2024 Community Health Needs Assessment

Pennsylvania MOUNTAINS CARE NETWORK

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PUNXSUTAWNEY AREA HOSPITAL

IRMC

Mission and Vision

To improve the quality of life for residents in our communities by partnering to create health care that is affordable, locally accessible, and evidence-based.

To be a vibrant network of healthcare providers achieving synergies and efficiencies through collaborative initiatives.

INTEGRITY, RESPECT, QUALITY, TEAMWORK

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Welcome to Our Community Health Needs Assessment

Thank you for being part of

Indiana Regional Medical Center (IRMC) and Punxsutawney Area Hospital (PAH) are proud to present the 2024 Community Health Needs Assessment (CHNA) Report. This report summarizes a comprehensive review and analysis of health status indicators, public health, socioeconomic, demographic and other qualitative and quantitative data from the primary service areas of IRMC and PAH. This report also includes secondary and disease incidence and prevalence data from Indiana and Jefferson counties, the primary service area of each hospital, respectively. The data was reviewed and analyzed to determine the top priority needs and issues facing the communities served as well as the region overall.

The primary purpose of this assessment was to identify the health needs and issues of Indiana and Jefferson counties defined as the primary service areas of IRMC and PAH. In addition, the CHNA provides useful information for public health and health care providers, policy makers, social service agencies, community groups and organizations, religious institutions, businesses, and consumers who are interested in improving the health status of the

community and region. The results enable the hospital, as well as other community providers, to more strategically identify community health priorities, develop interventions and commit resources to improve the health status of the region.

Improving the health of the community is the foundation of the mission of IRMC and PAH, and an important focus for everyone in the service region, individually and collectively. In addition to the education, patient care, and program interventions provided through the hospitals, we hope the information in this CHNA will encourage additional activities and collaborative efforts to improve the health status of the communities that IRMC and PAH serve.

our community.

Pennsylvania MOUNTAINS CARE NETWORK

WELCOME
FROM OUR PRESIDENT

Stephen A. Wolfe
PMCN President & CEO

On behalf of Indiana Regional Medical Center (IRMC) and Punxsutawney Area Hospital (PAH), I would like to thank you for your continued support and investment in our 2024-2027 Community Health Needs Assessment. In the fall of 2020, Indiana Regional Medical Center (IRMC) and Punxsutawney Area Hospital (PAH) formalized a collaboration under one governing board of directors called the Pennsylvania Mountains Care Network (PMCN). This collaboration continues to help sustain a high level of patient care that residents already receive in both Indiana and Jefferson Counties.

We are fortunate to live in Western Pennsylvania, with its great schools, resources, organizations, and abundant natural beauty. However, like any community, we have our health challenges, and these challenges require collaborative efforts. Both IRMC and PAH have proudly served the region as independent, non-profit organizations and plan to continue in this capacity for many years to come.

This Community Health Needs Assessment is the second assessment with both organizations as PMCN. The Community Health Needs Assessment is a valuable tool that helps us shape the decisions we make and guide the strategic direction of PMCN. It provides insight into the communities' needs and gives us the opportunity to partner with agencies throughout the region. While we can't solve every problem alone, we are confident that we can coordinate the resources to make our communities healthier.

I am extremely proud of the entire PMCN team. We appreciate the chance to continue to make an impact on the lives of the people we serve and look forward to sharing our plan with you.

Stephen A. Wolfe

IRMC

INDIANA REGIONAL MEDICAL CENTER

Indiana Regional Medical Center (IRMC) has been serving Indiana County and surrounding communities since 1914. As a nationally recognized employer, IRMC continues to meet the needs of patients and employees alike. IRMC maintains its commitment to serving the region by continually reinvesting in its facilities, technology and people in order to provide the highest levels of care possible. IRMC's vision to be the best community healthcare system in the country is the cornerstone to our commitment of caring.

PUNXSUTAWNEY AREA HOSPITAL

PUNXSUTAWNEY AREA HOSPITAL

Punxsutawney Area Hospital (PAH) continues to improve services, recruit skilled physicians, update technology, and focus on providing the best health care to people in the tri-county area. Garnering both state and national recognition, PAH is committed to upholding a 135-year tradition of meeting the health care needs of the people in Punxsutawney and surrounding communities. PAH's vision is to be valued as the highest quality community hospital in the region. As such, we will be your primary health care provider, committed to continuously improving services while containing costs.

Thank You.

We offer special thanks to the representatives of the CHNA Steering Committee and to the 961 citizens and stakeholder participants of the interviews and community survey who generously gave their time and input to provide insight and guidance to the process. Steering Committee members are listed below.

Steering Committee Members

2024 CHNA Committee

IRMC REPRESENTATION

Angela Jackson	United Way of Indiana County
Annie Rizzo	Indiana Regional Medical Center
Carolyn Princes	NAACP
Janine Maust	Aging Services of Indiana County
Jared Cronauer	Indiana Area School District
Kami Anderson	Armstrong Indiana Clarion Drug and Alcohol Commission
Kelly Meyer, MD	Indiana Regional Medical Center
Lisa Spencer	Indiana County Department of Human Services
Mark Richards	Indiana Regional Medical Center
Megan Miller	The Open Door
Melissa Dick	Indiana University of Pennsylvania
Melissa Mantini	Indiana Regional Medical Center
Michelle Jordan	The ARC of Indiana County
Mike Dunn	Citizens Ambulance Service
Sherene Hess	Indiana County Commissioner
Steven Lomax	Indiana County Chamber of Commerce

PAH REPRESENTATIVES

Amy Behrendt	Punxsutawney Area Hospital
Ben Hughes	Punxsutawney Area Hospital
Carol Jackson	Clearfield Jefferson Drug and Alcohol Commission
Curt Vasas	Assistant Superintendent Punxsutawney Area School District
Donnie Haines	Emergency Medical Services
Katie Donald	Punxsutawney Area Hospital
Katie Laska	Chamber of Commerce, Local business owner, School Board
Laura Deet	Mulberry Square Representative
Misty Fleming	Community Action
Rich Muth	IUP Punxsutawney Director
Scott North	Jefferson County Commissioner
Shirley Sharp	Punxsutawney Area Community Foundation
Tracy Zents	Jefferson County Emergency Management

Executive Summary

A Community Health Needs Assessment (CHNA) helps to gauge the health status of a community and guide development and implementation of strategies to create a healthier community. The CHNA process also promotes collaboration among local agencies and provides data to evaluate outcomes and impact of efforts to improve population health. The CHNA process supports the commitment of a diverse group of community agencies and organizations working together to achieve a healthy community.

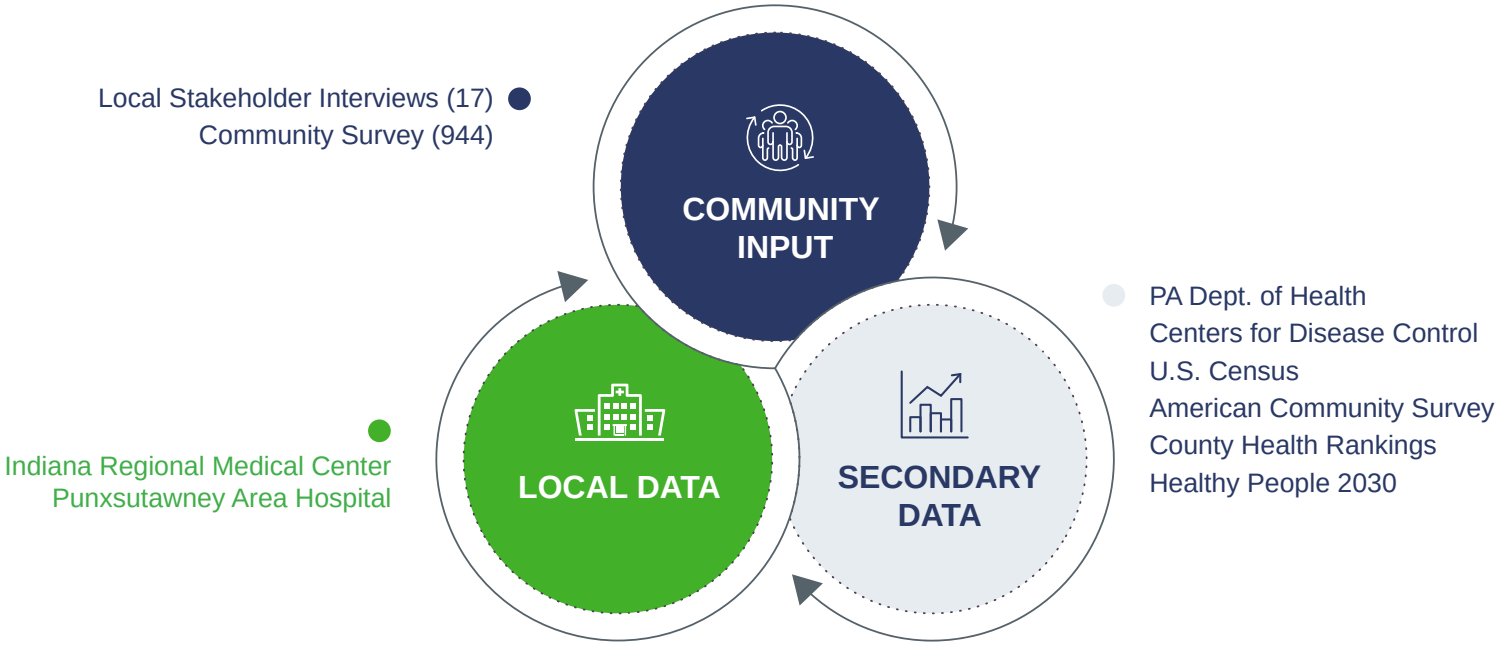
Facilitated by Strategy Solutions, Inc. (SSI), a planning and research firm with its mission to create healthy communities, this CHNA follows best practices as outlined by the Association for Community Health Improvement, a division of the American Hospital Association, and ensures compliance with Internal Revenue Service (IRS) guidelines (IRS Notice 2011-52) for charitable 501(c)(3) tax-exempt hospitals that was published in December 2014. The process has taken into account input from those who represent the broad interests of the communities served by Indiana Regional Medical Center and Punxsutawney Area Hospital, including those with knowledge of public health, the medically underserved, and populations with chronic disease.

The 2024 IRMC and PAH CHNA was conducted to identify primary health issues, current health status and needs to provide critical information to those in a position to make a positive impact on the health of the region's residents. The results enable community members to more strategically establish priorities, develop interventions, and direct resources to improve the health of people living in the community. This CHNA includes a detailed examination of the following areas as seen in Figure 1 below.

Figure 1: CHNA Topic Areas

To support this assessment, data from numerous qualitative and quantitative sources were used to validate the findings, using a method called triangulation outlined in Figure 2.

Figure 2: Data Triangulation



Secondary data on disease incidence and mortality, as well as behavioral risk factors were gathered from the Pennsylvania Department of Health and the Centers for Disease Control, as well as Healthy People 2030, County Health Rankings, US Census, American Community Survey, and the 2021 PA Youth Survey. Aggregate utilization data was included from IRMC and PAH patient records.

Demographic data was collected from Environics Analytics-Claritas. Primary data collected specifically for this study were based on the primary service areas of Indiana and Jefferson counties. IRMC and PAH collected a total of 944 community surveys and conducted 17 stakeholder interviews.

After review and analysis, the data suggested 27 distinct issues, needs and possible priority areas for intervention for IRMC, 31 for PAH and 20 for the system to address. After prioritization and discussion, the Board of Directors identified 4 needs as the top priorities for intervention and action planning at the system level 3 for IRMC and 6 for PAH. These priorities will be rolled into consolidated goals to focus on. **The PMCN Board of Directors approved the CHNA on June 30, 2024.**

Methodology

To guide this assessment, the leadership at IRMC and PAH formed a Steering Committee that consisted of hospital and community leaders who represented the broad interests of their local region. These included representatives who understood the needs and issues related to various underrepresented groups including medically underserved populations, low-income persons, minority groups, and those with chronic disease needs, individuals with expertise in public health, and internal program managers. The IRMC and PAH Steering Committee met twice between March 2024 and April 2024 to provide guidance on the various components of the CHNA.

Consistent with IRS guidelines at the time of data collection, IRMC defined its primary service area as Indiana County and PAH defined its primary service area as Jefferson County.

Stakeholder Interviews

The CHNA leadership at IRMC and PAH identified key community stakeholders to participate in a one-on-one interview as part of the CHNA. The CHNA Steering Committee refined the stakeholder list to ensure broad community representation. Strategy Solutions, Inc. developed the Stakeholder Interview Guide and created an online data collection tool to help record stakeholder responses. IRMC and PAH staff scheduled and conducted interviews and entered data into the collection tool. A total of 17 interviews were completed (9 for IRMC's service area and 8 for PAH's service area). The stakeholders interviewed included:

INDIANA REGIONAL MEDICAL CENTER

- Rob Heinrich, Superintendent of Schools, IASD
- Janine Maust, Director of Aging Services
- Mark Hilliard, Indiana County Chamber of Commerce
- Sherene Hess, Indiana County Commissioner
- Thomas Stutzman, Director, Indiana County EMA
- Adam Jones, Dean of Students, IUP
- Megan Miller, Executive Director, The Open Door
- Dr. Patrick Shannon, President, IRMC Medical Staff
- Clifford Greenfield, Community Services and Public Information Officer, Pennsylvania State Police

PAH REPRESENTATIVES

- Ben Hughes, Punxsutawney Area Hospital
- Tracy Zents, Director of Emergency Services, Jefferson County Department of Emergency Services
- Scott North, Jefferson County Commissioner
- Shirley Sharp, Punxsutawney Area Community Foundation and Punxsutawney Revitalization Board Member, Punxsutawney Area Historical and Genealogical Society Volunteer, Punxsutawney Area Hospital Patient Safety Committee
- Phillip States, Physician, Punxsutawney Area Hospital

PAH REPRESENTATIVES *(CONTINUED)*

- Jon Johnston, Groundhog Club, PAH Foundation, dentist
- Katie Laska, President, Chamber of Commerce and Restaurant Owner
- Courtney Grube, Pharmacist, PAH Foundation, Punxsutawney Area Elementary School PTO, Punxsutawney Area School District Parent Advisory Board

The stakeholder interviews were designed to capture the following information:

- Top community health needs
- Environmental factors driving the needs
- Needs and factors specific to target populations
- Efforts currently underway to address needs
- Advice for the Steering Committee

Community Survey

The community survey was modeled after the survey used in the 2021 CHNA process. The survey was launched on February 13, 2024, and remained open until April 11, 2024. The survey link was sent via email to hospital and physicians' group patients and employees, steering committee members, and posted via several social media and other digital platforms. Paper copies were also available at select community locations. A total of 944 surveys were completed within IRMC and PAH's service area.

Demographics

The population in Indiana County has been decreasing and is projected to continue to decrease into 2029. The population is predominately Caucasian (90.7%) and there is a comparable number of males (49.7%) and females (50.3%). The median age is 41.7 and is projected to remain steady over the next five years. Less than half of the population is married (44.4%), while 10.5% are divorced and 6.3% are widowed. The highest percentage of residents (42.1%) are high school or equivalent graduates, while 7.7% did not complete high school. One in ten (9.9%) have an advanced degree. The average household income is $73,497, with a median income of $56,322. Just under one in ten (8.6%) families live in poverty. Most of the labor force is employed (95.2%), with approximately half of those employed holding white collar occupations (52.9%). Figure 3 below shows the demographics breakdown for Indiana County.

