Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here: https://hscrc.maryland.gov/Pages/init_cb.aspx

In this reporting tool, responses are mandatory unless specifically marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for the fiscal year.

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: UPMC Western Maryland	◉	○	
Your hospital's ID is: 210027	◉	○	
Your hospital is part of the hospital system called UPMC.	◉	○	
The primary Narrative contact at your hospital is Jennifer Thomas	◉	○	
The primary Narrative contact email address at your hospital is thomasj39@upmc.edu	◉	○	
The primary Financial contact at your hospital is Amber Ruble	◉	○	
The primary Financial email at your hospital is rublear@upmc.edu	◉	○	

Q4. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q5. Please select the community health statistics that your hospital uses in its community benefit efforts.

- [x] Median household income
- [x] Percentage below federal poverty line (FPL)
- [x] Percent uninsured
- [ ] Percent with public health insurance
- [x] Percent with Medicaid
- [ ] Mean travel time to work
- [ ] Percent speaking language other than English at home
- [ ] Race: percent white
- [ ] Race: percent black
- [ ] Ethnicity: percent Hispanic or Latino
- [x] Life expectancy
- [ ] Crude death rate
- [ ] Other

Q6. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

https://www.countyhealthrankings.org/explore-health-rankings/maryland/allegany?year=2022 (Smoking, obesity, physical inactivity, poor physical and mental health days)

Q7. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Q8. Section I - General Info Part 2 - Community Benefit Service Area

Q9. Please select the county or counties located in your hospital's CBSA.

- [x] Allegany County
- [ ] Anne Arundel County
- [ ] Baltimore City
- [ ] Baltimore County
- [ ] Calvert County
- [ ] Caroline County
- [ ] Carroll County
- [ ] Cecil County
- [ ] Charles County
- [ ] Dorchester County
- [ ] Frederick County
- [ ] Garrett County
- [ ] Harford County
- [ ] Howard County
- [ ] Kent County
- [ ] Montgomery County
- [ ] Prince George's County
- [ ] Queen Anne's County
- [ ] Somerset County
- [ ] St. Mary's County
- [ ] Talbot County
- [ ] Washington County
- [ ] Wicomico County
- [ ] Worcester County

Q10. Please check all Allegany County ZIP codes located in your hospital's CBSA.

- [x] 21501
- [x] 21502
- [x] 21503
- [x] 21504
- [x] 21505
- [x] 21521
- [x] 21524
- [x] 21528
- [x] 21529
- [x] 21530
- [x] 21532
- [x] 21539
- [x] 21540
- [x] 21542
- [x] 21543
- [x] 21545
- [x] 21555
- [x] 21556
- [x] 21557
- [x] 21560
- [x] 21562
- [x] 21750
- [x] 21766

Q11. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q24. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q32. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q33. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

- [ ]

Based on ZIP codes in your Financial Assistance Policy. Please describe.

- [ ] Based on ZIP codes in your global budget revenue agreement. Please describe.
- [x] Based on patterns of utilization. Please describe.

UPMC Western Maryland is the only community hospital in the county. Since over 70% of our patients reside in Allegany County, we selected the county as the Community Benefit Service Area.

- [ ] Other. Please describe.

Q35. Provide a link to your hospital's mission statement.

https://www.wmhs.com/about/

Q36. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Q37. Section II - CHNAs and Stakeholder Involvement Part 1 - Timing & Format

Q38.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (●) Yes
- ( ) No

Q39. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q40. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

6/30/2021

Q41. Please provide a link to your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

https://www.upmc.com/about/community-commitment/community-health-needs-assessment

Q42. Please upload your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

western-central-pa-and-maryland-chna-report.pdf
7.8MB
application/pdf

Q43. Section II - CHNAs and Stakeholder Involvement Part 2 - Internal CHNA Partners

Q44. Please use the table below to tell us about the internal partners involved in your most recent CHNA development.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/ Population Health Director (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☑	☑	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (facility level)	☐	☐	☑	☐	☑	☑	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (facility level)	☐	☐	☑	☐	☑	☑	☑	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (system level)	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☐	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (system level)	☐	☐	☐	☑	☑	☑	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Physician(s)	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Nurse(s)	☐	☐	☑	☐	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Social Workers	☐	☐	☑	☐	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Hospital Advisory Board	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal HCB Partners

Q46. Please use the table below to tell us about the internal partners involved in your community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☐	☑	☑	☑	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☐	☐	☑	☐	☐	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
Community Benefit staff (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Nurse(s)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
Social Workers	☐	☐	☐	☐	☐	☐	☐	☑	☑	☐	
Hospital Advisory Board	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Other (specify) Community Health Workers	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	

Q47. Section II - CHNAs and Stakeholder Involvement Part 4 - Meaningful Engagement

Q48. Community participation and meaningful engagement is an essential component to changing health system behavior, activating partnerships that improve health outcomes and sustaining community ownership and investment in programs. Please use the table below to tell us about the external partners involved in your most recent CHNA. In the first column, select and describe the external participants. In the second column, select the level of community engagement for each participant. In the third column, select the recommended practices that each stakeholder was engaged in. The Maryland Hospital Association worked with the HSCRC to develop this list of eight recommended practices for engaging patients and communities in the CHNA process.

Refer to the FY 2022 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2022.

	Level of Community Engagement	Recommended Practices

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Department -- Please list the Local Health Departments here: Allegany County Health Department	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Improvement Coalition -- Please list the LHICs here: Allegany County Health Planning Coalition	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Maryland Department of Health	☑	☐	☐	☐	☑	☑	☐	☐	☐	☐	☑	☐	☐	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other State Agencies -- Please list the agencies here: Department of Social Services, University of Maryland Extension,	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Govt. Organizations -- Please list the organizations here: Allegany County Human Resources Development Commission, Allegany County Local Management Board, County United Way, Cumberland Housing Alliance, Allegany County Public Library System, Allegany County Chamber of Commerce,	☑	☑	☑	☑	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Faith-Based Organizations	☑	☐	☑	☑	☐	☐	☑	☑	☐	☐	☐	☑	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here: Allegany County Public Schools,	☑	☐	☑	☑	☐	☐	☑	☐	☐	☐	☑	☑	☐	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here: Allegany College of Maryland, Frostburg State University	☑	☐	☑	☑	☐	☐	☑	☐	☐	☐	☑	☑	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here: Archway Station, HOPE Station	☐	☐	☑	☑	☐	☐	☑	☑	☑	☐	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here: Associated Charities	☑	☐	☑	☐	☐	☐	☑	☑	☐	☑	☑	☐	☐	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here: N/A	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here: Cumberland YMCA, Western Maryland Food Bank, Community Trust Foundation	☑	☐	☑	☑	☐	☑	☑	☐	☐	☑	☑	☑	☑	☑
Consumer/Public Advocacy Organizations -- Please list the organizations here: Janes Place, Family Crisis Resource Center	☑	☑	☐	☑	☐	☐	☑	☑	☑	☐	☑	☐	☐	☑
Other -- If any other people or organizations were involved, please list them here: Tri-State Community Health Center, Area Health Education Center West, Mountain Laurel Medical Center, Gonzaga Pain Management	☑	☑	☑	☑	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑

Q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

Q50. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q51. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

3/24/2022

Q52. Please provide a link to your hospital's CHNA implementation strategy.

https://www.wmhs.com/about/chna

Q53. Please upload your hospital's CHNA implementation strategy.

UPMC Western Maryland Progress Report and Implementation Plan_FINAL TO BOARD.pdf
1.1MB
application/pdf

Q54. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q55. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q56. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

2022 Regional Progress Report_West Central Pennsylvania and Maryland_FINAL TO BOARD.pdf
5.7MB
application/pdf

Q57. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q58.
Using the checkboxes below, select the Community Health Needs identified in your most recent CHNA that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q59. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q60. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

UPMC Western Maryland's Center for Clinical Resources (CCR) addresses chronic disease management and financial assistance for patients whose income is 300% above the poverty level. Patients of the CCR are able to receive all services offered there including case management by a Social Worker and/or Community Health Worker, targeted health education, diabetes self-management, smoking cessation, medication assistance, and CRNP management of their disease(s). The Center for Hope and Healing is designed to help prevent or provide an alternative to psychiatric inpatient admission and help shorten the length of inpatient stay. We also connect patients to addiction services, inpatient and outpatient services, Medication Assisted Treatment programs, addictions Intensive Outpatient Program, Alcoholics Anonymous/Narcotics Anonymous and/or SMART Recovery. Efforts related to Diabetes include our Food Farmacy which provides patients with healthy food. PCP initiatives targeting Hypertension in which lists are pulled weekly for patients who are out of compliance (B/P target 140/90). Five community gardens are located within the community along with an orchard and walking path to address food insecurity and lack of resources to healthy food to the underserved population. Additionally, the gardens promote physical activity, self-sufficiency, stress relief, and social connectivity. A yearly survey is distributed among gardeners to track improved eating habits and access to fresh produce.

Q61. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [ ] None
- [x] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [ ] The COVID-19 Long-Term Care Partnership Grant
- [ ] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q62. If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q63. Section III - CB Administration

Q64. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- [x] Yes, by the hospital's staff
- [ ] Yes, by the hospital system's staff
- [ ] Yes, by a third-party auditor
- [ ] No

Q65. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q66. Does your hospital conduct an internal audit of the community benefit narrative?

- (•) Yes
- ( ) No

Q67. Please describe the community benefit narrative audit process.

The internal audit consists of a series of checks and balances. There is a group of reporters that enter occurrences into the UPMC Community Benefits Reporting Tool which are reviewed by the reporting team within UPMC Corporate. After each fiscal year closes, the Finance Director and System Administrator collaborate to obtain the missing data, and the Finance Director compiles the expenses for numerous activities. Since the Manager of Community Health serves as the Community Benefit Administrator and is engaged with the CHNA and implementation plan, this position is responsible for compiling the draft narrative. All members of the Community Benefits Committee review the narrative to ensure its accuracy. The Chief Financial Officer has the final review and sign off before it is shared with the UPMC WESTERN MARYLAND Board of Directors for review and action.

Q68. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (•) Yes
- ( ) No

Q69. Please explain:

This question was not displayed to the respondent.

Q70. Does the hospital's board review and approve the annual community benefit narrative report?

- (•) Yes
- ( ) No

Q71. Please explain:

This question was not displayed to the respondent.

Q72. Does your hospital include community benefit planning and investments in its internal strategic plan?

- (•) Yes
- ( ) No

Q73. Please describe how community benefit planning and investments were included in your hospital's internal strategic plan during the fiscal year.

The Population Health Council reviews the findings to identify key opportunities for involvement of UPMC Western Maryland internally and with the Local Health Improvement Coalition (LHIC) regarding the community. As a cycle of learning, these opportunities are then considered in the strategic planning process. Once priorities, plans and metrics are approved and aligned with the budget process, the CHNA and implementation plan are presented to the Board for approval, then implemented, tracked and measured.

Q74. If available, please provide a link to your hospital's strategic plan.

Q75. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents

  Regional Catalyst Grant with Meritus and Frederick Memorial, Diabetes Self-Management Programs and Diabetes Prevention Program, PCP track and measure A1C/glucose and BMI, utilization of CRISP

- [x] Opioid Use Disorder - Improve overdose mortality

  Expansion of the screening brief intervention and referral to treatment (SBIRT) model into practice workflows

- [ ] Maternal and Child Health - Reduce severe maternal morbidity rate

- [ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

- [ ] None of the Above

Q76. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q77. Section IV - Physician Gaps & Subsidies

Q78. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ( ) No
- (•) Yes

Q79. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	( )	(•)	
Anesthesiology	(•)	( )	
Cardiology	(•)	( )	Physician recruitment to meet community need
Dermatology	( )	(•)	
Emergency Medicine	( )	(•)	
Endocrinology, Diabetes & Metabolism	(•)	( )	Physician recruitment to meet community need
Family Practice/General Practice	( )	(•)	
Geriatrics	( )	(•)	
Internal Medicine	(•)	( )	Physician recruitment to meet community need

Medical Genetics	○	◉	
Neurological Surgery	○	◉	
Neurology	○	◉	
Obstetrics & Gynecology	◉	○	Physician recruitment to meet community need
Oncology-Cancer	◉	○	Physician recruitment to meet community need
Ophthalmology	○	◉	
Orthopedics	○	◉	
Otolaryngology	○	◉	
Pathology	○	◉	
Pediatrics	○	◉	
Physical Medicine & Rehabilitation	○	◉	
Plastic Surgery	○	◉	
Preventive Medicine	◉	○	Physician recruitment to meet community need
Psychiatry	◉	○	Physician recruitment to meet community need
Radiology	○	◉	
Surgery	○	◉	
Urology	○	◉	
Other. (Describe) See attached	○	○	

Q80. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

These are services that are necessary to manage patients in our medically underserved area and are not available within reasonable driving time. The closest hospitals are Meritus and Garrett, both over 40 miles away.

Q81. Please attach any files containing further information and data justifying physician subsidies at your hospital.

Physician Subsidy for Upload - FY22.xlsx
11.6KB
application/vnd.openxmlformats-officedocument.spreadsheetml.sheet

Q82. Section VI - Financial Assistance Policy (FAP)

Q83. Upload a copy of your hospital's financial assistance policy.

Financial Assistance 4_2022__Policy Manager Update RED DATA LISTED.docx
61.7KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q84. Provide the link to your hospital's financial assistance policy.

https://www.wmhs.com/patients-and-visitors/patients/financial-assistance/

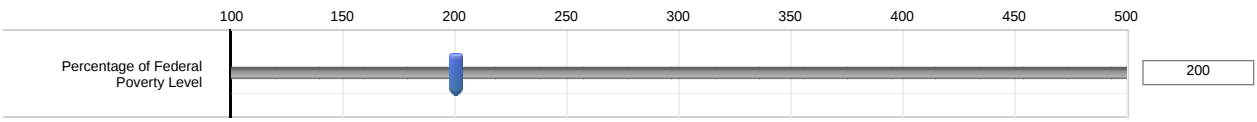
Q85. Has your FAP changed within the last year? If so, please describe the change.

○ No, the FAP has not changed.

◉ Yes, the FAP has changed. Please describe: Asset consideration section

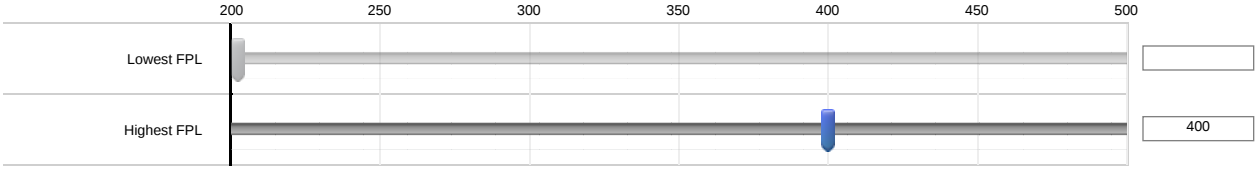
Q86. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

Please select the percentage of FPL below which your hospital's FAP offers free care.



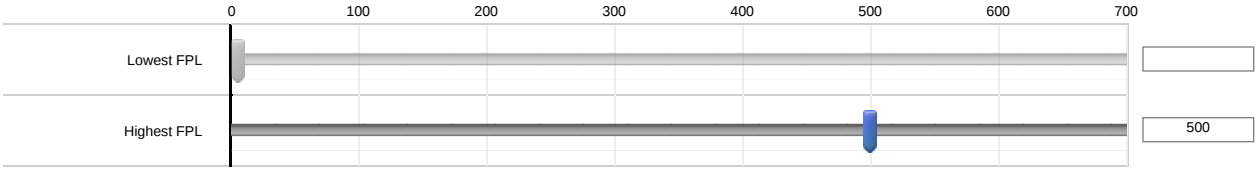
Q87. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.

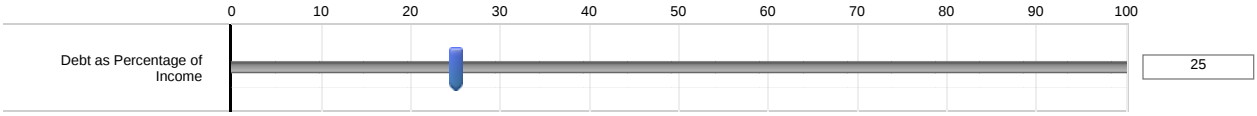


Q88. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship.



Q89. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q90. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding taxable year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax
- [x] State sales tax
- [x] Local property tax (real and personal)
- [ ] Other (Describe)

Q91. Summary & Report Submission

Q92.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

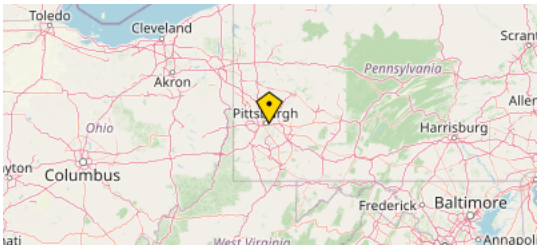
We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (40.4324, -79.9247)

Source: GeoIP Estimation



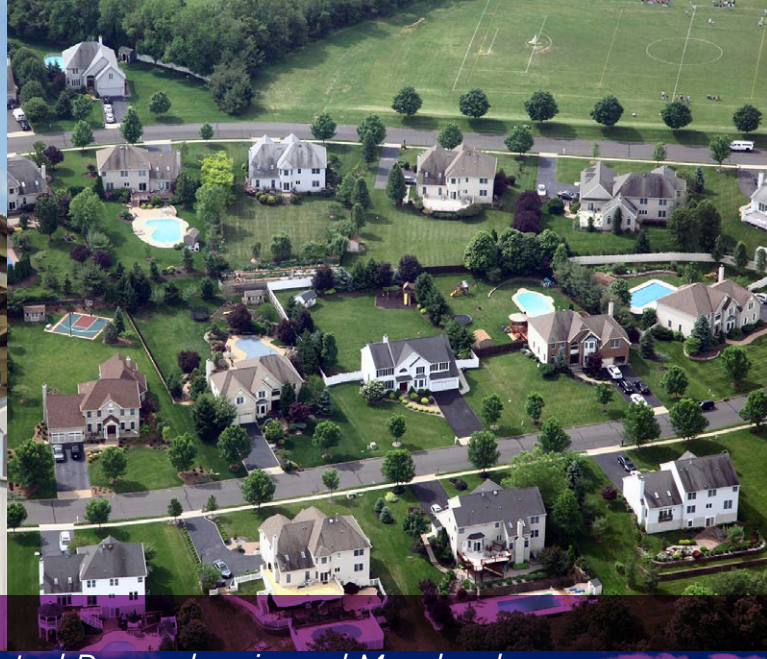
UPMC
LIFE CHANGING MEDICINE

COMMUNITY HEALTH NEEDS ASSESSMENT

Community Health Needs Assessment
Community Health Strategic Plan

Bedford, Blair, and Somerset Counties in Pennsylvania, and Allegany County in Maryland

June 30, 2022



West Central Pennsylvania and Maryland

Enhancing the Health of Our Communities

Bedford, Blair, and Somerset Counties in Pennsylvania, and Allegany County in Maryland

COMMUNITY HEALTH NEEDS ASSESSMENT UPDATE COVERING

UPMC ALTOONA

UPMC BEDFORD

UPMC SOMERSET

UPMC WESTERN MARYLAND

UPMC

LIFE CHANGING MEDICINE

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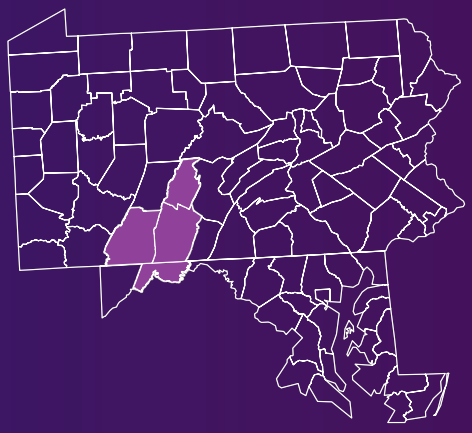


2019-2022
REGIONAL PROGRESS REPORT

UPMC is committed to improving the health and wellbeing of communities in Bedford, Blair, and Somerset counties in Pennsylvania, and in Allegany County in Maryland. Working with community partners and engaging system-wide resources, UPMC hospitals are making measurable progress to address community health needs.

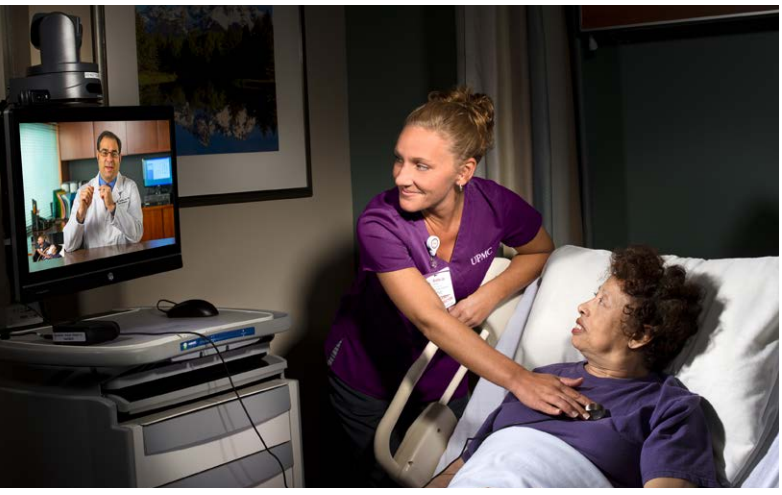
INCREASING LOCAL ACCESS TO WORLD-CLASS CARE

UPMC is taking steps to make health care more accessible.

- **Working Together to Recruit Physicians:** UPMC Altoona, UPMC Bedford, and UPMC Somerset continue to assess the community's needs for primary and specialty care, and collaborate to attract new physicians to the region.

UPMC Altoona, UPMC Bedford, and UPMC Somerset recruited 90+ physicians.

- **Connecting with Patients through Telemedicine:** Due to the COVID-19 pandemic, UPMC hospitals' rapidly expanded telemedicine capabilities in outpatient locations, including primary care, urology, and orthopaedics. UPMC hospitals also use teleconsult centers to link patients with specialists in Pittsburgh, while on-site staff help perform exams. In 2020, UPMC Bedford's Teleconsult Center adapted its service, leveraging the MyUPMC app, and in 2021, UPMC Somerset's newly established Outpatient Telemedicine Center began offering endocrinology and neurosurgery services, and will offer rheumatology in 2022.



ADDRESSING ACCESS TO BEHAVIORAL HEALTH SERVICES

UPMC hospitals in the four-county region continue to expand services to address behavioral health needs.

- **Reaching Out to Community Members in Crisis:** UPMC Altoona's Mobile Crisis Team provides on-site, face-to-face mental health services for individuals and families experiencing a crisis, such as police calls, deaths, and suicides. The program continues to see an increased need for mobile crisis intervention. In 2020, the program served 600-700 individuals.
- **Training Providers to Recognize the Signs and Symptoms of Addiction:** UPMC Somerset is training providers in the use of Screening Brief Intervention and Referral to Treatment (SBIRT), a model that encourages mental health and substance use screenings as a routine preventive service.

MANAGING CHRONIC DISEASE

UPMC offers education and high-quality treatment options for people impacted by chronic disease.

- **Improving Control of Diabetes:** Embedded within a primary care office, UPMC Bedford's diabetic educator assists patients with the latest management tools, including apps, glucose monitoring, and insulin pumps.
- **Supporting Patients with Heart Disease:** UPMC Somerset offers an expansive interventional cardiology program — with more than 700 visits to the cardiac cath lab each year. In addition, the hospital's cardiac rehabilitation program offers personalized treatment plans, which help keep patients out of the hospital, help prevent future cardiac events, and encourage patients to be active and independent.
- **Providing Resources for a Healthier Life:** The UPMC Western Maryland Center for Clinical Resources (CCR) supports patients managing chronic conditions, such as diabetes, heart failure, and lung disease, as well as patients taking anticoagulation medication. The CCR's goal is to effectively co-manage patients with chronic disease in an outpatient setting to help improve their health.

PROMOTING PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING

UPMC hospitals work with local organizations to encourage community participation in health education and screening events, as well as healthy activities.

- **Educating the Community about Cancer, Heart Disease, and Stroke:** To help raise awareness of the signs and symptoms of cancer, heart disease, congestive heart failure, and stroke, UPMC Altoona provides free education at community events, senior centers, and churches. Between July 2019 and March 2021, UPMC Altoona hosted 21 in-person and virtual events, with more than 450 participants.
- **Addressing Social Determinants of Health:** UPMC Western Maryland is using Path2Help, an online tool, to help connect people with community programs and services for food, shelter, health care, work, financial assistance, and more.

PARTNERING WITH ALLEGANY COUNTY HUMAN RESOURCES DEVELOPMENT COMMISSION

UPMC Western Maryland collaborates with Allegany County Human Resource Development Commission to help coordinate transportation for patients. Hospital staff assess a patient's transportation needs when scheduling an appointment or discharging a patient from the hospital. The hospital also provides walkers and wheelchairs.

UPMC Western Maryland helped provide 14,000+ rides to patients in 2020-2021.

CARING FOR OUR COMMUNITIES DURING THE COVID-19 PANDEMIC

UPMC is committed to keeping our patients, staff, and communities safe during this challenging time.

ADMINISTERING VACCINES

UPMC is proud to partner with community organizations to offer convenient and accessible COVID-19 vaccine clinics.

39,000+
Vaccine Doses Administered in the West Central Region*

PROTECTING VULNERABLE POPULATIONS

UPMC is dedicated to health equity in all vaccination efforts and is committed to vaccinating as many people as possible. Staff members at UPMC Altoona, UPMC Bedford, UPMC Somerset, and UPMC Western Maryland are volunteering their time and expertise to ensure the most vulnerable populations are protected from the virus.

LAUNCHING ONLINE PROGRAMS

UPMC expanded telemedicine capabilities to enable patients to receive care from the safety of their homes. In addition, UPMC hospitals adapted programs to allow community members to access health education, support, and resources through webinars, virtual discussions, and social media platforms.

OFFERING TESTING SITES

UPMC established seven regional collection centers to expand local testing. In addition, UPMC hospitals offer testing to patients before certain in-hospital procedures.

**Vaccine data as of November 22, 2021*

UPMC is addressing important community needs.

CHRONIC DISEASE MANAGEMENT
- Diabetes
- Heart Disease and Stroke

BEHAVIORAL HEALTH
- Access to Behavioral Health Services

ACCESS TO CARE AND NAVIGATING RESOURCES
- Primary Care
- Specialty Care
- Care Coordination / Transportation

PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING
- Community Prevention and Wellness Initiatives / Youth Risk Reduction
- Health-Related Social Needs / Social Determinants of Health

UPMC Somerset and UPMC Western Maryland were welcomed into the UPMC hospital network to ensure high-quality patient care for generations to come. UPMC has committed to enhance services and upgrade facilities, such as expanding clinical programs, recruiting and retaining outstanding medical staff, and updating information technology capabilities.

I. EXECUTIVE SUMMARY

UPMC's mission is to serve our community by providing outstanding patient care and to shape tomorrow's health system through clinical and technological innovation, research, and education.

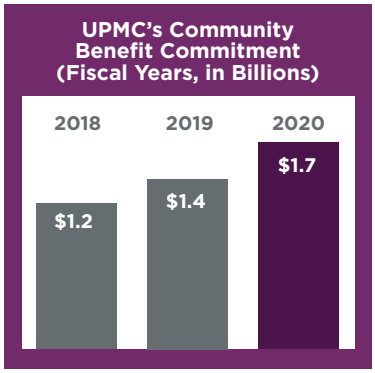
UPMC Plays a Major Role in Its Community:

UPMC is one of the world's leading Integrated Delivery and Financing Systems ("IDFS"), combining a major Health Services Division with 40 hospitals and 800 clinical locations, with a more than 4 million-member Insurance Services Division. One of the largest nonprofit health systems in the United States, UPMC is headquartered in Pittsburgh, Pennsylvania, and serves patients seeking highly specialized medical care primarily from communities across Pennsylvania, as well as throughout the nation and around the world. UPMC is also the largest medical insurer in western Pennsylvania, and is the largest insurer of Medical Assistance, Medicare Advantage, Children's Health Insurance, and Behavioral Health populations in the region.

Committed to its mission of service, UPMC provides more than $1 billion a year in benefits to the communities it serves, and delivers more care to the region's poor and underserved than any other health system in the state.

UPMC's commitment to service is seen in the following ways:

- **Establishing a healthy culture in the communities we serve:** UPMC enhances health and wellness through more than 3,000 community-focused programs.
- **Caring for the vulnerable:** In Fiscal Year 2020, UPMC subsidized $509 million in charity care and coverage for unreimbursed costs of care provided to Medicaid beneficiaries.
- **Providing state-of-the-art, life-saving care to the community:** In partnership with the University of Pittsburgh, UPMC makes significant investments in translational science, technology, research, and education designed to improve clinical quality, promote patient-centered care, and benefit the overall health of residents of our communities.
- **Contributing to a thriving future for the state:** UPMC fosters economic prosperity through direct investment and new product development, which improves the health of communities large and small. The largest nongovernmental employer in Pennsylvania, UPMC is a leader in workforce development efforts, supports nearly one in three hospital jobs in the commonwealth, and generates an annual economic impact of $46 billion in the region.
  - > UPMC invested $599 million in education and research in 2020, primarily at the University of Pittsburgh, which ranks #7 in National Institutes of Health (NIH) dollars.
  - > UPMC sponsors 98 percent of all hospital-funded research in western Pennsylvania.



Assessing the Significant Community Health Needs for the Four-County Region:

In Fiscal Year 2022, UPMC's four licensed hospitals — located in and serving Bedford, Blair, and Somerset counties in Pennsylvania, and Allegany County in Maryland — conducted a joint Community Health Needs Assessment (CHNA) in keeping with requirements described in section 501(r) of the Internal Revenue Code. Building on the initial CHNAs conducted in Fiscal Years 2013, 2016, and 2019, the Fiscal Year 2022 joint CHNA provided an opportunity for the hospitals to re-engage with community stakeholders in a rigorous, structured process guided by public health experts.

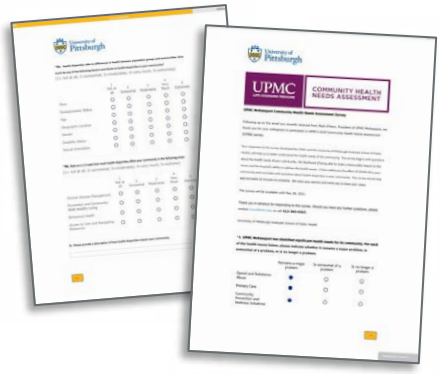
The collaborating hospitals in this CHNA deliver an array of specialized programs and services. UPMC Altoona, a tertiary care teaching hospital, serves as UPMC's regional hub in west central Pennsylvania. UPMC Bedford, an acute- care hospital, is the county's only hospital and delivers a full range of quality medical services — including specialized medical and surgical treatment. UPMC Somerset, an acute care hospital, provides access to medical, surgical, and rehabilitation care. UPMC Western Maryland, an acute care hospital, offers a wide range of inpatient and outpatient services through its accredited cancer center, robotic surgery program, and neurosurgery operating suite.

For the purpose of this joint CHNA, the collaborating UPMC hospitals define their community to be Bedford, Blair, and Somerset counties in Pennsylvania, and Allegany County in Maryland.

By combining efforts and resources, this joint assessment identifies important local health issues, while supporting a coordinated, system-wide community health strategy that extends across the region. Working together, UPMC's hospitals are committed to advancing health for residents in the community.

UPMC Licensed Hospitals in the Four-County Region	
UPMC Altoona	Blair County, Pennsylvania
UPMC Bedford	Bedford County, Pennsylvania
UPMC Somerset	Somerset County, Pennsylvania
UPMC Western Maryland	Allegany County, Maryland

Input from Community Stakeholders and Public Health Experts:



UPMC partnered with experts at the University of Pittsburgh Graduate School of Public Health (Pitt Public Health) to conduct the CHNA using a best-practice methodology. The assessment blended analysis of documented public health data, socioeconomic factors, and emerging health issues, including COVID-19 and health disparities, with a structured community input survey process that solicited feedback from community partners that represent patient constituencies within the community — including medically underserved, low-income, and minority populations.

CHNA Findings: Significant Community Health Needs for the Four-County Region:

The residents of the four-county region have a wide range of health concerns. The Fiscal Year 2022 joint CHNA identified four significant health needs of importance to the communities served by UPMC Altoona, UPMC Bedford, UPMC Somerset, and UPMC Western Maryland.

	Significant Health Needs	Health Issues	Importance to the Community
1	**Chronic Disease Management**	Obesity, Heart Disease and Stroke, Diabetes, Cancer	Approximately two-thirds of deaths in the community are attributable to chronic disease.
2	**Behavioral Health**	Opioid Addiction and Substance Abuse, Access to Behavioral Health Services	Behavioral health conditions are among the most common conditions in the nation. They have a far-reaching impact on the community. Individuals with a behavioral health condition are at greater risk for developing a wide range of physical health problems.
3	**Access to Care and Navigating Resources**	Primary Care, Specialty Care	Access to care and navigating resources have important implications for the health of the community in a variety of ways, including preventing disease and disability, detecting and treating illnesses or conditions, managing chronic disease, reducing preventable hospitalization, and increasing quality of life.
4	**Prevention and Community-Wide Healthy Living**	Community Prevention and Wellness Initiatives, Health-Related Social Needs	Preventive care efforts, such as preventive screenings, can help identify diseases early, improve management of diseases, and reduce costs.

Amplifying UPMC's Impact Across the Four-County Region:

In 2022, the Board of Directors for each UPMC licensed hospital adopted plans to address the significant health needs identified in the Fiscal Year 2022 joint CHNA, and to measure and track associated improvements. This report documents progress toward addressing significant health needs identified from prior CHNAs, as well as delineates hospital-specific implementation plans that will address community health needs over the Fiscal Year 2022-2025 period. These plans build upon the goals established in Fiscal Year 2019, recognizing that significant health needs will generally require more than two to three years to show meaningful improvement.

While tailored to each hospital, the implementation plans:

- **Focus on a Few High-Urgency Issues and Follow-Through:** UPMC hospitals in the four-county region are concentrating on a limited number of health issues that will address the significant health needs in the community.
- **Emphasize Populations Most in Need and Reduce Health Disparities:** Where applicable, implementation plans specify programs and outreach for population segments that include seniors, women and infants, children and adolescents, and other vulnerable, high-risk, or medically underserved community members.
- **Support a Wide Range of Chronic Disease Prevention and Care Initiatives:** Approximately two-thirds of deaths in the community are attributable to chronic disease. UPMC hospitals in the four-county region are promoting and increasing access to preventive care, immunizations, education, screenings, and COVID-19 vaccinations.
- **Enhance and Expand Efforts to Address Behavioral Health Needs:** Rated high in importance by community stakeholders, behavioral health conditions have a growing impact on the community. UPMC hospitals in the four-county region are working together to advance integration of behavioral health into physical health care disciplines, to address co-occurring conditions that result in complex care needs.

- **Promote Access and Navigating Available Resources:** Established health care programs in the region are often untapped due, in part, to social and logistical challenges faced among populations, and individuals lacking social support systems.
- **Leverage Community Partnerships:** An ongoing objective of the CHNA effort is to help align community programs and resources with community health needs. UPMC hospitals are collaborating successfully with local organizations to improve community health. The hospitals are also leveraging resources and synergies within the UPMC system, which include population-focused health insurance products and comprehensive programs and resources targeted at areas including behavioral health, seniors, and children.

The following chart illustrates how each UPMC hospital will contribute to addressing the significant health needs in the four-county region. Additionally, detailed hospital-specific implementation plans are provided in Section IV of this report.

2022 Significant Health Needs in Bedford, Blair, Somerset, and Allegany Counties										
UPMC Hospitals in Bedford, Blair, Somerset, and Allegany Counties	**Chronic Disease Management**				**Behavioral Health**		**Access to Care and Navigating Resources**		**Prevention and Community-Wide Healthy Living**	
	Obesity	Heart Disease and Stroke	Diabetes	Cancer	Opioid Addiction and Substance Abuse	Access to Behavioral Health Services	Primary Care	Specialty Care	Community Prevention and Wellness Initiatives	Health-Related Social Needs
UPMC Altoona		✓			✓	✓	✓	✓		✓
UPMC Bedford		✓					✓	✓	✓	
UPMC Somerset		✓	✓	✓	✓	✓	✓	✓		
UPMC Western Maryland	✓	✓	✓		✓	✓				

II. Overview and Methods Used to Conduct the Community Health Needs Assessment

CHNA Goals and Process Overview:

In Fiscal Year 2022, UPMC's four licensed hospitals in Bedford, Blair, and Somerset counties, in Pennsylvania, and in Allegany County, in Maryland, collaborated to conduct a joint CHNA, in keeping with IRS 501(r) guidelines. Through the assessment process, UPMC's hospitals identified the counties' significant health needs, prioritized those health needs, established action plans, and identified resources to address those needs.

The 2022 document builds upon prior assessments and implementation plans developed in Fiscal Years 2013, 2016, and 2019. UPMC approached the CHNA requirement as an opportunity to evaluate and assess needs through a formalized, rigorous, and structured process to ensure that health improvement efforts and resources are aligned with the most significant community health needs. Goals of the CHNA were to:

- Better understand community health care needs.
- Develop a roadmap to direct resources where services are most needed, and impact is most beneficial.
- Collaborate with community partners, where together, positive impact can be achieved.
- Improve the community's health and achieve measurable results.

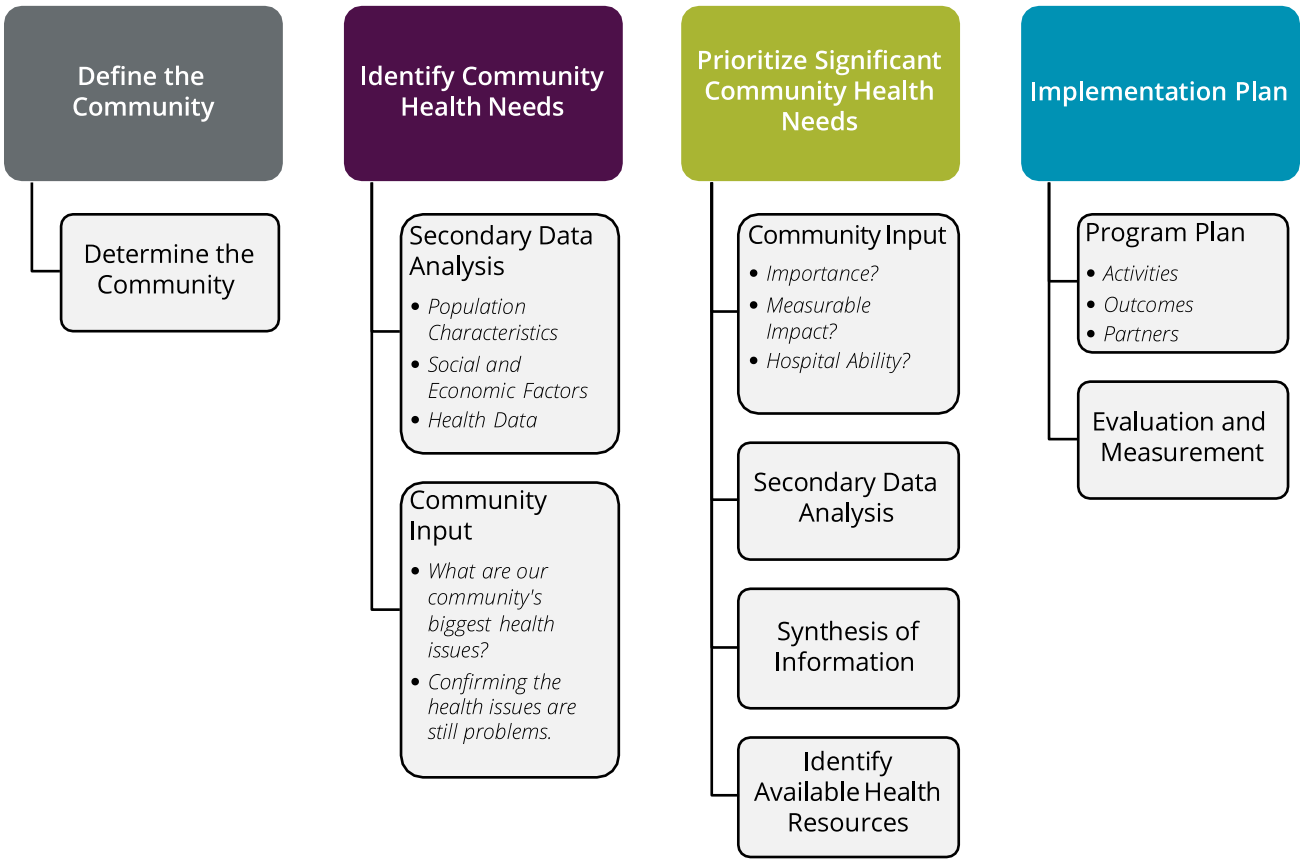
The CHNA incorporated analysis of public health data and input from individuals representing the broad interests of the community — including those with special knowledge and expertise in public health, and community stakeholders representing members of medically underserved, low-income, and minority populations. The overall health of the community is a shared responsibility among many stakeholders and entities, including government agencies, health care providers, nongovernmental organizations, and community members themselves. While the IRS CHNA requirements apply specifically to nonprofit hospital organizations, collaboration with community partners is essential for implementing and achieving effective community health improvement.

