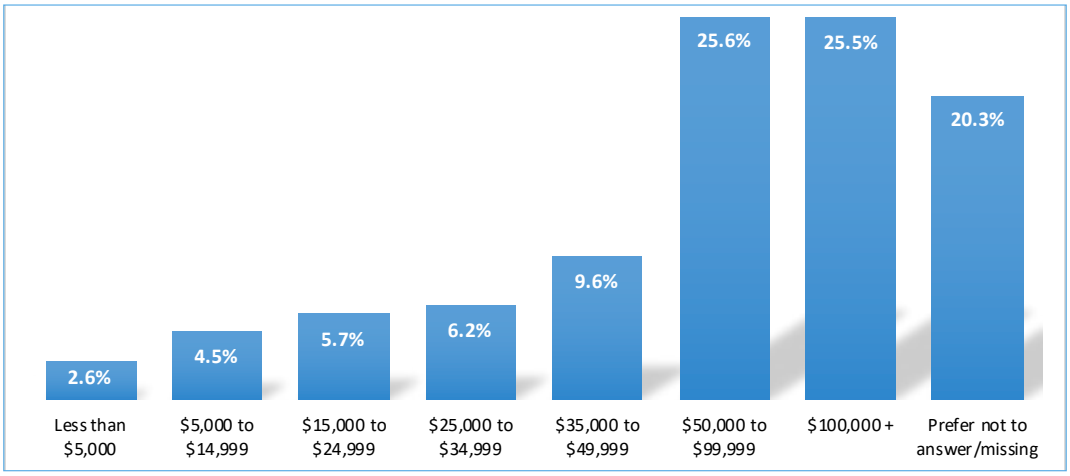
Education Level of Respondents



Employment Status of Respondents



Annual Household Income



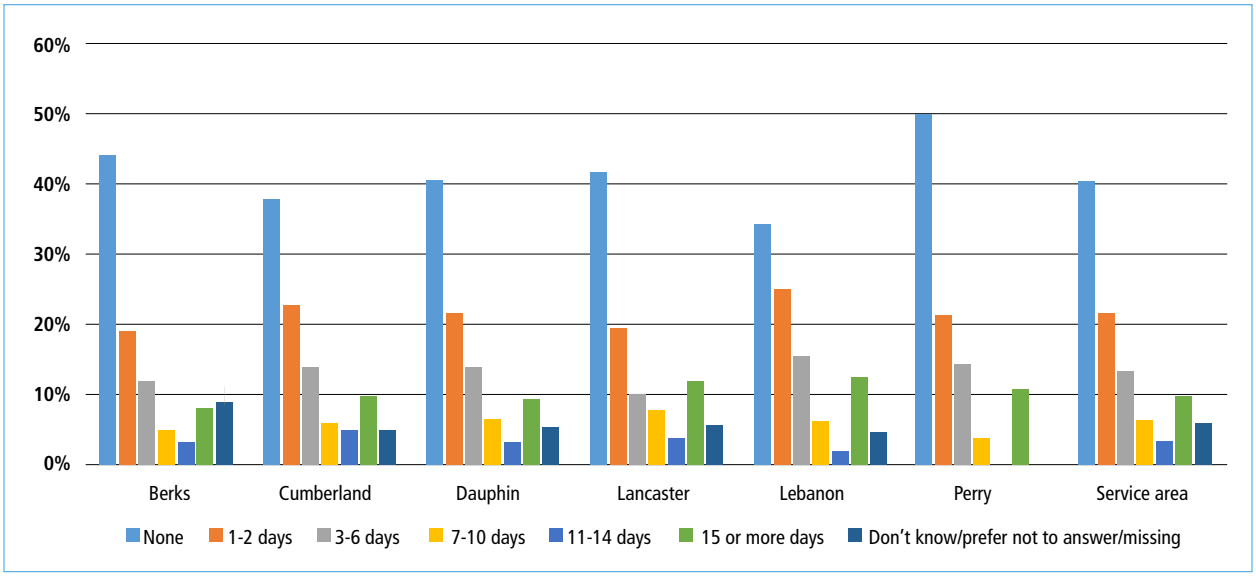
Mental Health

Across the region, 60% of respondents had at least one poor mental health day in the past month and one in 10 people reported 15 or more days of poor mental health. Among respondents from Cumberland, Lancaster and Lebanon counties, 20% or more reported poor mental health on more than seven days in the past month.

Approximately 18% of all respondents received services or treatment for a mental health issue in the past 12 months, and one in 11 respondents needed mental health services but did not receive them. Respondents from Cumberland County were the most likely to have received mental health services, while respondents from Lebanon County were most likely to have needed services but not received them.

2021 Community Survey Respondents

How Many Days During the Past 30 Days was Your Mental Health Not Good?



Mental Health Services or Treatment in the Past 12 Months

County	% Received Services	% Needed, But Did Not Receive Services
Berks	12.1%	6.6%
Cumberland	22.7%	9.3%
Dauphin	18.7%	8.7%
Lancaster	17.5%	9.7%
Lebanon	18.8%	11.9%
Perry	14.3%	3.6%
Service Area	17.8%	8.8%

Substance use can be both a cause and result of poor mental health. When asked about substance use, approximately 9% of respondents reported smoking cigarettes. Almost half (47%) reported having at least one drink in an average week, and one in 12 respondents had seven or more drinks per week. Approximately one in 15 respondents reported having ever taken a nonprescribed prescription drug, and 7% had ever taken an illegal drug. When asked about ease of access, marijuana was reported as the easiest recreational drug to access, followed by prescription opioids.

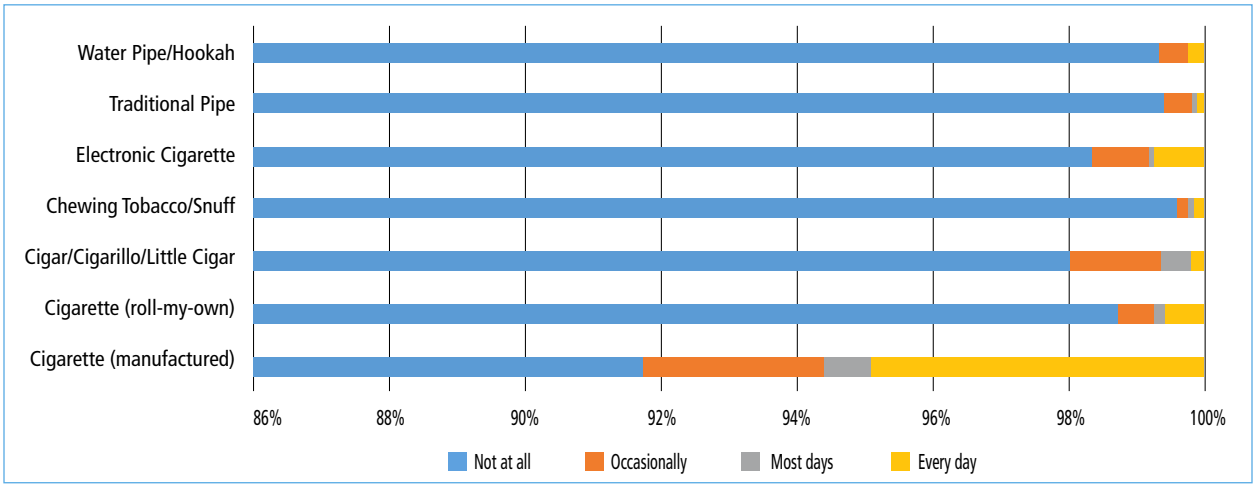
Amount of Alcoholic Drinks Consumed in an Average Week

County	None	1 to 6 Drinks	7 or More Drinks
Berks	54.9%	38.8%	6.3%
Cumberland	58.5%	32.6%	8.9%
Dauphin	50.5%	40.1%	9.4%
Lancaster	54.0%	39.5%	6.5%
Lebanon	53.4%	40.0%	6.6%
Perry	71.4%	25.0%	3.6%
Service Area	53.4%	38.6%	8.0%

Prescription and Illegal Drug Consumption

County	% Taken a Nonprescribed Prescription Drug	% Taken an Illegal Drug
Berks	6.5%	5.7%
Cumberland	6.1%	9.5%
Dauphin	6.0%	6.2%
Lancaster	7.3%	10.9%
Lebanon	6.9%	7.9%
Perry	7.1%	7.1%
Service Area	6.4%	7.3%

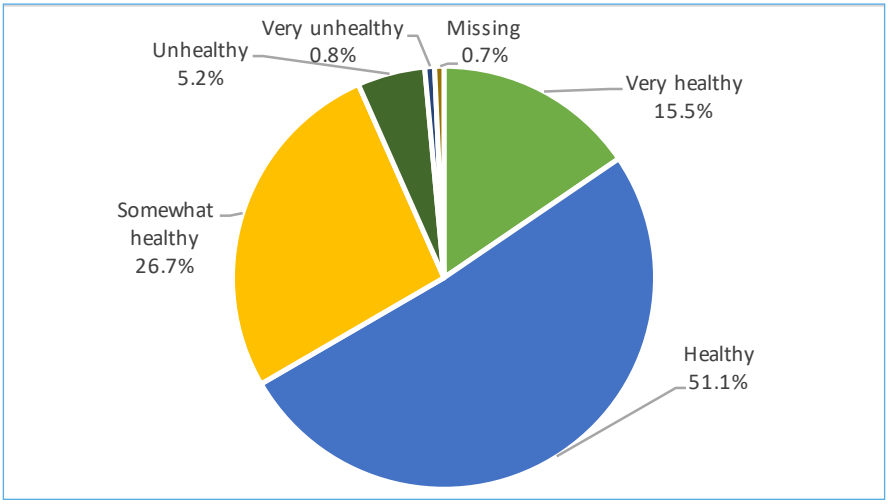
Tobacco Use in the Past 30 Days



Health Equity

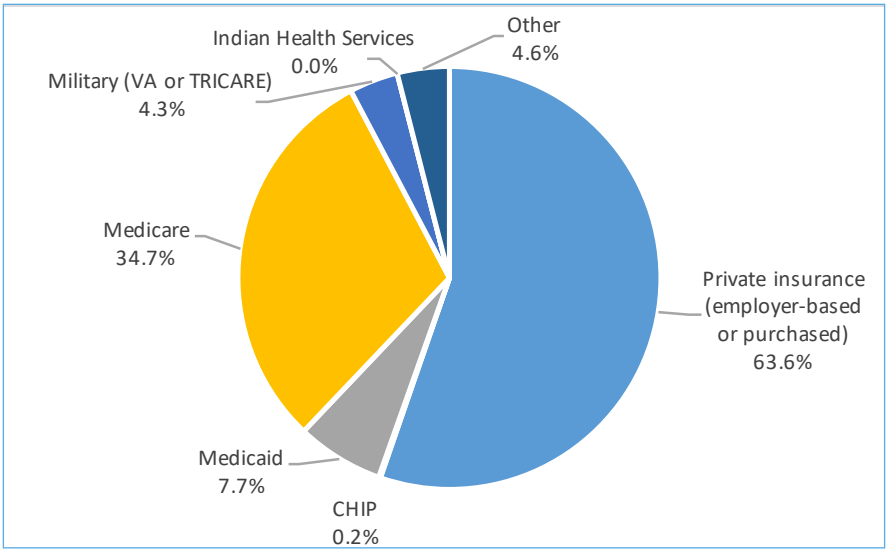
Approximately 67% of respondents reported that they are “healthy” or “very healthy,” and only 6% considered themselves to be “unhealthy” or “very unhealthy.”

How Would You Rate Your Health?



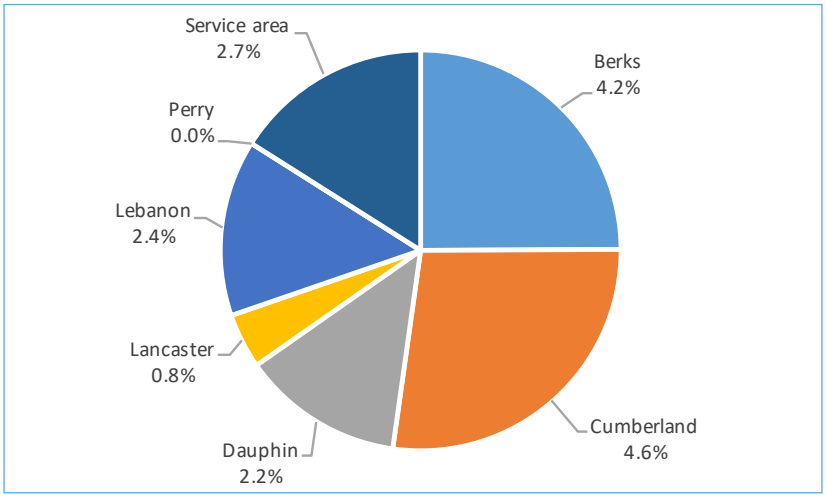
When asked about health insurance, almost two-thirds of insured respondents indicated they are covered by private insurance, while slightly more than one-third indicated they are covered by Medicare.

Health Insurance Type Among Insured Respondents

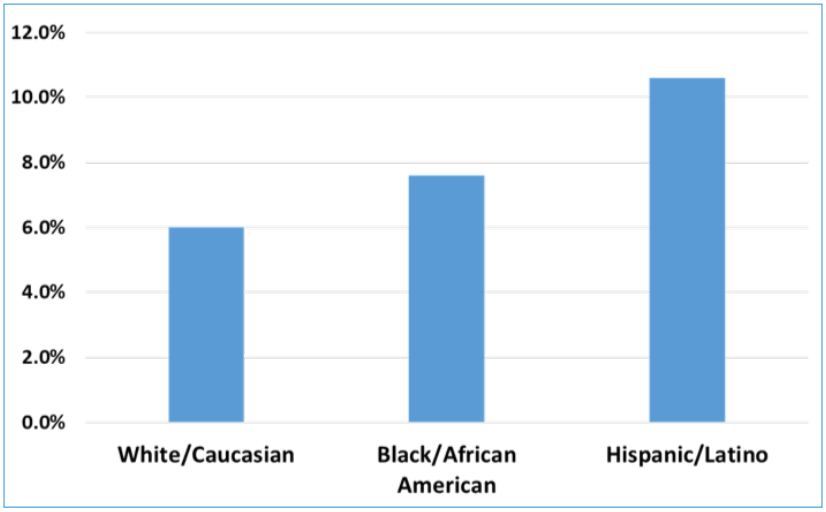


Of respondents who reported not having insurance, approximately 50% lived in Berks and Cumberland counties, and Hispanic/Latino individuals and Black/African American individuals were most likely to report being uninsured. For respondents who were uninsured, almost half indicated that they cannot afford insurance, while one-quarter indicated they are ineligible for employer-paid insurance.

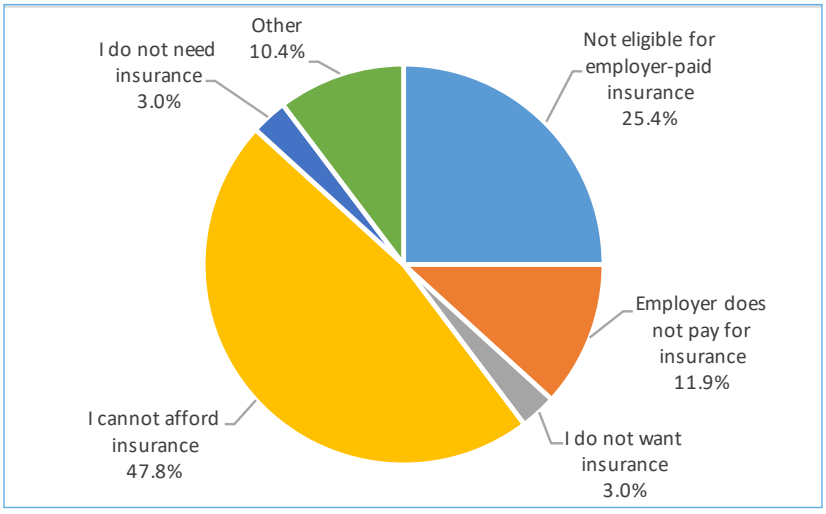
Uninsured Respondents by County



Percentage of Uninsured Respondents by Race and Ethnicity

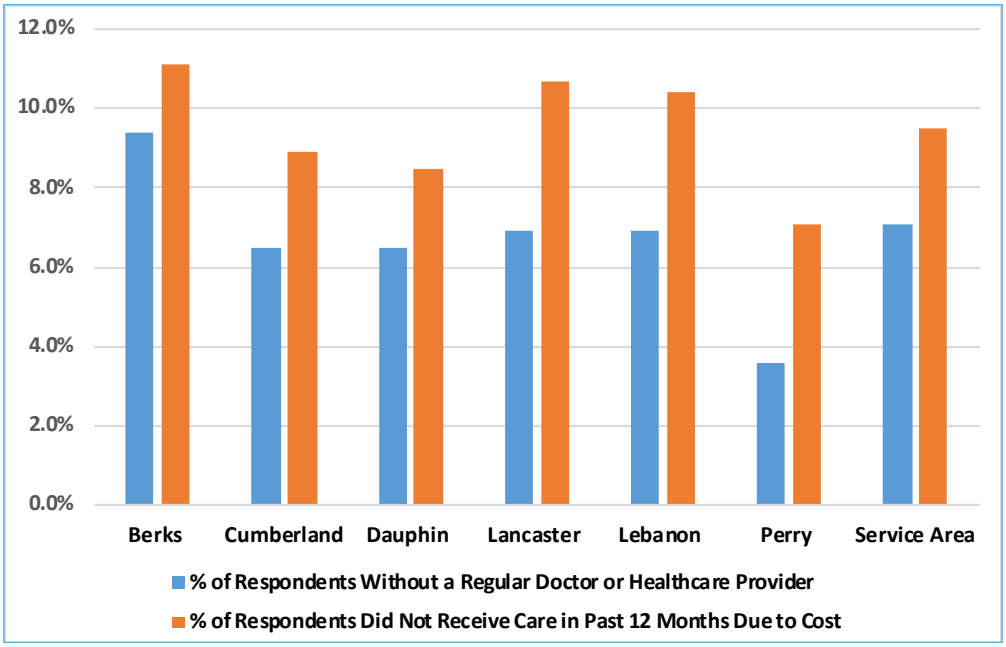


Reason for Not Having Health Insurance

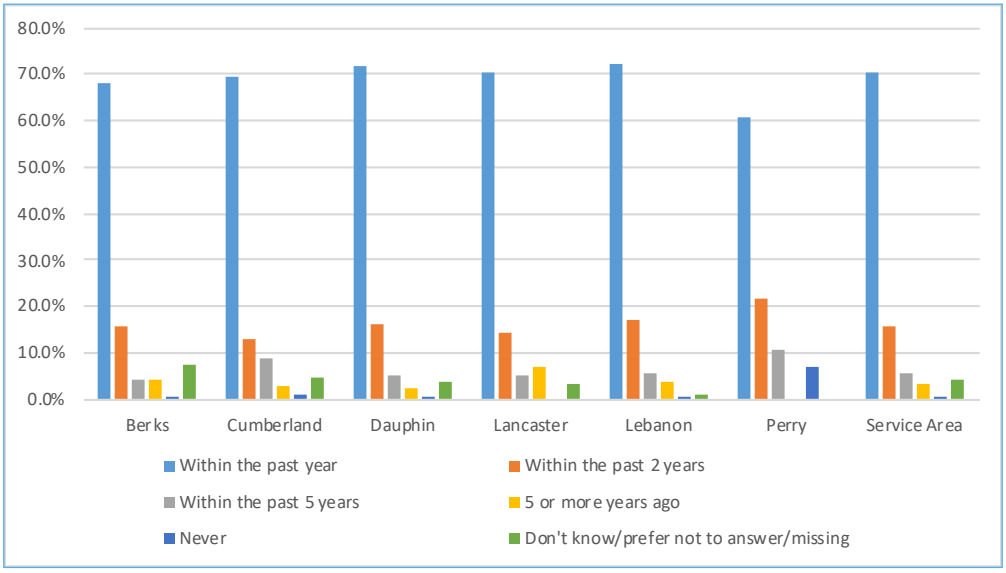


When asked about routine care and having a regular health care provider, one in 14 respondents did not have a regular doctor or health care provider and one in 11 did not receive care in the past year due to cost. Within the past year, Lebanon County respondents were the most likely and Perry County residents were least likely to receive a preventive checkup. When asked about the primary location they sought medical care, approximately 1% of respondents said it was the emergency department (compared to 7% in 2018) 3% said it was an urgent care center (5% in 2018), and 5% chose a community clinic or federally qualified health center.

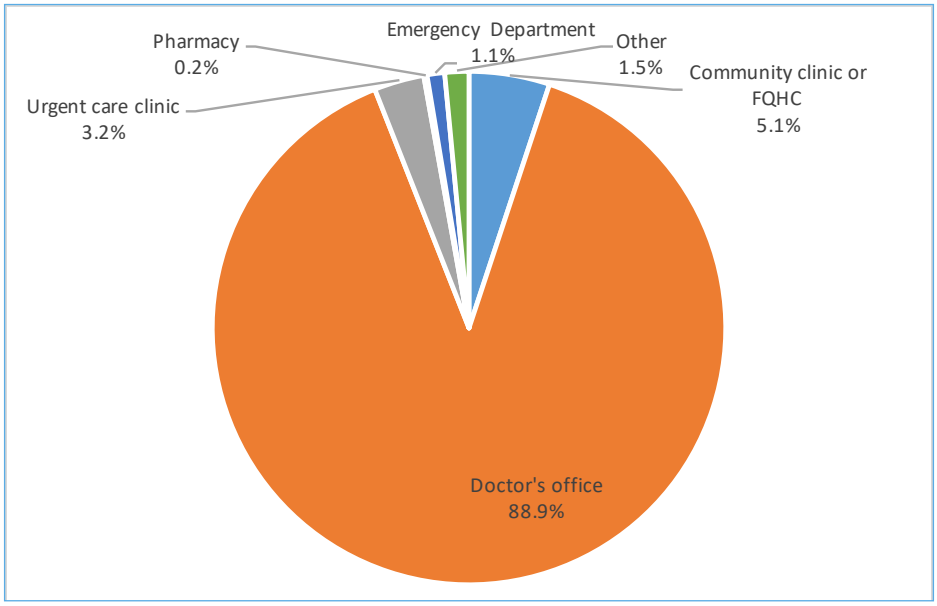
Respondents Without a Regular Provider and Those Who Did Not Receive Care in the Past 12 Months Due to Cost



Time of Last Preventive Checkup

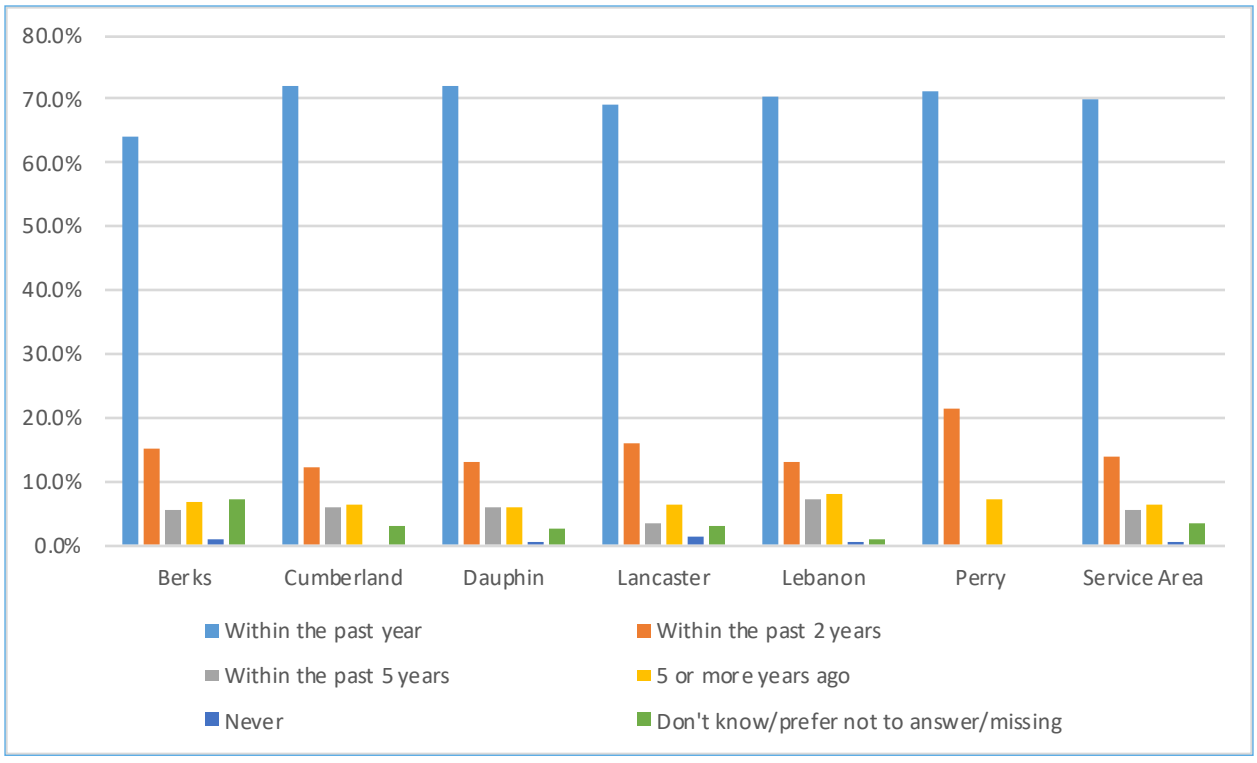


Primary Location for Seeking Medical Care

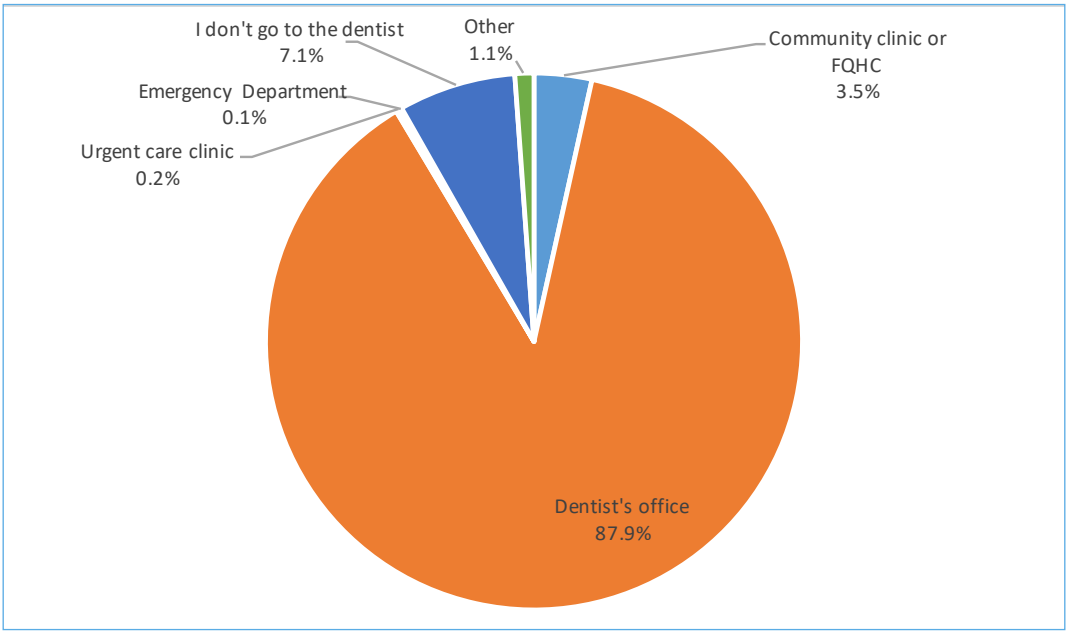


Regarding dental care, 30% of respondents across the service area had not been to the dentist within the past year, and Berks County respondents were least likely to have gone to the dentist in the past year. When asked about the primary location they sought dental care, approximately 7% of respondents said they don't go to the dentist.

Time of Last Dental Visit

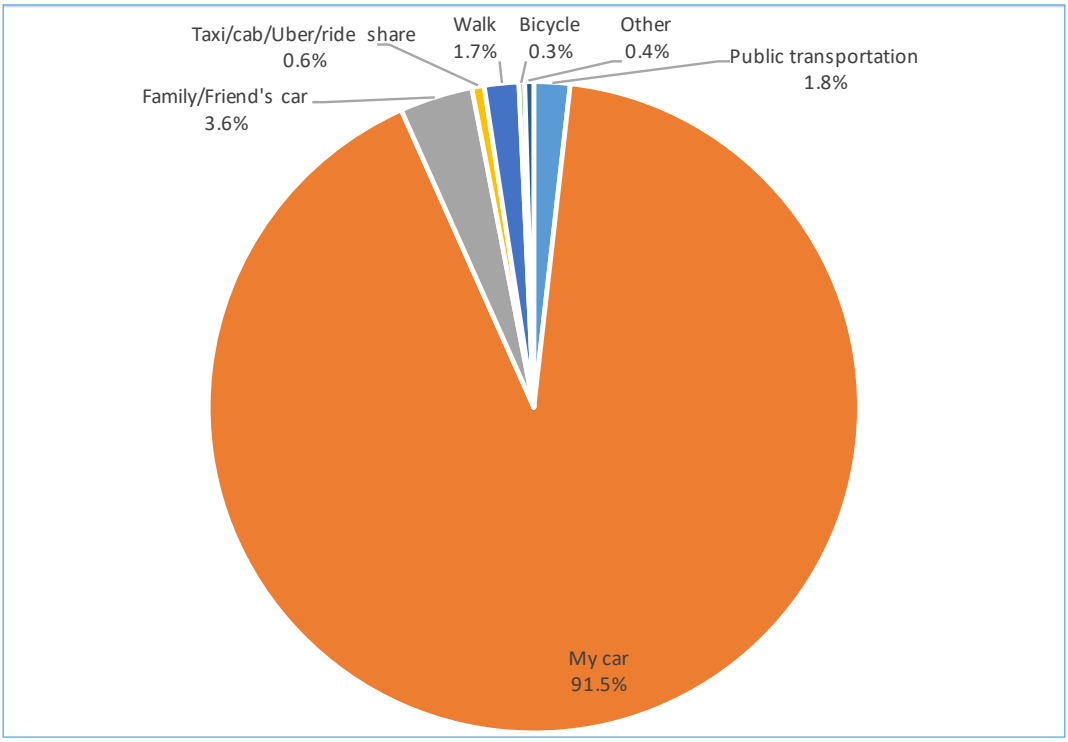


Primary Location for Seeking Dental Care



Community members were asked about transportation, and 2% of respondents said that public transportation was their main form of transportation, while 92% said it was their car. However, when asked about services needed in the community, one in 15 respondents indicated that they or their family needed transportation services but were not able to access them.

Main Form of Transportation



Community members were also asked about housing and safety. Across the service area, 30% of respondents did not feel extremely safe in their neighborhoods. Perry County respondents were most likely to feel safe, while Lancaster County respondents were least likely to feel safe. When examining safety by race/ethnicity, 72% of white/Caucasian respondents felt extremely safe in their neighborhoods, while only 58% of Black/African American respondents felt extremely safe.

How Safe Do You Feel in Your Neighborhood/Community?

County	Extremely Safe	Somewhat Safe	Not At All Safe
Berks	69.0%	29.2%	1.8%
Cumberland	70.3%	29.4%	0.3%
Dauphin	71.8%	27.1%	1.1%
Lancaster	64.8%	33.2%	2.0%
Lebanon	69.9%	29.2%	0.9%
Perry	78.6%	21.4%	0.0%
Service Area	70.2%	28.7%	1.2%

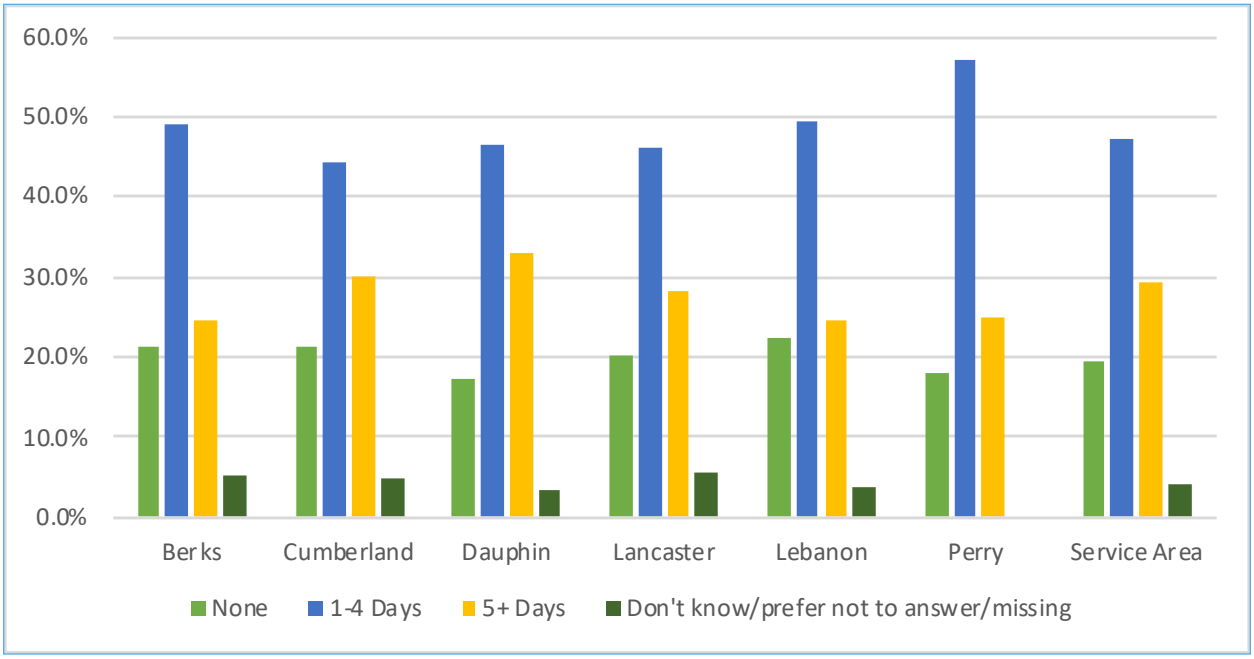
Respondents Who Feel Extremely Safe in Their Neighborhood/Community by Race/Ethnicity

Race/Ethnicity	Percent
Black/African American	58.0%
Hispanic/Latino	60.8%
American Indian/Alaska Native	62.5%
Asian	59.6%
White/Caucasian	71.7%

Wellness and Disease Prevention

According to the Office of Disease Prevention and Health Promotion, adults should participate in at least 150 minutes of moderate-intensity aerobic physical activity each week, the equivalent of 30 minutes on at least five days. Less than 30% of respondents met the physical activity guideline. Approximately one in 5 respondents across the service area reported no days of physical activity, and 54% of respondents reported ever being told by their health care provider to exercise more. Lebanon County respondents were the least likely to participate in any physical activity, followed by respondents from Berks and Cumberland counties.

Days Per Week Participating in 30 Minutes or More of Physical Activity



Approximately one in 8 respondents worried about running out of food before getting money to buy more. Respondents in Dauphin and Lancaster counties were the most likely to report being worried about running out of food. Thirty-two percent of Hispanic/Latino respondents worried about running out of food, while only 10.5% of white/Caucasian respondents worried about food. Perry County residents were most likely to report not having fresh, healthy foods (fruits/vegetables) when they wanted them. Among all respondents, 58% reported consuming less than the recommended serving of two to three cups of vegetables per day.

Food Insecurity by County

County	Within the past 12 months, I worried whether our food would run out before we got money to buy more. "Yes" Response	Are you able to have fresh, healthy foods (fruits/vegetables) when you want them? "No" Response
Berks	12.7%	2.5%
Cumberland	11.0%	2.4%
Dauphin	13.5%	1.7%
Lancaster	13.4%	3.7%
Lebanon	11.6%	1.5%
Perry	10.7%	7.1%
Service Area	12.7%	2.2%

Food Insecurity by Race and Ethnicity

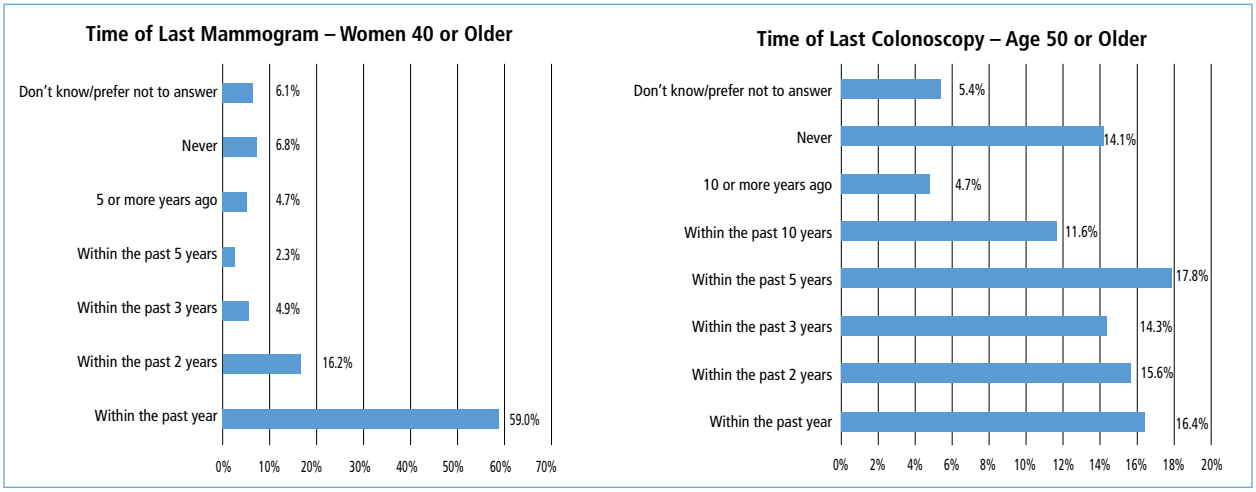
Race/Ethnicity	Within the past 12 months, I worried whether our food would run out before we got money to buy more. "Yes" Response	
	Percent	Count
Asian	22.2%	10
Black/African American	24.4%	30
Hispanic/Latino	32.1%	68
White/Caucasian	10.5%	215

When asked whether they had ever been told they have any of the following conditions, 44% of respondents across the service area reported having been told they're overweight/obese, 42% were told they have high blood pressure and 40% had high cholesterol. Cumberland County respondents were most likely to report having high cholesterol (44%), and half (50%) of respondents in Lebanon County reported being overweight/obese. In Perry County, 25% of respondents reported having been diagnosed with cancer.