Figure 3: IRMC Demographics

GENDER

FEMALE **50.3%**

MALE **49.7%**

AGE

MEDIAN AGE IS **41.7**
AND **IN 2029 WILL BE 41.8**

ETHNICITY

CAUCASIAN **90.7%**
ANOTHER RACE **5.2%**
AFRICAN AMERICAN **3.1%**
HISPANIC/LATINO **2.1%**
ASIAN **1.0%**

POPULATION

PROJECTED TO DECREASE
FROM **82,355** IN 2024 TO **81,685 IN 2029**

MARITAL STATUS

MARRIED **44.4%**
NEVER MARRIED **35.6%**
DIVORCED **10.5%**
WIDOWED **6.3%**
SEPARATED **3.1%**

EDUCATION

DID NOT COMPLETE HIGH SCHOOL **7.7%**
HIGH SCHOOL GRADUATE / GED **42.1%**
SOME COLLEGE, NO DEGREE **15.6%**
ASSOCIATES DEGREE **10.2%**
BACHELOR'S DEGREE **14.5%**
ADVANCED DEGREE **9.9%**

INCOME

AVERAGE HOUSEHOLD INCOME **$73,497**

MEDIAN HOUSEHOLD INCOME **$56,322**

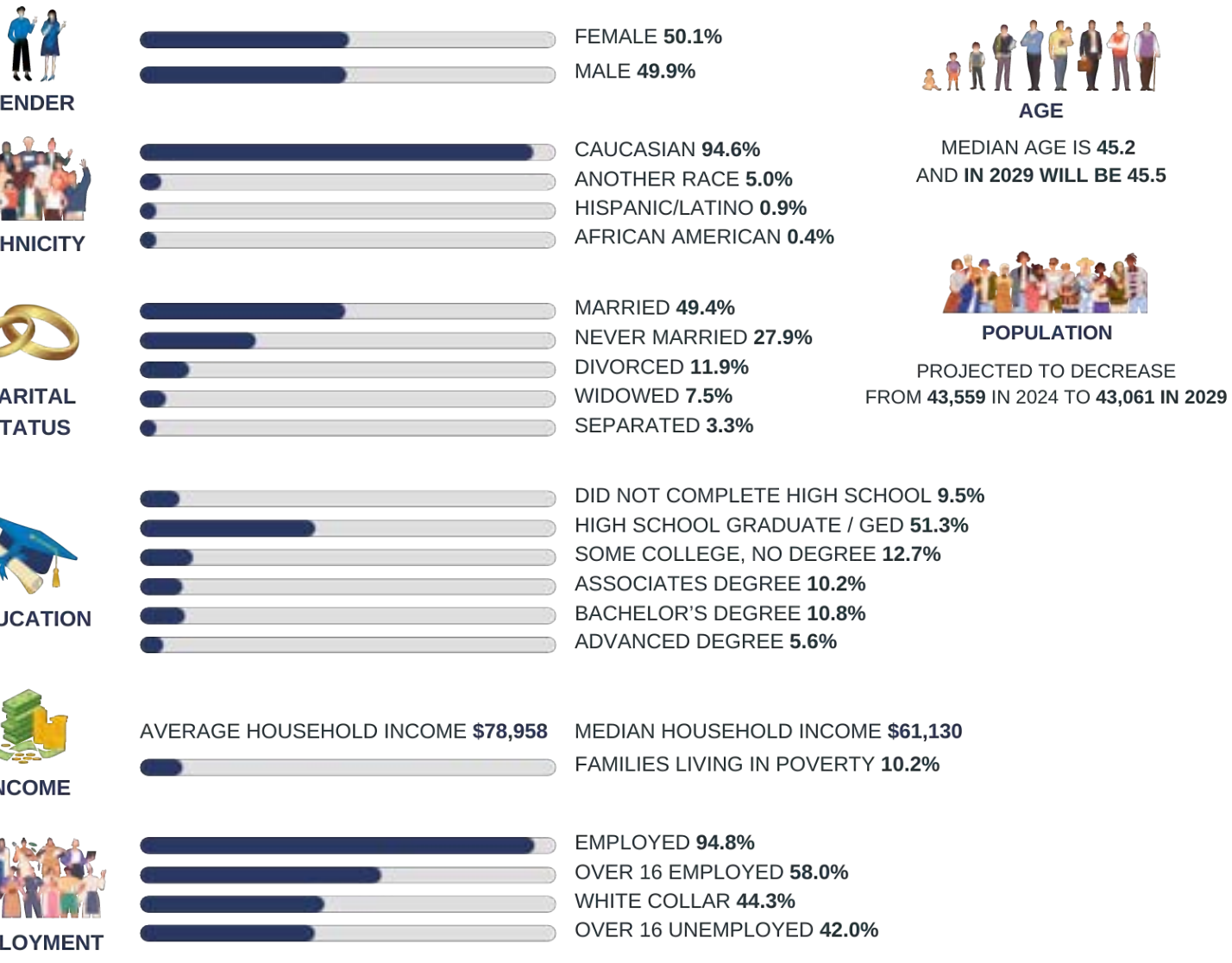
FAMILIES LIVING IN POVERTY **8.6%**

EMPLOYMENT

EMPLOYED **95.2%**
OVER 16 EMPLOYED **56.8%**
WHITE COLLAR **52.9%**
OVER 16 UNEMPLOYED **43.2%**

The population in Jefferson County has been decreasing and is projected to continue to decrease into 2029. The population is predominately Caucasian (94.6%) and there is a comparable number of males (49.9%) and females (50.1%). The median age is 45.2 and is projected to remain steady over the next five years. Just under half of the population is married (49.4%), while 11.9% are divorced and 7.5% are widowed. One in ten residents (9.5%) did not graduate high school, while 51.3% are high school or equivalent graduates. A small percentage of the population (5.6%) have an advanced degree. The average household income is $78,958, with a median income of $61,130. One in ten (10.2%) families live in poverty. Most of the labor force is employed (94.8%), with just under half of those employed holding white collar occupations (44.3%). Figure 4 below shows the demographics breakdown for Jefferson County.

Figure 4: PAH Demographics



Primary Service Area

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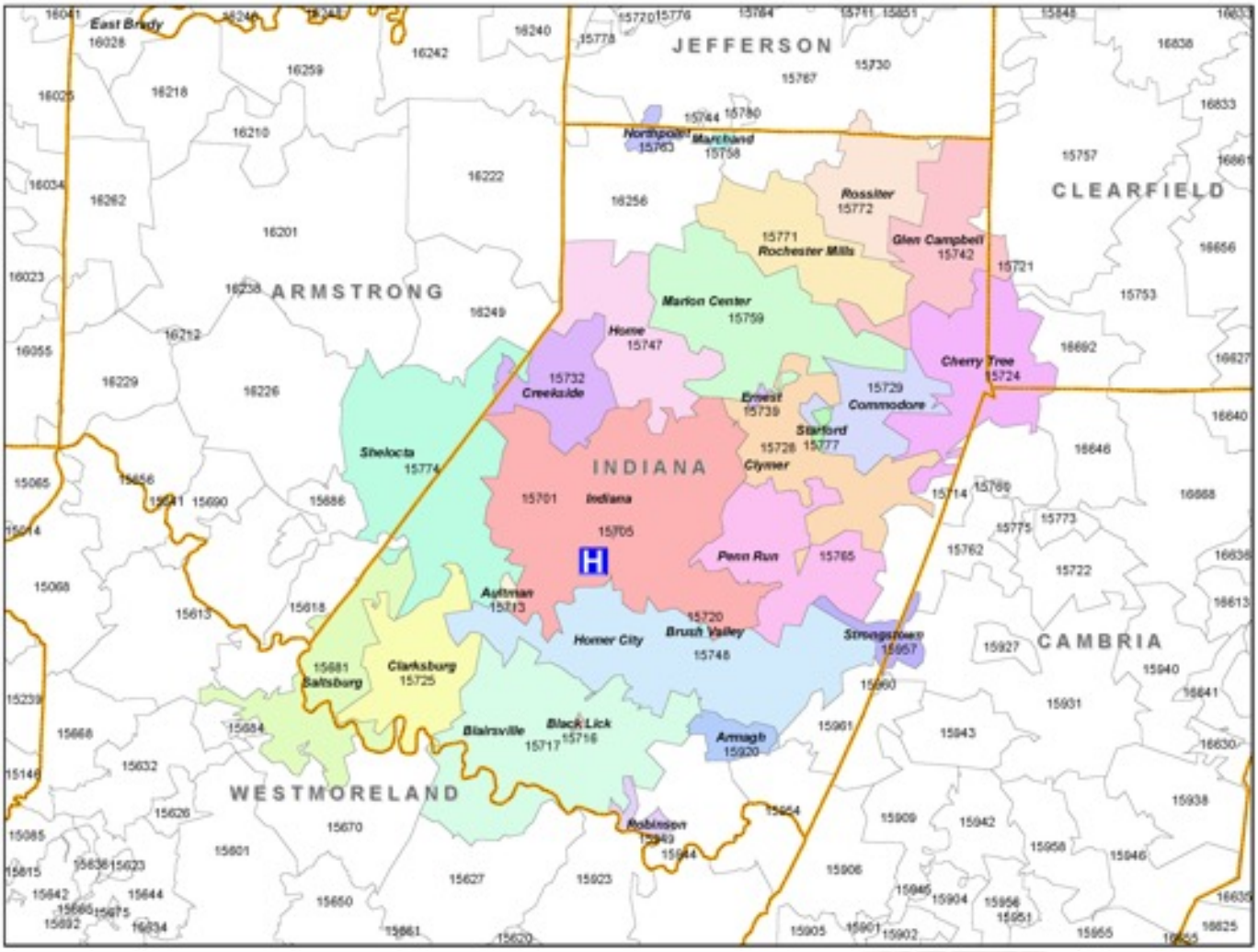
IRMC's primary service area covers Indiana County. The primary service area map depicting the zip codes serviced by the hospital is shown in Figure 5 below.

Figure 5: IRMC Primary Service Area



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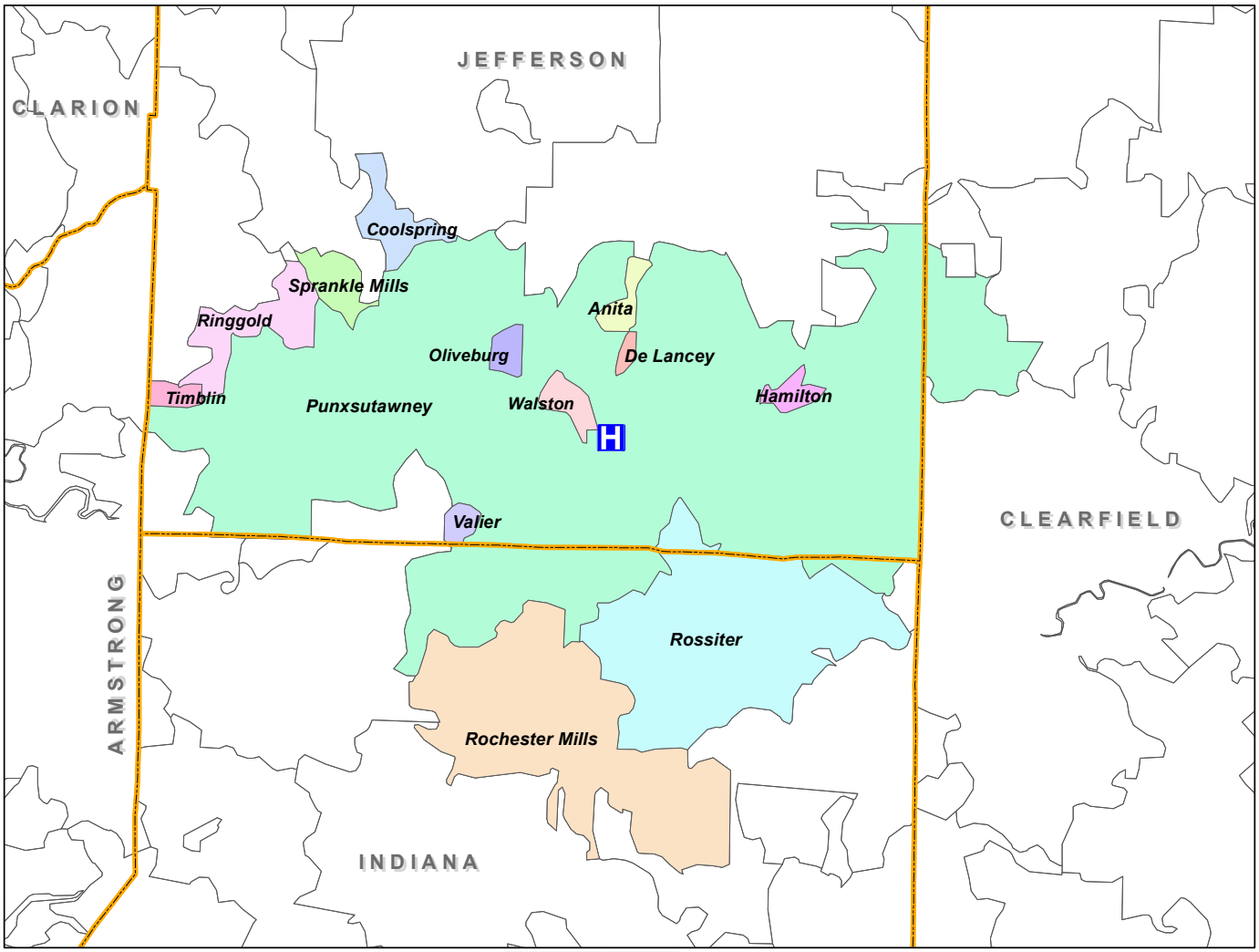
PAH's primary service area covers Jefferson County. The primary service area map depicting the zip codes serviced by the hospital is shown in Figure 6 below.

Figure 6: PAH Primary Service Area



Community & Hospital Resources

Resources that are available in IRMC's service area to respond to the significant health needs of the community can be found in the United Way's PA 2-1-1 System. The PA 2-1-1 System is part of the national 2-1-1 Call Centers initiative that seeks to provide an easy-to-remember telephone number and web resource for finding health and human services-for everyday needs and in crisis situations. Residents can search the United Way's vast database of services and providers to find the help they need. Figure 7 below shows the number of resources available within a 50 mile radius of IRMC's zip code (15701) per service category. For a complete listing of available resources, please visit https://www.pa211.org/.

Figure 7: PA 2-1-1 Service Category Breakdown for 50 Mile Radius of IRMC

SERVICES

Behavioral Health
Cancer Care
Cardiac and Vascular Care
Comprehensive Breast Center
Corporate Wellness
Dermatology
Diabetes and Nutrition
Emergency Department
Foot and Ankle Surgery (Podiatry)
Gastroenterology
Hospitalists
Imaging
Infectious Diseases
Infusion Services
Intensive Care Unit
Laboratory
Lifeline
Maternity Care
Neurology
OB-GYN
Occupational Health
Orthopedics
Palliative Care
Primary Care
Pulmonology
Rehabilitation
Rheumatology
Sleep Medicine
Spine & Pain Management
Sports Medicine
Surgical Services
Telemedicine
UrgiCare
Urology
Weight Management (Bariatric Surgery)
Wellness Center
Wound Care


INDIANA
Welcome To
IRMC
Main

Resources that are available in PAH's service area to respond to the significant health needs of the community can be found in the United Way's PA 2-1-1 System. The PA 2-1-1 System is part of the national 2-1-1 Call Centers initiative that seeks to provide an easy-to-remember telephone number and web resource for finding health and human services-for everyday needs and in crisis situations. Residents can search the United Way's vast database of services and providers to find the help they need. Figure 8 below shows the number of resources available within a 50 mile radius of PAH's zip code (15767) per service category. For a complete listing of available resources, please visit https://www.pa211.org/.

Figure 8: PA 2-1-1 Service Category Breakdown for 50 Mile Radius of PAH

SERVICES

Bariatrics
Cancer Care
Cardiology
Cardiopulmonary
Clinical Nutrition
Counseling Services
Dermatology
Discharge Planning
Emergency Services
Expecting You
Gastroenterology
General Surgery
Home Health Care
Intensive Care Unit
Laboratory
Medical Outpatient Clinic
Medical Surgical Unit
Neurology
OB-GYN
Otolaryngology
Pain Clinic
Patient Portal "How To" Video
Pediatrics
Pharmacy
Primary Care
Pulmonary/Critical Care
Radiology
Rapid Care
Rehabilitation
Short Procedure Unit and Surgical Services
Spine and Pain Management
Transitional Care Services
Urology


PUNXSUTAWNEY AREA HOSPITAL

Evaluation of 2021 CHNA

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IRMC conducted an evaluation of the implementation strategies undertaken since the completion of their 2021 CHNA. Although the status for most county level indicators did not move substantially, it is clear IRMC is working to improve the health of the community. Figure 9 below highlights the areas of major accomplishments that the hospital made in each of the three goals that were outlined in their implementation strategy action plan. Data is based on information that was available at the time and may not be inclusive of data collected each year. Year 3 data represents the first 6 months of the fiscal year.

Figure 9: IRMC Major Accomplishments

The following is a more detailed summary of the work IRMC has done related to its implementation strategy.

Goal 1: Improve Health Status by Increasing Participation in Education and Wellness, Focusing on Overweight/Obesity

Year 1

IRMC continued to offer our Wellness Program to employees and community partners serving 1,327 participants this year. Program participants lost a total of 833.6 pounds, with an average weight loss of 6.4 pounds. We offered 25 nutritional challenges with 700 participants, of which 75 completed the challenge (10.7%). Additionally, IRMC provided 245 health coaching sessions and had 15 educational encounters.

