

Executive Summary

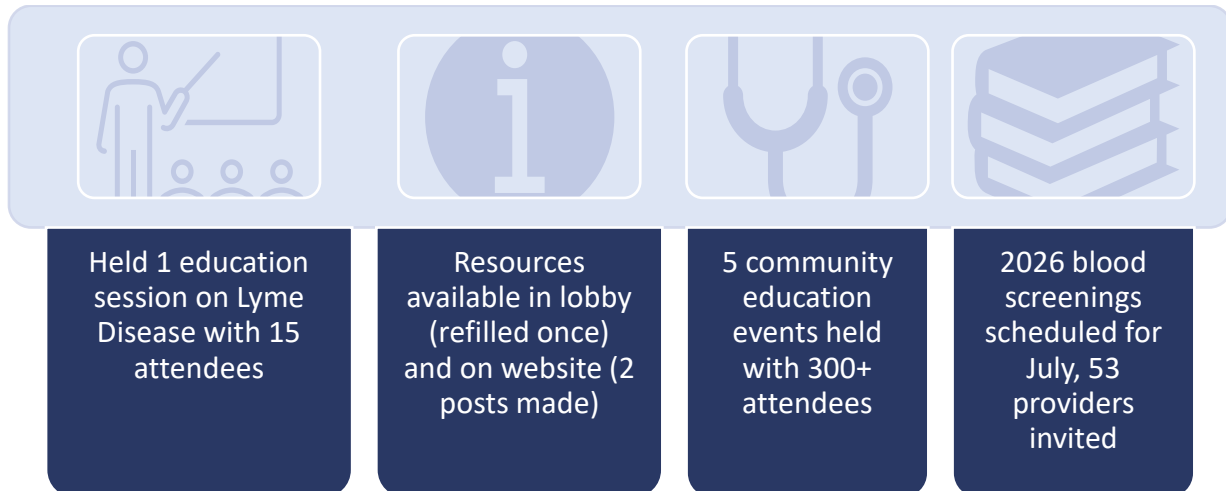
The PAH CHNA was approved by the board at the end of June 2024. At that time the hospital affirmed its Implementation Plan for 2024-2027. Data was collected for the second 6 months of year 2 related to Punxsutawney Area Hospital's Implementation Strategy. Data presented in this report is for January to June 2026. 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



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

Objective A: Decrease readmissions through better chronic care management

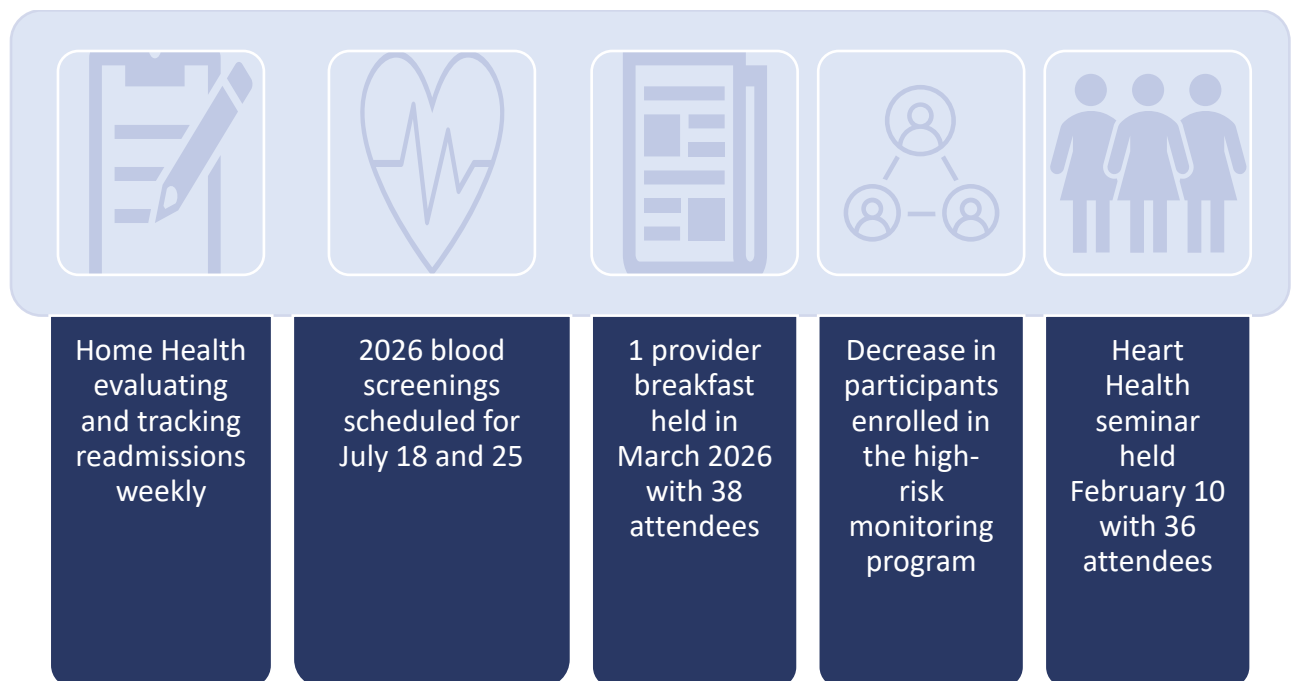
Objective B: Offer community blood screening