Percentage Respondents With Chronic Condition Diagnoses, by County

County	Cancer	Diabetes	Heart Problems	High Blood Pressure	High Cholesterol	Overweight/ Obesity
Berks	14.0%	16.3%	15.0%	38.3%	36.4%	42.5%
Cumberland	15.8%	15.5%	18.2%	39.1%	44.2%	46.3%
Dauphin	18.7%	14.8%	16.5%	43.3%	39.0%	42.3%
Lancaster	19.0%	18.2%	17.8%	43.1%	35.3%	46.1%
Lebanon	20.5%	15.2%	18.8%	41.1%	39.3%	50.0%
Perry	25.0%	17.9%	17.9%	42.9%	35.7%	42.9%
Service Area	17.8%	15.6%	16.9%	41.5%	38.8%	44.3%

Approximately one in 15 female respondents age 40 years or older had never received a mammogram, and about one in 7 respondents age 50 or older had never received a colonoscopy.



Secondary Data

Background

Secondary data, including demographic, social determinant and public health indicators, were analyzed for the six-county service area consisting of Berks, Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties. Community drivers of health status, health and socioeconomic trends and emerging community needs were examined through data analysis. Data focus on county-level reporting but were compared to state and national benchmarks, as available, to identify areas of strength and opportunity for the region.

The Health Equity section provides data related to the social determinants of health and access to health care. Social determinants include the conditions or environments in which people work, live, learn and play that can greatly affect their health risks and outcomes. The data included in this section are provided by the U.S. Census Bureau. The county-level demographic and socioeconomic data are reported from the 2015-2019 American Community Survey (ACS) five-year estimates, unless otherwise noted.

Public health data were analyzed for a number of health issues, including mental health and wellness and disease prevention. Data were compiled from secondary sources, including the Pennsylvania Department of Health, Centers for Disease Control and Prevention, U.S. Census Bureau, and University of Wisconsin County Health Rankings & Roadmaps, among other sources. Appendix A contains a comprehensive list of data sources.

Demographic Analysis and Health Equity

A total of 1,707,543 people live in the 3,784-square-mile report area. Lancaster County has the highest total population of 552,587, and Perry County has the lowest total population of the six-county region at 47,542. The populations of all six counties are expected to continue to grow from 2020 to 2025. Cumberland County is expected to have the greatest annual growth rate of 0.82%, which is greater than both the state and national averages. Perry County is expected to have the lowest annual growth rate of 0.31%, which is still greater than the state average but lower than the national average.

The median age for the six-county region is greatest in Perry County (43.3) and lowest in Lancaster County (38.6). The median age of all six counties is greater than the median age of the United States (38.1). For the report area, 22.6% of the population is 0 to 17 years of age, which is greater than the percentage for Pennsylvania (20.8%) but the same as the United States (22.6%). Lancaster County has the greatest percentage (23.7%) of residents aged 0 to 17, which is significantly greater than both the state and nation. Cumberland County has the lowest percentage (20.3%) of residents aged 0 to 17, which is lower than both the state and nation. For the report area, 17.5% of the population is greater than 65 years of age, which is lower than the percentage for Pennsylvania (17.8%) but higher than the United States (15.6%). Lebanon County had the highest percentage (19.1%) of residents greater than age 65 in the report area.

Population, Growth Rate and Age

County	Population 2020	Population Projection 2025	2020-2025 Annual Growth Rate	Median Age	Population Age 0-17	Population Age 65+
Berks County	426,258	433,130	.32%	39.9	22.5%	16.9%
Cumberland County	255,665	266,292	.82%	40.6	20.3%	18.1%
Dauphin County	280,234	285,840	.40%	39.7	22.5%	16.5%
Lancaster County	552,587	568,856	.58%	38.6	23.7%	17.5%
Lebanon County	145,257	150,775	.75%	41.0	22.9%	19.1%
Perry County	47,542	48,286	.31%	43.3	21.6%	18.0%
Service Area	1,707,543	1,753,179	.53%	39.8	22.6%	17.5%
Pennsylvania	12,991,367	13,107,352	.18%	40.8	20.8%	17.8%
United States	333,793,107	346,021,282	.72%	38.1	22.6%	15.6%

In Perry County, 96.9% of people reporting only one race are white, the highest percentage for the reporting area. For the overall six-county region, 6.8% of the population is Black, which is lower than both the state (11.2%) and nation (12.7%). Dauphin County has the greatest percentage (19.5%) of people who are black. For the report area, 11.9% of the population identify as being Hispanic or Latino, which is higher than the state (7.3%) but lower than the nation (18.0%). Berks County has the highest percentage (21.0%) of Hispanic or Latino population, and Perry County has the lowest (2.0%). The percentage (5.7%) of the population in the report area over the age of 5 that has limited English proficiency is higher than Pennsylvania (4.3%) but lower than the United States (8.4%).

Race and English Proficiency

County	White	Black	Asian	American Indian/ Alaska Native	Some Other Race	Multiple Races	Hispanic or Latino	Limited English Proficiency
Berks	82.4%	5.4%	1.4%	0.6%	5.6%	4.6%	21.0%	7.6%
Cumberland	87.7%	4.0%	4.3%	0.1%	1.2%	2.7%	3.9%	3.1%
Dauphin	70.1%	19.5%	4.4%	0.3%	2.6%	3.1%	9.2%	5.2%
Lancaster	88.5%	4.2%	2.2%	0.2%	2.5%	2.5%	10.5%	6.3%
Lebanon	86.6%	2.5%	1.4%	0.1%	7.3%	2.1%	13.1%	4.7%
Perry	96.9%	1.0%	0.4%	0.2%	0.4%	1.2%	2.0%	1.1%
Service Area	83.9%	6.8%	2.6%	0.3%	3.4%	3.1%	11.9%	5.7%
Pennsylvania	80.5%	11.2%	3.4%	0.2%	2.2%	2.5%	7.3%	4.3%
United States	72.5%	12.7%	5.5%	0.8%	4.9%	3.3%	18.0%	8.4%

Race and Ethnicity Projected Change, 2020-2025 (Advisory Board, Demographic Profiler)

County	White Population % Change	Black Population % Change	Asian Population % Change	Other Race % Change	Hispanic Population % Change
Berks	-0.9%	7.9%	31.9%	6.6%	7.0%
Cumberland	3.2%	11.5%	15.5%	4.7%	4.8%
Dauphin	-0.5%	8.2%	27.0%	7.2%	5.5%
Lancaster	0.2%	7.5%	22.7%	4.7%	4.3%
Lebanon	0.3%	10.4%	24.3%	9.3%	8.1%
Perry	1.6%	8.3%	12.8%	5.3%	5.2%
Service Area	0.4%	8.4%	23.9%	6.3%	6.1%

In the six-county region, the percentage of individuals greater than 25 years of age without a high school diploma (12.4%) is higher than both the state (9.5%) and nation (12.0%). Lancaster County has the highest percentage of population without a high school diploma (14.9%) and Cumberland County has the lowest (7.7%).

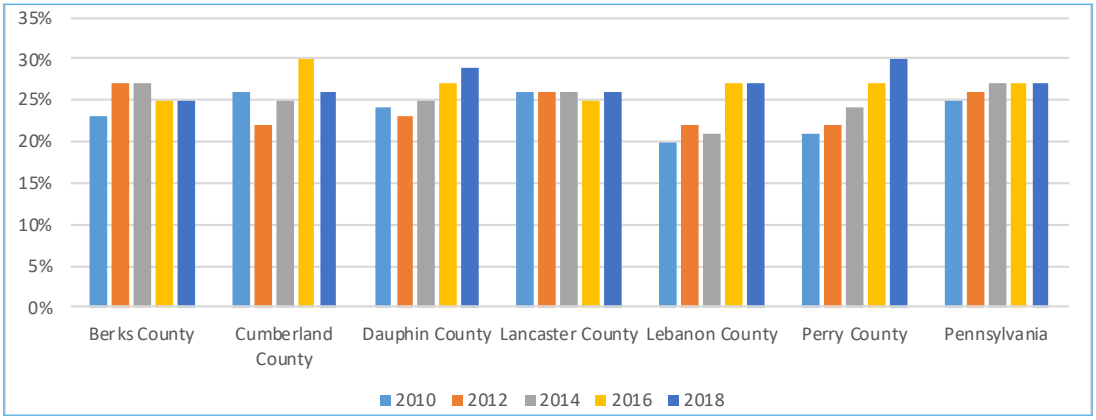
The median household income for the six-county region is $64,311, which is greater than both Pennsylvania ($61,744) and the United States ($62,843). Lebanon County has the lowest median household income ($60,281), and Cumberland County has the highest ($71,269). In the service area, 7.2% of families have an income below poverty level, and 15.8% of children under the age of 18 are living in poverty. In Dauphin County, 20.2% of children under the age of 18 are living in poverty, which is higher than both the state (17.6%) and the nation (18.5%). The percentage of children eligible for free or reduced lunch is highest in Dauphin County (59.8%) and Berks County (51.8%), both of which are higher than the state (50.9%) and nation (49.5%).

Education, Income and Poverty – ACS 2015-2019 Five Year Estimates

County	Percentage of Population Age 25+ With No High School Diploma	Median Household Income	Percentage of Families With Income Below Poverty Level	Percentage of Population Under Age 18 in Poverty	Children Eligible for Free/Reduced Price Lunch (2018-2019)
Berks	13.3%	$63,728	8.4%	18.7%	33,891 (51.8%)
Cumberland	7.7%	$71,269	4.3%	9.3%	9,905 (30.5%)
Dauphin	10.2%	$60,715	8.8%	20.2%	29,126 (59.8%)
Lancaster	14.9%	$66,056	6.6%	14.4%	31,698 (47.3%)
Lebanon	12.9%	$60,281	8.7%	16.5%	9,735 (48.9%)
Perry	12.6%	$63,718	5.5%	11.8%	2,344 (38.9%)
Service Area	12.4%	$64,311	7.2%	15.8%	
Pennsylvania	9.5%	$61,744	8.4%	17.6%	870,251 (50.9%)
United States	12.0%	$62,843	9.5%	18.5%	25,124,175 (49.5%)

Asset limited, income constrained, employed (ALICE) households are those that earn above the federal poverty level but not enough to afford basic household necessities (United Way, 2018). Across the service area, 27% of households are considered to be ALICE. Perry County has the greatest percentage (30%) of ALICE households, while Berks County has the lowest percentage (25%).

Asset Limited, Income Constrained, Employed (ALICE) Households – United Way, 2018



The percentage of the population in the service area that does not have health insurance (8.0%) is higher than the state (5.7%) but lower than the nation (8.8%). In the service area, 9.5% of individuals less than 18 years of age do not have insurance. Lancaster County has the greatest percentage (11.7%) of the population that does not have health insurance, with 17.0% of those under age 18 not having insurance. Dauphin County has the lowest percentage (5.3%) of people without health insurance.

A shortage of health professionals contributes to access and health status issues. Among all counties in the service area, Perry County residents have the lowest access to mental health providers, primary care physicians and dentists. Lebanon County has the greatest access to mental health providers, and residents of Dauphin County have the greatest access to primary care physicians and dentists.

Health Insurance and Provider Access

County	Percentage of Population Without Health Insurance (ACS, 2015-2019)	Percentage Under Age 18 Without Health Insurance (ACS, 2015-2019)	Ratio of Population to Mental Health Providers (National Provider Identifier, 2020)	Ratio of Population to Primary Care Physicians (Area Health Resources Files, 2018)	Ratio of Population to Dentists (Area Health Resources Files, 2019)
Berks	6.0%	4.6%	680:1	1,600:1	1,780:1
Cumberland	5.5%	6.1%	480:1	1,110:1	1,380:1
Dauphin	5.3%	3.4%	420:1	930:1	1,270:1
Lancaster	11.7%	17.0%	650:1	1,390:1	1,770:1
Lebanon	8.6%	9.5%	350:1	1,700:1	1,870:1
Perry	9.1%	13.1%	2,890:1	3,840:1	5,140:1
Service Area	8.0%	9.5%			
Pennsylvania	5.7%	4.3%	450:1	1,230:1	1,410:1
United States	8.8%	5.1%	490:1	1,300:1	1,650:1

Within the service area, Lebanon County had the greatest percentage of housing units that are overcrowded (2.6%), which is higher than the state (1.7%) but lower than the nation (4.4%). The percentage of occupied housing units with one or more substandard conditions is higher in Berks (29.4%), Lancaster (28.9%) and Lebanon (28.2%) counties than the state (28.1%), but all counties in service area are lower than the nation (31.9%)

Cost burden is experienced when housing costs exceed 30% of total household income. The information provides a measure of affordability and excessive expenses. For households with mortgages, Berks County has the highest percentage of households that are cost burdened (25.7%), followed closely by Lancaster County (25.5%), both of which are higher than Pennsylvania (25.0%). Housing cost burden for rental households is higher than for owner-occupied households. For example, over half (50.7%) of rental households in Berks County are cost burdened.

Housing Units With Substandard Conditions and Cost Burdened Households – ACS 2015-2019

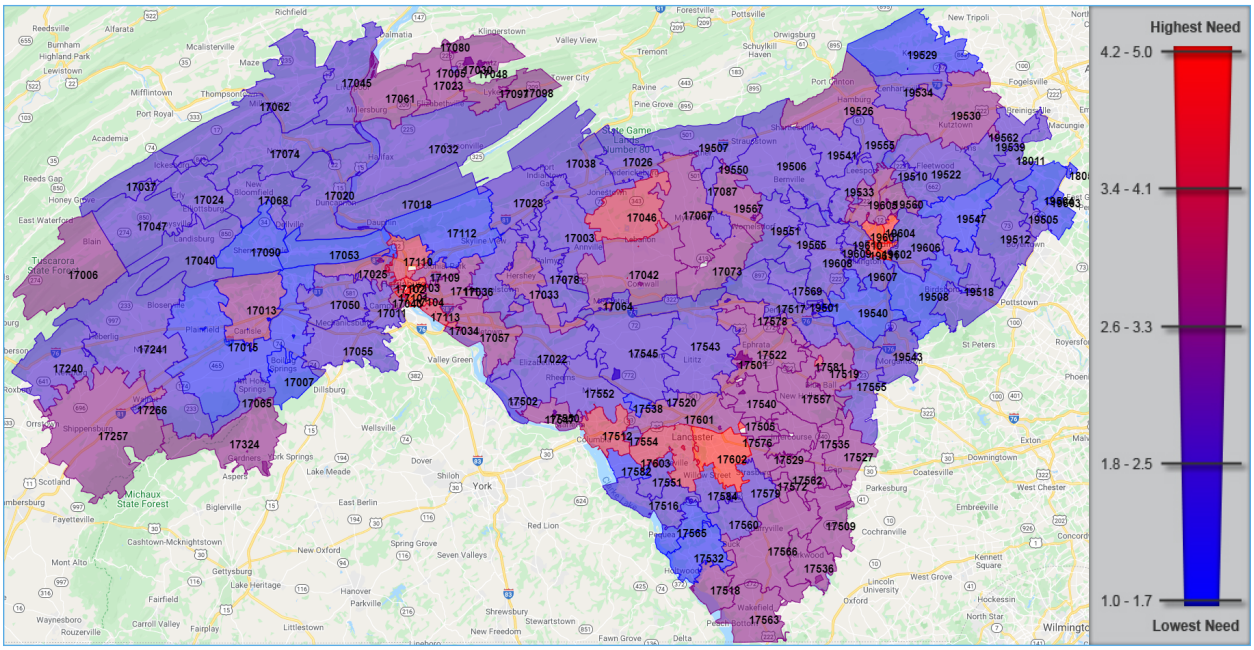
County	Housing Units That Are Overcrowded	Occupied Housing Units With One or More Substandard Conditions	Rental Households That are Cost Burdened	Owner Occupied Households With Mortgages That are Cost Burdened
Berks	2,190 (1.6%)	45,510 (29.4%)	20,844 (50.7%)	18,122 (25.7%)
Cumberland	795 (0.9%)	24,154 (24.2%)	12,118 (42.7%)	9,651 (21.4%)
Dauphin	1,627 (1.9%)	30,921 (27.6%)	17,111 (43.7%)	10,225 (23.0%)
Lancaster	3,963 (2.2%)	58,354 (28.9%)	29,460 (48.1%)	21,830 (25.5%)
Lebanon	1,246 (2.6%)	15,093 (28.2%)	7,072 (46.2%)	5,542 (24.5%)
Perry	299 (1.7%)	4,264 (23.4%)	1,235 (36.6%)	2,168 (25.0%)
Pennsylvania	72,925 (1.7%)	1,417,722 (28.1%)	692,584 (47.7%)	520,428 (25.0%)
United States	4,045,979 (4.4%)	38,530,862 (31.9%)	20,002,945 (49.6%)	13,400,012 (27.8%)

In summary, a recent qualitative study conducted in central Pennsylvania by Daniel George, et al. (2021) found the most common factors associated with diseases of despair (morbidity or mortality due to suicidality, drug abuse and alcoholism) to be financial distress, lack of infrastructure or social services, deteriorating sense of community and family fragmentation. Intervention strategies to address these factors included: (1) building resilience to despair through better community and organizational coordination and peer support at the local level and (2) encouraging broader state investments in social services and infrastructure to mitigate despair-related illness.

Community Need Index

The Community Need Index (CNI) scores are important in the process of collecting socioeconomic factors in the community. Based on a variety of demographic and economic data, the CNI provides a score ranging from 1.0 to 5.0 for each ZIP code across the United States. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need. The CNI is strongly linked to variations in community health care needs and is a strong indicator of a community's demand for various health care services.

In reviewing the CNI scores for the six-county region, the top ZIP codes that face the most barriers to health care are located in Berks and Dauphin counties. The 19601 (Reading), 19602 (Reading), 17101 (Harrisburg), and 17104 (Harrisburg) ZIP codes had the overall highest scores (4.8) in the six-county region, followed by 19604 (Reading) and 19611 (Reading).



Highest CNI Scores for Six-County Region (Highest level of socioeconomic barriers)

	ZIP Code	CNI Score	Population	City	County	State
	19601	4.8	33399	Reading	Berks	Pennsylvania
	19602	4.8	17961	Reading	Berks	Pennsylvania
	17101	4.8	2408	Harrisburg	Dauphin	Pennsylvania
	17104	4.8	21745	Harrisburg	Dauphin	Pennsylvania
	19604	4.6	28125	Reading	Berks	Pennsylvania
	19611	4.6	10773	Reading	Berks	Pennsylvania
	17103	4.2	12186	Harrisburg	Dauphin	Pennsylvania
	17602	4.2	54541	Lancaster	Lancaster	Pennsylvania
	17102	4	8095	Harrisburg	Dauphin	Pennsylvania
	17046	3.8	31333	Lebanon	Lebanon	Pennsylvania

The ZIP codes with the lowest CNI scores that face the least barriers to health care are located in Cumberland and Berks counties. The 17007 (Boiling Springs) ZIP code had the lowest overall score (1.2) in the six-county region, followed by 17015 (Carlisle) and 19504 (Barto).

Lowest CNI Scores for the Six-County Region (Lowest level of socioeconomic barriers)

	ZIP Code	CNI Score	Population	City	County	State
	19547	1.6	4350	Oley	Berks	Pennsylvania
	17090	1.6	5319	Shermans Dale	Perry	Pennsylvania
	17112	1.6	35904	Harrisburg	Dauphin	Pennsylvania
	17266	1.6	486	Walnut Bottom	Cumberland	Pennsylvania
	17538	1.6	5887	Landisville	Lancaster	Pennsylvania
	17582	1.6	2078	Washington Boro	Lancaster	Pennsylvania
	18011	1.6	5793	Alburtis	Berks	Pennsylvania
	19504	1.4	4995	Barto	Berks	Pennsylvania
	17015	1.4	23603	Carlisle	Cumberland	Pennsylvania
	17007	1.2	5618	Boiling Springs	Cumberland	Pennsylvania

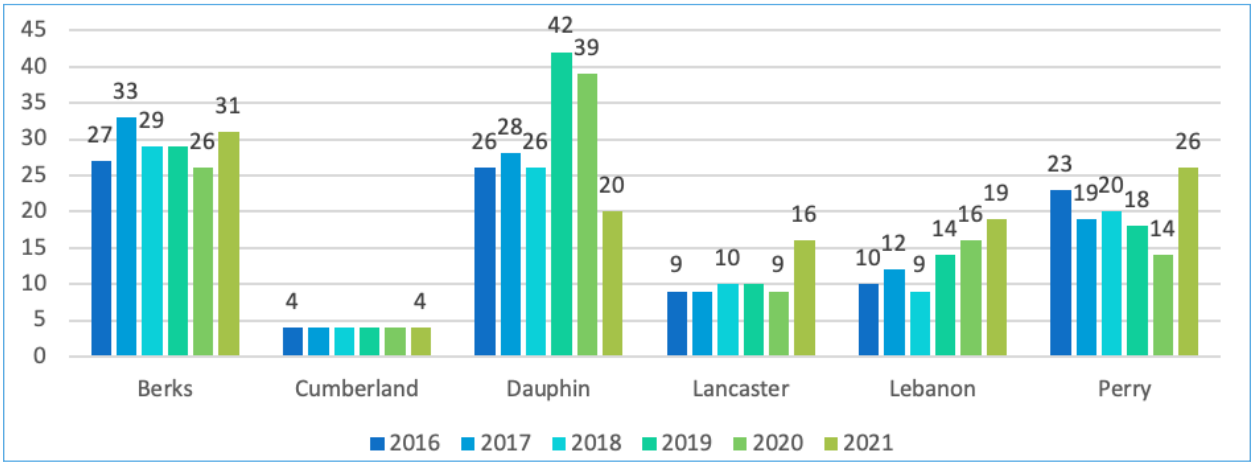
Public Health Analysis of the Six-County Region

Publicly reported health data were collected and analyzed to display health trends and identify health disparities across the six-county region. Data reported were compiled by secondary sources, such as the County Health Rankings & Roadmaps program, CARES Network and the Pennsylvania Department of Health's EDDIE system. A list of all data sources can be found at the end of the report.

County Health Rankings

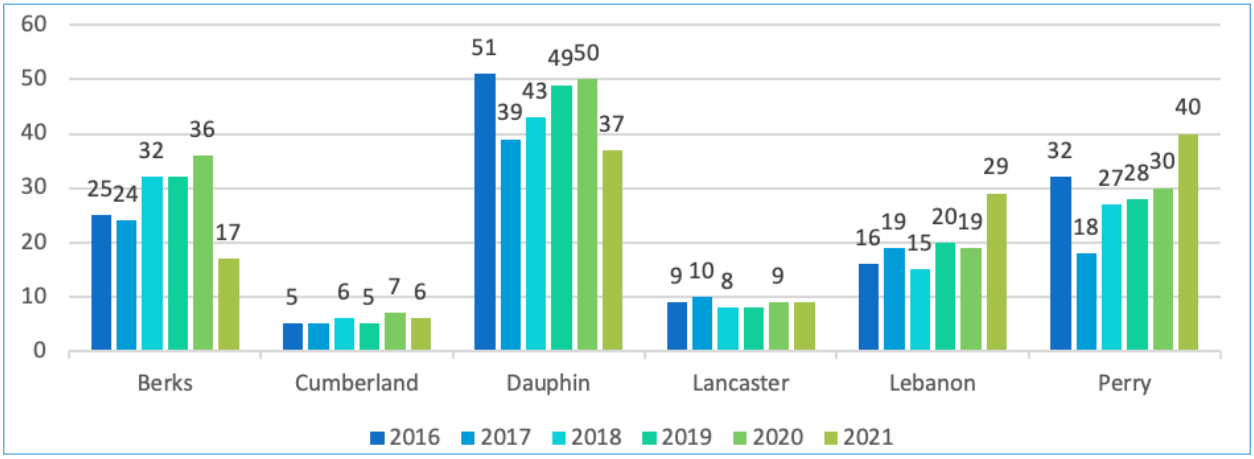
The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.

Health Factors Rank (out of 67 counties) – Lower = Better



The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The health outcomes ranks are based on two types of measures: how long people live and how healthy people feel while alive.

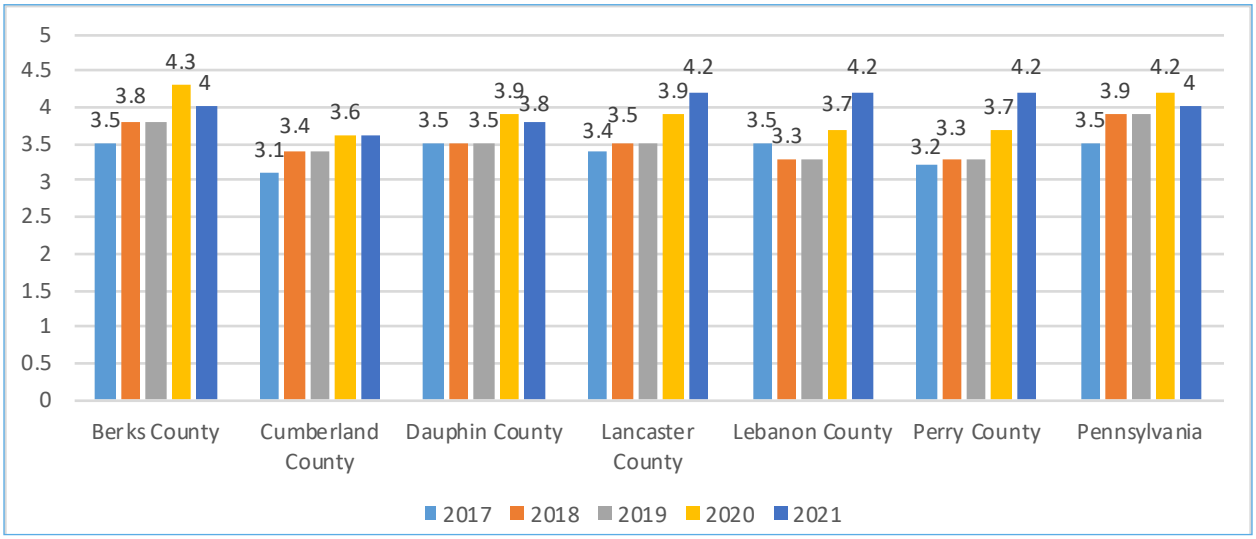
Health Outcomes Rank (out of 67 counties) – Lower = Better



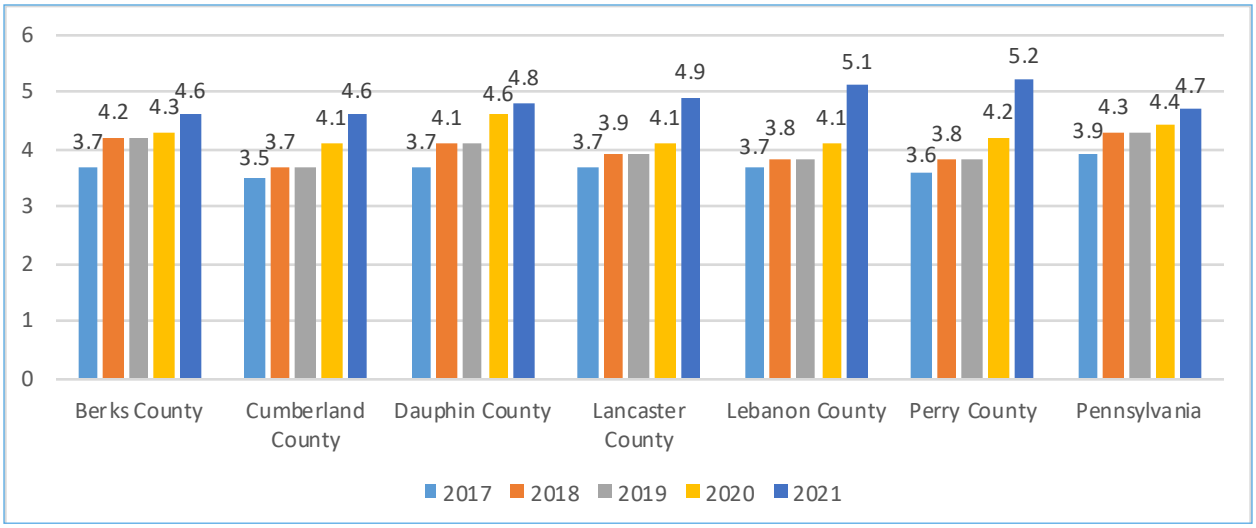
2021

In 2021, the number of physically unhealthy days reported in Lancaster, Lebanon and Perry counties (4.2) was greater than the Pa. average (4.0), and the number of mentally unhealthy days reported in Dauphin, Lancaster, Lebanon and Perry counties was greater than the Pa. average (4.7). It is important to note that, overall, there were more mentally unhealthy days reported than physically unhealthy days, and the total number of unhealthy days has continued to trend upward.

Average Number of Physically Unhealthy Days Reported in Past 30 Days (Age-Adjusted)



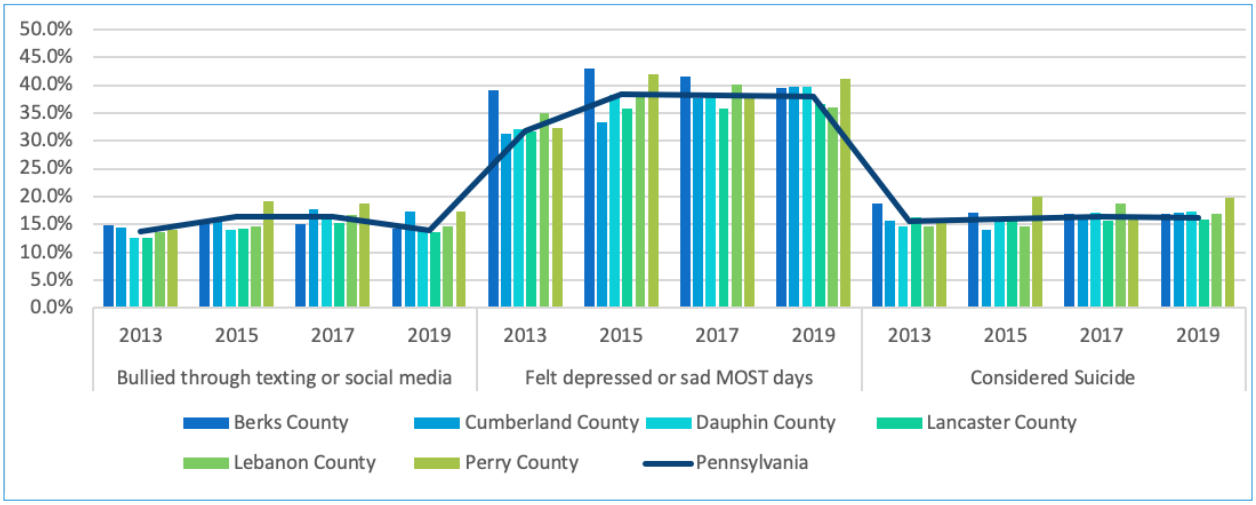
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)



Mental Health

The percentage of students who reported being bullied through texting or social media decreased in all counties from 2017 to 2019, with 14 to 17% reporting being bullied in 2019. More than a third of all students in all counties reported feeling sad or depressed most days in 2019, with Perry County having the highest percentage of students, at 41%, reporting feeling depressed or sad. This percentage increased in Cumberland, Dauphin, Lancaster and Perry counties from 2017 to 2019 but decreased in Berks and Lebanon counties. Finally, the percentage of students who reported considering suicide in the past year was highest in Perry County, at 20%. Cumberland, Dauphin, Lancaster and Perry counties saw an increase from 2017 to 2019, Lebanon saw a decrease and Berks stayed the same.

Bullying, Depression and Suicide – Past 12 Months (6, 8, 10 and 12 Grades)

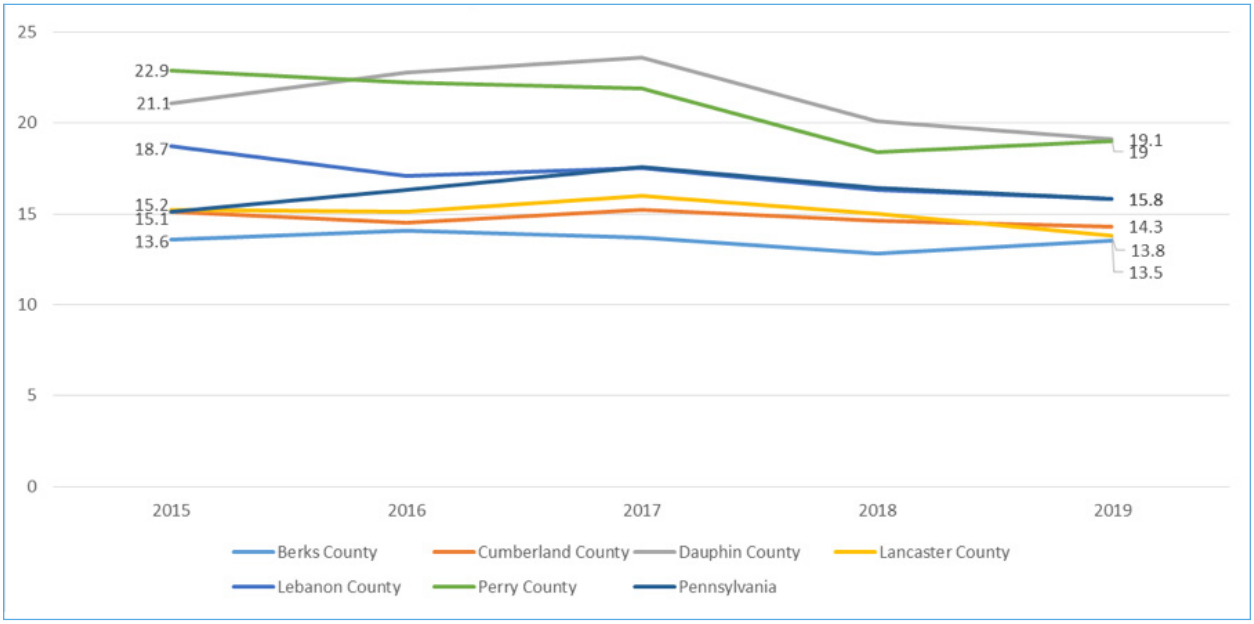


Bullying, Depression and Suicide – Past 12 months (6, 8,10 and 12 Grades)

County	Bullied via texting or social media				Felt depressed or sad most days				Considered Suicide			
	2013	2015	2017	2019	2013	2015	2017	2019	2013	2015	2017	2019
Berks	14.8%	15.6%	15.1%	14.3%	39.1%	42.9%	41.5%	39.4%	18.7%	17.2%	16.9%	16.9%
Cumberland	14.5%	15.4%	17.7%	17.4%	31.2%	33.3%	37.6%	39.7%	15.6%	14.1%	16.8%	17.2%
Dauphin	12.5%	14.0%	15.9%	14.4%	32.1%	38.2%	37.7%	39.6%	14.6%	16.1%	17.1%	17.4%
Lancaster	12.7%	14.2%	15.3%	13.6%	31.6%	35.7%	35.7%	36.6%	16.3%	16.1%	15.7%	15.9%
Lebanon	13.6%	14.6%	16.8%	14.6%	35.0%	38.5%	40.2%	36.0%	14.7%	14.7%	18.8%	16.9%
Perry	14.0%	19.2%	18.8%	17.3%	32.3%	41.9%	38.3%	41.2%	15.8%	19.9%	16.5%	19.7%
Pennsylvania	13.7%	16.3%	16.5%	14.0%	31.7%	38.3%	38.1%	38.0%	15.6%	16.0%	16.5%	16.2%

Child maltreatment has been trending downward from 2015 to 2019 in all counties in the service area (Pennsylvania Department of Human Services, 2017). Dauphin County had the highest rate of child maltreatment in 2019 at 19.1 children per 1,000, and Berks County had the lowest rate (13.5 per 1,000).

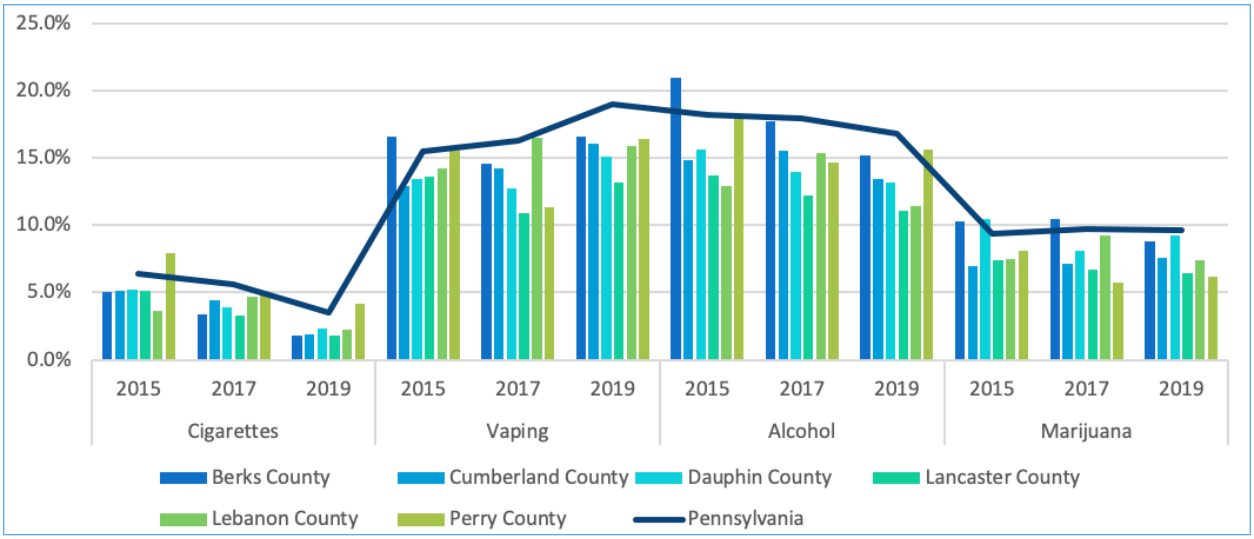
Child Maltreatment Rate Per 1,000 Children Under Age 18 – Pennsylvania Department of Human Services, 2013-2019



Current behaviors are determinants of future health, and smoking and drinking may cause significant health issues, such as cirrhosis, cancers and untreated mental and behavioral health needs.