Collaborated with Experts in Public Health:

To conduct the CHNA in a manner that reflects best practices, UPMC partnered with the University of Pittsburgh Graduate School of Public Health (Pitt Public Health). Pitt Public Health's mission is to provide leadership in health promotion, disease prevention, and the elimination of health disparities in populations. Aligning with assessments conducted in 2013, 2016, and 2019, Pitt Public Health faculty and researchers' expertise supported a structured process for obtaining community input on health care needs and perceived priorities, an in-depth review and summary of publicly available health data, and the establishment of criteria for evaluating and measuring progress.

Framework for Conducting the CHNA:

The Community Health Improvement Process developed by the Health and Medicine Division (HMD) of the National Academy of Medicine served as a guiding framework in assessing the health needs of the UPMC hospital communities. The hospitals adapted this model to guide the development of their CHNA.



Definition of the Community: Bedford, Blair, Somerset, and Allegany Counties:

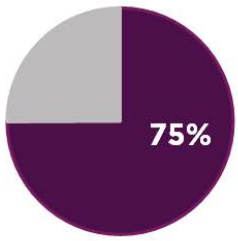
For the purpose of this joint CHNA, UPMC Altoona, UPMC Bedford, UPMC Somerset, and UPMC Western Maryland define their community to be Bedford, Blair, Somerset, and Allegany counties. With 75 percent of patients treated at UPMC Altoona, UPMC Bedford, UPMC Somerset, or UPMC Western Maryland residing in Bedford, Blair, Somerset, or Allegany counties, these four hospitals primarily serve residents of this geographic region. By concentrating on Bedford, Blair, Somerset, and Allegany counties, UPMC can consider the needs of the great majority of its patients, and do so in a way that allows accurate measurement, using available secondary data sources.

While the four-county region represents the basic geographic definition of each of these hospitals, this CHNA also considered characteristics of the broader area, such as state data, as well as specific populations within the defined community — such as minorities, low-income individuals, and those with distinct health needs.

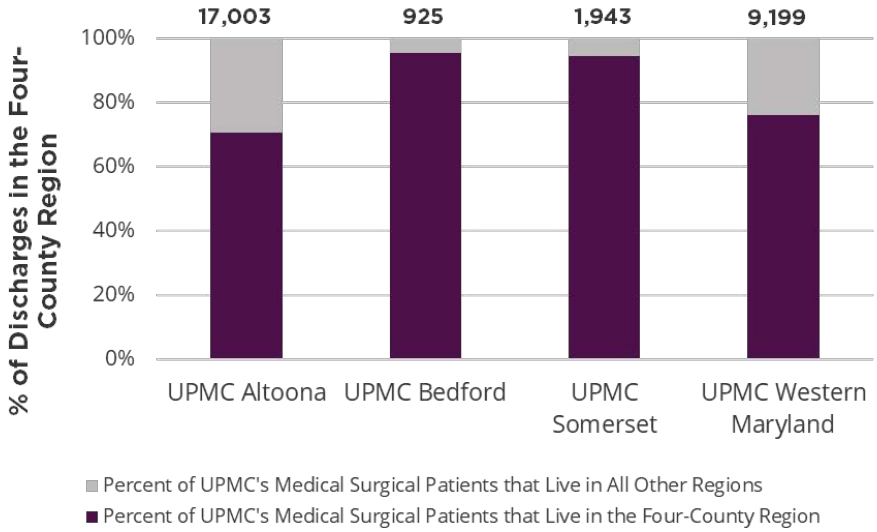
By combining efforts and resources, UPMC Altoona, UPMC Bedford, UPMC Somerset, and UPMC Western Maryland are focusing on important local health issues, while supporting a coordinated community health strategy across the region and system-wide.

Most Patients Treated at UPMC Hospitals in West Central Pennsylvania and Maryland Live in the Four-County Region: Bedford, Blair, Somerset, and Allegany Counties.

Of the patients seen at the four UPMC hospitals in the region, 75 percent live in Bedford, Blair, Somerset, or Allegany counties.



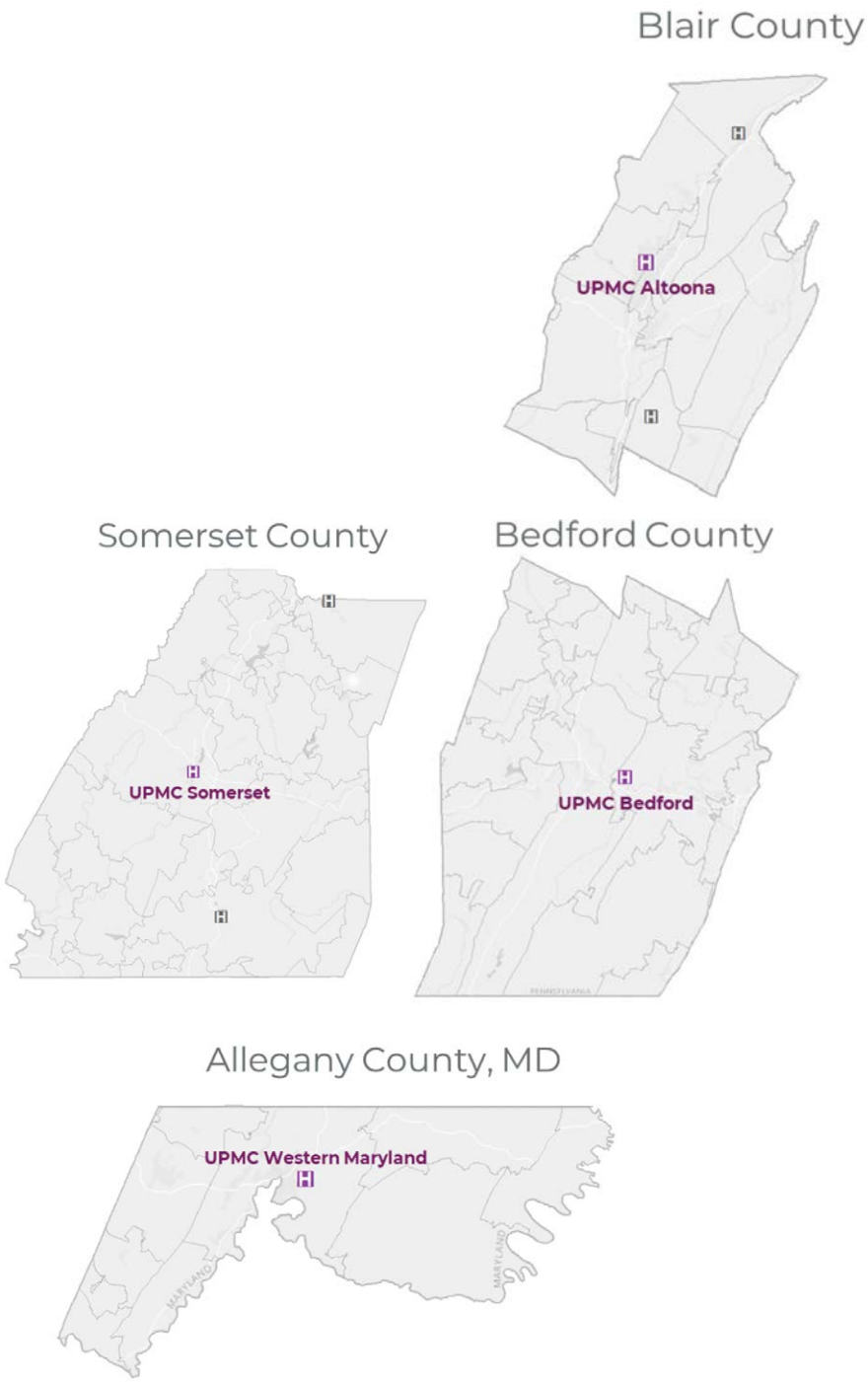
In Fiscal Year 2020, UPMC hospitals in West Central Pennsylvania and Maryland had 29,070 medical surgical discharges.



Source: *Pennsylvania Health Care Cost Containment Council, Fiscal Year 2020; UPMC Internal Data, Fiscal Year 2020*

Identifying UPMC's System-Wide Resources Available to Address the Region's Significant Health Needs

UPMC's hospitals are supported by a comprehensive network of additional health care resources in the area, including more than 50 UPMC outpatient locations within Allegany, Bedford, Blair, and Somerset counties. A leader in high-quality, specialty care, UPMC provides local access through UPMC Western Behavioral Health, UPMC Children's Community Pediatrics, UPMC Hillman Cancer Centers, and UPMC Magee-Womens specialty services locations. UPMC also offers a wide range of outpatient facilities, including imaging centers, labs, pharmacies, primary care offices, rehabilitation services, and urgent care centers.



Identifying and Prioritizing Significant Health Needs:

Secondary Data Analysis and Sources:

UPMC conducted an in-depth analysis of publicly available data in partnership with Pitt Public Health. Secondary data, including population demographics, mortality, morbidity, health behaviors, clinical care, socioeconomic, and health status data, were used to identify, prioritize, and confirm significant community health needs. A full list of secondary data sources used is listed in **Appendix A**. Community-level data (usually county-level) were compared to the state, nation, and *Healthy People 2020* and *Healthy People 2030* benchmarks to help identify key health issues. This information may be found in **Appendix B**.

Population characteristics, socioeconomic, and health status data were also examined. When available, data specific to low-income individuals, underserved minorities, and uninsured populations were examined. In addition, the analysis considered federal designations of Health Professional Shortage Areas (HPSAs) — defined as "designated as having a shortage of primary medical care providers," Medically Underserved Areas (MUAs) — which may consist of a whole county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts, and Medically Underserved Populations (MUPs) — which are specific sub-groups of people living in a defined geographic area with a shortage of primary care health services.

Community Input:

Community input on the perceived health needs and priorities of the region was used to complement analysis of publicly available data. To identify and prioritize health needs of the communities served, the CHNA solicited and took into account input from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health.

The Fiscal Year 2022 CHNA builds on the assessment processes applied in Fiscal Years 2013, 2016, and 2019, engaging community advisory panels to provide structured input on health needs present in each hospital's surrounding community. In May-June 2021, Pitt Public Health surveyed community leaders and stakeholders specific to each hospital's local community, as well as a system-wide panel of regional stakeholders. A survey was extended to a total of 2,868 community participants from 28 UPMC hospital communities.

Participants included:

- Leaders or members of medically underserved, low-income, or minority populations, and populations with chronic disease.
- Representatives from public health departments or governmental agencies serving community health.
- Medical staff leaders who have a unique perspective and view of the community.
- Other stakeholders in community health, such as consumer advocates, nonprofit and community-based organizations, local school districts, government organizations, and health care providers. See **Appendix C** for a complete list and description of community participants.

- **Community surveys, key informant interviews, and focus groups:** UPMC Altoona, through its membership on the Healthy Blair County Coalition, collaborated with 147 community member organizations, two acute-care hospitals, and the Altoona Veterans Administration hospital to more thoroughly understand the health needs in Blair County. During the period from June–November 2021, several community input surveys were administered to various constituents, including: a random household survey mailed to 3,000 households; a key informant survey emailed to state, county, and local officials, community leaders, and major employers; a service provider survey; and faith-based survey. Additionally, health provider interviews were conducted, along with the collection and analysis of indicator data for the county. Complete details of the Healthy Blair County Coalition survey process can be found in **Appendix E.**

UPMC's system-wide community input survey process consisted of multiple stages over the past four CHNA cycles; UPMC Altoona joined the process in the 2016 CHNA cycle; UPMC Somerset and UPMC Western Maryland joined the process in the 2022 CHNA cycle:

CHNA Year	Activity	Description
2013	**Brainstorming on Health Problems**	Each hospital's community advisory panel met to gather input on the question, "What are our community's biggest health care problems?" Brainstorming resulted in the development of a 50-item list of health problems.
2013	**Rating and Sorting Health Problems to Identify Significant Health Needs**	Community members participated in the rating and sorting process to prioritize the 50 health problems. Each participant sorted the list into overarching themes, and then rated the problems using a 1 to 5 Likert scale, according to the following criteria: • **How important is the problem to our community?** • **What is the likelihood of being able to make a measurable impact on the problem?** • **Does the hospital have the ability to address this problem?**
2013	**Concept Mapping**	Multi-dimensional scaling was applied to the sorting data to examine similarities between the 50 community health problems. Hierarchical clustering was used to group the sorting data into common thematic areas and to establish a final cluster map, which provided a visual representation of the data.
2016	**Confirming Health Issues**	Community advisory panels were surveyed about the continuing importance of the identified health issues. Advisory panel members participated in an online Qualtrics survey that solicited feedback on new health issues as well as reaffirming whether previously identified issues continue to be a problem in the community.
2019	**Confirming and Expanding Health Issues**	In partnership with Pitt Public Health, UPMC refined the community survey to incorporate emerging areas of exploration within the public health field (e.g., health- related social needs and interpersonal safety). Using a Qualtrics survey, community leaders also provided consideration on population segments with greatest health needs (e.g., seniors, children and adolescents, mothers and infants, general community, or other).
2022	**Aligning for the Future**	In partnership with Pitt Public Health, UPMC refined the community survey to incorporate emerging areas of exploration within the public health field (e.g., short- and long-term effects of COVID-19). Community stakeholders provided input on: • **The continued importance of the 2019 health issues.** • **Relative importance, ability to impact, and hospital ability to address an expanded list of health issues.** • **Determination of factors contributing to health disparities.**

Synthesis of Information and Development of Implementation Plans:

The secondary data analyses and results from the community input survey process were aggregated, evaluated, and synthesized with the assistance of public health experts from Pitt Public Health. Through this effort, UPMC hospital leadership identified a set of significant health needs and their composite health issues that are critical, addressable, and have high levels of urgency in the community. The process then matched those needs to:

- Best-practice methods for addressing these needs.
- Existing hospital community health programs and resources.
- Programs and partners elsewhere in the community that can be supported and leveraged.
- Enhanced data collection concerning programs.
- A system of assessment and reassessment measurements to gauge progress over regular intervals.

Outcomes and Evaluation of Hospital Implementation Plans:

UPMC engaged with researchers from Pitt Public Health to develop evaluation metrics to measure and track progress related to the implementation plans. The metrics vary by hospital, according to health outcomes, current hospital efforts, and hospital resources.

The implementation plans were developed with the expectation that future progress would be reviewed by the hospitals, as well as potentially by public health agencies. Therefore, two types of outcomes are considered:

- **Process Outcomes (directly relating to hospital/partner delivery of services):** Process outcomes indicate efforts hospitals and community partners can undertake to increase delivery of a service designed to change a health impact indicator. These mostly involve increases (or better targeting) in programming, outreach, publicity, or related efforts. Process outcomes can be measured by increases in investment (dollars or personnel), outreach (media messages, public service announcements), service units delivered (classes, screenings), people attending or completing programs, and number of sites for delivery of programs.
- **Health Impact Outcomes (applies to changes in population health for which the hospital's efforts are only indirectly responsible):** Health impact outcomes are changes in population health related to a broad array of factors, of which hospital and community partner efforts are only one contributing part. These outcomes include reductions in the prevalence of disease, risk factors, and health behaviors associated with disease. Benchmarks for progress in population indicators are available from *Healthy People 2020, Healthy People 2030,* and *Robert Wood Johnson County Health Rankings & Roadmaps.*

Although the Community Health Needs Assessments focus on three-year plans and progress reports, some evaluation is conducted to monitor longer-term health outcomes. Initial review of measures from the *Robert Wood Johnson County Health Rankings & Roadmaps* trended from 2013 through 2020 suggests improvements across some, but not all metrics. For example, health insurance coverage and the rate of preventable hospital stays, which can be used as a proxy for Access to Care and Navigating Resources, improved in Bedford, Blair, Somerset, and Allegany counties over this period. Access to providers, as measured by the ratio of population to mental health providers, also suggest improvements in meeting health needs in the four-county region. Yet outcome-oriented metrics including obesity and diabetes prevalence do not necessarily demonstrate improvements over this period nationwide or in west central Pennsylvania and Maryland. UPMC will continue to monitor these measures from a longer-term trend perspective.

III. Results of the Community Health Needs Assessment and In-Depth Community Profile

Characteristics of the Community:

The counties that compose the community are located in west central Pennsylvania and western Maryland. Bedford and Somerset counties, in Pennsylvania, are considered mostly rural based on their low population densities, while Blair County, in Pennsylvania, and Allegany County, in Maryland, are mostly urban.

Population Density				
	Bedford County	**Blair County**	**Somerset County**	**Allegany County**
2018 Population	48,176	122,492	73,952	70,975
Population Density	47.6	233.0	68.8	167.3

Source: *U.S. Census*

Rural areas, such as Bedford and Somerset counties, experience different health care challenges — national reports show that rural residents may have challenges in accessing health care services, including the services of primary care providers and specialists. Augmenting these access issues are that rural areas — in comparison to urban areas — tend to have a larger proportion of elderly residents and residents living in poverty.

Sizable Elderly Population with High Social Needs: A notable characteristic of Bedford, Blair, Somerset, and Allegany counties is the increasing percentage of elderly residents (65 years and older). Bedford, Blair, Somerset, and Allegany counties have large elderly populations (22 percent, 20 percent, 21 percent, and 20 percent, respectively), especially when compared to Pennsylvania (17 percent), Maryland (15 percent), and the United States (15 percent). A higher percentage of elderly in Bedford, Blair, Somerset, and Allegany counties live alone, compared to Pennsylvania, Maryland, and the United States. Reflective of the higher proportion of elderly, the percentage of Medicare recipients was higher in Bedford, Blair, Somerset, and Allegany counties, compared to Pennsylvania, Maryland, and the nation (See **Appendix B**).

Bedford, Blair, Somerset, and Allegany Counties Have Sizable Elderly Populations

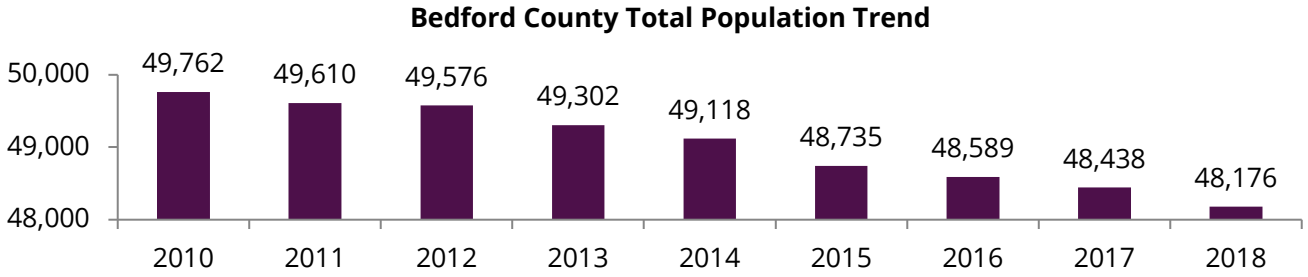
Age Distribution - 2018	Bedford County	Blair County	Somerset County	Allegany County	Pennsylvania	Maryland	United States
% Children (<18)	20.0	20.5	18.5	17.5	20.9	22.4	22.8
% 18-44	28.3	31.5	30.5	36.3	34.1	35.6	36.0
Median Age	46.2	43.4	45.9	41.7	40.7	38.6	37.9
% 45-64	29.9	28.1	29.8	26.6	27.6	27.4	26.0
% 65+	21.8	19.8	21.3	19.6	17.4	14.6	15.2
% 85+	3.2	3.0	3.2	2.8	2.5	1.8	1.9
% Elderly Living Alone	15.5	14.5	15.1	15.3	12.6	10.3	10.7

Source: *U.S. Census*

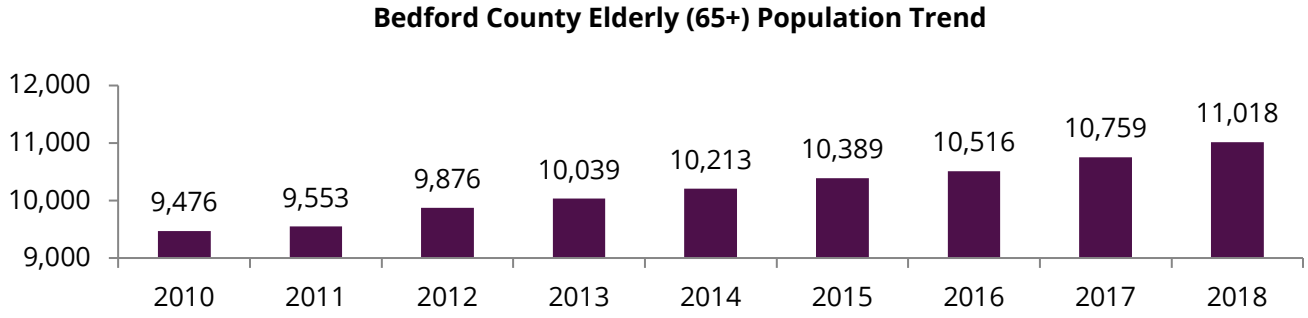
Total Population Decreasing but Aging Population Increasing in the Region: The total population in Bedford, Blair, Somerset, and Allegany counties has decreased since 2010, while the elderly population (age 65 and over) has increased significantly (see figures below).

Bedford County:

Bedford County's total population has seen a three percent decrease from 2010 to 2018.



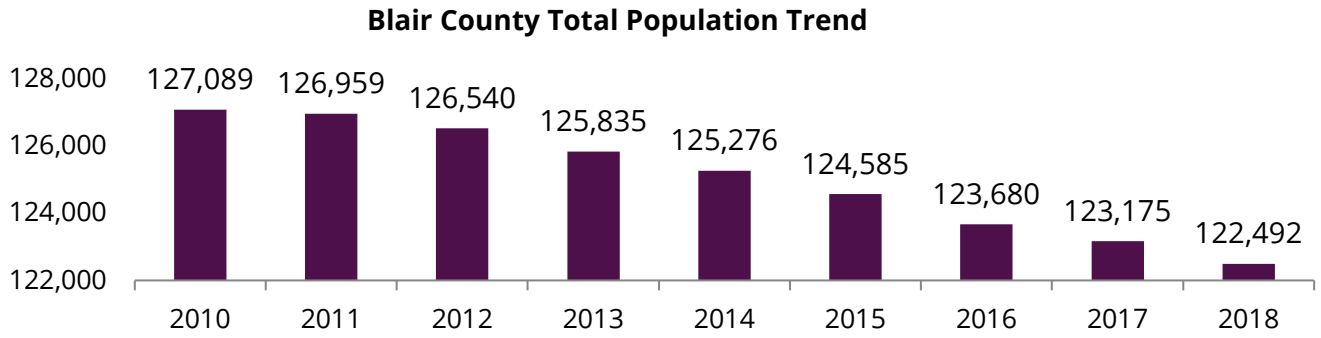
However, the elderly population in Bedford County (65+) has seen a 16 percent increase from 2010 to 2018.



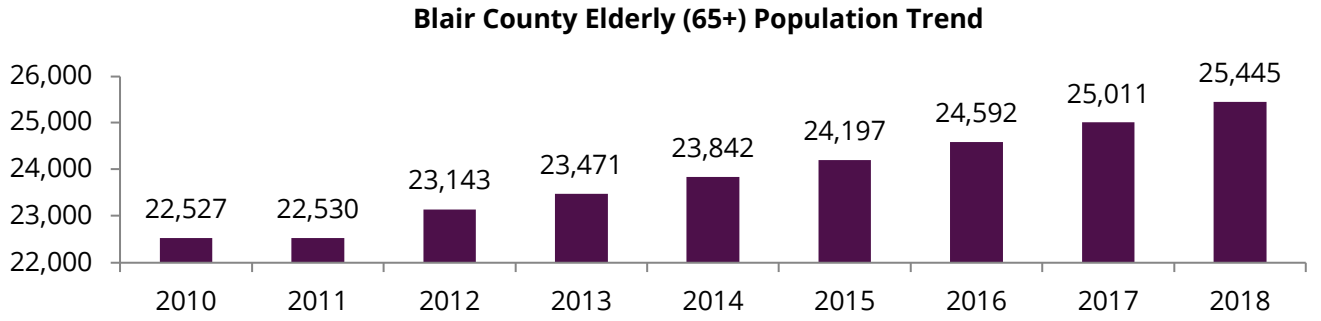
Source: *U.S. Census*

Blair County:

Blair County's total population has seen a four percent decrease from 2010 to 2018.



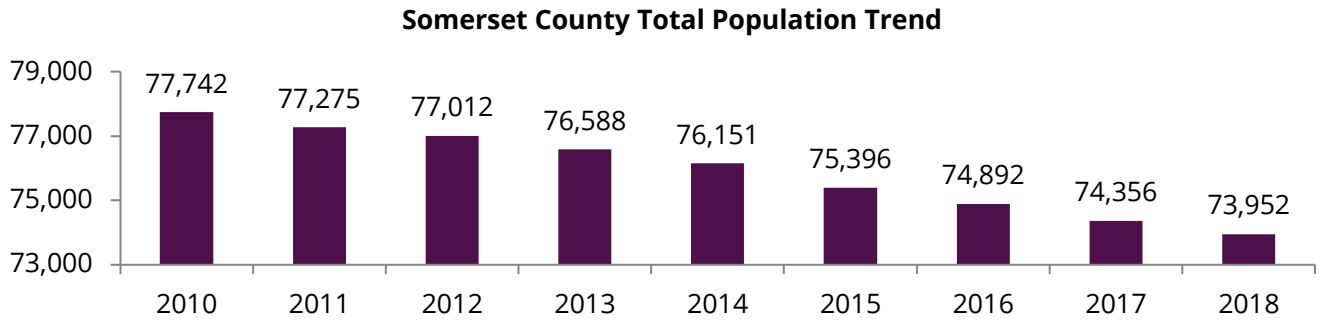
However, the elderly population in Blair County (65+) has seen a 13 percent increase from 2010 to 2018.



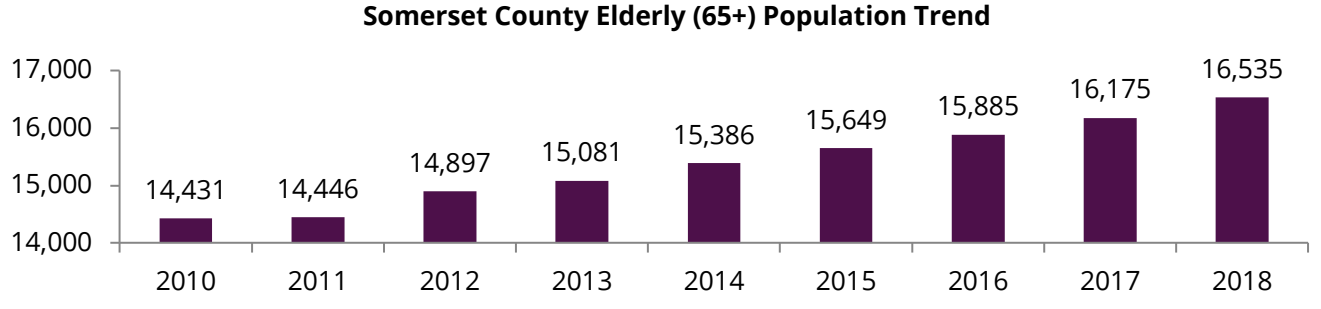
Source: *U.S. Census*

Somerset County:

Somerset County's total population has seen a five percent decrease from 2010 to 2018.



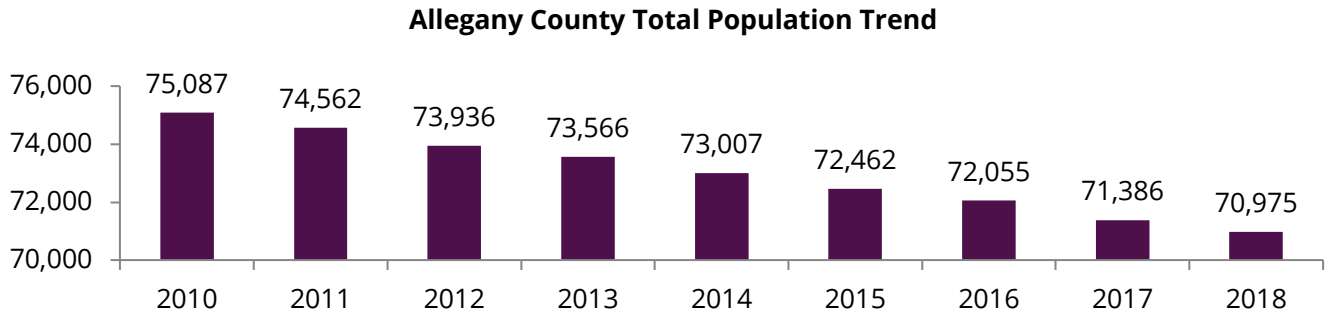
However, the elderly population in Somerset County (65+) has seen a 15 percent increase from 2010 to 2018.



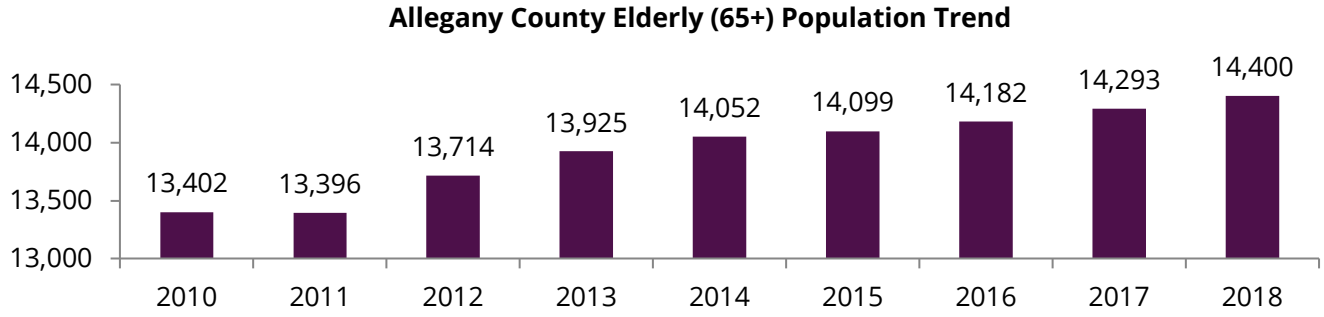
Source: *U.S. Census*

Allegany County:

Allegany County's total population has seen a five percent decrease from 2010 to 2018.



However, the elderly population in Allegany County (65+) has seen a seven percent increase from 2010 to 2018.



Source: *U.S. Census*

Socioeconomic Challenges in Bedford, Blair, Somerset, and Allegany Counties: The overall population of the community faces some economic challenges when compared to state and national benchmarks.

Bedford County tends to have:

- A lower median household income
- More residents with no high school diploma

Somerset County tends to have:

- A lower median household income

Blair County tends to have:

- A lower median household income
- A higher percentage of individuals living in poverty
- More recipients of the income-based Medicaid health insurance program (See **Appendix B**)

Allegany County tends to have:

- A lower median household income
- A higher unemployment rate
- A higher percentage of individuals living in poverty
- More recipients of the income-based Medicaid health insurance program (See **Appendix B**)

Social and Economic Population Demographics - 2018

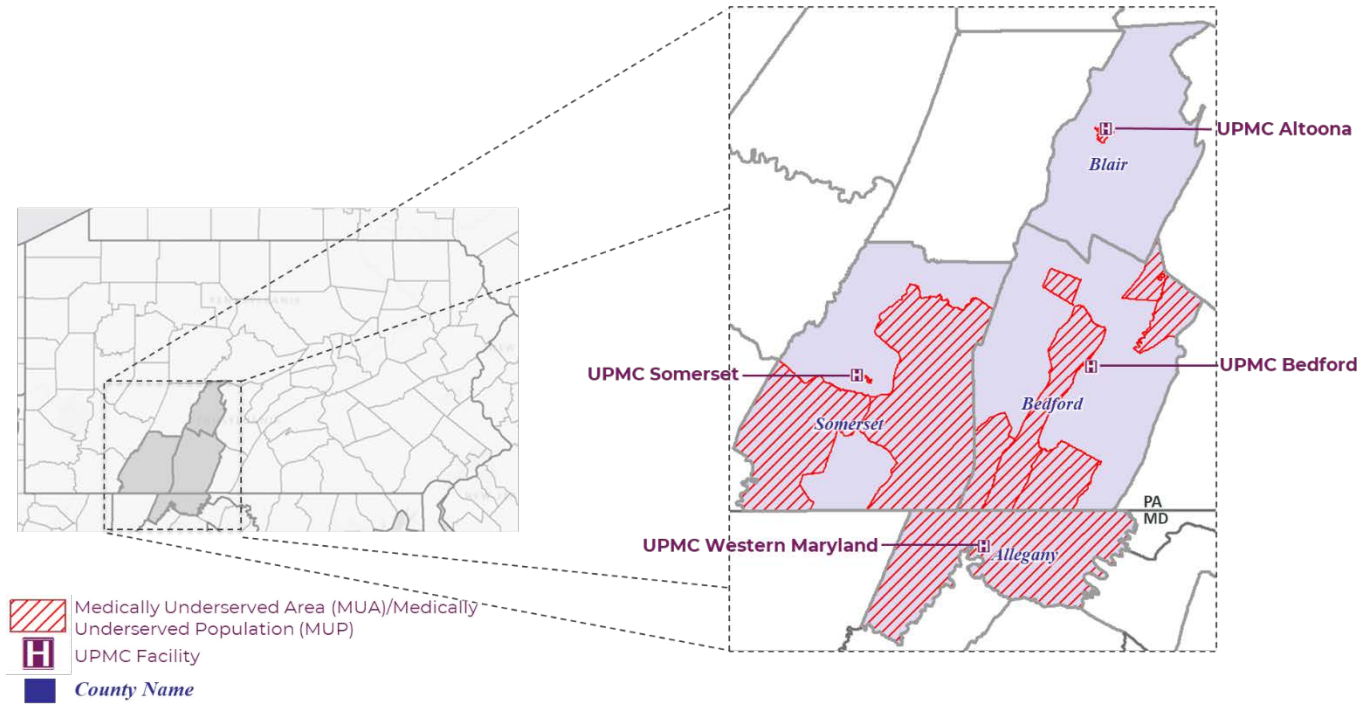
	Bedford County	Blair County	Somerset County	Allegany County	Pennsylvania	Maryland	United States
Median Age	46.2	43.4	45.9	41.7	40.7	38.6	37.9
Median Household Income	$49,146	$47,969	$48,224	$44,065	$59,445	$81,868	$60,293
% of People in Poverty	12.7	14.6	12.4	16.4	12.8	9.4	14.1
% with No High School Diploma (among those 25+)	12.5	9.1	12.0	10.1	9.8	10.0	12.4
% Unemployed (among those 16+ in labor force)	4.9	5.0	5.4	8.5	5.8	5.6	5.9
Racial Groups							
% White	97.6	95.5	95.2	88.2	80.8	56.2	72.7
% African-American	0.5	1.6	2.6	8.4	11.1	29.8	12.7
% Other Race	1.9	2.9	2.2	3.4	8.1	14.0	14.6

Source: *U.S. Census*

Medically Underserved Areas and Populations in Bedford, Blair, Somerset, and Allegany Counties: In Bedford, Blair, Somerset, and Allegany counties, there are some neighborhoods that have characteristics of populations more likely to experience health disparities. The map that follows indicates neighborhoods and populations in the counties that are federally designated by the Health Resources & Services Administration (HRSA) as Medically Underserved Areas (MUAs) or Medically Underserved Populations (MUPs).

The following factors are considered in the determination of MUAs and MUPs:

- A high percentage of individuals living below the poverty level
- A high percentage of individuals over age 65
- High infant mortality
- Lower primary care provider to population ratios



Percent Population that Lives in a HRSA-Designated Medically Underserved Area (MUA) Across the Region:

- 37.6 percent of the Bedford County population lives in a HRSA-designated Medically Underserved Area (MUA).
- 18.3 percent of the Blair County population lives in a HRSA-designated Medically Underserved Area (MUA).
- 35.4 percent of the Somerset County population lives in a HRSA-designated Medically Underserved Area (MUA).

The entire geographic region of Allegany County, Maryland contains HRSA-designated Medically Underserved Populations (MUPs).

Findings: Significant Health Needs for the Community:

Synthesizing data from the community input process and secondary data analyses for Bedford, Blair, Somerset, and Allegany counties yielded four significant health needs for the community:

- **Chronic Disease Management**
- **Behavioral Health**
- **Access to Care and Navigating Resources**
- **Prevention and Community-Wide Healthy Living**

Significant Health Needs for the Community	
Chronic disease management rated highly in importance for the community.	**Behavioral health** rated as highly important for the region, with an emphasis on opioid addiction and substance abuse.
Access to care and navigating resources was perceived as important in the hospitals' ability to address and likelihood of making a significant impact.	**Prevention and community-wide healthy living** was perceived as highly important for the community.

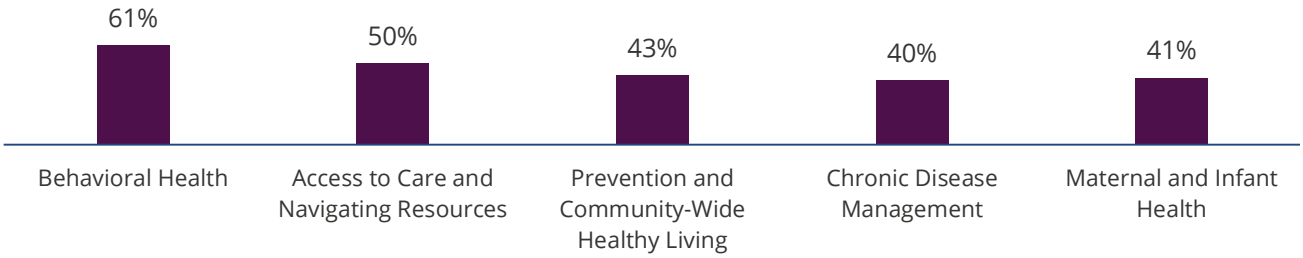
These four significant health needs were identified based on data from the community input process, earlier concept mapping efforts conducted with community participants, public health literature, and consultation with public health experts. Each need represents an area that is correlated with, and often drives, health outcomes, including mortality, quality of life, risk of hospitalization, and disease burden. All four significant health needs rated as a high priority on importance across the community leader surveys administered in Bedford, Blair, Somerset, and Allegany counties (scored above 4 on a scale of 1 to 5). For UPMC hospitals in Bedford, Blair, Somerset, and Allegany counties, the assessment also identified ten composite health topics within the overarching health priorities.

Bedford, Blair, Somerset, and Allegany County Significant Health Needs			
Chronic Disease Management	**Behavioral Health**	**Access to Care and Navigating Resources**	**Prevention and Community-Wide Healthy Living**
• Obesity • Heart Disease and Stroke • Diabetes • Cancer	• Opioid Addiction and Substance Abuse • Access to Behavioral Health Services	• Primary Care • Specialty Care	• Community Prevention and Wellness Initiatives • Health-Related Social Needs

Perceived Disparities Affecting Community Health:

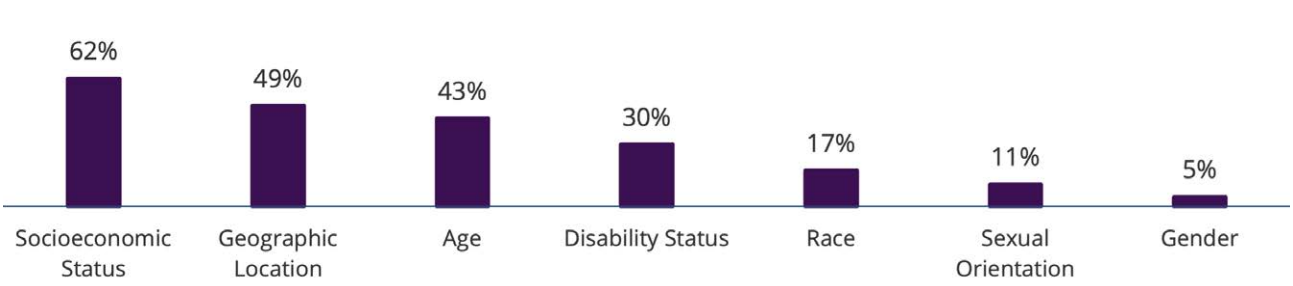
The community input process also assessed the extent to which disparities are perceived to exist for these significant health needs. Health disparities refer to preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities. Disparities in community health due to socioeconomic status and other non-medical factors were widely recognized by community stakeholders in the four-county region, and system-wide. A majority of respondents considered disparities to be "very much" or "extremely" affecting all community health needs assessed.