IRMC has continued to promote health and wellness to the community at-large. This was done through the Corporate BeWell Program with 901 participants. As well as through the S&T Wellness Center with 15,179 visits, with 1,264 visits on average per month. We provided medical nutrition therapy to 891 participants who lost a total of 25 pounds. Our bariatric center served 323 new patients, of which 55 were surgical. We followed up with 255 patients and performed 8 bariatric procedures. Surgical patients lost a total of 161.3 pounds. We also offered 23 educational sessions with a total of 299 participants. IRMC continued our LEAN weight management program online with 34 participants, with average weight loss of 11.7 pounds.

Year 2

IRMC has continued to offer our Wellness Program to employees and community partners with 747 participants this year, accounting for 53.3% of our employees. Program participants lost a total of 299.1 pounds, with an average weight loss of 3.7 pounds. We offered 57 nutritional challenges with 680 participants, of which 425 completed the challenge (62.5%). IRMC provided 246 health coaching sessions and had 33 educational encounters.

We continue to promote health and wellness to the community at-large with 16,902 visits to S&T Wellness Center with 1,408 visits on average per month. IRMC provided medical nutrition therapy to 926 participants who lost a total of 25 pounds. We provided services to 333 new patients through the bariatric center of which 70 patients were in the surgical pathway. There were 18 bariatric procedures performed at the center and patients lost a total of 1,040 pounds. We offered 23 educational sessions with a total of 517 participants and continued our LEAN weight management program online with 25 participants, with a total of 141.2 pounds lost.

Year 3

Our Wellness Program continued with 751 participants this year, representing 51% of our employees. We offered 11 nutritional challenges with 110 participants, of which 88 completed (80.0%). IRMC offered 24 educational encounters and did 9 health coaching sessions.

We had 9,822 visits to S&T Wellness Center. We continued to provide medical nutrition therapy to 285 participants. Our bariatric center saw 166 new patients, followed up with 101 patients and performed 13 bariatric procedures with patients losing a total of 876 pounds, accounting for 22.5% of their total body weight. We offered 11 educational sessions with a total of 833 participants. We offered one session through our online weight management program with 19 participants completing the program with a total weight lost of 206.2 pounds.

Goal 2: Increase Access to Mental Health Services and Supports

Year 1

IRMC served a community need by implementing a Behavioral Health (BH) Outreach Program to connect emergency department BH patients with outpatient services. Ambulatory Social Workers made 1,088 referrals, connected with 158 patients and spoke with 55 BH patients post-discharge. The Emergency Department had 1,209 BH related visits (68% were from Indiana County), with average wait time to transfer to a mental health facility of 14.86 hours.

IRMC continues to provide education and outreach and participated in Mental Health Awareness month, had a table of resources available at IRMC Park and engaged in conversations with community members. IRMC is an active member of the suicide taskforce and intervention subcommittee.

We have made online resources available through the hospital's webpage and added links to outside resources.

Year 2

We continued our Behavioral Health Outreach Program to connect emergency department BH patients with outpatient services. This year we had 917 patients seen by our psych liaison with 405 referrals made. The Emergency Department had 917 BH related visits, with average wait time to transfer to mental health facility of 14.11 hours. Our Ambulatory Social Workers made 1,226 referrals, connected with 50 patients and spoke with 286 BH patients post-discharge.

IRMC continues to provide education and outreach and participated in Mental Health Awareness month, had a table of resources available at IRMC Park and engaged in conversations with community members. We continue to be an active member of the suicide taskforce and intervention subcommittee.

We made online resources available through the hospital's webpage and added links to outside resources.

Year 3

Our Behavioral Health Outreach Program served 1,179 patients. The Emergency Department had 1,971 behavioral health related visits with the average wait time of 18:33 before they were transferred

to a mental health facility. Our Ambulatory Social Workers had 784 referrals, made 484 phone calls and did 171 client reaches.

We continue to provide community outreach participating in 9 events with a total of 253 served, for those programs where participation was tracked, in total the number served is much higher.

We continue to make online resources available through the hospital's webpage and added links to outside resources.

Goal 3: Decrease Drug and Alcohol Use in Indiana County by Collaborating with the Armstrong-Indiana-Clarion Drug & Alcohol Commission (ARMOT) on Prevention, Education, Intervention, and Treatment Strategies

Year 1

We have continued our relationships with local partners and participated in 7 community collaboratives. Through our collaborative relationships we distributed 12 NARCAN kits in the Emergency Department (ED). Emergency Department leadership and ARMOT collaborated to develop standard protocol for those who show up in the ED with an overdose/receive substance use disorder diagnosis. Our process changed from opt in to opt out which increased the number of referrals. There were 307 patients who presented to the ED with substance use as a factor.

IRMC has continued to refer Emergency Departments patients to community partners with 245 patients referred to ARMOT, of which 85 completed treatment. ARMOT referred 8 patients to Open Door or Crossroads. Buprenorphine was administered to 18 patients in the ED.

We provided education to staff, providers and the broader community in an effort to reduce stigma.

We held 101 educational events with 1,117 participants, distributed 1,117 NARCAN kits, and educated 61 IRMC staff on stigma reduction with 100% reporting reduced stigma pre/post training.

IRMC has increased access to inpatient rehab through local partnerships with 43 patients connected to Inpatient Treatment and 6 patients referred to outpatient treatment. ARMOT program helps to increase access to inpatient treatment for patients at IRMC.

IRMC is working to increase awareness of available services with marketing efforts to promote warmline for 24/7 access to services and a media campaign to promote AICDAC services.
We made online resources available through the hospital webpage with links to external resources.

Year 2

IRMC continues our relationship with local partners and participated in 7 community collaboratives. This allowed us to distribute 27 NARCAN kits in the Emergency Department. Emergency Department leadership and ARMOT collaborated to develop standard protocol for those who show up in

Emergency Department of an overdose/receive substance use disorder diagnosis. The process changed from opt in to opt out which increased the number of referrals. We had 141 patients present to the Emergency Department with substance use as a factor.

We continued to refer Emergency Department patients to community partners with 267 patients referred to ARMOT, of which 95 completed treatment. ARMOT referred 11 patients to Open Door or Crossroads. There were 22 pregnant substance use referrals to Maternal Opioid Medication Support (MOMS) and 3 patients enrolled. A total of 29 patients received Buprenorphine in the Emergency Department.

IRMC continues to provide education to staff, providers and the broader community in an effort to reduce stigma offering 95 educational events with 1,032 participants. Through these outreach efforts we distributed 1,269 NARCAN kits. We educated 61 IRMC staff on stigma reduction with 100% reporting reduced stigma pre/post training. We also had patients sign an opioid agreement when being prescribed an opioid by their primary care provider.

IRMC has increased access to inpatient rehab through local partnerships with 31 patients connected to Inpatient Treatment and 31 patients referred to Outpatient treatment. The ARMOT program helps to increase access to inpatient treatment for patients at IRMC.

We continued working to increase awareness of available services by marketing efforts to promote warmline for 24/7 access to services and a media campaign to promote AICDAC services.

IRMC made online resources available through the hospital webpage with links to external resources.

Year 3

IRMC participated in 14 community collaboratives. There were 17 NARCAN kits distributed in the Emergency Department. There were 623 patients who presented in the Emergency Department with substance use as a factor in their visit.

We continue to refer Emergency Department patients who present in the Emergency Department to our community partners. We made 152 referrals to ARMOT of which 37 refused services, 18 were admitted to a psychiatric unit or hospital and 13 completed a level of care assessment or were an emergency admission into residential treatment. A total of 5 individuals completed treatment and one was currently in treatment. There were 14 patients referred to outpatient recovery support services and two were transferred into a medical setting other than IRMC. One individual received Suboxone and was discharged from the hospital with no follow up services, one was a no show for their level of care assessment and one had an open case with a different AICDAC case manager.

IRMC has a protocol in place with ARMOT for mothers whose babies are born addicted. There were three patients referred to the Maternal Opioid Medication Support (MOMS) Perinatal Program, one of whom accepted and is currently engaged in the program. There were seven patients referred to the Plans of Safe Care Program, with two enrolling.

Protocol is in place in the Emergency Department to identify patients and treat with Buprenorphine to immediately stop cravings and send them home a 3 day dose and provide a warm hand off to a community partner. One patient received Buprenorphine in the Emergency Department and received a 3 day supply upon discharge and 156 were transferred to Open Door, Cross Road or ARMOT within 3 days.

A total of 13 individuals completed a level of care assessment or were an emergency admission into residential treatment. There were 14 patients referred to outpatient treatment or recovery support services.

IRMC continues community education providing 16 events with 155 participants. There were 155 NARCAN kits distributed during these events. IRMC has outdoor NARCAN vending machines available at three locations and a total of 1,116 NARCAN kits were distributed through those.

There were two staff trainings held in April 2023 and January 2024.

IRMC made online resources available through the hospital webpage with links to external resources.

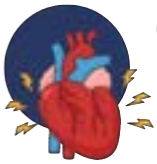
PUNXSUTAWNEY AREA HOSPITAL

PAH conducted an evaluation of the implementation strategies undertaken since the completion of their 2021 CHNA. Although the status for most county level indicators did not move substantially, it is clear PAH is working to improve the health of the community. Figure 10 below highlights the areas of major accomplishments that the hospital made in each of the five goals that were outlined in their implementation strategy action plan. Data is based on information that was available at the time and may not be inclusive of data collected each year.

Figure 10: PAH Major Accomplishments

Goal One: Increase awareness and prevention of Lyme Disease and Diabetes

- Created robust educational program for the community called Wellness Connections. These are monthly seminars on a variety of topics. PAH is also focusing on programming related to the social determinants of health. PAH provided 19 educational programs to almost 500 participants.
- Resources are posted to the PAH website and are shared with the community via social media and mass emailing lists as well as at community events PAH attends.
- Informational materials and resources are available year round in the hospital lobby.
- In 2023, PAH successfully conducted a community health screening that included blood pressure monitoring and high risk screening of participants. Overall, PAH screened 3,900 individuals.
- PAH is working to capture additional data to support the evaluation through the transition to Cerner at the physician offices as well as through the creation of an opt out button to gain permission to track data in conjunction with registration.



Goal Two: Increase Awareness and prevention of Cardiovascular Disease

- PAH has made efforts to decrease readmissions through better chronic disease management through the utilization of technology with home health patients for monitoring.
- Conducted community blood screenings where supplemental resources were provided to over 1,000 community members.
- PAH continues to engage physicians in discussions on the needs of the community based on information gathered at the blood screening.
- PAH staff have received education on the benefits of the Congestive Heart Failure Clinic. This is also given to providers in the region and is readily available for patients. Information on the clinic and success stories are routinely shared with providers.
- PAH continues to dialogue with the American Heart Association around information and programming.
- The hospital continues to explore the utilization of the registry of high-risk patients to increase PCP follow ups which has been challenging due to the number of PCP's not in the facility or in private practice.
- Expanded participants from 200 to 372 participants in the blood pressure/high risk monitoring program.

Goal Three: Position the hospital and community to respond to the National Opioid Crisis by using evidence based practices and research while partnering to ensure efficacy

- Created a resource guide with local contacts for professionals.
- In October 2023, PAH worked with Rural Health Redesign Center Authority and Jefferson Clearfield Drug and Alcohol Commission to implement the PREP (Peer Recovery Expansion Project) program. This program placed a PREP staff member in the hospital to support several addiction recovery initiatives and provide a Certified Recovery Specialist to work with our patients.
- Updated hospital webpage to include links to state and national resources that are routinely updated.
- Continue to collaborate with regional players for coordination of services as well as identifying collaborative grant opportunities.
- PMCN strategic plan identified opioids as a priority which included an opioid strategy to address local needs.

Goal Four: Improve access to mental health services

- Working on ER expansion project to assist with the care of mental health patients arriving in the ED with construction slated to start May 2024.
- We connected with high risk populations including IUP students, the Punxsutawney Area School District and the elderly population through various events and initiatives.
- Created a database of resources to assist patients with outpatient and other services.

PAH is excited to announce the development of our new Emergency Department that will occupy 9,113 square feet in a new building addition and create a total of 11 treatment spaces. These treatment spaces and common areas will provide optimal privacy that will improve patient experiences and satisfaction. PAH annually serves 148,983 patients. A new state of the art entrance area will bring an ease of use to all patients entering the facility along with the necessary safety precautions. Patients will experience a streamlined process when entering the facility and have access to the most up to date registration technology. This medically necessary service is staffed 24 hours a day, 7 days a week, for inpatient services and offers outpatient laboratory services for the community as well. At PAH, we provide comprehensive clinical testing based on your physician's orders. Staffed by certified medical technologists, technicians, and phlebotomists, our lab provides microbiology, chemistry, hematology, urinalysis, and blood bank services. Our professional staff is equipped to analyze all types of clinical specimens and perform complete blood counts (CBCs), blood Outpatient Service Entrance visitors including 11,908 through the Emergency Department. The design of the unit is based upon a radial ED design concept to provide staff a clear view of all patients at all times and was designed based on the high level of patient volume this department experiences. The new ED will have specific treatment rooms with increased safety measures available for those experiencing behavioral health concerns. Each room in the ED will also be equipment to handle patients experiencing any type of respiratory issue or concern. The rooms in the Emergency Department will include state of the art medical technology that will be present to assist our highly qualified staff throughout your or your loved one's treatment process.

The following is a more detailed summary of the work PAH has done related to its implementation strategy.

Goal 1 – Increase awareness and prevention of Lyme Disease and Diabetes

Year 1

PAH offered 2 educational programs one on Diabetes and one on the CHF Clinic. PAH made resources available on the hospital's website, through social media outlets and in the lobby as well as at hospital events.

PAH offered a test programs for two days in July with 762 participants. PAH has been working to track those who were screened at a community event to allow for follow up. As part of this process the hospital created an opt out button to gain permission to track data from participants.

PAH re-established structural relationships with PCPs for the 1,500 blood screening participants. The hospital expanded the blood screening program using evidenced based practices. The hospital also worked to survey physicians to strengthen collaborative efforts with stakeholders for the blood screening program.

Year 2

In year 2, PAH offered five educational programs on a variety of health and wellness topics with an average of 25 participants per program. A total of 75 women attended the Women's Health Fair. PAH made resources available on the hospital's website, through social media outlets and in the lobby.

PAH offered blood screenings to 1,200 individuals in year 2. PAH has been working to track those who were screened at a community event to allow for follow up with a 10% increase from prior year in terms of number followed up with PAH after screening. PAH created an opt out button to gain permission to track data. In addition to tracking data, PAH re-established structural relationships with PCPs for the blood screening participants, with relationships with 46 PCPs. PAH expanded the blood screening program using evidenced based practices including tracking email and website traffic. In year 2, PAH surveyed physicians to strengthen collaborative efforts with stakeholders for the blood screening program with potential changes to implementation discussed with 86.7% indicating they would keep the testing options the same.

Year 3

PAH has created a robust educational program for the community called "Wellness Connections". These seminars are held monthly and cover a wide range of topics including Lyme Disease. Resources continue to be posted on the hospital website and shared via social media and mass email distribution. Educational resource materials are available in the PAH library year round. PAH held a total of 12 educational programs with 325 participants.

A successful community health screening was conducted with planning underway for the upcoming year. A total of 1,200 patients participated in the blood screening. PAH recently transitioned from Medent to Cerner for the physician offices with staff learning its capabilities and report generation to assist in tracking clients over time. The hospital met with 44 PCPs to discuss community needs based on the blood screenings.

Goal 2 – Increase awareness and prevention of Cardiovascular Disease

Year 1

PAH worked to decrease readmissions through better chronic care management. At this time PAH was in the process of developing protocol for discharge planning to ensure patients have follow up appointment with PCP within 7 days as well as receive a discharge phone call within 72 hours of discharge. They also worked to create a process to track and verify patients participation in their chronic care management with PCP.

PAH offered community blood screenings with 321 Heart Health Participants receiving blood pressure screenings. Supplemental information was provided to patients at the screening. The hospital met with PCPs to discuss needs of the community based on input gathered from the blood screening.

In an effort to promote the CHF Clinic and increase number of patients utilizing clinic, PAH shared information with medical staff and conducted a Community CHF Clinic seminar. PAH has engaged in dialogue with the American Heart Association and are utilizing the references shared.

PAH is working to implement the use of the registry of high-risk patients to increase PCP follow ups.

PAH increased the number of participants in the blood pressure/high risk monitoring program from 200 to 300 and is working to increase clinical information provided to referring physicians for high-risk patients.

Year 2

PAH continued to work to decrease readmissions through better chronic care management. The hospital developed a protocol for discharge planning to ensure patients have a follow up appointment with PCP within 7 days as well as receive a discharge phone call within 72 hours of discharge. A total of 724 patients were followed up with, 100% in the identified timeframe. The hospital is working to create a process to track and verify patients participation in their chronic care management with PCP.