Cigarette use among children decreased in all counties from 2015 to 2019; however, in 2019, 13 to 16% of students reported vaping in the past 30 days in all counties, with only Lebanon County seeing a small decrease in the percentage of students having reported vaping. The percentage of students using alcohol increased in Perry County between 2017 and 2019 and decreased in all other counties, while the percentage of students using marijuana increased in Cumberland, Dauphin and Perry counties from 2017 to 2019. All counties in the report area had a lower percentage of students using marijuana compared to Pennsylvania overall.

Cigarettes, Vaping and Early Initiation and Higher Prevalence Drugs – 30 Day Use (6, 8, 10 and 12 Grades)



Cigarettes, Vaping, Alcohol and Marijuana – 30- Day Use (6, 8, 10 and 12 Grades)

County	Cigarettes			Vaping			Alcohol			Marijuana		
	2015	2017	2019	2015	2017	2019	2015	2017	2019	2015	2017	2019
Berks	5.0%	3.4%	1.8%	16.6%	14.6%	16.6%	21.0%	17.7%	15.2%	10.3%	10.5%	8.8%
Cumberland	5.1%	4.4%	1.9%	12.9%	14.2%	16.1%	14.8%	15.5%	13.4%	7.0%	7.1%	7.6%
Dauphin	5.2%	3.9%	2.3%	13.4%	12.7%	15.1%	15.6%	14.0%	13.2%	10.5%	8.1%	9.2%
Lancaster	5.1%	3.3%	1.8%	13.6%	10.9%	13.2%	13.7%	12.2%	11.1%	7.4%	6.7%	6.4%
Lebanon	3.6%	4.7%	2.2%	14.2%	16.5%	15.9%	12.9%	15.4%	11.4%	7.5%	9.2%	7.4%
Perry	7.9%	5.0%	4.2%	15.5%	11.3%	16.4%	18.1%	14.7%	15.6%	8.1%	5.7%	6.2%
Pennsylvania	6.4%	5.6%	3.5%	15.5%	16.3%	19.0%	18.2%	17.9%	16.8%	9.4%	9.7%	9.6%

2021

The percentage of current smokers has increased from 2020 to 2021 in all counties, and is higher than the state percentage in all counties except Cumberland. The percentages of excessive drinkers has either remained constant or increased from 2017 to 2021 in all counties, except for Lancaster, which saw a slight decrease over the last three years. Within the report area, Berks and Perry counties had the greatest percentage of adults who reported excessive drinking, at 21%.

Percentage of Adults Smoking and Drinking – County Health Rankings, 2017-2021

County	Current Smoker					Excessive Drinking				
	2017	2018	2019	2020	2021	2017	2018	2019	2020	2021
Berks	20%	17%	15%	17%	20%	16%	19%	19%	19%	21%
Cumberland	17%	16%	14%	16%	18%	18%	19%	20%	20%	20%
Dauphin	19%	17%	17%	19%	20%	17%	19%	19%	19%	19%
Lancaster	17%	16%	14%	15%	20%	17%	18%	21%	18%	17%
Lebanon	18%	17%	15%	16%	21%	17%	19%	20%	20%	20%
Perry	18%	16%	15%	17%	23%	18%	20%	21%	20%	21%
Pennsylvania	20%	18%	18%	19%	18%	18%	18%	21%	19%	20%

The percentage of students who reported it would "be sort of easy" or "very easy" to access prescription drugs decreased from 2017 to 2019 in all counties except Perry, and all counties had a lower percentage than the state in 2019.

Access to prescription drugs (6, 8, 10 and 12 Grades)

Ease of Access to Rx Pain Drugs				
County	2013	2015	2017	2019
Berks	25.5%	27.5%	24.9%	21.7%
Cumberland	26.1%	27.2%	27.1%	23.6%
Dauphin	24.7%	28.7%	25.9%	22.0%
Lancaster	26.5%	26.1%	24.2%	22.7%
Lebanon	24.4%	22.0%	26.1%	21.5%
Perry	26.4%	25.4%	22.0%	23.7%
Pennsylvania	24.3%	27.8%	25.5%	23.9%

Suicide due to overdose is an indicator of poor mental health. The rate of drug-related overdose deaths decreased from 2018 to 2019 in all counties except Dauphin, which saw a decrease. However, while Dauphin County had the highest rate of overdose death, it's important to note that Berks County had the highest raw count of overdose death. The 2019 rates were lower than the state rate in all counties except Dauphin.

Rate and Count of Drug-Related Overdose Deaths Per 100,000, 2015-2019

County	2015 Rate (Count)	2016 Rate (Count)	2017 Rate (Count)	2018 Rate (Count)	2019 Rate (Count)
Berks	16 (69)	27 (117)	27 (111)	23 (100)	28 (117)
Cumberland	15 (41)	23 (58)	30 (74)	19 (52)	16 (41)
Dauphin	29 (82)	30 (84)	35 (97)	44 (128)	36 (101)
Lancaster	14 (80)	22 (116)	30 (165)	20 (108)	19 (103)
Lebanon	15 (20)	12 (16)	21 (29)	19 (27)	16 (23)
Perry	7 (3)	20 (9)	22 (10)	33 (15)	n/a*
Pennsylvania	26.3 (3,264)	37.9 (4,642)	44.3 (5,456)	36.1 (4,491)	35.6 (4,458)
United States	16.3 (52,898)	19.8 (63,600)	21.7 (70,237)	20.7 (67,367)	21.6 (70,630)

Source: DEA Philadelphia Field Division
*Counties with overdose death counts between one and nine are suppressed.

Wellness and Disease Prevention

In 2019, 17% of students in Perry County reported being worried about running out of food, and all other counties had 12 to 15% of students being worried about running out food, all of which were higher than the state average. In 2019, 8% of students in Berks County reported that they did skip a meal because of family finances, and 7.5% of Lebanon County students reported skipping a meal.

Food and Stress (6, 8, 10 and 12 Grades)*

County	Worried About Running Out of Food*				Skipped a Meal Because of Family Finances*			
	2013	2015	2017	2019	2013	2015	2017	2019
Berks	17.3%	18.9%	17.7%	15.0%	7.5%	8.9%	8.7%	7.9%
Cumberland	9.5%	10.9%	10.8%	12.0%	4.4%	4.9%	5.2%	5.9%
Dauphin	11.1%	14.4%	14.0%	14.7%	5.1%	6.1%	6.5%	6.9%
Lancaster	11.1%	14.6%	12.9%	12.6%	5.5%	7.2%	6.4%	6.8%
Lebanon	12.4%	14.4%	15.7%	14.3%	5.5%	6.8%	7.7%	7.5%
Perry	10.4%	17.6%	15.0%	17.3%	5.0%	9.7%	7.0%	7.3%
Pennsylvania	9.5%	13.7%	13.4%	11.7%	4.4%	6.6%	6.8%	6.2%

*One or more times in the past year

2021

Limited access to healthy foods measures the percentage of the population that is low income and does live close to a grocery store. In the six-county region, Dauphin County has the greatest percentage (8%) of people who have limited access to healthy foods, and the percentages have stayed constant among all counties. Food insecurity estimates the percentage of the population without access to a reliable source of food during the past year. Food security was also highest in Dauphin County (11%). Considered together, food insecurity and access to healthy foods account for an overall food environment index score ranging from 0 (worst) to 10 (best). The highest or best score was in Cumberland County (8.8), and the lowest was in Dauphin County (8.1). All counties had a better score than the state (8.4), except for Dauphin County.

Food Access, Insecurity and Index – County Health Rankings, 2017-2021

County	Limited Access to Healthy Foods					Food Insecurity				
	2017	2018	2019	2020	2021	2017	2018	2019	2020	2021
Berks	3%	3%	3%	3%	3%	10%	9%	10%	9%	10%
Cumberland	3%	5%	5%	5%	5%	11%	10%	10%	9%	8%
Dauphin	12%	8%	8%	8%	8%	14%	14%	14%	13%	11%
Lancaster	5%	5%	5%	5%	5%	11%	10%	10%	10%	9%
Lebanon	4%	3%	3%	3%	3%	10%	10%	9%	9%	9%
Perry	4%	4%	4%	4%	4%	10%	10%	9%	9%	9%
Pennsylvania	4%	5%	5%	5%	5%	14%	13%	13%	12%	11%

Food Environment Index

County	2017	2018	2019	2020	2021
Berks	8.5	8.8	8.7	8.7	8.6
Cumberland	8.4	8.5	8.5	8.5	8.8
Dauphin	6.8	7.6	7.6	7.6	8.1
Lancaster	8.2	8.5	8.5	8.5	8.6
Lebanon	8.5	8.8	8.8	8.7	8.7
Perry	8.4	8.6	8.6	8.6	8.7
Pennsylvania	7.8	8.2	8.2	8.2	8.4

2021

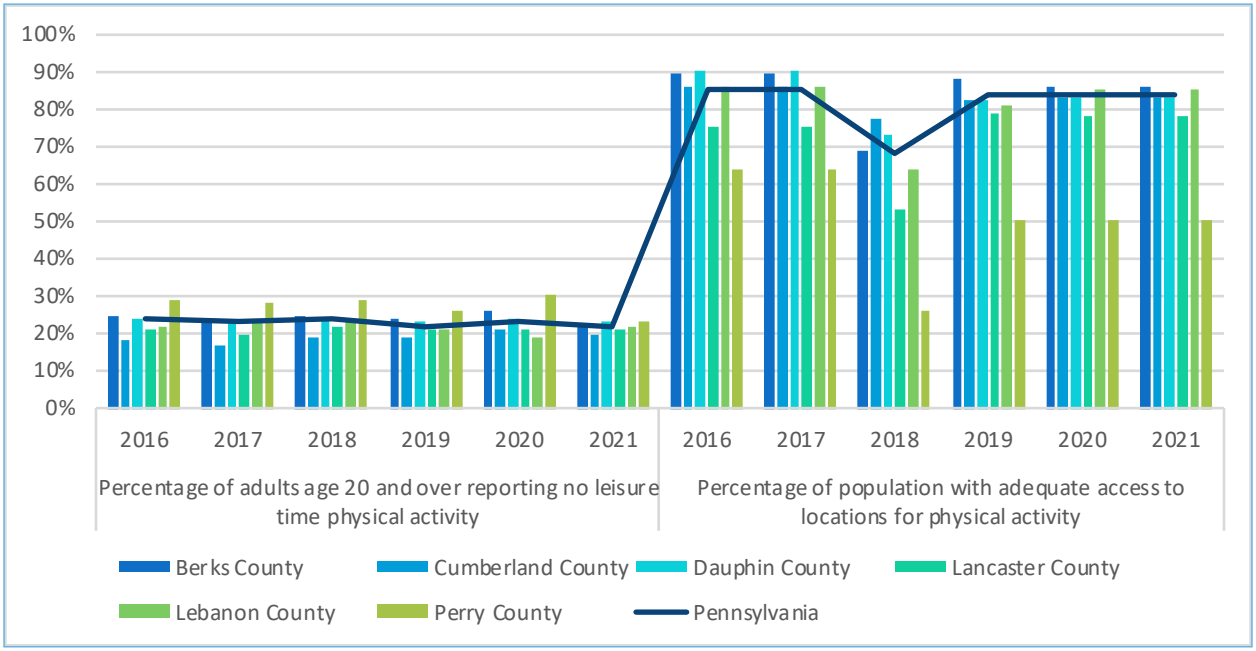
Current behaviors are determinants of future health and no leisure time physical activity may cause health issues, such as obesity and poor cardiovascular health. Access to exercise opportunities encourages physical activity and other healthy behaviors.

From 2017 to 2021, the percentage of adults reporting no leisure time physical activity stayed fairly constant in Berks, Dauphin, Lancaster and Lebanon counties, but increased in Cumberland and decreased in Perry. Dauphin and Perry counties had the highest (worst) percentage of adults reporting no physical activity, and Cumberland County had the lowest (best) percentage reporting no physical activity. Adequate access to exercise opportunities was lowest in Perry and highest in Berks.

Leisure Time Physical Activity and Adequate Access

County	Physical Inactivity Percentage of adults age 20 and over reporting no leisure time physical activity					Access to Exercise Opportunities Percentage of population with adequate access to locations for physical activity				
	2017	2018	2019	2020	2021	2017	2018	2019	2020	2021
Berks	23%	25%	24%	26%	22%	89%	69%	88%	86%	86%
Cumberland	17%	19%	19%	21%	20%	86%	77%	82%	83%	83%
Dauphin	23%	24%	23%	24%	23%	90%	73%	82%	83%	83%
Lancaster	20%	22%	21%	21%	21%	75%	53%	79%	78%	78%
Lebanon	23%	23%	21%	19%	22%	86%	64%	81%	85%	85%
Perry	28%	29%	26%	30%	23%	64%	26%	50%	50%	50%
Pennsylvania	23%	24%	22%	23%	22%	85%	68%	84%	84%	84%

Physical Inactivity and Access to Exercise Opportunities



Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues. In Lebanon County, one in 5 students in grades K to 6 and 7 to 12 were obese, while Dauphin and Perry counties had the greatest percentage (~22%) of students in grades 7 to 12 who were obese. Obesity among grades K to 6 increased or stayed constant in all counties except for Lancaster, which saw a small decrease. There was a greater percentage of obese students in grades 7 to 12 than K to 6.

Overweight and Obesity – Grades K to 6

County	Overweight (BMI > 85th to < 95th percentile)					Obese (BMI ≥ 95th percentile)				
	2013-14	2014-15	2015-16	2016-17	2017-18	2013-14	2014-15	2015-16	2016-17	2017-18
Berks	16.4%	17.2%	15.9%	15.8%	16.7%	18.2%	17.7%	18.1%	18.9%	19.4%
Cumberland	13.8%	13.9%	15.1%	14.7%	15.1%	15.0%	15.3%	14.2%	14.7%	14.7%
Dauphin	14.3%	14.6%	15.7%	15.3%	15.1%	16.6%	14.7%	17.3%	17.9%	17.9%
Lancaster	13.9%	14.7%	14.6%	14.1%	14.4%	15.2%	14.9%	15.2%	15.6%	15.3%
Lebanon	21.6%	15.1%	13.7%	16.6%	16.7%	14.7%	17.3%	19.4%	17.5%	20.0%
Perry	12.9%	13.1%	14.1%	14.0%	16.1%	15.5%	15.4%	15.9%	16.2%	17.7%
Pennsylvania	15.5%	15.1%	15.2%	15.5%	15.7%	16.3%	16.5%	16.7%	16.4%	16.8%

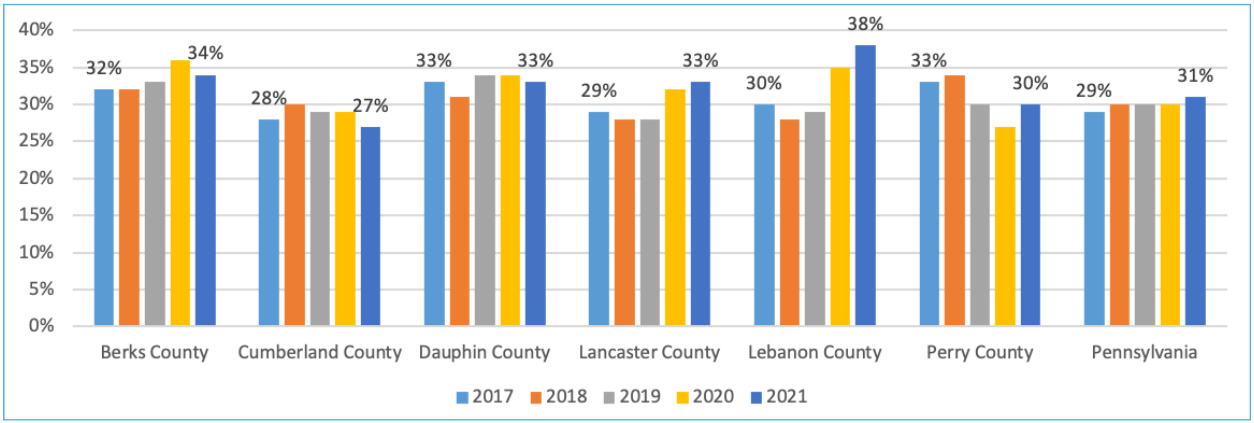
Overweight and Obesity – Grades 7 to 12

County	Overweight (BMI > 85th to < 95th percentile)					Obese (BMI ≥ 95th percentile)				
	2013-14	2014-15	2015-16	2016-17	2017-18	2013-14	2014-15	2015-16	2016-17	2017-18
Berks	18.6%	16.7%	17.6%	16.6%	22.7%	20.4%	20.6%	20.2%	20.9%	20.9%
Cumberland	14.2%	15.0%	16.4%	15.8%	16.2%	17.7%	17.2%	17.4%	17.7%	17.4%
Dauphin	16.3%	16.0%	16.3%	16.4%	17.2%	20.5%	20.5%	22.2%	21.8%	22.5%
Lancaster	15.2%	16.0%	16.0%	16.4%	16.1%	17.4%	17.8%	18.0%	18.8%	18.2%
Lebanon	15.5%	16.3%	15.9%	16.0%	17.0%	19.2%	19.6%	20.8%	21.3%	20.7%
Perry	14.8%	15.6%	16.2%	16.1%	17.6%	21.2%	22.2%	21.5%	21.7%	22.0%
Pennsylvania	16.3%	16.1%	16.5%	16.7%	17.1%	18.2%	18.6%	19.1%	18.9%	19.5%

2021

In 2021, the percentage of obese adults was greater in Berks, Dauphin, Lancaster and Lebanon counties than in the state, with Lebanon having the greatest percentage of obese adults. The percentage of obese adults was decreasing in Cumberland and Perry counties from 2017 to 2021, staying constant in Dauphin County and increasing in all other counties.

Obesity – Percentage of Adults Reporting a BMI of 30 or Higher



Lebanon County had the greatest percentage (9.7%) of adults indicating they had diabetes, which was higher than the state, and Cumberland County had the lowest percentage (8.9%). For both high blood pressure and high cholesterol, all counties except Dauphin and Lancaster had a higher percentage of Medicare fee-for-service population with high blood pressure or cholesterol, compared to the state and nation.

Prevalence of Respondent-Indicated Ailments, 2018-19
(Advisory Board, Demographic Profiler 2021)

County	Diabetes	High Cholesterol	High Blood Pressure	Heart Disease/ Heart Attack
Berks	9.6%	12.4%	17.1%	3.0%
Cumberland	8.9%	12.3%	17.3%	3.0%
Dauphin	9.2%	12.0%	17.2%	3.1%
Lancaster	9.4%	12.7%	17.4%	3.1%
Lebanon	9.7%	12.9%	18.0%	3.5%
Perry	9.0%	13.3%	18.8%	4.0%
Service Area	9.4%	12.5%	17.4%	3.1%
Pennsylvania	9.2%	12.1%	17.3%	3.3%

Medicare Beneficiaries with Diabetes, High Cholesterol,
High Blood Pressure and Heart Disease, 2017

County	Medicare Beneficiaries With Diabetes	Medicare Beneficiaries With High Cholesterol	Medicare Beneficiaries With High Blood Pressure	Medicare Beneficiaries With Heart Disease
Berks	12,491 (26.3%)	23,888 (50.2%)	29,552 (62.1%)	12,694 (26.7%)
Cumberland	6,824 (25.2%)	13,679 (50.5%)	16,813 (62.0%)	7,541 (27.8%)
Dauphin	6,300 (27.1%)	9,979 (42.9%)	13,603 (58.5%)	6,306 (27.1%)
Lancaster	14,305 (24.6%)	23,721 (40.8%)	33,828 (58.2%)	14,784 (25.4%)
Lebanon	4,256 (26.2%)	7,319 (45.1%)	9,845 (60.6%)	4,224 (26.0%)
Perry	1,300 (28.4%)	2,286 (49.9%)	2,841 (61.5%)	1,396 (30.5%)
Pennsylvania	354,833 (26.2%)	605,704 (44.7%)	793,672 (58.6%)	374,436 (27.6%)
United States	9,188,128 (27.2%)	13,714,033 (40.7%)	19,269,721 (57.1%)	9,076,698 (26.9%)

Engaging in cancer screening allows for early detection and treatment of any problems. Lack of screening can also indicate lack of access to preventive care, a lack of health knowledge, insufficient provider outreach and/or social barriers preventing utilization of services.

Dauphin County had the lowest percentage (43%) of female Medicare enrollees with an annual mammogram, and Lebanon County had the highest (49%). Hispanic females in Lebanon County had the lowest percentage (24%) receiving an annual mammogram, followed by black females at 26%.

Percentage of Medicare Enrollees Ages 65-74 Receiving Annual Mammography Screening, 2017

County	Total	White	Black	Asian	Hispanic
Berks	44%	44%	36%	37%	35%
Cumberland	48%	49%	34%	33%	40%
Dauphin	43%	44%	39%	40%	33%
Lancaster	47%	48%	42%	35%	34%
Lebanon	49%	49%	26%	47%	24%
Perry	45%	N/A	N/A	N/A	N/A
Pennsylvania	45%	N/A	N/A	N/A	N/A

In 2018, rates of melanoma in females and males were higher in Dauphin, Lancaster and Cumberland counties than in the state. Males had higher rates than females in all counties, with the highest rate among males in Cumberland. The breast cancer rate was highest in Lancaster County in 2018, which was also higher than the state's rate. Breast cancer rates were trending upwards in Berks, Cumberland, Lancaster and Perry counties. The prostate cancer rate was highest in Berks County in 2018, and both Berks and Lebanon counties had higher rates than the state. Prostate cancer rates were trending upward in all counties, except Dauphin.

Melanoma Incidence: Age-Adjusted Rates per 100,000, 2014-2018

County	Melanoma – Female					Melanoma – Male				
	2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Berks	18.6	19.5	17.8	15.0	16.4	23.0	26.3	18.2	31.6	22.7
Cumberland	27.3	18.8	26.1	24.0	19.7	44.4	19.6	41.7	25.6	38.4
Dauphin	18.1	20.5	25.1	22.9	25.0	37.6	35.8	30.1	35.4	29.9
Lancaster	17.7	26.3	25.8	24.6	24.9	35.0	41.2	40.2	32.4	34.8
Lebanon	23.3	27.1	ND (15)	ND (16)	ND (15)	ND (12)	27.1	40.0	33.7	24.0
Perry	ND (5)	ND (5)	ND (3)	ND (5)	ND (7)	ND (6)	ND (15)	ND (8)	ND (14)	ND (10)
Pennsylvania	21.8	21.8	18.8	17.4	17.4	31.9	31.4	29.3	26.9	26.0

*ND (Count) = Not displayed when counts less than 20

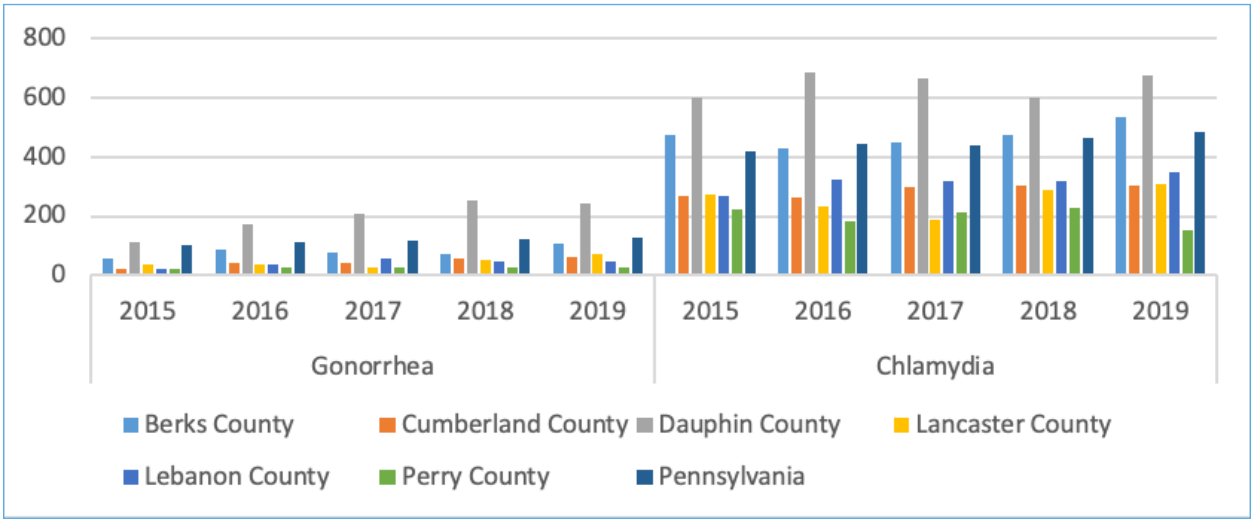
Breast and Prostate Cancer Incidence: Age-Adjusted Rates per 100,000, 2014-2018

County	Breast Cancer – Female					Prostate Cancer – Male				
	2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Berks	118.5	122.7	124.1	131.9	123.5	95.8	117.3	119.2	111.5	128.4
Cumberland	124.3	132.7	130.1	130.4	126.4	65.9	62.0	59.0	78.6	73.8
Dauphin	144.6	129.3	137.5	116.8	116.8	88.9	108.5	83.9	98.7	74.7
Lancaster	129.4	119.1	139.0	131.4	132.9	76.3	83.6	98.9	100.7	96.2
Lebanon	120.7	163.5	137.8	117.0	117.7	72.8	91.3	89.3	98.0	109.4
Perry	106.7	99.8	113.6	134.7	128.6	62.2	ND (14)	79.8	ND (16)	85.2
Pennsylvania	132.0	131.2	132.9	131.1	129.8	92.0	104.4	106.7	102.4	103.0

2021

Sexually transmitted diseases (STDs) are a measure of poor health status and indicate the prevalence of unsafe sex practices. The rates of gonorrhea and chlamydia are the highest in Dauphin County and are higher than the state rates. Overall, the rates of chlamydia have increased in all counties, except Perry, between 2015 and 2019, and the rates of gonorrhea have increased in all counties between 2015 and 2019.

Sexually Transmitted Diseases (STDs) per 100,000



Sexually Transmitted Diseases – Crude/Age-Specific Rates Per 100,000

County	Gonorrhea					Chlamydia				
	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019
Berks	57.1	86.8	75.1	74.7	109.9	475.1	430.1	451.1	472.4	536.4
Cumberland	22.7	39.8	44.4	58.9	62.8	268.3	265.2	297.9	301.1	301.9
Dauphin	111.4	173.9	206.0	250.8	240.7	602.2	685.8	667.0	598.3	673.7
Lancaster	38.2	38.6	24.9	52.1	73.1	273.2	232.7	186.6	288.8	310.2
Lebanon	19.7	34.6	57.2	48.8	45.8	269.2	324.1	317.7	320.6	348.4
Perry	21.9	26.2	28.2	28.2	28.1	225.5	181.1	212.5	227.6	153.4
Pennsylvania	99.9	114.3	119.0	124.0	125.6	417.6	445.4	440.8	463.3	482.2

Partner Forums

Background

Two Partner Forums were held virtually via Zoom sessions due to COVID-19 in-person meeting restrictions. Community partners and members were invited to attend one of two sessions held on May 12, 2021, from 11 a.m. to 12:30 p.m., and May 20, 2021, from 2:30 p.m. to 4 p.m. Participants from all six counties represented a wide variety of communities and organizations ,including public health and social service agencies, senior services, schools, religious institutions and other civic and social organizations. There were 112 attendees on May 12, 2021, and 103 on May 20, 2021.

The purpose of the forums was to share CHNA findings, solicit feedback from community representatives and provide a platform to identify opportunities to collaborate. Participants were not only asked to provide feedback on the CHNA findings, but were also asked to share their insight on priority health needs, underserved populations, existing community resources to address health needs and gaps in services. After the forums, a summary of all findings and recommendations was shared with participants, as well as a contact information list to foster collaboration, for those who wished to participate.

Prioritization Process

CHNA findings were provided to registrants in advance of the forum and formally presented to attendees. Questions about the data were encouraged and clarified. At the conclusion of the data presentation, a list of six health topics derived from an analysis of the key informant and Community Member Survey findings, and secondary data were presented to the group for discussion and recommendations in determining priority health needs. Discussion prior to voting included missing items, combining health issues and any additional feedback attendees wanted to provide.

Partner Forum participants were asked to participate in the prioritization exercise. Voting results were based on scoring the following criteria on a scale of 1 (low) to 4 (high) across each health issue.

Scope: How many people are affected?

- Magnitude or burden of the issue (i.e., the number of people impacted)
- High need among vulnerable populations

Severity: How critical is the issue?

- Degree to which health status is worse than state/national norms
- Cost/burden of the issue in the community (e.g., dollars, time, social)
- Focus on social determinants of health and eliminating health disparities

Ability to Impact: Can we achieve the desired outcome?

- Availability of resources/community capacity
- Community readiness to address the issue
- Can “move the needle” to demonstrate measureable outcomes

Voting results were combined for both sessions, and the top health issues were ranked as follows: 1. Mental Health (3.35), 2. Access to Care (3.18), 3. Social Determinants of Heath (3.14), 4. Chronic Disease Prevention and Management (3.12), 5. Substance Use Disorder (2.97), and 6. Food Access (2.95).

Prioritization Results

Priority	Overall Score 1 (Low) to 4 (High)
Mental Health	3.35
Access to Care	3.18
Social Determinants of Health	3.14
Chronic Disease Prevention and Management	3.12
Substance Use Disorder	2.97
Food Access	2.95

Small Group Discussion

Participants were divided into small breakout sessions based on their expertise, knowledge or interest to discuss the priority areas. Prior to breaking out, the participants were reminded to consider all factors that influence health when discussing possible interventions, such as environmental factors and policies, the physical environment, individual health behaviors and health care. They were asked to focus on the different factors that can affect the health of an individual, what relationships an individual has within the community and how to maximize collaboration with a wide range of community partners and members. Moderators led the group discussions to determine the top three goals to influence the priority by addressing the following questions:

1. What is going on in the community? – Who is most impacted? Which social determinants are involved?
2. How can we improve? – How can we partner? What can we do with existing resources?
3. How can we measure success? – What data points stick out the most that we should focus on?

Results from the breakout discussions are listed below. The top three goals recommended per priority per date are as follows:

Mental Health

May 12

- Provide more training for teachers, staff, providers, children and parents.
- Increase number of providers in the region.
- Increase number of support staff (crisis staff to support the influx of patients as additional Emergency Departments are established).
- Share information, resources, etc., among organizations; approach as united front.

May 20

- Partner among community organizations (instead of spreading resources, pull together).
- Use metrics to show what we are doing is improving access.
- Educate on self-care strategies for adults and children.
- Add clubhouses in communities.
- Provide stress management education.

Common themes from both sessions: additional community education/training and collaboration is needed.

Access to Care

May 12

- Improve navigation – provide clear navigation/instruction, make sure people know the resources that are available and help them get to the resources.
- Strengthen partnerships with community groups.
- Education – seems to be a knowledge deficit.

May 20

- Implement better telehealth programs (would help with transportation barriers).
- Collaborate with transportation companies (government entities, Uber, Lyft, taxi companies).
- Utilize navigators (social workers) to help with access.

Common themes from both sessions: improved navigation and collaboration is needed.

Social Determinants of Health

May 12

- Work to implement formal training and provide education in additional places throughout the community to combat racism.
- Work with community partner organizations to review and change local policies to help address the current housing crisis.
- Address disparities in the LGBTQ+ community.

May 20

- Housing: Establish incentives for large organizations to invest in affordable housing, advocate for local policies and partner with landlord associations, home sharing and bartering programs.
- LGBTQ+: Increase reach overall for related health services, especially in Lebanon County; engage medical students.
- Racism/discrimination: Require workplace training, and partner to increase education in the community.

Common themes from both sessions: focus on racism, housing and the LGBTQ community.

Chronic Disease Prevention and Management

May 12

- Educate youth/young adults on healthy eating – as an extension of our school assessment work with school nurses, to establish better habits at an earlier age.
- Collaborate and share information more formally with nonprofit service agencies to avoid overlapping work.
- Develop educational programming targeted to underserved communities on health reluctance topics (vaccination, trust of the medical system, etc.).

May 20

- Find ways to support those with chronic disease with health care education programs, information, etc.
- Better coordinate and communicate existing programs; do not duplicate effort but utilize programming already established.
- Identify programming for libraries, as they are known locations and organizations whose trust is already established.

Common themes from both sessions: focus on community education and collaboration.

Substance Use Disorder

May 12

- Conduct substance use screenings and brief interventions in the community, as well as at all care settings.
- Provide warm handoffs from emergency department and other settings where Narcan is given, using certified recovery specialists (CRSs), certified family recovery specialists (CFRSs) and community health workers (CHWs).
- Connect with adolescents and young adults where they are and provide supportive opportunities.
- Offer screening and education at all levels (youth/adults, providers, organizations, etc).

Note: No participants chose this breakout session on the May 20 forum.

Food Access

May 12

- Go into communities with coordinated efforts (food pantry programs, schools, bodegas and healthy corner stores).
- Work with schools and summer programs to reach kids and extend to families (train-the-trainer programs).
- Garden education (schools, community gardens, task force model with a part-time garden manager, container gardens).
- Urban planning for grocery stores and transportation.

May 20

- Provide education in multiple languages.
- Understand from ALICE Households what prevents access to healthier foods (time, money, transportation, choice, location).
- Partner with existing organizations, corner stores, bodegas and farm stands to increase access to healthier foods; connect farmers to corner stores.
- Share resources and best practices across the region, communicate more, develop a shared database.

Common themes from both sessions: Coordinate efforts regionally and educate in existing infrastructure, such as schools, food pantries, corner stores, markets, community gardens, etc.

Final Determination of Prioritized Community Health Needs

A CHNA Leadership Team representing all Penn State Health hospitals met on a regular basis throughout the CHNA process. This group reviewed all findings and forum breakout notes and goal suggestions to recommend the three top priority health needs to focus on. Next, these recommendations were brought to the Penn State Health Community Health Team (CHT). The CHT monthly meeting consists of community-minded positions from Penn State Health entities, as well as community partners. Most of the CHT members were engaged with the CHNA process many times through surveying, practice presentations and participating in the forums. Attendees of both meetings considered contributing social issues, existing community resources, gaps in services and expertise and resources within each medical center in determining recommendations for priority health issues.

Multiple meetings and discussions determined the top three prioritized health needs of **1) Mental Health** **2) Health Equity** and **3) Wellness and Disease Prevention.**

Mental Health includes a focus on community groups, such as the LGBTQ+ community, people of color and youth. Substance Use Disorder will also be addressed under this priority. Health Equity covers concerns such as access to care, elder issues with access, social determinants of health, racism, diversity, transportation and housing. Wellness and Disease Prevention encompasses food access and nutrition, substance use prevention, chronic disease prevention, health education and physical activity. Everyone agreed that these priorities, and focus areas within, represent all six ranked health concerns and that all of these areas are very interrelated. One cannot be addressed without the others.

Penn State Health, in partnership with key community stakeholders, will use this information and these intertwined priorities to develop community health and benefit activities over the next three-year cycle. By adopting systemwide priorities, Penn State Health seeks to promote a regional approach to addressing community health needs and foster partner collaboration.

Prior CHNA Implementation Plan – Evaluation of Impact and Comments Received

Evaluation of Impact

The Implementation Plan and Annual Report Cards can be found at: pennstatehealth.org/community

The findings of the 2018 CHNA conducted by Penn State Health (Milton S. Hershey Medical Center, St. Joseph Medical Center and Pennsylvania Psychiatric Institute) identified three overarching priorities, and each of these had subcategories of goals and measureable objectives established. Addressing access to care and social determinants of health were seen as crosscutting strategies needed to improve outcomes across all priority areas.

The following section highlights key achievements and impacts during the first two years of the Implementation Plan set to address these needs.

- An average of **91%** of the indicators set for the first two years of our CHNA Implementation Plan were achieved.

#1 Behavioral Health

Behavioral Health

- Pennsylvania Psychiatric Institute reached over **1,000** participants with mental health training to identify warning signs and symptoms. This education was provided to community members and professionals, including law enforcement, Pennsylvania State Police cadets, Dauphin County correctional and probation officers, the Pennsylvania Driving Under the Influence (DUI) Association and local school districts.
- The Center for the Protection of Children iLookOut team has worked to make a new, online, state-authorized version of the iLookOut for Child Abuse Mandated Reporter Training available to all mandated reporters in Pennsylvania. This program is believed to play a significant role in helping protect children who are at risk for abuse.
- Community Relations grants were initiated with community partners to support drive-through Narcan education and distribution events, CRS and CFRS scholarships, community harm reduction education, art for public health, substance use disorder newsletter campaigns and trauma informed care.
- A Comprehensive Drug Safety Program provides for storage of medications and safe disposal at home, drop boxes on the Penn State Health campuses, Drug Take-Back Days and community Narcan distribution in underserved communities.
- **3,700** DisposeRx Packets, **2,000+** lock boxes and **hundreds** of doses of Narcan were distributed over the two-year period.
- Drug Take-Back boxes were established in the hospital lobbies and Drug Take-Back Days were held in partnership with local police departments, collecting over **2,500** pounds of discarded medications and **49** sharps containers over the two-year period.

#2 Healthy Lifestyles

Healthy Lifestyles

Nutrition

- According to countyhealthrankings.org, the percentage of persons who lack adequate Access to Food improved in Dauphin County over the two year period and the target we set for this metric was met. We are also seeing a slight decrease in the percentage of adults who report a BMI of ≥ 30 in both Dauphin and Berks Counties. We cannot directly say that these trends are the result of our efforts, but hopefully all of our nutrition and food outreach efforts, such as our Food Box initiatives, Farmers' Market, Food Pantry, Community Garden, Farm Stand and Veggie Rx Program, reaching over **120,000** individuals with healthy food choices and consistent MyPlate (choosemyplate.gov) messaging contributed to these positive trends.
- At the St. Joseph Medical Center Downtown Campus, Veggie Rx Program, 111 patients were initially enrolled, impacting over 215 family members. During the last two fiscal years, **36,771** vouchers were redeemed, totaling **$75,542** spent on local fruits and veggies.
- Through a Highmark Foundation Grant, multiple fresh produce outreaches to community food pantries were completed by our community health nurses. MyPlate messaging, recipes and cooking utensils were provided with the produce to create a healthy meal. Participants across all food pantry health outreach efforts expressed appreciation for these services. Despite moving to pickup service-only during the COVID-19 pandemic, blood pressure checks and other health education and screenings were continued outside. Through this program, much-needed care and conversation are brought to community members where they are. For example, one participant was referred to a smoking cessation counselor and was very proud that she hadn't smoked two weeks later. Another participant who was struggling with an amputation was connected to a community health worker who assisted with obtaining a prostheses and a job. Many participants have their blood pressure, cholesterol and glucose measurements tracked who would otherwise not be monitored.

