PUNXSUTAWNEY AREA HOSPITAL

Community Health Needs Assessment
2024 Year 1, 6 Month Evaluation
January – June 2025

Executive Summary

The PAH CHNA was approved by the board at the end of June 2024. At that time the hospital affirmed its Implementation Plan for 2024-2027. Data was collected for the last 6 months related to Punxsutawney Area Hospital's Implementation Strategy. Data presented in this report is for January to June 2025. PAH retained the services of Strategy Solutions, Inc. to produce a summary of the data collected.

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

Objective A: Increase awareness of Lyme Disease and available community resources
Objective B: Conduct annual blood screening program
Objective C: Provide education to the community

Hosted 1 education session on diabetes and healthy eating with 25 attendees	Resources available in lobby (refilled twice) and on website (made 3 posts)	Annual blood screening scheduled for July 2025	Broadening relationship with PCPS for screenings, 74 providers participated

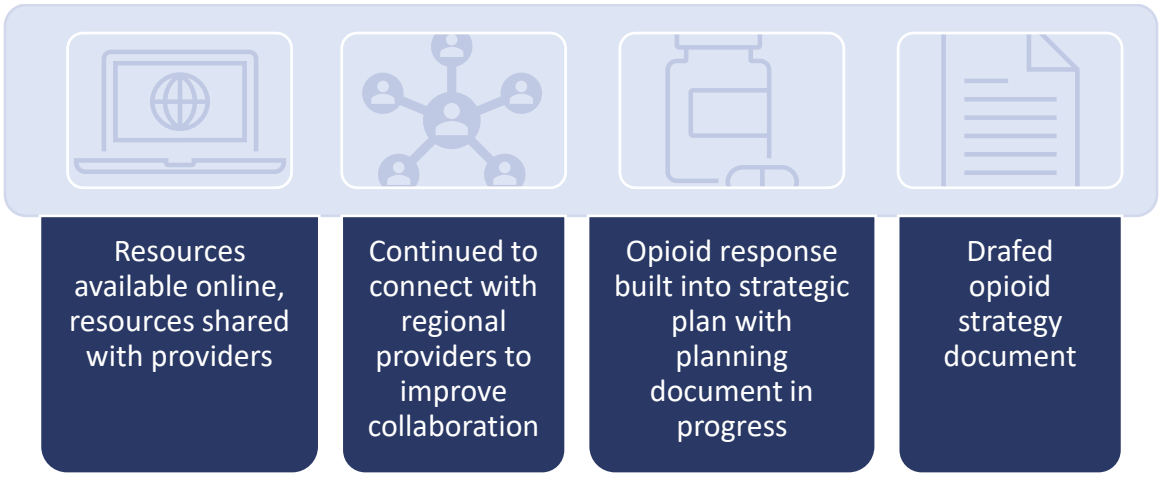
Goal 2: Increase awareness and prevention of Cardiovascular Disease (heart disease, high blood pressure, etc.)

Objective A: Decrease readmissions through better chronic care management
Objective B: Offer community blood screening
Objective C: Promote the hospital's Congestive Heart Failure (CHF) Clinic and increase the number of patients utilizing the clinic annually
Objective D: Reach out to the American Heart Association to support their regional and national initiatives
Objective E: Manage high risk population
Objective F: Provide education to the community

Home Health working on program to decrease readmissions	Blood screening scheduled in July 2025, 28 providers gathered to discuss need based on past screening	Information on Congestive Heart Failure Clinic sent twice to 90 providers	Distributed 2,000 handouts on diabetes, high blood pressure, cholesterol and heart failure	Held 6 sessions at Women's Clinic with total of 22 participants

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

Objective A: Identify health and human service in the local region to partner
Objective B: Online resources made available through the hospital's webpage
Objective C: Connect to regional players for better collaboration of services
Objective D: Provide resource list to physicians and providers in the region
Objective E: State data provided through the webpage and shared with collaborative partners
Objective F: Collaborative grant identified
Objective G: Create a PMCN strategy to improve regional efforts
Objective H: Create an opioid strategy document to address local needs