PAH continued to offer community blood screening with 372 blood screening participants who are being tracked over a 5 year period. Participants were provided supplemental information at the screening. Events and educational sessions were completed and PAH has been utilizing the mobile wellness unit to attend community events. The hospital met with 36 PCPs to discuss the needs of the community based on input gathered from the blood screening. In an effort to promote the CHF Clinic and increase number of patients utilizing clinic, PAH shared information with 400 medical staff.

Patient Success Story: *In the spring of 2018, I suffered a "widow maker" heart attack and was taken to the Punxsutawney Hospital for emergency treatment. The quick and decisive actions by the physicians, nurses and staff members were critical to survival. Since that day, I've often thought how lucky Punxsutawney is to have a hospital with the level of service it maintains staffed by talented professionals who genuinely care. Preventive medicine is the best prescription for good health. To spotlight that statement, and over many years, the Punxsutawney Area Hospital and Punxsutawney Rotary Club have sponsored an annual community multiphasic blood testing program, while serving thousands of participants at a fraction of the normal cost. As a participant of this program, I know firsthand how maintaining good health or early detection of medical concerns is a key part of staying healthy through preventive measures. Our community is very fortunate for our hospital to provide this comprehensive service which includes connections to resources and education after the results are received each year. Community health is truly a priority of the Punxsutawney Area Hospital.*

PAH has continued to engage in dialogue with the American Heart Association and are utilizing the references shared. The hospital delivered 3 education sessions specific to heart health with 75 participants. PAH increased the number of participants in the blood pressure/high risk monitoring program from 300 to 372 and is working to increase clinical information provided to referring physicians for high-risk patients.

Year 3

Decreasing readmissions through chronic care management is a goal with our Rural Health Model. We are using new technology with our home health patients for monitoring that is assisting with the decrease in readmissions. Home Health is monitoring and tracking information on patients participation with their chronic care management PCP. The new technology that Home Health has implemented is showing validation for the technology assisting with chronic care management.

Supplemental information continues to be provided to blood screening participants. Participants are being tracked for 5 years, with 3 years worth of data currently collected.

PAH continues to promote the Congestive Heart Failure clinic through education with hospital staff as well as provider outreach. The hospital also has continued to engage with the American Heart Association to promote and support programming.

The number of participants in the blood pressure/high risk monitoring program continues to increase.

Goal 3 - Position the hospital and community to respond to the National Opioid Crisis by using evidence based practices and research while partnering to ensure efficacy

Year 1

PAH was working to develop a collaborative resource guide with IRMC. PAH has made resources available through the hospital's website and plans to continually update with new resources. The hospital has made initial connections with law enforcement, Clearfield Jefferson Drug and Alcohol and Punxsutawney EMS and is working to more formally establish relationships. The hospital completed a collaborative grant with key stakeholders. PAH created a regional opioid response and strategy as part of the hospital's strategic plan and is currently working with RHM to become a PEER Recovery Hospital Participant.

Year 2

PAH worked with IRMC to review and update the collaborative resource guide. PAH continued to make resources available through the hospital's website and plans to continually update with new resources. PAH collaborated with Clearfield and Jefferson Drug and Alcohol Commission on the PREP program with the RHM. A peer recovery specialist will be placed at PAH in fall of 2023. PAH continues to share resources with community partners of physicians and providers in the community to assist in referrals. PAH completed a collaborative grant with key stakeholders. CRS will be coming into the facility as a result of the grant. The hospital created a regional opioid response and strategy as part of the hospital's strategic plan. There were 12 NARCAN kits distributed through the ED.

Year 3

PAH worked with IRMC to review and update the collaborative resource guide. PAH continued to make resources available through the hospital's website and plans to continually update with new resources. PAH continues to share resources with community partners of physicians and providers in the community to assist in referrals. The hospital has an opioid response strategy as part of the overall strategic plan that continues to be implemented.

Goal 4 – Improve access to mental health services

PAH has been working on the ER expansion project and revisiting the components to ensure patients showing up in the ER with mental health emergencies receive the appropriate level of care. Planning is complete with construction slated to begin May 2024.

PAH also developed a database of available community services which was reviewed and updated annually.


GOBBLER'S KNOB
PHIL

Hospital Utilization Data

INDIANA REGIONAL MEDICAL CENTER

As seen in Table 1 from 2021 through 2023, hospital ER discharges for ambulatory care sensitive conditions for IRMC increased for: dental conditions, bacterial pneumonia, cellulitis, convulsions, dehydration, gastroenteritis, hypoglycemia, kidney/urinary infection, pelvic inflammatory disease, asthma, COPD, congestive heart failure, diabetes, grand mall/epileptic and hypertension.

Table 1: Ambulatory Care Sensitive Conditions – ER Only

PREVENTABLE CONDITIONS	2021	2022	2023
Congenital Syphilis	0	0	0
Failure to Thrive	0	0	0
Dental Conditions	222	259	313
Vaccine Preventable Conditions	2	2	1
Iron Deficiency Anemia	12	11	10
Nutritional Deficiencies	0	0	0
ACUTE CONDITIONS	**2021**	**2022**	**2023**
Bacterial Pneumonia	13	47	55
Cellulitis	91	92	101
Convulsions	118	156	170
Dehydration	9	21	10
Gastroenteritis	114	117	115
Hypoglycemia	22	23	34
Kidney/Urinary Infection	516	511	550
Pelvic Inflammatory Disease	2	4	5
Severe Ear, Nose and Throat Infections	856	902	696
CHRONIC CONDITIONS	**2021**	**2022**	**2023**
Angina	5	5	3
Asthma	231	283	325
COPD	170	225	275
Congestive Heart Failure	71	80	73
Diabetes with Ketoacidosis	64	77	99
Diabetes with other complications	91	105	139
Diabetes without complications	808	558	295
Grand Mall/Epileptic	18	31	37
Hypertension	204	210	239

For the same time period, hospital ER and/or inpatient discharges increased for mental health for IRMC, as seen in Table 2, increased for: adjustment related, alcohol related, anxiety, bipolar, conduct/social disturbances, dementia, drug related, emotional disorders youth, mental retardation, other org psych conditions, personality disorders, psychogenic disorders, schizophrenia, sleep disorders, and stress related.

Table 3 shows that from 2021 to 2023, hospital DRG conditions for IRMC increased for: hypertension, breast cancer, pneumonia, bronchitis/asthma, alcohol/drug related, COPD, and fractures.

Table 2: Mental Health ICD-9 and ICD-10 Codes

CODE	2021 ER	2021 IN	2022 ER	2022 IN	2023 ER	2023 IN
Adjustment related	43	87	44	92	44	120
Alcohol Related	327	209	294	199	288	228
Anxiety	939	611	699	710	679	861
Bipolar	487	220	170	236	105	242
Conduct/Social Disturbance	66	22	81	22	69	16
Dementia	63	341	70	381	76	390
Depression	327	388	83	330	51	372
Drug Related	350	184	244	197	235	200
Eating Disorders	4	3	2	7	3	2
Emotional Disorders Youth	51	6	37	6	32	12
Manic Disorders	2	1	3	3	1	0
Mental Retardation	24	38	41	44	38	50
Other org psych conditions	18	58	13	131	8	73
Paranoia/Psychosis	107	88	173	76	106	87
Personality Disorders	20	43	20	37	20	50
Psychogenic Disorders	7	2	10	3	10	5
Schizophrenia	63	52	64	54	38	64
Sleep Disorders	2	2	2	3	0	6
Stress Related	65	20	64	71	60	106
Transient Organic Psychotic Conditions	2	97	3	77	1	57

Table 3: Hospital Inpatient Conditions

DIAGNOSIS RELATED GROUPS	2021	2022	2023
Hypertension	6	19	13
Congestive Heart Failure	242	243	242
Breast Cancer	0	3	1
Cancer	14	10	9
Pneumonia	98	126	124
Complications Baby	0	0	0
Reproductive Disorder	2	4	1
Bronchitis/Asthma	8	12	22
Alcohol/Drug Abuse	42	31	46
COPD	31	84	91
Fracture	23	27	25
Behavioral Health	198	130	149
Other org psych conditions	18	58	13
Paranoia/Psychosis	107	88	173
Personality Disorders	20	43	20
Psychogenic Disorders	7	2	10
Schizophrenia	63	52	64
Sleep Disorders	2	2	2
Stress Related	65	20	64

Table 1-3 Source: Indiana Regional Medical Center, 2024

Hospital Utilization Data

PUNXSUTAWNEY AREA HOSPITAL

As seen in Table 4 from 2021 through 2023, hospital ER discharges for ambulatory care sensitive conditions for PAH increased for: dental conditions, vaccine preventable conditions, bacterial pneumonia, gastroenteritis, pelvic inflammatory disease, diabetes with other complications, and diabetes with ketoacidosis.

Table 4: Ambulatory Care Sensitive Conditions – ER Only

PREVENTABLE CONDITIONS	2021	2022	2023
Failure to Thrive	0	0	0
Dental Conditions	151	179	203
Vaccine Preventable Conditions	0	0	2
Iron Deficiency Anemia	7	5	4
ACUTE CONDITIONS	**2021**	**2022**	**2023**
Bacterial Pneumonia	0	2	1
Cellulitis	59	41	55
Convulsions	87	74	71
Dehydration	171	110	162
Gastroenteritis	129	168	159
Hypoglycemia	9	5	8
Kidney/Urinary Infection	304	196	236
Pelvic Inflammatory Disease	1	2	3
Severe Ear, Nose and Throat Infections	429	430	390
CHRONIC CONDITIONS	**2021**	**2022**	**2023**
Angina	8	6	4
Asthma	225	218	146
COPD	369	330	252
Congestive Heart Failure	118	82	109
Diabetes with Ketoacidosis	47	67	70
Diabetes with other complications	57	87	81
Diabetes without complications	641	635	403
Grand Mall/Epileptic	21	23	21
Hypertension	63	67	63

For the same time period, hospital ER and/or inpatient discharges for mental health for PAH, as seen in Table 5, increased for: alcohol related, anxiety, conduct/social disturbance, eating disorders, mental retardation, paranoia/psychosis, schizophrenia and transient organic psychotic conditions

Table 6 shows that from 2021 to 2023, hospital DRG conditions for PAH increased for: congestive heart failure, pneumonia, complications baby, and bronchitis/asthma

Table 5: Mental Health ICD-9 and ICD-10 Codes

CODE	2021 ER	2021 IN	2022 ER	2022 IN	2023 ER	2023 IN
Adjustment related	10	14	3	15	5	8
Alcohol Related	18	38	20	33	10	51
Anxiety	355	232	206	226	238	258
Bipolar	36	62	26	50	15	47
Conduct/Social Disturbance	0	0	2	1	5	3
Dementia	70	149	52	142	32	113
Depression	131	191	18	22	14	21
Drug Related	46	57	27	40	25	42
Eating Disorders	2	0	2	0	1	2
Emotional Disorders Youth	1	1	0	1	1	3
Manic Disorders	0	0	0	0	0	0
Mental Retardation	13	10	9	12	8	12
Other org psych conditions	4	23	6	17	0	13
Paranoia/Psychosis	14	6	7	6	6	17
Personality Disorders	0	3	0	3	0	3
Psychogenic Disorders	0	1	0	0	0	1
Schizophrenia	4	5	7	9	0	12
Sleep Disorders	0	0	0	0	0	0
Stress Related	18	4	13	8	11	2
Transient Organic Psychotic Conditions	0	5	0	3	0	6

Table 6: Hospital Inpatient Conditions

DIAGNOSIS RELATED GROUPS	2021	2022	2023
Hypertension	11	0	0
CHF	50	66	63
Breast Cancer	0	0	0
Cancer	2	0	0
Pneumonia	39	54	59
Complications Baby	10	16	18
Bronchitis/Asthma	14	50	83
Alcohol/Drug Abuse	46	12	28
COPD	30	22	30
Fracture	14	11	6
Behavioral Health	153	204	112

Tables 4-6 Source: Punxsutawney Area Hospital, 2024

Health Status

Measures of general health status provide information on the health of a population, especially through the monitoring of life expectancy, health life expectancy, years of potential life lost, physically and mentally unhealthy days, self-assessed health status, limitation of activity, and chronic disease prevention.

Where We Are Making A Difference

The percentage of adults who report that their physical health was not good one or more days in the past month has decreased in the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean and Warren from 39.0% in 2011-2013 to 33.0% in 2020-2022. In 2022, the percentage in the combined counties (33.0%) was equal to the state (33.0%) and lower than the nation (37.7%).

Where There Are Opportunities

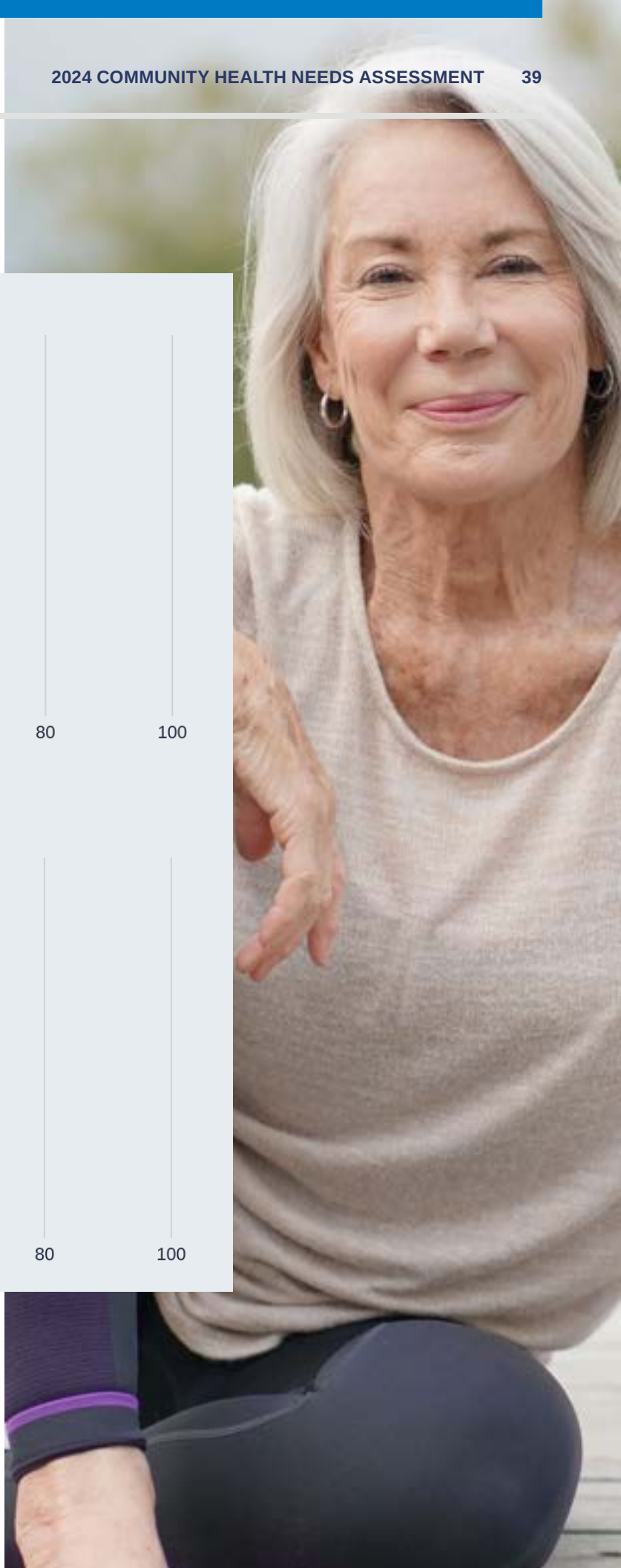
In 2010-2022, the percentage of adults who reported their health as Fair or Poor in the combined counties of Indiana, Cambria, Somerset and Armstrong (22.0%) was higher than the state (16.0%) and nation (17.1%). The same is true for the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean and Warren (20.0%).

The percentage of adults who report their physical health was not good one or more days in the past month was higher in the combined counties of Indiana, Cambria, Somerset and Armstrong (39.0%) in 2020-2022 in comparison to 33.0% in the state.