Oral Health

- The Dental Operatory opened at Hershey Medical Center, and planning has begun to initiate a dental residency program, as well as an outpatient dental clinic to increase access to dental care in our community.
- An oral health resource was collaborated on with **pa211.org,** and oral health messaging focused on brushing twice per day and the importance of fluoride reached **700+** members of underserved communities.
- A pediatric ongoing quality study has demonstrated that brushing habits and fluoride use have improved.
- St. Joseph Medical Center worked with the Pennsylvania Area Health Education Center (AHEC) office and Oral Health Task Force to update the CHW training curriculum to include early childhood oral health education with an online component that is publicly available.

Physical Activity

- According to countyhealthrankings.org, the percentage of adults who report no leisure time physical activity is improving.
- Over **40,000** community members were reached through initiatives to improve walkability, a bike-share program, walking and biking trails and social walking and safety programs, as well as a youth tennis program initiated in underserved communities.
- "Racquets and Recipes" was offered as an extension of the youth tennis program in Lebanon to provide healthy cooking demonstrations and snacks to parents while their children learned to play tennis.
- Pediatric Trauma and Injury Prevention used community relations grant funds to engage with **16** local police departments and provide **720** bike helmets to promote bike safety to avoid injury, as well as bring communities together. Officers took a seven question pre-test, completed a training (train the trainer), then took a seven question post-test. A statistically significant increase in knowledge was shown.

#3 Disease Management

Disease Management

- Community paramedicine reduced chronic disease readmissions for heart failure and stroke patients and expanded these efforts from Hershey Medical Center to St. Joseph Medical Center. Our CHW programs and Training Institute and Patient Navigation Program also improved access to care and important community services.
- Just over **37,000** community members were reached by disease prevention screening, education, navigation and support programs focused on cancer, cardiovascular diseases and stroke. These teams coordinated efforts to organize a common message between disease programs and offer these programs in high-need communities.
- The "Let's Get Educated Against Cancer" Spanish monthly webinar series was initiated in partnership with the Spanish American Civic Association (SACA). After the first six webinars were offered, **181** participants attended the live sessions and **2,001** viewed the recordings.

COVID-19 Response

Although COVID-19 changed many of our plans, we were able to quickly adapt to the pandemic and serve our community in other ways needed, such as with increasing access to community COVID-19 vaccines through pop-up sites and transportation vouchers, employee food pantries and collaborating with the Caring Cupboard Food Pantry to support food delivery to COVID-positive patients. Additional initiatives included an outdoor farm stand in downtown Reading that also distributed "COVID relief bucks" the form of $2 in Berks Farm Bucks (vouchers) to every shopper, the OnDemand COVID-19 screening app, drive-thru testing, Community Donation Center, contact tracing, nursing home support and radio/TV educational sessions.

The COVID-19 OnDemand app is provided as a free community benefit to increase access to screening, testing and contact tracing and reached over **13,000** people during the pandemic. A focus group was held with community partners to assess the interest in COVID-19 vaccinations, hesitancy concerns and community locations where they should be offered. As a result, COVID-19 vaccine pop-up events were held in **46** underserved communities, thus taking almost **10,000** doses of this important intervention to community members who, for many reasons, may not have been able to receive their vaccination.

Community Health – FY 2020

- Community Health includes all community health improvement projects offered (not only those prioritized by our CHNA process), cash and in-kind contributions, community building activities and community benefit operations.
- Overall in **FY 2020,** Penn State Health **served over 580,000 community members,** with over **124,000 employee hours** and **76,000 volunteer hours**, resulting in **over $4.8 million** in Community Health services provided to our community.

Community Benefit – FY 2020

- Community Benefit is the total value of quantifiable benefits provided to our community and reported to the IRS. This number does not include research, bad debt or Medicare.
- In **FY 2020**, Penn State Health provided **$117,694,540 in community benefit.**

Comments Received

Community members were asked to provide their feedback on previous CHNAs conducted by Penn State Health as part of the Key Informant Survey, as well as during the Community Partner Forums. The opportunity to provide feedback is also available to the general public on an ongoing basis via a link posted on pennstatehealth.org/community. Overall, the feedback was positive, with many comments indicating that respondents felt Penn State Health has been doing an excellent job with facilitating collaboration, fostering partnerships and documenting and sharing findings. Some respondents expressed a desire for Penn State Health to have a stronger presence in various geographical locations and to utilize its influence to have an impact on systemic factors that influence health. A full list of comments received is included in Appendix C.

Conclusion

Based on the results of the current Implementation Plan, Penn State Health hospitals will continue into the final year of the strategy intending to accomplish the established indicators, as well as any not yet met or reestablished due to COVID-19. Data sources will be monitored with the overarching goal of demonstrating improved community health. These accomplishments and new partnerships provided input into the 2021 CHNA process and priorities determination and will inform the next Implementation Plan.

Existing Community Assets to Address Community Health Needs

Community Benefit Inventory

All Penn State Health hospitals maintain an inventory of community partners in a community benefit database, the Community Benefit Inventory for Social Accountability (CBISA) Plus™ for Healthcare by Lyon Software (lyonsoftware.com/). These partner inventories include over 300 community organizations and multiple contacts for each one and highlight programs and services within the six-county assessment area. They are continually updated by the CBISA project managers to remain current and include contact names, organization name, emails, telephone numbers, addresses, program descriptions and relationship to Penn State Health. A current copy of these inventories can be generated in real time upon request.

Because these inventories represent organizations our entire health system works with, they identify a wide range of community organizations and public health agencies that are serving the various target populations within our service area. Therefore, it was used to generate an initial list to invite organizations to provide their input on community health needs via Key Informant Surveys, assist with conducting Community Member Surveys and attend Community Forums.

In addition to this list, other departments across Penn State Health who are very active in the community maintain lists of their key community contacts. Owners of these lists were invited to complete the Key Informant Survey and were asked to share it with their contacts to also complete. For example, the Pediatric Trauma and Injury Prevention Program shared it with their Safe Kids Coalition and Penn State Cancer Institute shared it with their Community Advisory Board. The invitation was also sent to the Penn State College of Medicine Department of Public Health Sciences workforce development list, which includes excellent connections to several Pennsylvania Department of Health divisions.

Names of the organizations and groups engaged in any aspect of our CHNA process can be found in Appendix B. Please note this list may not be all-inclusive since participants could remain anonymous.

Community Grants

The Penn State Health Community Relations department offers grants to engage employees across the health system to partner with community organizations and initiate a program addressing at least one of the health need priorities identified by the CHNA. Not only do these grants provide local health programming, they also 1) engage employee talent in community outreach, 2) help develop an organizational culture of community health improvement and 3) provide our employees and students with the opportunity to learn from community partners and better understand the social influences on health that our patients experience outside of our hospital walls. Grant examples and outcomes are available in real time upon request.

Appendix A: Secondary Data References

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- Pennsylvania Department of Health. *Bureau of Health Statistics*, 2019.
- Pennsylvania Department of Health. *Enterprise Data Dissemination Informatics Exchange (EDDIE)*, 2021.
- Pennsylvania Department of Health. *School Health Statistics*, 2013-18.
- The Advisory Board Company. *Demographic Profiler*, 2021.
- The United Way. *ALICE Threshold*, 2018.
- United States Census Bureau. *American Community Survey (ACS) 5-year Estimates*, 2015-2019.
- United States Department of Agriculture, Economic Research Service. *USDA - Food Environment Atlas*, 2015 and 2018.
- United States Department of Health and Human Services, Center for Medicare & Medicaid Services. *NPI Registry*, 2020.
- United States Department of Health and Human Services, Health Resources and Services Administration. *Area Health Resource File*, 2018 and 2019.
- University of Wisconsin Population Health Institute. *County Health Rankings*, 2021.

Appendix B: Participating Community Organizations

Thank you to these community organizations, and others that may not be included below, that contributed time, space, feedback, advertising or other support to the 2021 Penn State Health Community Health Needs Assessment.

Ability Prosthetics & Orthotics

AccessMatters

Adagio Health

Advance African Development, Inc.

Advanced Metrics

Aetna

A.J. Drexel Autism Institute

Alder Health Services

Allison Hill Community Center

Alzheimer's Association

American Lung Association

American Red Cross

AmeriHealth Caritas

Anchor Lancaster

Armstrong-Indiana-Clarion Drug & Alcohol Commission Inc.

ASERT Collaborative

Aspirations

Band Together

Beacon Clinic

Bell & Evans

Berks Alliance

Berks Area Regional Transportation Authority

Berks Community Health Center

Berks Counseling Center Inc.

Berks County

Berks County Area Agency on Aging

Berks County Community Foundation

Berks County Department of Emergency Services

Berks County Intermediate Unit

Berks County Office of Mental Health and Developmental Disabilities

Berks Encore

Berks Nature

Berks Teens Matter

Bethany Christian Services

Bethesda Mission

Bloomsburg University

Blue Mountain Academy Agriculture

Borough of Hamburg

Borough of West Reading

Breast Cancer Support Services of Berks County

Brethren Housing Association

Calvary United Church of Christ, Reading

Capital Area Head Start

Capital Blue Cross

Carlisle Community Area Action Network

Cathedral Parish of Saint Patrick

Catholic Health Initiatives St. Joseph Children's Health

Central Pennsylvania Food Bank

Central Pennsylvania Youth Ballet

Child Care Consultants Inc.

Church of the Good Shepherd

Church World Service-Lancaster

City of Harrisburg

City of Lebanon

City of York Bureau of Health

Cocoa Packs Inc.

Commonwealth Media Services

Communities Practicing Resiliency (CPR) of Greater Harrisburg

Community CARES

Community First Fund

Community Health Council of Lebanon County

Community Prevention Partnership

Community Services Group

Conquista Y Victoria

CONTACT Helpline 211

Contact to Care

Council on Chemical Abuse

Cumberland Area Economic Development Corporation

Cumberland County Aging & Community Services

Cumberland County Housing & Redevelopment Authorities

Cumberland/Perry County Mental Health, Intellectual & Developmental Disabilities

Cumberland Valley School District

Dauphin County Case Management Unit

Dauphin County Coroner's Office

Dauphin County Court Appointed Special Advocates

Dauphin County Drug & Alcohol Services

Dauphin County Health Improvement Partnership

Dauphin County Human Services

Dauphin County Library System

Dauphin County Medical Society Alliance

Dauphin County Prison

Derry Township

Derry Township School District

Dickinson College

Diocese of Harrisburg

Domestic Violence Intervention of Lebanon County

Domestic Violence Services of Lancaster County, Inc.

Downtown Daily Bread

Drexel University

Early Learning Resource Center

East Hanover Township

Ebenezer Baptist Church

Elizabethtown Area School District

Elizabethtown Community Housing & Outreach Services

Employment Skills Center

Epilepsy Foundation Eastern Pennsylvania

Episcopal Church of the Nativity and St. Stephen, Newport

Family Guidance Center

Family Promise of Harrisburg Capital Region

First United Church of Christ

Fishburn Church

Gateway Health

Gather the Spirit for Justice

Gemma's Angels

GLO

Grace Lutheran Church

Grantville Area Food Pantry

Greater Reading Chamber Alliance

Hadee Mosque

Hamburg Emergency Medical Services

Hamilton Health Center

HANDS of Wyoming County

Hanoverdale Church

Harrisburg Area Community College

Harrisburg Area YMCA

Harrisburg School District

Harrisburg University of Science and Technology

Healthy Family Partnership

Healthy Steps Diaper Bank

Heartshine

Hempfield recCenter

Hershey Entertainment & Resorts

Hershey Plaza Apartments

Highmark

Hill Terrace

Hope Within Ministries

Hospice of Central PA

Hoy Towers

Hummelstown Food Pantry

Hummelstown United Church of Christ

Immediate Homecare & Hospice

Jabbok Counseling

Jewel David Ministries Inc.

Jewish Family Service of Greater Harrisburg

Jewish Federation of Greater Harrisburg

Jewish Federation of Reading/Berks

Jewish Home of Greater Harrisburg

Joseph T. Simpson Public Library

Joy of Sports Foundation

Keystone Health Agricultural Worker Program

Lancaster Behavioral Health Hospital

Lancaster Family YMCA

Lancaster LGBTQ+ Coalition

Lancaster Osteopathic Health Foundation

Latino Connection

Latino Hispanic American Community Center

Lebanon County Christian Ministries

Lebanon County Mental Health /Intellectual Disabilities/ Early Intervention Program

Lebanon Diversity Social

Lebanon Family Health Services

Lebanon School District

Lebanon Valley Community Tennis Association

Lebanon Valley Family YMCA

LGBT Center of Central PA

LionReach

Literacy Council of Reading-Berks

LivingWell Institute

Lower Dauphin Communities That Care

Manna Food Pantry

Maple Terrace

Mary's Helpers Food Pantry and Clothing Store

Maternal & Family Health Services

Mechanicsburg Area School District

Merakey

Messiah Lifeways

Messiah University

Metropolitan Community Church of the Spirit

Middletown Food Pantry

MidPenn Legal Services

Milton Hershey School

Minersville Area School District

Mohler Senior Center

Monongalia County Health Department

Montgomery County Department of Health and Human Services

Mount Nittany Health

National Institute for Coordinated Health Care

New Hope Ministries

New Life Community Church

Northern Dauphin Human Services Center

Our Lady of Lourdes

PA Coalition for Oral Health

Palmyra Grace Church

Partnership for Better Health

Penn Medicine Lancaster General Health

Penn National Race Course

Penn State Addiction Center for Translation

Penn State Berks

Penn State Cancer Institute

Penn State College of Medicine

Penn State College of Medicine Student-run and Collaborative Outreach Program for Health Equity (SCOPE)

Penn State College of Nursing

Penn State Extension

Penn State Harrisburg

Penn State Health Medical Group

Penn State PRO Wellness

Penn Street Market

Pennsylvania Association of Community Health Centers

Pennsylvania Department of Conservation and Natural Resources

Pennsylvania Department of Health

Pennsylvania Department of Human Services

Pennsylvania Fetal Alcohol Task Force

Pennsylvania Health Access Network

Pennsylvania Link to Aging and Disability Resources

Pennsylvania Office of Vocational Rehabilitation

Pennsylvania Recovery Organizations Alliance

Pennsylvania Special Supplemental Nutrition Program for Women, Infants and Children

Pennsylvania State University

Perry County

Perry County Area Agency on Aging

Perry County Emergency Management Agency

Perry County Health Coalition

Perry Human Services

Planned Parenthood Keystone

Poplar Terrace Apartments

Prince of Peace Parish

Pyramid Healthcare

Racial and Ethnic Approaches to Community Health

Reading Farm Stand

Reading Hospital

Reading Housing Authority

Reading School District

Riverfront Federal Credit Union

Safe Berks

Safe Harbour

Safe Kids Dauphin County

Safe Kids Pennsylvania

Saint Clair Area School District

Saint Elizabeth Ann Seton Parish, Mechanicsburg

Samara

SAMBA – Susquehanna Area Mountain Bike Association

Samaritan Fellowship

Saratoga Area Senior Coordinating Council

Schaner Senior Center

Sexual Assault Resource and Counseling Center

Shippensburg Civic Club

Shippensburg Community Resource Coalition

Slippery Rock University

Southeastern Health Care at Home

South Central Transit Authority

St. Anne Catholic Church

St. John's United Church of Christ

St. Peter the Apostle Roman Catholic Church

Steelton-Highspire School District

Success Against All Odds

Susquenita School District

Tamaqua Area School District

The Caring Cupboard

The Danya Institute Inc.

The Food Trust

The Foundation for Enhancing Communities

The Hershey Company

The Kidney Foundation of Central PA

The Period Project Harrisburg

The Salvation Army

The Salvation Army Harrisburg Capital City Region

The Salvation Army of Reading

The Wyomissing Foundation

Threshold Rehabilitation Services

Tioga County Partnership for Community Health

TLR Business Solutions, Inc.

TLR Insurance

Trans Advocacy Pennsylvania

Trehab Community Action Agency

Tri County Community Action

Trinity Preschool, Harrisburg

Tri-State Advocacy Project

Tulpehocken Terrace

Unitarian Church

United Community Services for Working Families

United Way of Berks County

United Way of Carlisle & Cumberland County

United Way of Lebanon County

United Way of the Capital Region

University of Pittsburgh Medical Center (UPMC)

UPMC Harrisburg

UPMC Health Plan

Vickie's Angel Foundation

Visiting Nurse Association of Central PA

Volunteers of America of Pennsylvania

Weidenhammer

WellSpan Good Samaritan Hospital

WellSpan Philhaven

West Chester University

West Reading Borough

West Shore Chamber of Commerce

West Shore School District

West Shore YMCA

Western Berks Free Medical Clinic, Inc.

Wilkes-Barre City Health Department

Willow Terrace Senior Apartments

YMCA Center for Healthy Living

YMCA of Reading and Berks County

York College of Pennsylvania

YWCA Carlisle & Cumberland County

Zion Lutheran Church, Union Deposit

Appendix C: Feedback Comments for Past CHNAs and Implementation Plans

- *"Additional questions specifically about LGBTQ+ community."*
- *"I have been impressed with the work that has been done to address community health needs."*
- *"Collaboration is key to help meet the goals and effect change."*
- *"Each county is unique, and the response should be tailored as such."*
- *"Good job compiling information. Would love to see a graph of measurable impact since CHNA began. This might be helpful in determining/revising next steps."*
- *"Are you using the ACEs survey? ACEs and toxic stress syndrome are powerful determinants of physical and mental health."*
- *"Asking people to indicate if they are: male, female, transmale, transfemale, gender fluid or not listed (please tell us) is flawed. Male and female and biological sexes. Transgender and nonbinary identities are gender identities. These are two entirely different categories. Instead, respondents should be asked, in two different questions, about their sex and gender identity. Furthermore, this question does not help us collect data on intersex folks. The terms "transmale" and "transfemale" are outdated and flawed language. These questions need to be asked in a different way in order to gather accurate data."*
- *"I believe we must better address mental health treatment needs."*
- *"Since mental health is an increasing problem throughout the country, are there any plans to increase providers (inpatient/outpatient)?"*
- *"Comprehensive programs defined with measurable outcomes."*
- *"Great info! One small question – for the tobacco module, should it be specifically named nicotine and include vaping? We have seen a number of stats demonstrating that smoking is declining, but vaping is more than making up for the decrease. Just a thought."*
- *"I think it's important to include a diverse range of stakeholders on the implementation task forces."*

- *"I applaud the efforts. I have seen a significant decrease in the ability of Penn State Health St. Joseph Medical Center staff to participate in community collaboration meetings in the community. They are invited but not at the table. The overwhelming response is we are short-staffed/spread thin. This is concerning to me. Especially in the past 14 months with virtual formats, staff had the opportunity to collaborate with minimal time commitment."*

- *"I believe that St. Joseph Medical Center did an outstanding job identifying the needs of the community. I am unaware of how the plan was implemented, but I am certain that they followed through."*

- *"I do not have any but THANK YOU so much for doing these CHNA. I think this CHNA is a great approach to helping the public get better health care services. Thank you again."*

- *"I think it's wonderful that Penn State Health has initiated these plans. I hope that these assessments continue to be made a part of all hospitals' responsibilities, even if the Affordable Care Act does not mandate it. The results of the implementation of these plans should be on the Penn State Health organization's website, if they aren't already."*

- *"I understand the need, in our current structures, to prioritize need areas. At the same time, this needs to be done in conjunction with deep systems work that includes the voices of all the people being served by the system – a very challenging task in something as huge as health care, but the pandemic is showing us what some of the systemic issues are. A good place to start?"*

- *"I would like to see more research on local transgender and nonbinary populations. It would also be additionally helpful to see how folks who have intersecting marginalized identities are affected when seeking out and accessing care."*

- *"I'd like to be able to see the responses and feed back from needs assessments."*

- *"It is my hope that Penn State Health will consider a network of social service agencies working in partnership with St. Joseph Medical Center to address the social determinants of health that are identified, as well as the issues raised through this CHNA."*

- *"Just keep continuing to engage the greater Reading community in this process as much as you can."*

- *"This should be more than just what additional services could be offered. Penn State Health has a physical presence in downtown Reading, but it needs to have an investment presence."*

- *"Transportation is our largest barrier to get folks to medical appointments. CAT share and bus is not always practical for disabled and elderly. Poverty in general, housing specifically, is prioritized over medical care. This survey did not include access to Internet, computer, smartphones, assisting elderly with technology – this is a huge barrier."*

- *"We value our collaboration with Penn State Health and have seen firsthand how it strengthens the community."*

- *"While I'm sure it took more time to create, the Progress Report through 2015 provided solid data on what happened and related it clearly to the goals. The reporting documents since then haven't been quite as impressive or helpful in my opinion."*

- *"This was wonderful! Would like to see this implemented statewide!"*

- *"Excellent"*

- *"I noticed that during break outs that there was only one person who joined substance abuse discussion – may be reason for lowest prioritization."*

- *"I always welcome and APPRECIATE each and every opportunity to work with Penn State Health. These opportunities have afforded our community members to learn of available services and receive health and wellness services through local events and our NDHI network."*

- *"I am recently very pleased about our agency's opportunity to actively work with and collaborate with Penn State Health here in Berks County. In the past, it has been very difficult to forge a strong relationship. We are very grateful to [redacted] for her involvement with our agency and the manner in which she has led us through the process to open new doors and opportunities to work together."*

- *"I began pressing for health care services for East Hanover Township in the 1970s when the newly opened Hershey Medical Center denied new patient services to our residents. Then, Hershey Medical Center rescinded their limits and accepted our residents. Many things have changed over the years and the Medical Center has expanded its services north, south, and west. Now, how about spreading your services north to your very close neighbor that abuts the mountains and would benefit greatly from your services? We have mobile home parks, an aging population and minority workers at the track who need you. A disappointed resident, [redacted]"*

- *"I believe what is currently being done in terms of partnership is what was on the implementation plan."*

- *"Thank you for including Western Berks Free Medical Clinic in this important survey! Let us know if we can help in any way."*

- *"Thanks for asking for our input."*
- *"We appreciate the opportunity to be included in your CHNA. Best wishes!"*
- *"We are a rural community with some essential services but many that are not available."*
- *"We worked with Penn State Health and Penn State St. Joseph several years ago. We had two or three Sundays. If memory serves, a few people dropped down in the church hall after mass. One of two were very interested. To live healthily requires much discipline. And time. (Shop right. Exercise. Prepare a balanced meal vs. take out. Many of our people don't have the luxury of time.)"*

PennState Health

2021

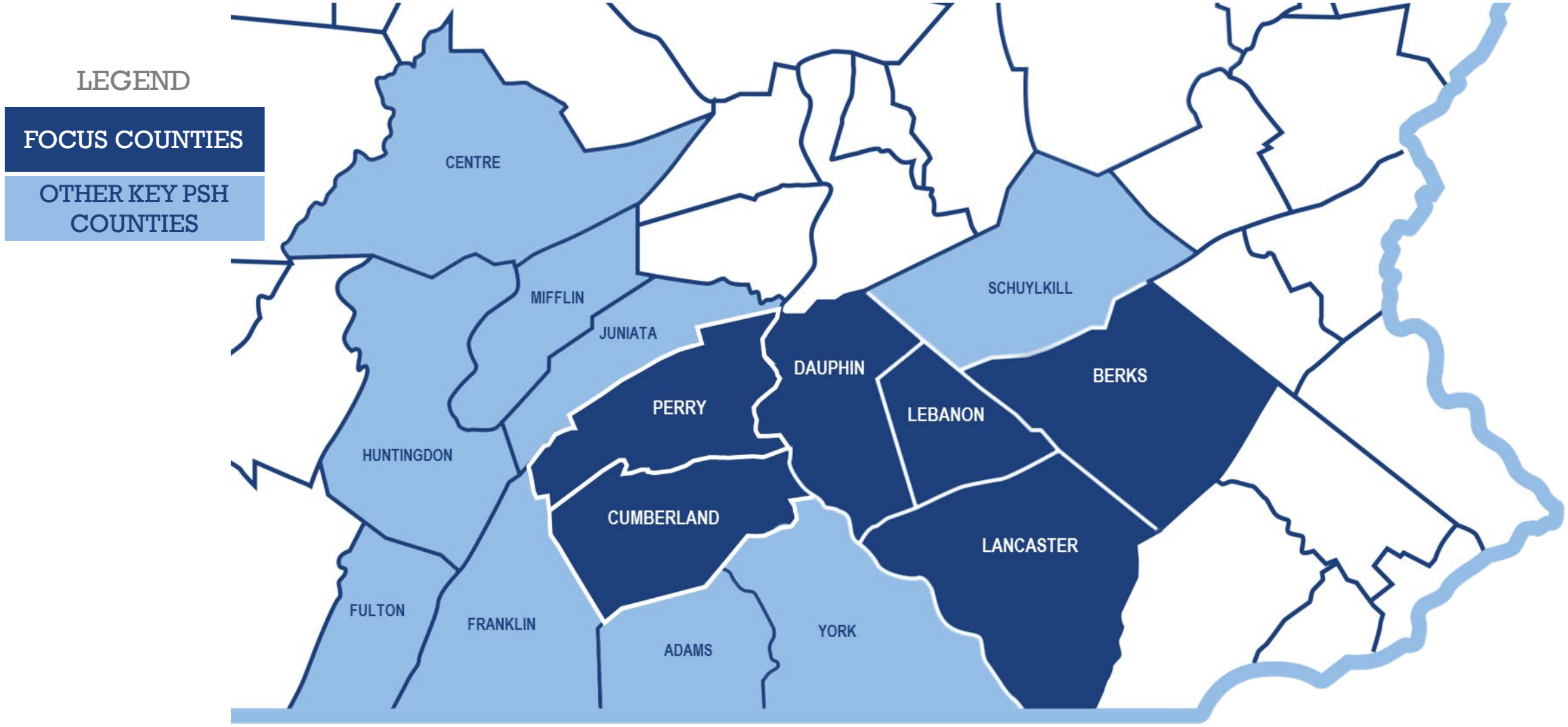
Penn State Health

Community Health Needs Assessment (CHNA)

Partner Forums – May 2021

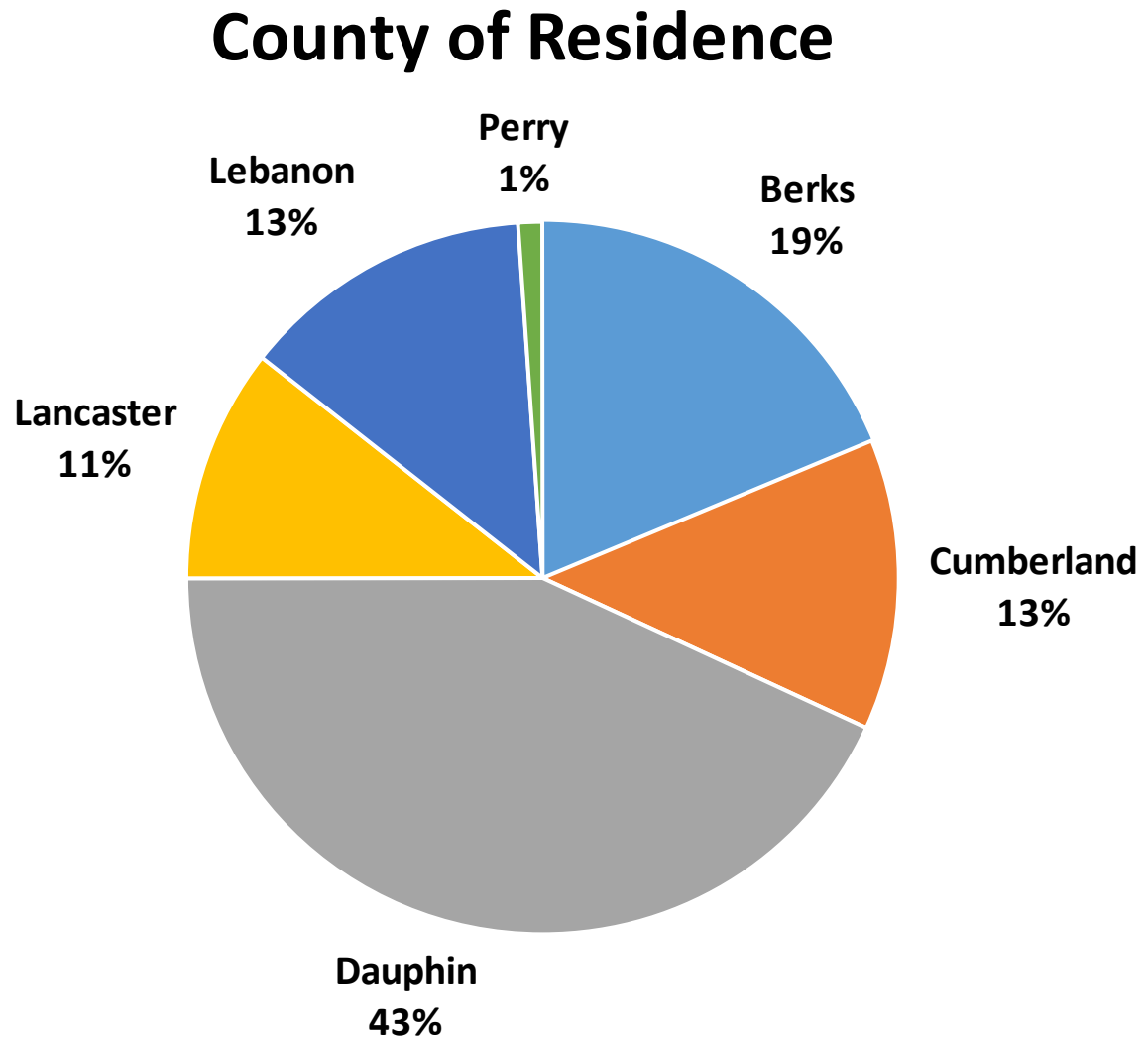
CHNA Findings

Our Community



County and ZIP Code Representation

- A total of 2,778 individuals responded to the community member survey (CMS) and 2,532 responses were able to be used based upon county of residence and age.
- A total of 317 individuals/organizations responded to the key informant survey (KIS).
- Used paper and electronic surveys to reach as many people as possible within the restrictions of COVID.
- Focused on highest need ZIP Codes based upon the Community Need Index.

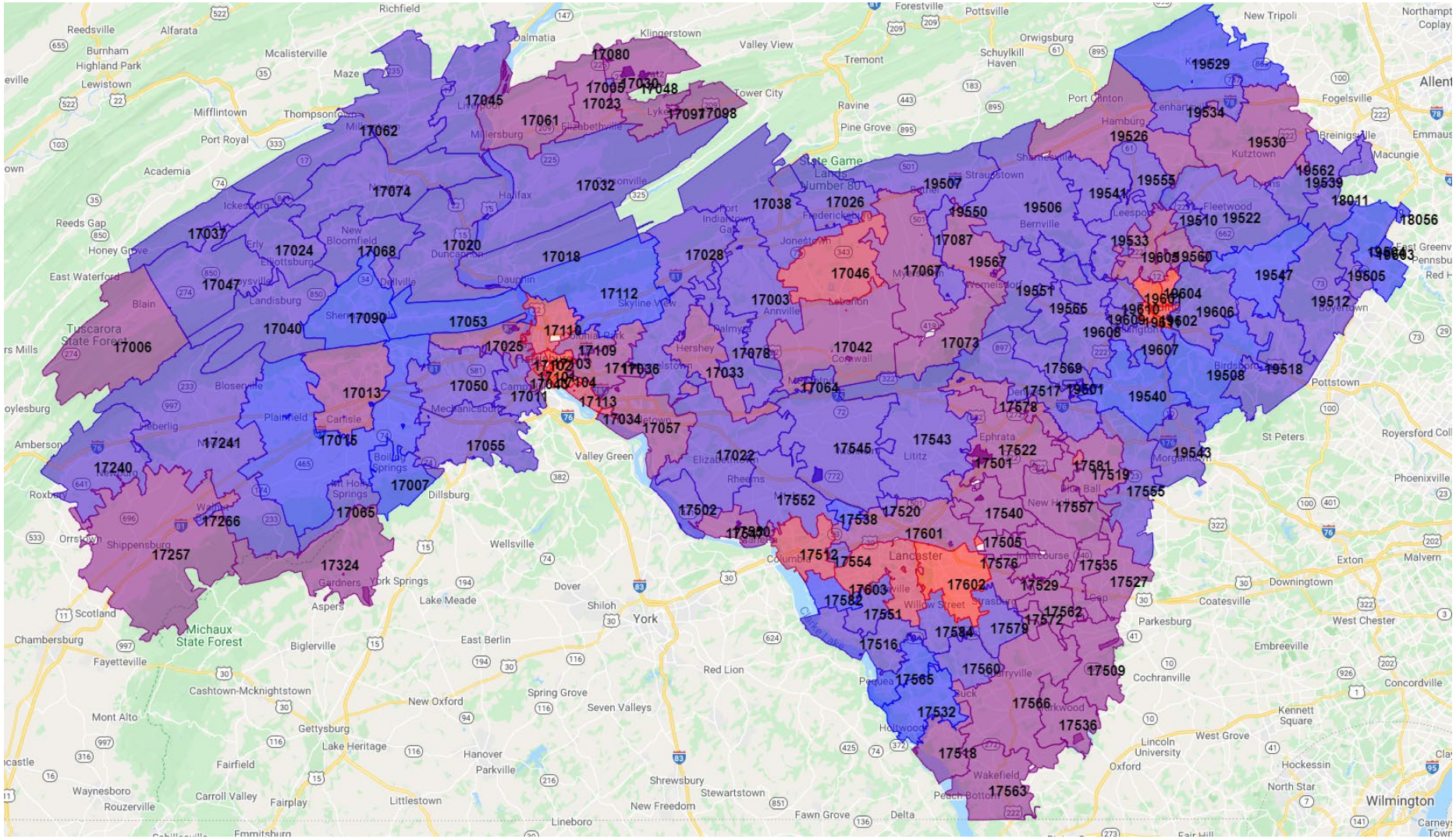


County and ZIP Code Representation Cont.

Top Three Zip Codes of Community Member Residence by County

Berks County	Cumberland County	Dauphin County	Lancaster County	Lebanon County	Perry County
19601, Reading (10.7%)	17050, Mechanicsburg (23.1%)	17036, Hummelstown (28.5%)	17022, Elizabethtown (22.4%)	17078, Palmyra (34.4%)	17053, Marysville (20.8%); 17068, New Bloomfield (20.8%)
19606, Reading (9.4%)	17055, Mechanicsburg (20.3%)	17033, Hershey (25.5%)	17603, Lancaster (14.8%)	17042, Lebanon (27.8%)	17020, Duncannon (12.5%); 17074, Newport (12.5%)
19604, Reading (8.1%)	17011, Camp Hill (17.5%)	17112, Harrisburg (7.7%)	17602, Lancaster (11.2%)	17046, Lebanon (13.6%)	17090, Shermans Dale (8.3%)

Community Need Index



Service Area - Demographics

- A total of 1,707,543 people live in the 3,784 square mile report area.
- From 2020-2025, the annual growth rate is projected to be 0.53%, with Cumberland County growing the fastest and Perry County growing slowest.
- The median age of the six-county region is about 40 years, and 23% of the population is 0-17 years of age while 18% are 65+ years of age.