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



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

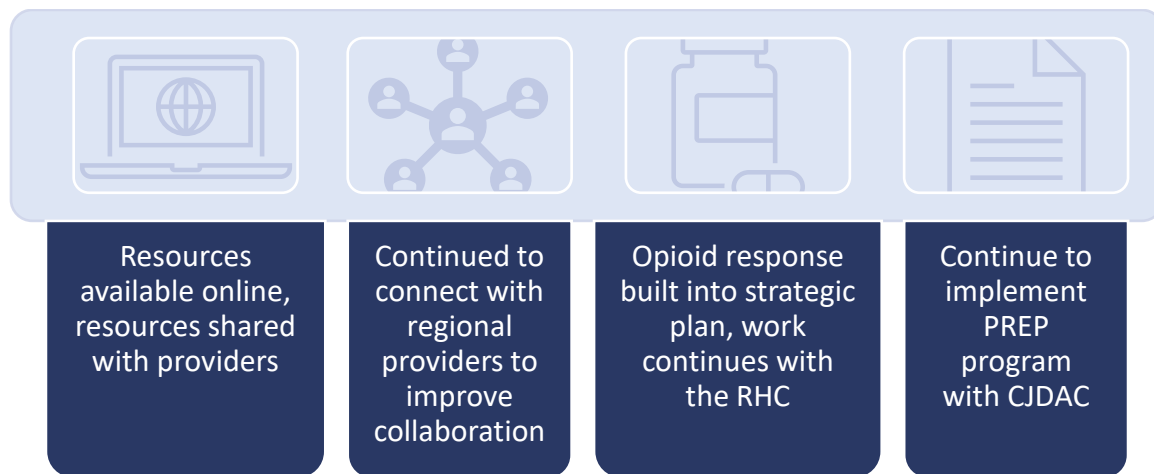
Objective D: Provide resource list to physicians and providers in the region

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

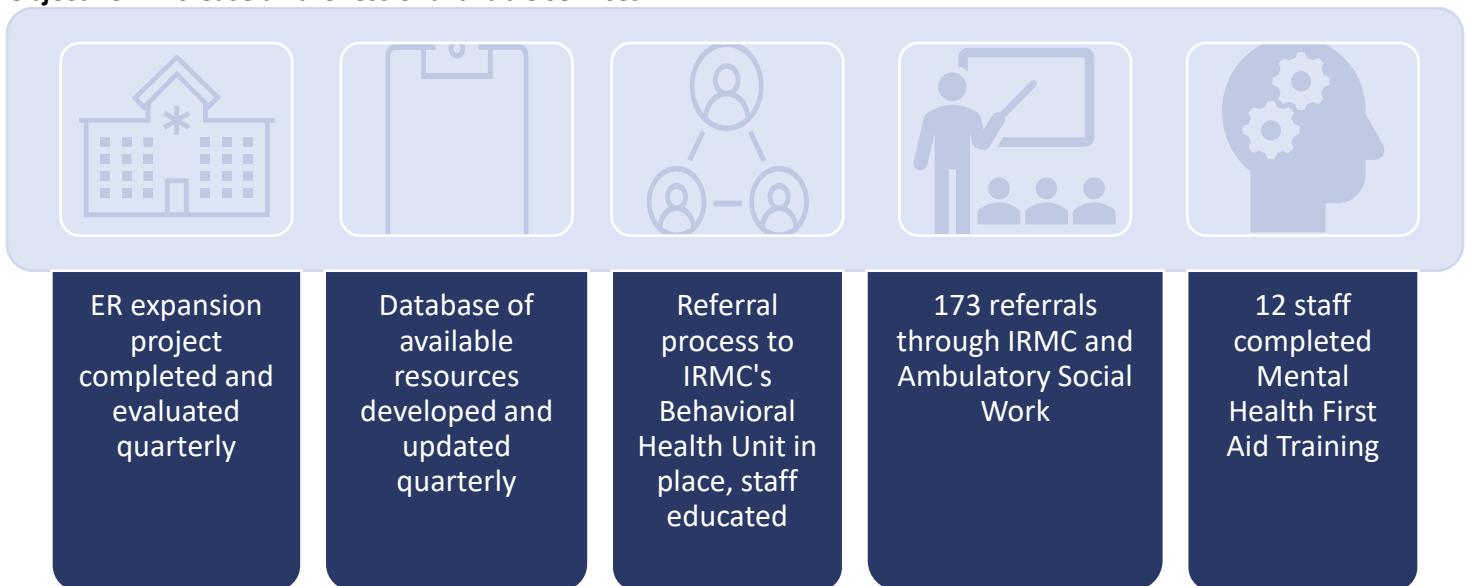
Objective E: Decrease the number of suicides