Proportion Reporting Community Health Need Is Strongly Affected by Disparities, West Central Pa. and Md.



Note: *Proportion reporting each source contributes "very much" or "extremely" to disparities in the community health needs.*
Source: *UPMC System-wide Community Input Process, 2021*

Proportion Reporting Source of Disparities in Community Health Needs, West Central Pa. and Md.



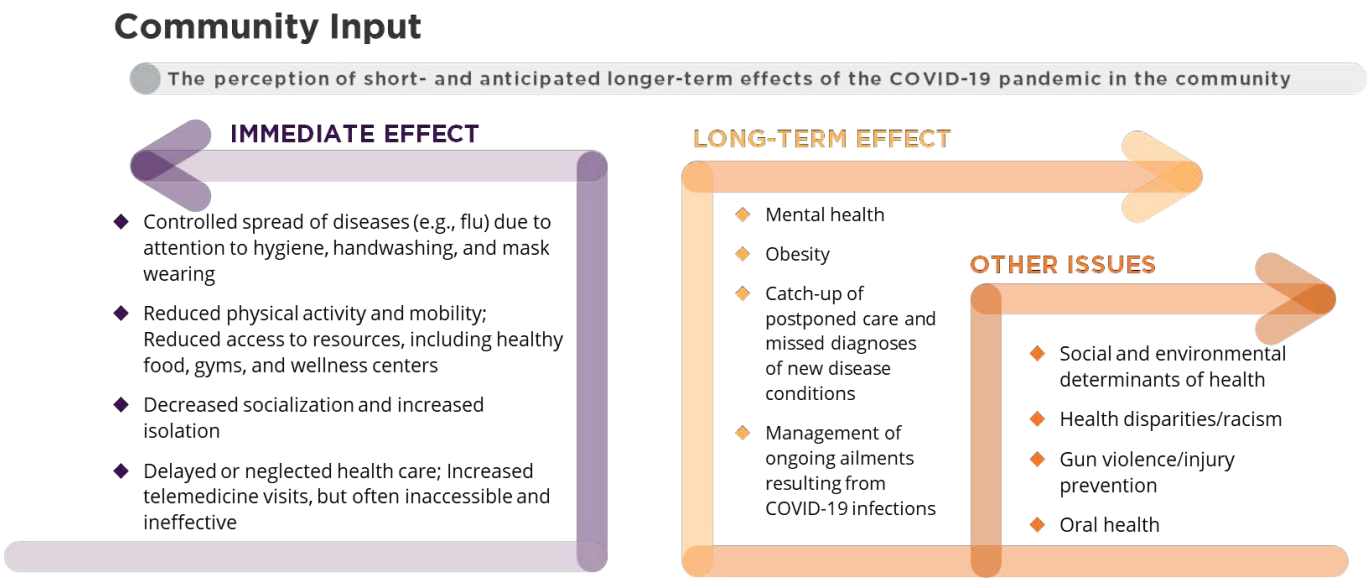
Note: *Proportion reporting each source contributes "very much" or "extremely" to disparities in the community health needs.*
Source: *UPMC System-wide Community Input Process, 2021*

New and Emerging Health Issues in the Community:

On March 11, 2020, the World Health Organization declared COVID-19 a pandemic, which marked the beginning of a global health crisis. Fourteen months later, there were 32.7 million confirmed cases of COVID-19 across the nation, including 1.2 million in Pennsylvania and a half million in Maryland. Of the cases reported in Bedford, Blair, Somerset, and Allegany counties, more than 900 deaths occurred.

The regional approach to control the spread of the virus included social distancing, masking, limiting travel and size of in-person gatherings, and conducting contact tracing. By early 2021, vaccines became widely available to the public, and by December 2021, 49 percent of the eligible population residing in Bedford, Blair, Somerset, and Allegany counties were vaccinated with at least one dose.

COVID-19 produced both short- and long-term consequences for the community's health and wellness and confirmed the significance of the four identified health needs. Emergency measures to treat patients with COVID-19 and contain the outbreak had a direct impact on the community's immediate access to health care. Further, as indicated through the community stakeholder survey, COVID-19 was perceived to exacerbate previously identified significant community health needs, such as behavioral health, which was marked by increased social isolation, and chronic disease management, which was affected by delayed care and reduced physical activity. In other cases, certain aspects of the health topics, such as health-related social needs, emerged with increasing importance and reaffirmed the significance of prevention and community-wide healthy living.



Source: *UPMC System-wide Community Input Process, 2021*

Chronic Disease Management — Importance to the Community:

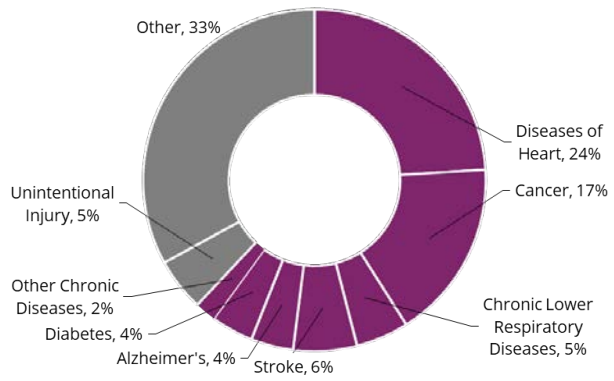
Chronic diseases represent the leading causes of death nationally and in the community.

Chronic diseases are the leading cause of death nationally, in Pennsylvania and Maryland, and in the four-county region. In Bedford, Blair, Somerset, and Allegany counties, approximately two-thirds of deaths are attributable to chronic disease. Chronic diseases have implications for the health and wellness and costs of care for community members. Seniors are particularly vulnerable, as age is correlated with increased likelihood of developing chronic disease.

Chronic Disease is a Leading Cause of Death in the Four-County Region

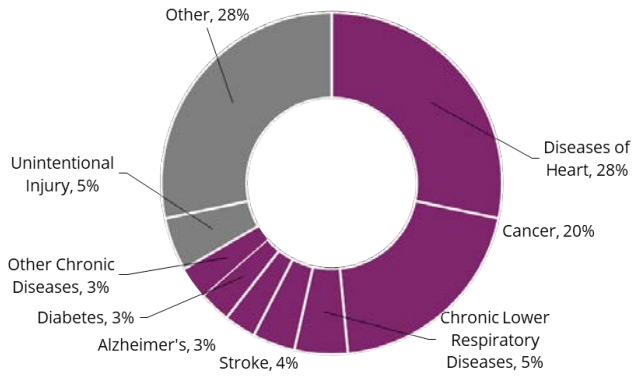
Bedford County

62 percent of deaths are attributable to chronic disease in the county



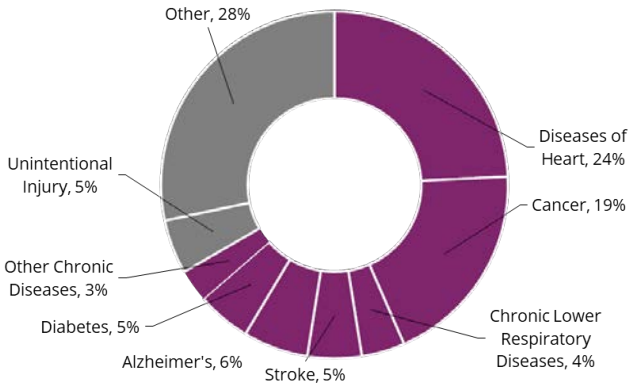
Blair County

67 percent of deaths are attributable to chronic disease in the county



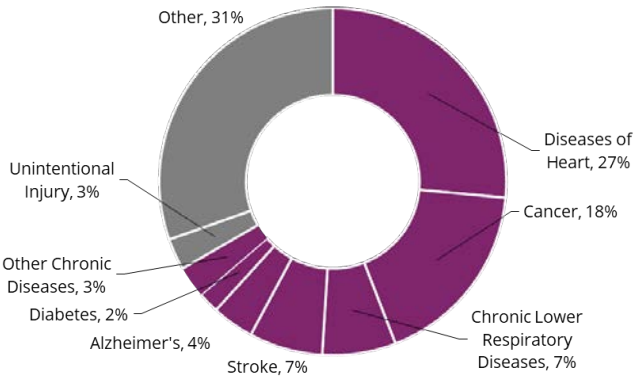
Somerset County

66 percent of deaths are attributable to chronic disease in the county



Allegany County

67 percent of deaths are attributable to chronic disease in the county



Legend:

- Chronic Disease
- Other Conditions

Source: *Pennsylvania Department of Health, 2019; Centers for Disease Control and Prevention, National Center for Health Statistics, 2019*

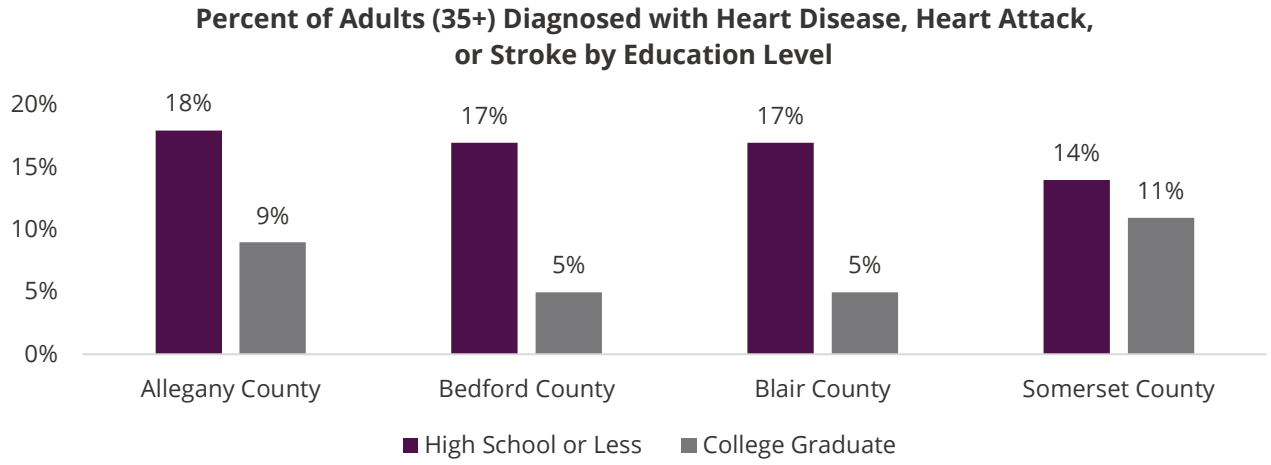
Chronic diseases have important implications for the health and wellness of the community.

Managing chronic diseases is becoming more complex as an increasing number of individuals suffer from multiple chronic conditions or comorbidities.

Chronic Disease	Significance
Obesity	Many populations continue to see steady increases in obesity rates. Obesity is a serious health concern because it is associated with the development of other chronic diseases, including diabetes, heart disease, stroke, and cancer. Nearly 1 in 5 children in grades 7-12 (19.1 percent) in Pennsylvania are obese. In Maryland, 17.6 percent of adolescents ages 10-17 are obese.
Heart Disease	Heart disease is the leading cause of death nationally, in Pennsylvania, and in Maryland. Heart disease is responsible for nearly 1 in every 4 national deaths.
Stroke	Stroke is the fifth leading cause of death for Americans and is responsible for 1 out of every 20 deaths.
Diabetes	Diabetes is among the top 10 causes of death nationally, in Pennsylvania, and in Maryland. In Pennsylvania and Maryland, more than 1 in 10 adults suffer from diabetes.
Cancer	More than 1.6 million people are diagnosed with cancer each year in the United States. Cancer is the second leading cause of death nationally, in Pennsylvania, and in Maryland.

Risks for chronic diseases vary across population segments in Bedford, Blair, Somerset, and Allegany counties, with differences demonstrated for some medically underserved, low-income, and minority populations.

Public health data suggest that lower education and lower income are often associated with increased prevalence of certain chronic diseases. For example, the percentage of adults (35+) in the region who have a high school education or less are more likely to have been diagnosed with heart disease, a heart attack, or stroke, compared to those with a college degree.



Source: *Pennsylvania Department of Health, 2017-2019; Maryland Department of Health, 2019*

COVID-19's Impact on Chronic Disease Management

Chronic disease emerged as an increasingly important health factor during the COVID-19 pandemic, as the prevalence and severity of COVID-19 was linked to preexisting chronic diseases.

Underlying Medical Conditions Increase Risk for Severe COVID-19 Illness: People with chronic conditions (e.g., obesity, diabetes, heart disease, and cancer) faced a higher risk of suffering from severe illness, hospitalization, and even death, compared to those without pre-existing conditions.

Additionally, there is evidence of excess deaths due to chronic conditions (e.g., stroke, heart disease) in the early stage of the pandemic, when people were less likely to seek care due to fear of COVID-19 exposure.

Socioeconomically disadvantaged neighborhoods and minority ethnic communities have higher rates of almost all of the known underlying clinical risk factors for COVID-19 infections, including hypertension, diabetes, asthma, chronic obstructive pulmonary disease (COPD), heart disease, liver disease, renal disease, cancer, cardiovascular disease, obesity, and smoking. Such preexisting health and socioeconomic disparities were found nationally to result in an excess burden of COVID-19 morbidity and mortality.

Behavioral Health — Importance to the Community:

Access to behavioral health services, including assistance to combat opioid and substance use disorders, has significant community health implications.

Behavioral health disorders include a spectrum of conditions, such as anxiety, depression, and bipolar disorder, as well as substance use disorders, such as opioid addiction or alcohol abuse. Behavioral health conditions are among the most common health conditions in the nation.

Public health research has shown that individuals with a behavioral health condition are at greater risk of developing a wide range of physical health problems (e.g., chronic diseases).

Behavioral Health Issues Are Widespread Across the Population Nationally and in Bedford, Blair, Somerset, and Allegany Counties

>50%
Of the national population will be diagnosed with a mental illness during their lifetime.

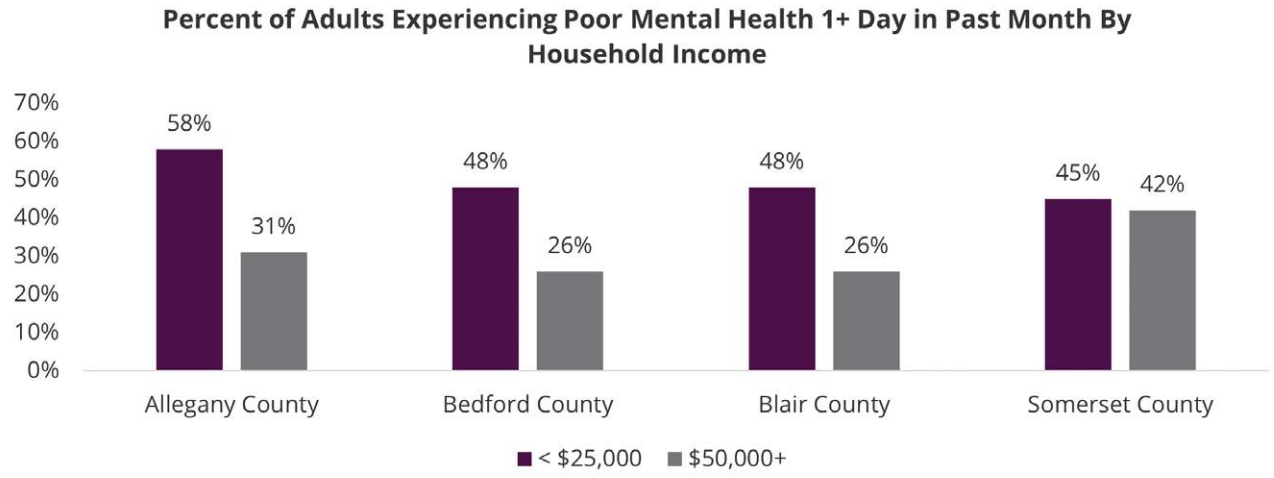
1 in 5
Americans will experience a mental illness in a given year.

1 in 5
Children either have had or have a seriously debilitating mental illness.

Source: *U.S. Centers for Disease Control and Prevention (CDC)*

The percentage of adults who reported experiencing poor mental health in the past month was 36 percent in Bedford and Blair counties, 37 percent in Somerset County, and 38 percent in Allegany County, as compared to 39 percent in the nation.

Behavioral health needs occur at higher rates for some medically underserved, low-income, and minority sub-populations in the community.



Source: *Pennsylvania Department of Health, 2017-2019; Maryland Department of Health, 2019*

Opioid and substance use disorders are an epidemic of concern in Pennsylvania, Maryland, and the United States.

Nationally in 2019, approximately 20.4 million people 12 years or older had a substance use disorder (SUD) associated with alcohol or illicit drug use in the past year. Pennsylvania has also been affected by the opioid epidemic. In Pennsylvania, 65 percent of drug overdose deaths involved opioids in 2018 — a total of 2,866 fatalities. On May 7, 2021, Pennsylvania Governor Tom Wolf signed the 14th renewal of his January 2018 opioid disaster declaration to help the state fight the opioid and heroin epidemic. In Maryland, nearly 90 percent of drug overdose deaths involved opioids in 2018 — a total of 2,087 deaths.

	Bedford County	Blair County	Somerset County	Allegany County	Pennsylvania	Maryland
Drug overdose mortality rate per 100,000 population	29	26	29	45	37	38

Source: *Robert Wood Johnson County Health Rankings & Roadmaps, 2021*

COVID-19's Impact on Behavioral Health

The COVID-19 pandemic and the resulting economic recession negatively affected many individuals' mental health, as adults reported considerably elevated adverse mental health conditions. Symptoms of anxiety disorder and depressive disorder increased considerably in the United States during the COVID-19 pandemic.

- **Opioid Addiction and Substance Use:** Nationally, about 1 in 8 adults started or increased substance use to cope with stress or emotions related to COVID-19, which was elevated from 1 in 13 adults who had a substance use disorder (SUD) in 2018. Substance use is defined as the use of "alcohol, legal or illegal drugs, or prescription drugs that are taken in a way not recommended by your doctor."
- **Minority populations reported disproportionately worse mental health and increased substance use. The pandemic disproportionately affected minority populations nationally:** African American adults (48 percent) and Hispanic or Latino adults (46 percent) were more likely to report symptoms of anxiety and/or depressive disorder than Non-Hispanic White adults (41 percent).

Access to Care and Navigating Resources — Importance to the Community:

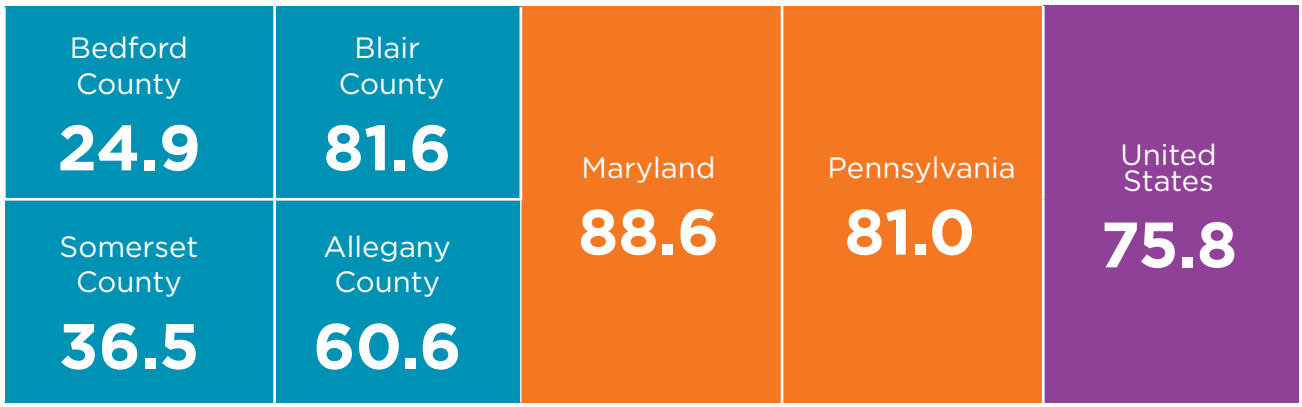
Access to health services and navigating the health care system contribute to positive health outcomes.

Access to care and navigating resources have important implications for the health of the community in a variety of ways, including preventing disease and disability, detecting and treating illnesses or conditions, managing chronic disease, reducing preventable hospitalization, and increasing quality of life.

Primary care services can play a key role in facilitating access. Those without access to usual sources of primary care, such as a primary care physician, are less likely to receive preventive services, such as recommended screenings.

Primary care physician supply in Bedford, Somerset, and Allegany counties is lower compared to state and national benchmarks, while Blair County primary care physician supply is comparable to state and national benchmarks. Within the region, there are populations that may exhibit impeded access to care. Bedford, Blair, Somerset, and Allegany counties contain a number of Health Professional Shortage Area (HPSA) designations, defined as geographic areas or population groups that indicate health provider shortages.

Primary Care Physicians Per 100,000 Population



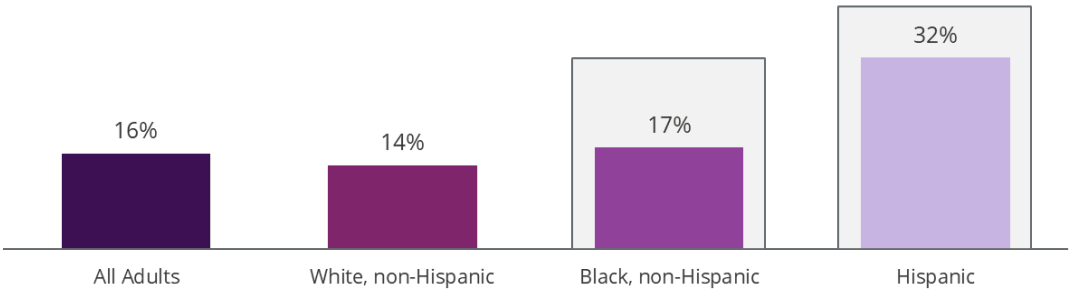
Source: *Robert Wood Johnson County Health Rankings & Roadmaps, 2021*

Fourteen percent of adults in Bedford, Blair, and Somerset counties, and 12 percent of adults in Allegany County reported that they do not have a personal health care provider. Similarly, access to specialty care is an important part of disease care and management, but patients may encounter challenges accessing services.

Available and ready access to primary care services has implications for medically underserved, low-income, and minority populations.

In Pennsylvania in 2019, more Hispanics (32 percent) and African Americans (17 percent) reported not having a personal health care provider compared to White, non-Hispanics (14 percent). In Maryland, data showed comparable rates across White and African American populations for those reporting that they did not have a personal health care provider, but a higher rate for the Hispanic population.

PA Adults That Report Not Having a Personal Health Care Provider in 2019 (percent), by Race/Ethnicity



Source: *Pennsylvania Department of Health, 2019*

In Bedford and Blair counties, residents with a lower level of education (high school or less) were more likely to report not having a personal health care provider (14 percent) compared to those with a college degree (12 percent). In Somerset County, 15 percent of residents with a high school education or less reported not having a personal health care provider, compared to eight percent with a college degree.

COVID-19's Impact on Access to Care and Navigating Resources

Challenges in accessing and coordinating health care were magnified during the COVID-19 pandemic as the population's movement and ability to travel was limited statewide. As in-person visits to physician practices declined, telehealth visits rapidly increased. While telehealth visits serve to mitigate some access challenges, they introduce new ones, such as reliance on the internet, acquiring technological devices, such as a smartphone or computer, and competence in operating the technology. In Bedford, Blair, Somerset, and Allegany counties, more than 1 in 4 households report lack of access to internet at home.

Reluctance to Seek In-Person Health Care During the Pandemic: The risk of contracting COVID-19 affected patients' ability to visit a health care provider or dentist for wellness care. Rates for routine preventive care and chronic condition monitoring dropped as efforts increased to limit exposure and spread of the COVID-19 virus. About 1 in 3 adults avoided seeking or delayed routine care during the pandemic, placing patients at a higher risk for increased morbidity and mortality associated with treatable and preventable health conditions.

NEARLY
HALF

of adults (40 percent) in the United States delayed medical care during the COVID-19 pandemic.

1 in 3

Adults in the United States avoided seeking or delayed **routine care** during the pandemic, resulting in missed opportunities for management of chronic conditions, receipt of routine vaccinations, or early detection of new conditions.

1 in 8

Adults in the United States avoided **urgent or emergency care** during the pandemic, particularly those with multiple underlying conditions or disabilities.

Source: *U.S. Centers for Disease Control and Prevention, 2020*

Prevention and Community-Wide Healthy Living — Importance to the Community:

Preventive care efforts are effective tools to improve community health.

Preventive care efforts, such as preventive screenings, can help identify diseases early, improve management of diseases, and reduce costs. Pennsylvania and Maryland have lower rates for mammography and colon cancer screenings compared to Healthy People 2030 benchmarks.

Medically underserved, low-income, and minority populations may be less likely to access or receive preventive care.

Adults in the region with a college degree were more likely to report having a flu shot in the past 12 months (48 percent) compared to those with less than a college education (43 percent).

Health-related social needs (lack of affordable housing, food insecurity, and unemployment) are associated with negative health outcomes.

Health-related social needs (HRSN) are the economic and social conditions that impact health, including housing instability, food insecurity, and unemployment. Academic research and government agencies continue to study the impact of health-related social needs on health outcomes. Research shows a strong association between health-related social needs and the incidence and severity of disease, life expectancy, and overall wellbeing.

Prevention also includes efforts to keep the community safe.

Accidental, or unintentional injury, is the third leading cause of death nationally and in Pennsylvania, and the fourth leading cause of death in Maryland. Interpersonal safety (accidental/unintentional injury, violence) may disproportionately impact minority populations nationwide.

COVID-19's Impact on Prevention and Community-Wide Healthy Living

Community Prevention and Wellness Initiatives were similarly limited by travel restrictions and social distancing. However, new preventive care efforts have gained prominence relating to COVID-19 vaccines, testing, and containment. The COVID-19 pandemic also has an impact on health-related social needs, such as increased unemployment, food insecurity, and housing insecurity.

- **Unemployment:** Nationally, about 1 in 9 individuals in the labor force were unemployed in June 2020. In west central Pennsylvania and Maryland, the unemployment rate more than doubled during the pandemic. Unstable employment status is shown to be associated with stress-related morbidity and various chronic conditions.
- **Food Insecurity:** Nationally, about 45 million people (1 in 7), including 15 million children (1 in 5), experienced food insecurity in 2020, with a higher prevalence among African Americans compared to white (21.6 percent vs. 12.3 percent). The national prevalence of food insecurity in 2020 was 1.3 times the rate in 2019 (13.9 percent vs 10.9 percent). Two factors that influence food insecurity include unemployment and poverty, both of which increased during the COVID-19 pandemic.

UPMC Is Working to Address Significant Health Needs:

UPMC hospitals in Bedford, Blair, Somerset, and Allegany counties are dedicated to addressing significant health needs in the community.

UPMC hospitals continue to build an extensive suite of programs and services to address the four significant health needs of chronic disease management, behavioral health, access to care and navigating resources, and prevention and community-wide healthy living. UPMC hospitals leverage community-based partnerships and system-wide resources to support residents in need.

Chronic Disease Management

UPMC hospitals in the region are working to increase awareness, prevention, and management of chronic diseases in the community. The hospitals continue to employ and expand a broad array of tactics, including community education and outreach, preventive screenings, and comprehensive, evidence-based chronic disease programs to address chronic disease management in the community.

Behavioral Health

UPMC hospitals in the region continue to enhance and expand efforts to address behavioral health needs in the community through a wide variety of channels and services. Efforts include expanding drug and alcohol rehabilitation programs to include outpatient behavioral health, increasing access to behavioral health specialists, a warm hand-off program, suicide prevention, and community education.

Access to Care and Navigating Resources

Collaborating with local community organizations, as well as pioneering innovative care models, UPMC hospitals in Bedford, Blair, Somerset, and Allegany counties are working to extend access to primary and specialty care with telehealth capabilities, walk-in clinics, expanded office hours and office locations, and recruiting providers to the community.

Prevention and Community-Wide Healthy Living

UPMC hospitals in the region continue to partner with local organizations to enhance and develop programs that promote health and wellness in the community. UPMC hospitals in Bedford, Blair, Somerset, and Allegany counties are promoting healthy lifestyle choices, offering screenings and vaccinations, and advocating for consistent school attendance as a vehicle for improving physical, educational, and social wellbeing of at-risk adolescents and children.

2022 Significant Health Needs in Bedford, Blair, Somerset, and Allegany Counties										
UPMC Hospitals in Bedford, Blair, Somerset, and Allegany Counties	**Chronic Disease Management**				**Behavioral Health**		**Access to Care and Navigating Resources**		**Prevention and Community-Wide Healthy Living**	
	Obesity	Heart Disease and Stroke	Diabetes	Cancer	Opioid Addiction and Substance Abuse	Access to Behavioral Health Services	Primary Care	Specialty Care	Community Prevention and Wellness Initiatives	Health-Related Social Needs
UPMC Altoona		✓			✓	✓	✓	✓		✓
UPMC Bedford		✓					✓	✓	✓	
UPMC Somerset		✓	✓	✓	✓	✓	✓	✓		
UPMC Western Maryland	✓	✓	✓		✓	✓				

IV. UPMC Hospitals Are Improving Community Health

2019-2022 Progress Reports and 2022-2025 Implementation Plans by Hospital

Charting Progress: Reflecting on the Impact UPMC Has Had Over the Past Three Years:

UPMC Altoona, UPMC Bedford, UPMC Somerset, and UPMC Western Maryland have worked to continuously improve community health since the last CHNA cycle. The following reports showcase the extensive range of innovative programs and initiatives these hospitals have put in place to promote community health and wellbeing.

Moving Forward: Continuing to Promote Health and Wellbeing in the Community:

To address the significant community health needs identified through the 2022 CHNA process, UPMC Altoona, UPMC Bedford, UPMC Somerset, and UPMC Western Maryland each developed an implementation plan. The hospital plan relies on collaboration and partnership with many of the same organizations and stakeholders that participated in the assessment process. In addition, the plan considers input from:

- Community-based organizations
- Government organizations
- Non-government organizations
- UPMC hospital and Health Plan leadership
- Public health experts that include Pitt Public Health

The following section contains a description of each hospital, its 2019 CHNA priorities, a progress report documenting initiatives taken to respond to those priorities over the 2019 to 2022 time period, and the hospital's CHNA priorities and implementation plan for 2022 to 2025.

Community Health Improvement Progress and Plan

2019 – 2022 Progress Report and

2022 – 2025 Implementation Plan

UPMC | ALTOONA

Caring for the Community

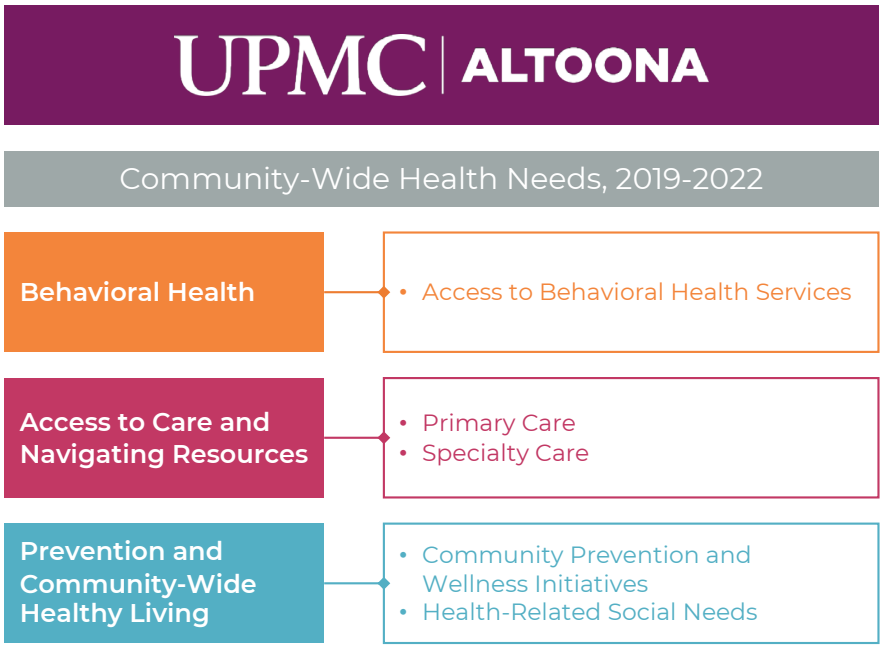
UPMC Altoona is a nonprofit, 398-bed tertiary care teaching hospital located in Blair County, Pennsylvania. In operation since 1886, the hospital became affiliated with UPMC in 2013 and now serves as its regional hub in west central Pennsylvania. It is the largest employer in the county and delivers an array of specialized programs and services to the residents of Blair County and surrounding areas, including medical, surgical, behavioral health, obstetrics, and advanced wound care.

Known for its expertise in trauma care, stroke care, and advanced cardiothoracic, neurological, and vascular surgery, UPMC Altoona stands apart from other hospitals in the region. UPMC Altoona's designated adult Level II Trauma Center and Primary Stroke Center serve patients in a 20-county region, and comprehensive programs for cancer care, heart and vascular services, neurosurgery, and other specialized minimally-invasive and robotic surgical services, draw patients from across the area. Since affiliating with UPMC, the hospital has benefited from a $250 million commitment to improve health care facilities and services for patients.

VITAL STATISTICS Calendar Year 2020		JOBS AND STRENGTHENING THE LOCAL ECONOMY	
Licensed Beds	398	Employees	2,780
Hospital Patients	23,880	Community Benefits Contributions	$41.2 million
Emergency Dept. Visits	51,856	Free and Reduced Cost Care	$17.4 million
Total Surgeries	16,232	Total Economic Impact of Hospital Operations	$689.0 million

Addressing the Community's Significant Health Needs

When the Fiscal Year 2019 CHNA was conducted, UPMC Altoona affirmed the following significant health needs:



Advancing Community Health Initiatives While Navigating the COVID-19 Pandemic

Beginning in March 2020, the COVID-19 pandemic disrupted Pennsylvania's communities, economy, and health care organizations. To help slow the spread of COVID-19 throughout the region, state and local governments issued community mitigation and social distancing measures, impacting UPMC Altoona's ability to implement planned community health improvement initiatives. As a result, UPMC Altoona temporarily suspended or modified in-person programs to promote social distancing, educated the community about the health risks of COVID-19, increased access to telehealth services, established COVID-19 testing and vaccine sites, and worked with state and local leaders to deliver COVID-19 vaccines. Additionally, UPMC Altoona is one of the UPMC sites where monoclonal antibody therapy is provided to patients. While UPMC Altoona navigated the complexities of the pandemic, the hospital continued to address identified health needs by developing innovative approaches and strategies to engage with its communities.

Behavioral Health

Access to Behavioral Health Services

UPMC Altoona continues to address behavioral health in the community, with a particular focus on meeting the needs of children and adolescents.

GOAL:

Increase awareness of and access to behavioral health services

STRATEGY:

Improve communication, coordination, and cooperation among and between service providers

ACTIONS:

- ✓ Identify opportunities to improve and expand services in existing programs that aim to provide access to behavioral health specialists in the community

TARGET POPULATION:

- General community
- Children and adolescents

PROGRAMS:

- Behavioral Health Crisis Center's Mobile Crisis Team program
- Discharge Care Coordination/Communication
- Warm Hand-Off program
- Community Conversations about Mental Health for Children and Adolescents
- Screening Brief Intervention and Referral to Treatment (SBIRT)
- Columbia-Suicide Assessment tool training

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2019-2022)

1,308
Mobile Crisis Team Visits
(July 2019 – March 2021)

54,126
SBIRT Screenings Conducted
(March 2017 – March 2021)

939
Patients Engaged with a Recovery Specialist for a Warm Hand-Off to Support Services
(July 2019 – March 2021)

PROGRAM HIGHLIGHTS:

Reaching Out to Community Members in Crisis

Over the last three years, the Mobile Crisis Team, part of UPMC Altoona's Behavioral Health Department's Crisis Center, continued to provide on-site, face-to-face mental health services for individuals and families experiencing a behavioral health crisis and to provide intervention in situations to prevent them from escalating into crises. Mobile Crisis Team counselors respond to crises in the community, such as police calls, deaths, and suicides. They meet with family members and patients in these scenarios and help to provide support, resources, and assessments anywhere in Blair County.

The UPMC Altoona Mobile Crisis Team is reachable 24/7, 365 days a year, at 814-889-2141.

- **Increased Demand for Services:** Over the last six years, the program has continued to see an increased need for mobile crisis intervention. In 2018, the program served approximately 400-500 individuals per year. In 2020, the program served 600-700 individuals, meeting 70 percent of requests.

Screening More than 54,000 Patients and Offering Referrals to Treatment

Since 2017, UPMC Altoona and its community partners have continued to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT), an approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders. SBIRT is a tool that can be used by health care professionals in multiple care and treatment settings, including primary care physician offices and pregnancy care centers, who have established relationships with patients. SBIRT can also be used in an episodic care setting, such as a pharmacy or emergency situation with first responders. Accomplishments include:

- **More than 54,000 patients screened over four years:** Since implementation of SBIRT with the initial Blair County community providers: Empower 3 Center for Health (fully implemented in March 2017), the UPMC Altoona Pregnancy Care Clinic (fully implemented in June 2018), and UPMC Altoona Family Physicians Family Medicine Residency Program (fully implemented in June 2018), more than 54,000 patients have been screened and, as indicated, offered referral.
- **More than 140 first responders trained to use SBIRT:** In 2020, the Blair Drug and Alcohol Partnerships received a federal grant to provide SBIRT training to first responders, including emergency medical technicians and police officers. As a result, 78 EMS staff and 63 police officers were trained, and more than 150 patients were screened and referred for treatment between September 2020 and March 2021.

Supporting Patients with Warm Hand-Offs to Treatment Services

The hospital's Emergency Department (ED) hosts a Certified Recovery Specialist (CRS) from the Blair Drug and Alcohol Partnership. This CRS engages patients with substance use disorders at the time they present in the ED, targeting overdose survivors.

- From July 1, 2019 to January 2021, 939 individuals in UPMC Altoona's Emergency Department were engaged by the embedded CRS. Of the 652 patients who accepted referral to treatment, 492 (75 percent) attended their first treatment appointment.

COMMUNITY PARTNERS:

Healthy Blair County Coalition Mental Health Work Group, Blair County Department of Social Services, Altoona Area and Hollidaysburg high schools, Blair County Children, Youth, and Families, Blair County Drug and Alcohol Partnership, local police departments and EMS services, Altoona Family Physicians, local schools

Access to Care and Navigating Resources

Primary Care and Specialty Care

UPMC Altoona continues to address access to care and navigating resources in the community. The hospital is further augmenting efforts to bring specialty care services to the community.

GOAL:

Improve access to primary care and specialty care in the region

STRATEGY:

Leverage UPMC's extensive provider network to provide specialty care to residents in the community

ACTIONS:

- ✓ Increase access to primary care
- ✓ Enhance and expand telehealth services for specialty care

TARGET POPULATION:

- General community

PROGRAMS:

- Telehealth services
- Evaluate expansion of current hospital-based urgent care/walk-in clinic
- Initiate medical staff development planning efforts to quantify primary care and specialty physician need
- Develop and implement physician and recruitment plan to meet current and projected physician need
- Partnership initiatives among regional UPMC hospitals that foster collaborative recruitment efforts to maximize success in recruitment of primary care and specialty physicians

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2019-2022)

19,390
Walk-In Center Visits
(July 2019 – March 2021)

56
Physicians Recruited to Region
(January 2019 – March 2021)

PROGRAM HIGHLIGHTS:

Successfully Recruiting Physicians

UPMC Altoona continues to assess the community's needs for primary and specialty care. UPMC Altoona, UPMC Bedford, UPMC Somerset, and UPMC Western Maryland leaders discuss physician recruitment needs on a monthly basis and work together to recruit needed physicians to the region. The Physician Recruitment Team at UPMC Altoona also helps to recruit physicians for UPMC Bedford.

In 2019, UPMC Altoona and UPMC Bedford worked with 3D Health, a national staff development plan consulting firm, to create a three-year: 2019 - 2022 Medical Staff Development Plan for both hospitals. Both plans quantify primary care physician and specialist needs in the region. In this context, primary care is defined as "family medicine, general internal medicine, hospitalist, and emergency medicine." For the 27-month period (January 2019 through March 2021), UPMC Altoona and UPMC Bedford successfully recruited a total of 56 new physicians, including 33 primary care physicians and 23 specialists.