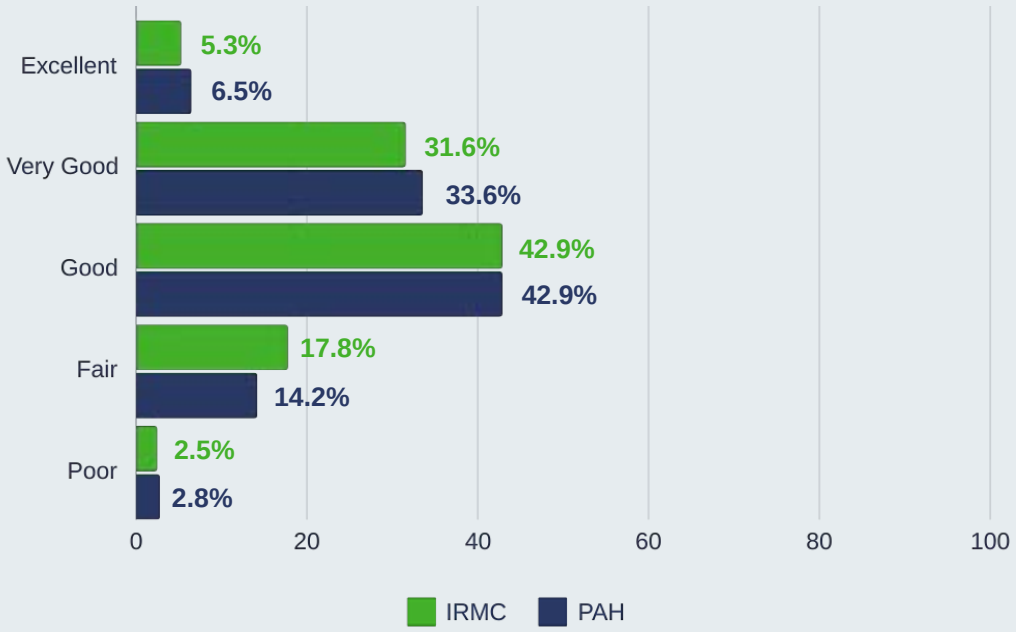
The percentage of adults who report that poor physical or mental health prevented usual activities in the past month has increased in the combined counties of Indiana, Cambria, Somerset and Armstrong from 23.0% in 2011-2013 to 26.0% in 2020-2022. During this time the percentage also increased from 19.0% to 24.0% in the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean and Warren.

What The Community is Saying

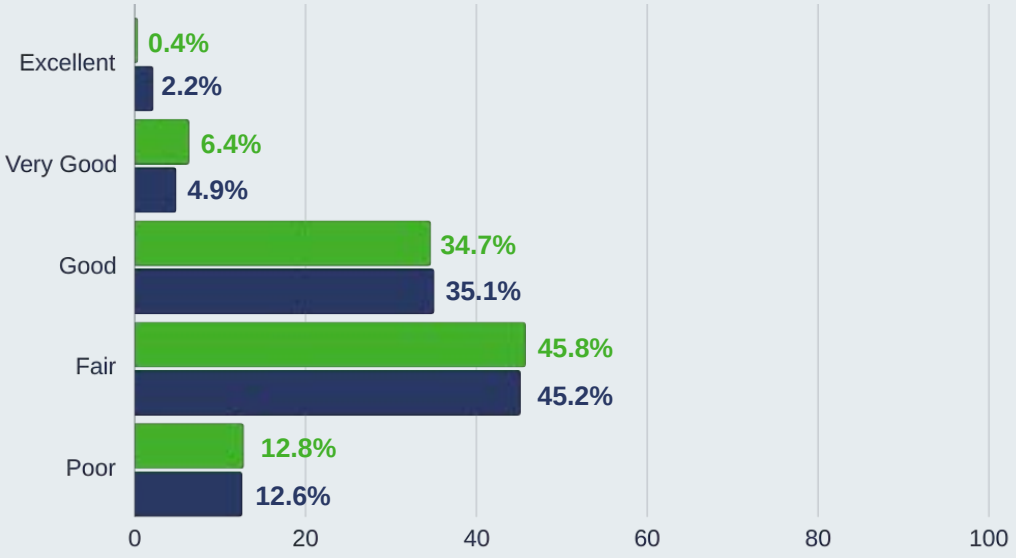
Community survey respondents were more likely to rate their personal health as good, very good, or excellent in both IRMC (79.8%) and PAH's (83.0%) service areas than the overall IRMC (41.5%) and PAH (42.2%) communities. *Results on page 39.*



PERSONAL HEALTH



OVERALL COMMUNITY HEALTH



Access to Quality Health Services

Access to comprehensive, quality health care is important for the achievement of health equity and for increasing the quality of life for everyone. Poverty, employment and affordability; education; transportation and location; community; and quality and availability of providers all affect access.

Where We Are Making A Difference

The percentage of adults in the combined counties of Indiana, Cambria, Somerset, Armstrong who do not have health insurance decreased from 15.0% in 2011-2013 to 9.0% in 2018-2020. This trend also occurred in the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean, Warren (17.0% to 11.0%).

The percentage of adults in the combined counties of Indiana, Cambria, Somerset, Armstrong who do not have a personal health care provider decreased from 11.0% in 2011-2013 to 8.0% in 2020-2022. In 2020-2022 the county rate was lower in comparison to the state (12.0%), nation (16.3%) and Healthy People 2030 Goal (16.0%). This trend also occurred in the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean, Warren (12.0% to 14.0%).

The percentage of adults in the combined counties of Indiana, Cambria, Somerset, Armstrong who had a routine check-up within the past 2 years increased from 83.0% in 2011-2013 to 91.0% in 2020-2022, which was higher in comparison to the state (89.0%) and nation (87.8%). This trend also occurred in the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean, Warren (84.0% to 87.0%).

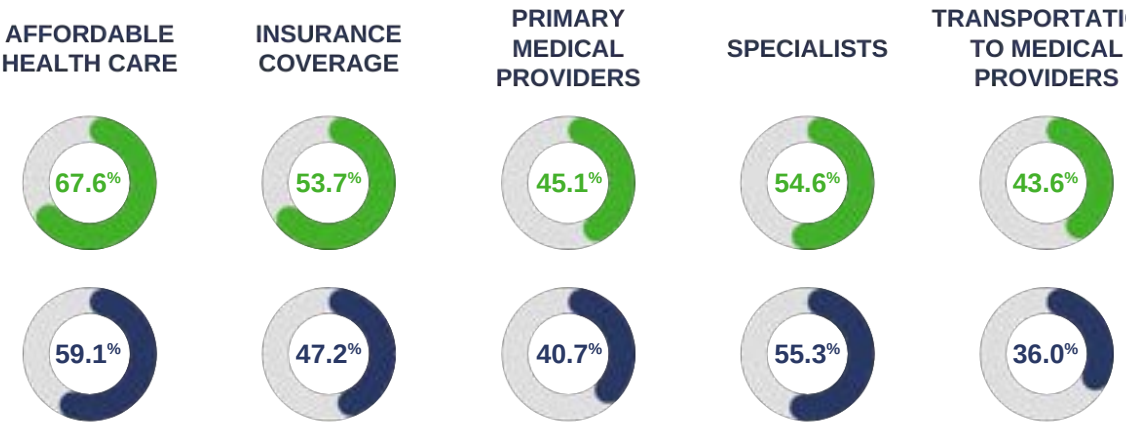
The percentage of adults in the combined counties of Indiana, Cambria, Somerset, Armstrong who needed to see a doctor but could not due to cost in the past year decreased from 12.0% in 2011-2013 to 8.0% in 2020-2022, which was lower in comparison to the nation (10.1%).

Where There Are Opportunities

No areas were prevalent from the secondary data.

What The Community is Saying

The majority of community survey respondents from IRMC (86.6%) and PAH (88.7%) service areas have had a routine physical in the past year. Most have also had their blood cholesterol checked within the past year (IRMC: 81.4%, PAH: 77.3%). Over two-thirds of the respondents who should be receiving preventative screenings are. Of the respondents to the community survey who are males ages 55 and older, 67.4% of those in IRMC's service area and 75.0% in PAH's service area had received a PSA Test in the past year. When looking at female respondents ages 40 and older, 71.5% of those in IRMC's service area and 74.1% in PAH's service area have had a mammogram in the past year. For woman ages 25 and older, 66.7% (IRMC) and 56.4% (PAH) had received a pap test within the past 2 years.



Access to affordable health care was identified as a serious or very serious problem by 67.6% of community survey respondents from IRMC's service area and 59.1% of the respondents from PAH's service area. Access to insurance coverage was identified as a problem by 53.7% of respondents from IRMC's service area and 47.2% for PAH. Access to primary medical care providers (IRMC: 45.1%, PAH: 40.7%) and access to specialists (IRMC: 54.6%, PAH: 55.3%) were also identified as problems. Transportation to medical providers and services were seen as a problem by 43.6% of respondents from IRMC and 36.0% of respondents from PAH.

One stakeholder for IRMC identified declining health among the top identified health related needs noting an aging population. It was noted that this population uses more resources such as home healthcare which is currently experiencing workforce shortages. Another mentioned pre-hospital healthcare access and emergency services, noting efforts to come up with a more efficient way to deliver EMS services to the county. A different stakeholder identified access to dental care among the top health related issues talking about the challenges those with medical assistance face when trying to find a dentist. While there are several dentists in the community, only

What The Community is Saying *(Continued)*

a small number will see patients with certain types of insurance or no insurance. This stakeholder also noted that most people do not understand the connection between dental health and physical health.

Transportation was noted as a barrier for people accessing health care. Not all areas have access to public transportation and others may not have their own vehicle and need to rely on family and friends to get them to appointments. Another stakeholder noted that it is not uncommon to see people several days after they should have received care because that was the earliest they could get a ride. There is the opportunity to work on community outreach projects where people can access care via mobile outreach services or telemedicine. This could be targeted in underserved areas and specifically to underserved populations.

In addition to transportation, childcare and economic barriers were also identified as impacting access to healthcare. It was also noted that people are not prioritizing health and wellness or even work/life balance.

Community education was mentioned by a few stakeholders noting that people are not aware of all that is available in the community. This was seen as particularly challenging in a rural community with limited access to media. Social media can be a great resource to disseminate information, although not all areas have access to internet services.

It was also noted that the minority voice is still underrepresented. In particular LGBTQ+ groups, the migrant population and the BIPOC population were mentioned.

Health literacy was identified among the top 3 health related issues by a stakeholder for PAH. There is also the need to prioritize health. Access to care was noted as was the impact of social determinants of health. The lack of a workforce in healthcare was also mentioned by a stakeholder noting that everyone is struggling to find workers. There also continues to be a lack of trust or mistrust of professionals as a result of the pandemic.

Another mentioned availability of healthcare staff, access to modern facilities and transportation for low income individuals as the top 3 health related issues. They noted economic labor market pressures, inflation and economic viability as contributing factors to these health related issues.

Another identified the need for OB/GYN and infant care along with specialty care access. They noted quality of life concerns and reimbursement for practitioners and facilities. Pediatric and elder care were noted by another stakeholder. They spoke of the importance of ensuring children have the resources to be healthy and successful. It was noted that the older population is often on fixed income where they need to choose between medications, food and paying bills. Creating a one stop shop for resources and information was mentioned.

Chronic Disease

Conditions that are long-lasting, relapse, and are characterized by remission and continued persistence are categorized as chronic diseases.

Where We Are Making A Difference

HEART RELATED

The percentage of adults aged 35 and older in the combined counties of Indiana, Cambria, Somerset, Armstrong who have ever been told they have heart disease decreased from 8.0% in 2011-2013 to 5.0% in 2020-2022.

The percentage of adults aged 35 and older in the combined counties of Indiana, Cambria, Somerset, Armstrong who have ever been told they had a heart attack decreased from 8.0% in 2011-2013 to 5.0% in 2020-2022.

In Jefferson County the heart disease mortality rate per 100,000 decreased from 180.4 in 2011 to 169.3 in 2021 which was lower in comparison to both the state (180.3) and nation (215.1).

The coronary heart disease mortality rate per 100,000 in Jefferson County has decreased from 104.4 in 2011 to 86.1 in 2021, which is below the state (107.0) and nation (118.0).

In Jefferson County the cardiovascular mortality rate per 100,000 decreased between 2011 (261.3) and 2021 (228.5) and was lower than the state (234.5).

The cerebrovascular mortality rate per 100,000 decreased in Jefferson County from 50.1 in 2011 to 26.4 in 2021, lower in comparison to the state (37.6) and Healthy People 2030 Goal (33.4).

CANCER

The bronchus and lung cancer incidence rate per 100,000 has decreased in Indiana County from 43.3 in 2011 to 39.0 in 2020, lower in comparison to the state (50.9) and nation (47.1). The mortality rate also decreased in the county from 38.5 in 2011 to 27.1 in 2021, lower than the state (32.4) and nation (31.8). The incidence rate also decreased in Jefferson County during this time from 71.7 to 48.3, also lower than the state (50.9) as did the mortality rate (42.5 to 29.9).

In Indiana County the colorectal cancer incidence rate per 100,000 decreased from 42.8 in 2011 to 32.0 in 2020 as did the mortality rate (24.2 in 2011 to 11.5 in 2021).

The morality rate in 2021 was lower in comparison to the state (13.0). The colorectal cancer incidence rate also decreased in Jefferson County from 49.8 in 2011 to 39.9 in 2019 as did the mortality rate (21.6 in 2011 to 13.6 in 2020).

The prostate cancer incidence rate per 100,000 decreased in Indiana County between 2011 (116.1) and 2020 (73.1). The rate in 2020 was lower than both the state (93.1) and nation (100.0). Limited data is available on the mortality rate although in 2018 (19.7) the rate was lower than it had been in 2011 (24.5). The incidence rate has decreased in Jefferson County from 175.1 in 2011 to 105.5 in 2020 but remains higher than the state (93.1) and nation (100.0). Mortality data is not available for Jefferson County.

OTHER HEALTH CONDITIONS

The percentage of adults in the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean, Warren who have ever been told they have diabetes decreased from 12.0% in 2011-2013 to 10.0% in 2020-2022, which was comparable to the state (11.0%) and nation (11.6%).

The Alzheimer's mortality rate per 100,000 has decreased in Indiana County (23.4 in 2011 to 19.3 in 2021) and Jefferson County (24.6 in 2011 to 17.7 in 2020). In the most recent year, both were lower in comparison to the state (22.7) and nation (37.0).

Where There Are Opportunities

HEART RELATED

The percentage of adults aged 35 and older in the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean, Warren who have ever been told they had a heart attack, have heart disease or had a stroke increased from 15.0% in 2011-2013 to 18.0% in 2020-2022, which was higher than the state (14.0%).

In Indiana County the heart disease mortality rate per 100,000 increased from 160.1 in 2011 to 199.0 in 2021, which was higher than the state (180.3). The heart failure mortality rate per 100,000 also increased in Indiana County between 2011 (13.1) and 2021 (28.8), which was higher than the state (26.6). The rate also increased in Jefferson County from 26.1 in 2013 to 34.3 in 2021, also higher than the state.

The coronary heart disease mortality rate per 100,000 increased from 104.6 in 2011 to 114.0 in 2021 in Indiana County which was higher than the state (107.0) and above the Healthy People 2030 Goal (71.1).

Where There Are Opportunities *(Continued)*

In Indiana County the cardiovascular mortality rate per 100,000 increased between 2011 (211.0) and 2021 (257.5) and was higher than the state (234.5).

In 2021, the cerebrovascular mortality rate per 100,000 in Indiana County (40.9) was higher in comparison to the state (37.6) and above the Healthy People 2030 Goal (33.4).

CANCER

In Indiana County, the breast cancer incidence rate per 100,000 has increased from 92.5 in 2011 to 123.5 in 2020, which was higher in comparison to the state (118.2) and nation (119.2). The late-stage breast cancer incidence rate per 100,000 also increased in Indiana County from 37.1 to 44.1, also higher than the state (37.8).

The rate also increased in Jefferson County during this time from 62.5 to 100.6. Data was not available on late-stage breast cancer in Jefferson County.

OBESITY AND OVERWEIGHT

The percentage of adults considered overweight (BMI 25+) in the combined counties of Indiana, Cambria, Somerset, Armstrong increased from 68.0% in 2011-2013 to 76.0% in 2020-2022, which was significantly higher in comparison to the state (67.0%) and twice as high as that of the nation (34.2%). This is also the case for adults considered obese (BMI 30+) which increased from 36.0% to 45.0% during the same time period. In 2020-2022 the percentage for the county cluster was significantly higher than the state (33.0%) as well a higher than the nation (33.6%).

In 2020-2022 in the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean, Warren the percentage of adults considered overweight (BMI 25+) (68.0%) was twice as high as the nation (34.2%). The percentage considered obese (BMI 30+) increased from 30.0% in 2011-2013 to 39.0% in 2020-2022, which was higher than both the state (33.0%) and nation (33.6%).