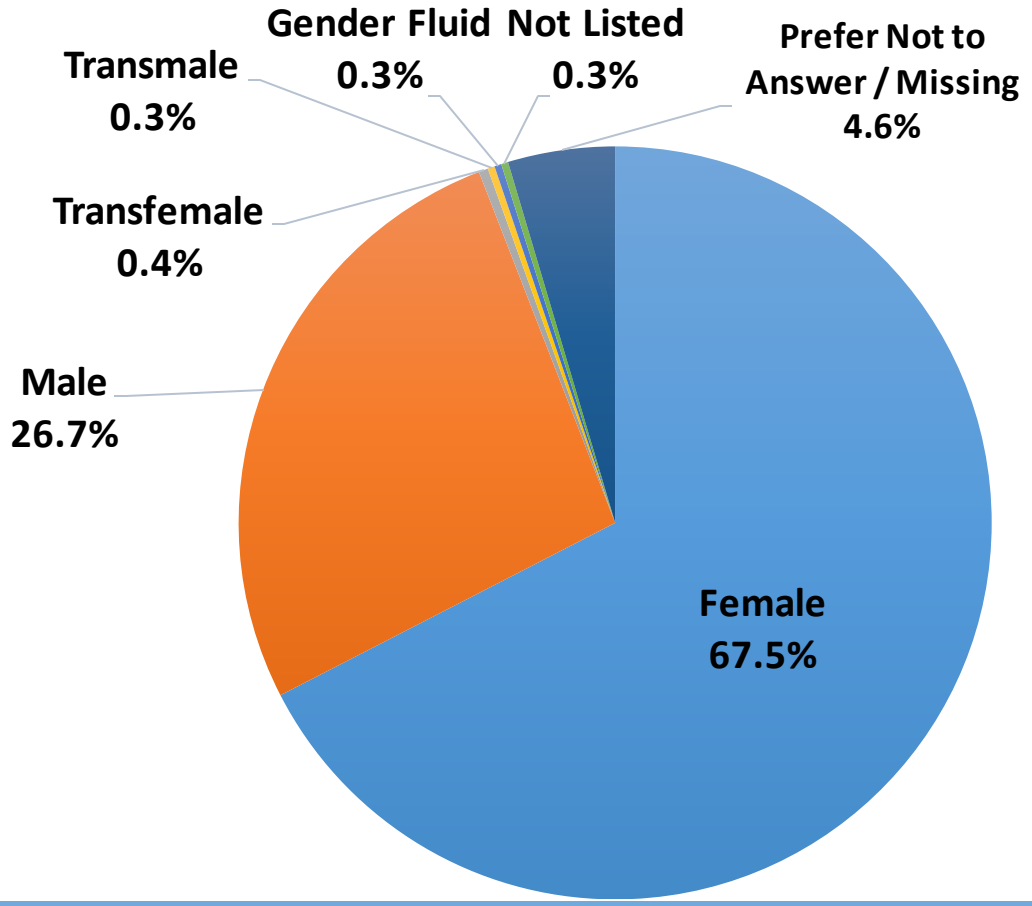
Population, Growth Rate, and Age

	Population 2020	Population Projection 2025	2020-2025 Annual Growth Rate	Median Age	Population Age 0-17	Population Age 65+
Service Area	1,707,543	1,753,179	.53%	39.8	22.6%	17.5%
Berks County	426,258	433,130	.32%	39.9	22.5%	16.9%
Cumberland County	255,665	266,292	.82%	40.6	20.3%	18.1%
Dauphin County	280,234	285,840	.40%	39.7	22.5%	16.5%
Lancaster County	552,587	568,856	.58%	38.6	23.7%	17.5%
Lebanon County	145,257	150,775	.75%	41.0	22.9%	19.1%
Perry County	47,542	48,286	.31%	43.3	21.6%	18.0%
Pennsylvania	12,991,367	13,107,352	.18%	40.8	20.8%	17.8%
United States	333,793,107	346,021,282	.72%	38.1	22.6%	15.6%

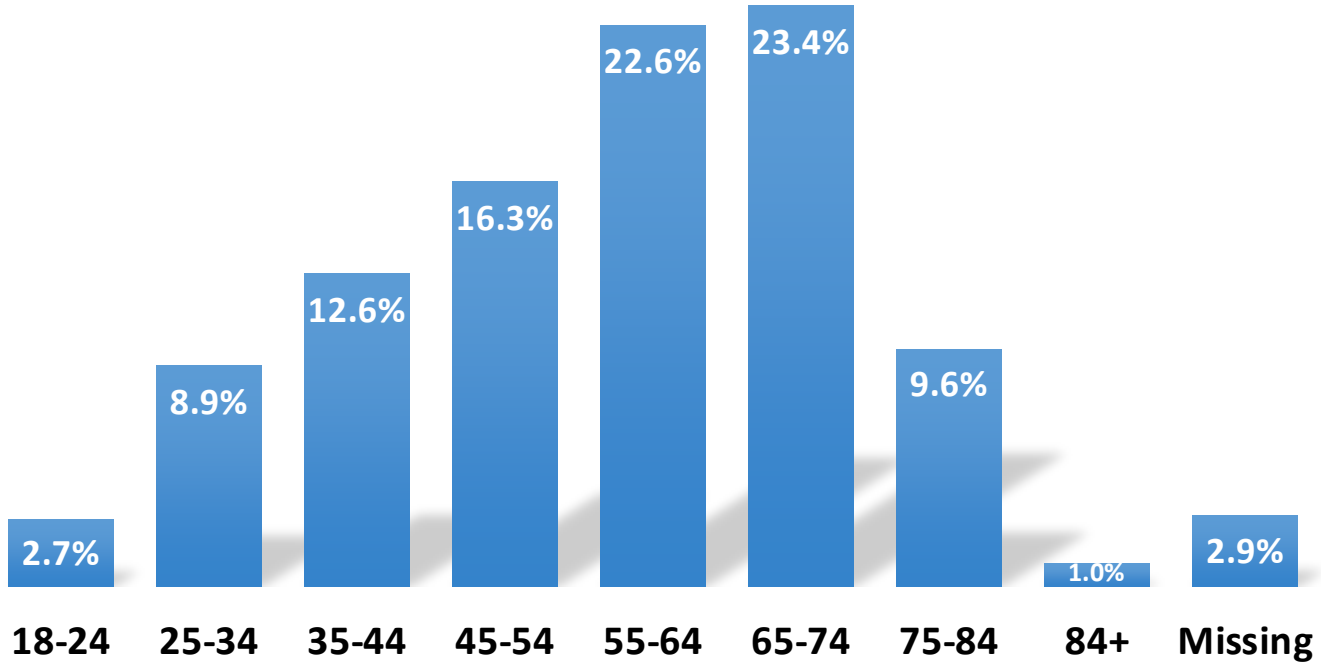
Age and Gender

- CMS respondents were primarily female and 55 to 74 years of age.

Gender of Respondents



Age of Respondents



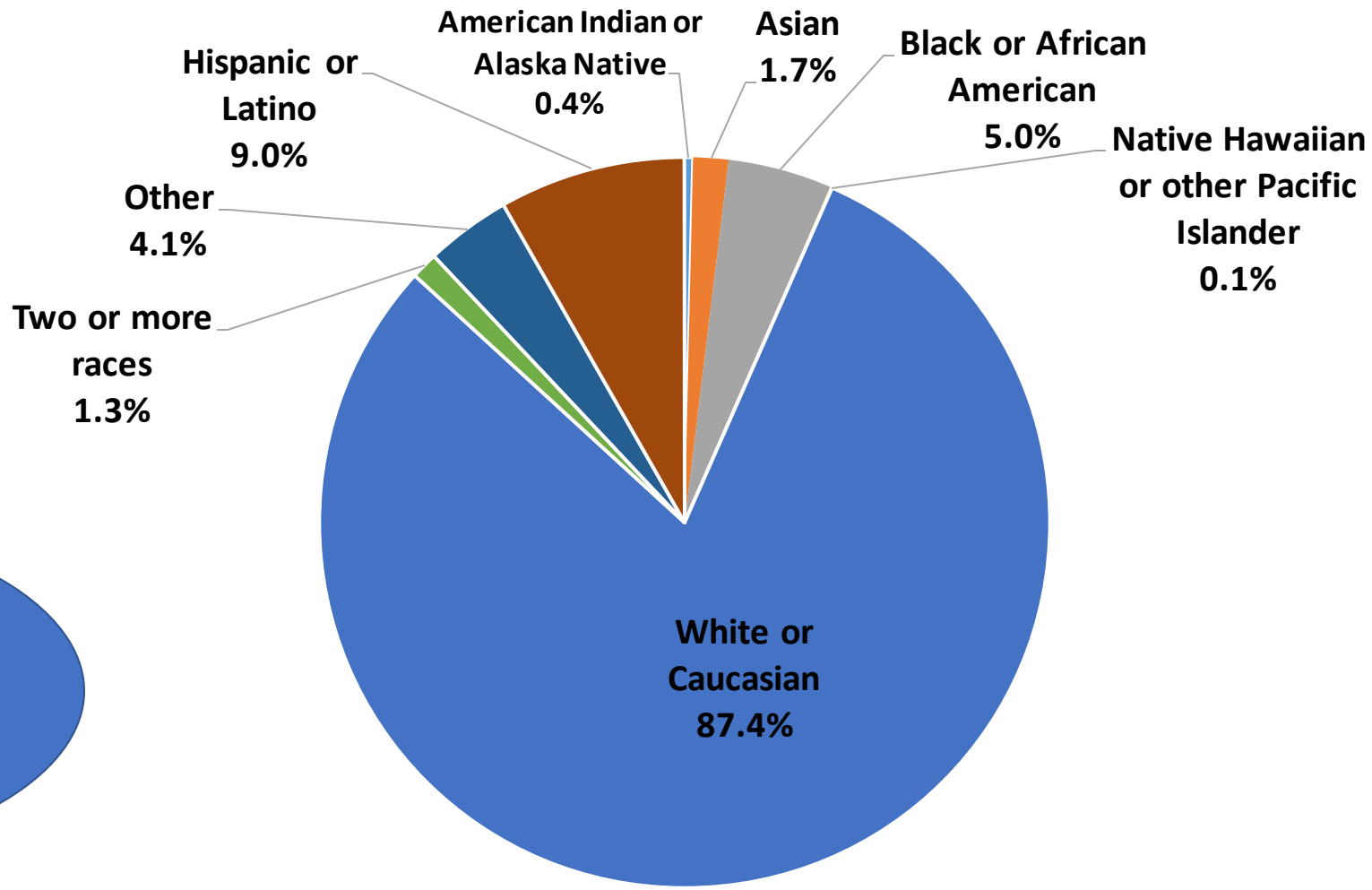
- The median age of the population in the service area is 40 years old (ACS, 2015-2019).

Race and Ethnicity

- The Asian population will increase the most from 2020 to 2025 (Advisory Board, 2020).
- The White population will increase the least (Advisory Board, 2020).
- Lebanon County is projected to have the greatest increase in Hispanic population (Advisory Board, 2020).

"Underlying all of our problems in the community and our country are racism and inequality."
- Community Member

Race & Ethnicity of CMS Respondents



Race and Ethnicity Cont.

Race and Ethnicity – ACS 2015-2019 5-Year Estimates

	White	Black	Asian	American Indian / Alaska Native	Some Other Race	Multiple Races	Hispanic or Latino	Limited English Proficiency
Service Area	83.9%	6.8%	2.6%	0.3%	3.4%	3.1%	11.9%	5.7%
Berks County	82.4%	5.4%	1.4%	0.6%	5.6%	4.6%	21.0%	7.6%
Cumberland County	87.7%	4.0%	4.3%	0.1%	1.2%	2.7%	3.9%	3.1%
Dauphin County	70.1%	19.5%	4.4%	0.3%	2.6%	3.1%	9.2%	5.2%
Lancaster County	88.5%	4.2%	2.2%	0.2%	2.5%	2.5%	10.5%	6.3%
Lebanon County	86.6%	2.5%	1.4%	0.1%	7.3%	2.1%	13.1%	4.7%
Perry County	96.9%	1.0%	0.4%	0.2%	0.4%	1.2%	2.0%	1.1%
Pennsylvania	80.5%	11.2%	3.4%	0.2%	2.2%	2.5%	7.3%	4.3%
United States	72.5%	12.7%	5.5%	0.8%	4.9%	3.3%	18.0%	8.4%

Race and Ethnicity Projected Change, 2020-2025 (Advisory Board, Demographic Profiler)

	White Population % Change	Black Population % Change	Asian Population % Change	Other Race % Change	Hispanic Population % Change
Service Area	0.4%	8.4%	23.9%	6.3%	6.1%
Berks County	-0.9%	7.9%	31.9%	6.6%	7.0%
Cumberland County	3.2%	11.5%	15.5%	4.7%	4.8%
Dauphin County	-0.5%	8.2%	27.0%	7.2%	5.5%
Lancaster County	0.2%	7.5%	22.7%	4.7%	4.3%
Lebanon County	0.3%	10.4%	24.3%	9.3%	8.1%
Perry County	1.6%	8.3%	12.8%	5.3%	5.2%

Education, Income, & Employment

- 15.6% of respondents graduated high school or earned a GED.
- 2.8% did not complete high school.

"Many of the supports offered regarding food or health care are aimed at those who are eligible for free gov't programs but there are many of us who are in the 'working poor' category who qualify for nothing."
-Community Member

- 19% of respondents reported a household income of less than $35,000.
- 27% of households in the service area earn above the poverty level but below the cost of living (United Way, 2018).
- In the service area, 15.8% of the population under age 18 lives in poverty (ACS, 2015-2019).

Employment

- 8% of respondents were unemployed or unable to work.
- 11% of Black/African American respondents were unemployed compared to only 3% of White/Caucasian respondents.

Education, Income, Poverty

Education, Income, and Poverty – ACS 2015-2019 5-Year Estimates

	Percent Population Age 25+ with No High School Diploma	Median Household Income	Percent Families w/ Income Below Poverty Level	Percent Population Under Age 18 in Poverty
Service Area	12.4%	$64,311	7.2%	15.8%
Berks County	13.3%	$63,728	8.4%	18.7%
Cumberland County	7.7%	$71,269	4.3%	9.3%
Dauphin County	10.2%	$60,715	8.8%	20.2%
Lancaster County	14.9%	$66,056	6.6%	14.4%
Lebanon County	12.9%	$60,281	8.7%	16.5%
Perry County	12.6%	$63,718	5.5%	11.8%
Pennsylvania	9.5%	$61,744	8.4%	17.6%
United States	12.0%	$62,843	9.5%	18.5%

Top Health Concerns

Community Member Survey			
Ranking	Health Concern	%	N
1	Overweight/Obesity	37.1%	939
2	Cancers	35.9%	891
3	Infectious Disease (Including COVID-19)	34.4%	871
4	Mental Health Conditions	32.9%	834
5	Diabetes	25.7%	651
6	Substance Use Disorder	25.4%	644
7	Heart Disease and Stroke	24.0%	607
8	Alzheimer's Disease/Dementia	12.8%	324
9	Domestic Violence	6.5%	164
10	Disability	5.1%	129

Key Informant Survey			
Ranking	Health Concern	%	N
1	Mental health conditions	61.8%	196
2	Substance Use Disorder	43.9%	139
3	Overweight/Obesity	30.9%	98
4	Diabetes	26.5%	84
5	Heart disease and stroke	19.6%	62
6	Infectious disease (including COVID-19)	16.7%	53
7	Disability	12.9%	41
8	Cancers	11.4%	36
9	Domestic violence	9.5%	30
10	Alzheimer's disease/dementia	7.3%	23

KIS – Health Concerns/Contributing Factors

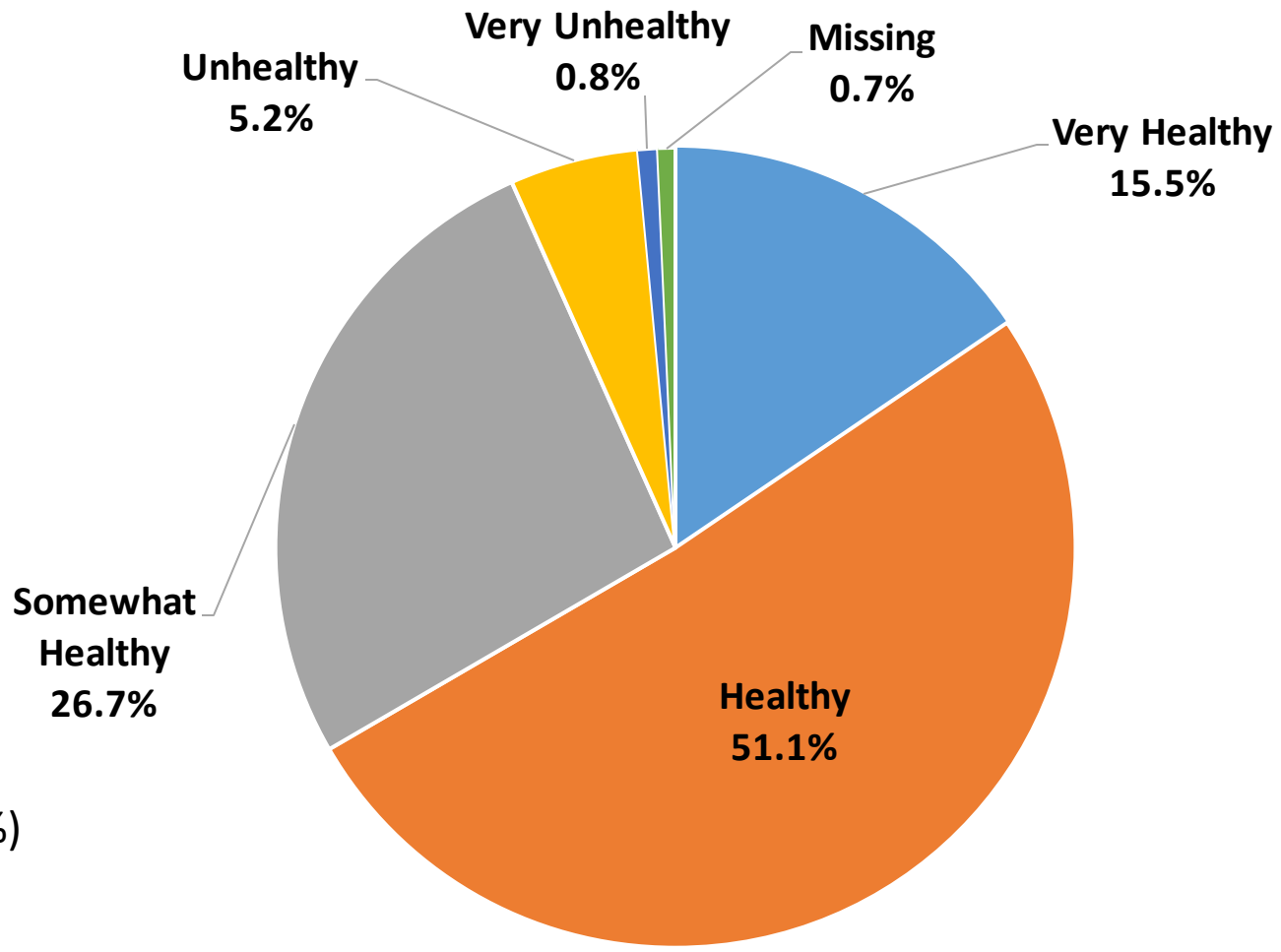
Overall Health

- Slightly over half of all CMS respondents reported that they are "healthy."

- Only 6% of respondents considered themselves "unhealthy" or "very unhealthy" (Compared to 14% in 2018).

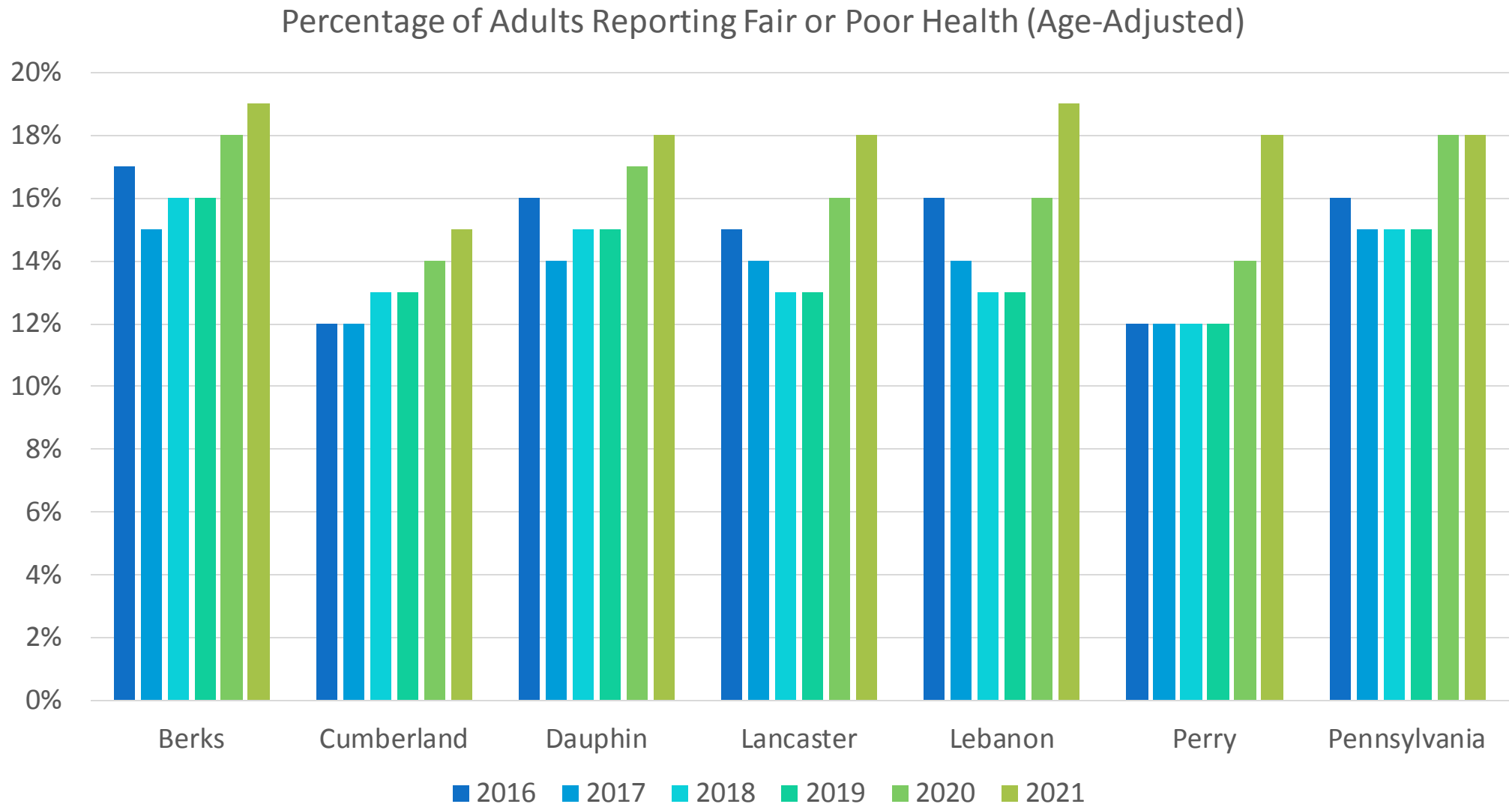
- Just over half (51.1%) of KIS respondents disagreed that their community is healthy.

How Would You Rate Your Health?

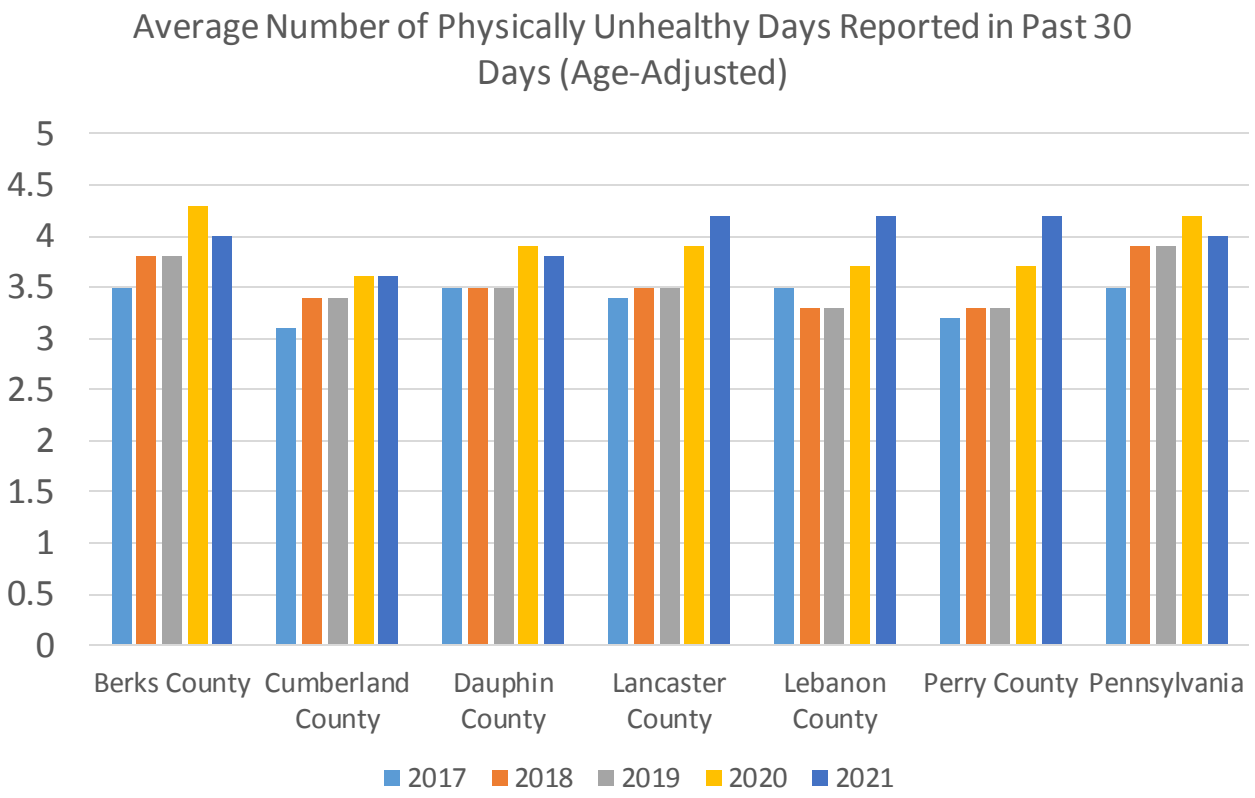


Overall Health Cont.

- The percentage of adults reporting fair or poor health has been increasing.

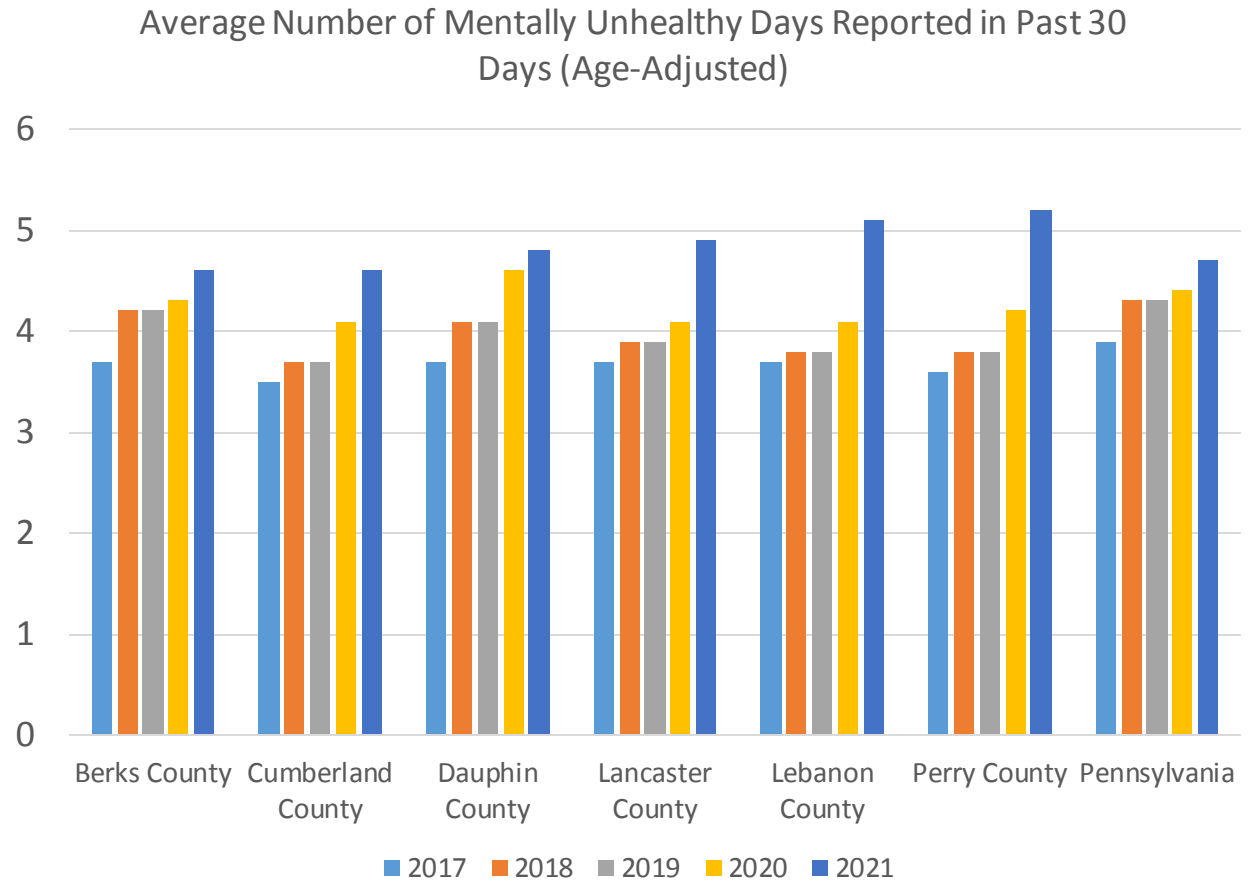


Physically and Mentally Unhealthy Days



- The number of physically and mentally unhealthy days reported have been increasing (BRFSS, 2018).

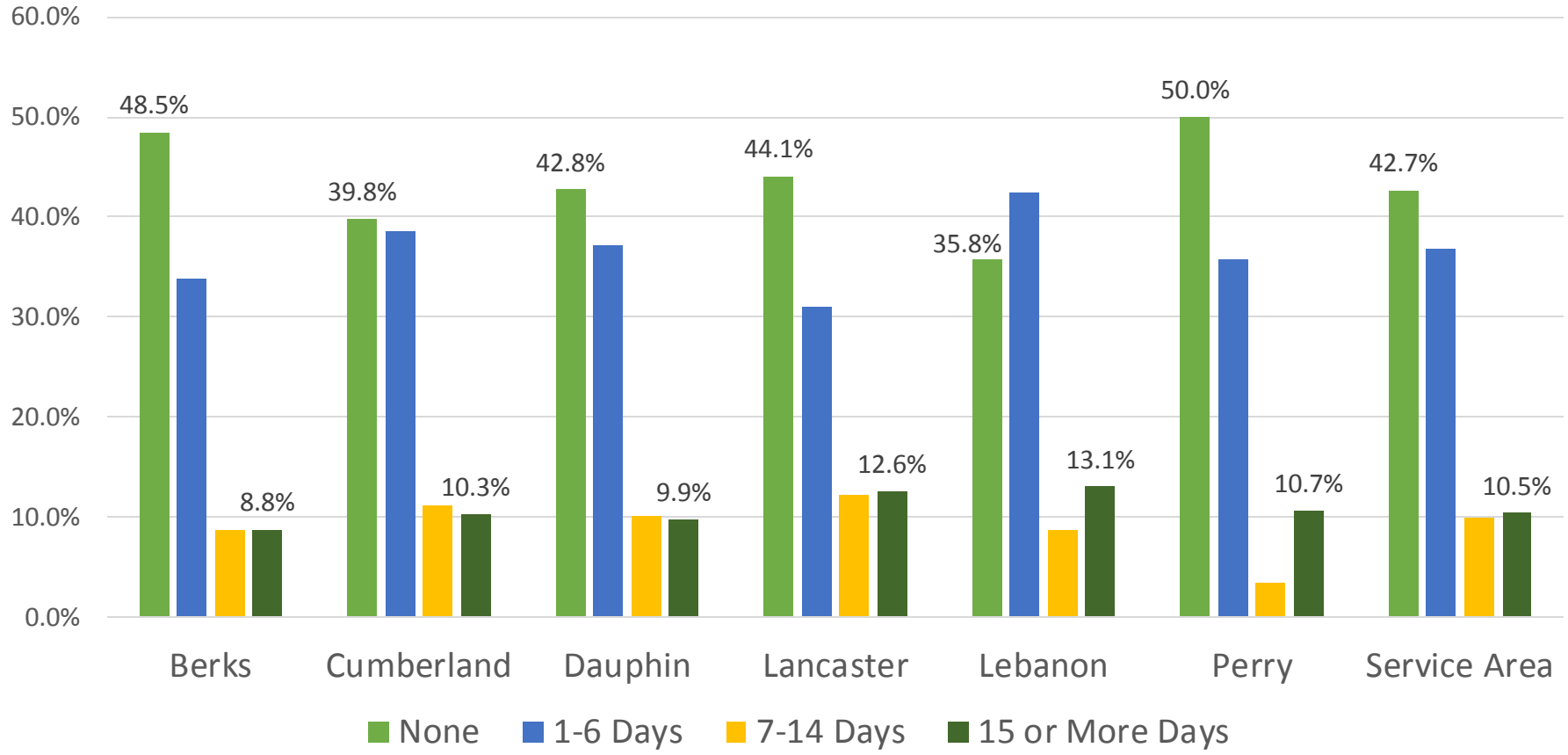
- More mentally unhealthy days are reported than physically unhealthy days (BRFSS, 2018).



Mental Health

- 57% of respondents had at least 1 poor mental health day in the past month (54% in 2018 survey).
- 1 in 10 people reported 15 or more days of poor mental health.

How many days during the past 30 days was your mental health not good?



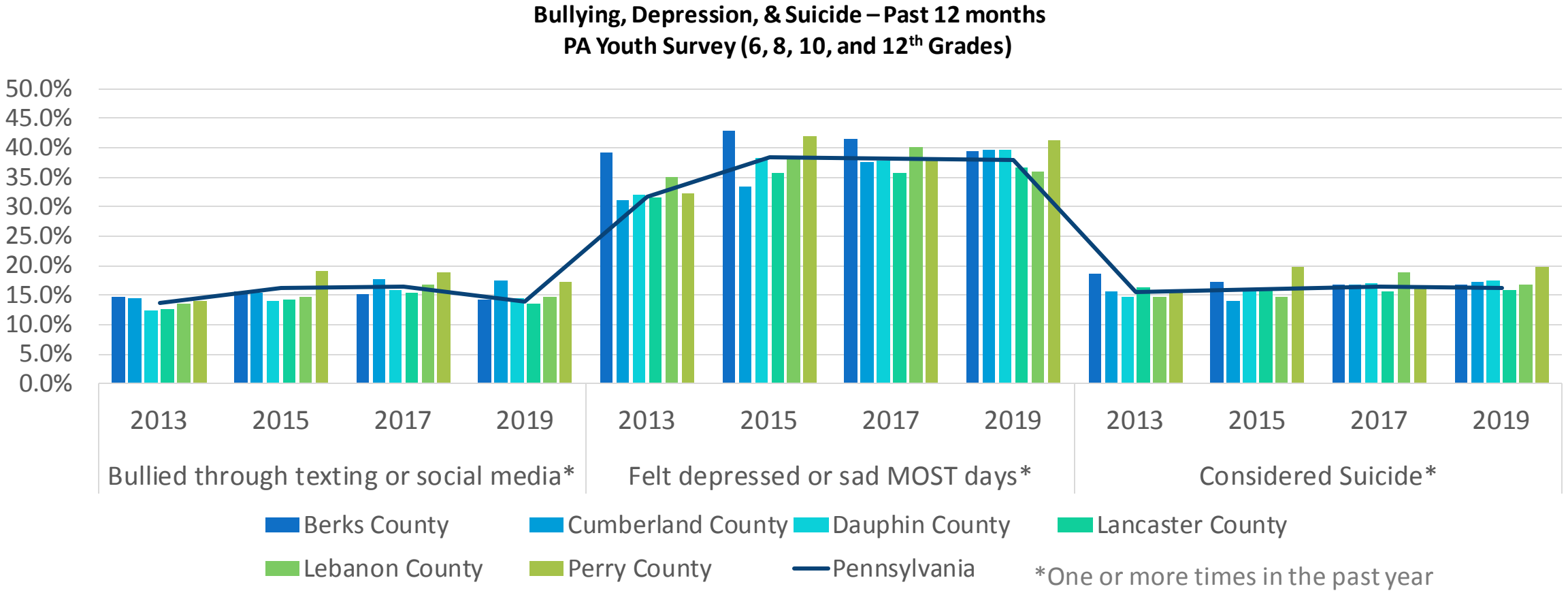
- 63% of the LGBTQ population said depression was a top 3 health concern (LGBTQ Health Needs Assessment, 2020).
- 18% of respondents received mental health services in the past year.
- Approximately 1 in 11 respondents needed mental health services but did not receive them.

Mental Health Cont.

Mental Health Services or Treatment in the Past 12 Months – Community Member Respondents

County	% Received Services	% Needed, but did not receive services
Berks	12.1%	6.6%
Cumberland	22.7%	9.3%
Dauphin	18.7%	8.7%
Lancaster	17.5%	9.7%
Lebanon	18.8%	11.9%
Perry	14.3%	3.6%
Service Area	17.8%	8.8%

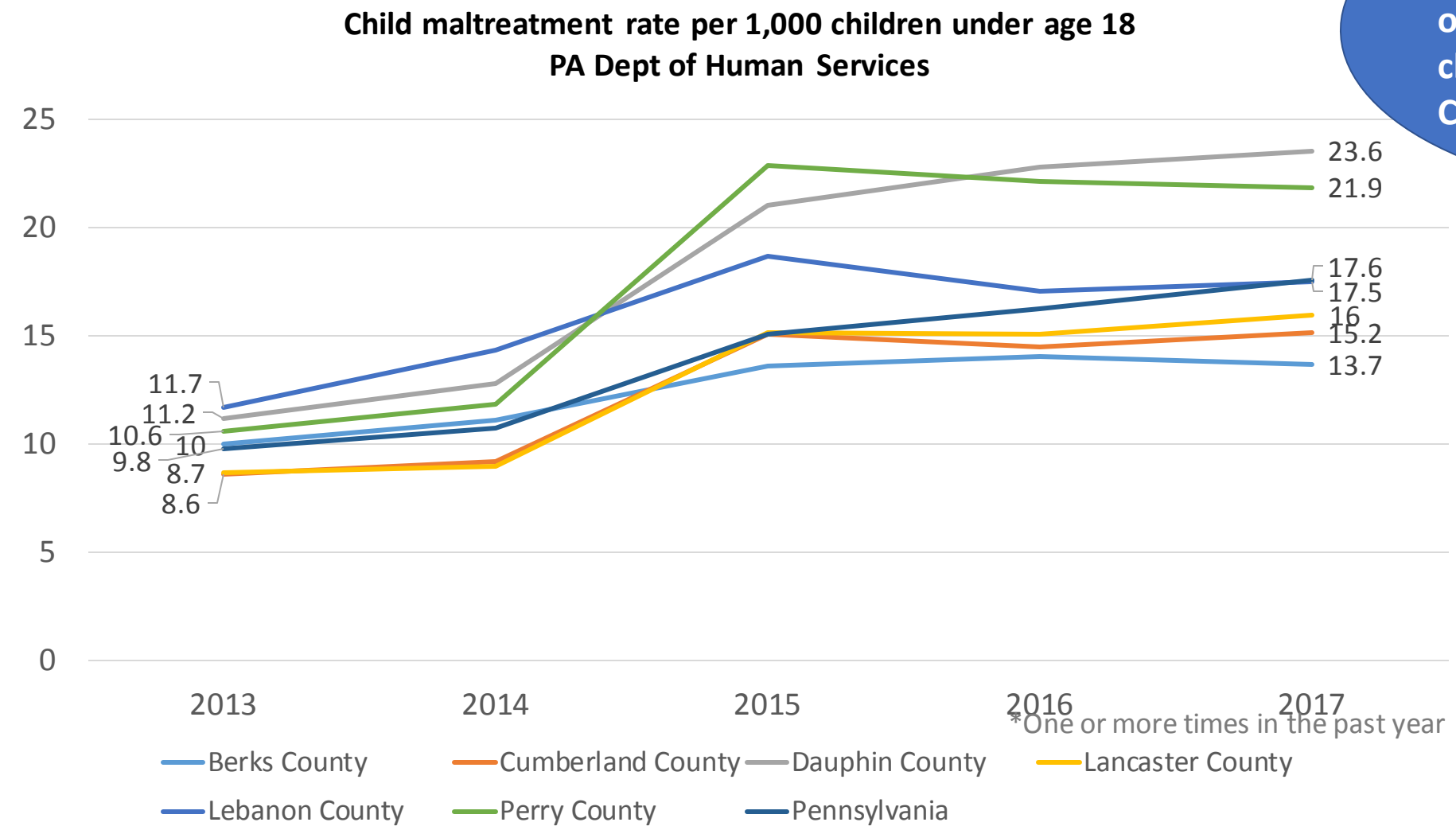
Mental Health – Children



- Approximately 40% of children reported feeling depressed or sad most days (PAYS, 2019).
- About 1 in 7 children reported being bullied through texting/social media and 1 in 6 reported considering suicide (PAYS, 2019).