Improving Access to Primary Care through a Walk-In Center

In July of 2017, in response to growing patient need, as evidenced by an increasing number of visits to the hospital emergency department for non-urgent and primary care needs, UPMC Altoona opened a Walk-In Center. The Walk-In Center is located at Station Medical Center, which is on a main traffic route in the city, making it easily accessible to patients. UPMC Altoona's Primary Care Walk-In Center offers a convenient option to the community and serves those without a primary care provider. The Altoona Walk-In Center sees patients ages five years and older for acute minor illnesses, injuries, sports physicals, and some diagnostic services.

Visits to Walk-In Center

Calendar Year	Total Number of Visits	Monthly Average
2018	10,433	869
2019	11,981	998
2020	10,805	900
2021 Q1	2,045	682
Total: 38,599		

- Responding to an increased community need to improve access to services, the Walk-In Center expanded clinic hours in September 2019 and is now operational Monday through Friday from 7:30 am to 7:30 pm and on Saturdays from 8:00 am to 12:00 pm.
- As of March 2021, the Center has had 38,599 visits since it opened in July 2017.
- Due to the pandemic, the Center saw a ten percent decrease in monthly visits. For the first three months of 2021, as the effects of the pandemic lessened, the Center had 2,045 visits, for a monthly average of 682.

COMMUNITY PARTNERS:

UPMC Presbyterian, UPMC Mercy, UPMC Magee-Womens Hospital, 3D Health, Inc.

Prevention and Community-Wide Healthy Living

Community Prevention and Wellness Initiatives

UPMC Altoona embraces a community-oriented approach to providing a range of initiatives that promote healthy behaviors and support at-risk populations. The hospital continues to collaborate with many local organizations, such as the Healthy Blair County Coalition, to offer effective programming that encourages increased physical activity and healthier nutrition.

GOAL:
Promote healthy behaviors throughout the community

STRATEGY:
Continue targeted initiatives to combat obesity, promote healthy behaviors, and increase diabetes awareness

ACTIONS:

- ✓ Enhance efforts to promote healthier nutrition
- ✓ Encourage increased physical activity
- ✓ Increase education and awareness about cancer, diabetes, and heart disease and stroke
- ✓ Promote dental health

TARGET POPULATION:

- General community

PROGRAMS:

- Healthy Steps in Motion
- Yoga
- Diabetes awareness and education
- Senior health and fitness
- Heart disease and congestive heart failure
- Exercise and aging
- Health fairs
- Real Solutions for Success
- Giant Eagle food tours
- Freedom from Smoking
- Blair County Corporate Fitness Challenge
- Let's Move Blair County
- Sponsor publishing of Active Living brochure
- Dental health initiatives

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2019-2022)

2,011
Community Members Engaged in Health Education
(July 2019 – March 2021)

406
Attendees at 14 Health Screenings Events
(July 2019 – March 2021)

466
Participants in Cancer, Heart Disease, and Stroke Events
(July 2019 – March 2021)

PROGRAM HIGHLIGHTS:

Educating the Community about Cancer, Heart Disease, and Stroke

To help increase awareness about the signs and symptoms of cancer, heart disease, congestive heart failure, and stroke, UPMC Altoona provides free education at various community events, senior centers, community centers, and churches. Between July 2019 and March 2021, UPMC Altoona hosted 21 in-person and virtual events, with a total of 466 community participants who learned about the early warning signs of cancer, heart disease, and stroke.

Offering Screenings and Education

UPMC Altoona continues to offer preventive screenings and community education to increase awareness and promote early detection and treatment of disease. Over the last three years, the hospital hosted 14 screening events, reaching 406 total attendees. Health education topics included breast health, breast cancer awareness, gynecological cancer, and colorectal cancer.

Encouraging Weight Loss Through Exercise and Education

- UPMC Altoona continues to collaborate with community partners, such as the Healthy Blair County Coalition, to implement strategies and programs throughout the region that promote active lifestyles and healthy eating. Efforts include: Healthy Steps in Motion, Yoga, and Real Solutions for Weight Loss. From July 2019 through March 2021, UPMC Altoona held 18 events, with 264 community participants.
- **Active Living Brochure:** In collaboration with the South Hills School of Business & Technology, the hospital continues to sponsor an Active Living Brochure/Map. This brochure serves as a resource for the community to learn about activities, facilities, and events in Blair County that promote healthy behaviors. Since 2019, 20,000 copies have been distributed.

Increasing Access to Dental Care for Low-Income Individuals

UPMC Altoona's Partnership for a Healthy Community provides low-income individuals with access to dental care. For the last several years, the UPMC Dental Clinic has conducted exams and offered fluoride varnishes at two Head Start centers. This effort resulted in a 25 percent increase in screenings for children and helped to improve parental follow-up for dental visits. The UPMC Dental Clinic received a grant to purchase mobile dental equipment and had planned to expand services to other sites. However, due to the pandemic, dental care at Head Start has been postponed and expansion to new sites has been put on hold.

- From July 2019 to February 2021, the UPMC Dental Clinic had 6,903 patient visits: 4,300 adults visits and 2,603 child visits for dental services.

COMMUNITY PARTNERS:

Healthy Blair County Coalition, Let's Move Blair County, Blair County Planning Commission, Blair County Chamber of Commerce, Blair County Drug and Alcohol Program, Youth Connection Task Force, Giant Eagle grocery store, local YMCAs, local employers, Robert Wood Johnson Foundation, social service agencies

Prevention and Community-Wide Healthy Living

Health-Related Social Needs

UPMC Altoona embraces a community-oriented approach to promoting healthy behaviors and supporting at-risk populations.

GOAL:
Promote healthy behaviors through the community

STRATEGY:
Support programs aimed at helping children and adolescents living below the poverty line

ACTIONS:

- ✓ Promote consistent school attendance as a vehicle for improving physical, educational, and social wellbeing of at-risk adolescents and children

TARGET POPULATION:

- Children and adolescents
- Low-income families

PROGRAMS:

- Explore opportunities to partner with local organizations (e.g., Youth Connection Task Force)

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2019-2022)

1 out of 12
Counties Selected by the National Association of Counties to Receive Community Coaching to Reduce Poverty
(July 2019 – March 2021)

$20,000
Grant Earned from Robert Wood Johnson Foundation to Build Connection with At-Risk Youth
(August 2019)

PROGRAM HIGHLIGHTS:

Supporting Blair County Youth

Blair County was one of twelve counties across the country to be chosen by the National Association of Counties (NACo) in partnership with the *Robert Wood Johnson Foundation County Health Rankings & Roadmaps* program to receive community coaching on efforts to reduce childhood poverty with an emphasis on youth connections.

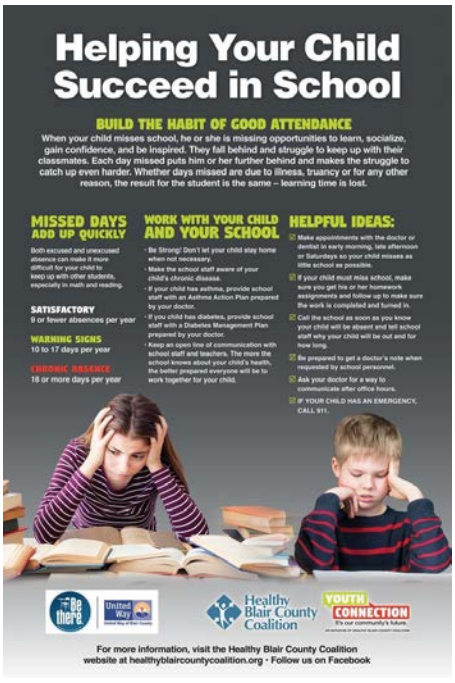
Blair County Rises in County Health Rankings

Blair County ranked #39 out of 67 Pennsylvania counties in the most recent county health ranking by the Robert Wood Johnson Foundation, released on March 31, 2021. This is a 23-county ranking improvement from #62 in 2011.

Youth Connection Task Force: In October 2017, the Healthy Blair County Coalition held a Call to Action Summit to engage community stakeholders in understanding the impact of youth disconnectedness and to provide input on addressing the issue with the county. As a result, the Youth Connection Task Force was formed and includes membership from youth services agencies, schools, health care, workforce development, juvenile probation, drug and alcohol, etc. Their purpose is (1) to develop and implement strategies and programs to encourage youth connections,

and (2) to form partnerships that support and provide resources that give youth pathways of opportunity. As part of its work with the Healthy Blair County Coalition (HBCC), UPMC Altoona supports the Youth Connection Task Force, which is working to help launch the Be There Program and Be There Buddy Mentoring Program in Blair County as part of the Rural Impact County Challenge. Accomplishments include:

- Sponsored training in March 2019 for school districts to implement the Be There School Attendance Challenge and Be There Buddy Mentoring Program. This is a data-driven initiative with training, toolkits, marketing materials, and resources that were given to Blair County. The Be There Challenge is a series of activities designed to encourage students to come to school. The Be There Buddy Mentoring Program identifies a small group of students who need additional support and mentoring so that they are more likely to attend school.
- School Attendance Task Force members conducted presentations and/or engaged in discussions with UPMC Altoona physicians and health care providers on the connection between health and school attendance. Health care provider and family posters outlining the connection between health and school attendance were distributed throughout the county.
- In August 2019, HBCC/Blair County received a $20,000 Robert Wood Johnson Foundation grant. This grant focused on sharing a successful program with another community for the purpose of replication and collaborative learning. The grant was used to replicate the Graduation Initiative/Connect like Crazy Program developed in the Tyrone Area School District and replicated in the Altoona Area School District. The goal of this program is to build connections with at-risk students, their families, and communities to help increase a student's access to post-secondary education and sustainable work. Funds were used for training school staff, strategic planning sessions, developing a brochure and Standard Operating Procedures (SOP) for distribution to other interested school districts, and supplies needed for youth involved in the program.



COMMUNITY PARTNERS:
Healthy Blair County Coalition, Youth Connection Task Force, School Attendance Task Force, Blair County school districts, Sheetz, Inc.

UPMC Altoona Is Addressing High Priority Health Issues:

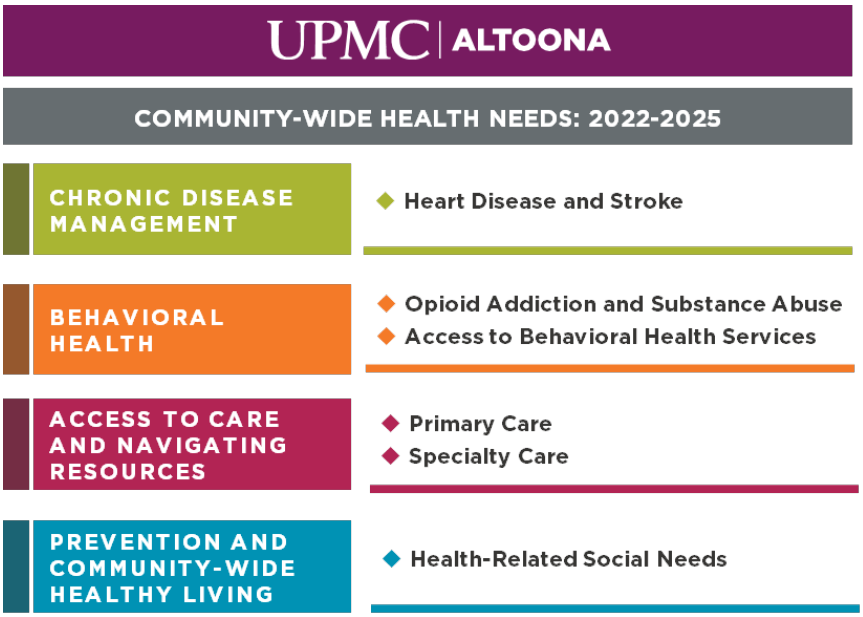
Adoption of the Implementation Plan

On June 16, 2022, the UPMC Altoona Board of Directors adopted an implementation plan to address the significant health needs identified:

- Chronic Disease Management
- Behavioral Health
- Access to Care and Navigating Resources
- Prevention and Community-Wide Healthy Living

UPMC Altoona Is Leveraging UPMC and Community Resources

By providing a comprehensive suite of programs, UPMC Altoona plays an important role in addressing the community health needs that were identified in the recent Community Health Needs Assessment. The hospital will support the priority areas with internal resources, through grants, and by strengthening collaborations with numerous community partners.



Working to Advance Health Equity

UPMC Altoona recognizes that a broad range of efforts both within and beyond health care will be instrumental in addressing issues that contribute to health disparities. UPMC Altoona's 2022-2025 Implementation Plan includes health equity-promoting programs and initiatives, which aim to help address socioeconomic and other factors that may contribute to health disparities. Efforts include:

- **Developing Models to Overcome Geographic Barriers to Care:** Creating approaches and implementing strategies to help improve access to primary, specialty, and behavioral health care in rural communities, including enhancing provider recruitment and providing on-site crisis intervention.
- **Increasing Access to Care for Rural Communities:** Increasing the convenience and accessibility of primary and specialty care services by expanding access to providers, reducing patient wait times for appointments, and exploring opportunities to offer telehealth services.

COMMUNITY HEALTH NEED

CHRONIC DISEASE MANAGEMENT

UPMC Altoona will help educate community members and health care professionals about recent advances in the prevention, early detection, and treatment of heart disease and stroke. UPMC Altoona will recruit additional physicians to provide care to chronic disease patients, including cardiologists and neurologists.

HEALTH PRIORITY

Heart Disease and Stroke

GOAL

Improve the health of residents in the community through education, early detection, and treatment of chronic disease

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Improve the health and wellbeing of area residents through education and promotion of healthy lifestyle practices.	• Provide heart disease and stroke education and screenings
2. Provide heart disease and stroke education to health care professionals, raising awareness of current treatments and services.	• Educate health care professionals about current treatments for heart disease and stroke to help improve patient care and outcomes
3. Enhance patient access to specialists.	• Recruit physicians to UPMC Altoona Regional Health Services, with a focus on cardiologists and neurologists

TARGET POPULATION

General community

PLANNED COLLABORATIONS

UPMC Altoona Regional Health Services, UPMC Locum Clinicians, UPMC Office of Graduate Medical Education, service area rural hospitals and emergency services providers, physician recruitment firms

COMMUNITY HEALTH NEED

BEHAVIORAL HEALTH

UPMC Altoona is taking a proactive approach to address opioid addiction and substance abuse in the community through early identification of patients at-risk of substance use disorder and timely referrals for intervention and treatment. UPMC Altoona will continue to provide Medication-Assisted Treatment (MAT), the use of medications in combination with counseling and behavioral therapies to treat opioid addiction, to expectant mothers with substance use disorder.

HEALTH PRIORITY #1

Opioid Addiction and Substance Abuse

GOAL

Increase access to intervention and treatment services for substance use disorders

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Train new family medicine residents in the use of Screening Brief Intervention and Referral to Treatment (SBIRT) for substance use disorder and mental health needs, with case manager referrals to appropriate agencies.	• Conduct SBIRT training to onboard new family medicine residents • Identify patients at-risk for substance use disorder and patients with mental health needs and provide referrals to intervention and treatment
2. Continue to provide Medication-Assisted Treatment (MAT) to expectant mothers with substance use disorder.	• Improve the health of expectant mothers and their babies through reduced dependance on opioids
3. Help improve patient health through reduced dependance on opioids at Altoona Family Physicians family medicine practice.	• Explore opportunities to expand MAT to family medicine practices

TARGET POPULATION

General community, women

PLANNED COLLABORATIONS

Altoona Family Physicians, Blair County Drug and Alcohol Partnership, Healthy Blair County Coalition, Healthy Blair County Coalition – Mental Health Work Group

COMMUNITY HEALTH NEED

BEHAVIORAL HEALTH

UPMC Altoona will continue to focus efforts on increasing access to behavioral health services in the community by leveraging UPMC's extensive provider network to recruit additional psychiatrists. UPMC Altoona will also continue to provide on-site behavioral health crisis intervention services through its mobile crisis team.

HEALTH PRIORITY #2

Access to Behavioral Health Services

GOAL

Reduce patient wait times to access behavioral health services in the region

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Recruit psychiatrists to provide services for an expanded patient base.	• Work with physician recruitment firms to secure psychiatrist candidates • Work with UPMC Western Psychiatric Hospital to recruit psychiatry residents to Altoona • Work with UPMC Office of Graduate Medical Education to recruit a psychiatry resident following graduation
2. Provide community outreach and education.	• Provide on-site crisis intervention • Provide community education on suicide prevention

TARGET POPULATION

General community

PLANNED COLLABORATIONS

UPMC Locum Clinicians, physician recruitment firms, UPMC Office of Graduate Medical Education, UPMC Western Psychiatric Hospital

COMMUNITY HEALTH NEED

ACCESS TO CARE AND NAVIGATING RESOURCES

UPMC Altoona will continue to enhance access to specialty care for residents in the region by recruiting the physicians needed to provide care.

HEALTH PRIORITY #1

Primary Care

GOAL

Improve access to primary care providers

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Increase access to primary care by recruiting providers to the region.	• Work with physician recruitment firms to recruit primary care physicians • Collaborate with UPMC Altoona – Altoona Family Physicians: family medicine residency program to recruit residents • Partner with UPMC Office of Graduate Medical Education to recruit family medicine residents following graduation
2. Expand the reach of primary care through virtual visits.	• Continue to offer and promote utilization of video visits as a convenient and secure way to get care through a real-time video conversation with a primary care provider

TARGET POPULATION

General community

PLANNED COLLABORATIONS

UPMC Medical and Surgical departments, UPMC Office of Graduate Medical Education, UPMC Locum Clinicians, physician recruitment firms, 3D Health, Inc.

COMMUNITY HEALTH NEED

ACCESS TO CARE AND NAVIGATING RESOURCES

UPMC Altoona will continue to enhance access to specialty care for residents in the region by recruiting the physicians needed to provide care.

HEALTH PRIORITY #2

Specialty Care

GOAL

Improve access to medical and surgical specialists

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Recruit medical and surgical specialists to increase access to specialist physicians.	• Work with physician recruitment firms to recruit medical and surgical specialists • Work with the UPMC Office of Graduate Medical Education to recruit resident and fellows following graduation
2. Leverage UPMC's extensive provider network to provide specialty care to residents in the community.	• Work collaboratively with other regional UPMC hospitals to share physician specialists • Continue to connect patients with specialists through virtual visits

TARGET POPULATION

General community

PLANNED COLLABORATIONS

UPMC Medical and Surgical Departments, UPMC Office of Graduate Medical Education, UPMC Locum Clinicians, physician recruitment firms, 3D Health, Inc.

COMMUNITY HEALTH NEED

PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING

UPMC Altoona, in collaboration with community partners, will address health-related social needs by supporting programs that promote school attendance.

HEALTH PRIORITY

Health-Related Social Needs

GOAL

Raise awareness about improving school engagement

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Support programs aimed at helping children and adolescents living at or below the poverty line.	• Promote consistent school attendance as a vehicle for improving physical, educational, and social wellbeing of at-risk adolescents and children • Foster partnerships to help encourage school engagement and address truancy and chronic absence

TARGET POPULATION

Children and adolescents, low-income populations

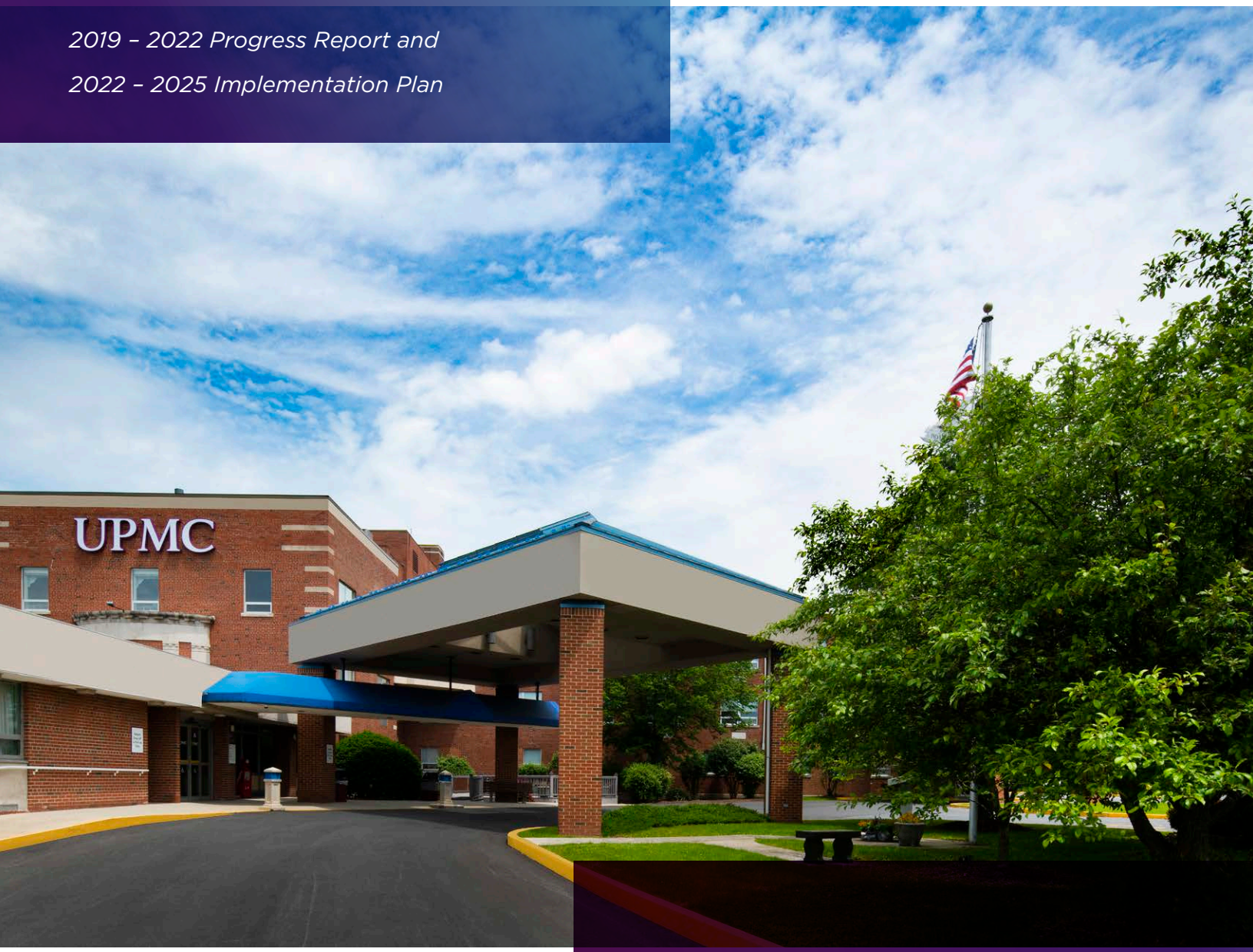
PLANNED COLLABORATIONS

Healthy Blair County Coalition partners, Youth Connection Task Force, School Attendance Task Force

Community Health Improvement Progress and Plan

2019 – 2022 Progress Report and

2022 – 2025 Implementation Plan



UPMC | BEDFORD

Caring for the Community

UPMC Bedford is a nonprofit, 40-bed acute-care hospital located in Bedford County, Pennsylvania. It is the county's only hospital and delivers a full range of quality medical services — including specialized medical and surgical treatment — to the residents of Bedford County. The hospital provides area residents with access to medical, surgical, and rehabilitation care, as well as specialized services, including virtual care, CT imaging, MRI, stroke and coronary care, diabetic care, specialty surgical services (orthopaedics, ENT, dermatology, and gynecology), and cardiopulmonary rehab. UPMC Bedford is certified as an Acute Stroke Ready Hospital by the Joint Commission, in collaboration with the American Heart Association/American Stroke Association.

UPMC Bedford maintains a historically strong connection with its rural community. In addition to being the primary source of health care services in the county, the hospital offers an array of community-oriented programs and services to improve the health of local residents.

VITAL STATISTICS Calendar Year 2020		JOBS AND STRENGTHENING THE LOCAL ECONOMY	
Licensed Beds	40	Employees	262
Hospital Patients	1,438	Community Benefits Contributions	$3.6 million
Emergency Dept. Visits	15,101	Free and Reduced Cost Care	$2.6 million
Total Surgeries	1,555	Total Economic Impact of Hospital Operations	$94.0 million

Addressing the Community's Significant Health Needs

When the Fiscal Year 2019 CHNA was conducted, UPMC Bedford affirmed the following significant health needs:

UPMC | BEDFORD

Community-Wide Health Needs, 2019-2022

Chronic Disease Management
- Diabetes
- Heart Disease and Stroke

Access to Care and Navigating Resources
- Primary Care
- Specialty Care

Advancing Community Health Initiatives While Navigating the COVID-19 Pandemic

Beginning in March 2020, the COVID-19 pandemic disrupted Pennsylvania's communities, economy, and health care organizations. To help slow the spread of COVID-19 throughout the region, state and local governments issued community mitigation and social distancing measures, impacting UPMC Bedford's ability to implement planned community health improvement initiatives. As a result, UPMC Bedford temporarily suspended or modified in-person programs to promote social distancing, educated the community about the health risks of COVID-19, increased access to telehealth services, established COVID-19 testing sites, and worked with state and local leaders to deliver COVID-19 vaccines. While UPMC Bedford navigated the complexities of the pandemic, the hospital continued to address identified health needs by developing innovative approaches and strategies to engage with its communities.

Chronic Disease Management

Diabetes

UPMC Bedford continues to address chronic disease management with a focus on diabetes awareness, prevention, and management. The hospital leverages partnerships with community organizations to build an extensive suite of offerings to manage diabetes in the community, from outreach and education, to evidence-based interventions that link diabetic patients to specially-trained educators.

GOAL:
Increase awareness of disease prevention and management and encourage healthy behaviors

STRATEGY:
Take a comprehensive approach to diabetes awareness, prevention, and management within the community

ACTIONS:
- ✓ Provide chronic disease education, screenings, and intervention in the community
- ✓ Engage in community outreach and events to promote chronic disease awareness
- ✓ Conduct assessment to determine feasibility of an outpatient wound care clinich

TARGET POPULATION:
- General community
- Seniors

PROGRAMS:

Diabetes Prevention and Detection

Education and Screenings

- National Diabetes Day Health Fair
- Diabetes talk at schools and businesses
- Diabetes Academy with a celebrity chef
- Monthly multiphasic screenings

Diabetes Management

Support and Training

- Diabetes management through primary care settings
- Glucose to Goal
- Insulin training provided to personal care home facilities
- Outpatient Wound Care Clinic

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2019-2022)

Hosted the Future of Diabetes Event
(February 2020)

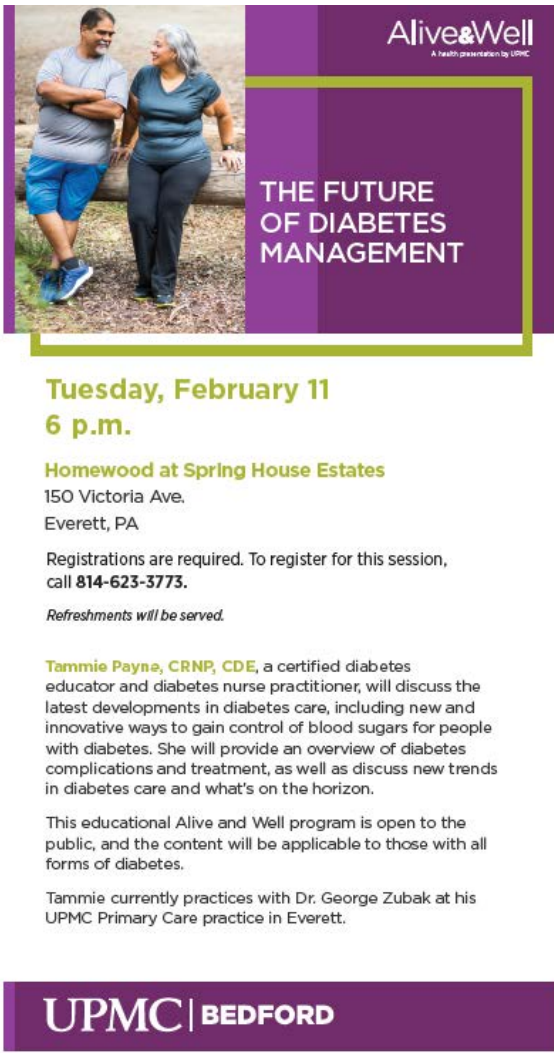
2,100
Total Participantsin Monthly Multi-phasic Screenings
(January 2019 — December 2020)

PROGRAM HIGHLIGHTS

Raising Awareness about Diabetes Prevention and Detection

Over the last three years, UPMC Bedford has continued to offer a range of programs to help community members learn about how to prevent, detect, and manage diabetes. Efforts include:

- **Hosting community education events:** In February 2020, the hospital hosted "The Future of Diabetes," an in-person community education event, which reached 30 participants. Due to the pandemic, UPMC Bedford cancelled its annual diabetes health fair in November 2020.
- **Providing low-cost multiphasic screenings:** Over the past three years, UPMC Bedford continued to offer monthly multiphasic screenings at locations throughout Bedford County.
  - > In 2019, the hospital hosted 12 multiphasic screening events. As a result, 375 individuals were screened for HbA1c and 1,237 were screened for glucose levels. This is an increase of 22 percent compared to 2018.
  - > In 2020, the pandemic impacted the schedule, delivery, and volume of screenings — necessitating the cancellation of April and May events. Screenings resumed in June 2020 by appointment only at locations that safely allow for social distancing. Due to the pandemic, 2020 overall screening volume was 35 percent less than 2019. However, the hospital still provided 246 individuals with screenings for HcA1c and 803 were screened for glucose.



Improving Control of Diabetes

UPMC Bedford continues to provide programs that support self-management of diabetes.

- **Glucose to Goal:** The hospital continues to offer its successful Glucose to Goal program, which links patients to diabetes educators — an approach considered highly effective in primary care settings. By harnessing the potential of electronic medical records, the hospital identifies individuals with diabetes who need help managing their disease and connects them with a certified diabetes educator who can help modify behaviors, such as controlling sugar levels through healthier eating.
  - > From January 2020 through March 2021, 80 patients were seen for diabetes self-management education and counseling. Though the COVID-19 pandemic initially impacted the diabetes educator's ability to meet in-person, the educator adapted by expanding availability for telephone appointments. As it became safer to meet with patients in-person, the diabetes educator offered outpatient hospital appointments and returned to the primary care offices.
  - > 28 percent of participants achieved a reduction in A1c at or near their goal after six months of engaging with the Glucose to Goal program.

- **Diabetes management through primary care settings:** To help support more patients with diabetes, UPMC Bedford embedded a Certified Nurse Practitioner (CRNP)/diabetic educator within a primary care office. This CRNP offers consultation and assistance with the latest in diabetic management tools, including apps, glucose monitoring, and insulin pumps, as well as insulin and oral hyperglycemic medications.
  - > Since June 2019, 123 patients have been referred for diabetic consultation from other primary care locations. 90 additional diabetic patients are engaged with the new CRNP/Diabetes Educator for primary care as well as diabetes management.

Providing Insulin Training to Area Schools

Due to the pandemic, parents were not allowed to attend athletic events, which impacted the health and safety of students with Type 1 Diabetes. To fill a knowledge gap, the hospital offered a training program to the Everett Area School District in August 2020, which taught 10 principals and coaches about insulin delivery devices and how to recognize signs of hypoglycemia.

COMMUNITY PARTNERS:

Hyndman Area Health Center, Bedford County Cooperative Extension Office, primary care practices in Bedford County, including Chestnut Ridge Family Medicine, Pennwood Family Medicine, George Zubak Family Medicine, Bedford Internal Medicine

Chronic Disease Management

Heart Disease and Stroke

UPMC Bedford continues to address chronic disease management, targeting heart disease and stroke. The hospital is maintaining Stroke Readiness Certification, as well as reaching out to the community to provide heart disease and stroke education.

GOAL:
Increase awareness of disease prevention and management and encourage healthy behaviors

STRATEGY:
Leverage a suite of services to promote heart failure and stroke awareness, prevention, and management within the community

ACTIONS:
✓ Provide chronic disease education, screenings, and intervention in the community

TARGET POPULATION:
- General community
- Seniors

PROGRAMS:
- Stroke Readiness Certification
- Community outreach and educational events
- Heart failure education for seniors and the general community
- Specialist recruitment to provide access to heart disease specialty care
- Community blood pressure screenings

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2019-2022)

Certified Stroke Ready Hospital
(July 2019 and July 2021)

984
Blood Pressure Screenings
(January 2019 – March 2020)

PROGRAM HIGHLIGHTS:

Educating the Community about Heart Disease

To help increase awareness about the signs and symptoms of heart disease, congestive heart failure, and stroke, the hospital provides free education at various community events, senior centers, community centers, and churches. Due to the COVID-19 pandemic, the hospital adapted its in-person education programs to a virtual platform — offering an online stroke awareness event in September 2020 to help community members learn about early warning signs, symptoms, and emergency treatment.

Increasing Access to Specialists for Heart Disease

To help increase access to specialty care for heart disease, the hospital continues to recruit providers to Bedford County. In August 2019, UPMC Bedford successfully added a new cardiology practice. Located in Everett, Pennsylvania, this practice has three cardiologists who rotate to provide five-day-per-week coverage to the community and see inpatients in UPMC Bedford's cardiology consult unit. In 2021, this office also recruited a Certified Nurse Practitioner, increasing access and appointment availability.

Earning and Maintaining Stroke Readiness Certification

In 2017, UPMC Bedford earned Advanced Disease-Specific Care Certification for Acute Stroke Ready Hospital from The Joint Commission and the American Heart Association/American Stroke Association. This certification recognizes that UPMC Bedford is equipped to diagnose and treat stroke patients with timely, evidence-based care prior to transferring them to a primary or comprehensive stroke center for more in-depth neurological follow-up.

- In July 2019 and July 2021, UPMC Bedford successfully earned a two-year recertification for Acute Stroke Readiness.
  - > Over the past several years, UPMC Bedford's Stroke Ready Program has continued to see successful patient outcomes and improved stroke response times. In 2017, the hospital's door to needle (medication) times averaged 108 minutes. In 2020, door to needle times were reduced to an average of 73 minutes. This represents an improvement of 33 percent in the delivery time of thrombolytics during a life threating/debilitating ischemic stroke event. Telemedicine link times in 2017 averaged 36 minutes from time of identification to time of link-up with a telemedicine neurologist. Telemedicine link times have been reduced to 16 minutes in 2020, decreasing the time to evaluation of the patient by a telemedicine neurologist by 20 minutes.

COMMUNITY PARTNERS:

Hyndman Area Health Center, Bedford County Cooperative Extension Office, primary care practices in Bedford County, including Chestnut Ridge Family Medicine, Pennwood Family Medicine, and Bedford Internal Medicine

Access to Care and Navigating Resources

Primary Care and Specialty Care

UPMC Bedford is working to expand access to care in the community by leveraging UPMC's extensive network and system-wide resources. The hospital continues to develop innovative models to ensure residents receive the best care close to home.

GOAL:
Increase availability of and access to primary care and specialty care services

STRATEGY:
Leverage UPMC's extensive provider network to expand access to care to residents in the community

ACTIONS:
- ✓ Support pipeline of physicians
- ✓ Increase access to care through various strategies (e.g., physician recruitment, increased awareness of walk-in clinic and expanded hours, and enhanced coordination to schedule appointments prior to discharge)
- ✓ Enhance teleconsult services for specialty care
- ✓ Collaborate with other area providers to improve access, diagnosis, and treatment of geriatric depression

TARGET POPULATION:
General community

PROGRAMS:

Primary Care
- Walk-in clinic and expanded hours
- Physician recruitment

Specialty Care
- UPMC Bedford Teleconsult Center
- Appropriate behavioral health referrals to local resources of Nulton Diagnostics and Hyndman Health Center

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2019-2022)

12
Physicians Recruited to the Region
(2019-2020)

366
Teleconsult Visits
(2019-2020)

PROGRAM HIGHLIGHTS:

Offering Access to Specialty Care Using Telemedicine

When a specialist is not available in Bedford County, UPMC Bedford brings specialty physicians close to home by using telemedicine, which increases access to care and helps save patients travel time to and from Pittsburgh.

- **UPMC Bedford's Teleconsult Center:** Using HIPAA-secure teleconferencing technology and dedicated on-site staff, the Teleconsult Center connects patients directly to specialists in Pittsburgh and on-site medical staff help perform exams and share their findings in real time with the expert physician.
  - > In 2019, the Teleconsult Center hosted an average of 31 telemedicine visits per month.
  - > In 2020, the Teleconsult Center hosted an average of 15 telemedicine visits per month. This decrease in visit volume was due to the pandemic; however, specialists were able to adapt their services and reach their patients through phone or app visits.
- **UPMC Virtual Visits:** During the COVID-19 pandemic, patients wanted to receive timely treatment at home and reduce trips to the doctor's office. To address this need for virtual visits, the MyUPMC app offers patients a convenient, secure way to get care through a real-time video conversation with UPMC providers, using a smartphone, tablet, or computer.
  - > In 2020, UPMC Bedford's Teleconsult Center adapted its service and leveraged the MyUPMC app. From Quarter 3, 2020 to Quarter 1, 2021, telemedicine visits increased by 53 percent.

Successfully Recruiting Physicians

UPMC Bedford continues to assess the community's needs for primary and specialty care. Over the past three years, UPMC Bedford has collaborated with UPMC Altoona to recruit providers to the region. In 2019, UPMC Bedford worked with UPMC Altoona and 3D Health, a national staff development plan consulting firm, to create a Medical Staff Development Plan, which quantifies primary care physician and specialist needs in the region.

- **Primary Care:** Since July 2019, UPMC Bedford has recruited two primary care physicians and three hospitalists, as well as four additional Nurse Practitioners in the primary care role.
- **Specialty Care:** Since November 2019, UPMC Bedford has recruited eight providers to the region, in specialties including, general surgery, podiatric surgery, orthopedic, pulmonology, and Ear, Nose, and Throat (ENT). In 2020, the hospital successfully recruited a full-time dermatologist for the first time.

Responding to Community Need for Primary Care

Established in June 2016, UPMC Bedford's walk-in clinic offered community members convenient access to primary care services. In 2019, the walk-in clinic was open six days per week and saw an average of 750 visits per month. However, the COVID-19 pandemic caused a significant decline in monthly visits. To continue to meet the community's need for access to primary care, the hospital changed the walk-in clinic's model. In November 2020, the clinic became part of UPMC Bedford's Internal Medicine practice. It is open from 8am to 6pm, Monday through Friday, and offers walk-in appointments. The walk-in clinic plays an important role in the community by providing local access to primary care that would otherwise not be available. From November 2020 through March 2021, 744 patients have utilized walk-in appointments, averaging 149 appointments per month.

Connecting Patients with Behavioral Health Services

In partnership with local providers, UPMC Bedford continues to work to improve the mental health of Bedford County's residents by referring patients to Nulton Diagnostics and Hyndman Health Center.

- Since 2019, UPMC Bedford has made 289 behavioral health referrals.
- The hospital is also exploring opportunities to share psychiatric providers within the telemedicine communities of UPMC Altoona and UPMC Bedford in 2021.

COMMUNITY PARTNERS:

Healthy Blair County Coalition, Youth Connection Task Force, School Attendance Task Force, Blair County school districts, and Sheetz, Inc.

UPMC Bedford Is Addressing High Priority Health Issues:

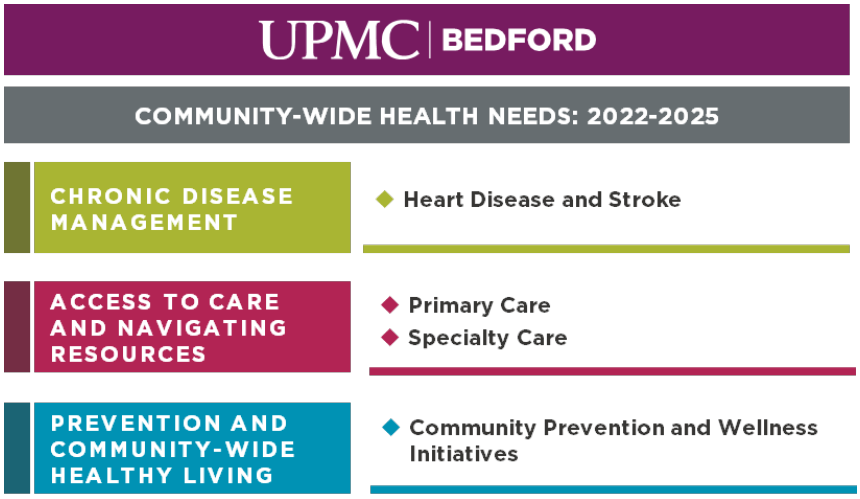
Adoption of the Implementation Plan

On June 16, 2022, the UPMC Bedford Board of Directors adopted an implementation plan to address the significant health needs identified:

- Chronic Disease Management
- Access to Care and Navigating Resources
- Prevention and Community-Wide Healthy Living

UPMC Bedford Is Leveraging UPMC and Community Resources

By providing a comprehensive suite of programs, UPMC Bedford plays an important role in addressing the community health needs that were identified in the recent Community Health Needs Assessment. The hospital will support the priority areas with internal resources, through grants, and by strengthening collaborations with numerous community partners.