OTHER HEALTH CONDITIONS

The percentage of adults who were ever told they had diabetes in the combined counties of Indiana, Cambria, Somerset, Armstrong increased from 11.0% in 2011-2013 to 13.0% in 2020-2022, which was higher than both the state (11.0%) and nation (11.6%).

In 2021, In Indiana County, the diabetes mortality rate per 100,000 (27.1) was higher in comparison to the state (23.5) and the rate for Jefferson County (41.7) was significantly higher in comparison to the state.

The Lyme disease rate in 2020 was significantly higher in Indiana County (39.7) and Jefferson County (72.0) in comparison to the state (25.7).

What The Community is Saying

Approximately half (52.7%) of community survey respondents from PAH's service area have ever been told they have high blood pressure compared to 43.5% of those from IRMC's service area. Very few community survey respondents from IRMC (13.5%) or PAH (16.9%) have ever been told they have diabetes.

Community survey respondents from IRMC's service area identified the following conditions among the Top 10 problems: Obesity and Overweight (77.8%), Diabetes (71.2%), Cancer (68.4%), Childhood Obesity (63.6%). Cardiovascular Disease and Stroke (64.2%) and Hypertension/High Blood Pressure (51.6%).

Community survey respondents from PAH's service area identified the following conditions among the Top 10 problems: Obesity and Overweight (82.6%), Diabetes (70.4%), Childhood Obesity (70.0%), Cancer (67.9%) and Hypertension/High Blood Pressure (52.3%).

Stakeholders for IRMC did not talk about chronic conditions among the top identified health related needs with the exception of childhood obesity noting that 30% of children in the elementary school are considered obese. Lack of sleep, poor nutrition, large portion sizes and eating unhealthy foods were all identified as contributing factors.

A stakeholder for PAH identified heart disease, diabetes and lyme disease among the top 3 health related issues in the county. Another mentioned diabetes and the lingering effects of COVID-19. It was noted that the cost of diabetic drugs can be a challenge with people not being able to afford some drugs like injectables. This is a challenge outside of county control as pharmacy companies are allowed to charge high amounts for these drugs and many insurance companies are denying them. The stakeholder noted that there is also not a lot known about COVID-19 and people still have lingering effects that were not necessarily identified during the illness.

Another mentioned obesity and cardiovascular disability among the top 3 health related issues facing the county. They talked about the need for people to be physically active and maintain a healthy lifestyle early in life to help prevent cardiovascular disability. This requires educating parents on raising healthy children, encouraging young adults to maintain cardiovascular health and for older individuals to recognize the signs of cardiovascular health problems.

One mentioned prevention of chronic disease and access to treatment for chronic disease. It was noted that chronic disease reduces quality of life, reduces productivity and increases the cost of care for this population. This stakeholder suggested the need for incentives for healthy lifestyle choices. Another specifically mentioned treatment for cancer and heart conditions. One spoke specially about the need for preventative care and community education on chronic conditions. Another mentioned the overprescription of Ozempic for weight loss.

Healthy Environment

Environmental quality is a general term which can refer to varied characteristics of the natural environment such as air and water quality, pollution, noise, weather and the potential effects on physical and mental health caused by human activities. Environmental quality also refers to socioeconomic characteristics of a given community or area, including economic status, education, crime and geography.

Where We Are Making A Difference

The unemployment rate in Jefferson County has decreased from 8.2% in 2011 to 6.5% in 2023 which was comparable to the state (6.3%) and nation (5.4%).

In 2023 the high school graduation rate in Indiana County (91.7%) and Jefferson County (93.4%) were higher than the state (87.7%) and nation (87.0%). The graduation rate in Jefferson County has also been increasing from 89.0% in 2011 to 93.4% in 2023.

The percentage of children living in poverty has decreased in Jefferson County from 23.0% in 2011 to 18.7% in 2023.

The percentage of children living in single parent homes has decreased in Indiana County from 21.9% in 2011 to 16.0% in 2023, which was lower than the state (25.4%) and nation (25.0%). During this time the percentage also decreased in Jefferson County from 28.0% to 20.5%.

In Indiana County, the percentage of disconnected youth decreased from 11.1% in 2017 to 7.3% in 2023.

Where There Are Opportunities

In the combined counties of Indiana, Cambria, Somerset and Armstrong, the percentage of adults who have ever been told they have asthma has increased from 12.0% in 2011-2013 to 21.0% in 2020-2022. During this time period, the percentage also increased in the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean and Warren (13.0% to 18.0%). In 2020-2022 the percentage in both of the combined county clusters was higher than both the state (15.0%) and nation (15.7%). In 2020-2022 the percentage of adults who currently have asthma in the combined counties of Indiana, Cambria, Somerset and Armstrong (18.0%) was significantly higher in comparison to the state (10.0%) and was also higher than the nation (10.4%).

In 2023 in Jefferson County the percentage of disconnected youth (13.1%) was twice as high as the state (6.3%) and nation (7.0%), although it has been decreasing.

What The Community is Saying

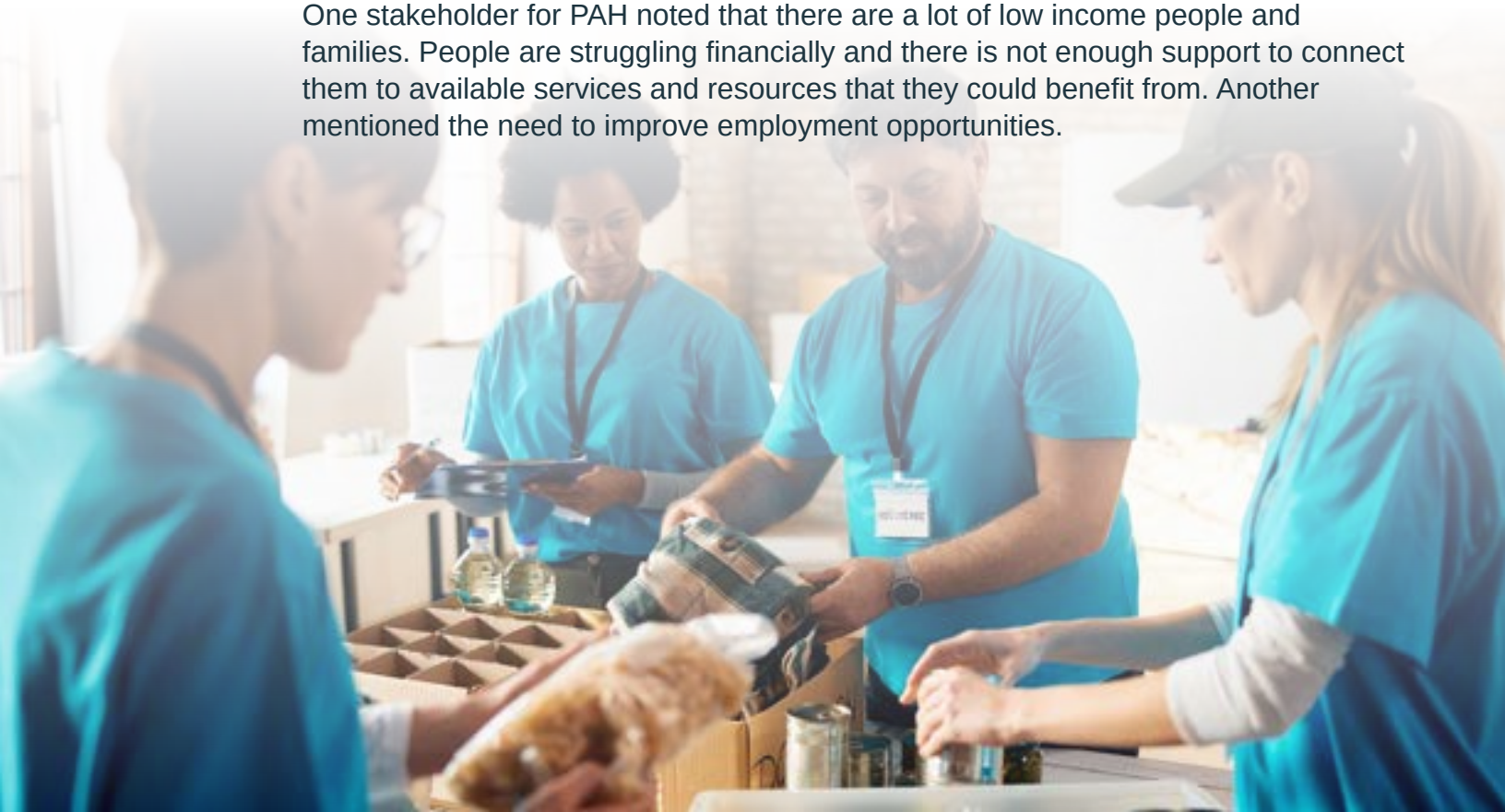
Community survey respondents identified poverty/living paycheck to paycheck among the Top 10 problems facing the community for both IRMC (76.3%) and PAH (79.0%).

Poverty also came up during stakeholder interviews which is an ongoing problem and concern in the county. Employers have laid off individuals who have not been able to find work elsewhere. It was also noted that poverty leads to crime citing an increase in retail theft.

One stakeholder for IRMC talked about the lack of affordable senior housing. It was noted that there is an abundance of student housing, but not enough for an aging population. The lack of a quality workforce was also mentioned. Another mentioned housing in general noting that homelessness is a relatively new challenge the county is facing. There are also seniors whose homes need repairs or are no longer able to remain in their home for safety reasons but they do not have anywhere to turn for help. There are not enough personal care homes or assisted living facilities for the population.

The county is not as populous as it used to be, which is impacting the workforce and ultimately the economy. There is a need to attract a younger workforce but to do that employers need to shift their culture. You can’t continue to do things they way you did in years past as this generation wants different things from their employer and the work environment.

One stakeholder for PAH noted that there are a lot of low income people and families. People are struggling financially and there is not enough support to connect them to available services and resources that they could benefit from. Another mentioned the need to improve employment opportunities.



Infectious Disease

Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another. These diseases can be grouped in three categories: diseases which cause high levels of mortality; diseases which place on populations heavy burdens of disability; and disease which owing to the rapid and unexpected nature of their spread can have serious global repercussions (World Health Organization).

Where We Are Making A Difference

In the combined counties of Indiana, Cambria, Somerset and Armstrong the percentage of adults aged 65 and older who have had a pneumonia vaccine increased from 70.0% in 2011-2013 to 76.0% in 2019-2021.

The percentage of adults ages 18-64 who have ever been tested for HIV increased in the combined counties of Indiana, Cambria, Somerset and Armstrong from 25.0% in 2011-2013 to 31.0% in 2020-2022, although remains lower than the state (40.0%) and nation (36.3%).

In Indiana County the influenza and mortality rate per 100,000 decreased from 16.5 in 2011 to 14.2 in 2021, although remained higher than the state (10.3). The rate decreased in Jefferson County during this time from 19.8 to 15.6, although was higher than the state.

In 2021 the chlamydia rate per 100,000 in Indiana County (301.6) and Jefferson County (149.6) were significantly lower in comparison to the state (409.8) and was lower than the nation (495.5).

In Indiana County in 2021 the gonorrhea rate per 100,000 was significantly lower (47.1) than the state (145.9) and lower than the nation (214.0). Data was not available for Jefferson County.

Where There Are Opportunities

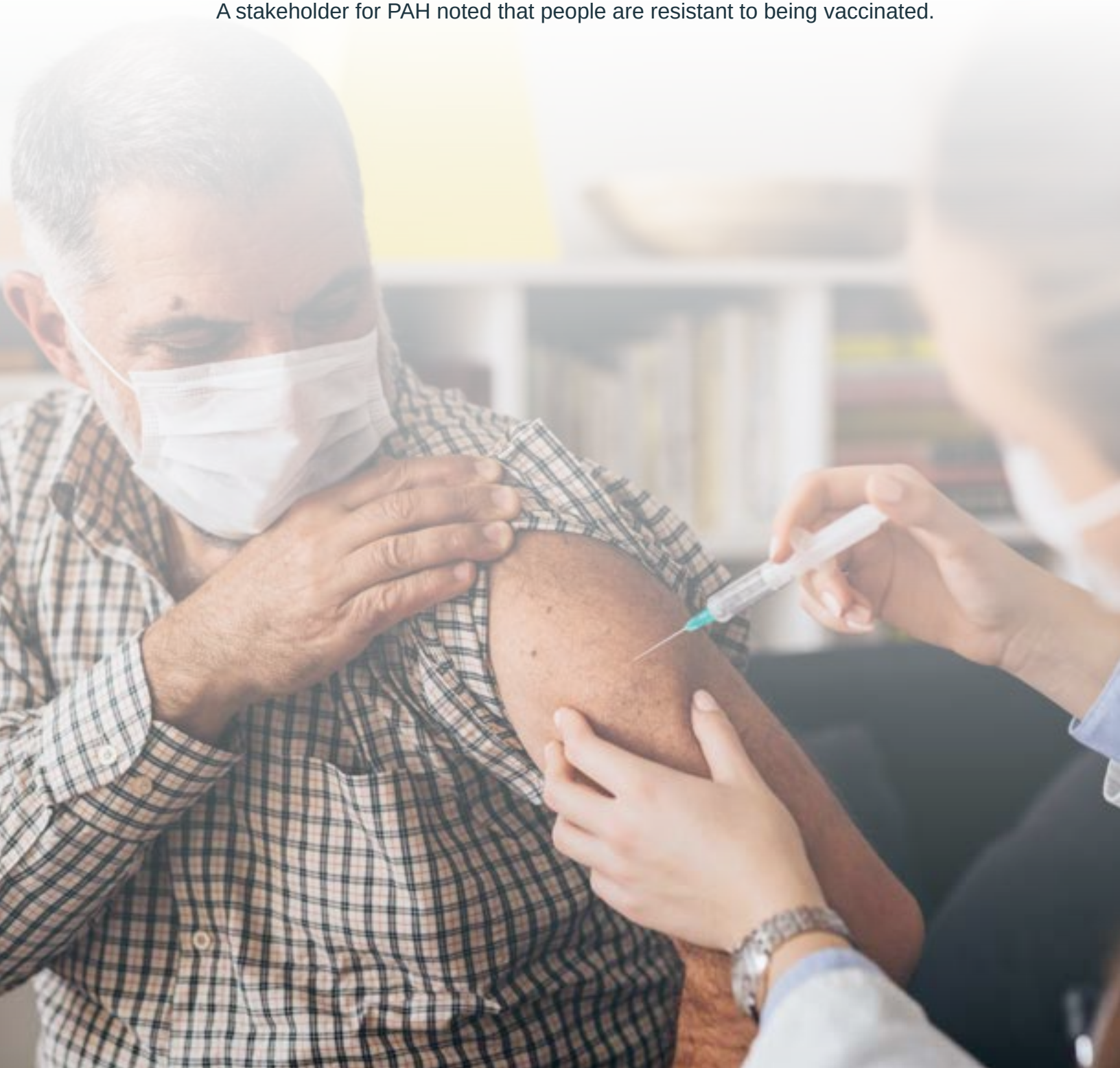
In the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean and Warren there has been little change in the percentage of adults aged 65 and older who had a pneumonia vaccine and in 2020-2022 (68.0%) the percentage was lower than the state (72.0%) and nation (71.4%).

In 2020-2022 the percentage of adults ages 18-64 who have ever been tested for HIV was significantly lower in the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean and Warren (28.0%) in comparison to the state (40.0%) and was lower than the nation (36.3%).

What The Community is Saying

Community survey respondents for IRMC did not view access to adult immunizations (11.7%) or access to childhood immunizations (8.6%) or COVID-19 (20.6%) as big problems in the community. Respondents from PAH also did not identify access to adult immunizations (8.2%) or access to childhood immunizations (7.4%) or COVID-19 (15.2%) as big problems in the community.

A stakeholder for PAH noted that people are resistant to being vaccinated.



Mental Health and Substance Use Disorder

Mental Health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the World Health Organization's definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease." It is related to promotion of well-being, prevention of mental disorders and treatment and rehabilitation of people affected by mental disorders.

Post-Traumatic Stress Disorder (PTSD) is a natural but sometimes debilitating reaction to events that cause extreme trauma. These events include, but are not limited to: exposure to combat conditions, being the victim of a terrorist attack, sexual or physical abuse as a child, a serious accident or a natural disaster. Three mechanisms typically may lead to the formation of PTSD are:

- **Trauma**—a single moment, like an injury, or an episode of extreme fear, danger, or a state of helplessness
- **Fatigue**—wear and tear from living in abnormally stressful conditions
- **Loss**—grief, and often misplaced guilt, over the death of others

According to the World Health Organization, substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome – a cluster of behavioral, cognitive and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance and sometimes a physical withdrawal state.