Mental Health – Children Cont.

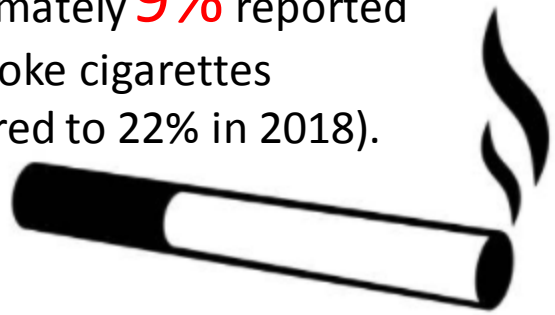
"I think that our largest community health issue, which is of epidemic proportions, is childhood trauma/Adverse Childhood Experiences (ACEs)."
-Community Member



- Child maltreatment has been trending upwards from 2013 to 2017 (PA Dept of Human Services, 2017).
- Dauphin County has the highest rate increase at 23.6 children per 1,000.

Tobacco and Alcohol

- Among respondents, approximately 9% reported they smoke cigarettes (compared to 22% in 2018).



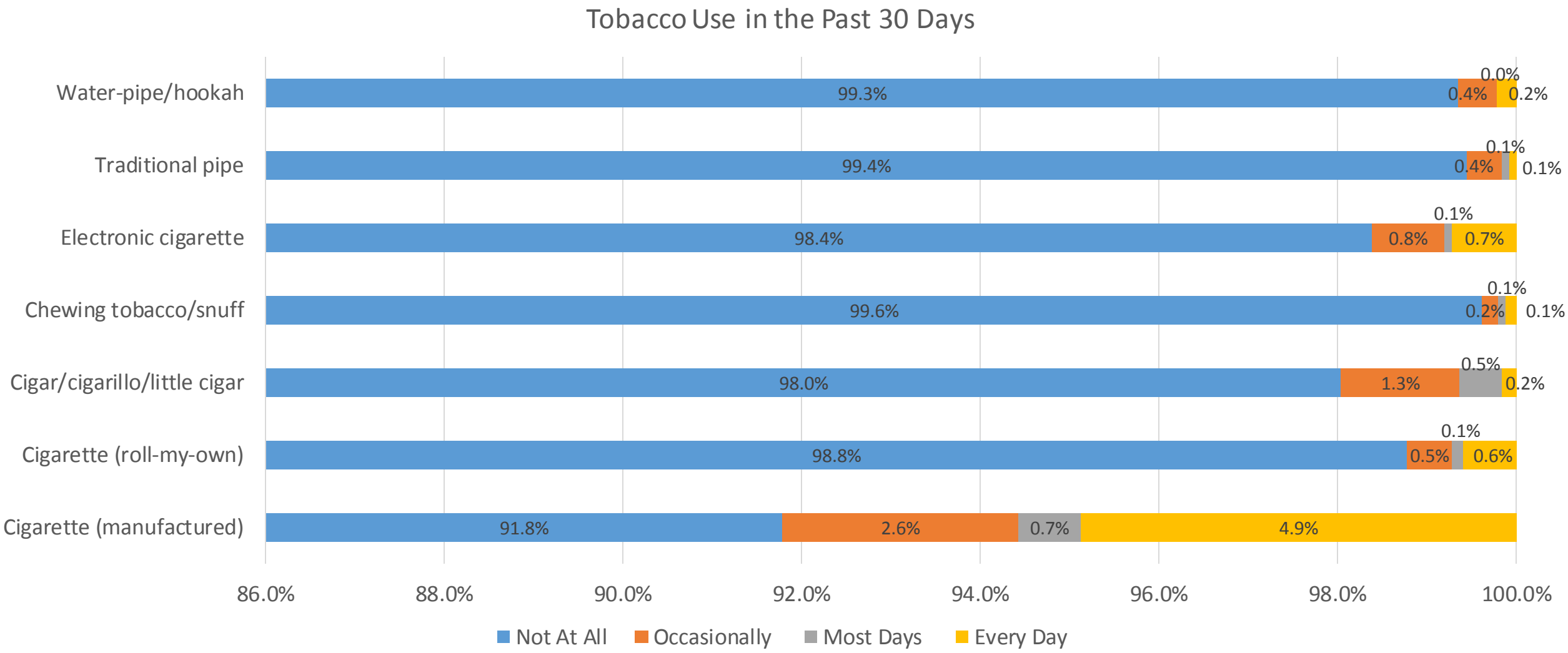
- 16% of Black/African American respondents reported smoking cigarettes compared to only 8% of White respondents.
- 12% of the LGBTQ population reported that they smoke cigarettes (LGBTQ Health Needs Assessment, 2020).
- According to 2018 BRFSS data, 18% of Pennsylvania adults smoke and 20% report excessive drinking.
- Approximately 47% of respondents reported having at least 1 drink in an average week.

Amount of Alcoholic Drinks Consumed in an Average Week

County	None	1 to 6 Drinks	7 or More Drinks
Berks	54.9%	38.8%	6.3%
Cumberland	58.5%	32.6%	8.9%
Dauphin	50.5%	40.1%	9.4%
Lancaster	54.0%	39.5%	6.5%
Lebanon	53.4%	40.0%	6.6%
Perry	71.4%	25.0%	3.6%
Service Area	53.4%	38.6%	8.0%

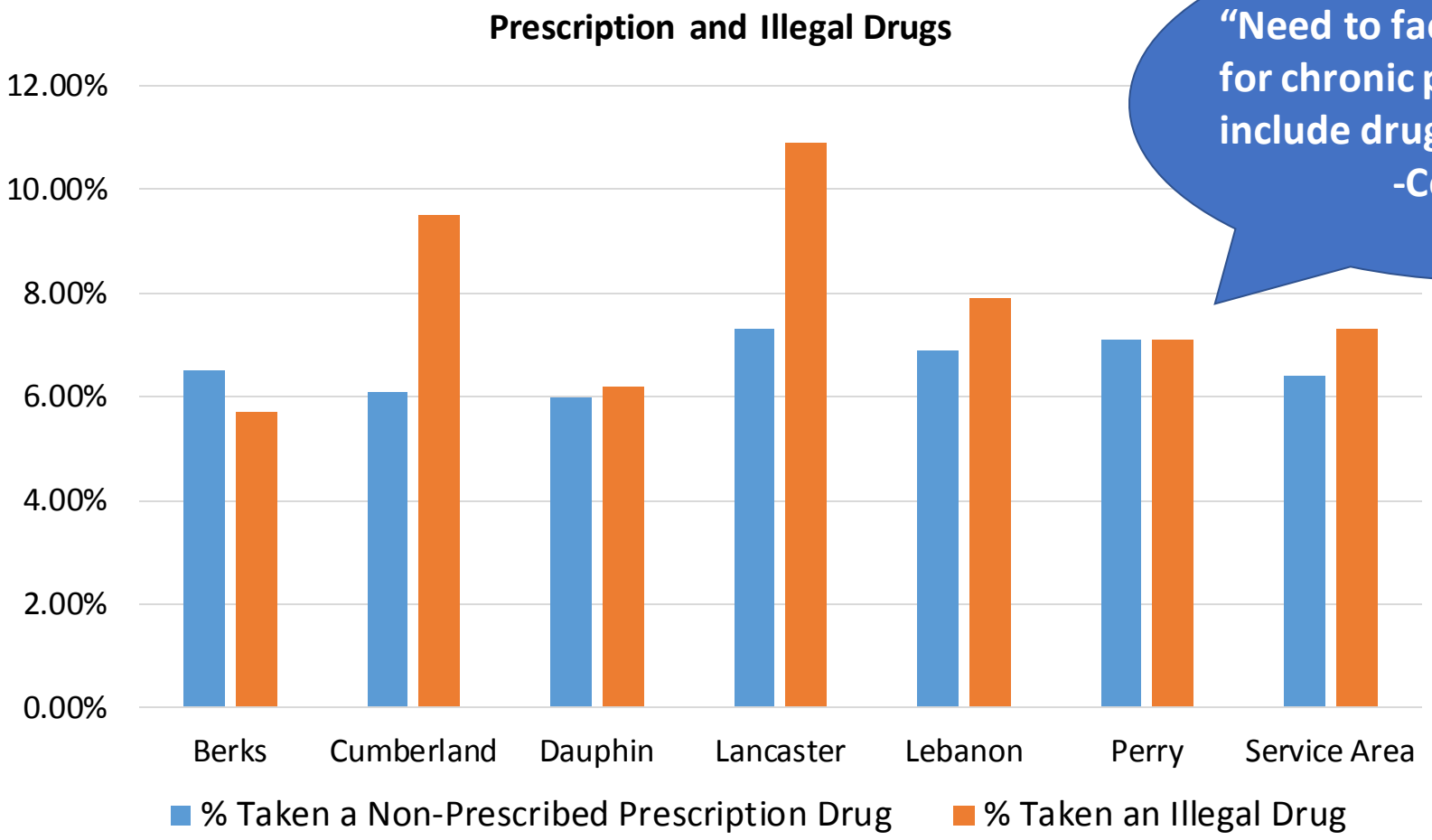
- Approximately 1 in 12 respondents had 7 or more drinks per week.

Tobacco and Alcohol Cont.



Prescription and Illegal Drugs

- Approximately **1 in 15** respondents reported taking a non-prescribed prescription drug.



"Need to facilitate treatment for chronic pain, that do not include drugs or alcohol."
-Community Member

- In Lancaster County, **11%** of respondents reported taking an illegal drug.

- **1 in 5** respondents reported that marijuana is "easy" or "very easy" to access.

- **1 in 13** said prescription opioids are "easy" or "very easy" to access if they wanted them.

Prescription and Illegal Drugs Cont.

County	% Taken a Non-Prescribed Prescription Drug	% Taken an Illegal Drug
Berks	6.5%	5.7%
Cumberland	6.1%	9.5%
Dauphin	6.0%	6.2%
Lancaster	7.3%	10.9%
Lebanon	6.9%	7.9%
Perry	7.1%	7.1%
Service Area	6.4%	7.3%

Perceptions of Ease of Accessing Recreational Drugs

Drugs	Very Difficult	Difficult	Easy	Very Easy	Don't Know/Prefer Not To Answer/Missing
Club drugs (cocaine, ecstasy, LSD)	40.4%	5.6%	3.8%	2.1%	48.0%
Opioids (Heroin)	40.9%	5.9%	3.2%	1.8%	48.2%
Marijuana or synthetic marijuana	28.8%	6.0%	11.3%	10.4%	43.5%
Prescription opioids (OxyContin, Fentanyl, Vicodin)	36.9%	8.4%	5.3%	2.4%	47.0%

Overdose Deaths

Rate and Count of Drug-Related Overdose Deaths per 100,000 – 2015-2019

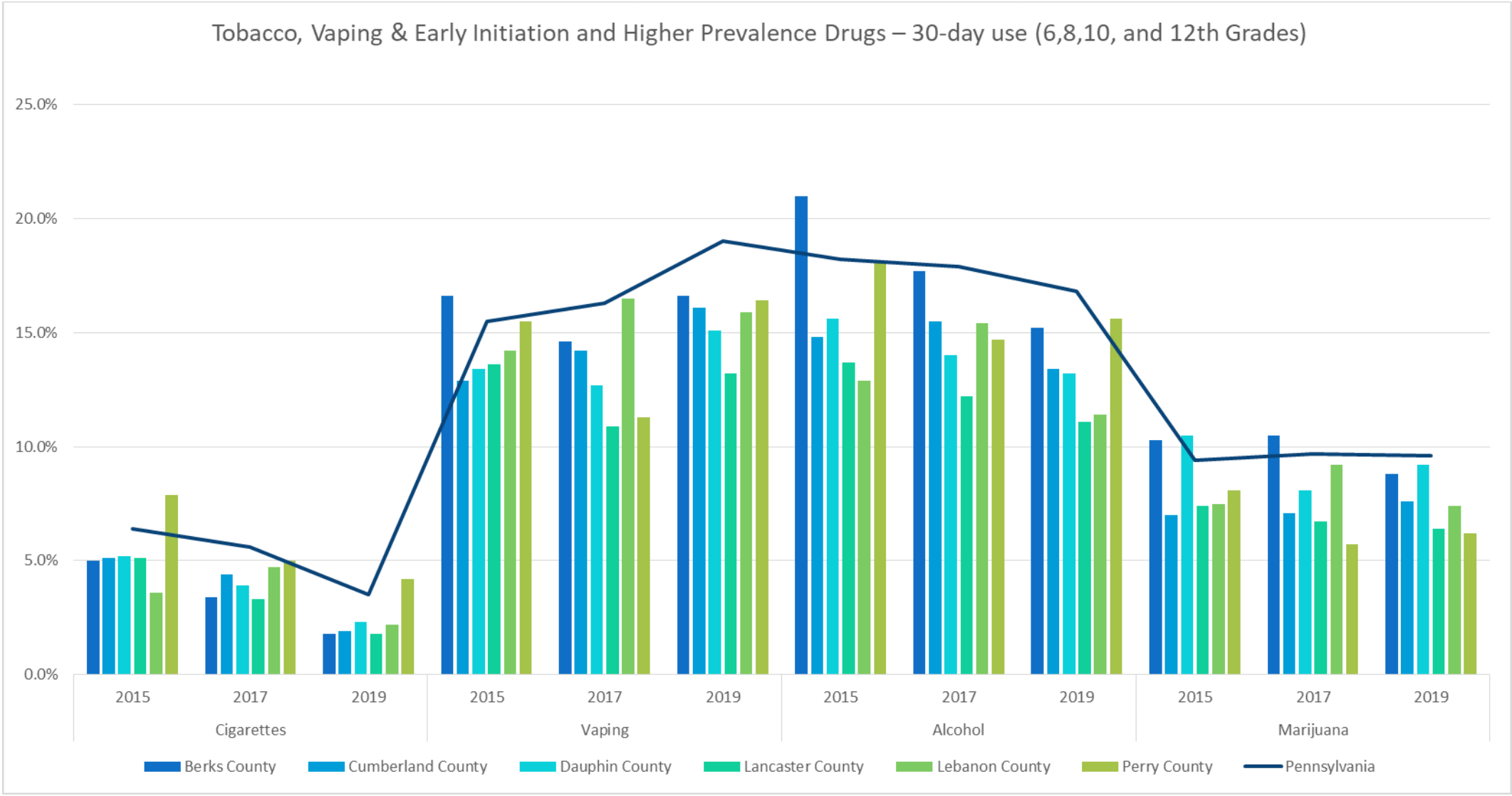
	2015 Rate (Count)	2016 Rate (Count)	2017 Rate (Count)	2018 Rate (Count)	2019 Rate (Count)
Berks County	16 (69)	27 (117)	27 (111)	23 (100)	28 (117)
Cumberland County	15 (41)	23 (58)	30 (74)	19 (52)	16 (41)
Dauphin County	29 (82)	30 (84)	35 (97)	44 (128)	36 (101)
Lancaster County	14 (80)	22 (116)	30 (165)	20 (108)	19 (103)
Lebanon County	15 (20)	12 (16)	21 (29)	19 (27)	16 (23)
Perry County	7 (3)	20 (9)	22 (10)	33 (15)	n/a*
Pennsylvania	26.3 (3,264)	37.9 (4,642)	44.3 (5,456)	36.1 (4,491)	35.6 (4,458)
United States	16.3 (52,898)	19.8 (63,600)	21.7 (70,237)	20.7 (67,367)	21.6 (70,630)

Source: DEA Philadelphia Field Division

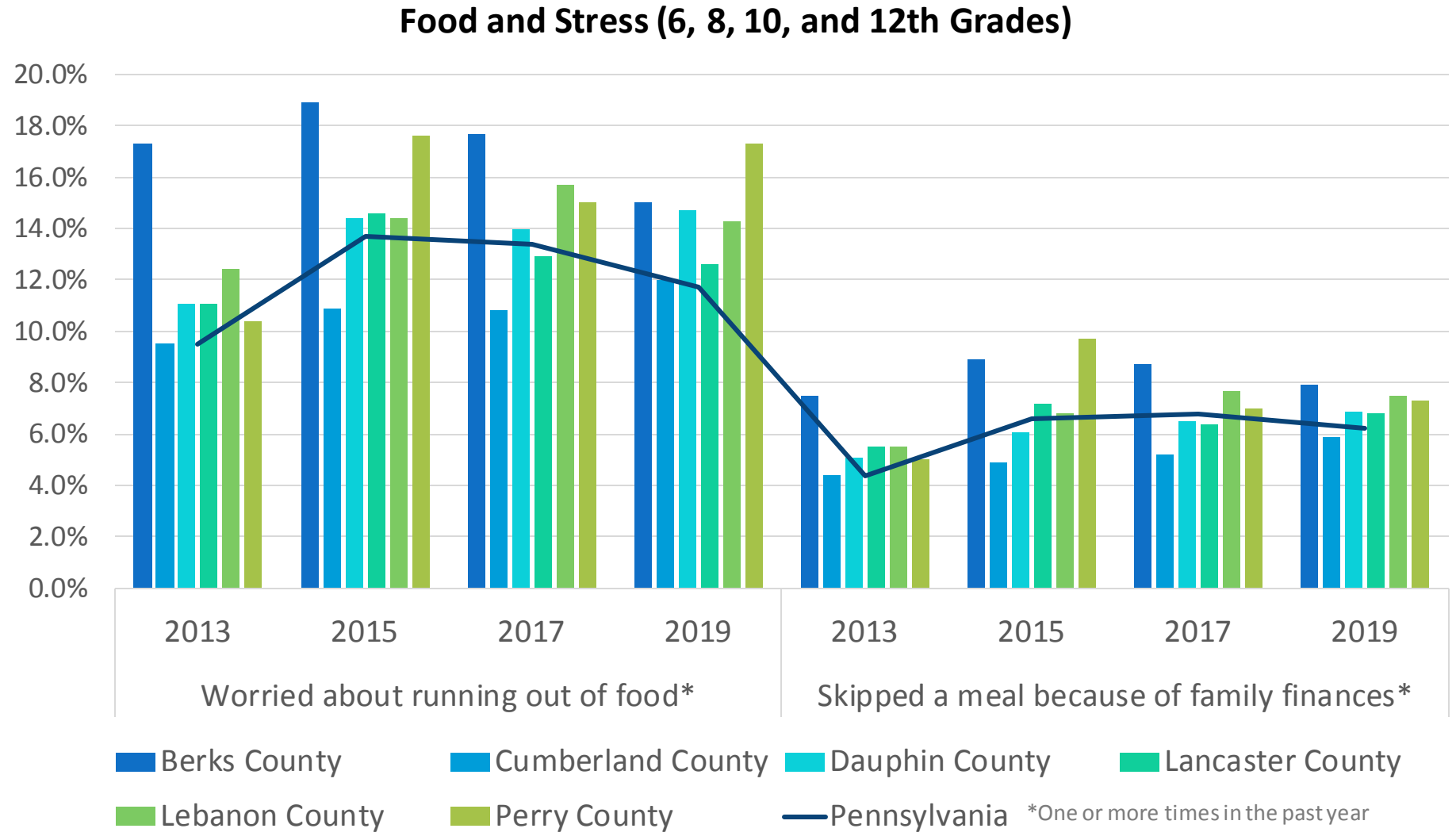
*Counties with overdose death counts between 1 and 9 are suppressed.

Substance Use – Children (PAYS, 2019)

- Cigarette use has been declining and was reported among less than 5% of children.
- Vaping was the most used "substance" and has been increasing.
- Alcohol use has been slightly decreasing.

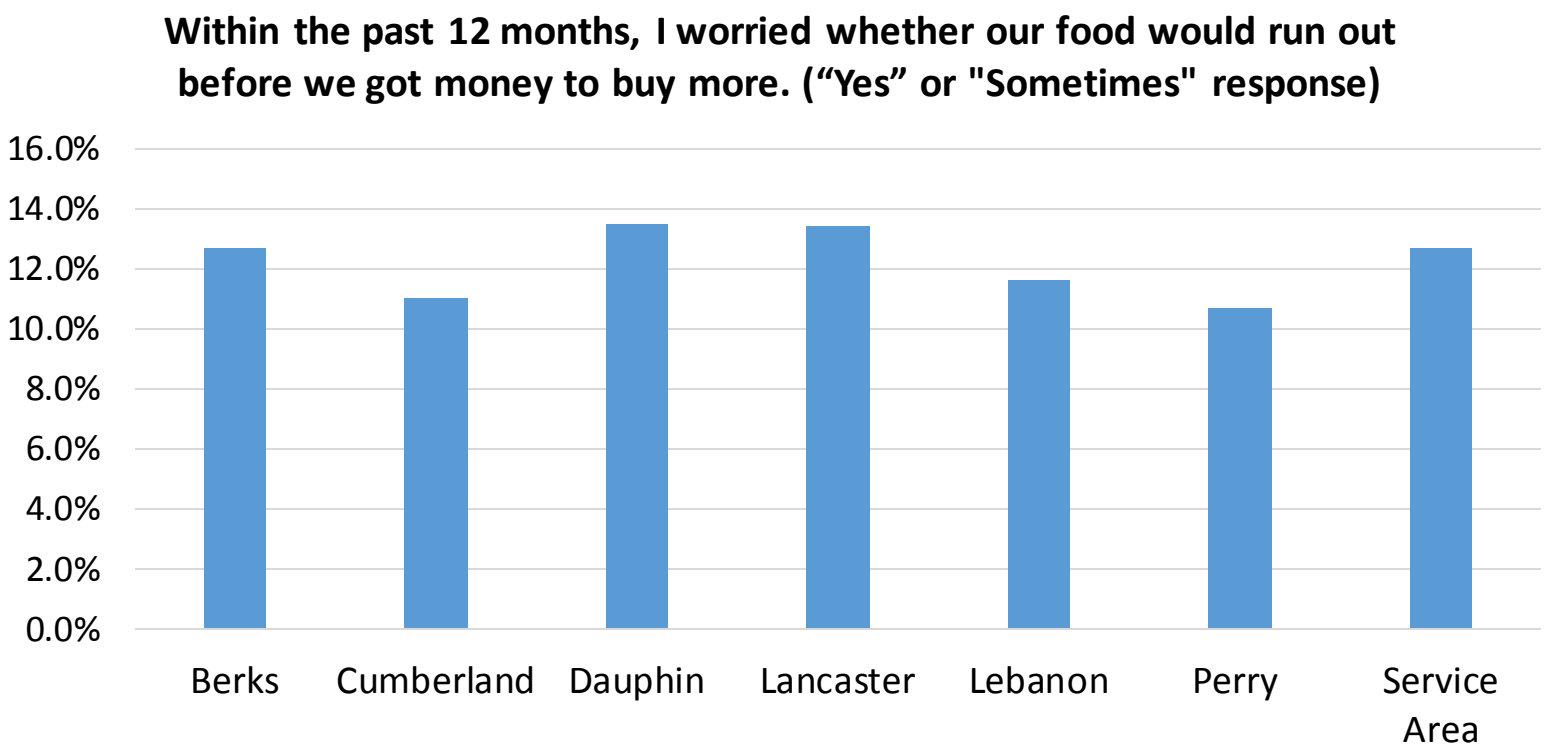


Mental Health and Food – Children (PAYS, 2019)



- Approximately 1 in 7 children reported being worried about running out of food.
- About 1 in 14 reported having skipped a meal due to family finances.
- These numbers have been trending upwards in almost all counties.

Food



- Approximately 1 in 8 respondents worried about running out of food before getting money to buy more.

> ***"I feel that food insecurity and poverty lead to a lot of the other factors listed. Poverty causes health disparities and issues obtaining healthy foods that lead to healthy eating habits."***
>
> ***-Key Informant***

Worried About Running Out of Food By Race/Ethnicity

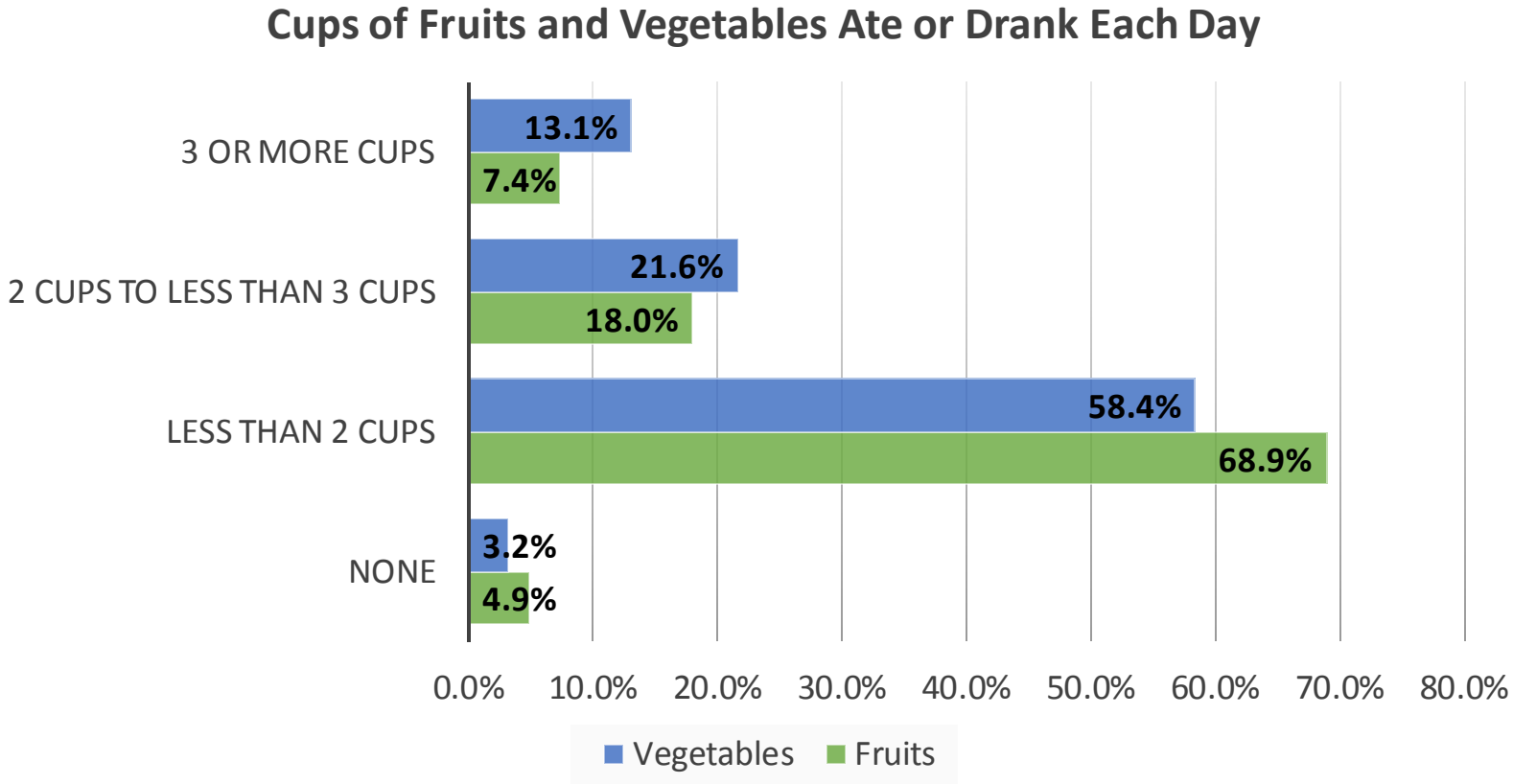
Race/Ethnicity	%	N
Asian	22.2%	10
Black/African American	24.4%	30
Hispanic/Latino	32.1%	68
White/Caucasian	10.5%	215

- 32% of Hispanic/Latino respondents worried about running out of food, while only 10.5% of White/Caucasian respondents worried about food.

Food Cont.

Food Access

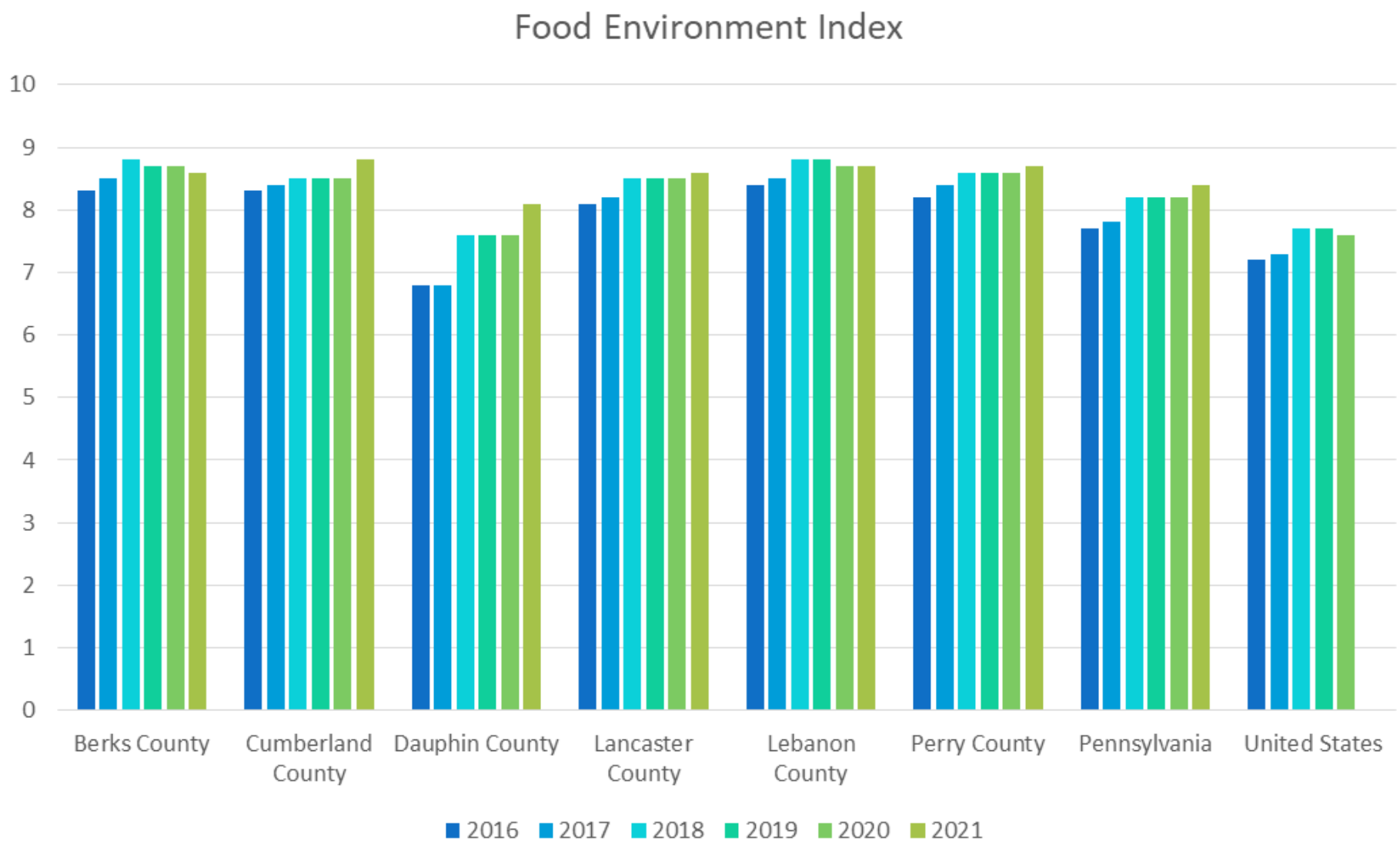
County	Are you able to have fresh, healthy foods (fruits/vegetables) when you want them? ("No" response)
Berks	2.5%
Cumberland	2.4%
Dauphin	1.7%
Lancaster	3.7%
Lebanon	1.5%
Perry	7.1%
Service Area	2.2%



- 98% of respondents were able to have fresh/healthy foods when they want them.

Food Cont.

- The Food Environment Index ranges from a scale of 0 (worst) to 10 (best).
- The scores have been improving among all counties in the service area.
- Dauphin County has a lower score than the PA average.



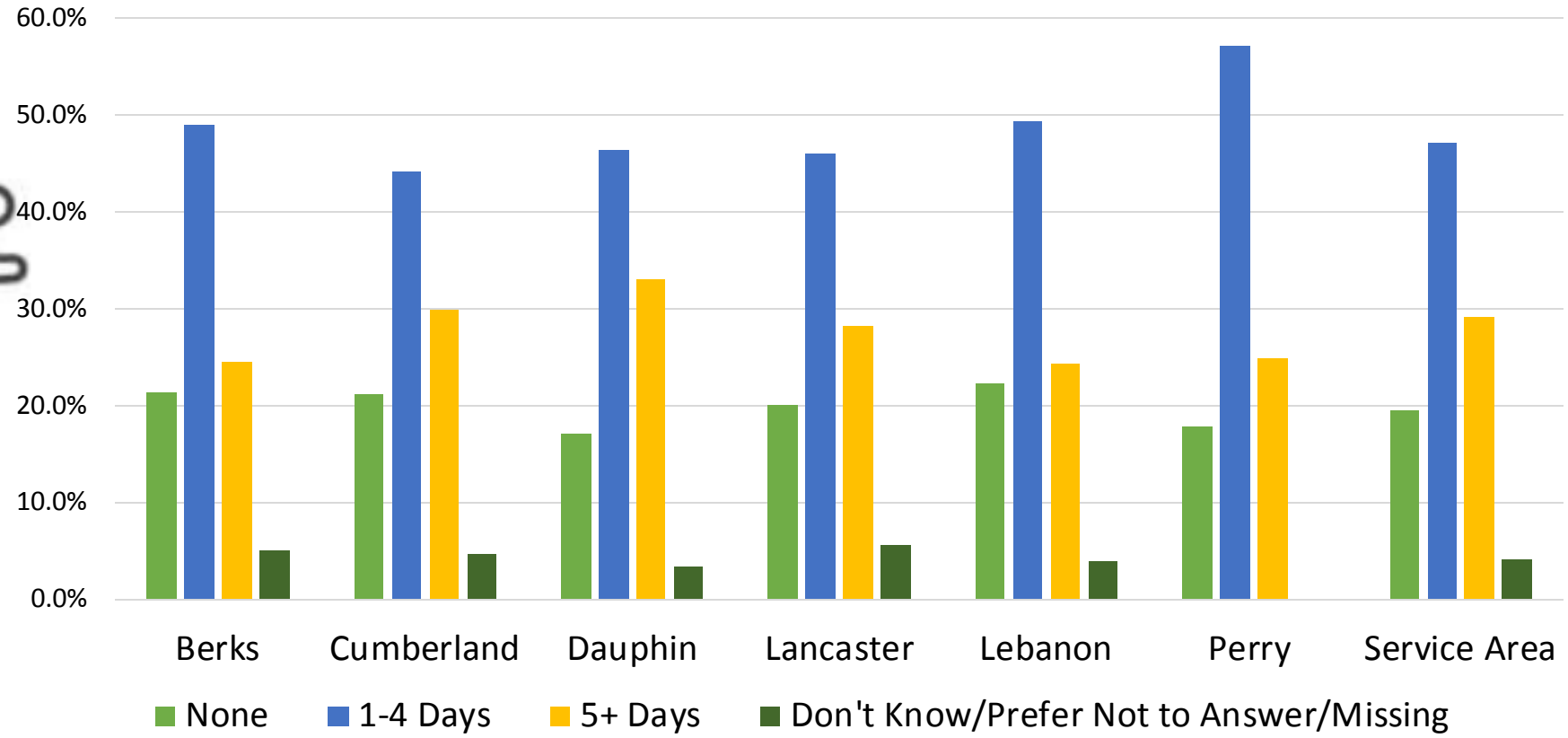
Physical Activity

"More free community exercise programs"
-Community Member

- Approximately 1 in 5 community member respondents reported no days of physical activity (21% in 2018).
- 22% of adults in PA report no leisure-time physical activity (BRFSS, 2017).

- 54% of CMS respondents reported ever being told by their healthcare provider to exercise more.

Days Per Week Respondents Participated in 30 Minutes or More of Physical Activity

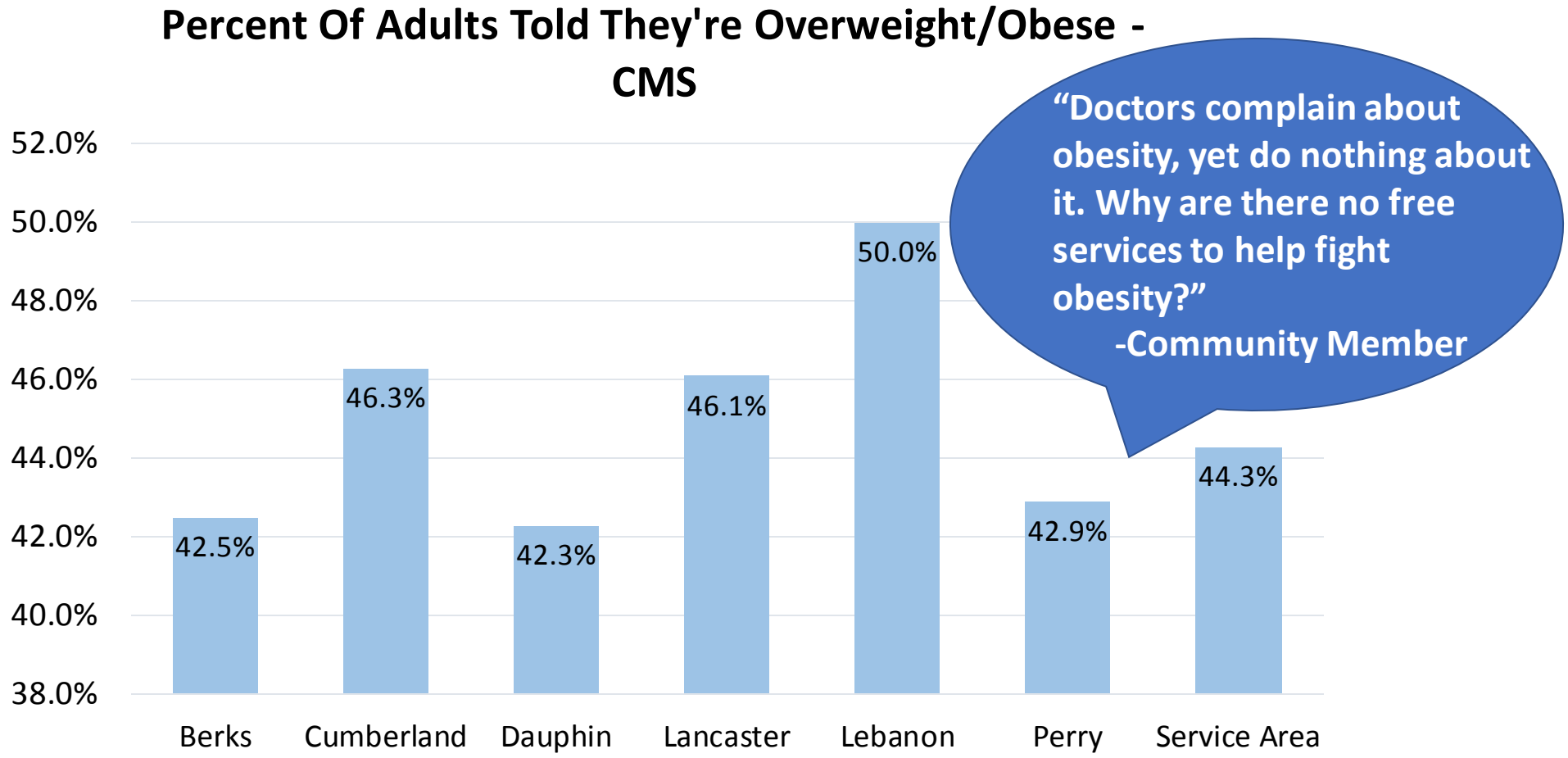


- Only 50% of the population in Perry County had adequate access to exercise opportunities (County Health Rankings, 2021).
- Access to exercise opportunities is decreasing within all counties.