Working to Advance Health Equity

UPMC Bedford recognizes that a broad range of efforts both within and beyond health care will be instrumental in addressing issues that contribute to health disparities. UPMC Bedford's 2022-2025 Implementation Plan includes health equity-promoting programs and initiatives, which aim to help address socioeconomic and other factors that may contribute to health disparities. Efforts include:

- **Developing Models to Overcome Geographic Barriers to Care:** Creating approaches and implementing strategies to help improve access to primary and specialty care in rural communities, including enhancing provider recruitment and investing in telemedicine technologies.
- **Increasing Access to Care for Rural Communities:** Increasing the convenience and accessibility of health care services by expanding access to providers and reducing patient wait times through a walk-in clinic with expanded hours.

COMMUNITY HEALTH NEED

CHRONIC DISEASE MANAGEMENT

UPMC Bedford will continue to address chronic disease management, with a dedicated focus on heart disease and stroke, to strengthen access to local resources within the community.

HEALTH PRIORITY

Heart Disease and Stroke

GOAL

Increase awareness of disease prevention and management and encourage healthy behaviors

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Enhance awareness of the risks for heart disease and stroke.	• Raise community awareness of risks of stroke and heart disease through education programs
2. Provide education on how to recognize and quickly respond to the signs and symptoms of stroke.	• Increase the speed for emergency response in early stroke symptoms • Maintain Acute Stroke Ready Hospital certification

TARGET POPULATION

General community, first responders

PLANNED COLLABORATIONS

Cardiology practice, primary care practices in Bedford County, local emergency medical services

COMMUNITY HEALTH NEED

ACCESS TO CARE AND NAVIGATING RESOURCES

UPMC Bedford plans to enhance the existing complement of primary care physicians to provide additional resources and opportunities for the community to receive care in Bedford County.

HEALTH PRIORITY #1

Primary Care

GOAL

Increase availability of and access to primary care services in the community

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Leverage UPMC's extensive provider network to increase access to primary care services in the community.	• Support pipeline of physicians • Provide alternate clinic resources to provide acute sick care visits

TARGET POPULATION

General community

PLANNED COLLABORATIONS

UPMC Altoona Residency Program, UPMC Bedford walk-in-clinic, primary care practices

COMMUNITY HEALTH NEED

ACCESS TO CARE AND NAVIGATING RESOURCES

UPMC Bedford plans to augment and expand the opportunities for patients to receive specialty care within the community.

HEALTH PRIORITY #2

Specialty Care

GOAL

Increase availability of and access to specialty care services in the community

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Expand Cardiology and General Surgery resources in the local area.	• Recruit specialists, with an emphasis on cardiology and general surgery, in partnership with UPMC hospitals in the region • Expand telemedicine capabilities, focusing on cardiology and general surgery services
2. Enhance local wound care.	• Open a local wound care clinic • Provide specialty wound care in the community to provide better healing and improve health outcomes
3. Provide additional opportunities for COVID-19 treatments within the region.	• Explore opportunities to provide COVID-19 treatments and therapies in the local community (e.g., monoclonal antibody infusion center)

TARGET POPULATION

General community

PLANNED COLLABORATIONS

Cardiology office, General Surgery office, UPMC Bedford Telemedicine Clinic, regional UPMC partners of UPMC Altoona, UPMC Somerset, UPMC Western Maryland

COMMUNITY HEALTH NEED

PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING

UPMC Bedford serves as a resource for the community and promotes prevention and wellness activities within Bedford County.

HEALTH PRIORITY

Community Prevention and Wellness Initiatives

GOAL

Promote healthy behaviors throughout the community

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Provide wellness and prevention resources to the residents of Bedford County.	• Offer vaccinations to help reduce the risk of preventable diseases • Offer screenings to the community to enable early identification of treatable conditions or diseases • Help connect patients to the appropriate level of care • Promote healthy lifestyle choices through awareness campaigns

TARGET POPULATION

General community, seniors, children and adolescents

PLANNED COLLABORATIONS

UPMC Bedford Occupational Health, local employers, UPMC Community Medicine, Inc.

Community Health Improvement Progress and Plan

2019 – 2022 Progress Report and

2022 – 2025 Implementation Plan

UPMC | SOMERSET

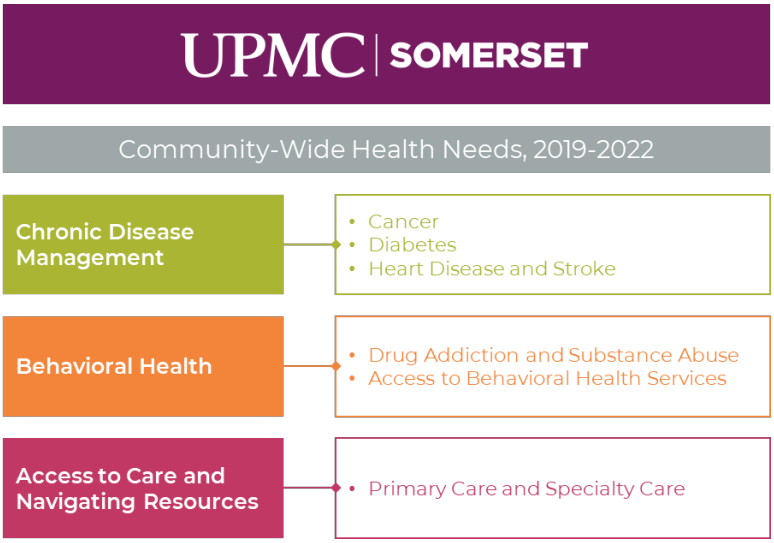
Caring for the Community

UPMC Somerset is a nonprofit, acute care hospital located in Somerset, Pennsylvania. Established in 1921, UPMC Somerset provides access to medical, surgical, and rehabilitation care to Somerset County and beyond. Specialty services include cardiology, orthopaedics surgery, general surgery, pain management, gastroenterology, neurology, pulmonology, urology and gynecology. UPMC Somerset is also a certified Primary Stroke Center.

VITAL STATISTICS Calendar Year 2020		JOBS AND STRENGTHENING THE LOCAL ECONOMY	
Licensed Beds	111	Employees	764
Hospital Patients	3,699	Community Benefits Contributions	$2.5 million
Emergency Dept. Visits	14,815	Free and Reduced Cost Care	$1.3 million
Total Surgeries	3,859	Total Economic Impact of Hospital Operations	$101.4 million

Addressing the Community's Significant Health Needs

When the Fiscal Year 2019 CHNA was conducted, UPMC Somerset affirmed the following significant health needs:



Advancing Community Health Initiatives While Navigating the COVID-19 Pandemic

Beginning in March 2020, the COVID-19 pandemic disrupted Pennsylvania's communities, economy, and health care organizations. To help slow the spread of COVID-19 throughout the region, state and local governments issued community mitigation and social distancing measures, impacting UPMC Somerset's ability to implement planned community health improvement initiatives. As a result, UPMC Somerset temporarily suspended or modified in-person programs to promote social distancing, educated the community about the health risks of COVID-19, increased access to telehealth services, established COVID-19 testing sites, and worked with state and local leaders to deliver COVID-19 vaccines. While UPMC Somerset navigated the complexities of the pandemic, the hospital continued to address identified health needs by developing innovative approaches and strategies to engage with its communities.

Chronic Disease Management

Cancer, Diabetes, and Heart Disease and Stroke

UPMC Somerset continues to address chronic disease prevention and management by offering education and high-quality treatment options for people impacted by chronic disease.

GOAL:
Increase awareness of chronic disease, emphasizing prevention and detection

STRATEGY:
Offer education and high-quality treatment for people impacted by chronic disease

ACTIONS:
- ✓ Continue to promote the importance of early detection for cancer
- ✓ Continue to offer education programs through the Diabetes Education Center
- ✓ Continue to focus on the treatment of heart disease through the cardiology service line and increase awareness about heart disease

TARGET POPULATION:
- General community
- Individuals diagnosed with diabetes
- Individuals diagnosed with heart disease

PROGRAMS:

Cancer
- Colorectal cancer screenings
- Mammograms and programs that assist with paying for mammograms
- Community education on the signs and symptoms of cancer
- Develop a seminar/education series on chronic disease prevention

Diabetes
- Individual and group education
- Diabetes support group
- Grocery store tours
- Education about diabetes prevention
- Develop a seminar/education series on chronic disease prevention

Heart Disease and Stroke
- Interventional cardiology service
- Primary Stroke Center
- Cardiac rehabilitation
- Promote diet, exercise, and stress management at community events
- Blood pressure screenings
- CPR courses
- Develop a seminar/education series on chronic disease prevention

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2019-2022)

5,460
Mammograms Conducted
(July 2019 – March 2021)

1.36
Average decrease in HgbA1C for Patients at Diabetes Education Center
(July 2019 – March 2021)

1,791
Visits to the Cardiac Catheterization Lab
(July 2019 – March 2021)

PROGRAM HIGHLIGHTS:

Supporting Patients with Heart Disease

UPMC Somerset continues to focus on the treatment of heart disease through its cardiology service line and to increase awareness about heart disease and support patients who have experienced a cardiac event with education and rehabilitation.

- **Interventional Cardiology Services:** The hospital offers an expansive interventional cardiology program, including cardiac catheterization, coronary angioplasty, stenting, vascular interventions, peripheral procedures, pacemakers, deep vein and pulmonary artery de-clotting and thrombolysis.
  - > In 2019, there were 735 total visits to the cardiac cath lab, including services for PCI, diagnostic, and pacemaker/loop.
  - > In 2020, visit numbers increased with 780 total visits to the cardiac cath lab.
  - > In November 2019, the cath lab received a two-year re-accreditation from Corazon Inc. for its Percutaneous Coronary Intervention (PCI) program.
- **Cardiac Rehabilitation (CR):** The hospital's cardiac rehabilitation program offers individualized and personalized treatment plans for those individuals with heart disease. These plans include evaluation and instruction on physical activity, nutrition, stress management, and other health related areas. The CR program has had a positive impact on UPMC Somerset's cardiac patients — helping to keep patients out of the hospital, preventing future cardiac events, and encouraging patients to be active and independent in the community. Progress includes:
  - > 183 patients participated in the CR program between July 2019 and March 2021.
  - > The American College of Cardiology recommends automatic referrals for key patient groups. In 2020, the hospital successfully added this capability into its record system to help increase the number of cardiac patients who might benefit from referrals to the CR program.
  - > In 2019, the hospital added a supervised exercise program for patients with Peripheral Arterial Disease (PAD), which has seen 9 patients between July 2019 and March 2021.

Promoting Mammograms to Detect Breast Cancer Early

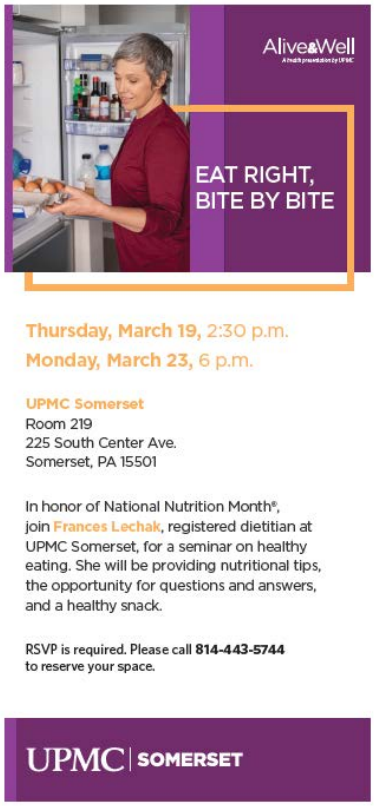
UPMC Somerset continues to promote the importance of early detection for cancer and encourages women to schedule annual mammograms. In addition to promoting breast cancer screenings, the hospital also raises awareness about the availability of the Healthy Woman program and Mammogram Voucher program.

- **Offering 3D Mammography:** The hospital is proud to offer the Genius 3D Mammography exam. This procedure has revolutionized how breast cancer is detected by providing a better option for women of all breast densities. This technology increases the detection of invasive breast cancers, reduces callbacks, and takes about the same time as a conventional 2D mammogram.
  - > Between July 2019 and March 2021, the hospital performed 5,460 mammograms.
  - > In October 2020, the hospital expanded access to breast cancer screenings by offering the first screening clinic that did not require a physician order. Four mammograms were performed this day. UPMC Somerset will continue to offer these clinics at least annually.
- **Mammogram Voucher Program:** Funded by the Pittsburgh affiliate of Susan G. Komen for the Cure, the voucher program assisted 55 women from July 2019 to March 2021.

Raising Awareness through Education

Over the last three years, UPMC Somerset has continued to offer a range of programs to help community members learn about chronic disease risks, prevention, early detection, and management. Efforts include:

- **Diabetes Education Center:** Founded in 2004 to meet the growing need for diabetes education in the community, the Diabetes Education Center maintains recognition by the American Diabetes Association as a facility meeting the national standards for diabetes self-management education. Staffed by a full-time Registered Dietitian, the center works with health care providers, individuals, businesses, and the community as a whole, to increase awareness of the prevention and treatment of diabetes.
  - > In January 2020, the center hired a new staff member and expanded hours to see patients five days per week. This has led to an increase in patient volumes — 151 patients were seen from July 2019 to March 2021.
  - > **For 151 patients participating in 1:**1 education sessions, the average HgbA1c decreased by 1.36 (for patients that had a repeat HgbA1c).
- **Community Education Programs:** The hospital developed and planned educational seminars that focus on tobacco cessation, weight management, physical activity, and nutrition. Hospital departments, such as Dietary, Rehabilitation Services, and Cardiopulmonary have taken ownership of these educational programs.
  - > Between July 2019 and March 2021, approximately 1,600 individuals participated in in-person education through learning programs and community participation in health fairs.



COMMUNITY PARTNERS:

Adagio Health, Area Agency on Aging, Boys and Girls Club, Community Action Partnership, Lions Club, local ambulance, Local school districts, Pennsylvania Department of Health, primary care providers in the community, both hospital-owned and independent, Somerset Health Services, Susan G. Komen Foundation, UPMC Telestroke and Teleneurology

Behavioral Health

Drug Addiction and Substance Abuse and Access to Behavioral Health Services

UPMC Somerset continues to address behavioral health in the community and to explore options for expanding services.

GOAL:
Increase awareness of and access to behavioral health care

STRATEGY:
Provide comprehensive behavioral health services

ACTIONS:
- ✓ Continue to provide comprehensive drug and alcohol treatment services, while also focusing on prevention efforts, community awareness and stigma reduction
- ✓ Continue to provide comprehensive behavioral health services
- ✓ Continue training Somerset Health Service providers, as well as Emergency Room and Hospitalist providers in the use of Screening Brief Intervention and Referral to Treatment (SBIRT)
- ✓ Continue prevention efforts with adolescents and children in the schools
- ✓ Explore the integrated primary care provider tele-psych model

TARGET POPULATION:
- General community
- Children and adolescents

PROGRAMS

Drug Addiction and Substance Abuse
- Community Conversations about Drug and Alcohol Use
- Warm Hand-Off Program
- Provider training in the use of Screening Brief Intervention and Referral to Treatment (SBIRT)
- Botvin Lifeskills Program
- Healthy Alternatives for Little Ones (HALO)
- Recovery to Work Program

Access to Behavioral Health Services
- Community Conversations about Mental Health
- Discharge Care Coordination/Communication
- Wellness Recovery Action Plan (WRAP)
- Integrated primary care provider tele-psych model
- Explore needs for traditional outpatient psychiatry setting
- Communication and education with local nursing homes
- Education and awareness for employees

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2019-2022)

121
Clinical Staff Educated about SBIRT
(July 2019 – March 2021)

73
Warm Hand-Offs to Treatment Services
(July 2019 – March 2021)

84%
Wellness Recovery Action Plans Completed
(July 2019 – March 2021)

PROGRAM HIGHLIGHTS:

Training Providers to Recognize the Signs and Symptoms of Addiction

Over the last three years, UPMC Somerset has worked to train providers, including Primary Care providers, emergency department providers, and hospitalists, in the use of Screening Brief Intervention and Referral to Treatment (SBIRT), a model that encourages mental health and substance use screenings as a routine preventive service in health care.

- In 2019, the hospital established a work group for senior hospital leaders and Twin Lakes Center to address provider training in the use of SBIRT so that providers recognize the signs and symptoms of addiction. As of March 31, 2021, seven providers and 114 clinical staff have been trained in SBIRT.

Helping Patients Navigate Treatment and Addiction Support Services

UPMC Somerset continues to offer comprehensive warm hand-offs to help overdose survivors who appear in the hospital's Emergency Department receive counseling and a referral to substance use disorder (SUD) treatment. These warm hand-offs connect patients with treatment and support services, which helps to improve the prospect of recovery. Accomplishments over the past three years:

- From July 2019 to March 2021, 73 in-person warm hand-offs were conducted. 46 patients accepted treatment and four patients were admitted to the hospital.
- In August 2020, the hospital established a work group to increase staff awareness and utilization of the warm hand-off program — 100% of Emergency Department staff participated in training. This is monitored monthly for new employees.

Coordinating Care

Over the last three years, UPMC Somerset has worked to enhance discharge care coordination, focusing on implementing the Wellness Recovery Action Plan (WRAP). Recognized by the United States Substance Abuse and Mental Health Services Administration (SAMHSA), WRAP is an evidence-based practice that is critical to the success of patients once they are discharged from a facility.

- Between July 2019 and March 2021, 25 staff members were trained in WRAP.
- 84 percent of WRAPs were completed. Coordination with Bedford-Somerset Developmental and Behavioral Health Services has indicated that the WRAP plans that patients receive have been very effective in their treatment after discharge.

COMMUNITY PARTNERS:

Bedford-Somerset Developmental and Behavioral Health Services, Behavioral Health Services of Somerset and Bedford Counties, Inc., Community Care, Daily American/Our Town, Next Step Center, State Correctional Institution at Laurel Highlands, The Village at Somerset, Twin Lakes Center, UPMC Western Psychiatric Hospital

Access to Care and Navigating Resources

Primary and Specialty Care

UPMC Somerset continues to assess primary care needs and to expand access to specialists in Somerset County, with an emphasis on growing telemedicine offerings.

GOAL:
Increase access to primary and specialty care in Somerset County

STRATEGY:
Recruit and retain primary care and specialty providers

ACTIONS:
- ✓ Recruit primary care providers and specialists
- ✓ Assess the need for primary care providers in remote areas
- ✓ Expand primary care locations for better access
- ✓ Develop telemedicine program, specifically Tele-Pulmonary, Tele-Infectious Disease, Tele-Stroke, Tele-Neuro, Tele-Psychiatry, and Tele-Dermatology

TARGET POPULATION:
- General community
- Children and adolescents

PROGRAMS
- Primary care provider and specialty provider recruitment
- Assessment of need for primary care in remote areas
- Expansion of primary care locations
- Telemedicine program

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2019-2022)

34
Providers Recruited to Somerset County
(July 2019 – March 2021)

13
Telemedicine Specialties Offered
(July 2019 – March 2021)

PROGRAM HIGHLIGHTS:

Successfully Recruiting Providers to Somerset County

Since joining UPMC in 2019, UPMC Somerset has collaborated with UPMC Altoona and UPMC Bedford to recruit providers to the region. Progress includes:

- **Primary Care:** Since 2019, UPMC Somerset has recruited 5 primary care physicians to Somerset County and acquired an additional primary care physician in Cambria County.
- **Specialty Care:** Since 2019, UPMC Somerset has recruited 29 specialists to Somerset County. Specialties include: cardiology, emergency medicine, gynecology, orthopaedics psychiatry, and urology. In addition, the hospital acquired an ENT practice with two locations in December 2019 — opening up the market for specialty services in the northern area of Somerset County and in southern Cambria County. In August 2020, UPMC Somerset added outpatient neurology to its services and in November 2020, added gastroenterology — filling a huge gap in the community.

Improving Access to Primary Care with New Locations

In March 2020, UPMC Somerset opened a new location of Somerset Family Practice, which allowed the hospital to establish a location that is central to the northern portion of the county. In April 2021, UPMC Somerset acquired a practice in Cambria County with two locations.

Expanding Specialty Care through Telemedicine Offerings

Over the last three years, UPMC Somerset has continued to explore opportunities to leverage technology to bring specialty physicians close to home. In response to needs identified in 2019, the hospital set out to develop a telemedicine program, specifically focusing on Tele-Pulmonary, Tele-Infectious Disease, Tele-Stroke, Tele-Neuro, Tele- Psych, and Tele-Derm. The COVID-19 pandemic accelerated the hospital's development of a telemedicine program, which has been well-received by the community.

- **Established inpatient telemedicine services:** In February 2019, the hospital launched its initial telemedicine offerings with telestroke and a 24/7 connection for neurology. In 2020, infectious disease, pulmonology, nephrology, and intensive care were added, reducing the need for transfers and increasing access to high quality care.
- **Expanded telemedicine to all outpatient locations:** Due to the COVID-19 pandemic, the hospital rapidly expanded telemedicine capabilities in outpatient care locations, including primary care, urology, orthopaedics, pain management, pulmonology, ENT, and general surgery.
- **UPMC Somerset Outpatient Telemedicine Center:** A location has been secured for the new outpatient telemedicine center and a nurse has been hired to coordinate services. The center began offering endocrinology and neurosurgery, and will be adding rheumatology.

COMMUNITY PARTNERS:

Somerset Health Services, UPMC Altoona, UPMC Bedford

UPMC Somerset Is Addressing High Priority Health Issues:

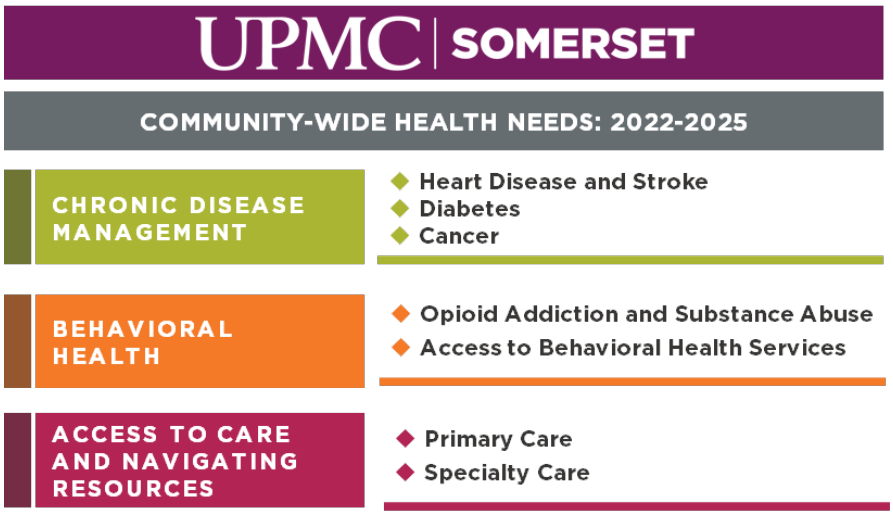
Adoption of the Implementation Plan

On March 10, 2022, the UPMC Somerset Board of Directors adopted an implementation plan to address the significant health needs identified:

- Chronic Disease Management
- Behavioral Health
- Access to Care and Navigating Resources

UPMC Somerset Is Leveraging UPMC and Community Resources

By providing a comprehensive suite of programs, UPMC Somerset plays an important role in addressing the community health needs that were identified in the recent Community Health Needs Assessment. The hospital will support the priority areas with internal resources, through grants, and by strengthening collaborations with numerous community partners.



Working to Advance Health Equity

UPMC Somerset recognizes that a broad range of efforts both within and beyond health care will be instrumental in addressing issues that contribute to health disparities. UPMC Somerset's 2022-2025 Implementation Plan includes health equity-promoting programs and initiatives, which aim to help address socioeconomic and other factors that may contribute to health disparities. Efforts include:

- **Advancing Behavioral Health Programs for Vulnerable Populations:** Providing new recovery options that meet the needs of complex care patients by expanding drug and alcohol rehabilitation programs to include outpatient behavioral health.
- **Enhancing Access to Care for Rural Communities:** Increasing the convenience and accessibility of health care services by expanding primary care locations, increasing access to specialists through telemedicine initiatives, and partnering with UPMC Hillman Cancer Center to establish oncology services at the hospital campus.

COMMUNITY HEALTH NEED

CHRONIC DISEASE MANAGEMENT

UPMC Somerset is implementing strategies to help reduce heart disease death, including prevention, early detection, and increasing awareness of, and access to, high quality services.

HEALTH PRIORITY #1

Heart Disease and Stroke

GOAL

Increase awareness of, and access to, prevention, and management of heart disease and stroke

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Increase access to care by promoting available services offered and providing early identification and treatment.	• Provide access to cardiology services • Promote availability of cardiac rehabilitation • Promote primary stroke center
2. Promote education and prevention throughout the community to increase awareness of risk factors associated with heart disease and stroke.	• Provide education to the community to increase knowledge of the risk factors for heart disease and stroke and awareness of personal risk factors

TARGET POPULATION

General community, individuals diagnosed with heart disease

PLANNED COLLABORATIONS

Physician offices (both affiliated and non-affiliated), community organizations, including senior centers, human service agencies, and churches

COMMUNITY HEALTH NEED

CHRONIC DISEASE MANAGEMENT

UPMC Somerset will continue to expand upon its efforts to address diabetes, as it remains a prevalent disease impacting the community.

HEALTH PRIORITY #2

Diabetes

GOAL

Improve self-management of diabetes in the community through education and support

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Increase awareness of prevention, management, and treatment of diabetes.	• Offer tele-endocrinology services for better management of diabetes • Raise community awareness of diabetes • Continue to provide diabetes self-management education and support

TARGET POPULATION

General community, individuals diagnosed with diabetes

PLANNED COLLABORATIONS

Physician offices, senior centers, human service agencies, churches, UPMC Division of Endocrinology

COMMUNITY HEALTH NEED

CHRONIC DISEASE MANAGEMENT

UPMC Somerset is partnering with UPMC Hillman Cancer Center — one of the largest integrated cancer networks in the nation — to establish oncology services at the hospital campus. UPMC Somerset recognizes that cancer is a top priority for the community, including early detection and treatment, and through this partnership UPMC Somerset is providing the community world-class care close to home.

HEALTH PRIORITY #3

Cancer

GOAL

Expand the availability of cancer care in the community and focus on early detection

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Bring oncology services to Somerset County to provide patients with local access to breakthrough research and leading-edge therapies.	• Offer oncology care through the UPMC Hillman Cancer Center at the UPMC Somerset hospital campus
2. Expand cancer screening program, with a focus on early detection.	• Offer cancer screenings, while removing barriers to access

TARGET POPULATION

General community

PLANNED COLLABORATIONS

UPMC Hillman Cancer Center, Pittsburgh Affiliate of Susan G. Komen, Adagio Health

COMMUNITY HEALTH NEED

BEHAVIORAL HEALTH

UPMC Somerset will continue to address opioid addiction and substance abuse — through expanded treatment services and prevention education — as it remains a top priority of the community.

HEALTH PRIORITY #1

Opioid Addiction and Substance Abuse

GOAL

Reduce opioid addiction and substance abuse in the community by increasing access to treatment services and focusing on prevention

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Offer high quality treatment services for people with substance use disorders.	• Provide new recovery options that meet the needs of complex care patients by expanding drug and alcohol rehabilitation programs to include outpatient behavioral health • Continue to improve comprehensive warm hand-off program • Focus on recovery support services
2. Make education available to providers.	• Offer provider education on recognizing substance abuse and other trainings
3. Provide prevention education for community and youth.	• Continue to offer and expand upon prevention programs that are delivered in school and community settings

TARGET POPULATION

General community, children and adolescents, individuals with substance use disorders

PLANNED COLLABORATIONS

UPMC Western Behavioral Health – Twin Lakes Center, Somerset County Drug Free Communities (all eleven Somerset County Public Schools, Somerset County Technology Center, Single County Authority for Drug and Alcohol, United Way of the Laurel Highlands, Community Action Partnership, Somerset Borough Police, Children and Youth Services of Somerset County, PA National Guard, SCI Laurel Highlands, Fike, Cascio, Boose Law Firm, Children's Aid Home, Boys and Girls Club of Somerset County, Pennsylvania State Police, Somerset County Probation, Daily American, Somerset County Commissioners, Behavioral Health Services of Somerset and Bedford Counties, Somerset County District Attorney's Office, Somerset Trust Company, The Learning Lamp, Somerset County Chamber of Commerce, St. Paul's Presbyterian Church), Bedford-Somerset Developmental and Behavioral Health Services Crisis Intervention, local police and emergency medical services, local outpatient psychiatry programs, Somerset Family Practice, local nursing homes

COMMUNITY HEALTH NEED

BEHAVIORAL HEALTH

UPMC Somerset will continue to enhance access to behavioral health services in the community through treatment, care coordination, and education.

HEALTH PRIORITY #2

Access to Behavioral Health Services

GOAL

Continue to provide inpatient behavioral health services

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Provide behavioral health services to patients in the inpatient setting.	• Utilize Wellness Recovery Action Plans (WRAP) with patients • Improve coordination between the hospital's inpatient behavioral health services and drug and alcohol rehabilitation services in Somerset County • Focus on discharge care coordination • Continue to provide education for employees

TARGET POPULATION

General community

PLANNED COLLABORATIONS

Bedford-Somerset Developmental and Behavioral Health Services, local outpatient programs, UPMC Western Psychiatric Hospital

COMMUNITY HEALTH NEED

ACCESS TO CARE AND NAVIGATING RESOURCES

UPMC Somerset will continue to expand efforts to provide individuals access to primary care providers and services, as this is the foundation for managing health.

HEALTH PRIORITY #1

Primary Care

GOAL

Increase access to primary care services through additional providers and expanded locations

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Increase number of providers and locations to improve access.	• Recruit primary care providers to the area • Expand primary care locations

TARGET POPULATION

General community

PLANNED COLLABORATIONS

Somerset Health Services, UPMC Graduate Medical Education, UPMC Human Resources, recruitment agencies

COMMUNITY HEALTH NEED

ACCESS TO CARE AND NAVIGATING RESOURCES

UPMC Somerset is working to increase local access to high quality specialty services in rural areas.

HEALTH PRIORITY #2

Specialty Care

GOAL

Increase access to specialty care

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Increase access to specialty services by adding providers, expanding current specialties, and assessing the need for additional specialties.	• Recruit specialty providers • Expand telemedicine program • Explore opportunities to add new services
2. Improve the process for referring patients for tertiary care.	• Explore ways to improve patient referrals to tertiary care services, including best practices leveraged at UPMC hospitals • Plan and implement enhancements to streamline and simplify the referral process

TARGET POPULATION

General community

PLANNED COLLABORATIONS

Somerset Health Services, UPMC Graduate Medical Education, UPMC Human Resources, recruitment agencies, UPMC Altoona

Community Health Improvement Progress and Plan

2019 – 2022 Progress Report and

2022 – 2025 Implementation Plan

UPMC | WESTERN MARYLAND

Caring for the Community

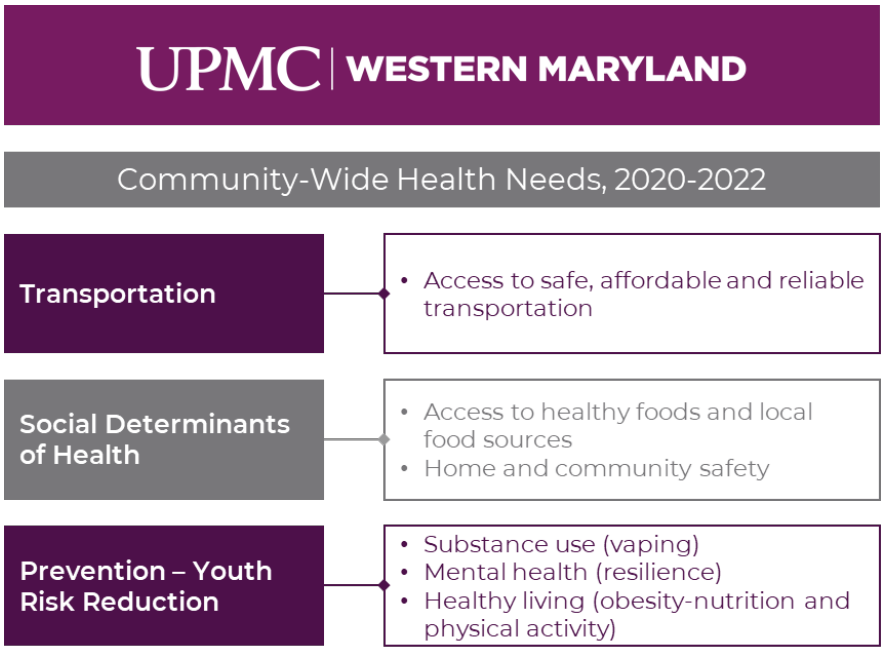
UPMC Western Maryland is a nonprofit, acute-care hospital located in Cumberland, Maryland, that serves residents in Allegany County and the surrounding counties in Maryland, West Virginia, and Pennsylvania. The hospital offers a wide range of inpatient and outpatient services through its accredited cancer center, robotic surgery program and cutting-edge neurosurgery operating suite. UPMC Western Maryland is also recognized for having an award-winning cardiac surgery program and offers the only open-heart surgery in the state, west of Baltimore. In addition, UPMC Western Maryland has received the following designations from the Maryland Institute for Emergency Medical Services Systems: Designated Cardiac Interventional Center, Primary Stroke Center, and Level III Adult Trauma Center.

UPMC Western Maryland has been at the forefront of value-based care and is continuously working to improve the overall health of the community through a variety of population health initiatives.

VITAL STATISTICS Calendar Year 2020		JOBS AND STRENGTHENING THE LOCAL ECONOMY	
Licensed Beds	224	Employees	2,131
Hospital Patients	12,850	Community Benefits Contributions	$68.0 million
Emergency Dept. Visits	37,044	Free and Reduced Cost Care	$17.0 million
Total Surgeries	5,904	Total Economic Impact of Hospital Operations	$690.1 million

Addressing the Community's Significant Health Needs

When the Fiscal Year 2020 CHNA was conducted, UPMC Western Maryland affirmed the following significant health needs:



Advancing Community Health Initiatives While Navigating the COVID-19 Pandemic

Beginning in March 2020, the COVID-19 pandemic disrupted Maryland's communities, economy, and health care organizations. To help slow the spread of COVID-19 throughout the region, state and local governments issued community mitigation and social distancing measures, impacting UPMC Western Maryland's ability to implement planned community health improvement initiatives. As a result, UPMC Western Maryland temporarily suspended or modified in-person programs to promote social distancing, educated the community about the health risks of COVID-19, increased access to telehealth services, established COVID-19 testing sites, and worked with state and local leaders to deliver COVID-19 vaccines. While UPMC Western Maryland navigated the complexities of the pandemic, the hospital continued to address identified health needs by developing innovative approaches and strategies to engage with its communities.

Access to Care and Navigating Resources

Transportation: Access to Safe, Affordable, and Reliable Transportation

UPMC Western Maryland continues to work to reduce the percent of patients without transportation or faced with transportation barriers when trying to access care or return home. Though not a direct connection, by increasing access to needed care, it is anticipated that medically unnecessary visits to the ED and readmissions will be reduced. Transportation also allows patients to receive more timely care and identify health issues earlier.

GOAL:

Increase access to safe, affordable, and reliable transportation

STRATEGY:

Provide underserved residents with rides to health and human service appointments when no other resources are available thereby improving access to care

ACTIONS:

- ✓ Educate at least 100 transportation users or service providers and the transportation options and system changes
- ✓ Identify existing transportation alternatives and seek at least one new option to reduce the transportation barrier

TARGET POPULATION:

- Seniors
- Individuals with disabilities
- Low-income residents

PROGRAMS:

- Mobility Management Program
- AllTrans
- On-Demand Transportation/Taxi Service Arrangement
- Taxi Vouchers
- One Call Click System

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2020-2022)

121
Total Rides Provided to Patients for Appointments
(January 2020 – April 2021)

3,905
Rides Required Wheelchair Transportation
(January 2020 – April 2021)

$150-200k
Annual Cost Savings Based on Projected Ambulance Spend
(2020 – 2021)

PROGRAM HIGHLIGHTS:

Improving Access to Care with Transportation Assistance

Since 2012, UPMC Western Maryland has worked to improve access to care by helping to coordinate rides to health and human services appointments for underserved residents. By increasing access to needed care, the hospital aims to reduce medically unnecessary visits to the Emergency Department and readmissions. By helping to provide appropriate transportation to preventive care and services, the hospital is helping patients to receive more timely care, identifying health issues earlier and reducing the potential need for high levels of care.

- **Partnering with Allegany County Human Resources Development Commission (HRDC):** UPMC Western Maryland collaborates with several community agencies to help coordinate transportation for patients. Hospital staff are trained to assess a patient's need for transportation when scheduling a patient's appointment or discharging a patient from the hospital. When transportation assistance is needed, hospital staff enter a request into the Trip Master portal monitored by Allegany County Human Resources Development Commission (HRDC). HRDC determines the most appropriate mode of transportation based on the request. If a patient qualifies for the Mobility Management Program or AllTrans, those services will be used. When a request does not fit the criteria for other services, HRDC provides the On-Demand transportation or arranges for a taxi. If the patient uses a wheelchair, walker, or is unsteady and needs assistance, HRDC assists the patient to the front door or across the threshold of a provider's office or their residence. UPMC Western Maryland partners with HRDC to provide walkers, wheelchairs, and other needed equipment to aid patients. When HRDC cannot provide a ride, UPMC Western Maryland also uses taxi vouchers.

  Community Partnership to Provide Continuum of Care

  > Between January 2020 and April 2021, the hospital helped provide 14,466 total rides. Of all rides, about 27 percent required wheelchair transportation.
- UPMC Western Maryland continues to work with the partners in Mobility Management to identify ways to improve transportation coordination in the area. There is still an interest in developing a One Call One Click system for transportation, but a lead agency has not been found. Other efforts included a blending of policy across agencies, targeted education, and an examination of routes to outlying areas.

COMMUNITY PARTNERS:

Transportation Committee, UPMC Western Maryland Mobility Mgmt.-HRDC Med Trans- NEMT ACHD or Statewide vendor, All Trans- County Transit Taxi (Crown, Yellow, QCity) County Medical Transport, Bay Runner, Garrett Transit, Mineral County Logisticare, PVTA, CUW, Communities for Life, Service Providers, Human Resource Development Commission, Alleghany County Health Department-Behavioral Health Systems Office, Alleghany Transit, Committed to Change, Progressive PT, BACHS, Devlin Manor and Mountain City Nursing and Rehab, County Medical Transport, CTS -Trip Master, and other transportation providers

Prevention and Community-Wide Healthy Living

Social Determinants of Health: *Access to Healthy Foods and Home and Community Safety*

UPMC Western Maryland continues to address social determinants of health, focusing on access to healthy foods and improved home and community safety, by leveraging support from the hospital's Center for Clinical Resources (CCR). In addition to providing evidence-based programs for diabetes, heart disease, and nutrition and weight status, the CCR engages patients in chronic disease self-management and addresses unemployment, poverty, health literacy, and other social determinants of health.

GOAL:

Increase access to healthy foods and local food sources, improve home and community safety (fire, security, safety), and help to address other social determinants of health

STRATEGY:

Identify key strategies to help close the gap for food insecurity and safe, affordable housing/ home sharing

ACTIONS:

- ✓ Utilize information obtained through food system mapping to identify and establish five sites per cycle year where healthy food choices or local food sources will be increased
- ✓ Provide education and assessment process focused on improving home and community safety for 100 or more people
- ✓ By June 2023, assess and assist 100 individuals with home or community safety need

TARGET POPULATION:

- Seniors
- Low-income individuals with chronic conditions

PROGRAMS:

- Community gardens
- Farmers Market vouchers
- Wellness Ambassadors
- Center for Clinical Resources (CCR)
- PATH2HELP
- Bridges to Opportunity

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2020-2022)

6,760
Patient Encounters in the Center for Clinical Resources
(June 2019 – July 2020)

266
Referrals to Resources through Path2Help
(July 2019 – May 2021)

PROGRAM HIGHLIGHTS:

Addressing Social Determinants of Health

The UPMC Western Maryland Center for Clinical Resources (CCR) is a source of support for patients managing chronic medical conditions such as diabetes, heart failure, and lung disease, or taking anticoagulation medication. CCR's goal is to effectively co-manage at-risk patients who have a chronic disease in an outpatient setting to help improve their health.