Where We Are Making A Difference

MENTAL HEALTH

In 2020-2022, the percentage of adults who report their mental health was not good one or more days in the combined counties of Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean and Warren (33.0%) was lower than the state (40.0%) and nation (42.8%).

SUBSTANCE USE

The percentage of adults who report excessive drinking has decreased in Indiana County from 23.7% in 2011 to 20.6% in 2023.

In Jefferson County, alcohol impaired driving deaths decreased from 52.9% in 2014 to 3.2% in 2023, which was also lower than the state (25.4%), nation (27.0%) and

Healthy People 2030 Goal (28.3%). During this time the rate also decreased in Indiana County from 36.4% to 32.3%.

In Indiana County, the percentage of youth who report lifetime use of alcohol has decreased. There was a reduction overall (40.1% in 2009 to 31.8% in 2021) and for students in grades 6 (16.1% to 13.8%), grade 8 (52.4% to 24.7%), grade 10 (43.2% to 38.6%) and grade 12 (57.1% to 54.4%). In Jefferson County, there was a reduction overall from 50.9% to 44.3%) during this same time period. A decrease was seen for students in grade 6 (14.3% to 18.2%), grade 10 (65.2% to 58.9%) and grade 12 (64.9% to 62.0%).

The percentage of students in grade 10 (7.1% to 3.0%), grade 12 (11.6% to 7.6%) and overall (5.7% to 2.6%) who drove after drinking decreased in Jefferson County between 2009 and 2021.

Between 2019 and 2021, the percentage of youth who report lifetime use of prescription narcotics decreased in Indiana County for students in grade 10 (13.6% to 3.6%), grade 12 (10.2% to 4.0%) and overall (6.6% to 3.4%). During this time, the percentage decreased in Jefferson County for students in grade 8 (6.6% to 4.0%), grade 10 (13.3% to 8.0%), grade 12 (9.6% to 5.9%) and overall (8.7% to 5.3%).

Where There Are Opportunities

MENTAL HEALTH

The percentage of adults who report their mental health was not good one or more days in the past month has increased in the combined counties of Indiana, Cambria, Somerset and Armstrong from 34.0% in 2011-2013 to 40.0% in 2020-2022.

The percentage of adults who report frequent mental distress increased from 12.3% in 2016 to 16.9% in 2023 in Indiana County and from 12.4% to 17.2% in Jefferson County. Both were higher than the nation (14.0%).

In Indiana County the drug induced mortality rate per 100,000 increased from 30.9 in 2011 to 70.0 in 2021, which was significantly higher in comparison to the state (43.7) and was higher than the nation (32.1) and Healthy People 2030 Goal (20.7). The rate increased in Jefferson County from 23.8 in 2012 to 35.6 in 2020, data was not available in 2021.

The mental and behavioral disorders mortality rate per 100,000 increased from 75.3 in 2011 to 84.0 in 2021 in Indiana County which was significantly higher than the state (42.8). During this time the rate also increased in Jefferson County from 18.0 to 58.0 (also higher than the state 42.8).

SUBSTANCE USE

In Indiana County the percentage of overall youth reporting lifetime marijuana use increased from 8.6% in 2009 to 14.4% in 2021. In Jefferson County, the percentage increased for students in grade 10 (28.1% to 24.0%) and grade 12 (28.2% to 40.8%).

The percentage of students in grade 12 who drove after drinking increased in Indiana County from 2.2% in 2009 to 4.9% in 2021.

What The Community is Saying

Community survey respondents from IRMC identified illegal drug use (79.2%) among the Top 10 problems facing the community. Respondents from PAH identified illegal drug use (84.5%) and prescription drug abuse (64.0%) among the Top 10 problems facing the community.

Of those who responded to the community survey 30.0% of respondents from IRMC and 29.7% of respondents from PAH report binge drinking in the past month. Approximately a third of those from IRMC's service area (36.1%) and PAH's service area (30.0%) report feeling down, depressed or hopeless in the past 2 weeks.

Just under half of the respondents from IRMC's service area identified social isolation (41.4%) as a serious or very serious problem. Access to mental health care services was identified among the Top 10 problems by 61.4% of respondents, while 46.8% identified access to drug and alcohol treatment services as a problem.

Social isolation was identified as a serious or very serious problem by 38.7% of community survey respondents from PAH's service area. Almost half (47.5%) identified access to mental health care services as a problem, while 45.9% identified access to drug and alcohol treatment services as a problem.

Several stakeholders in IRMC's service area identified mental health among the top 3 health related needs facing Indiana County. This was noted by those representing multiple age groups. At IUP it was noted that there are several students in need of counseling and/or just someone to talk to. Another spoke of the challenges youth are facing around body image and social interactions. They talked about the increase in screen time for children, which is something that society is driving. There also tends to be a focus on prescribing medication to children to manage their mental health as opposed to focusing on diet and sleep. The school district notes that 22% of the student population are on some type of medication.

It was also mentioned that a lot of individuals have a dual diagnosis where substance abuse and mental health are both at play and they feed off one another. It was also noted that there continues to be a stigma around mental health treatment and that it is "cool" or accepted for women but not necessarily for men.

What The Community is Saying *(Continued)*

One stakeholder for IRMC shared that there has been an increase in 911 calls related to mental health issues with family members trying to get help for a family member who is unwilling. This is also something that police are seeing an increase in. There are individuals posting to social media expressing suicidal ideation. It is not uncommon for the police to do a welfare check as a result of things someone posts on social media. It was also noted that drug overdoses are an ongoing problem although it is not as bad as in years' past. This stakeholder shared that resources are going to support an overdose patient once they are already recovering which takes away the resources from another patient. There is a need to involve EMS services sooner when an overdose occurs. Life circumstances and challenges around housing and employment were identified as contributing factors to mental health and substance use. It was also noted that drugs are readily available in the community given the proximity to the city.

Another noted that medications are not a cure all and that mental and physical health can be affected. It was noted that prescription marijuana can be abused. Furthermore, a stakeholder commented that substances are a quick fix and escape from the real life issues people are dealing with. It was mentioned that mental health is something that also impacts the workforce as it relates to productivity. It was noted that most businesses do not have the culture that support mental health and wellbeing.

A stakeholder for PAH identified overdoses among the top 3 health related issues facing the county. They noted overdose as it relates to over the counter medication, prescription drugs and opioids. It was noted that drugs can be a way for someone to earn money.

Another spoke of social isolation. They talked about changes in society that have moved towards isolation such as home schooling, online classes and working from home. This creates an environment where people do not have the opportunity for social engagement which results in a lack of social skills to navigate society. There is a lack of community supports and programming to address social isolation. It was also noted that social isolation can lead to overeating or dysfunctional eating. They highlighted the need to create opportunities for young individuals to be involved in groups that would allow them to learn social skills.

One stakeholder spoke of the need for behavioral health therapists as well as increased drug and alcohol therapy. They indicated that there are no social workers available and that there is a high drug prevalence in the county. Another mentioned the need for mental health treatment speaking to the over prescription of depression medication without therapy. The need for mental health support for youth was also mentioned.

Healthy Women, Mothers, Babies and Children

Improving the well-being of women, mothers, babies and children is a critical and necessary community health need identified for the IRMC and PAH service areas. The well-being of children determines the health of the next generation and can help predict future public health challenges for families, communities and the health care system. The Healthy Women, Mothers, Babies and Children section addresses a wide range of conditions, health behaviors and health systems indicators that affect the health, wellness and quality of life for the entire community.

Where We Are Making A Difference

In Indiana County the percentage of mothers reporting WIC assistance (40.5% to 28.2%) and Medicaid assistance (36.1% to 33.0%) decreased between 2011 and 2021. The percentage also decreased in Jefferson County for WIC assistance (47.6% to 31.9%) and 47.8% to 37.7% for Medicaid assistance. In 2021, the percentage of mothers receiving WIC assistance in Jefferson County while lower than prior years remained significantly higher in comparison to the state (27.0%).

The percentage of breastfeeding mothers increased in Indiana (74.8% to 77.3%) between 2011 and 2021, although in 2021 remained significantly lower than the state (82.4%). During this time the percentage of breastfeeding mothers also increased in Jefferson County (72.1% to 80.4%).

In Indiana County the teen pregnancy rate per 1,000 ages 18-19 decreased from 21.5 in 2011 to 17.1 in 2021, which was significantly lower than the state (31.5). In Jefferson County, the rate decreased from 65.0 in 2013 to 34.7 in 2021.

The percentage of children grades K-6 considered overweight (18.2% to 15.9%) or obese (22.1% to 19.5%) decreased in Indiana County between 2011 and 2021.

Where There Are Opportunities

The percentage of women who received prenatal care in their first trimester has decreased in Indiana County from 65.6% in 2011 to 61.6% in 2021 and was significantly lower in comparison to the state (73.3%) and lower than the nation (78.3%) and Healthy People 2030 Goal (80.5%). While the percentage has increased in Jefferson County from 56.7% in 2011 to 66.8% in 2021, the percentage was significantly lower than the state (73.3%) and lower than the nation (78.3%) and Healthy People 2030 Goal (80.5%).

The percentage of non-smoking mothers during pregnancy in both Indiana (87.7%) and Jefferson (81.8%) counties increased between 2011 and 2021 but remain significantly lower than the state (92.6%) and is lower than the nation (95.4%) and Healthy People 2030 Goal (95.7%). The same is true for nonsmoking mothers 3 months prior to pregnancy (83.6% in Indiana, 77.2% in Jefferson, and 90.0% in Pennsylvania).

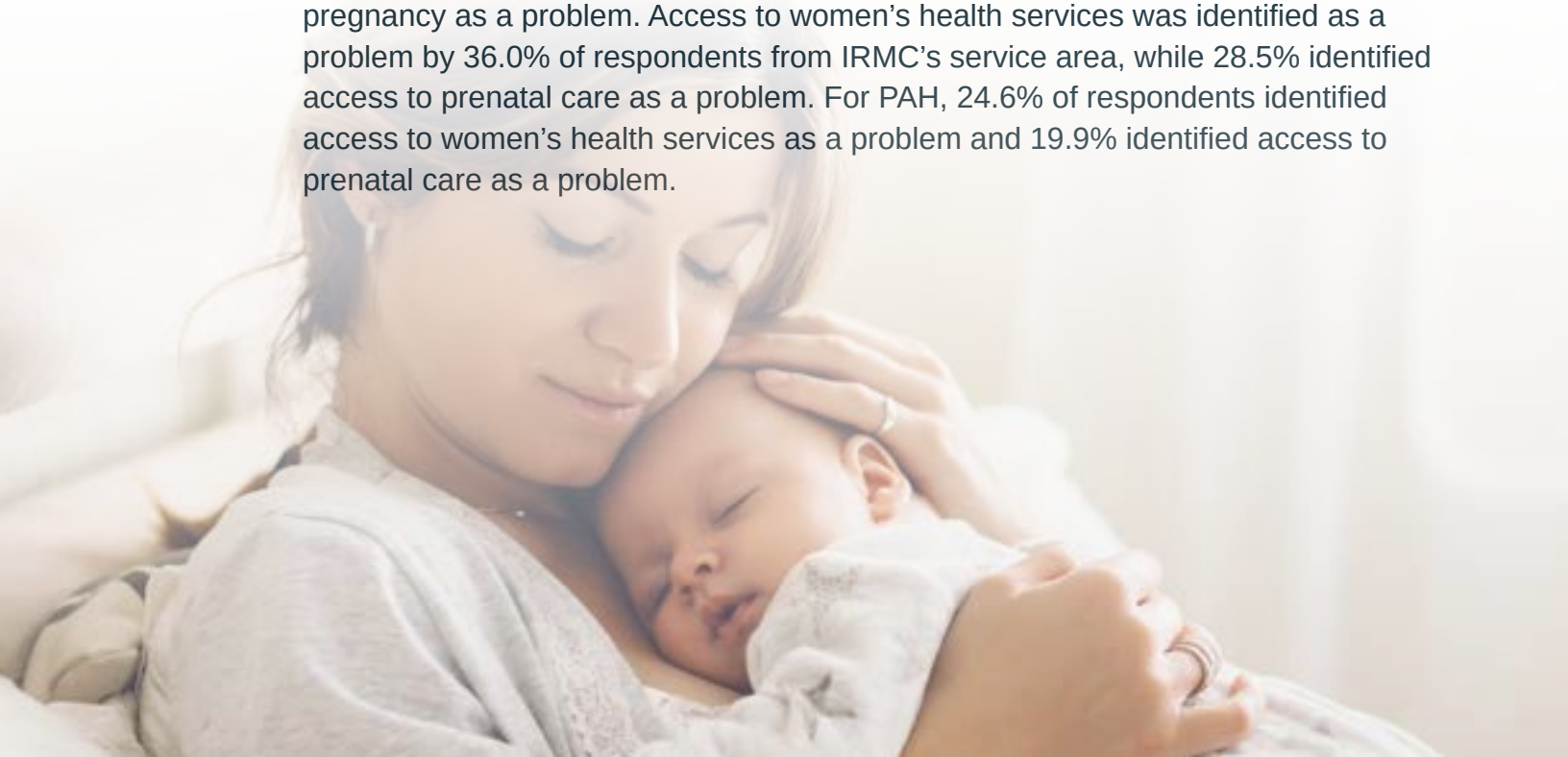
The percentage of low birth weight babies in Jefferson County has increased from 7.8% in 2011 to 10.7% in 2021 higher than the state (8.3%) and nation (7.8%).

The percentage of live birth outcomes for teens age 18-19 decreased between 2011 and 2021 in Indiana (70.8% to 64.9%) and Jefferson (91.9% to 84.2%) counties.

In Indiana County the percentage of students grades 7-12 considered overweight increased from 14.9% in 2011 to 18.5% in 2018. Between 2011 and 2018 the percentage of students grades 7-12 who were considered obese increased in Indiana County (19.7% to 24.1%) and Jefferson County (21.8% to 26.7%).

What The Community is Saying

Access to early childhood development was identified as a serious or very serious problem by 48.2% of respondents from IRMC's service area and 51.6% of respondents from PAH's service area. Teenage pregnancy was identified as a problem by 30.0% of respondents from IRMC and 44.3% identified tobacco use in pregnancy as a problem. Of the respondents from PAH's service area, 32.0% identified teenage pregnancy as a problem and 46.3% identified tobacco use in pregnancy as a problem. Access to women's health services was identified as a problem by 36.0% of respondents from IRMC's service area, while 28.5% identified access to prenatal care as a problem. For PAH, 24.6% of respondents identified access to women's health services as a problem and 19.9% identified access to prenatal care as a problem.



Physical Activity and Nutrition

Regular physical activity reduces the risk for many diseases, helps control weight, and strengthens muscles, bones, and joints. Proper nutrition and maintaining a healthy weight are critical to good health.

Where We Are Making A Difference

In 2023, the percentage of adults with limited access to healthy foods was lower in Indiana (2.5%) and Jefferson (2.3%) counties in comparison to the state (4.6%) and nation (6.0%).

Where There Are Opportunities

In 2020-2022 the percentage of adults who report no leisure time physical activity was higher in Indiana County (28.0%) and Jefferson County (27.0%) in comparison to the state (24.0%) and nation (23.5%).

In Indiana (12.6%) and Jefferson (12.3%) counties in 2023 a higher percentage of adults reported food insecurity in comparison to the state (8.9%) and were twice as high as the Healthy People 2030 Goal (6.0%).

The percentage of youth receiving free or reduced lunch has increased in Indiana County from 33.5% in 2013 to 49.0% in 2023 and from 36.0% in 2011 to 53.9% in 2023 in Jefferson County.

What The Community is Saying

The lack of exercise/physical activity was identified among the Top 10 problems identified by community survey respondents from PAH's service area (68.8%). Access to high quality affordable healthy foods was identified as a serious or very serious problem by 55.7% of respondents from IRMC's service area and 35.9% identified access to emergency food as a problem. Of the community survey respondents from PAH's service, 51.2% identified access to high quality affordable healthy foods as a serious or very serious problem and 35.5% identified access to emergency food as a problem.

One stakeholder for the IRMC service area noted that people are stressed out and not eating right. People are eating too many carbs and putting unhealthy things into their body. There are a lot of people eating prepackaged foods. Another identified food insecurity among the top 3 community health needs.

One stakeholder from PAH talked about the importance of healthy eating and physical activity for youth as well as to prevent chronic conditions. Another mentioned that the quality of food given at school is not great given the level of preservatives.