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

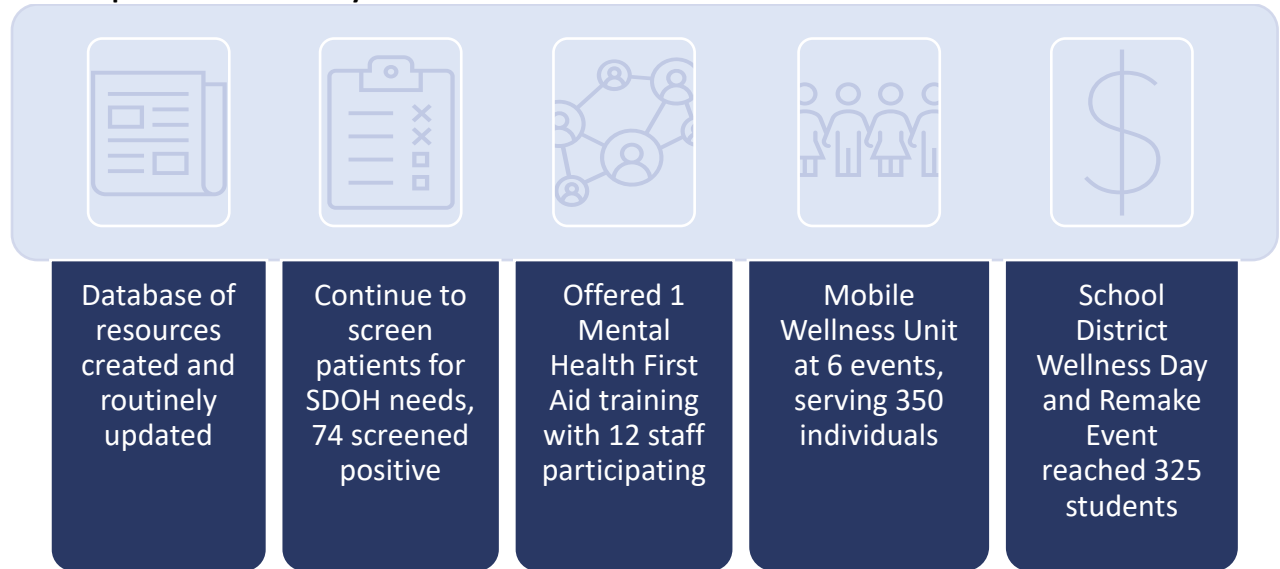
Objective I: Increase awareness of available services