- **Improving access to healthy foods:** Over the past three years, the hospital has worked with local farmers to provide access to fresh, local food within food deserts and address chronic disease and obesity associated with lack of access to fresh food. Since 2018, the hospital and several organizations adopted a platform to provide community organizations and community members access to resources through an online resource guide and referral system.
  - > **Leveraging technology to increase access to resources:** Path2Help is an online tool that makes it easy for people to find appropriate programs and services for food, shelter, health care, work, financial assistance and more.

- **Assisting with home and community safety:** The hospital's Bridges to Opportunity initiative strives to help move individuals from poverty to self-sufficiency, reduce social costs related to crime, poor health, and welfare, strengthen educational attainment and job skills, enhance economic development, and revitalize neighborhoods.
- **Addressing chronic disease to help reduce hospital readmissions:** UPMC Western Maryland continues to help patients manage their health conditions and barriers to let them live the life they want and in turn reduce potentially avoidable readmissions and Emergency Department visits. Since 2019, the hospital has worked with medical staff, area providers and community partners to provide assistance, resources and education to those dealing with chronic diseases. By addressing the social determinants of health and self-management, the impact has saved more than $600,000 in hospital utilization.

COMMUNITY PARTNERS:

Bridges to Opportunity, SunLife Partners, Aramark, Western Maryland Food Council, Western Maryland Food Bank, Allegany College of Maryland, Area Health Education West, Associated Charities, Allegany County Human Resources Development Commission, UPMC Western Maryland., University of Maryland Extension., Frostburg State University, Allegany County Health Department, Funders-CareFirst, Singer, Cumberland Housing Authority and Alliance, Human Resources Development Commission, Allegany County Health Department , local Law Enforcement and Fire Dept. Home Care and CHW, FSU, AHEC Committee, Aunt Bertha, Western Maryland Food Council

Prevention and Community-Wide Healthy Living

Prevention – Youth Risk Reduction: Substance Use, Mental Health, and Healthy Living

UPMC Western Maryland embraces a community-oriented approach to promoting healthy behaviors and supporting at-risk populations.

GOAL:
Improve the mental and physical health of youth

STRATEGY:
Focus prevention and risk reduction efforts on substance use (vaping), mental health (resilience), and healthy living (obesity-nutrition and physical activity)

ACTIONS:
- ✓ By June 2023, engage 500 or more youth in mind body skills groups and targeted prevention programs in the community
- ✓ Each cycle year host at least three cross sector forums regarding identified risk behaviors of youth and potential prevention strategies for our community

TARGET POPULATION:
- Children and adolescents

PROGRAMS:
- Mind and Body Skills Groups
- Vaping Prevention Program
- Stigma – Distorted Prevention Program
- Family Needs and Trauma-Informed Care
- Physical Activity Programs
- After School Programming

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2020-2022)

22
School Partnerships
(July 2019 – May 2021)

Launched New Local Hiking Program
(July 2021 – August 2021)

PROGRAM HIGHLIGHTS:

Engaging Allegany County Youth in Prevention Education Programs

Over the last two years, UPMC Western Maryland has worked with local organizations and the surrounding school districts to provide health education by certified trainers.

- **Vaping Prevention Program:** This initiative takes a community-based approach to decrease the number of Allegany County youth who engage in vaping or tobacco use to educate as early as elementary aged youth and their guardians.
- **Mind and Body Skills Groups:** This effort reaches out to local youth through Allegany and Mineral County schools to provide wellness programs and activities surrounding the mind and the body.

UPMC Western Maryland primary care practices screened 94 percent of the Maryland Primary Care Program (MDPCP) patients using the SBIRT tool and provided a follow-up plan — exceeding Maryland's state benchmark by 24 percent in 2021.

Encouraging Active Lifestyles with Happy Feet Youth Hiking

In June 2021, UPMC Western Maryland Wellness Center and Rocky Gap State Park teamed up to offer a fun youth hiking series to parents and youth as part of the Healthy Parks Healthy People program. Through the Happy Feet Youth Hiking program, Allegany County families can join a hike led by UPMC Western Maryland staff every Thursday to engage in the outdoors and explore local trails.

COMMUNITY PARTNERS:

Allegany County Health Department, Frostburg Coalition, Allegany County Public Schools, Local Management Board, Department of Juvenile Services, Allegany College of Maryland, Center for Mind-Body Medicine, Area Health Education Center West, Families First, Family Junction, 4H, University of Maryland Extension, Allegany County Public Libraries

UPMC Western Maryland Is Addressing High Priority Health Issues:

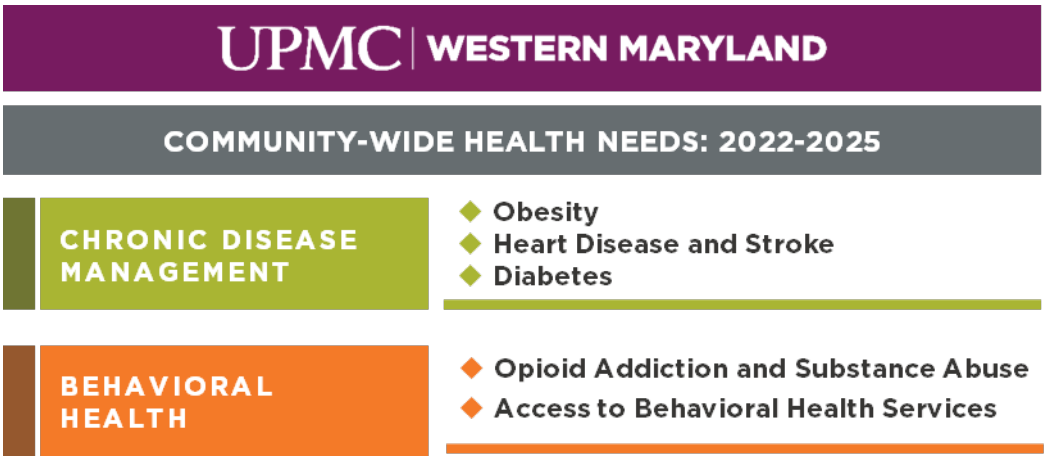
Adoption of the Implementation Plan

On March 24, 2022, the UPMC Western Maryland Board of Directors adopted an implementation plan to address the significant health needs identified:

- Chronic Disease Management
- Behavioral Health

UPMC Western Maryland Is Leveraging UPMC and Community Resources

By providing a comprehensive suite of programs, UPMC Western Maryland plays an important role in addressing the community health needs that were identified in the recent Community Health Needs Assessment. The hospital will support the priority areas with internal resources, through grants, and by strengthening collaborations with numerous community partners.



Working to Advance Health Equity

UPMC Western Maryland recognizes that a broad range of efforts both within and beyond health care will be instrumental in addressing issues that contribute to health disparities. UPMC Western Maryland's 2022-2025 Implementation Plan includes health equity-promoting programs and initiatives, which aim to help address socioeconomic and other factors that may contribute to health disparities. Efforts include:

- **Advancing Access to Behavioral Health Programs for Vulnerable Populations:** Creating approaches and implementing strategies to help improve access to behavioral health care in rural communities, including embedding behavioral health specialists in primary care offices and offering local access to a residential crisis service facility.

COMMUNITY HEALTH NEED

CHRONIC DISEASE MANAGEMENT

UPMC Western Maryland is taking a community-based approach to address obesity by providing a range of community health improvement programs that promote healthy behaviors and support at-risk populations. The hospital will continue to collaborate with local organizations, including the Allegany County Health Planning Coalition, to increase programming that encourages healthy eating and physical activity.

HEALTH PRIORITY #1

Obesity

GOAL

Increase awareness of obesity prevention and management and encourage healthy behaviors

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Take a comprehensive approach to help reduce obesity within the community, by providing education and promoting healthy eating and physical activity.	• Provide education about achieving and maintaining healthy lifestyles, including methods to prevent chronic illnesses • Engage in community outreach events to raise awareness about the links between obesity and chronic diseases • Encourage physical activity by promoting fitness classes and events

TARGET POPULATION

General community

PLANNED COLLABORATIONS

Allegany County Health Department, Allegany County Public Schools, Rocky Gap State Park, Wellness Ambassadors, Allegany County Human Resources Development Commission (HRDC Senior Centers), Area Health Education Center West (AHEC West), Allegany County Public Library System, Western Maryland Food Council, Allegany College of Maryland, Frostburg State University, local municipalities

COMMUNITY HEALTH NEED

CHRONIC DISEASE MANAGEMENT

UPMC Western Maryland will focus on heart disease and stroke through prevention, education, awareness, and management, while seeking new and innovative strategies to help ensure residents can receive the best care close to home.

HEALTH PRIORITY #2

Heart Disease and Stroke

GOAL

Increase awareness of disease prevention and management and encourage healthy behaviors

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Host a suite of services to promote heart failure and stroke awareness, prevention, and management within the community.	• Provide chronic disease education and support in the community • Continue to offer a cardiac rehab program to help lower the risk of death, complications, and risk for readmission for patients who have had a cardiac event or procedure • Provide interventions and screenings for community members • Monitor symptoms of heart failure and connect patients with a source of support for managing chronic medical conditions, such as diabetes, anticoagulation medication, heart failure, and chronic obstructive pulmonary disease (COPD)

TARGET POPULATION

General community

PLANNED COLLABORATIONS

Allegany County Health Department, Allegany County Public Schools, Wellness Ambassadors, Allegany Human Resources Development Commission (HRDC Senior Centers), faith-based institutions, Area Health Education Center West, Heart Institute at UPMC Western Maryland, Stroke Center

COMMUNITY HEALTH NEED

CHRONIC DISEASE MANAGEMENT

UPMC Western Maryland will address diabetes with a focus on awareness, prevention, and management through a suite of offerings, including community outreach, preventive screenings, and evidence-based interventions that link diabetic patients to specially-trained educators.

HEALTH PRIORITY #3

Diabetes

GOAL

Increase awareness of diabetes prevention and management and encourage lifelong healthy behaviors

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Increase awareness of diabetes prevention and management within the community.	• Provide diabetes education and training • Leverage referring providers to increase awareness and promote participation in diabetes management programs • Offer preventive screenings to identify and treat potential health problems before they develop or worsen • Increase community engagement through outreach events and health fairs • Offer medical nutrition therapy to support behavioral or lifestyle changes and provide individualized meal planning

TARGET POPULATION

General community

PLANNED COLLABORATIONS

UPMC Primary Care Practices, local primary care practices, Mountain Laurel Medical Center, Human Resources Development Commission (HRDC), Area Health Education Center West (AHEC), Allegany County Health Department

COMMUNITY HEALTH NEED

BEHAVIORAL HEALTH

UPMC Western Maryland will address the community's needs relating to opioid addiction and substance use disorders through multiple channels, including linking individuals to the right levels of care, outreach initiatives, and partnerships with community-based behavioral health services organizations.

HEALTH PRIORITY #1

Opioid Addiction and Substance Abuse

GOAL

Increase awareness and access to substance misuse resources and interventions

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Further augment current behavioral health programs to address addiction and substance abuse.	• Improve coordination and communication between service providers with embedded behavioral health specialists at primary care locations • Continue to offer a residential crisis service facility to provide support for adults with mental health illnesses and addictions • Increase awareness throughout the community to help reduce the stigma of addiction • Partner with local community organizations to provide education and training • Develop and support programming to address substance misuse and addiction recovery • Provide early intervention and treatment to people with substance use disorders and those at risk of developing these disorders

TARGET POPULATION

General community

PLANNED COLLABORATIONS

Allegany County Health Department, Archway Station, Potomac Behavioral Health, Allegany County Sheriff's Department, Maryland State Police, Cumberland City Police Department, Frostburg State University Police, Department of Social Services, Allegany County Human Resources Development Commission, Healing Allegany, local nursing homes, Frostburg State University, Allegany College of Maryland, Allegany County Drug and Alcohol Abuse Council and Overdose Prevention Task Force, Prescribe Change

COMMUNITY HEALTH NEED

BEHAVIORAL HEALTH

UPMC Western Maryland will continue to address access to behavioral health services in the community by embedding behavioral health specialists in primary care offices, enhancing telehealth capabilities, and collaborating with local organizations.

HEALTH PRIORITY #2

Access to Behavioral Health Services

GOAL

Improve access and coordination of care for behavioral health services

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Improve access to behavioral health services by increasing access points for individuals to be connected to the right level of care across the continuum.	• Embed behavioral health services into primary care settings • Offer telehealth services for behavioral health care • Track and improve access to care through provider referrals • Provide education and training to community members on how to offer initial help to individuals with the signs and symptoms of mental illness or in a crisis, and connect them with the appropriate professional, peer, social, or self-help care

TARGET POPULATION

General community, adults

PLANNED COLLABORATIONS

Allegany County Health Department, Archway Station, Potomac Behavioral Health, Allegany County Sherriff's Department, Maryland State Police, Cumberland City Police Department, Frostburg State University Police, Department of Social Services, HRDC, Healing Allegany, local nursing homes, Frostburg State University, Allegany College of Maryland, Allegany County Drug and Alcohol Abuse Council and Overdose Prevention Task Force, Prescribe Change

Appendices
A-E

UPMC
LIFE CHANGING MEDICINE

APPENDIX A: Secondary Data Sources and Analysis

Overview:

To identify the health needs of a community, UPMC conducted an analysis of publicly available data. Secondary data — including population demographics, mortality, morbidity, health behavior, and clinical care data — were used to identify and prioritize significant community health needs. Data which informed this CHNA were compiled from a variety of state and national data sources and are reflected in the table below.

Population characteristics, socioeconomic, and health status data were also examined. Community-level data (county-level) were compared to the state, nation, *Healthy People 2020*, and *Healthy People 2030* benchmarks to help identify key health issues. When available, data specific to low-income individuals, underserved minorities, and uninsured populations were examined. In addition, analysis considered federal designations of Health Professional Shortage Areas (HPSAs) — defined as "designated as having a shortage of primary medical care providers" and Medically Underserved Areas (MUAs) — which may consist of a whole county or a group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts.

Publicly Available Data and Sources Used for Community Health Needs Assessment

Data Category	Data Items	Description	Source
Demographic Data	Population Change	Comparison of total population and age-specific populations in 2010 and 2018 by county, state, and nation.	U.S. Census
	Age and Gender	Median age, gender, and the percent of elderly living alone by county, state, and nation in 2018.	
	Population Density	2018 total population divided by area in square miles (2010) by county, state, and nation.	
	Median Income/Home Values	By county, state, and nation in 2018.	
	Race/Ethnicity	Percent for each item by county, state, and nation in 2018.	
	Insurance: Uninsured, Medicare, Medicaid		
	Female Headed Households		
	Individuals with a Disability		
	Poverty		
	Unemployed		
	No High School Diploma		

APPENDIX A:
Secondary Data Sources and Analysis

Data Category	Data Items	Description	Source
Morbidity Data	Adult Diabetes	2017-2020 data collected and compared by county, state, and nation.	PA Department of Health PA Department of Health - Behavioral Risk Factors Surveillance System Maryland Department of Health Maryland Department of Health – Behavioral Risk Factors Surveillance System U.S. Centers for Disease Control and Prevention U.S. Centers for Disease Control and Prevention - Behavioral Risk Factors Surveillance System U.S. Centers for Disease Control and Prevention - National Center for Health Statistics
	Mental Health		
	Birth Outcomes		
Health Behaviors Data	Obesity (Childhood and Adult)		
	Alcohol Use		
	Tobacco Use		
	Sexually Transmitted Disease		
Clinical Care Data	Immunization	2017-2019, 2021 data collected and compared by county, state, and nation.	PA Department of Health - Behavioral Risk Factors Surveillance System Maryland Department of Health – Behavioral Risk Factors Surveillance System U.S. Centers for Disease Control and Prevention - Behavioral Risk Factors Surveillance System Robert Wood Johnson County Health Rankings & Roadmaps
	Cancer Screening (Breast/Colorectal)		
	Primary Care Physician Data		
Mortality Data	Mortality Rates	2019 data collected and compared by county, state, and nation.	PA Department of Health U.S. Centers for Disease Control and Prevention, National Center for Health Statistics
Benchmark Data	Morbidity Rates, Health Behaviors, and Clinical Care Data	National benchmark goal measures on various topics for the purpose of comparison with current measures for county, state, and nation.	Healthy People 2020 Healthy People 2030

In addition, local and state public health department input and data were obtained and utilized in this community health needs assessment. UPMC relied on publicly available Pennsylvania and Maryland Department of Health reports and additional local health department information accessed via email communication and in-person meetings.

Information Gaps Impacting Ability to Assess Needs Described:

The best available data were used to obtain the most meaningful comparison and analysis possible. Public data sources, however, are limited by some information gaps, and small sample sizes can represent statistically unreliable estimates.

The community definition hinged at the county level, in part, because the quality and availability of data at this level was generally most comprehensive and allowed for meaningful comparisons with state and national data. Whenever possible, population health data were examined for sub-populations, including low-income, minority, and uninsured populations.

APPENDIX B: Detailed Community Health Needs Profile

Population Demographics:

Characteristics	Allegany County	Bedford County	Blair County	Somerset County	Maryland	Pennsylvania	United States
Area (square miles)	424.2	1,012.3	525.8	1,074.4	9,707.2	44,742.7	3,531,905.4
Density (persons per square mile)	167.3	47.6	233.0	68.8	621.8	286.1	92.5
Total Population, 2018	70,975	48,176	122,492	73,952	6,035,802	12,800,922	326,687,501
Total Population, 2010	75,087	49,762	127,089	77,742	5,773,552	12,702,379	308,745,538
Population Change ('10-'18)	(4,112)	(1,586)	(4,597)	(3,790)	262,250	98,543	17,941,963
Population % Change ('10-'18)	-5.5	-3.2	-3.6	-4.9	4.5	0.8	5.8
Age							
Median Age	41.7	46.2	43.4	45.9	38.6	40.7	37.9
% <18	17.5	20.0	20.5	18.5	22.4	20.9	22.8
% 18-44	36.3	28.3	31.5	30.5	35.6	34.1	36.0
% 45-64	26.6	29.9	28.1	29.8	27.4	27.6	26.0
% 65+	19.6	21.8	19.8	21.3	14.6	17.4	15.2
% 85+	2.8	3.2	3.0	3.2	1.8	2.5	1.9
Gender							
% Male	52.3	49.8	48.9	52.1	48.5	49.0	49.2
% Female	47.7	50.2	51.1	47.9	51.5	51.0	50.8
Race/Ethnicity							
% White*	88.2	97.6	95.5	95.2	56.2	80.8	72.7
% African-American*	8.4	0.5	1.6	2.6	29.8	11.1	12.7
% American Indian and Alaska Native*	0.1	0.1	0.0	0.1	0.3	0.2	0.8
% Asian*	0.9	0.4	0.7	0.4	6.2	3.3	5.4
% Native Hawaiian/Other Pacific Islander*	0.0	0.0	0.0	0.0	0.1	0.0	0.2
% Hispanic or Latino**	1.8	1.2	1.2	1.5	9.8	7.1	17.8
% Disability	18.5	17.4	17.4	16.5	10.9	13.9	12.6

**Reported as single race; **Reported as any race*
Source: *U.S. Census, 2010, 2018*

Social and Economic Factors:

Characteristics	Allegany County	Bedford County	Blair County	Somerset County	Maryland	Pennsylvania	United States
Income, Median Household	$44,065	$49,146	$47,969	$48,224	$81,868	$59,445	$60,293
Home Value, Median	$119,200	$128,200	$120,300	$104,300	$305,500	$174,100	$204,900
% No High School Diploma*	10.1	12.5	9.1	12.0	10.0	9.8	12.4
% Unemployed**	8.5	4.9	5.0	5.4	5.6	5.8	5.9
% of People in Poverty	16.4	12.7	14.6	12.4	9.4	12.8	14.1
% Elderly Living Alone	15.3	15.5	14.5	15.1	10.3	12.6	10.7
% Female-headed households with own children <18	6.0	3.5	6.2	4.0	6.9	6.1	6.7
Health Insurance							
% Uninsured	4.8	7.2	5.3	7.4	6.5	6.2	9.4
% Medicaid	22.1	15.1	17.9	15.6	15.0	15.1	17.2
% Medicare	14.7	17.3	14.9	16.3	10.4	13.2	11.2

**Based on those ≥25 years of age; **Based on those ≥16 years and in the labor force*
Source: U.S. Census, 2018

Leading Causes of Mortality for the United States Compared to Maryland, Pennsylvania, and the Following Counties: Allegany, Bedford, Blair, and Somerset:

Causes of Death	Allegany County	Bedford County	Blair County	Somerset County	Maryland	Pennsylvania	United States
	Percent of Total Deaths	Percent of Total Deaths	Percent of Total Deaths	Percent of Total Deaths	Percent of Total Deaths	Percent of Total Deaths	Percent of Total Deaths
All Causes	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Diseases of Heart	27.0	23.6	28.4	24.3	23.2	24.1	23.1
Malignant Neoplasms (Cancer)	17.5	16.8	19.6	18.7	21.1	20.7	21.0
Accidents (Unintentional Injuries)	2.9	5.3	4.5	5.4	4.8	6.4	6.1
Chronic Lower Respiratory Diseases	6.7	5.0	5.5	4.1	4.2	4.7	5.5
Cerebrovascular Diseases	6.7	5.8	4.5	5.0	6.0	5.0	5.3
Alzheimer's Disease	3.5	3.9	3.3	6.0	2.0	3.1	4.3
Diabetes Mellitus	1.9	4.5	3.0	5.3	3.0	2.7	3.1
Nephritis, Nephrotic Syndrome, and Nephrosis	1.9	2.2	2.3	3.4	1.4	2.2	1.8
Influenza and Pneumonia	2.0	3.6	1.8	1.6	1.6	1.8	1.7
Intentional Self-Harm (Suicide)	1.1	2.2	1.2	1.1	1.3	1.4	1.7
Chronic Liver Disease and Cirrhosis	2.0	1.4	1.3	0.5	1.1	1.1	1.6
Septicemia	2.6	3.1	1.2	2.3	1.6	1.7	1.3
Essential Hypertension and Hypertensive Renal Disease	ND*	0.0	0.9	0.1	1.2	0.8	1.3
Parkinson's Disease	1.3	0.9	1.1	2.2	1.2	1.2	1.2
Pneumonitis Due to Solids and Liquids	1.8	0.7	0.9	0.7	0.8	0.8	0.7

Sources: *Pennsylvania Department of Health, 2019; U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, 2019*
**Data for Essential Hypertension and Hypertensive Renal Disease is suppressed for Allegany County due to confidentiality restraints*

APPENDIX B:
Detailed Community Health Needs Profile

Comparison of Additional Health Indicators for Allegany, Bedford, Blair, and Somerset Counties to Maryland, Pennsylvania, United States, Healthy People 2020, and Healthy People 2030:

Characteristics	Allegany County	Bedford County	Blair County	Somerset County	Maryland	Pennsylvania	United States	Healthy People 2020	Healthy People 2030
Morbidity									
Diabetes (%)	15.5	11.0	11.0	15.0	11.0	11.0	10.7	NA	NA
Mental Health (Mental health not good ≥1 day in past month) (%)	37.7	36.0	36.0	37.0	38.0	38.0	38.6	NA	NA
Low Birthweight (% of live births)	10.5	6.4	6.7	7.1	8.7	8.5	8.3	7.8	NA
Health Behaviors									
Obesity (Adult) (%)	39.2	34.0	34.0	39.0	32.3	33.0	32.1	30.5	36.0
Childhood Obesity (Grades K-6) (%)	NA	20.9	19.3	17.9	NA	17.1	19.3	15.7	NA
Childhood Obesity (Grades 7-12) (%)	NA	23.6	22.3	19.8	NA	19.2	20.9	16.1	NA
Excessive Alcohol Use (%)	15.4	15.0	15.0	15.0	13.8	17.0	16.8	24.2	25.4
Current Tobacco Use (%)	21.5	19.0	19.0	21.0	12.7	17.0	16.0	12.0	5.0
STDs (Gonorrhea per 100,000)*	31.0	18.4	68.5	10.0	146.7	114.8	152.6	251.9	NA
Clinical Care									
Immunization: Ever had a Pneumonia Vaccination (65+) (%)	73.5	67.0	67.0	75.0	76.6	74.0	73.3	90.0	NA
Cancer Screening									
Mammography (%)	77.6	NA	NA	NA	76.1	65.0	71.8	81.1	77.1
Colorectal Screening (%)	71.3	NA	NA	NA	68.2	71.0	64.3	70.5	74.4
Primary Care Physician: Population (PCP Phys/100K Pop)	60.6	24.9	81.6	36.5	88.6	81.0	75.8	NA	NA
Receive Prenatal Care in First Trimester (%)	75.8	76.9	80.2	63.9	69.9	74.2	77.6	77.9	NA

Sources:
Allegany County Data: *Maryland Department of Health, 2018, 2019; Robert Wood Johnson County Health Rankings & Roadmaps, 2021*

Bedford, Blair, and Somerset Counties: *Pennsylvania Department of Health, 2017-2019 (Childhood Obesity Data, 2019-2020); Robert Wood Johnson County Health Rankings & Roadmaps, 2021*

Maryland Data: *Maryland Department of Health, 2019; U.S. Centers for Disease Control and Prevention, 2018, 2019; Robert Wood Johnson County Health Rankings & Roadmaps, 2021*

Pennsylvania Data: *Pennsylvania Department of Health, 2018, 2019 (Childhood Obesity Data, 2019-2020); Robert Wood Johnson County Health Rankings & Roadmaps, 2021*

U.S. Data: *U.S. Centers for Disease Control and Prevention, 2018, 2019; Robert Wood Johnson County Health Rankings & Roadmaps, 2021*

***Gonorrhea data:** *Allegany County rate includes all ages and genders; Blair County and Pennsylvania rates are for women ages 15+; Bedford County and Somerset County rates include women 15-24 and women 35+ (data for women 25-34 years of age was unavailable due to small sample size); Maryland and National rates are for women of all ages; Healthy People 2020 rates are for 15-44 year old women*

APPENDIX C: Input from Persons Representing the Broad Interests of the Community

Community Representation and Rationale for Approach

UPMC hospitals solicited and took into account input received from individuals representing the broad interests of the community to identify and prioritize significant health needs. Each hospital community advisory panel consisted of hospital board members, physicians, hospital leadership, and community members. Community members were leaders of organizations that represented different patient constituencies and medically underserved, low-income, and minority populations and were invited to participate to ensure that a wide range of community interests were engaged in identifying community health needs. Organizations serving the medically underserved were well represented on the panels. In addition to hospital panels, the CHNA also included a system-wide panel consisting of health departments, mental health service providers, philanthropies, and other agencies providing health services not linked to particular hospitals.

Community survey responses were analyzed at the local hospital level, the regional level, and at the system-wide level in collaboration with the University of Pittsburgh's Graduate School of Public Health. Further analyses disaggregated ratings to confirm that ratings were stable across different stakeholders.

The panels ensured that a wide variety of constituencies had an opportunity to weigh in on hospital community health priorities. Use of advisory panels and a survey explicitly assessing the continuing relevance of prior health priorities offers a number of advantages:

- It explicitly assesses stability/change of community health needs, while allowing participants an opportunity to consider new health priorities
- It uses the same measures to assess importance, impact, and hospital ability to address health priorities, which will allow tracking over time
- It elicits perceptions of a broad and inclusive list of hospital and community leaders who in turn represent a broad group of constituents
- It allows assessment of consensus across different kinds of stakeholders

UPMC
LIFE CHANGING MEDICINE

APPENDIX C: Input from Persons Representing the Broad Interests of the Community

UPMC hospitals in Bedford, Blair, and Somerset counties in Pennsylvania, and Allegany County in Maryland, invited representatives from the following organizations to participate in the community health needs survey conducted in May-June 2021:

Pennsylvania Hospitals

UPMC Altoona

- Altoona-Blair County Development Corporation, Altoona, PA
- Blair County Department of Social Services, Hollidaysburg, PA
- Blair County Juvenile Probation Office, Hollidaysburg, PA
- Blair County Planning Commission, Hollidaysburg, PA
- Blair Drug and Alcohol Partnerships, Altoona, PA
- Blair Health Choices, Hollidaysburg, PA
- Conemaugh Nason Medical Center, Roaring Spring, PA
- Drenning Leasing Company, Altoona, PA
- Family Services, Inc., Altoona, PA
- Healthy Blair County Coalition, Duncansville, PA
- Hollidaysburg Area School District, Hollidaysburg, PA
- Home Nursing Agency WIC Program, Altoona, PA
- James E. Van Zandt VA Medical Center, Altoona, PA
- Lee Industries, Philipsburg, PA
- Lung Disease Center of Central PA, Altoona, PA
- Office of the County Commissioner, County of Blair, Hollidaysburg, PA
- Office of the Honorable Lisa Pupo Lenihan, Magistrate Judge, US District Court, Western District of Pennsylvania, Pittsburgh, PA
- Office of the Mayor, City of Altoona, Altoona, PA
- Operation Our Town, Altoona, PA
- Penn State Altoona, Altoona, PA
- Pennsylvania Office of Rural Health, University Park, PA
- Reilly, Creppage & Company, Inc., Altoona, PA
- Reliance Bank, Altoona, PA
- Sheetz, Inc., Altoona, PA
- Stuckey Ford, Hollidaysburg, PA
- the Center for Independent Living of South-Central Pennsylvania, Altoona, PA
- United Way of Blair County, Duncansville, PA

UPMC Bedford

- Allegany College of Maryland, Everett Campus, Cumberland, MD
- Bedford Area School District, Bedford, PA
- Bedford County Area Agency on Aging, Bedford, PA
- Bedford County Chamber of Commerce, Bedford, PA
- Bedford County Children and Youth Services, Bedford, PA
- Bedford County Development Association, Bedford, PA
- Hometown Bank of Pennsylvania, Bedford, PA
- McFarland's Furniture Co. & Mattress Center, Everett, PA
- Pennwood Family Medicine, Everett, PA
- Pennwood Ophthalmic Associates, PC, Everett, PA
- Personal Solutions Inc., Bedford, PA
- Reed Wertz & Roadman, Inc., Bedford, PA
- State Health Center - Bedford County, Bedford, PA
- Structural Fiberglass, Inc., Bedford, PA
- United Way of Bedford County, Bedford, PA
- Your Safe Haven, Inc., Bedford, PA

UPMC Somerset

- AK Coal Resources, Inc., Friedens, PA
- Bedford Somerset Development & Behavioral Health Services, Somerset, PA
- Beggs Printing, Confluence, PA
- Boys and Girls Club of Western PA, The Georgian Place, Somerset, PA
- Community Action Partnership for Somerset County, Somerset, PA
- Community Foundation for the Alleghenies, Johnstown, PA
- Community LIFE, Somerset, PA
- Croyle-Nielsen Therapeutic Associates, Inc., Somerset, PA
- CVS Health, Somerset, PA
- Fairfield Inn & Suites by Marriot Somerset, Somerset, PA
- Hollern & Koontz Insurance Agency, Windber, PA
- Next Step Center Inc., Somerset, PA
- Office of the County Commissioner, Somerset County, Somerset, PA
- Penn State Extension, Somerset County, Somerset, PA
- Pennsylvania Highlands Community College, Somerset, PA
- Riggs Industries, Boswell, PA
- RMB Realty, Somerset, PA

- Rockwood Area School District, Rockwood, PA
- Saint Paul's United Church of Christ, Somerset, PA
- Salvation Army, Somerset, PA
- SCI Laurel Highlands, Somerset, PA
- SCI Somerset, Somerset, PA
- Sodexo Campus Services, Somerset, PA
- Somerset Area School District, Somerset, PA
- Somerset Borough Police Department, Somerset, PA
- Somerset Borough, Somerset, PA
- Somerset Chamber of Commerce, Somerset, PA
- Somerset County Children and Youth Services, Somerset, PA
- Somerset County Department of Emergency Services, Somerset, PA
- Somerset County Economic Development Council, Somerset, PA
- Somerset County Farm Bureau, Somerset, PA
- Somerset County Library, Somerset, PA
- Somerset County Recreation and Trails Association, Somerset, PA
- Somerset County Veterans Affairs, Somerset, PA
- Somerset Daily American, Somerset, PA
- Somerset Mobile Food Bank, Somerset, PA
- Somerset Single County Authority for Drug and Alcohol, Somerset, PA
- Somerset Trust Company, Somerset, PA
- Somerset WIC Tapestry of Health, Somerset, PA
- Somerset, Inc., Somerset, PA
- The Area Agency on Aging of Somerset County, Somerset, PA
- The Children's Aid Home and Society of Somerset County, Somerset, PA
- The EADS Group, Somerset, PA
- The Patriot, a Choice Community, Somerset, PA
- Twin Lakes Center, Somerset, PA
- United Way of the Laurel Highlands, Johnstown, PA

Maryland Hospitals

UPMC Western Maryland

- Aetna, Cumberland, MD
- Aircon Engineering, Inc., Cumberland, MD
- Allegany Arts Council, Inc., Cumberland, MD
- Allegany College of Maryland, Cumberland, MD
- Allegany County Board of County Commissioners, Cumberland, MD
- Allegany County Department of Social Services, Cumberland, MD
- Allegany County Health Department, Cumberland, MD
- Allegany County Human Resources Development Commission, Cumberland, MD
- Allegany County Library System, Cumberland, MD
- Allegany County Sheriff's Office, Cumberland, MD
- Allegany Transit, Cumberland, MD
- Archway Station, Inc., Cumberland, MD
- Associated Charities of Cumberland, Inc., Cumberland, MD
- Boggs & Company, Cumberland, MD
- CBIZ, Inc., Cumberland, MD
- Central Assembly of God, Cumberland, MD
- Chapman and Associates Health Care, LaVale, MD
- Chessie Federal Credit Union, Cumberland, MD
- Christ Lutheran Church, Lavale, MD
- City of Cumberland Parks and Recreation Department, Cumberland, MD
- City of Cumberland Police Department, Cumberland, MD
- Community Trust Foundation, Cumberland, MD
- Cornerstone Baptist Church, Cumberland, MD
- County United Way, Cumberland, MD
- CRGA Design, Baltimore, MD
- Cumberland Housing Authority, Cumberland, MD
- Cumberland Area Interfaith Ministerial Association, Cumberland, MD
- Danville Community Baptist Church, Rawlings, MD
- Dr. Mary Anne Jenkins Orthodontics, Cumberland, MD
- Excel Propulsion & Armaments Consulting, New Creek, WV
- Exclamation Labs, Cumberland, MD
- Family Crisis Resource Center, Inc., Cumberland, MD
- First English Baptist Church, Frostburg, MD
- Friends Aware, Inc., Cumberland, MD
- Friendship Haven Church, Cumberland, MD
- Frostburg State University, Frostburg, MD
- Geppert, McMullen, Paye, & Getty, Cumberland, MD
- Gods Ark of Safety Church, Frostburg, MD
- Jane's Place, Inc., Allegany County Child Advocacy Center, Cumberland, MD

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- Lifetime Dental Care of Frostburg, Frostburg, MD
- Local Management Board of Allegany County, Cumberland, MD
- Maryland Area Health Education Center West (AHEC West), Cumberland, MD
- Maryland Physicians Care, Cumberland, MD
- Melvin United Methodist Church, Cumberland, MD
- Mountain Laurel Medical Center, Oakland, MD
- NAACP Allegany County Branch, Unit 7007, Cumberland, MD
- New Venture Christian Church, Cumberland, MD
- Office of George C. Edwards, Maryland Senate, District 1, Annapolis, MD
- Office of Jason Buckel, Maryland House of Delegates, District 1B, Annapolis, MD
- Office of Mike McKay, Maryland House of Delegates, District 1C, Annapolis, MD
- Office of the Mayor, City of Cumberland, Cumberland, MD
- Office of the Mayor, City of Frostburg, Frostburg, MD
- Office of the Mayor, City of Lonaconing, Lonaconing, MD
- Office of the Mayor, City of Westernport, Westernport, MD
- Office of the Mayor, Town of Barton, Barton, MD
- Office of the Mayor, Town of Luke, Luke, MD
- Office of Wendell Beitzel, Maryland House of Delegates, District 1A, Annapolis, MD
- Our Lady of the Mountains (St. Mary), Cumberland, MD
- Pressley Ridge, Cumberland, MD
- Queen City Creamery, Cumberland, MD
- Rocky Gap State Park, Flintstone, MD
- The Belt Group of Companies, Cumberland, MD
- The Board of Education of Allegany County, Cumberland, MD
- The Family Junction, Inc., Cumberland, MD
- The PharmaCare Network, Cumberland, MD
- The Salvation Army, Cumberland, MD
- Tri-State Community Health Center, Cumberland, MD
- University of Maryland Extension, Allegany County, Cumberland, MD
- Western Maryland Food Bank, Cumberland, MD
- Western Maryland Food Council, Cumberland, MD
- Western Maryland Health System Auxiliary, Cumberland, MD
- Western Maryland Health System Foundation, Cumberland, MD
- YMCA of Cumberland, Cumberland, MD

Additionally, a UPMC system-wide group comprised of individuals and organizations representing the broad interests of the region's communities — including representatives from medically underserved, low-income, and minority populations — was invited to participate in the survey. Invitees included representatives from the following organizations:

- 10,000 Friends of Pennsylvania, Harrisburg, PA
- 100 Black Men of Western Pennsylvania Inc., Pittsburgh, PA
- 1889 Foundation, Johnstown, PA
- 2021 Greater Wilkinsburg Community Advancement Assoc., Wilkinsburg, PA
- 5A Elite Youth Empowerment, Pittsburgh, PA
- A Glimmer of Hope Foundation, Wexford, PA
- A Second Chance, Inc., Pittsburgh, PA
- A Woman's Concern, Lancaster, PA
- A. Philip Randolph Institute (APRI), Pittsburgh Chapter, Pittsburgh, PA
- A+ Schools, Pittsburgh, PA
- Accessible YOUniverse, Pittsburgh, PA
- Acculturation for Justice, Access, and Peace Outreach [AJAPO], Pittsburgh, PA
- ACH Clear Pathways, Pittsburgh, PA
- Achieva, Pittsburgh, PA
- Achievement Center of LECOM Health, Erie, PA
- Achieving Greatness, Inc., Pittsburgh, PA
- ACMH Hospital, Kittanning, PA
- ACTION-Housing, Inc., Pittsburgh, PA
- Active Aging Foundation, Meadville, PA
- Adams County Housing Authority, Gettysburg, PA
- Adams Rescue Mission, Gettysburg, PA
- Adonai Center for Black Males, Inc., Pittsburgh, PA
- Africa 6000 International, Inc., Erie, PA
- African American Chamber of Commerce of Western PA, Pittsburgh, PA
- AHEDD, Pittsburgh, PA
- Ahmadiyya Muslim Community Mosque, Pittsburgh, PA
- Alder Health Services, Harrisburg, PA
- Alex's Lemonade Stand Foundation, Wynnewood, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- All About Character, Inc., Erie, PA
- All For All, powered by The Global Switchboard, Pittsburgh, PA
- Allegheny Christian Ministries, Inc., Laurel View Village, Davidsville, PA
- Allegheny County Department of Human Services, Pittsburgh, PA
- Allegheny County Medical Society, Pittsburgh, PA
- Allegheny County/City of Pittsburgh Transition Coordinating Council, Pittsburgh, PA
- Allegheny Intermediate Unit, Homestead, PA
- Allegheny Lutheran Social Ministries, Altoona, PA
- Allegheny/Fayette Central Labor Council, AFL-CIO, Pittsburgh, PA
- Allen Place Community Services, Inc., Pittsburgh, PA
- Allentown Area Ecumenical Food Bank, Allentown, PA
- Allentown Housing Authority, Allentown, PA
- Allentown Rescue Mission, Allentown, PA
- Alliance for Building Communities, Allentown, PA
- Allies for Health + Wellbeing, Pittsburgh, PA
- Alpha & Omega Community Center, Lancaster, PA
- Alpha Alpha Omega Chapter of Alpha Kappa Alpha Sorority, Inc., Pittsburgh, PA
- Alpha Omicron Lambda Charities, Pittsburgh, PA
- Altoona Chapter of AMBUCS, Hollidaysburg, PA
- Altoona Community Theatre (ACT), Altoona, PA
- Alzheimer's Association, Greater Pennsylvania Chapter, Pittsburgh, PA
- Amachi Pittsburgh, Pittsburgh, PA
- AMD3 Foundation, Pittsburgh, PA
- Amen Corner, Pittsburgh, PA
- American Association of People with Disabilities (AAPD), Washington, DC
- American Diabetes Association of Western Pennsylvania, Merrifield, VA
- American Heart Association - Philadelphia, Philadelphia, PA
- American Heart Association - Harrisburg, Harrisburg, PA
- American Middle East Institute, Pittsburgh, PA
- Americans for the Competitive Enterprise System, Inc., Erie, PA
- Amyloidosis Foundation, Clarkston, MI
- Anchorpoint Counseling Ministry, Pittsburgh, PA
- Andrew Carnegie Free Library & Music Hall, Pittsburgh, PA
- Antioch Baptist Church, Fairfax Station, VA
- Apraxia Kids, Pittsburgh, PA
- Aquinas Academy of Pittsburgh, Gibsonia, PA
- Arbutus Park Retirement Community, Johnstown, PA
- Armstrong County Community Action Agency, Kittanning, PA
- Armstrong-Indiana-Clarion Drug and Alcohol Commission, Inc., Shelocta, PA
- Arthritis Foundation, Pittsburgh, PA
- ArtsAltoona, Altoona, PA
- Asbury Woods Nature Center, Erie, PA
- Ascender, LLC, Pittsburgh, PA
- Aspinwall Chamber of Commerce, Aspinwall, PA
- Aspinwall Neighborhood Watch, Aspinwall, PA
- Aspinwall Riverfront Park, Aspinwall, PA
- Assemble, a community space for arts + technology, Pittsburgh, PA
- Associated Artists of Pittsburgh, Pittsburgh, PA
- Association of Fundraising Professionals (AFP), Pittsburgh, PA
- Athena Erie, Erie, PA
- ATU Local 85, Pittsburgh, PA
- Auberle, McKeesport, PA
- August Wilson African American Cultural Center, Pittsburgh, PA
- August Wilson House, Pittsburgh, PA
- Aurora Social Rehabilitation Services, Harrisburg Social Rehabilitation Center, Harrisburg, PA
- Aurora Social Rehabilitation Services, Mechanicsburg Social Rehabilitation Center, Mechanicsburg, PA
- Autism Society of Berks, Wyomissing, PA
- Autism Society of Northwestern PA, Erie, PA
- Baptist Homes Foundation, Pittsburgh, PA
- Barber National Institute, Bridgeville, PA
- Beacon Clinic for Health and Hope, Harrisburg, PA
- Beaver County Chamber of Commerce, Beaver, PA
- Beaver Falls Community Development Corporation, Beaver Falls, PA
- Bedford County Chamber of Commerce, Bedford, PA
- Bender Consulting Services, Inc., Pittsburgh, PA
- Benedictine Sisters of Pittsburgh, Bakerstown, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- Bengali Association of Greater Pittsburgh (BAP), Pittsburgh, PA
- Bethany House Academy, Pittsburgh, PA
- Bethel Village AME Church, Harrisburg, PA
- Bethesda Children's Home, Meadville, PA
- Bethesda Foundation for Children, Meadville, PA
- Bethlehem Area Public Library, Bethlehem, PA
- Bethlehem Haven, Pittsburgh, PA
- Bethlehem Housing Authority, Bethlehem, PA
- Bethlen Communities, Ligonier, PA
- Beverly's Birthdays, Pittsburgh, PA
- Bhutanese Community Association of Pittsburgh (BCAP), Pittsburgh, PA
- Bids for Kids, Erie, PA
- Bidwell Training Center, Inc., Pittsburgh, PA
- Big Brothers Big Sisters of Blair County, Inc., Altoona, PA
- Big Brothers Big Sisters of Greater Pittsburgh, Pittsburgh, PA
- Big Brothers Big Sisters of the Lehigh Valley, Allentown, PA
- Big Brothers Big Sisters of the Twin Tiers, Wellsboro, PA
- Big Brothers Big Sisters of York & Adams Counties, York, PA
- Big Brothers Big Sisters of the Laurel Region, Greensburg, PA
- Bike PGH, Pittsburgh, PA
- Birmingham Free Clinic, Pittsburgh, PA
- Black Girl Health Foundation, Washington, DC
- Blair County Arts Foundation, Altoona, PA
- Blair County Chamber of Commerce, Altoona, PA
- Blair County Conservation District, Hollidaysburg, PA
- Blair County Department of Emergency Services, Altoona, PA
- Blair County Health and Welfare Council, Altoona, PA
- Blair County NAACP, Altoona, PA
- Blair Regional YMCA, Hollidaysburg, PA
- Blair Senior Services, Altoona, PA
- Blair Type 1 Diabetes Foundation, Altoona, PA
- Bloomsburg Food Cupboard, Bloomsburg, PA
- Boy Scouts of America - Laurel Highlands Council, Pittsburgh, PA
- Boy Scouts of America, Hawk Mountain Council, Reading, PA
- Boy Scouts of America, Juniata Valley Council, Reedsville, PA
- Boy Scouts of America, Minsi Trails Council, Allentown, PA
- Boyertown Area Multi-Service, Inc., Boyertown, PA
- Boys & Girls Club of Allentown, Allentown, PA
- Boys & Girls Club of Bethlehem Pa., Bethlehem, PA
- Boys & Girls Club of Chambersburg and Shippensburg, Shippensburg, PA
- Boys & Girls Club of Lancaster, Lancaster, PA
- Boys and Girls Club of Philadelphia, Philadelphia, PA
- Boys and Girls Club of Scranton, Scranton, PA
- Bradbury-Sullivan LGBT Community Center, Allentown, PA
- Brandywine Valley Active Aging - Coatesville Campus, Coatesville, PA
- Breathe Pennsylvania, Cranberry Township, PA
- Brethren Housing Association, Harrisburg, PA
- Brevillier Village, Erie, PA
- Bridge Builders Community Foundations, Oil City, PA
- Bridge of Hope, Malvern, PA
- Bridgeway Capital, Pittsburgh, PA
- Bright Side Opportunities Center, Malvern, PA
- Brooks-TLC Hospital System, Inc., Dunkirk, NY
- Brother's Brother Foundation, Pittsburgh, PA
- Brown Mamas, Pittsburgh, PA
- Brownsville Free Public Library, Brownsville, PA
- Buffalo Elementary School, Sarver, PA
- Buhl Park, Hermitage, PA
- Butler Community College, Butler, PA
- Bynums Marketing & Communications, Inc., Pittsburgh, PA
- Cambria Regional Chamber of Commerce, Johnstown, PA
- Cameron and Elk Counties Behavioral and Developmental Programs, Ridgway, PA
- Camp Erin, Pittsburgh, PA
- Camp Kon-O-Kwee Spencer YMCA, Fombell, PA
- Cancer Caring Center, Pittsburgh, PA
- Capital Area Coalition on Homelessness, Harrisburg, PA
- Carbon-Monroe-Pike Mental Health and Developmental Services, Stroudsburg, PA
- Carlow University, Pittsburgh, PA
- Carnegie Library of Pittsburgh, Homewood, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- Carnegie Library of Pittsburgh, Pittsburgh, PA
- Carnegie Mellon University's Martin Luther King, Jr. Day Writing Awards, Pittsburgh, PA
- Casa Guadalupe Center, Allentown, PA
- CASA of Allegheny County, Pittsburgh, PA
- CASA of Lancaster County, Lancaster, PA
- CASA of Venango County, Oil City, PA
- Casa San José, Pittsburgh, PA
- Casey Cares Foundation, Columbia, MD
- Catasauqua Food Bank, Catasqua, PA
- Cathedral Preparatory School, Erie, PA
- Catholic Charites of the Diocese of Altoona-Johnstown, Altoona, PA
- Catholic Charities Counseling and Adoption Services, Erie, PA
- Catholic Charities Free Health Care Center, Pittsburgh, PA
- Catholic Charities of the Diocese of Harrisburg, Harrisburg, PA
- Catholic Diocese of Pittsburgh, Pittsburgh, PA
- Catholic Harvest Food Pantry, York, PA
- Cay Galgon Life House, Bethlehem, PA
- CCAC Educational Foundation, Pittsburgh, PA
- Center for Advocacy for the Rights & Interests of the Elderly (CARIE), Philadelphia, PA
- Center for Civic Arts, Pittsburgh, PA
- Center For Independent Living of Central Pennsylvania, Camp Hill, PA
- Center for Schools and Communities, Camp Hill, PA
- Center for Victims, Pittsburgh, PA
- Center for Women's Entrepreneurship at Chatham University, Pittsburgh, PA
- Center in the Park, Philadelphia, PA
- Center of Life, Pittsburgh, PA
- Center that Cares, Pittsburgh, PA
- Central Blair Recreation Commission, Altoona, PA
- Central Catholic High School, Pittsburgh, PA
- Central PA Autism Society, Hollidaysburg, PA
- Central Pennsylvania Association of Health Underwriters, Harrisburg, PA
- Central Pennsylvania Coalition to Fight Cancer, Harrisburg, PA
- Centre Region Down Syndrome Society, State College, PA
- Centro Hispano, Reading, PA
- Chabad of Squirrel Hill, Pittsburgh, PA
- Challenges: Options in Aging, New Castle, PA
- Chan Soon-Shiong Medical Center at Windber (CSSMCW), Windber, PA
- Change Agency, Pittsburgh, PA
- Charleroi Area Public Library, Charleroi, PA
- Charleroi Area School District Education Foundation, Charleroi, PA
- Charter Arts Foundation, Bethlehem, PA
- Chester County Department of Drug and Alcohol Services, West Chester, PA
- Chester County Food Bank, Exton, PA
- Cheyenne Regional Medical Center Foundation, Cheyenne, WY
- Child Care Consultants, York, PA
- Child Health Association of Sewickley, Sewickley, PA
- Children's Advocacy Centers of Pennsylvania, Erie, PA
- Children's Aid Society, Clearfield, PA
- Children's Home of Pittsburgh, Pittsburgh, PA
- Children's Museum of Pittsburgh, Pittsburgh, PA
- Children's Service Center, Wilkes Barre, PA
- Children's Hospital of Pittsburgh Foundation, Pittsburgh, PA
- Chinese Association for Science and Technology (CAST), Wexford, PA
- Christian Churches United of the Tri-County, Harrisburg, PA
- Christopher's Kitchen, Pittsburgh, PA
- Chuckie Mahoney Memorial Foundation, Presto, PA
- Church in the Round, Aliquippa, PA
- Church of the Covenant Preschool, Washington, PA
- Churchill-Wilkins Rotary Club, Pittsburgh, PA
- City of Asylum, Pittsburgh, PA
- City of Chester, Bureau of Health, Chester, PA
- City of Greensburg, Parks and Recreation Department, Greensburg, PA
- City of Pittsburgh EARN program, Pittsburgh, PA
- City of Washington Citywide Development Corporation, Washington, PA
- City Theatre Company, Pittsburgh, PA
- Clare House, Lancaster, PA
- Clarion County Coalition for Suicide Prevention, Clarion, PA
- Clarion County Human Services, Clarion, PA
- Clarion County YMCA and Oil City YMCA, Oil City, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- Clarion Forest VNA, Inc., Clarion, PA
- Clark Memorial Baptist Church, Homestead, PA
- CLASS - Community Living and Support Services, Pittsburgh, PA
- Classrooms Without Borders, Pittsburgh, PA
- Claysburg Education Foundation, Claysburg, PA
- Clean Slate, Pittsburgh, PA
- Clear Thoughts Foundation, Wexford, PA
- Clearfield County Communities That Care (CenClear), Bigler, PA
- Climate Changers, Inc., Erie, PA
- Club Serenity, Inc., Charleroi, PA
- CMSU Service System, Danville, PA
- COBYS Family Services, Lancaster, PA
- Code & Supply Scholarship Fund, Pittsburgh, PA
- CodeDay, Walnut, CA
- Colon Cancer Coalition, Edina, MN
- Colorectal Cancer Alliance, Washington, DC
- Columbia University, New York, NY
- Communities In Schools of Eastern Pennsylvania, Inc., Allentown, PA
- Community Action Lehigh Valley, Bethlehem, PA
- Community Action Partnership of Lancaster County, Lancaster, PA
- Community Arts Center of Cambria County, Johnstown, PA
- Community Blood Bank of Northwestern Pennsylvania and Western New York, Erie, PA
- Community Care Behavioral Health Organization, Pittsburgh, PA
- Community College of Allegheny County, Pittsburgh, PA
- Community Empowerment Association, Pittsburgh, PA
- Community First Fund, Philadelphia, PA
- Community Food Warehouse of Mercer County, Sharon, PA
- Community Forge, Wilkinsburg, PA
- Community Foundation for the Alleghenies, Johnstown, PA
- Community Foundation of Fayette County, Uniontown, PA
- Community Intensive Supervision Program (CISP), Pittsburgh, PA
- Community Kitchen Pittsburgh, Pittsburgh, PA
- Community Liver Alliance, Pittsburgh, PA
- Community Options, Inc., Princeton, NJ
- Community Progress Council, Inc., York, PA
- Community REACH, Inc., Red Lion, PA
- Community Services for Children, Allentown, PA
- Community Shelter Services, Erie, PA
- Compeer of Lebanon County, Lebanon, PA
- Concordia Lutheran Ministries, Cabot, PA
- Confluence Tourism Association, Confluence, PA
- Congregation Beth Shalom, Pittsburgh, PA
- Congregation Poale Zedeck, Pittsburgh, PA
- Congreso de Latinos Unidos, Inc., Philadelphia, PA
- Connecting Champions, Pittsburgh, PA
- Consumer Health Coalition, Pittsburgh, PA
- Contemporary Craft, Pittsburgh, PA
- Coraopolis Community Development Foundation, Coraopolis, PA
- CORO Pittsburgh, Pittsburgh, PA
- County of Allegheny, Office of Community Affairs, Pittsburgh, PA
- Cranberry Township EMS, Cranberry Twp, PA
- Creative Community Connectors, Erie, PA
- Creative York, York, PA
- Cribs for Kids, Pittsburgh, PA
- Crime Victim Center of Erie County, Inc., Erie, PA
- Crispus Attucks Community Center, Lancaster, PA
- Crohn's & Colitis Foundation, Pittsburgh, PA
- Cultivating Resilient Youth, Pittsburgh, PA
- Cystic Fibrosis Foundation, Western Pennsylvania Chapter, Pittsburgh, PA
- Daughters of Zion 101, Pittsburgh, PA
- DePaul School for Hearing and Speech, Pittsburgh, PA
- Developmental and Disability Services of Lebanon County, Lebanon, PA
- Disability Options Network, New Castle, PA
- Dollar Energy Fund, Inc., Pittsburgh, PA
- Down Syndrome Association of Pittsburgh, Pittsburgh, PA
- Doylestown Health Foundation, Doylestown, PA
- Dreams Go On, Hollidaysburg, PA
- Dreams of Hope, Pittsburgh, PA
- Dress for Success Pittsburgh, Pittsburgh, PA
- Dubois Lions Club, Dubois, PA
- Duquesne University, Pittsburgh, PA
- Dystonia Medical Research Foundation, Chicago, IL
- Early Connections (Erie), Erie, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- East Liberty Development, Inc., Pittsburgh, PA
- East Liberty Family Health Care Center, Pittsburgh, PA
- Eastern Amputee Golf Association (EAGA), Bethlehem, PA
- Eastern Great Lakes Region at The Leukemia & Lymphoma Society, Pittsburgh, PA
- Eastern Minority Supplier Development Council, Philadelphia, PA
- Eastern Society for Pediatric Research, The Woodland, TX
- Easterseals Western and Central PA, Pittsburgh, PA
- Easton Area Neighborhood Center, Easton, PA
- Easy Does It, Inc., Leesport, PA
- Ebenezer Missionary Baptist Church, Pittsburgh, PA
- Ebensburg Main Street Partnership, Ebensburg, PA
- EcoDistricts Incubator, Pittsburgh, PA
- Edinboro University, Edinboro, PA
- Edinboro Volunteer Fire Department, Edinboro, PA
- EDSI Solutions, Pittsburgh, PA
- Educating Teens about HIV/Aids Inc., Pittsburgh, PA
- Elana's Blessings, Washington, PA
- Embracing Our Veterans, Erie, PA
- Emergency Nurses Association, Schaumburg, IL
- Emergycare, Erie, PA
- Emma's Footprints, Erie, PA
- Emmaus Community of Pittsburgh, Pittsburgh, PA
- EMS West, Pittsburgh, PA
- Energy Innovation Center, Pittsburgh, PA
- Ephrata Community Health Foundation, Ephrata, PA
- Epilepsy Foundation Western/Central Pennsylvania, Pittsburgh, PA
- Erie Arts & Culture, Erie, PA
- Erie Bayhawks, Erie, PA
- Erie City Mission, Erie, PA
- Erie County Drug & Alcohol Coalition, Erie, PA
- Erie County Historical Society, Erie, PA
- Erie County Medical Society, Erie, PA
- Erie DAWN, Erie, PA
- Erie Day School, Erie, PA
- Erie Downtown Partnership, Erie, PA
- Erie Neighborhood Growth Partnership, Inc., Erie, PA
- Erie Otters, Erie, PA
- Erie Philharmonic, Erie, PA
- Erie Playhouse, Erie, PA
- ERIE Regional Chamber and Growth Partnership, Erie, PA
- Erie SeaWolves, Erie, PA
- Erie Sports Commission, Erie, PA
- Erie United Methodist Alliance, Erie, PA
- Erie Zoo, Erie, PA
- Erie's Blue Coats, Erie, PA
- Erie-Western PA Port Authority, Erie, PA
- Every Child, Inc., Pittsburgh, PA
- expERIEnce Children's Museum, Erie, PA
- Extra Mile Education Foundation, Pittsburgh, PA
- Families Matter Food Pantry, Monaca, PA
- Family & Friends Initiative of Pittsburgh, Pittsburgh, PA
- Family Guidance, Pittsburgh, PA
- Family House, Pittsburgh, PA
- Family Medicine Education Consortium, Inc., Dayton, OH
- Family Promise of Lehigh Valley, Allentown, PA
- Family Promise Harrisburg Capital Region, Camp Hill, PA
- Family Resources, Pittsburgh, PA
- Family Services of NW PA, Erie, PA
- Family Services of Warren County, Warren, PA
- Familylinks, Pittsburgh, PA
- Fayette County Community Action Agency, Inc., Uniontown, PA
- Fayette County Cultural Trust, Connellsville, PA
- Feel Your Boobies Foundation, Harrisburg, PA
- Film Pittsburgh, Pittsburgh, PA
- Fineview Citizens Council, Pittsburgh, PA
- First Baptist Church of Pittsburgh, Pittsburgh, PA
- First Community Foundation Partnership of Pennsylvania (FCFP), Williamsport, PA
- First Step Recovery Homes, McKeesport, PA
- First Tee – Pittsburgh, Pittsburgh, PA
- First United Church of Christ, Carlisle, PA
- Focus on Renewal, McKees Rocks, PA
- FOCUS Pittsburgh, Pittsburgh, PA
- Forward Cities, Durham, NC
- Foundation for Free Enterprise Education (FFEE), Erie, PA
- Foundation of HOPE, Pittsburgh, PA
- Fox Chapel Area Rotary Club, Fox Chapel, PA
- Franklin Area Chamber of Commerce, Franklin, PA
- Franklin County Housing Authority, Chambersburg, PA
- Friends of UPMC Somerset, Somerset, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- Friends of the Poor, Scranton, Scranton, PA
- Friendship Community Presbyterian Church, Pittsburgh, PA
- Fulton County Food Basket, Inc., McConnellsburg, PA
- Garvey Manor Nursing home, Hollidaysburg, PA
- Gateway Medical Society, Pittsburgh, PA
- Gateway Rehabilitation Center, Pittsburgh, PA
- Gaudenzia, Norristown, PA
- GFWC Hollidaysburg Area Women's Club, Hollidaysburg, PA
- Ghana Association of Pittsburgh, Pittsburgh, PA
- GIFT - Giving It Forward, Together, Pittsburgh, PA
- Girl Scouts Western Pennsylvania, Pittsburgh, PA
- Girls Hope of Pittsburgh, Inc., Baden, PA
- Girls on the Run at Magee-Womens Hospital in Pittsburgh, Pittsburgh, PA
- Glade Run Lutheran Services, Zelienople, PA
- Glamorous Gutless Girls of Kent State University, Kent, OH
- Gliding Stars of Erie, Erie, PA
- Global Links, Pittsburgh, PA
- Global Minds Initiative, Pittsburgh, PA
- Global Pittsburgh, Pittsburgh, PA
- Good Shepherd Catholic Church, Braddock, PA
- Good Shepherd Rehabilitation Network, Allentown, PA
- Goodwill of Southwestern Pennsylvania, Pittsburgh, PA
- Goodwin Memorial Baptist Church, Harrisburg, PA
- Goulden Touch, Howard, PA
- Grace Community Foundation, Allentown, PA
- Grace United Methodist Church, Lemoyne, PA
- Grantmakers of Western Pennsylvania, Pittsburgh, PA
- Greater Altoona Career & Technology Center, Altoona, PA
- Greater Erie Alliance for Equality, Erie, PA
- Greater Harrisburg NAACP, Harrisburg, PA
- Greater Philadelphia Health Action, Inc. (GPHA), Philadelphia, PA
- Greater Philadelphia YMCA, Media, PA
- Greater Pittsburgh Arts Council, Pittsburgh, PA
- Greater Pittsburgh Community Food Bank, Pittsburgh, PA
- Greater Pittsburgh Literacy Council, Pittsburgh, PA
- Greater Reading Chamber Alliance, Reading, PA
- Greater Reading Mental Health Alliance, Wyomissing, PA
- Greater Washington County Food Bank, Brownsville, PA
- Green Building Alliance, Pittsburgh, PA
- Greenville Heritage Days, Greenville, PA
- Grounded Strategies, Pittsburgh, PA
- Guardian Angels Parish, Natrona Heights, PA
- Gwen's Girls, Pittsburgh, PA
- Habitat for Humanity of Berks County, Reading, PA
- Habitat for Humanity of Greater Pittsburgh, Pittsburgh, PA
- Habitat for Humanity of the Lehigh Valley, Allentown, PA
- HACC, Central Pennsylvania's Community College, Harrisburg, PA
- Hair Peace Charities, Pittsburgh, PA
- Hamilton Health Center, Harrisburg, PA
- Hampton Alliance for Educational Excellence (HAEE), Allison Park, PA
- Hanover Area Diversity Alliance, Hanover, PA
- Harrisburg Housing Authority, Harrisburg, PA
- Havin, Inc., Kittanning, PA
- Hazelwood Initiative, Inc., Pittsburgh, PA
- Head for the Cure Foundation, Kansas City, MO
- Healthcare Financial Management Association, Westchester, IL
- Healthcare Information and Management Systems Society (HIMSS), Central Pennsylvania Chapter, Harrisburg, PA
- Healthy Steps Diaper Bank, Harrisburg, PA
- HEARTH, Glenshaw, PA
- Hedwig House, Ardmore, PA
- Heinz Endowments, Pittsburgh, PA
- Hello Neighbor, Pittsburgh, PA
- Helping Harvest, Reading, PA
- Heritage Community Initiatives, Braddock, PA
- Heritage Public Library, McDonald, PA
- Heritage Valley Health System, Sewickley, PA
- Hershey Food Bank and Community Outreach, Hershey, PA
- HF Lenz Company, Pittsburgh, PA
- Hidden Valley Foundation, Somerset, PA
- Higher Achievement, Pittsburgh, PA
- Highlands Health Clinic, Johnstown, PA
- Hill Community Development Corporation, Pittsburgh, PA
- Hill District Education Council, Pittsburgh, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- Hillel Jewish University Center of Pittsburgh, Pittsburgh, PA
- Hilltop Alliance, Pittsburgh, PA
- Hispanic American Organization, Inc., Allentown, PA
- Hispanic Center Lehigh Valley, Bethlehem, PA
- HM3 Partners Independence Fund, Gibsonia, PA
- Holcomb Behavioral Health Systems, Exton, PA
- Hollidaysburg Area Arts Council (HAAC), Hollidaysburg, PA
- Hollidaysburg Area Community Partnership, Hollidaysburg, PA
- Holy Family Institute, Pittsburgh, PA
- Home Nursing Agency, Altoona, PA
- Homeless Children's Education Fund, Pittsburgh, PA
- Homewood at Martinsburg, Martinsburg, PA
- Homewood Children's Village, Pittsburgh, PA
- Homewood-Brushton YMCA, Pittsburgh, PA
- Hope Drop-In Center, Altoona, PA
- Hope Grows, Moon Township, PA
- HOPE Ministries and Community Services, Lancaster, PA
- Hope Rescue Mission, Reading, PA
- Hôpital Albert Schweitzer Haiti, Deschapelles, Haiti
- Housing Alliance of Pennsylvania, Jenkintown, PA
- Housing and Neighborhood Development Service (HANDS), Erie, PA
- Huddle Up for Kids Foundation, Mars, PA
- Hugh Lane Wellness Foundation, Pittsburgh, PA
- Human Services Development Fund (HSDF), York, PA
- Human Services Inc., Thorndale, PA
- Humane Animal Rescue, Pittsburgh, PA
- Huntingdon Community Center, Huntingdon, PA
- Huntingdon County Head Start, Huntingdon, PA
- Huntingdon County Housing Authority, Huntingdon, PA
- Huntingdon County PRIDE, Inc., Huntingdon, PA
- Hydrocephalus Association, Bethesda, MD
- I Am So Hill Organization, Pittsburgh, PA
- IdeasPgh, Pittsburgh, PA
- Iglesia Juan 3:16, Harrisburg, PA
- II-VI Foundation, Bridgeville, PA
- Imani Christian Academy, Pittsburgh, PA
- In the Light Ministries, Lancaster, PA
- Inclusant, Harrisburg, PA
- Indiana County Community Action Program (ICCAP), Indiana, PA
- Indiana Healthcare Foundation, Indiana, PA
- Infinite Lifestyle Solutions, Pittsburgh, PA
- Ingomar Franklin Park Little League, Ingomar, PA
- Inner-City Neighborhood Art House, Erie, PA
- Institute for Research, Education and Training in Addictions (IRETA), Pittsburgh, PA
- Institute of Medical and Business Careers (IMBC), Pittsburgh, PA
- International Association of Emergency Managers (IAEM), Falls Church, VA
- Iota Phi Foundation, Pittsburgh, PA
- Irish Partnership of Pittsburgh d.b.a. Pittsburgh Irish Festival, Pittsburgh, PA
- Iroquois School District Foundation, Erie, PA
- Islamic Center of Pittsburgh, Pittsburgh, PA
- Ivies on the Lake Foundation, Erie, PA
- Jack and Jill of America · Pittsburgh Chapter, Pittsburgh, PA
- JADA House International, Pittsburgh, PA
- Jaffa Shriners, Altoona, PA
- Jake Wheatley, Jr. Health and Wellness Weekend, Pittsburgh, PA
- Jamestown Community College, Jamestown, NY
- Jamestown Renaissance Corporation (JRC), Jamestown, NY
- Jana Marie Foundation, State College, PA
- JCC of Greater Pittsburgh, Pittsburgh, PA
- Jefferson Hills Recreational Initiative, Jefferson Hills, PA
- Jerome Bettis The Bus Stops Here Foundation, McKees Rocks, PA
- JEVS Human Services, Philadelphia, PA
- Jewish Association on Aging (JAA), Pittsburgh, PA
- Jewish Family & Children's Service, Pittsburgh, PA
- Jewish Family and Community Services, Pittsburgh, PA
- Jewish Family Service of Greater Harrisburg, Harrisburg, PA
- Jewish Family Service of the Lehigh Valley, Allentown, PA
- Jewish National Fund, New York, NY
- Job Corps, Washington, DC
- Johnstown Area Heritage Association (JAHA), Johnstown, PA
- Johnstown Walk of Hope, Johnstown, PA
- Josh Gibson Foundation, Pittsburgh, PA
- Juniata College, Huntingdon, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- Junior Achievement of Western Pennsylvania, Pittsburgh, PA
- Kappa Chapter, Inc. of Chi Eta Phi Sorority Incorporated, Pittsburgh, PA
- Kappa Scholarship Endowment Fund of Western PA, Pittsburgh, PA
- Kelly Strayhorn Theater, Pittsburgh, PA
- Keystone Blind Association, Hermitage, PA
- KeystoneCare, Wyndmoor, PA
- Kids Chance of Pennsylvania, Pittsburgh, PA
- Kids Escaping Drugs, West Seneca, NY
- KidsVoice, Pittsburgh, PA
- Kollel Jewish Learning Center, Pittsburgh, PA
- Labor Council for Latin American Advancement (LCLAA), Pittsburgh, Pittsburgh, PA
- Lackawanna County Reentry Task Force, Scranton, PA
- Ladies of Charity, Catholic Diocese of Pittsburgh, Pittsburgh, PA
- Lake Erie Arboretum at Frontier Park, Erie, PA
- Lake Erie College of Osteopathic Medicine (LECOM), Erie, PA
- Lakemont Lions Club, Altoona, PA
- Lakeshore Community Services, Inc., Erie, PA
- Lancaster County Food Hub, Lancaster, PA
- Lancaster County Project for the Needy, Lancaster, PA
- Lancaster Lebanon Habitat for Humanity, Lancaster, PA
- Lancaster Recreation Commission, Lancaster, PA
- Lancaster Science Factory, Lancaster, PA
- Landforce, Pittsburgh, PA
- Larimer Consensus Group (LCG), Pittsburgh, PA
- Latin American Cultural Center -Lancaster LACC, Lancaster, PA
- Latino Community Center, Pittsburgh, PA
- Latrobe Art Center, Latrobe, PA
- Laurel Life, Chambersburg, PA
- Lawrence County Regional Chamber of Commerce, New Castle, PA
- Lawrenceville Corporation, Pittsburgh, PA
- Le Creme Music Festival, Allentown, PA
- Leadership Pittsburgh Inc. (LPI), Pittsburgh, PA
- LeadingAge PA, Mechanicsburg, PA
- Lebanon County Community Action Partnership, Lebanon, PA
- Lebanon County Head Start, Lebanon, PA
- Lebanon Family Health Services, Lebanon, PA
- Legacy Faith Church, Harrisburg, PA
- Lehigh Valley - American Association of Physicians of Indian Origin (LVAAPI), Bethlehem, PA
- Lehigh Valley Center for Independent Living, Allentown, PA
- Lehigh Valley Children's Centers (LVCC), Allentown, PA
- Lehigh Valley Families Together, Inc., Allentown, PA
- Lending Hearts, Pittsburgh, PA
- Let Freedom Sing, Pittsburgh, PA
- LGBT Elder Initiative, Philadelphia, PA
- Liberty Resources, Inc., Philadelphia, PA
- Life Center, Franklin, PA
- Life Choices Clinic, Camp Hill, PA
- LifeSpan, Inc., Homestead, PA
- Life'sWork of Western PA, Pittsburgh, PA
- Light of Life Rescue Mission, Pittsburgh, PA
- LINKS Charity, Jamestown, NY
- Literacy Pittsburgh, Pittsburgh, PA
- Little Italy Days, Pittsburgh, PA
- Little Sisters of the Poor, Pittsburgh, PA
- Living Water Community Church, Harrisburg, PA
- Luminari Inc., Pittsburgh, PA
- Lupus Foundation of Pennsylvania, Pittsburgh, PA
- Luzerne County Child Advocacy Center+, Wilkes Barre, PA
- Lycoming-Clinton Counties Commission for Community Action (STEP), Williamsport, PA
- Macedonia Family and Community Enrichment Center, Inc., Pittsburgh, PA
- Magee-Womens Research Institute and Foundation, Pittsburgh, PA
- Mainstay Life Services, Pittsburgh, PA
- Make a Wish Foundation, Pittsburgh, PA
- Manchester Bidwell Corporation, Pittsburgh, PA
- Manchester Youth Development Center (MYDC), Pittsburgh, PA
- Manna Food Pantry A Ministry of Penbrook United Church of Christ, Harrisburg, PA
- Manufacturer & Business Association, Erie, PA
- Maria House Project, Erie, PA
- Mario Lemieux Foundation, Pittsburgh, PA
- Mary's Shelter, Reading, PA
- Mason-Dixon Community Services, Inc., Delta, PA
- Mayor, City of Chester, Chester, PA
- McGuire Memorial, New Brighton, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- McKees Point Development Group, McKeesport, PA
- McKees Rocks Community Development Corporation, McKees Rocks, PA
- Meals On Wheels Erie, Erie, PA
- Mel Blount Youth Leadership Initiative, Claysville, PA
- Mercy Center for Women, Erie, PA
- Mercy Hilltop Center, Erie, PA
- Mercy Neighborhood Ministries, Inc., Philadelphia, PA
- Mercyhurst Preparatory School, Erie, PA
- METAvivor, Annapolis, MD
- Michael Making Lives Better, Erie, PA
- Milagro House, Lancaster, PA
- Milestone Centers, Inc., Pittsburgh, PA
- Minding the Gap, Pittsburgh, PA
- Mission of Mercy Pittsburgh, Pittsburgh, PA
- Mom's House of Lancaster, Lancaster, PA
- Mon Valley Academy for the Arts, Charleroi, PA
- Monongahela Valley Hospital, Monongahela, PA
- Monroeville American Legion, Monroeville, PA
- Monroeville Rotary Club, Monroeville, PA
- Montgomery County Office for Aging, Inc., Amsterdam, NY
- Montour Trail Council, Bridgeville, PA
- Morning Star Pregnancy Services, Harrisburg, PA
- Mosser Village Family Center, Allentown, PA
- Mother Theresa Academy, Erie, PA
- Mother of Sorrows Church, Murrysville, PA
- Mount Aloysius College, Cresson, PA
- Mount Nittany Health Foundation, State College, PA
- Mount Washington Community Development Corporation, Pittsburgh, PA
- M-PowerHouse, Pittsburgh, PA
- Mt Zion Missionary Baptist Church, Pittsburgh, PA
- Mt. Ararat Community Activity Center, Pittsburgh, PA
- Mt. Lebanon Artists' Market, Pittsburgh, PA
- Mt. Lebanon Partnership, Pittsburgh, PA
- Multi-Cultural Health Evaluation Delivery System, Inc., Erie, PA
- Muscular Dystrophy Association, Pittsburgh, PA
- Muslim Association of Lehigh Valley, Whitehall, PA
- My Brother's Keeper, City of Pittsburgh, Pittsburgh, PA
- NAACP Washington, PA Branch, Washington, PA
- NACD Three Rivers Chapter, Bridgeville, PA
- NAIOP's Developing Leaders, Pittsburgh, PA
- NAMI Blair County PA, Altoona, PA
- NAMI Luzerne / Wyoming County PA, Kingston, PA
- NAMI of Erie County, Erie, PA
- NAMI Scranton and Northeast Region PA, Scranton, PA
- NAMI York-Adams Counties PA, York, PA
- Nancy's Revival, Pittsburgh, PA
- National Association of African Americans in Human Resources (NAAAHR-Pittsburgh), Pittsburgh, PA
- National Association of Orthopaedic Nurses (NAON), Chicago, IL
- National Civil War Museum, Harrisburg, PA
- National Council of Jewish Women (NCJW), Pittsburgh Section, Pittsburgh, PA
- National Diversity Council, Houston, TX
- National Down Syndrome Congress, Roswell, GA
- National Eating Disorders Association, New York, NY
- National Kidney Foundation Serving the Alleghenies, Pittsburgh, PA
- National Multiple Sclerosis Society, Pennsylvania Keystone Chapter, Pittsburgh, PA
- National Neurotrauma Society, Windermere, FL
- National Organization of Social Workers, Washington, DC
- National Ovarian Cancer Coalition-Pittsburgh, Pittsburgh, PA
- National Refuge for Women, Emergency Housing Pittsburgh, Moon Township, PA
- National Veterans Resource Center, Onward to Opportunity, Syracuse, NY
- Nazareth Area Food Bank, Nazareth, PA
- Negro Educational Emergence Drive (NEED), Pittsburgh, PA
- Nehemiah Project International Ministries, Vancouver, WA
- Neighborhood Allies, Pittsburgh, PA
- Neighborhood Health Centers of the Lehigh Valley, Allentown, PA
- Neighborhood Housing Services of Greater Berks, Reading, PA
- Neighborhood Housing Services of the Lehigh Valley, Allentown, PA
- Neighborhood Learning Alliance, Pittsburgh, PA
- NeighborWorks Association of Pennsylvania, Pittsburgh, PA
- New Bethany Ministries, Bethlehem, PA
- New Choices Career Development Program, Media, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- New Hope Ministries, Dillsburg, PA
- New Journey Community Outreach, Inc., Reading, PA
- New Pittsburgh Courier, Pittsburgh, PA
- New Sun Rising, Millvale, PA
- New Creation Free Methodist Church, New Castle, PA
- North Allegheny Foundation (NAF), Pittsburgh, PA
- Northeast Community Center for Behavioral Health, Philadelphia, PA
- Northeast Neighborhood Association, York, PA
- Northeast Region - Institute of Industrial and Systems Engineers, Boston, MA
- Northern Area MultiService Center, Pittsburgh, PA
- Northern Pennsylvania Regional College, Warren, PA
- Northside Common Ministries, Pittsburgh, PA
- Nursing Foundation of Pennsylvania (NFP), Harrisburg, PA
- NW PA Pride Alliance, Inc., Erie, PA
- Oakmont Chamber of Commerce, Oakmont, PA
- OCA-Asian Pacific American Advocates, Washington, DC
- Office of Community Services, Washington, DC
- Office of Minority Health (OMH) at the U.S. Department of Health and Human Services (HHS), Rockville, MD
- Office of the Treasurer, Duncansville Borough, Duncansville, PA
- Office of Vocational Rehabilitation Services, Pittsburgh Office, Pittsburgh, PA
- Oil City Catholic Community, Oil City, PA
- Olivet Boys & Girls Club, Reading, PA
- OMA Center for Mind Body Spirit, Pittsburgh, PA
- Omega Psi Phi Fraternity, Inc., Iota Chapter, Pittsburgh, PA
- OMHSAS Bureau of Children's Behavioral Health Services, Harrisburg, PA
- Omicelo Cares Inc., Pittsburgh, PA
- One Day to Remember, Pittsburgh, PA
- Onyx Woman Network (OWN), Pittsburgh, PA
- Open Field @ Ascender, Pittsburgh, PA
- Open Streets Lancaster, presented by Lancaster Rec, Lancaster, PA
- Operation Better Block, Inc., Pittsburgh, PA
- Operation Enduring Warrior (OEW), Midlothian, VA
- Operation Troop Appreciation, Pittsburgh, PA
- Operation Walk Pittsburgh, Pittsburgh, PA
- Opportunity House, Reading, PA
- Opportunity Zone Association of America, Washington, DC
- Our Hearts to Soles, Ingomar, PA
- Our Lady of the Blessed Sacrament Food Pantry, Harrisburg, PA
- Outreach Teen & Family Services, Pittsburgh, PA
- Over the Rainbow Children's Advocacy Center, Chambersburg, PA
- PA CareerLink Pittsburgh, Pittsburgh, PA
- PA CareerLink Pittsburgh, Veterans Services, Pittsburgh, PA
- PA CareerLink Berks County, Reading, PA
- PA Chamber of Business and Industry, Harrisburg, PA
- PA Chapter, American Academy of Pediatrics, Media, PA
- PA Connecting Communities, Carnegie, PA
- PACDC Philadelphia Association of Community Development Corporations, Philadelphia, PA
- Pancreatic Cancer Action Network, Manhattan Beach, CA
- Parent Education & Advocacy Leadership (PEAL) Center, Pittsburgh, PA
- Parkinson Partners of NW PA, Inc., Erie, PA
- Parkinson Foundation Western Pennsylvania (PFWPA), Bellevue, PA
- Pars for Postpartum Depression Golf Outing, Pittsburgh, PA
- Partner4Work, Pittsburgh, PA
- Pediatric Palliative Care Coalition (PPCC), Pittsburgh, PA
- Penn Hills Police Department, Pittsburgh, PA
- PennAEYC, Harrisburg, PA
- Pennsylvania Assisted Living Association, Camp Hill, PA
- Pennsylvania Assistive Technology Foundation (PATF), King of Prussia, PA
- Pennsylvania Association of Community Health Centers, Wormleysburg, PA
- Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA), Harrisburg, PA
- Pennsylvania Coalition Against Domestic Violence (PCADV), Harrisburg, PA
- Pennsylvania College Access Program (PA-CAP), Pittsburgh, PA
- Pennsylvania Department of Labor and Industry, Pittsburgh, PA
- Pennsylvania District Kiwanis International, Harrisburg, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- Pennsylvania Geriatric Society - Western Division, Pittsburgh, PA
- Pennsylvania Health Access Network (PHAN) - Pittsburgh, Office, Pittsburgh, PA
- Pennsylvania Health Care Association (PHCA), Harrisburg, PA
- Pennsylvania Highlands Community College Foundation, Johnstown, PA
- Pennsylvania Homecare Association, Lemoyne, PA
- Pennsylvania Housing Finance Agency (PHFA), Harrisburg, PA
- Pennsylvania Interfaith Impact Network (PIIN), Pittsburgh, PA
- Pennsylvania Mental Health Consumers' Association (PMHCA), Harrisburg, PA
- Pennsylvania Office of Vocational Rehabilitation, Pittsburgh, PA
- Pennsylvania Peer Support Coalition (PaPSC), Lancaster, PA
- Pennsylvania Psychological Association, Harrisburg, PA
- Pennsylvania Women Work, Pittsburgh, PA
- Pennsylvanians for Modern Courts, Philadelphia, PA
- PERSAD Center, Pittsburgh, PA
- Perseus House, Inc., Erie, PA
- Pettigrew Endowed Fund, Pittsburgh, PA
- Pinebrook Family Answers, Allentown, PA
- Pine-Richland Youth Center, Gibsonia, PA
- Pink Pamper, Bethel Park, PA
- Pittsburgh Action Against Rape (PAAR), Pittsburgh, PA
- Pittsburgh Airport Area Chamber of Commerce, Moon Township, PA
- Pittsburgh Alumnae Chapter of Delta Sigma Theta Sorority, Inc., Pittsburgh, PA
- Pittsburgh Association of the Deaf, Pittsburgh, PA
- Pittsburgh Black Pride, Pittsburgh, PA
- Pittsburgh Board of Education, Pittsburgh, PA
- Pittsburgh Career Institute, Pittsburgh, PA
- Pittsburgh Chapter, German American Chamber of Commerce, Inc., Pittsburgh, PA
- Pittsburgh Community Reinvestment Group (PCRG), Pittsburgh, PA
- Pittsburgh Community Services, Inc., Pittsburgh, PA
- Pittsburgh Cultural Trust, Pittsburgh, PA
- Pittsburgh Downtown Partnership, Pittsburgh, PA
- Pittsburgh Gateways Corporation, Pittsburgh, PA
- Pittsburgh Hires Veterans, Pittsburgh, PA
- Pittsburgh Hispanic Development Corporation (PHDC), Pittsburgh, PA
- Pittsburgh Institute of Mortuary Science (PIMS), Pittsburgh, PA
- Pittsburgh Job Corps Center, Pittsburgh, PA
- Pittsburgh Learning Commons, Pittsburgh, PA
- Pittsburgh Lesbian & Gay Film Society, Pittsburgh, PA
- Pittsburgh Mercy, Pittsburgh, PA
- Pittsburgh Student Chapter of Engineers Without Borders, Pittsburgh, PA
- Pittsburgh Technical College (PTC), Oakdale, PA
- Pittsburgh Urban Christian School, Pittsburgh, PA
- Pittsburgh Urban Magnet Project (PUMP), Pittsburgh, PA
- Pittsburgh Urban Media, Pittsburgh, PA
- Pittsburgh's Premedical Organization for Minority Students (POMS), Pittsburgh, PA
- Planned Parenthood of Western PA, Pittsburgh, PA
- POISE Foundation, Pittsburgh, PA
- Presbyterian SeniorCare, Oakmont, PA
- Presque Isle Partnership, Erie, PA
- Pressley Ridge Foundation, Pittsburgh, PA
- Primary Care Collaborative, Washington, DC
- Primary Care Health Services, Inc., Pittsburgh, PA
- Professional Women's Network (PWN), Pittsburgh, PA
- Program to Aid Citizen Enterprise (PACE), Pittsburgh, PA
- Project Management Institute (PMI) Pittsburgh Chapter, Pittsburgh, PA
- Prostate Conditions Education Council (PCEC), Centennial, CO
- PublicSource, Pittsburgh, PA
- PulsePoint, Pleasanton, CA
- Rainbow Kitchen, Homestead, PA
- Reading Area Community College (RACC), Reading, PA
- Reading is Fundamental Pittsburgh, Pittsburgh, PA
- Rebuilding Together Pittsburgh (RTP) Pittsburgh, PA
- Recovery Community Connection, Williamsport, PA
- Redevelopment Authority of County of Greene, Waynesburg, PA
- Reel Q Film Festival, Pittsburgh, PA
- resolve Crisis Services, Pittsburgh, PA
- Retreat & Refresh Stroke Camp, Peoria, IL
- Robert Morris University, Moon Township, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- Rodman Street Missionary Baptist Church, Pittsburgh, PA
- Ronald McDonald House Charities of Central Pennsylvania, Hershey, PA
- Ronald McDonald House Scranton, Scranton, PA
- Roots of Faith Ministry Center, a location of Faith United Methodist Church, Sharpsburg, PA
- Rotary Club of Harrisburg (RCH), Harrisburg, PA
- Rotary Club of Pittsburgh, Pittsburgh, PA
- Safe Berks, Reading, PA
- Safe Harbor Easton, Easton, PA
- SafeNet Erie, Erie, PA
- Saint Patrick Church, Erie, PA
- Salem Square Community Association, York, PA
- Samaritan Counseling Center, Lancaster, PA
- Sarah A. Reed Children's Center, Erie, PA
- Sarah Heinz House, Pittsburgh, PA
- Schuylkill County's VISION, Schuylkill Haven, PA
- Second Harvest Food Bank of Northwest Pennsylvania, Erie, PA
- SEMPER GRATUS, Pittsburgh, PA
- Serving Other Souls, Inc., Pittsburgh, PA
- Sharing and Caring, Inc., Pittsburgh, PA
- Sharpsburg Neighborhood Organization (SNO), Pittsburgh, PA
- Shenango Valley Urban League, Inc., Farrell, PA
- Shriners Hospitals for Children — Erie, Erie, PA
- Side Project Inc., West Palm Beach, FL
- Silk Screen, Asian American Arts & Culture Organization, Pittsburgh, PA
- Sister Cities Association of Pittsburgh, Pittsburgh, PA
- SisTers PGH, Swissvale, PA
- Sisters Place, Inc., Pittsburgh, PA
- Skills of Central PA, State College, PA
- Small Seeds Development Inc., Pittsburgh, PA
- Smart Futures, Pittsburgh, PA
- Society of St. Vincent de Paul Council of Altoona-Johnstown, Altoona, PA
- Softer Side Seminars, Pittsburgh, PA
- Sojourner House, Pittsburgh, PA
- Sonny Pugar Memorial, Inc., Pittsburgh, PA
- South Central Community Action Programs (SCCAP), Gettysburg, PA
- South Park Education Foundation, South Park, PA
- South Side Community Council, Pittsburgh, PA
- Southwestern Pennsylvania Area Agency on Aging, Inc., Charleroi, PA
- Special Olympics Pennsylvania, Norristown, PA
- SpiriTrust Lutheran, Chambersburg, PA
- Spoken Language Interpreting Services Pittsburgh Language Access Network (PLAN), Pittsburgh, PA
- Springboard Consulting, LLC, Highland Beach, FL
- Squirrel Hill Health Center, Pittsburgh, PA
- Squirrel Hill Urban Coalition (SHUC), Pittsburgh, PA
- St. Barnabas Charities, Gibsonia, PA
- St. Francis University, Loretto, PA
- St. Martin Center, Inc., Erie, PA
- St. Matthew Lutheran Church, Millerstown, PA
- St. Paul Baptist Church, Pittsburgh, PA
- STANDING FIRM, a national program of Women's Center & Shelter of Greater Pittsburgh, Pittsburgh, PA
- Steel Smiling, Pittsburgh, PA
- Steel Valley Rotary Club, Munhall, PA
- Strong Women, Strong Girls, Pittsburgh, PA
- Student National Medical Association, University of Pittsburgh School of Medicine Chapter, Pittsburgh, PA
- Susan G. Komen Pennsylvania, Dallas, TX
- Sustainable Pittsburgh, Pittsburgh, PA
- Team PHenomenal Hope, Inc., Beloit, Wisconsin
- Temple Emmanuel of South Hills, Pittsburgh, PA
- The 9th Street Clinic, McKeesport, PA
- The African American Directors Forum (AADF), Pittsburgh, PA
- The Afro-American Music Institute (AAMI), Pittsburgh, PA
- The Aging Institute of UPMC Senior Services and the University of Pittsburgh, Pittsburgh, PA
- The Aleph Institute - N.E. Regional Headquarters, Pittsburgh, PA
- The Allegheny Conference on Community Development, Pittsburgh, PA
- The ALS Association Western Pennsylvania Chapter, Pittsburgh, PA
- The American Institute of Architects (AIA), Pittsburgh Chapter, Pittsburgh, PA
- The American Red Cross Greater Pennsylvania, Pittsburgh, PA
- The Arc of Dauphin County, Harrisburg, PA
- The Arc of Erie County, Erie, PA
- The BHS Foundation, Butler, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- The Bradley Center, Pittsburgh, PA
- The Brain Recovery Project, Los Angeles, CA
- The Brashear Association, Pittsburgh, PA
- The Cambria County Library System, Johnstown, PA
- The Center for Hearing & Deaf Services, Inc. (HDS), Pittsburgh, PA
- The Center for Student Wellbeing, Duquesne University, Pittsburgh, PA
- The Chester County Community Foundation, West Chester, PA
- The Children's Heart Foundation, Northbrook, IL
- The Citizens Science Lab, Pittsburgh, PA
- The Colon Club, Gansevoort, NY
- The Community Alliance for Suicide Prevention, Mayville, NY
- The Community Health Center of Butler County (CHC), Butler, PA
- The Consortium for Public Education, McKeesport, PA
- The Duane Williams Memorial Scholarship Fund (DWMSF), Pittsburgh, PA
- The Education Partnership, Pittsburgh, PA
- The Epilepsy Project, Erie, PA
- The Erie Art Museum, Erie, PA
- The Foundation for IUP, Indiana, PA
- The Franklin / Grove City YMCA, Franklin, PA
- The Frick Pittsburgh, Pittsburgh, PA
- The Friendship Circle of Pittsburgh, Pittsburgh, PA
- The Giorgio Foundation, Duncansville, PA
- The Greater Pittsburgh Coalition Against Violence, Pittsburgh, PA
- The Greater Pittsburgh Police Emerald Society, Pittsburgh, PA
- The House of Mercy, Eastside Grassroots Coalition, Erie, PA
- The Housing Authority of the City of Erie (HACE), Erie, PA
- The Independent Council on Aging, Inc. (ICA), Erie, PA
- The Ireland Funds, Pittsburgh, PA
- The Jewish Federation of Greater Pittsburgh, Pittsburgh, PA
- The Joe Beretta Foundation, Mt. Juliet, TN
- The Ladies Hospital Aid Society, Pittsburgh, PA
- The LeMoyne Community Center, Washington, PA
- The Mendelssohn Choir of Pittsburgh (MCP), Pittsburgh, PA
- The Mental Health Association of Northwestern Pennsylvania, Erie, PA
- The Mentoring Partnership of Southwestern PA, Pittsburgh, PA
- The Midwife Center for Birth and Women's Health, Pittsburgh, PA
- The Mission Continues, St. Louis, MO
- The Monongahela Valley Hospital Foundation, Monongahela, PA
- The North East Community Foundation, North East, PA
- The PA Breast Cancer Coalition, Lebanon, PA
- The PBA Commission on Women, Harrisburg, PA
- The Pennsylvania Health Law Project, Pittsburgh, PA
- The Pittsburgh Metropolitan Area Hispanic Chamber of Commerce (PMAHCC), Pittsburgh, PA
- The Pittsburgh Project, Pittsburgh, PA
- The Prevent Another Crime Today (PACT) Initiative, Pittsburgh, PA
- The Salvation Army Harrisburg Capital City Region, Harrisburg, PA
- The Salvation Army Lehigh Valley, PA, Easton Corps, Easton, PA
- The Salvation Army Western PA Division, Rochester, PA
- The Sherwood Oaks Fund, Pittsburgh, PA
- The Sight Center of Northwest PA, Erie, PA
- The Society of St. Vincent de Paul Council of Pittsburgh, Pittsburgh, PA
- The Still Remembered Project, Bethel Park, PA
- The University of Pittsburgh Alzheimer's Disease Research Center, Pittsburgh, PA
- The UPMC Jameson Health Care Foundation, New Castle, PA
- The Western Pennsylvanian Conservancy, Pittsburgh, PA
- The Woodlands Foundation, Wexford, PA
- The Black Political Empowerment Project (B-PEP), Pittsburgh, PA
- The Black Women's Health Alliance, Philadelphia, PA
- The Clarion Chamber of Business & Industry, Clarion, PA
- The Clemente Collection at Engine House 25, Pittsburgh, PA
- The Global Switchboard, Pittsburgh, PA
- The Hospice and Palliative Nurses Association (HPNA), Pittsburgh, PA
- The Ireland Institute of Pittsburgh, Pittsburgh, PA
- The Kiwanis Club of Altoona, Altoona, PA