Goal 4: Improve access to mental health services and supports

Objective A: ER expansion project
Objective B: Develop a database of available community services
Objective C: Establish relationship with IRMC for new behavioral health unit
Objective D: Expand services through IRMC's Integrated Behavioral Health Building
Objective E: Decrease the number of suicides
Objective F: Collaborate with Clearfield Jefferson Drug and Alcohol Commission to make the PREP Program available
Objective G: Serve community need by supporting IRMC's BH Outreach Program to connect emergency department BH patients with outpatient
Objective H: Increase access to inpatient rehab
Objective I: Increase awareness of available services

Working in ER expansion project	Database of available resources developed	IRMC's Behavioral Health Unit opened in April	6 referrals made to PREP program, 3 staff educated on program	14 individuals diagnosed at risk for suicide

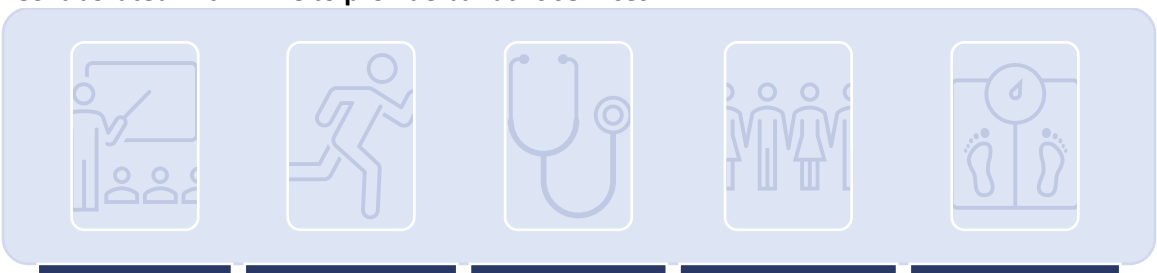
Goal 5: Increase access to resources and health literacy

Objective A: Create community health resource directory
Objective B: Improve health literacy

Database of resources created and routinely updated	Screened 521/558 patients for rate of 93.4%	100 patients referred to social services	450 students participated in Wellness Days	Assisted 36 patients who qualify for financial assistance or were un/under insured

Goal 6: Increase awareness and strategies to reduce obesity and maintain a healthy weight

Objective A: Provide education, resources and support to the community
Objective B: Improve the quality of food available at PAH
Objective C: Collaborated with IRMC to provide bariatric services



6 seminars with an average of 20 participants per session	450 students and 21 faculty participated in Wellness Day	1 education session on importance of exercise with 20 attendees	Teacher screenings and National Night Out scheduled for August 2025	7 patients referred for bariatric services

Methodology

PAH conducted an evaluation of the Community Health Needs Assessment implementation strategies that have been underway over the first year of the implementation plan (January through June 2025). The evaluation process included submission and review of the outcomes and impact data that was tracked and reported during this timeframe.

Progress Reports and Evaluation Discussion

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

- PAH has offered educational programs and made resources available
  - Held 1 education session focused on diabetes and healthy eating with 25 attendees
  - PAH has continued to connect people to resources, making online resources available, making 3 posts during this timeframe
  - PAH continues to make resources available in the lobby, on the website and at community events. Brochure holders in the lobby were refilled twice.
- PAH offered community blood screenings
  - Blood screening scheduled for July 2025
  - PAH continues to strengthen collaborative efforts with stakeholders in the blood screening program, with 74 participating providers
- PAH provided education to the community
  - Held 1 education session focused on diabetes and healthy eating with 25 attendees

Goal 2: Increase awareness and prevention of Cardiovascular Disease (heart disease, high blood pressure, etc.)

- PAH is working to decrease readmissions through better chronic care management
  - Home Health is working on a program to decrease readmissions through a telehealth system
  - Hospital has process in place to track and verify patients participation in their chronic care management with PCP, which is ongoing
- PAH offered community blood screening
  - Screening scheduled for July 2025
  - In March, 28 providers attended a meeting to discuss community needs based on information gathered at blood screenings
- PAH will promote the Congestive Heart Failure (CHF)
  - There were delays based on CHF providers employment status changing with PAH
  - Success stories were shared twice with 90 providers across the region
- PAH has engaged in dialogue with the American Heart Association and are utilizing the references shared
  - PAH has engaged in ongoing dialogue with the American Heart Association
  - Materials were printed and shared at 2 events
  - Delivered 1 education session on diabetes and healthy eating with 25 attendees
  - 2,000 handouts were distributed on diabetes, high blood pressure, cholesterol and heart failure
- PAH is managing high risk populations
  - Blood screening scheduled for July 2025
  - Completed evaluation of materials sent to referring physicians and will send information quarterly
- PAH provides education to the community
  - Held 1 education session with 25 attendees on diabetes and healthy eating
  - Held 1 education session with 12 attendees on pulmonology and asthma
  - Held 6 sessions at the Women's Clinic with a total of 22 participants