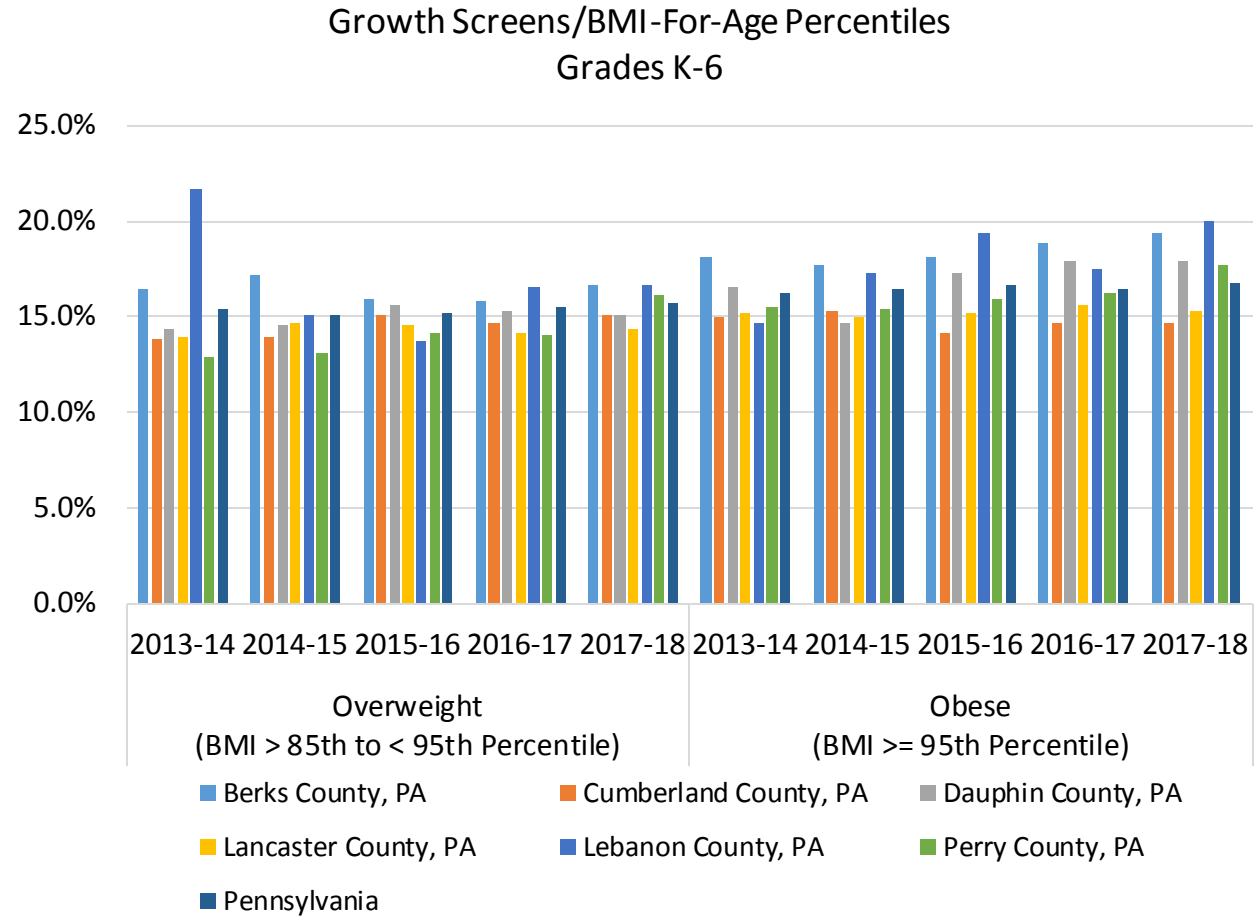
Overweight/Obesity

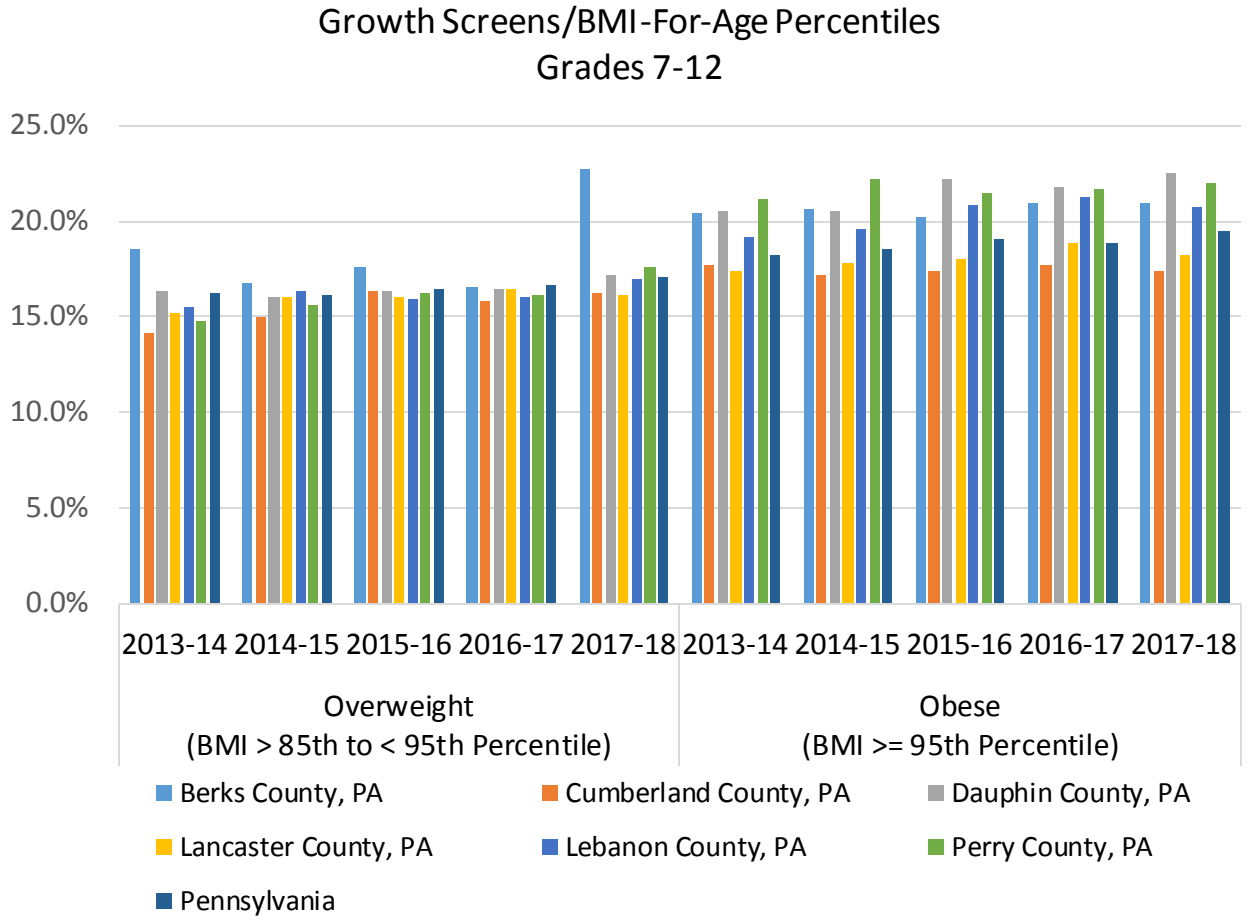
- 44% of CMS respondents reported being told that they're overweight or obese (41% in 2018).

- About 33% of adults in the service area are obese, compared to 30% in PA (BRFSS, 2017).



Overweight/Obesity Cont.





- 18% of children in grades K-6 and 20% of children in grades 7-12 were obese during the 2017-2018 school year (School Health Statistics, 2017-18).

Chronic Conditions

- 42% of CMS respondents reported having been told they have high blood pressure and 39% had high cholesterol.

- In 2017, approximately 60% of the Medicare beneficiary population had high blood pressure, and 47% had high cholesterol.

Chronic Condition Diagnoses by County

County	Diabetes	High Cholesterol	High Blood Pressure	Heart Problems
Berks	16.3%	36.4%	38.3%	15.0%
Cumberland	15.5%	44.2%	39.1%	18.2%
Dauphin	14.8%	39.0%	43.3%	16.5%
Lancaster	18.2%	35.3%	43.1%	17.8%
Lebanon	15.2%	39.3%	41.1%	18.8%
Perry	17.9%	35.7%	42.9%	17.9%
Service Area	15.6%	38.8%	41.5%	16.9%

- 22% of Hispanic/Latino respondents had diabetes compared to 16% of non-Hispanics/Latinos.

- 11% of adults (age 20+) in PA report having diabetes (BRFSS, 2017).

- Non-Hispanic Black adults were more likely to be diagnosed with diabetes compared to Non-Hispanic White adults (15% vs 9%) (USDSS, 2018).

Chronic Conditions Cont.

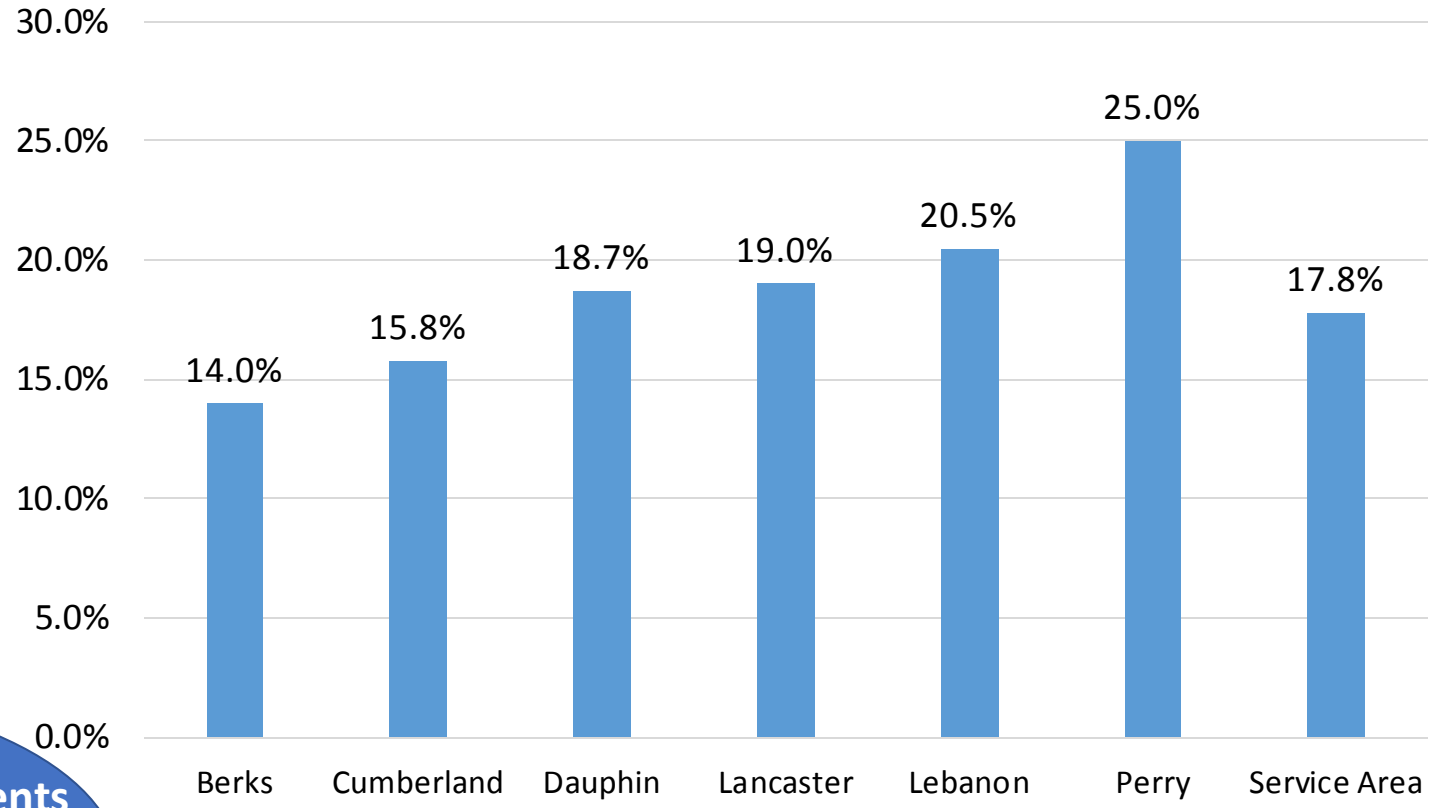
Medicare Beneficiaries with Diabetes, High Cholesterol, High Blood Pressure, and Heart Disease, 2017

	Medicare Beneficiaries with Diabetes	Medicare Beneficiaries with High Cholesterol	Medicare Beneficiaries with High Blood Pressure	Medicare Beneficiaries with Heart Disease
Berks County	12,491 (26.3%)	23,888 (50.2%)	29,552 (62.1%)	12,694 (26.7%)
Cumberland County	6,824 (25.2%)	13,679 (50.5%)	16,813 (62.0%)	7,541 (27.8%)
Dauphin County	6,300 (27.1%)	9,979 (42.9%)	13,603 (58.5%)	6,306 (27.1%)
Lancaster County	14,305 (24.6%)	23,721 (40.8%)	33,828 (58.2%)	14,784 (25.4%)
Lebanon County	4,256 (26.2%)	7,319 (45.1%)	9,845 (60.6%)	4,224 (26.0%)
Perry County	1,300 (28.4%)	2,286 (49.9%)	2,841 (61.5%)	1,396 (30.5%)
Pennsylvania	354,833 (26.2%)	605,704 (44.7%)	793,672 (58.6%)	374,436 (27.6%)
United States	9,188,128 (27.2%)	13,714,033 (40.7%)	19,269,721 (57.1%)	9,076,698 (26.9%)

Cancer

- Within the service area, there were 30.8 cases of melanoma of the skin per 100,000 people compared to 26.9 in all of PA (PA Cancer Registry, 2018).

Have You Ever Been Told That You Have Cancer?
('Yes' Responses)



- Within the service area, there were 44.9 cases of colon/rectum cancer per 100,000 people compared to 49.4 in all of PA (PA Cancer Registry, 2018).

"Dermatologist appointments are not available in a reasonable time frame or at all."
-Community Member

- Approximately 1 in 15 women respondents aged 40+ had not received a mammogram (1 in 10 in 2018).
- About 1 in 7 respondents age 50 or older had never received a colonoscopy (1 in 4 in 2018).

Cancer Cont.

Melanoma Incidence: Age-Adjusted Rates per 100,000 (2014-2018)

	Melanoma - Female					Melanoma - Male				
	2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Berks County	18.6	19.5	17.8	15.0	16.4	23.0	26.3	18.2	31.6	22.7
Cumberland County	27.3	18.8	26.1	24.0	19.7	44.4	19.6	41.7	25.6	38.4
Dauphin County	18.1	20.5	25.1	22.9	25.0	37.6	35.8	30.1	35.4	29.9
Lancaster County	17.7	26.3	25.8	24.6	24.9	35.0	41.2	40.2	32.4	34.8
Lebanon County	23.3	27.1	ND (15)	ND (16)	ND (15)	ND (12)	27.1	40.0	33.7	24.0
Perry County	ND (5)	ND (5)	ND (3)	ND (5)	ND (7)	ND (6)	ND (15)	ND (8)	ND (14)	ND (10)
Pennsylvania	21.8	21.8	18.8	17.4	17.4	31.9	31.4	29.3	26.9	26.0

Breast and Prostate Cancer Incidence: Age-Adjusted Rates per 100,000 (2014-2018)

	Breast Cancer - Female					Prostate Cancer - Male				
	2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Berks County	118.5	122.7	124.1	131.9	123.5	95.8	117.3	119.2	111.5	128.4
Cumberland County	124.3	132.7	130.1	130.4	126.4	65.9	62.0	59.0	78.6	73.8
Dauphin County	144.6	129.3	137.5	116.8	116.8	88.9	108.5	83.9	98.7	74.7
Lancaster County	129.4	119.1	139.0	131.4	132.9	76.3	83.6	98.9	100.7	96.2
Lebanon County	120.7	163.5	137.8	117.0	117.7	72.8	91.3	89.3	98.0	109.4
Perry County	106.7	99.8	113.6	134.7	128.6	62.2	ND (14)	79.8	ND (16)	85.2
Pennsylvania	132.0	131.2	132.9	131.1	129.8	92.0	104.4	106.7	102.4	103.0

Safety and Housing

- 30% of respondents did not feel extremely safe in their neighborhoods.

- 72% of White/Caucasian respondents felt extremely safe in their neighborhoods, while only 58% of Black/African American respondents felt extremely safe.

Respondents Who Feel "Extremely Safe" in Their Neighborhood/Community by Race and Ethnicity

Race/Ethnicity	%	N
Black/African American	58.0%	76
Hispanic/Latino	60.8%	135
American Indian/Alaska Native	62.5%	15
Asian	59.6%	28
White/Caucasian	71.7%	1490

- 1 in 18 respondents indicated that they or their family needed services for housing assistance but were not able to access them.

"Housing exists. We need something that is in between public housing and fair market rent. Right now, people are trapped in public housing because the leap to fair market is too great to make."
-Key Informant

- 28% of homes in the service area had one or more substandard conditions (ACS, 2015-2019).

Safety and Housing Cont.

Housing Units with Substandard Conditions and Cost Burdened Households, 2015-2019

	Housing Units that are Overcrowded	Occupied Housing Units with One or More Substandard Conditions	Rental Households that are Cost Burdened	Owner Occupied Households w/ Mortgages that are Cost Burdened
Berks County	2,190 (1.6%)	45,510 (29.4%)	20,844 (50.7%)	18,122 (25.7%)
Cumberland County	795 (0.9%)	24,154 (24.2%)	12,118 (42.7%)	9,651 (21.4%)
Dauphin County	1,627 (1.9%)	30,921 (27.6%)	17,111 (43.7%)	10,225 (23.0%)
Lancaster County	3,963 (2.2%)	58,354 (28.9%)	29,460 (48.1%)	21,830 (25.5%)
Lebanon County	1,246 (2.6%)	15,093 (28.2%)	7,072 (46.2%)	5,542 (24.5%)
Perry County	299 (1.7%)	4,264 (23.4%)	1,235 (36.6%)	2,168 (25.0%)
Pennsylvania	72,925 (1.7%)	1,417,722 (28.1%)	692,584 (47.7%)	520,428 (25.0%)
United States	4,045,979 (4.4%)	38,530,862 (31.9%)	20,002,945 (49.6%)	13,400,012 (27.8%)

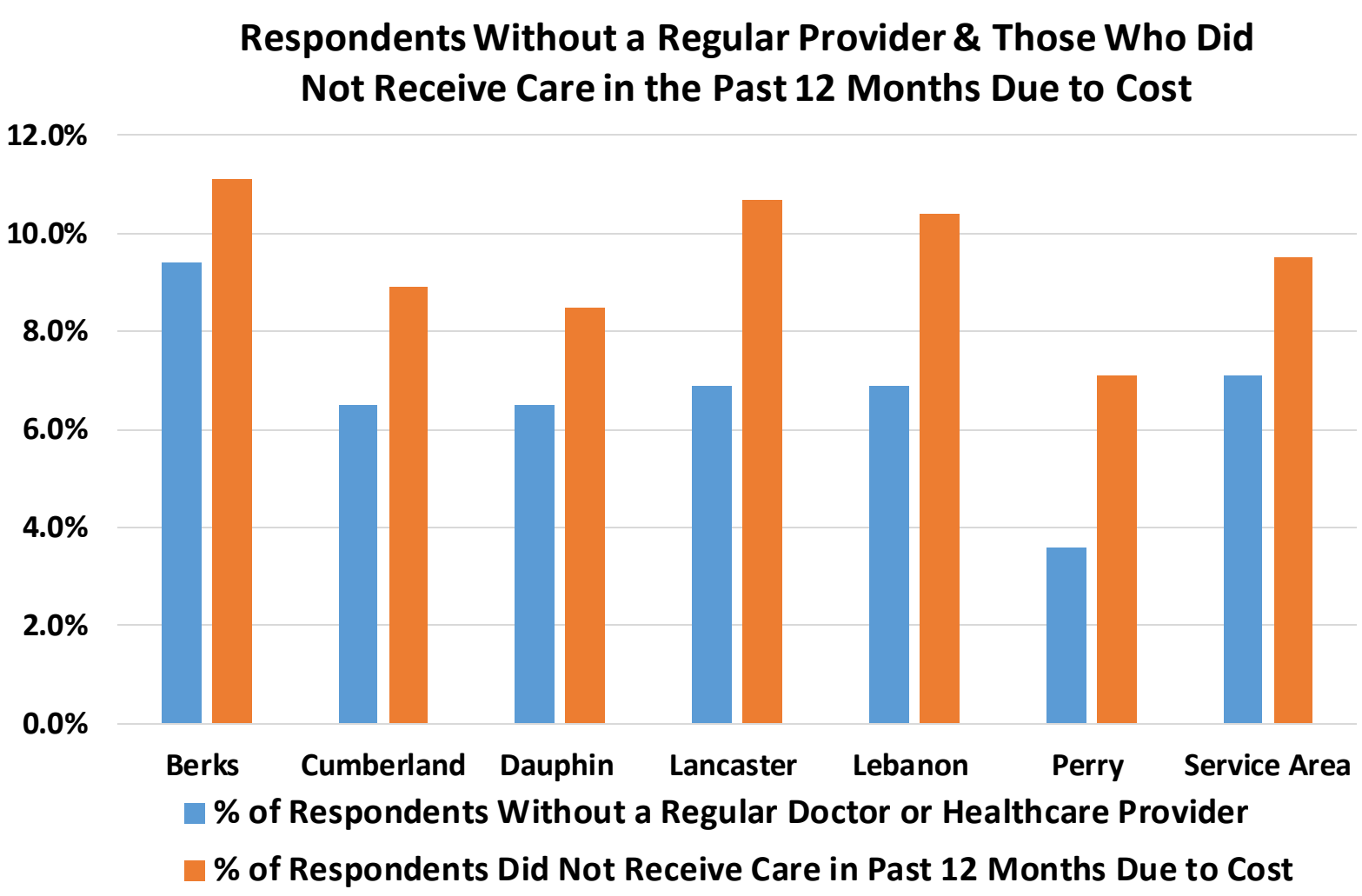
Transportation

- Approximately 2% of respondents said their main form of transportation is public transportation, while 92% of respondents said it's their car.

"Public transportation is a huge barrier in our rural area - that includes access to food, medical appointments, and educational initiatives."
-Key Informant

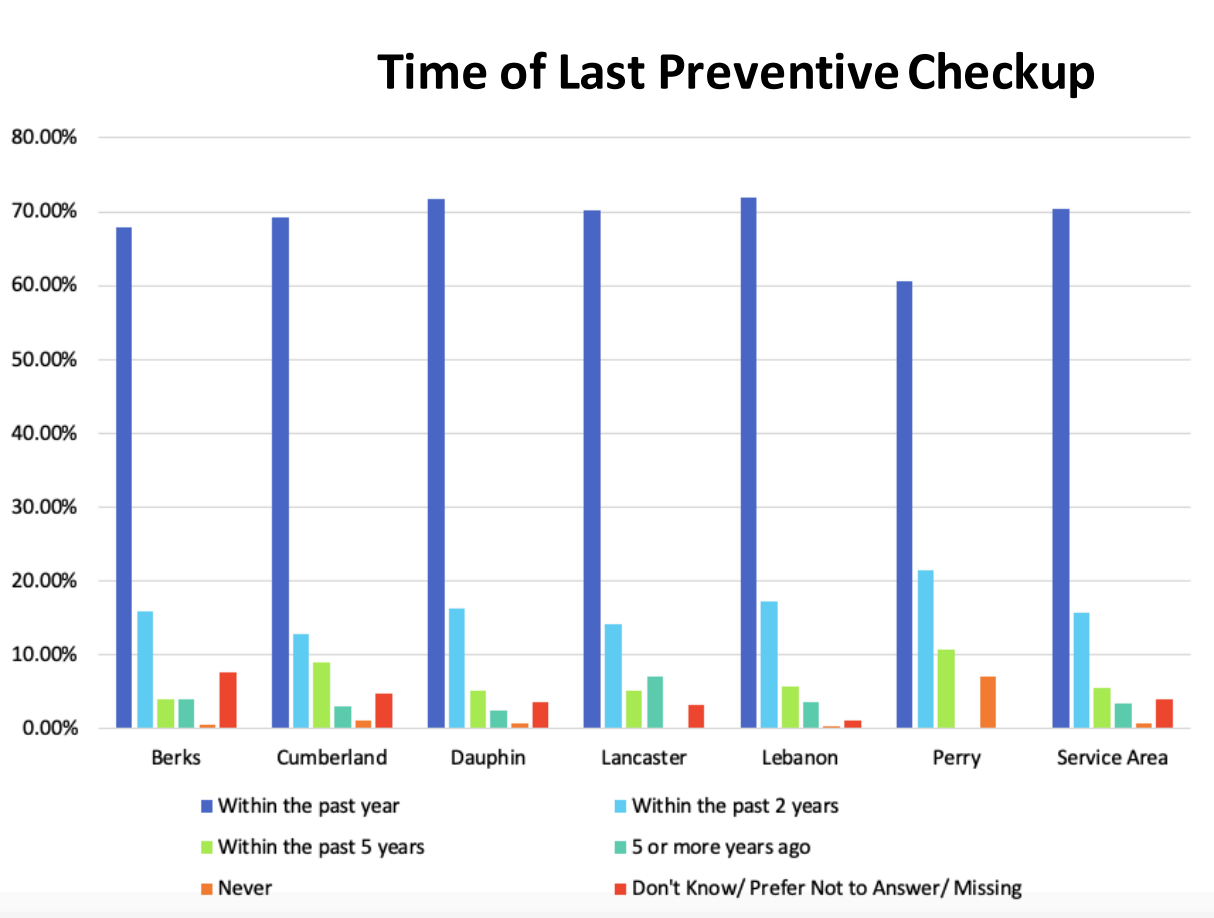
- 1 in 15 respondents indicated that they or their family needed transportation services but were not able to access them.
  - Key Informants listed "lack of transportation to healthcare services" as their number 3 reason as to why individuals with health insurance still do not seek routine care.

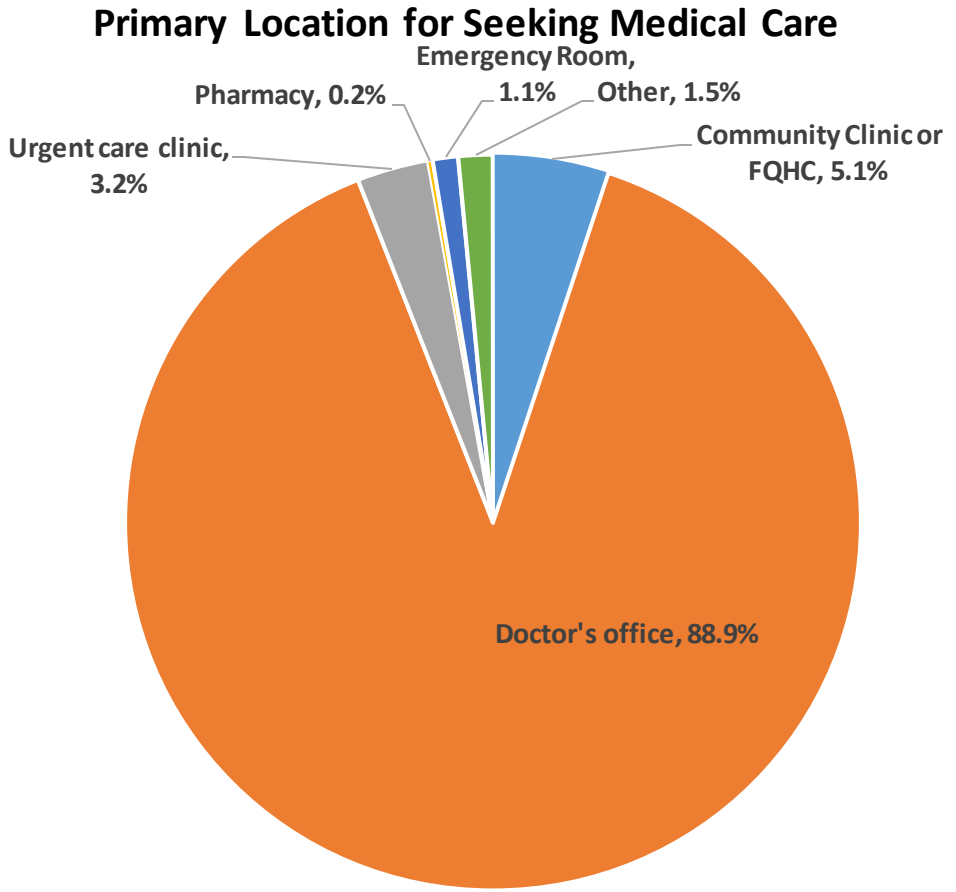
Regular Provider/Routine Care



- 1 in 14 respondents did not have a regular doctor or healthcare provider and 1 in 11 did not receive care in the past year due to cost.
- 58% of Key Informants agreed that residents have a regular care provider; however, 54.1% disagreed that residents have available transportation for medical appointments.
- Lebanon County respondents were most likely to receive a preventive checkup in the past year, and Perry County residents were least likely.

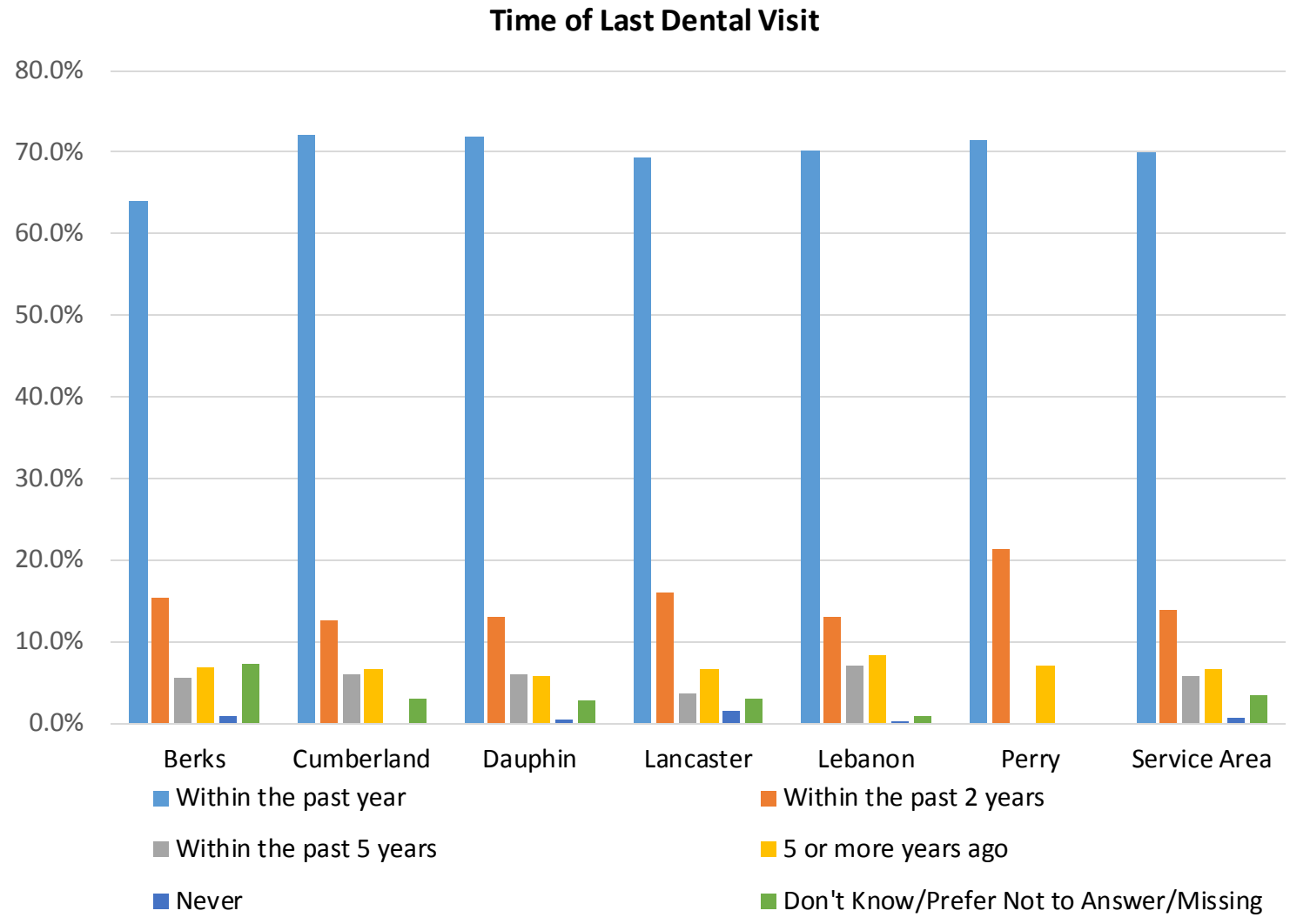
Time and Location of Medical Care

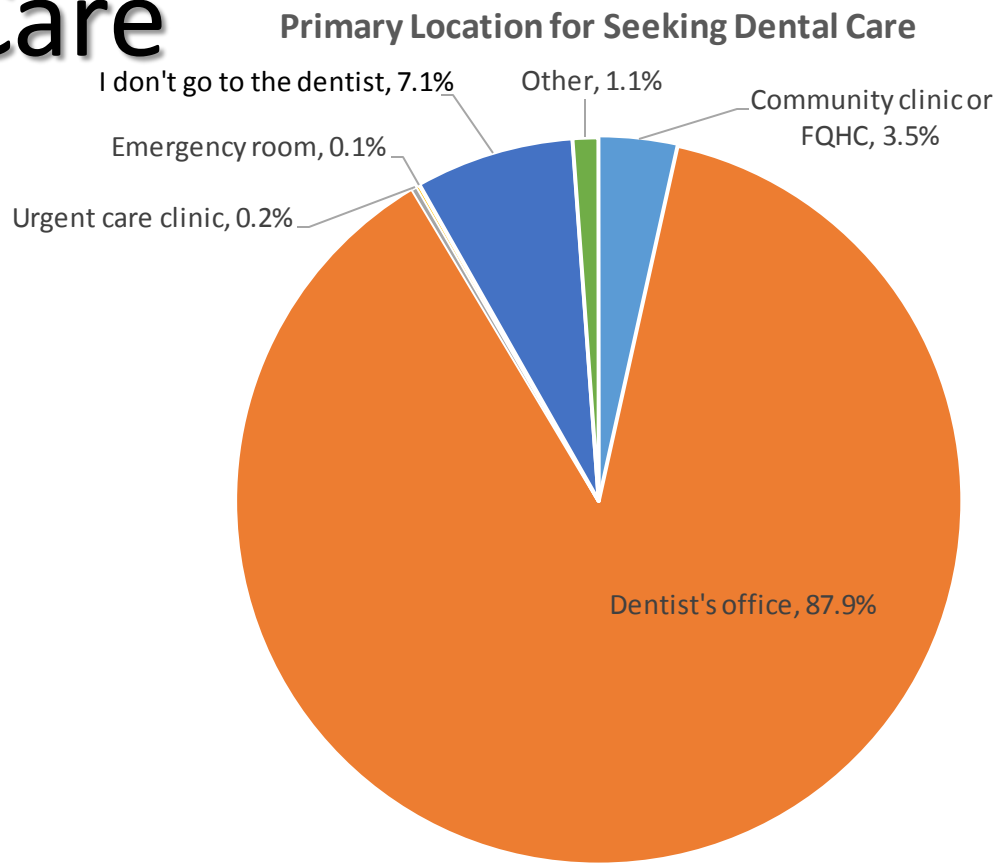




- Within the past year, Lebanon County respondents were the most likely to receive a preventive checkup, while Perry County residents were least likely to receive a preventive checkup.