Goal 5: Increase access to resources and health literacy

Objective A: Create community health resource directory

Objective B: Improve health literacy

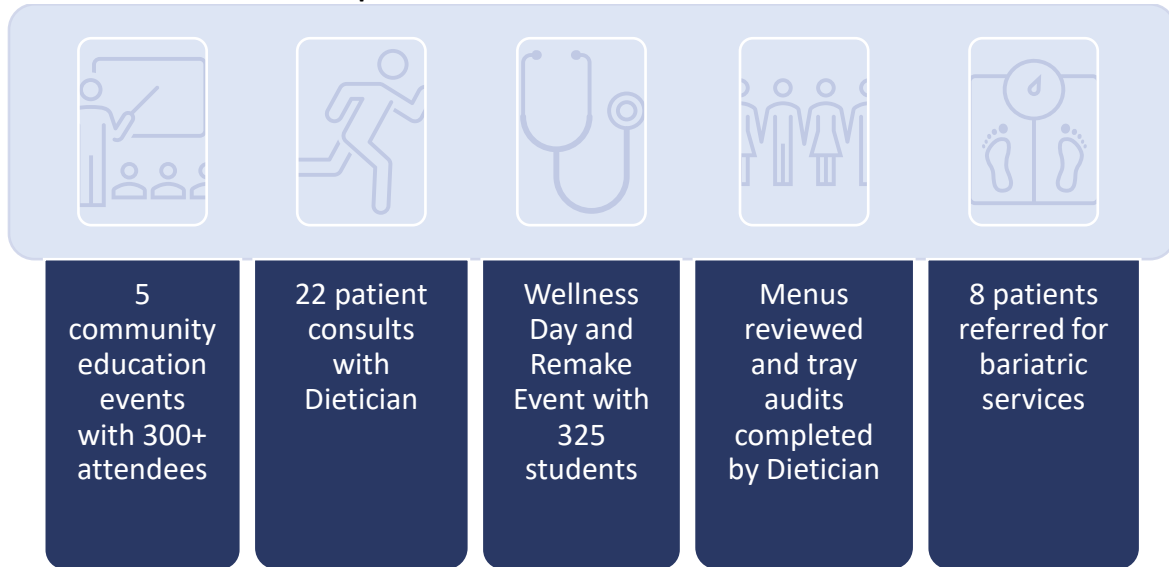


Goal 6: Increase awareness and strategies to reduce obesity and maintain a healthy weight

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



Methodology

PAH conducted an evaluation of the Community Health Needs Assessment implementation strategies that have been underway during the second half of year 2 of the implementation plan (January through June 2026). 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 Lyme Disease with 15 attendees
 - Made 2 posts sharing online resources during this timeframe
 - Resources remain available in the lobby, on the website and at community events; lobby materials were replenished once
- PAH is preparing for the 2026 community blood screening program
 - The 2026 blood screenings are scheduled for July 18 and July 25
 - Permission to be listed as a participating provider for the 2026 screening was sent to 53 providers
 - Participant follow-up tracking, the registration opt-out and the post-event provider survey are all tied to the July 2026 events
- PAH provided education to the community
 - Heart Health talk, February 10 – 36 attendees



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

- Colorectal health talk, March 10 – 17 attendees
- National Hospital Week kickoff on community health trends and available resources, May 11 – 47 attendees
- Congestive Heart Failure booth at the Barclay Square Festival, June 29 – 100+ attendees
- Heart Health booth at the Barclay Square Festival, June 30 – 100+ 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
 - Readmissions are evaluated and tracked on a weekly basis
 - The process to track and verify patient participation in chronic care management with their PCP remains in progress
- PAH is preparing for the 2026 community blood screening
 - The 2026 blood screenings are scheduled for July 18 and July 25
 - Supplemental materials, post-event wrap-around education and five-year participant tracking are all tied to the July 2026 events
 - Held 1 provider breakfast in March 2026 with 38 attendees
- PAH will promote the Congestive Heart Failure (CHF) Clinic
 - No progress made towards this objective during this timeframe
- PAH has engaged in dialogue with the American Heart Association and is utilizing the resources shared
 - Communicated with the American Heart Association one time
 - Visited the AHA website twice for resources
 - Delivered 1 educational program, the Heart Health event held February 10
 - Continues to use the registry of high-risk patients to increase PCP follow-ups
 - AHA resources continue to be made available to patients on an ongoing basis
- PAH is managing high risk populations
 - Number of participants enrolled in the high-risk monitoring program decreased; new approaches to promote participation are being explored
 - Additional clinical information for referring physicians will be provided in conjunction with the July 2026 screening
 - Tracking high-risk patients through to physician follow-up remains challenged by two separate EMRs; a new EMR is scheduled to be in place in September 2026
- PAH provides education to the community
 - Held 1 Heart Health seminar on February 10 with 36 attendees

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 continues to disperse the resource guide with local contacts for professionals on a regular basis
 - Patients are evaluated for social determinants of health (SDOH) needs and resources are provided when a need is identified
- PAH makes resources available through the hospital's webpage