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

- PAH developed a resource guide with local contacts for professionals and will update quarterly
- PAH makes resources available through the hospitals' webpage
  - Redesigned the webpage to adequately provide educational resources, with materials identified just not yet added to the website
  - Has made web-based resources available
  - PAH is monitoring website traffic for engagement of posted links
- PAH continues to connect with regional players to improve collaboration
- PAH completed a resource list for physicians and providers in the region and continues to review to ensure resources and updated and available
- PAH continues to look for collaborative grant opportunites with key community stakeholders
- Pennsylvania Mountains Care Network includes opioids as a priority to address in its strategic plan
- PAH has drafted an opioid strategy document to address local needs which will be shared with collaborative partners and opioid stakeholders

Goal 4: Improve access to mental health services and supports

- PAH is working on the ER expansion project and evaluating numbers of patients identifies for work flow in the new ED
- PAH created a database of available community services and resources to assist patients with outpatient and other services and will update quarterly
- PAH is working to establish a referral process to admit patients to IRMC's behavioral health unit, which opened in April
- Through a collaboration with Clearfield Jefferson Drug and Alcohol Commission the PREP Program is available at PAH with 6 referrals made
- 14 individuals had a suicide diagnosis (9 ER, 1 inpatient, 4 observation)
- PAH is working with community providers to develop opioid prescribing guidelines
- PAH has made 4 connections with other facilitates to increase patient access to inpatient rehab
- PAH has created a collaborative resource guide between PAH, IRMC and ACMH with local contacts for professionals

Goal 5: Increase access to resources and health literacy

- PAH created a community health resource directory of available community resources that is available online and a print copy is provided to patients
- PAH is asking questions related to SDOH to inpatients and providing a resource guide and supplemental food if food is needed
    - 521/558 screened
        - 4 food insecurity
        - 3 housing instability
        - 2 transportation
        - 3 utility difficulty
        - 21 interpersonal safety
    - 110 patients referred to social services
        - 14 care coordination
        - 6 food
        - 4 housing
        - 3 mental health outpatient
        - 27 resource education/referral
        - 2 safety concerns
        - 6 SNF/PCH placement referral
        - 11 insurance coordination
        - 7 chronic care management
        - 7 financial resources
        - 16 transportation
        - 2 SUD
        - 5 medication assistance

Goal 5: Increase access to resources and health literacy

- PAH is committed to improving health literacy
  - Held 12 events with a total of 1,000 attendees
  - Educated children at the Punxsutawney Area School District through Wellness Days for students in grades 4-6, reaching 450 kids
  - Partnered with IUP to deliver 2 programs with 14 participants
  - Assisted 36 patients who qualify for financial assistance or were uninsured or underinsured
  - Ensured all print, digital and social messaging is accessible and written at a grade level the general population can read and understand

Goal 6: Increase awareness and strategies to reduce obesity and maintain a healthy weight

- PAH provided education, resources and support to the community
  - Held 6 seminars with an average of 20 attendees at each
  - There was a delay in the dietician creating recipe guides and offering consults with a dietician
  - 4 different resources shared from the American Heart Association
  - Collaborated with Punxsutawney Area School District to provide Wellness Days for students and faculty, serving 450 kids and 21 faculty
  - Will collaborate with Punxsutawney Area School District to provide blood pressure and stress screening for teachers in August 2025
  - PAH will partner for National Night Out in August 2025
- PAH is working to improve the quality of food available at PAH
  - Dietician will review menus and meals available through food service in August 2025 to ensure PAH is providing healthy meals and options
- Collaborated with IRMC to provide bariatric services
  - 7 referrals made for bariatric services
    - 1 scheduled for medical weight management
    - 2 seen by surgical weight management for initial visit