Time and Location of Dental Care





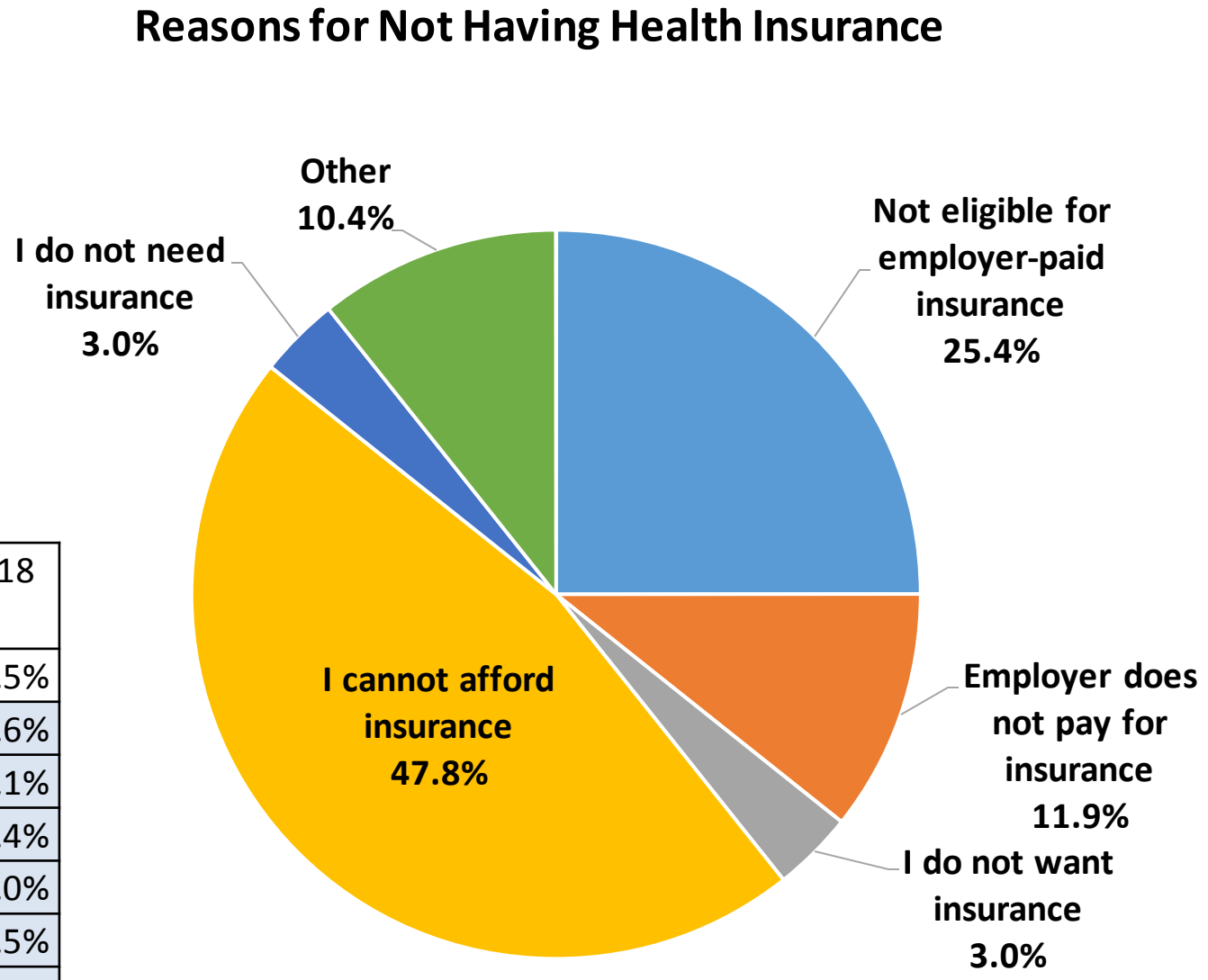
- 1 in 14 respondents indicated that they do not go to the dentist.
- 30% of respondents had not been to the dentist within the past year.

Health Insurance

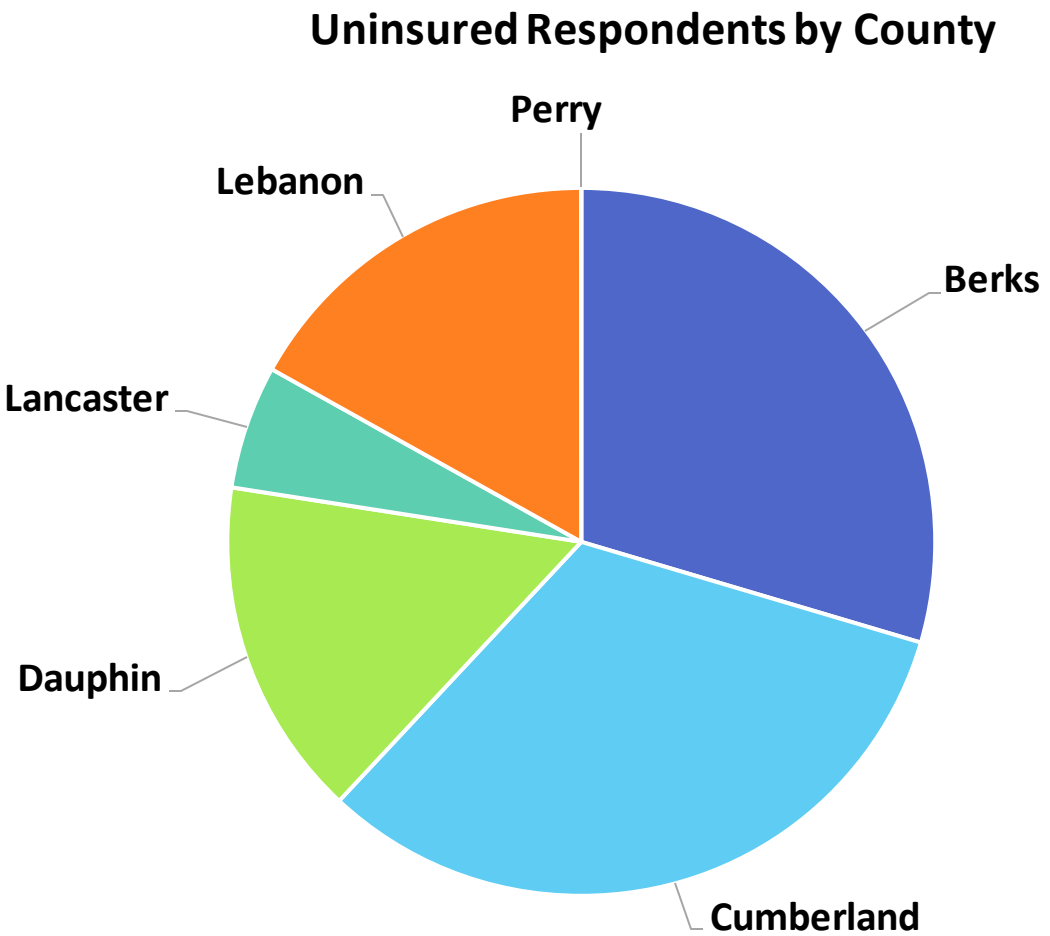
- 97% of respondents reported having some type of health insurance.
- For respondents who are uninsured, almost half indicated that they cannot afford insurance, while one-quarter indicated they are ineligible for employer-paid insurance.

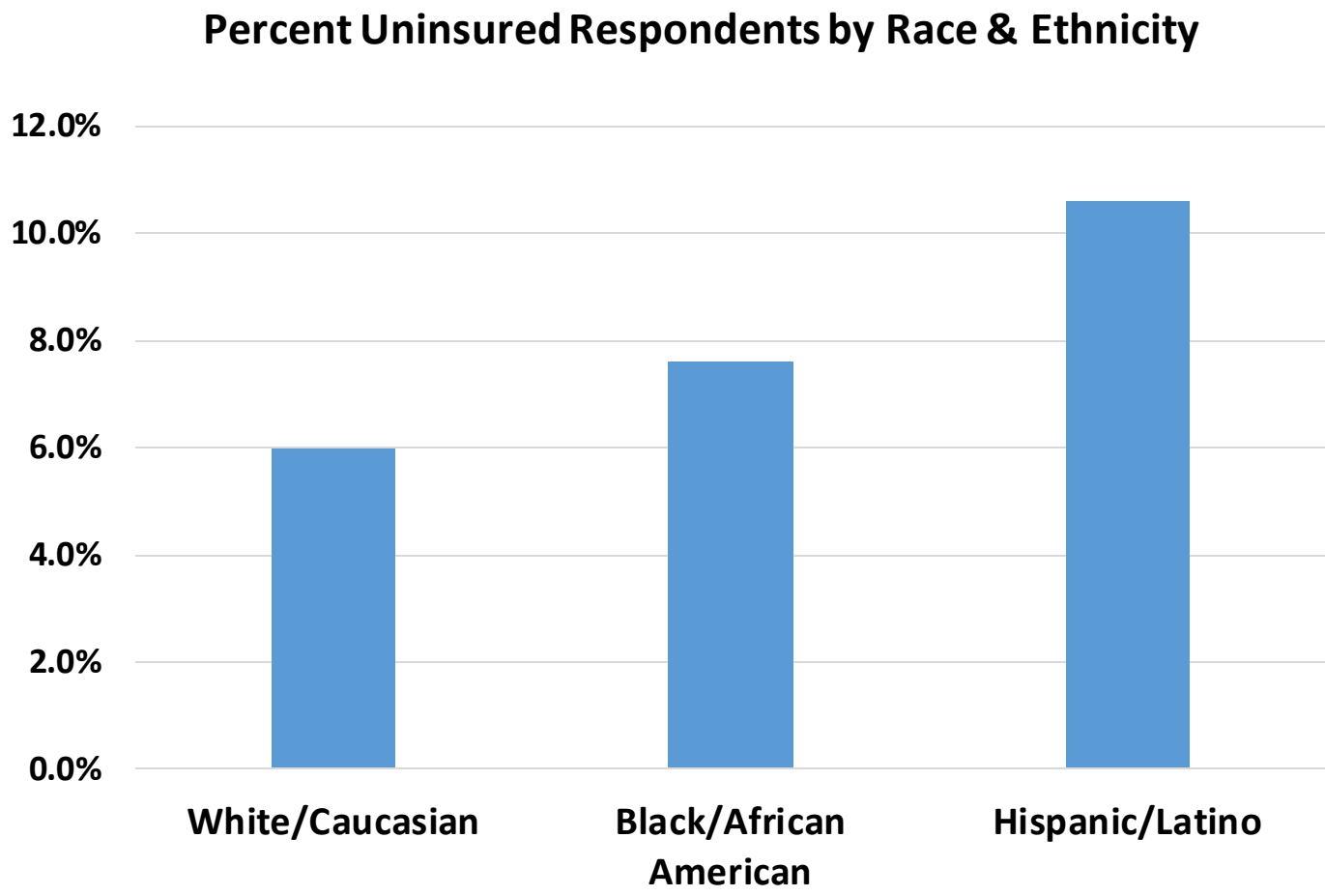
Child Health Insurance – ACS 2015-2019 5-Year Estimates

	Percent Population Under Age 18 Without Health Insurance
Service Area	9.5%
Berks County	4.6%
Cumberland County	6.1%
Dauphin County	3.4%
Lancaster County	17.0%
Lebanon County	9.5%
Perry County	13.1%
Pennsylvania	4.3%



Health Insurance Cont.





- Cumberland and Berks counties had the highest percentages (4.6% and 4.2%) of uninsured respondents.
- Hispanic/Latino individuals and Black/African American individuals were most likely to report being uninsured.

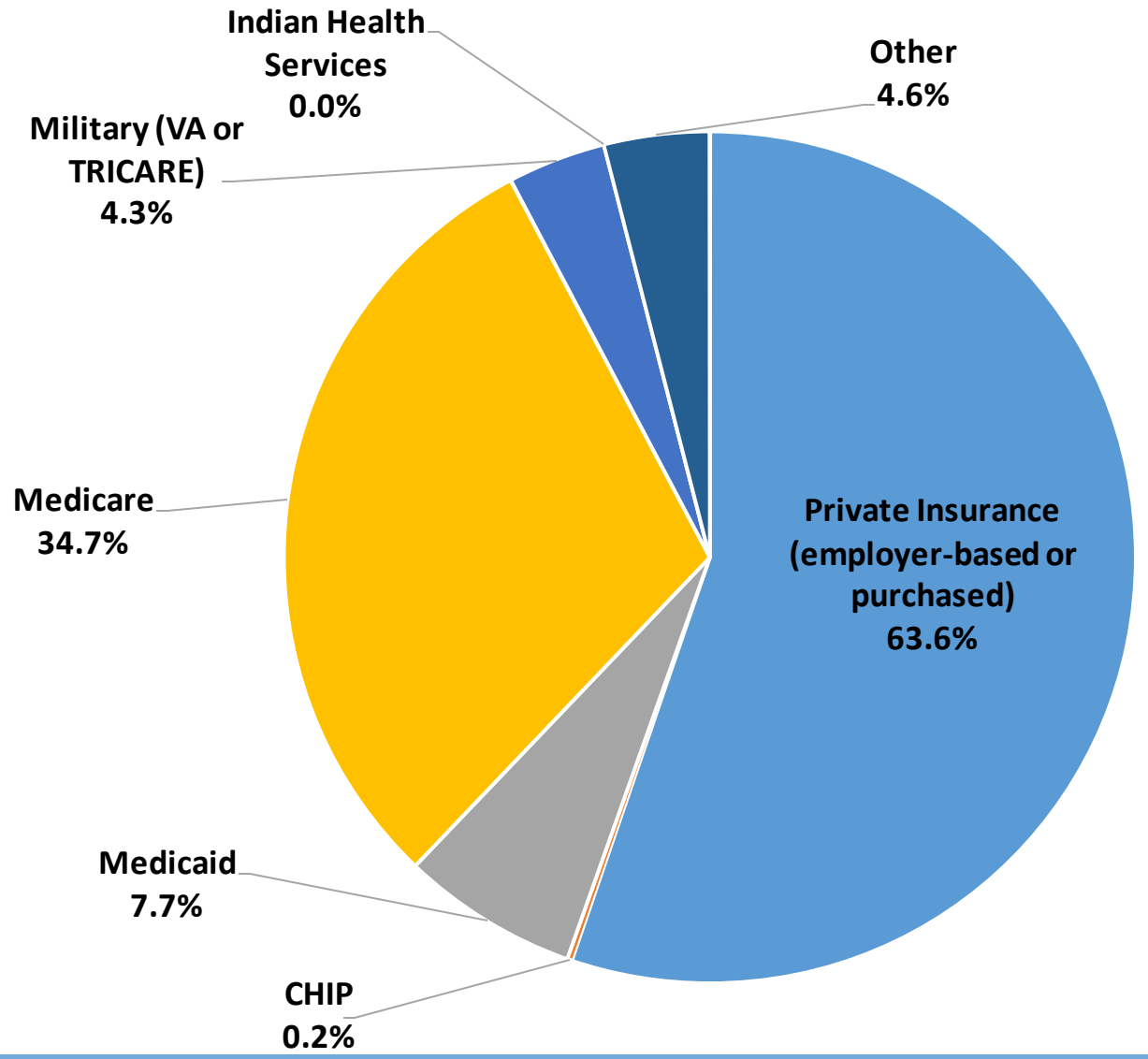
Health Insurance Cont.

"Most people are forced to travel outside of an hour to get to doctors who accept Medicaid or Medicare."
-Key Informant

- 1 in 13 respondents had Medicaid as their primary health insurance.

- 4% of respondents had health insurance through the military.

Health Insurance Type Among Insured Respondents



KIS – Open-Ended Reasons Not Seeking Care

Questions Regarding Findings?

CHNA@pennstatehealth.psu.edu

Appendix C: 211 Counts Data: Top SDOH Needs in Rural Areas of the County

HMA looked at **United Way 211 PA Counts data broken down by school districts in rural areas.**[19]

The data points below are based on 211 total requests between September 2021 and August 2022 from individuals in the following rural school districts:

- Hamburg Area School District
- Kutztown Area School District
- Oley Valley School District
- Tulpehocken Area School District
- Twin Valley School District

Table 7: 211 Counts Data

TOP SDOH NEEDS IN RURAL AREAS		
Domain	**% of Total Requests**	**Top Specific Needs**
#1 – Housing	47%	• Rent assistance (39%) • Shelter (30%) • Low-cost housing (20%)
#2 – Assistance with Utilities	17%	• Electric (59%) • Internet/phone (12%)
#3 – Food	7%	• Food pantries (57%) • Help buying food (23%)
#4 – Employment and Income	6%	• Financial assistance (71%) • Job search (15%)

[19] 211 Counts, Pennsylvania, 2022, https://pa.211counts.org/

Appendix D: Essential Public Health Services

The 10 Essential Public Health Services provide a framework to guide public health professionals in their work with the aim of strategically promoting and protecting the health of all people in all communities. The Essential Public Health Services seeks to achieve equity by actively promoting policies, systems, and overall community conditions that facilitate optimal health for all county residents and with the aim removing systemic and structural barriers. The 10 Essential Public Health Services seek to address barriers to optimal health such as poverty, racism, gender discrimination, ableism, and other forms of oppression. The 10 Essential Public Health Services fall into three categories: Assessment, Policy Development, and Assurance. Implementing these services falls is cyclical, assess and monitor population health and investigate concerns then begin policy development where communication, partnerships, policy implementation, and regulatory action occurs. Followed by Assurance where efforts to improve and maintain initiatives occur including building diversity and equity, research and evaluation, quality improvement, and building strong organizational infrastructure. See **Figure 16** for details.

Figure 16: 10 Essential Public Health Services[20]

[20] Essential Public Health Services, https://phnci.org/uploads/resource-files/EPHS-English.pdf

Appendix E: Focus Group Methods and Questions

Focus groups were conducted in September–December 2022. Typically organized as small groups of up to 10 participants, HMA facilitated the focus groups, which had semi-structured conversations exploring a selection of topics tied to the core public health services and functions.

By design, the focus groups sought to engage laypeople and professionals "closer to the ground" in terms of delivering and receiving public health services. We sought input from rank-and-file county residents and frontline workers who provide health and human services in Berks County. We developed the categories of focus group respondents in conjunction with the Core Planning Team assembled for this project.

As **Table 8** shows, 81 individuals participated in the focus groups. While HMA aimed to assemble six to10 participants per focus group, the final size of the focus groups varied widely.

Table 8: Focus Group Participants by Category

Focus Group Category	Number of Participants
Hispanic/Latino Adults from Urban Communities	15
Emergency Response Staff	9
People in Transitional or Emergency Housing	7
Business/Employer Group	5
School Health Staff	10
Food Delivery Volunteer Group	5
CBO Staff	3
People who Access or Provide Services for People with Disabilities	11
Older Adults from Rural Communities	11
Community Health Center Staff	5
Total	**81**

Our aim in forming the focus groups was to understand perceptions and perspectives on public health needs in Berks County. Areas of inquiry explored how participants understood the current state, while also soliciting input on opportunities and suggestions for improving the quality and responsiveness of public health services in the county. To encourage candor, we promised to protect the confidentiality of focus group participants and to present findings only in aggregate form by topic.

We grounded our questions and areas of inquiry in the core services and functions of public health. Table 9 presents the distribution of topics by focus group.

Table 9: Mapping Focus Groups to Public Health Services and Functions

Focus Group Participants	Public Health Services and Functions *How can we design a Public Health entity to deliver the following key services and functions?*					
	Assess and Monitor Population Health *What kind of data and information need to be available and shared widely?*	***Address Health Hazards and Root Causes*** *How might we address the root causes of chronic disease and poor health?*	***Communicate to inform and educate*** *How do differences in health literacy impact health access and outcomes?*	***Mobilize communities and partnerships*** *Which partnerships offer the best opportunities for encouraging community health and wellness?*	***Enable Equitable Access*** *What are the key barriers to more equitable access to healthcare that must be addressed and overcome?*	***Champion and implement policies and laws*** *What can county organizations do to encourage health and wellness?*
Older adults from rural community		✓	✓	✓		
People who access or provide services for people with disabilities	✓		✓	✓	✓	✓
Hispanic/Latino adults living in a low-resource community (in Spanish)		✓	✓		✓	
Business/ Employer group	✓		✓	✓		✓
People in transitional or emergency housing		✓	✓		✓	
Food delivery volunteer group	✓	✓		✓		
Community health center staff	✓		✓		✓	
CBO staff	✓	✓	✓	✓		✓
Emergency response staff		✓	✓	✓	✓	
School health staff	✓	✓	✓		✓	

Two HMA colleagues conducted the focus groups—one facilitating the focus group and one taking detailed notes. A few focus groups met in person, but most occurred in a virtual setting.

Below is a summary of the questions that we used to guide these conversations.

Address Health Hazards and Root Causes: How might we address the root causes of chronic disease and poor health?

- What do you or your community need to better manage living with chronic disease (e.g., cancer, heart disease, diabetes, stroke, Alzheimer's)
    - If you had the resources, what would you do to reduce the number of people living with chronic disease and poor health?
- What financial or community resources are needed?

Enable Equitable Access: What are the key barriers to more equitable access to healthcare that must be addressed and overcome?

- What are barriers you personally experience to accessing healthcare?
- What are the most common barriers you see to improving community health and wellness?
    - Which populations are most likely to experience difficulties? Which groups need additional support and assistance?
- What would make healthcare easier to access for you /in your community?

Communicate to inform and educate: How do differences in health literacy impact health access and outcomes?

- What could Berks County do differently to improve health communications for your community?
    - Which populations need a differentiated communications strategy? Why?
    - What suggestions do you have on how to target or segment communication to these populations?
- Where do you think Berks County (all agencies public and private) should focus to better educate and inform residents about health (Health Literacy) going forward?
    - What changes could be made to health communications to improve your understanding and impact on your health?
- [Only if necessary] Are there any lessons you learned from the COVID-19 pandemic that illustrate what can be done better going forward?

Assess and Monitor Population Health: What kinds of data and information need to be available and shared widely?

One key function of public health is using data to: a) raise awareness about specific health needs; b) suggest reallocation of resources to specific populations or communities; and c) showcase progress in mitigating or improving community health.

- To what extent is data being used in any of the ways just described?
- What kind of data or informational resources would help you better serve your community?

***Mobilize communities and partnerships*:** Which partnerships offer the best opportunities for encouraging community health and wellness?

- What community partnerships have helped encourage community health and wellness? In your community? With your employees?
- What role would you like to see provided by Berks County agencies (nonprofits and other non-governmental agencies) in encouraging health and wellness?
- Which community partnerships would you like to see nurtured and fostered, whether these exist currently or need to be developed?

***Champion and implement policies and laws*:** What can County organizations do to encourage health and wellness?

- How can Berks County Government support or encourage health and wellness for your community?
    - What policies or laws would better support community health?
    - What policies or laws would reinforce or support the role of community agencies (e.g., CBOs) as service providers and intermediaries advancing public health?

Appendix F: Interview Methods and Questions

We conducted Informant interviews in November 2022–January 2023, after completing most of the focus groups. Interviews focused on soliciting input from key community and institutional leaders representing multiple stakeholder groups. Interviewees were selected based on recommendations from the Core Planning Team assembled for this project.

Table 10 shows that a total of 10 informant interviews were conducted, typically involving one to four individuals in each session. One HMA colleague conducted the virtual interviews.

Table 10: Informant Interviews

Interview Category	Number of Participants
Community-Based Organizations	2
City and County Government Leaders and Agency Heads	4
Hospitals, Managed Care and Other Healthcare Providers	3
School District Leads involved in Health and Family Outreach	1
Total	**10**

Interviews centered on gathering perspectives on the level of coordination within the existing public health-related programs and systems. We also asked interviewees about their suggestions and preferences for redesigning the public health ecosystem in Berks County. Throughout, we allocated time during interviews to discuss future opportunities and points of leverage tied to enhancing collaboration in public health. To encourage candor, we agreed to protect the confidentiality of interview participants and present findings only in aggregate form by topic.

As in the case of the focus groups, we grounded our interview questions and areas of inquiry in the core services and functions of public health. Below, are the questions used to guide these semi-structured interviews.

Address Health Hazards and Root Causes:

We learned a lot about the health needs in Berks County during our focus groups. Some of the things we heard were, difficulty finding healthy food, homelessness, and increased housing costs. In other words, we heard about the Social Determinants of Health. We also heard there is a need for more integrated, holistic care. For example, care that treats both physical and mental health.

- How could a County-wide public health organization assist or support the work you are doing to address the health needs of the community?
    - Where are opportunities to work collaboratively on specific public health campaigns or initiatives? Addressing upstream factors aka SDOH?

    - What would that support or collaboration to look like? (financial/grants, resources, data, information, education)
- How could a County-wide public health organization support the integration of physical and mental health?
    - Do you have any suggestions for how the County might proceed on this front?

Enable Equitable Access:

At present, there is a feeling that many people in Berks County that are falling through the cracks when it comes to health care and social services. There are disparities and inequalities that exist in the system. We have heard many of you are working hard to reach and support these people, but often there just is not enough time, resources, finances to go around.

- Thinking about the current public health system in Berks County, who is falling through the cracks?
    - What could a County-wide public health organization do to increase support for these individuals and communities?
- Thinking about your most vulnerable patients or patients experiencing health disparities. How could a County-wide public health organization support these individuals and communities?

Mobilize Communities and Partnerships:

We have heard about many existing strong partnerships in Berks County that have been essential to the public health work, especially throughout COVID-19. We heard a desire for these partnerships to continue and expand. We also heard that partnerships need more coordination and coherence, especially if they are going to be scaled up and sustained.

- Within Berks County, which partnerships are working well?
    - In your opinion, what makes this partnership successful and/or lasting?
- To expand partnership with public health, who from your organization needs to participate?
    - What is the best way to engage with them or bring them to the table?
- How would you suggest we organize or coordinate County public health partnerships?
    - How do you see yourself collaborating with a County-wide public health organization?

Communicate to inform and educate:

Many people we have spoken to have said Berks County needs a united and focused communication strategy, people used the term "one voice". We also heard about the need for tailored messaging to better reach different populations and communities, as well as messaging coming from multiple sources (online, in-person, provider, school, etc.).

- What topics would you want to see the County organize messaging around?
    - Are these messages you are already focused on (i.e., you'd like to see reinforcement) or does this represent an area that you think has not been sufficiently addressed?

- What would make the biggest difference in terms of tailoring messaging to different communities? (Translation, source, technology, format)
    - How would you approach this?
- What other suggestions do you have for addressing health literacy in the County?
- How could a County-wide public health organization engage your organization to do this work?

Assess and Monitor Population Health:

At present, most of the population health data is coming from the State. There are only a few data points available on a County-level. Throughout COVID-19 it has become clearer that County-level data is not there when you need it. A County-level Public Health organization may be able to fill this gap.

- What public health data about Berks County does your organization need?
    - Which data is missing? Not available in disaggregated fashion? Not timely enough?
- Would it be helpful to have one place you could go for all Berks County public health data?
    - What data would you like to see there?
    - Where would this data come from?
    - What would having these data allow you to do that you are not currently doing?

Appendix G: Summary of Pennsylvania Legal Authorities

In Pennsylvania, single-county departments of health may be authorized, by resolution or by referendum, under Act 315.[21] Before enacting a resolution or before submitting the question at an election, county commissioners must request a certificate of approval from the State Secretary of Health. Immediately upon the authorization of the establishment of a single-county department of health (resolution adopted or referendum passed), the county commissioners must give written notice to the State Secretary of Health. Act 315-funded health departments are required to provide public health programs in the areas of administrative and supportive services, personal health services and environmental health services. Act 315, which provides for a grant from the Commonwealth, was amended in 1976 by Act 12 to add support for environmental health initiatives including, but not limited to, food and water supply protection, water pollution control, public bathing place sanitation, vector control, solid waste management, and institutional, recreational, and housing environment inspection.

Each County/Municipal health department (CMHD) has a board of health, which appoints a health director. The county commissioners shall appoint five resident citizens to the board of health, including two physicians licensed to practice in Pennsylvania, all of whom shall serve without compensation. The health director is responsible for the administration of the County/Municipal health department and has certain other enumerated powers. The duties of the CMHD are remarkably similar to those of the Pennsylvania Department of Health (DOH). By Code, County/ Municipal health departments must provide administrative, personal health, and environmental health services. These services are outlined in Pennsylvania Code: Title 28: Chapter 15. Chapter 17 includes more detail around environmental health services and Chapter 13 outlines personnel administration. CMHDs provide these services through comprehensive programs of disease reporting, surveillance, and outbreak investigation as well as environmental programs.

The CMHD's jurisdiction generally is limited to the geopolitical boundary of the entity forming the department, i.e., Berks County. A municipality can be exempt from the jurisdiction of the County/Municipal health department if: (1) It had its own department or board of health at the time the County/Municipal health department was established, (2) DOH approves, and (3) the exempt municipality had not, by ordinance, opted to become subject to the jurisdiction of the County/Municipal health department. The specific structure of each local health authority is determined by local regulations and ordinances.

Act 12 Supplemental Funds

Act 12 sets out a complementary but somewhat overlapping set of expectations (Standards for Environmental Health Services) for a CMHD, and the Commonwealth will pay an additional annual grant, through Act 12, for environmental services that include but are not limited to:

[21] https://www.health.pa.gov/topics/Documents/Administrative/County%20Muni%20HD%20ACT315.pdf

- Air and noise pollution control
- Restaurant and wholesale food inspection
- Rodent and vector control
- Water and sewage inspection
- Housing code enforcement
- Other similar services in addition to other local health grants for Public Health services.

PA Code Chapter 13: Personnel Administration in County Health Departments[22]

The county health director exercises the power conferred upon the County Department of Health to employ personnel, though the County Board of Health will not appoint a County Health Director until the Department first certifies that the proposed applicant possesses the required minimum qualifications set forth in the position-classification plan. As a third-class county, Berks County will also need a health officer who must be a physician licensed to practice medicine or osteopathy, or eligible for such licensure, in the Commonwealth. The individual serving as the health director and the health officer need not be the same individual. In hiring CMHD personnel, preference is given to professional and technical personnel employed by municipal departments or boards of health, if dissolved, and to professional and technical personnel employed by DOH whose positions in the county or counties served by the County Department of Health may have been terminated as a result of the establishment of a CMHD

PA Code Chapter 15: State Aid to Local Health Departments[23]

CMHD applications for Commonwealth grants must be submitted within 30 days after passage of the budget of the local health department. The initial application should include a narrative statement describing the functions of the subdivisions of the CMHD. Later applications need only describe changes in functions. Each application must contain all of the following information:

1) A detailed budget of proposed expenditures for public health programs
2) The subdivisions of the local health department (may be incorporated into budget)
3) The title, annual salary rate, and amount for each position (may be incorporated into budget)
4) The amounts allocated for equipment costs, automobile costs, rent, travel expenses, and other expenses (may be incorporated into budget)
5) An estimate of expected revenues
6) Copies of pertinent resolutions
7) Copies of pertinent contracts for services to be rendered

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[22] Pennsylvania Code and Bulletin, Chapter 13, http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter13/chap13toc.html&d=reduce

[23] Pennsylvania Code and Bulletin, Chapter 15, http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter15/chap15toc.html&d=reduce

8) A program plan indicating measurable objectives for each program being funded and the evaluation criteria to be used to measure results
9) A completed budget summary on a form prescribed by the Department. This form shall also be used as an expenditure summary to accompany the end of year certified statement of expenditures

Chapter 15 outlines the requirements for county health departments in three areas: (1) Administrative and supportive services, (2) Personal Health services, and (3) Environmental Health services. These areas encompass the following general programs that a Health Department in Berks County would be mandated to provide:

1. Administrative and supportive services include but are not limited to: administration and program direction; budget; accounting; personnel administration including merit system supervision; public health education, public health statistics, public health laboratory services. Administrative staff shall include a director and necessary professional, technical and clerical personnel.
2. Personal health services include but are not limited to: chronic disease; communicable disease control, including tuberculosis control and venereal disease control; maternal and child health services; and public health nursing services.
3. Environmental health services include but are not limited to: food protection, water supply, water pollution control, bathing places, vector control, solid wastes, institutional environment, recreational environment and housing environment.

Personnel and Staffing

Each local health department is administered by a full-time director. The director must be either a physician with a minimum of 2 years of supervisory or administrative experience in the field of public health, licensed to practice medicine or osteopathy in this Commonwealth, or eligible for licensure within 1 year of appointment, or, if not a physician, a person with at least 4 years of supervisory or administrative experience in the field of public health supplemented by a master's degree in public health, hospital administration, public administration or a related discipline. The CMHD must employ at least one full-time physician, who may, but is not required to, be the director of the local health department. The CMHD must also employ a director of public health nursing and a director of environmental health services, working under the supervision of the CMHD director.

The CMHD must adopt written job specifications, approved by DOH, for each local health department position. The descriptions must include the minimum experience and education required of appointees to that position.

Limitations on the use of the State's Act 315 grants are detailed in Chapter 15. Prohibitions include, but are not limited to, cost of hospital care, construction of public hospitals, or purchase of ambulances.

PA Code Chapter 17: Standards for Environmental Health Services[24]

This chapter applies to all local health departments which receive Commonwealth grants under the act and sets forth the minimum standards of performance for those departments in the mandated programs in the area of environmental health services. The CMHD is responsible for conducting evaluations of the environmental programs they carry out and for promptly reporting the results of such evaluations to the Secretary. These regulations outline minimum program activities, training, and evaluation procedures for vector management, water pollution control, and solid waste management.

PA Code Chapter 27: Communicable and Noncommunicable Diseases[25]

This chapter outlines the responsibilities of a CMHD and the Department of health when dealing with communicable and non-communicable disease. Chapter 27 delineates a local health department's authority to establish quarantine or isolation, including surveillance, segregation, quarantine or modified quarantine of a person or an animal with a communicable disease or infection. Other disease control measures may also be considered if the CMHD considers to be appropriate for the surveillance of disease, when the disease control measure is necessary to protect the public from the spread of infectious agents. The local health authority will determine the appropriate disease control measure based upon the disease or infection, the patient's circumstances, the type of facility available and any other available information relating to the patient and the disease or infection. The local health authority may investigate any case or outbreak of disease it judged to be a potential threat to the public health, including a confidential review of medical records.

Phased Approach to Act 315 Compliance

State regulations makes a distinction between when a CMHD is created and when a CMHD is established. Request of a Certificate of Approval from the Secretary of Health and a local referendum/resolution is required to create a CMHD. Once a CMHD is created county commissioners must work to comply with the Act 315 regulations.

County commissioners must create a board of health.

- The county commissioners shall appoint five resident citizens, two of whom shall be physicians licensed to practice in Pennsylvania.
- A chairman shall be elected at the organizational meeting for a term of one year
- Must appoint a health director

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[24] Pennsylvania Code and Bulletin, Chapter 17, http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter17/chap17toc.html&d=reduce

[25] Pennsylvania Code and Bulletin, Chapter 27, http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter27/chap27toc.html&d=reduce

- The health director shall be the secretary of the board but he shall not be a member thereof.
- The members of the board shall serve without compensation,

Administrative requirements include:

- Annual Program Plan, and
- Merit system requirements for personnel administration.

The State Secretary of Health determines when a proposed county department of health is ready to exercise its powers and duties. That determination is made only when (1) local funds have been appropriated, (2) the organization of the county department of health has been completed, (3) personnel have been employed in accordance with the regulations of the State Department of Health, (4) required facilities and equipment have been obtained, and (5) necessary rules and regulations have been prepared by the board of health to the extent that the county department of health will be able to achieve the purposes of this act. The Secretary will then transmit a certificate of her finding to the county commissioners. Thirty (30) days after the notice has been given by the county commissioners to executives of all municipalities within Berks County, the county department of health shall be considered to be established and shall begin the exercise of its powers and duties.

The county commissioners submit to the State Secretary of Health, on forms prescribed by DOH, an initial estimate of expenditures to cover the operation of the county department of health from the date of its establishment to the end of the calendar year in which it is established. The initial estimate of expenditures should state the names of the exempt municipalities which have not decided to become subject to the jurisdiction of the county department of health. The estimate shall be submitted within thirty (30) days prior to the date of establishment.

No county department of health shall begin to receive annual grants until the calendar year following the one in which it was established.

Appendix H: Sample Health Director Position Descriptions[26]

SAMPLE #1

Illustrative Public Health Director Job Description

Responsible for overseeing public health programs and activities in a county. This includes developing and implementing public health policies, organizing and conducting public health surveys, and providing public health education.

Responsible for maintaining the health and well-being of the community by providing public health leadership and direction. Works with other community members to identify and prevent health problems and promote healthy lifestyles. The public health officer's responsibilities include ensuring that communities have access to healthy food, water, and air; developing and implementing public health policies; and providing public health services.

The public health officer's job is to protect the public's health by monitoring and promoting health and safety, detecting, and preventing outbreaks, and promoting public health education.

Skills, Knowledges and Proficiencies

- An advanced degree in public health or related field.
- An understanding of health policy and how it is developed and implemented.
- An understanding of the social, economic, and political determinants of health.
- Ability to work with people from different cultures and backgrounds.
- Good organization and problem-solving skills.
- An ability to use data and evidence to inform decision making.
- Good project management and research skills.
- An ability to think critically and creatively.

SAMPLE #2

The Prince George's County Department of Health seeks a visionary executive to lead its public health programs affecting the County, including Behavioral Health, Environmental Health, Communicable Disease Prevention and Control, Family Health Services, and Health and Wellness. This individual selected will serve as the County Health Officer under the authority of the Maryland Department of Health and the Prince George's County Executive.

The Prince George's County Department of Health is a comprehensive local health department with a staff of more than 500 employees and an annual budget of approximately $75 million. This position is the ideal role for a driven, highly competitive health professional eager to play a key role and have a large impact within a dynamic community. The Health Officer will advise and/or consult with the County Executive, the Prince George's County Council, and the State Department of Health. The Health Officer will play a critical

[26]Public Health Officer Job Description, https://www.leadlake.com/post/public-health-officer-job-description-duty-skill-requirement-tips/

role in protecting and improving the health of Prince George's County and positioning the county as one of the healthiest places to live in the United States.

The Health Officer is responsible for the formulation, development, and execution of public health programs reflecting State and local needs and application and/or enforcement of appropriate State laws and regulations of the Secretary of the Maryland Department of Health and Prince George's County.

Essential job functions and assigned duties include the following:

Administer public health programs for Prince George's County, including management of personnel, funds, facilities, and all assets of the Department. Administer the Department's nearly $75,000,000 operating budget comprised of Core Public Health Funding; County, Federal, and State grant funding; and revenues derived from fee collections. Reallocate budgetary and department resources within the Department to maximize service output.

Responsible for development, promotion, and management of public health programs for Prince George's County, including evaluating community needs and initiating new programs as deemed necessary to meet State and County objectives and to achieve a healthy population. Provide clinical oversight of public health programs in the Department.

Enforce Federal, State, and County laws, rules, and regulations to protect the public health and safety of the population, including environmental health rules. Execute policies and procedures established by the State and County as they relate to health matters applicable to Prince George's County. Direct the development and revision of Departmental policies and procedures in accordance with these rules and regulations.

Coordinate or combine the resources of health care institutions, social service organizations, public safety personnel, or other agencies to enhance community health.

Proposes Federal, State, and County laws, rules and regulations pertaining to administration of health services. Provide testimony to the State Legislature and County Council as appropriate concerning new or amended legislation affecting the Department.

Design or use monitoring tools, like as screening, lab records, and vital information, to recognize health risks.

Develop tools to address behavioral causes of diseases.

Decide retention, expansion, or abolition of program services and other departmental resources.

Integrate the plans, activities and staffing of Department Divisions and Programs.