Tobacco Use

According to the Centers for Disease Control, Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964. Tobacco use causes cancer, heart disease, lung diseases (including emphysema, bronchitis, and chronic airway obstruction), premature birth, low birth weight, stillbirth, and infant death. There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS). Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

Where We Are Making A Difference

The percentage of youth who report vaping in the past 30 days has decreased in Indiana County between 2015 and 2021 for students in grade 8 (16.3% to 9.7%), grade 10 (28.5% to 14.7%) and overall (20.7% to 13.2%). In Jefferson County, the percentage decreased for those in grade 8 (13.1% to 10.4%), grade 10 (37.7% to 34.8%) and overall (23.4% to 20.9%).

Where There Are Opportunities

In 2020-20222, the percentage of adults who report currently smoking in the combined counties of Indiana, Cambria, Somerset and Armstrong (20.0%) and Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean and Warren (20.0%) was higher in comparison to the state (15.0%) and nation (13.5%) and Healthy People 2030 Goal (5.0%).

In 2020-20222, the percentage of adults who report currently using chewing tobacco, snuff or snus in the combined counties of Indiana, Cambria, Somerset and Armstrong (8.0%) and Forest, Elk, Cameron, Clearfield, Jefferson, Clarion, McKean and Warren (9.0%) was higher in comparison to the state (4.0%) and nation (3.4%), with the combined county cluster with Jefferson County significantly higher in comparison to the state.

What The Community is Saying

Tobacco use was among the Top 10 problems identified by community survey respondents from PAH's service area (64.7%). Very few community survey respondents from IRMC (5.9%) or PAH (7.9%) report being a current smoker.

Injury

The topic of injury relates to any intentional or unintentional injuries that can be suffered by individuals.

Where We Are Making A Difference

The suicide rate per 100,000 in Indiana County has decreased from 16.2 in 2011 to 13.8 in 2020.

Where There Are Opportunities

In Indiana County the auto accident mortality rate per 100,000 increased from 11.8 in 2011 to 19.5 in 2020, which was significantly higher than the state (10.0) and higher than the nation (13.7%). Limited data is available for Jefferson County but in 2021 the rate (19.7) was higher than both the state and nation.

Limited data is available on the suicide rate per 100,000 for Jefferson County but in 2020 the rate (26.7) was higher than the state (13.9) and Healthy People 2030 Goal (12.8).

In 2021, the fall mortality rate per 100,000 in Jefferson County (16.5) was higher than both the state (13.4) and nation (13.5).

What The Community is Saying

Stakeholders did not comment on this topic.

Prioritization

On April 24, 2024, the IRMC and PAH Steering Committee met to review the primary and secondary data collected through the needs assessment process and discussed needs and issues present in their respective hospital's local service territory. Jacqui Catrabone, Director of Community and Nonprofit Services, of Strategy Solutions, Inc., presented the data to the IRMC and PAH Steering Committee and discussed the needs of the local area and potential priorities for the hospital and overall system to focus on over the next few years. A total of 27 possible needs and issues were identified for IRMC and 31 for PAH, based on disparities in the data (differences in sub-populations, comparison to state, national or Healthy People 2030 goals, negative trends, or growing incidence). Two criteria, including accountable role and magnitude of the problem, were identified that the group would use to evaluate identified needs and issues. The Steering Committees for each hospital reviewed and discussed the identified potential priorities and created the final list for inclusion in the prioritization exercise which included 20 possible priorities for both IRMC and PAH. Table 7 identified the selection criteria.

Table 7: Prioritization Selection Criteria

		SCORING		
ITEM	DEFINITION	LOW (1)	MEDIUM (5)	HIGH (10)
Accountable Organization	The extent to which the issue is an important priority to address in this action planning effort for either the health system or the community	This is an important priority for the community to address	This is important but is not for this action planning effort	This is an important priority for the health system (s)
Magnitude of the Problem	The degree to which the problem leads to death, disability, or impared quality of life and/or impared quality of life and/or could be an epidemic based on the rate or % of population that is impacted by the issue	Low numbers of people affected; no risk for an epidemic	Moderate numbers/% of people affected and/ or moderate risk	High numbers/% of people affected and/or risk for epidemic

During the two weeks after the meeting, Steering Committee members completed the prioritization exercise using the Survey Monkey Internet survey tool to rate each of the needs and issues on a one to ten scale by each of the selected criteria listed above. Table 8 illustrates the needs of the service area ranked by the IRMC Steering Committee. Table 9 illustrates the needs of the service area ranked by the PAH Steering Committee. Items highlighted in yellow scored an 8 or higher for accountability suggesting the hospital or system should address.

Table 8: Indiana Regional Medical Center Prioritization Results

INDIANA REGIONAL MEDICAL CENTER PRIORITIES				
	ACCOUNTABILITY	MAGNITUDE	TOTAL	RANKING
Mental Health	7.00	10.00	17.00	1
Overweight/Obesity/Childhood Obesity	6.00	9.29	15.29	2
Substance Use/Youth Substance Use	5.44	8.33	13.78	3
Heart Disease	9.00	7.86	16.86	4
Diabetes	9.00	7.86	16.86	5
Physical Activity/Exercise (and its impact on other issues)	5.44	7.14	12.59	6
Access to Services (i.e. transportation/ copay/co-insurance)	4.89	6.83	11.72	7
Community Education	7.44	6.17	13.61	8
Preventative Care/Preventative Screenings	8.44	5.86	14.30	9
Tobacco Use	8.44	5.71	14.16	10
Poverty/Economy	4.78	5.14	9.92	11
Food Insecurity	1.89	5.00	6.89	12
Housing	4.78	5.00	9.78	13
Influenza and Pneumonia	8.33	4.33	12.67	14
Lyme Disease	6.78	4.17	10.94	15
Breast Cancer	10.00	3.14	13.14	16
Auto Accidents/Driving Under the Influence	4.33	2.60	6.93	17
Fall prevention	7.89	2.57	10.46	18
Early Prenatal Care/Breastfeeding /Non-Smoking Mothers During Pregnancy	7.22	2.40	9.62	19
Asthma	7.22	2.00	9.22	20

Table 9: Punxsutawney Area Hospital Prioritization Results

PUNXSUTAWNEY AREA HOSPITAL PRIORITIES				
	ACCOUNTABILITY	MAGNITUDE	TOTAL	RANKING
Chronic Disease Treatment and Prevention	9.00	7.78	16.78	1
Overweight/Obesity	4.55	9.44	13.99	2
Heart Disease/Diabetes	5.36	7.78	13.14	3
Community resource directory on available community programs and services (which would include education on several originally identified priority areas)	5.82	7.22	13.04	4
Lyme Disease	6.70	5.67	12.37	5
Health Literacy	7.20	5.11	12.31	6
Transportation	5.90	6.22	12.12	7
Elderly Care	5.50	6.22	11.72	8
Mental Health/Suicide/Social Isolation	5.82	5.56	11.37	9
Physical Activity/Exercise	2.70	7.89	10.59	10
Influenza and Pneumonia	4.30	6.22	10.52	11
Poverty	4.90	5.56	10.46	12
Prostate Cancer/Cancer Treatment	5.60	3.89	9.49	13
Substance Use/Drug use/Youth Substance Use	4.45	4.56	9.01	14
Asthma	5.20	3.56	8.76	15
Tobacco Use	2.90	5.67	8.57	16
Early Prenatal Care	4.36	4.00	8.36	17
Disconnected Youth	2.10	5.00	7.10	18
Low Birthweight Babies	5.50	1.56	7.06	19
Non-Smoking Mothers During Pregnancy	4.64	2.00	6.64	20

The above significant needs will be addressed in IRMC, PAH and system-wide Implementation Strategy, which will be published under a separate cover and accessible to the public. The leadership of each hospital reviewed the results from the prioritization exercise completed by the Steering Committee and selected the following priority areas to include in their Implementation Strategy based on need and availability of programs and services to address each area.

	INDIANA REGIONAL MEDICAL CENTER	PUNXSUTAWNEY AREA HOSPITAL	PA MOUNTAIN NETWORK
Mental Health/Suicide			✓
Substance/Drug Use			✓
Chronic Disease Treatment & Prevention *(Overweight/Obesity, Heart Disease/Diabetes)*	✓	✓	
Community Resource Directory on Available Community Programs & Services		✓	
Lyme disease		✓	
Health Literacy		✓	

Review & Approval

This report serves to identify and assess the health needs of the community served by IRMC and PAH. *This hospital's 2021 CHNA was approved on June 30, 2024, for its fiscal year ending on June 30, 2024.* This schedule complied with federal tax law requirements set forth in Internal Revenue Code section 501(c) and to satisfy the requirements set forth in IRS Notice 2011-52 and the Affordable Care Act for hospital facilities owned and operated by an organization described in Code 501(c)(3).

PAYS DATA	Indiana County							
MENTAL HEALTH AND SUBSTANCE ABUSE	2009	2011	2013	2015	2017	2019	2021	*2023
Alcohol Child/Adolescent Lifetime Use								
Grade 6	16.1%	20.1%	13.9%	25.7%	17.5%	20.1%	13.8%	13.5%
Grade 8	52.4%	37.1%	40.2%	39.7%	31.5%	30.9%	24.7%	21.7%
Grade 10	43.2%	56.4%	59.4%	60.1%	54.7%	50.7%	38.6%	37.2%
Grade 12	57.1%	65.7%	71.4%	65.8%	69.2%	61.9%	54.4%	42.2%
Overall	40.1%	45.3%	48.2%	52.8%	43.4%	40.0%	31.8%	28.7%
Marijuana Child/Adolescent Lifetime Use								
Grade 6	1.6%	0.4%	0.5%	1.7%	0.2%	1.8%	1.6%	1.6%
Grade 8	2.3%	6.2%	6.2%	6.3%	4.3%	7.6%	5.1%	5.8%
Grade 10	18.2%	18.7%	22.6%	20.9%	18.9%	18.2%	12.1%	13.5%
Grade 12	14.2%	35.0%	32.4%	29.6%	34.7%	33.0%	24.7%	22.9%
Overall	8.6%	15.3%	16.4%	17.8%	14.4%	14.4%	14.4%	11.0%
% of Children/Adolescents Who Drove After Drinking								
Grade 6	0.0%	0.0%	0.3%	1.2%	0.9%	0.5%	0.0%	
Grade 8	0.0%	1.5%	0.6%	1.0%	1.2%	1.6%	0.4%	
Grade 10	0.0%	4.7%	1.5%	2.6%	2.1%	1.5%	0.8%	
Grade 12	2.2%	12.4%	10.6%	5.6%	8.5%	5.8%	4.9%	
Overall	0.5%	4.7%	3.5%	3.1%	3.1%	2.2%	1.4%	
% of Children/Adolescents Who Drove After Using Marijuana								
Grade 6	0.0%	0.0%	0.3%	1.2%	0.9%	0.2%	0.0%	
Grade 8	0.0%	1.1%	0.2%	0.0%	0.5%	1.1%	0.0%	
Grade 10	2.3%	1.1%	2.3%	2.6%	1.9%	1.5%	0.4%	
Grade 12	4.3%	9.8%	10.0%	7.7%	12.1%	7.8%	4.1%	
Overall	1.6%	3.0%	3.4%	3.7%	3.7%	2.5%	1.0%	
Pain Reliever (Prescription Narcotics) Child/Adolescent Lifetime Use								
Grade 6	0.0%	2.4%	1.0%	1.7%	1.9%	2.4%	1.8%	2.2%
Grade 8	0.0%	2.6%	4.4%	3.8%	2.3%	1.9%	3.4%	2.9%
Grade 10	13.6%	5.3%	9.8%	8.8%	7.0%	3.5%	3.6%	3.8%
Grade 12	10.2%	14.0%	12.4%	12.0%	10.8%	7.3%	4.8%	2.1%
Overall	6.6%	6.0%	7.3%	7.7%	5.4%	3.6%	3.4%	2.8%

* indicated preliminary data accessed March 2023. It was only available at the County level and only for the 3 indicators here that have data: lifetime alcohol use, lifetime marijuana use, and lifetime prescription use

For Indiana County the Districts participating online and in this preliminary report are:
Homer-Center, Indiana Area, Marion Center Area, Penns Manor Area, Purchase Line, River Valley and United.

For Jefferson County it only listed School A and School B totals were calculated from an average since they were not available in the current reports. The online report lets you hover over sections to get numbers to one decimal point, and these were used to calculate that numbers in this spreadsheet. The printed version only has whole numbers.

Indiana County Prelim PAYS: https://reporting.alchemer.com/r/601923_65a1ad4bdad6d2.94056821

Jefferson County Prelim PAYS:
https://surveys.bach-harrison.com/r/601923_65a5bb451eb540.32708055

Trend 2021 +/-/=	PA Comp 2021	MTF Comp 2021	Jefferson County 2009	2011	2013	2015	2017	2019	2021	*2023	Trend +/-/=	PA 2021	MTF 2021
-	-		14.3%	26.6%	18.1%	16.7%	20.2%	16.1%	18.2%	12.0%	+	+	
-	-	+	40.1%	40.4%	42.1%	39.8%	40.6%	42.8%	41.5%	31.6%	+	+	+
-	-	+	65.2%	57.2%	65.1%	57.9%	64.7%	56.4%	58.9%	50.0%	-	+	+
-	-	+	64.9%	63.2%	68.0%	73.5%	67.2%	63.6%	62.0%	54.2%	-	+	+
-	-		50.9%	48.8%	50.3%	46.7%	48.1%	44.0%	44.3%	37.0%	-	+	
=	+		0.0%	2.3%	0.4%	1.7%	1.8%	0.8%	0.7%	4.7%	+	-	
+	-	-	5.6%	4.3%	4.9%	6.5%	9.9%	8.8%	6.3%	6.8%	+	+	-
-	-	-	28.1%	21.7%	2.2%	18.5%	22.9%	27.7%	24.0%	21.8%	-	+	+
+	-	-	28.2%	27.9%	34.1%	33.9%	32.3%	30.4%	40.8%	28.2%	+	+	+
+	+		18.2%	15.4%	15.1%	14.8%	16.6%	16.6%	17.1%	15.4%	-	+	
=	-		0.8%	0.0%	0.6%	0.0%	2.5%	0.0%	0.4%		-	+	
+	+		0.5%	1.8%	0.0%	0.4%	3.4%	2.2%	0.4%		-	+	
+	+		7.1%	3.3%	2.4%	2.0%	1.6%	5.6%	3.0%		-	+	
+	-		11.6%	10.9%	13.0%	7.4%	7.7%	5.7%	7.6%		-	+	
+	-		5.7%	4.5%	3.9%	2.6%	3.7%	3.3%	2.6%		-	+	
=	-		0.0%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%		=	-	
=	-		0.5%	0.0%	0.0%	0.7%	2.3%	1.3%	0.0%		-	-	
-	-		6.4%	5.9%	1.8%	1.2%	1.6%	5.6%	2.2%		-	+	
-	-		10.7%	9.2%	7.9%	10.9%	8.4%	5.6%	9.1%		-	+	
-	-		5.1%	4.3%	2.5%	3.4%	3.1%	3.1%	2.5%		-	+	
+	-		0.8%	2.3%	1.7%	1.0%	2.8%	3.7%	3.1%	3.9%	+	=	
+	+		6.6%	3.1%	2.9%	4.8%	6.4%	3.7%	4.0%	6.8%	-	+	
-	+		13.3%	6.7%	6.5%	7.7%	6.8%	7.6%	8.0%	6.8%	-	+	
-	+	+	9.6%	15.4%	13.4%	10.9%	7.6%	5.6%	5.9%	13.8%	-	+	+
-	+		8.7%	7.3%	6.1%	6.0%	5.9%	5.2%	5.3%	7.8%	-	+	

PAYS County Early Reports

This link will direct you to county-level reports containing a variety of information to provide schools, communities, and families with an early snapshot of the results from the survey so that they can begin to act upon it. These reports contain information on student mental health, substance use behaviors, and other important data. Only those counties that took part in the survey online and who had a minimum of two participating districts have a report available. If a district within a county took part via paper/pencil, those results are not included in the county reports. Additionally, please note that this is meant to be preliminary data; there may be some slight changes in the final number report in the Full Summary Reports that will be released in May. This would be due to the addition of additional data from Districts and Other Schools in the County who took part using paper/pencil.

These reports contain selected data to provide schools with an early snapshot of their students' responses. Only those counties that took part in the survey online and who had a minimum of two participating districts have a report available. If a district within a county took part via paper/pencil, those results are not included in the county reports. Additionally, please note that this is meant to be preliminary data; there may be some slight changes in the final number report in the Full Summary Reports that will be released in May. This would be due to the addition of additional data from Districts and Other Schools in the County who took part using paper/pencil.