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

- Website updated quarterly
 - Web-based resources identified and linked
 - Engagement is tracked by individual post
- PAH continues to connect with regional players to improve collaboration
 - Relationships have continued with identified partners
- PAH maintains a resource list for physicians and providers in the region, completed and updated quarterly
- Communication with collaborative partners regarding available state data and resources was completed in March 2026
- PAH continues to research collaborative grant opportunities with key community stakeholders on an ongoing basis
- PAH initiated conversation on a regional approach to the opioid crisis
 - IRMC has included the opioid priority in its plan; operating across two counties remains a challenge because several groups and resources are county based
- PAH is continuing to work with the RHC and has the PREP program in place
 - Additional meetings are being held with the Clearfield Jefferson Drug and Alcohol Commission (CJDAC)

Goal 4: Improve access to mental health services and supports

- ER expansion project completed, with evaluation ongoing on a quarterly basis
- PAH maintains a database of available community services and resources to assist patients with outpatient and other services, updated quarterly
- PAH continues its relationship with IRMC for the behavioral health unit
 - Hospital staff educated on available services
 - Referral process and direct admit process in place
 - Informal marketing of the facility created
 - Expanding services through IRMC's Integrated Behavioral Health Building continues to be challenged by facility capacity and insurance-related hurdles
 - Referrals made through IRMC are tracked with Ambulatory Social Work referrals and are reported below
 - Admission, level of service and length-of-stay data for the behavioral health unit were not available for this period
- PAH is working to decrease the number of suicides
 - Suicide risk assessment created and implemented; no report can currently be run in Meditech, which may be possible with Cerner
 - The process to manage patients screened at risk is ongoing
- Through a collaboration with the Clearfield Jefferson Drug and Alcohol Commission the PREP Program is available at PAH
 - Referral tracking is taking place, though referral counts were not available for this period
 - 12 staff completed Mental Health First Aid Training
- IRMC and Ambulatory Social Work received 173 referrals



Goal 4: Improve access to mental health services and supports

- Chronic care management was the top need (44), followed by care coordination (25), transportation (20) and resource education/referral (18)
- 19 of the 173 were cancer program assessments that identified no need, leaving 154 referrals with an identified need
- Punxsutawney PCPs were the largest referral source (112), followed by the PPG cancer program (26)
- PAH continues to work to increase access to inpatient rehab
 - No additional relationships with facilities were formed during this timeframe
- The collaborative resource guide developed with IRMC and ACMH is updated quarterly

Goal 5: Increase access to resources and health literacy

- PAH maintains a community health resource directory of available community resources, available online with a print copy provided to patients
- PAH is asking questions related to SDOH of inpatients and providing a resource guide and supplemental food if food is needed
 - All inpatients screened
 - 74 screened positive for a need
 - 63 interpersonal safety
 - 7 transportation
 - 2 housing instability
 - 1 food insecurity
 - 1 utility difficulty
- PAH is committed to improving health literacy
 - Mobile wellness unit attended 6 events and served 350 individuals
 - Punxsutawney Area School District Wellness Day for grades K-6 held in March 2026 with 150 students
 - Punxsutawney Area School District Remake Event for grades K-6 held in May 2026 with 175 students
 - Offered 1 Mental Health First Aid training to staff with a total of 12 participants
 - All print, digital and social messaging continues to be reviewed quarterly to ensure it is accessible and written at a grade level the general population can read and understand
 - Counts of patients assisted through financial assistance, and of the expansion of SDOH screening into the ER, were not available for this period



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

- PAH provided education, resources and support to the community
 - Heart Health talk, February 10 – 36 attendees
 - Colorectal health talk, March 10 – 17 attendees
 - National Hospital Week kickoff, May 11 – 47 attendees
 - Congestive Heart Failure and Heart Health booths at the Barclay Square Festival, June 29 and June 30 – 100+ attendees at each
 - School District Wellness Day, March 2026 – 150 students, and Remake Event, May 2026 – 175 students, both including education on the importance of exercise
 - Utilized American Heart Association resources for recipe guides and for healthy shopping and food label education at the Women’s Health Event with 55 attendees
 - 22 outpatient consults with the dietician; no weight loss data available
 - Blood pressure and stress screening for teachers was not completed this period and is scheduled for August 2026
- PAH is working to improve the quality of food available at PAH
 - Dietician completed a review of menus and meals available through food service, and tray audits were completed
- Collaborated with IRMC to provide bariatric services
 - 8 referrals made for bariatric services
 - 2 received services; neither has continued to follow up, so no weight loss data is available