APPENDIX C:
Input from Persons Representing the Broad Interests of the Community

- The LGBT Center of Greater Reading, Reading, PA
- The Pittsburgh Promise, Pittsburgh, PA
- The Salvation Army of Chambersburg PA, Chambersburg PA
- The Salvation Army Western PA Division, Carnegie, PA
- The Union of African Communities in Southwestern PA (UACSWPA), Pittsburgh, PA
- The Western Pennsylvania Chapter of the National Hemophilia, Cranberry Twp, PA
- The Zionist Organization of America: Pittsburgh, Pittsburgh, PA
- Three Rivers Business Alliance, Pittsburgh, PA
- Three Rivers Youth, Pittsburgh, PA
- Threshold Rehabilitation Services, Inc., Reading, PA
- Tickets for Kids Foundation, Pittsburgh, PA
- Tiger Pause Youth Ministry, Beaver Falls, PA
- Trade Institute of Pittsburgh, Pittsburgh, PA
- Transforming Health of African American Women, Inc. (THAW), Pittsburgh, PA
- Transitional Paths to Independent Living (TRPIL), Washington, PA
- Transitions, Lewisburg, PA
- Turning Point of Lehigh Valley, Allentown, PA
- Twilight Wish Foundation, Doylestown, PA
- United Way of Blair County, Duncansville, PA
- United Way of Butler County, Butler, PA
- United Way of Indiana County, Indiana, PA
- United Way of Pennsylvania, Lemoyne, PA
- United Way of Southwestern Pennsylvania, Pittsburgh, PA
- University of Pittsburgh office of Health Sciences Diversity, Equity and Inclusion, Pittsburgh, PA
- University of Pittsburgh, Cancer Institute, Pittsburgh, PA
- University of Pittsburgh, Clinical & Translational Science Institute, Pittsburgh, PA
- University of Pittsburgh, Innovation Institute, Pittsburgh, PA
- University of Pittsburgh, Institute for Clinical Research Education (ICRE), Pittsburgh, PA
- University of Pittsburgh, Institute for Entrepreneurial Excellence, Pittsburgh, PA
- University of Pittsburgh, Office of Health Sciences Diversity, Pittsburgh, PA
- UPMC Altoona Foundation, Altoona, PA
- UPMC Hillman Cancer Center Academy, Pittsburgh, PA
- UPMC Senior Services, Pittsburgh, PA
- Uptown Partners of Pittsburgh, Pittsburgh, PA
- Urban Impact Foundation, Pittsburgh, PA
- Urban League of Greater Pittsburgh, Pittsburgh, PA
- Ursuline Support Services, Pittsburgh, PA
- URU The Right to Be, Inc., West Haven, CT
- VA Pittsburgh Healthcare System, Pittsburgh, PA
- Valley Youth House, Bethlehem, PA
- Venango County Association for the Blind, Seneca, PA
- Venango County Suicide Awareness Prevention Task Force, Franklin, PA
- Venango Training & Development Center, Inc., Seneca, PA
- Verland Foundation, Sewickley, PA
- Veterans Leadership Program of Western Pennsylvania, Inc., Pittsburgh, PA
- Veterans of Foreign Wars (VFW), Kansas City, MO
- Veterans Place of Washington Boulevard, Pittsburgh, PA
- VIBRANT - A Christian Church, Lambs Gap Campus, Mechanicsburg, PA
- VIBRANT - A Christian Church, York Haven Campus, York Haven PA
- Vibrant Pittsburgh, Pittsburgh, PA
- Vietnam Veterans Memorial Fund, The Wall that Heals, Arlington, VA
- Villa Maria Academy, Erie, PA
- Vincentian Collaborative System, Pittsburgh, PA
- Vision Toward Peace, LLC, Wilkinsburg, PA
- VisitPITTSBURGH, Pittsburgh, PA
- Vitamin C Healing, Pittsburgh, PA
- Warren United Methodist Church, Pittsburgh, PA
- Warriors Rock, Greensburg, PA
- Waynesboro Community and Human Services, Waynesboro, PA
- Wesley Center AME Zion Church, Pittsburgh, PA
- Wesley Family Services, Wilkinsburg, PA
- Western Pennsylvania Chapter at American Foundation for Suicide Prevention, Pittsburgh, PA
- Westminster Presbyterian Church, Pittsburgh, PA
- Westmoreland Community Action, Greensburg, PA
- Westmoreland County Food Bank, Delmont, PA
- Westmoreland County Human Services, Greensburg, PA
- Westmorland-Fayette Workforce Investment Board (WFWIB), Youngwood, PA

- When She Thrives, Coraopolis, PA
- Wilkes-Barre Family YMCA, Wilkes Barre, PA
- Women of Providence in Collaboration, Madison, IL
- Women's Center & Shelter of Greater Pittsburgh, Pittsburgh, PA
- Women's Center of Beaver County, Beaver, PA
- Women's Resource Center, Scranton, PA
- Workforce Development Global Alliance (WDGA), Monroeville, PA
- Wounded Warrior Project, Pittsburgh, PA
- Ya Momz House, Inc., Pittsburgh, PA
- Yates Fund for Cancer Hope, Sewickley, PA
- YMCA of Greater Pittsburgh, Pittsburgh, PA
- YMCA of the Twin Tiers, Bradford YMCA, Bradford, PA
- York Opioid Collaborative, Red Lion, PA
- You Matter Marathon, Philadelphia, PA
- Youth Reach, Inc., Allison Park, PA
- YouthPlaces, Inc., Pittsburgh, PA
- YWCA Gettysburg & Adams County, Gettysburg, PA
- YWCA Greater Harrisburg, Harrisburg, PA
- YWCA of Greater Pittsburgh, Pittsburgh, PA

Additional Stakeholder Input

For the 2022 CHNA, during the period from July to December 2021, the Healthy Blair County Coalition utilized several sources to obtain input. The household survey included questions regarding demographics, neighborhood/community strengths, community concerns, issues within the household, impact of COVID-19, and healthcare challenges and needs. The household survey was administered to a random sample of 3,000 households, to clients/consumers of three community agencies (UPMC WIC Program, Center for Independent Living, and Blair County NAMI), and 203 key informants in Blair County (e.g., state, county, and local government officials, police chiefs, school superintendents, board/association presidents, hospital CEOs, media, selected major employers, executive directors of other groups such as the library, planning offices, etc.). In addition, separate surveys were administered to assess community assets, programs, and services that are already in place to serve the community. Asset surveys were administered to service providers and faith-based organizations. Additional community input efforts included interviews with health care providers. A Data Analysis Work Group reviewed the survey data along with indicator data for Blair County.

Appendix D: Concept Mapping Methodology

Overview:

UPMC's 2022 CHNA builds on the assessment process originally applied in 2013. In 2013, UPMC hospitals began conducting formal community health needs assessments and with consultation and support from Pitt Public Health, utilized a research method known as concept mapping to develop a better understanding of perceived health problems for their communities. Concept mapping is well suited for a Community Health Needs Assessment because the research method involves stakeholders in the process and allows for prioritization of health problems based on community input.

Concept mapping is a participatory research method that yields a conceptual framework for how a group of stakeholders views a particular topic or issue. The method explores the relationships of ideas and concepts and allows for the development of group consensus. It allows for the collection of a wide range of stakeholder-generated ideas and applies quantitative analytical tools (i.e., multidimensional scaling and hierarchical cluster analysis). Concept mapping output includes a concept map, which is a diagram that illustrates the relationships between ideas. The research method is used to facilitate the creation of a shared vision and understanding within a group. The research method synthesizes individual data and includes a rating process that is used to prioritize key issues.

In 2013, UPMC hospitals completed concept mapping, and through the process, identified hospital-specific community health priorities based on stakeholder input. In the concept mapping effort, community advisory panels at each UPMC hospital participated in focus groups to brainstorm and then sort a set of 50 community health problems. Concept mapping software used this sorting data to create a display that illustrated the relationships between health topics and allowed for aggregation of topics into thematic areas. The 50 topics were grouped into three main thematic areas: prevention and healthy living, chronic disease, and navigating the health care system.

Application of Concept Mapping - Two-Stage Process:

UPMC hospitals established community advisory panels. Participants contributed through face-to-face meetings and online input.

The concept mapping research method consisted of two stages:

- Brainstorming — gathering stakeholder input
- Sorting and Rating — organizing and prioritizing the stakeholder input

Brainstorming - Identifying Health Needs:

In the brainstorming meeting, each hospital's community advisory panel met in person to solicit members' input on the focal question, "What are our community's biggest health problems?"

Panel members first brainstormed independently, and then shared their lists with the Pitt Public Health research team. Their responses were then compiled to generate a full list of community health problems for the hospital. The Pitt Public Health research team shared the full list with the group and facilitated a group discussion of the responses to ensure the list was comprehensive and reflected the scope of health problems faced in the community.

APPENDIX D:
Concept Mapping Methodology

All of the hospital-specific brainstorming lists were integrated together to develop a final master list of community health problems to be used in the subsequent concept mapping sorting and rating. A consolidated final master list of the 50 community health problems was distilled from the robust community input. The following table presents each of the 50 community health problems and provides a numerical value in parentheses so that the item can be linked with the concept map in the following figure.

Final Master List of 50 Community Health Problems				
Nutrition and healthy eating (1)	Diabetes (11)	Medication management and compliance (21)	High blood pressure/ Hypertension (31)	Smoking and tobacco use (41)
Immunizations/ Vaccinations (2)	Health literacy – ability to understand health information and make decisions (12)	Exercise (22)	Breast cancer (32)	Adolescent health and social needs (42)
Lung cancer (3)	Urgent care for non-emergencies (13)	Navigating existing health care and community resources (23)	Pediatrics and child health (33)	Depression (43)
Maternal and infant health (4)	End of life care (14)	Preventive screenings (cancer, diabetes, etc.) (24)	Sexual health including pregnancy and STD prevention (34)	Support for families/ caregivers (44)
Alcohol abuse (5)	Asthma (15)	Heart disease (25)	Dementia and Alzheimer's (35)	Health insurance: understanding benefits and coverage options (45)
Adult obesity (6)	Prenatal care (16)	Primary Care (26)	Chronic Obstructive Pulmonary Disease (COPD) (36)	Preventive health/ wellness (46)
Drug abuse (7)	Dental care (17)	Childhood obesity (27)	Stroke (37)	Injuries including crashes and sports related, etc. (47)
Access to specialist physicians (8)	Financial access: understanding options (18)	Intentional injuries including violence and abuse (28)	Post-discharge coordination and follow-up (38)	Childhood developmental delays, including Autism (48)
Behavioral health/ Mental health (9)	High cholesterol (19)	Cancer (29)	Arthritis (39)	Eye and vision care (49)
Geographic access to care (10)	Care coordination and continuity (20)	Social support for aging and elderly (30)	Senior health and caring for aging population (40)	Environmental health (50)

Sorting and Rating – Prioritizing Health Needs:

The hospitals' community advisory panels completed the sorting and rating activities via the Internet. Each participant was asked to sort the master list of 50 community health problems into thematic areas, and to then rate the problems using a 1 to 5 Likert scale, according to the following criteria:

Importance:

How important is the problem to our community?

(1 = not important; 5 = most important)

Measurable Impact:

What is the likelihood of being able to make a measurable impact on the problem?

(1 = not likely to make an impact; 5 = highly likely to make an impact)

Hospital Ability to Address:

Does the hospital have the ability to address this problem?

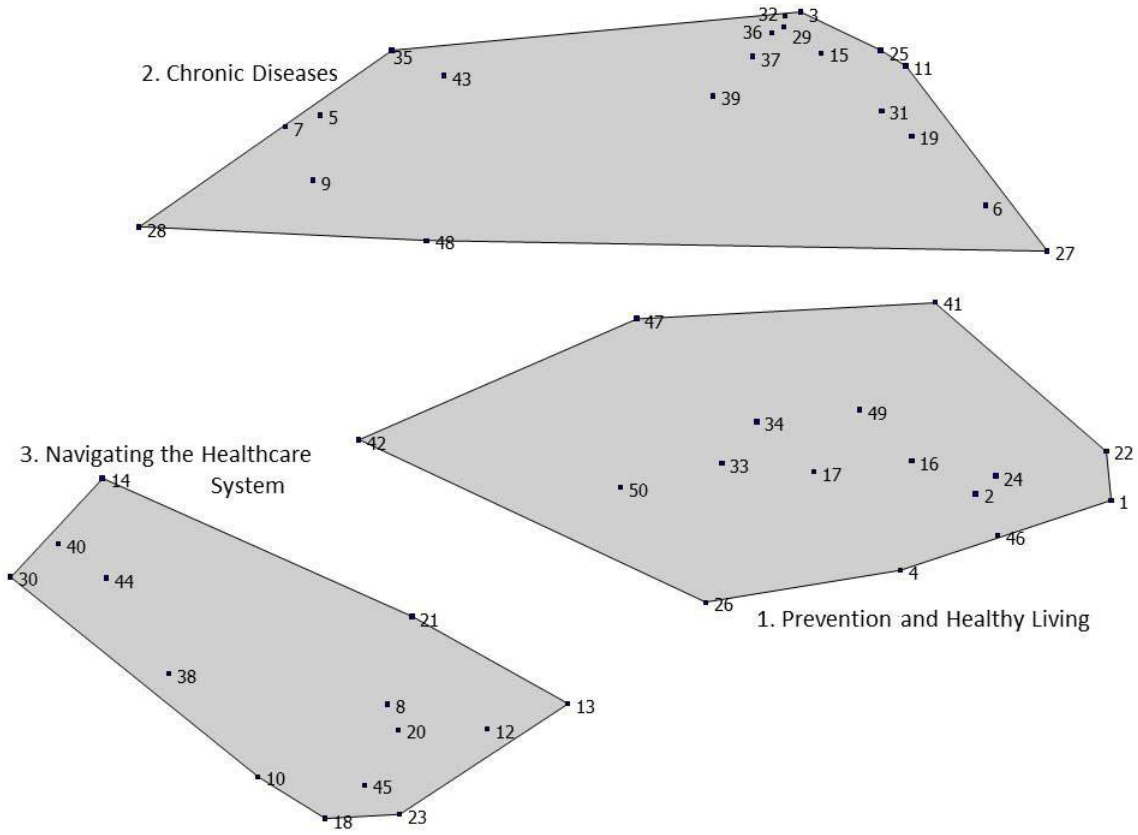
(1 = no ability; 5 = great ability)

Multi-dimensional scaling was applied to the sorting data to examine similarities between the 50 community health problems. Hierarchical clustering was used to group the sorting data into common thematic areas and to establish a final cluster map which provided a visual representation of the data. The final cluster map of the 50 community health problems reflects three thematic areas (See Figure below):

- Prevention and Healthy Living (16 items)
- Chronic Diseases (20 items)
- Navigating the Healthcare System (14 items)

Each of the 50 community health problems are represented in the figure below as a point. The numbers next to each point correspond to the item number. For example, item #31 is High Blood Pressure/Hypertension. The proximity of the points to each other illustrates the group thoughts about the degree of similarity between the items. For example, item #31 (High Blood Pressure/Hypertension) and item #19 (High Cholesterol) were felt to be very similar. Those two community health problems appear on the right side of the Chronic Diseases cluster.

Final Cluster Map:



For each of the rating criteria, the rating levels were broken into three equal distributions (tertiles) representing high, moderate, and low priority. The cut points for each rating criteria are as follows:

Importance:

Low (1-3.67); Moderate (3.68-4.06); High (4.07-5.0)

Measurable Impact:

Low (1-3.33); Moderate (3.34-3.83); High (3.84-5.0)

Hospital Ability to Address:

Low (1-3.20); Moderate (3.21-3.85); High (3.86-5.0)

Within each cluster, the rating data for each individual community health problem was examined across all three rating criteria. For example, in the Prevention and Healthy Living cluster, the 16 individual community health problems were identified as being low, moderate, or high for the importance, measurable impact, and hospital ability to address rating criteria.

The rating categories results were then combined with results from secondary data analyses and used to identify high priority community health problems for each UPMC hospital. UPMC hospital leadership next consulted with experts from Pitt Public Health and members of the community advisory panel to review the list of high priority community health problems and identify the set of needs that are critical, addressable, and have high levels of urgency in the community.

The resulting list constituted the top tier of health problems for the community.

APPENDIX E:
Healthy Blair County Coalition: Community Health Needs Assessment and Implementation Plan

Appendix E: Healthy Blair County Coalition: Community Health Needs Assessment and Implementation Plan

UPMC Altoona collaborates with the Healthy Blair County Coalition (HBCC) to help promote healthy living through community interventions that result in the improvement of social, economic, and environmental factors.

HBCC is a partnership of individuals and organizations working together to understand, assess, and address the challenges and needs of the residents of Blair County. HBCC, which includes all three hospitals serving the Blair County Region — UPMC Altoona, Conemaugh Nason Medical Center, and Tyrone Regional Health Network — chose to conduct a joint community health needs assessment and subsequently, issue a joint implementation plan.

The fifth needs assessment that has been conducted in Blair County since 2007, **Appendix E: Healthy Blair County Coalition: Community Health Needs Assessment and Implementation Plan** describes the methods HBCC used while conducting the survey, highlights the results of surveys and health care interviews, and summarizes community indicator data. This report also highlights the outcomes, accomplishments, and future strategies that will be implemented over the next three years.

BLAIR COUNTY PROFILE 5
Community Health Needs Assessment and Implementation Plan

Healthy Blair County Coalition – June 2022

www.healthyblaircountycoalition.org

Prepared for the Healthy Blair County Coalition by:

Coleen A. Heim, M.S., Director

The Healthy Blair County Coalition (HBCC) is a partnership of individuals and organizations working to promote the social, economic, emotional, and physical well-being of area residents. Their mission is to assess facets of a healthy Blair County by sharing resources, engaging local partnerships, and implementing strategies and programs to make a positive impact on the lives of the people in our community. The ultimate vision is a healthy Blair County. The Coalition, joined by the three hospitals serving the Blair County Region, chose to conduct a joint community health needs assessment and subsequently, issue a joint implementation plan.

This report, ***Blair County Profile 5: Community Health Needs Assessment and Implementation Plan*** describes our methods used while conducting the needs assessment, highlights the results of surveys and healthcare interviews, and summarizes community indicator data. This is the fifth needs assessment that has been conducted in Blair County since 2007. This report will highlight the accomplishments, outcomes, and strategies that will be implemented over the next three years. This process confirmed that Blair County has many assets, including community leaders, businesses, service providers, community organizations and individuals who are deeply committed to assuring the overall health and well-being of Blair County. Those individuals who took time to complete the household survey and those who dedicated many hours as members of the Healthy Blair County Coalition are some of what makes Blair County a great place to live. The results of this needs assessment indicate that we must continue to address not only specific health needs, but, whenever feasible, the underlying causes.

With the support and dedication of the individuals who served on the Steering Committee, work groups/ committees, and Coalition, we have achieved many accomplishments since the last needs assessment. We will also address in this report the impact of COVID-19 on our community and the implementation of strategies. We hope those individuals, new partners, and most of all the residents of Blair County will join us in implementing programs and strategies that will improve the overall health of Blair County.

Sincerely,

Coleen A. Heim, Director
Healthy Blair County Coalition

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INTRODUCTORY COMMENTS

As described in this Community Health Needs Assessment (CHNA) Report the Health Blair County Coalition (HBCC) is a collaborative partnership of over 161 community organizations in Blair County, including our community hospitals: UPMC Altoona, Penn Highlands Tyrone, and Conemaugh Nason Medical Center.

On April 5, 2013, the Department of Treasury, Internal Revenue Service issued 26 CFR Parts 1 and 53, (REG 106499-12) / RIN 1543 – BL30: Community Health Needs Assessments for Charitable Hospitals, issued in the Federal Register Vol. 78, No 66, pp 20523 – 20544.

Consistent with these proposed regulations (p. 20532, Sec. 3, a, v.) this is a joint Community Health Needs Assessment issued by the Healthy Blair County Coalition, and the three Blair County community hospitals: UPMC Altoona, Conemaugh Nason Medical Center, and Penn Highlands Tyrone. Additionally, this joint CHNA Report is consistent with these proposed regulations, specifically as:

- All of the collaborating facilities may produce a joint CHNA report as long as all of the facilities define their community to be the same and conduct a joint CHNA process.

- This CHNA Report clearly identifies each hospital facility to which it applies.

- Additionally, consistent with these proposed regulations (p. 20533) regarding UPMC Altoona - the UPMC Altoona Board of Directors approved and adopted this joint CHNA Report including the Implementation Strategies, as outlined, at its June 16, 2022 meeting.

- Additionally, consistent with these proposed regulations (p. 20533) regarding Nason Hospital - the Conemaugh Nason Medical Center Board of Trustees approved and adopted this joint CHNA Report including the Implementation Strategies, as outlined, at its June 16, 2022 meeting.

- Additionally, consistent with these proposed regulations (p. 20533) regarding Penn Highlands Tyrone - the Penn Highlands Tyrone Board of Directors approved and adopted this joint CHNA Report including the Implementation Strategies, as outlined, at its June 20, 2022 meeting.

- As an active member of the Healthy Blair County Coalition, UPMC Altoona has actively participated in the needs assessment and prioritization of the identified community needs. UPMC Altoona, in collaboration with the Coalition, is actively participating in implementing strategies to meet the overall identified priorities, and UPMC Altoona is taking a leadership role in meeting specifically three of these identified, priority needs: chronic disease prevention and promoting a healthy lifestyle (obesity, physical inactivity, and diabetes); substance use; and behavioral health (mental health needs). In addition, another priority for the hospital itself is access to care.

- As an active member of the Healthy Blair County Coalition, Conemaugh Nason Medical Center has actively participated in the needs assessment and prioritization of the identified community needs. Conemaugh Nason Medical Center, in collaboration with the Coalition, is actively participating in

implementing strategies to meet the overall identified priorities. Specifically, Conemaugh Nason Medical Center is taking a leadership role in promoting a heart healthy lifestyle through initiatives aimed at decreasing obesity, physical inactivity, and diabetes rates. The Medical Center also has other priorities that are important to their mission.

- As an active member of the Healthy Blair County Coalition, Penn Highlands Tyrone has actively participated in the needs assessment and prioritization of the identified community needs. Penn Highlands Tyrone, in collaboration with the Coalition, is actively participating in implementing strategies to meet the overall identified priorities. Penn Highlands Tyrone is taking a leadership role in chronic disease management, including diabetes and access to behavioral health care. In addition, two other priorities for the hospital itself are access to care and education for staff and patients regarding health literacy.

- Consistent with the proposed regulations (p. 20529 – 30: Sec 3 a iii) UPMC Altoona, Conemaugh Nason Medical Center, and Penn Highlands Network have made this CHNA Report "widely available to the public" by placing it on their respective websites, and by making a "hard copy" available to the public.

- The Healthy Blair County Coalition, UPMC Altoona, Conemaugh Nason Medical Center, and Penn Highlands Tyrone welcome public input and comments regarding the CHNA Report. Comments may be provided via the avenues described in the Report.

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List of Tables and Figures

Executive Summary

The Healthy Blair County Coalition (HBCC) is a collaboration among community partners to conduct a comprehensive and enduring community health needs assessment. Its purpose is to identify community assets, identify targeted needs, and develop an implementation plan to fill those needs. In 2007, the United Way of Blair County and the Blair County Human Services Office invited organizations to collaborate on a community-wide needs assessment. The outcome was the publication of two documents: Blair County Profile: Our Strengths, Challenges, and Issues (January 2009) and the Blair County Community Plan (March 2012). Then as a result of the Patient Protection and Affordable Care Act Public Law 111-148 Section 501(r)(3) which requires a hospital organization to conduct a community health needs assessment (CHNA) at least once every three years and adopt an implementation strategy, the three hospitals located in Blair County chose to collaborate not only with each other but with the existing partnership. In 2013, our community health needs assessment report entitled, Blair County Profile II: Community Health Needs Assessment was published. This was followed by the third report entitled, Blair County Profile III: Community Health Needs Assessment and Implementation Plan (June 2016). Blair County Profile IV: Community Health Needs Assessment and Implementation Plan was adopted in June 2019.

Healthy Blair County Coalition

Our Mission: To assess facets of a healthy Blair County by sharing resources, engaging local partnerships, and implementing strategies and programs to make a positive impact on the lives of the people in our community.

Vision: A healthy Blair County community.

Organizational Structure and Funding

The community health needs assessment process was directed by a Steering Committee, including a consultant who was hired as the part-time Director of the Healthy Blair County Coalition. UPMC Altoona, Conemaugh Nason Medical Center, and Penn Highlands Tyrone are active participants on the HBCC Steering Committee. In addition, the Steering Committee collaborated with a broader group of 161 partners identified as the Healthy Blair County Coalition. Members of the Coalition included stakeholders on whom the community decisions would have an impact, who had an interest in the effort, who represented diverse sectors of the community, and who were likely to be involved in developing an Implementation Plan.

For this reporting period, the HBCC Steering Committee convened to meet the following objectives:

- Conduct a comprehensive community health needs assessment to determine the overall health status of Blair County (July 2021 – September 2021).
- Solicit input from individuals and organizations that represent the broad interests of the community served by the hospitals (July 2021 – January 2022).

- Present and publish the findings of the community health needs assessment in a report that outlines trends, creates a baseline for strategic planning decisions, highlights outcomes and accomplishments, and assists in developing an implementation plan (June 2022).

- Continue to implement programs and services to address identified needs (July 2018 – present).

- Review accomplishments and measure the impact of selected programs and activities (July 2018 – June 2021).

There were ten work groups and/or committees that met to develop goals and implement strategies to address the priorities identified in the needs assessment.

- **Substance Use & Physical Health Coalition**
- **Pathways of Opportunity Network**
- **Food for Life Initiative**
- **Youth Connection Task Force**
- **School Attendance Task Force**
- **Let's Move Blair County Committee**
- **Mental Health Work Group**
- **Alliance for Nicotine Free Communities**
- **Dental Care Work Group**
- **Blair County Farm to ECE Collaborative**

HBCC was involved in the development of the Chamber of Commerce Workplace Wellness Committee and continues to support and participate in all programs and activities. It is a committee of the Chamber of Commerce and not the Healthy Blair County Coalition.

Although there is not a formal Marketing Work Group, a variety of methods are used to provide awareness of the Healthy Blair County Coalition, inform residents and community members about the surveys and how to participate, share the results of the needs assessment, and increase collaboration and partnerships among all aspects of the community. Information is shared through the Healthy Blair County Coalition's website, Facebook page, Active Living/Let's Move Facebook page, Youth Connection Facebook page, podcasts, brochures, posters, meetings and conferences, newspaper, television, and radio.

The community health needs assessment and HBCC are primarily funded by UPMC Altoona and Penn Highlands Tyrone. Additional funding was provided by Conemaugh Nason Medical Center, Blair County Drug and Alcohol Partnerships, Blair HealthChoices, Blair Planning, and Blair County Human Services Block Grant. However, several other agencies contributed significantly to the project including Penn State Altoona and the United Way of Blair County. In-kind services such as meeting rooms, printing, use of equipment, donation of services, and volunteer hours were provided by many other organizations. In addition, grants were received from the Robert Wood Johnson Foundation, The Food Trust, Highmark, and the Thomas Jefferson University.

Methods

The Community Health Needs Assessment (CHNA) was conducted as a result of the Affordable Care Act Section 501(r)(3) which requires a hospital organization to conduct a CHNA at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA. The CHNA will also support the overall validity of the community benefit strategy which will be used to demonstrate non-profit tax-exempt status; while, providing hospitals and other organizations with an essential understanding of the health of Blair County.

This current needs assessment will help to determine whether challenges and issues have changed since the first comprehensive needs assessment was conducted in 2007. In Blair County, the community health needs assessment included a broad perspective of physical, social, emotional, and economic health issues.

The CHNA was enhanced by a mixed methodology that included both quantitative and qualitative community input as well as collection and analysis of incidence data through secondary research. The community health needs assessment in Blair County focused on the following areas:

- Neighborhood and Community Strengths
- Community Challenges and Issues
- Household Challenges and Issues
- Impact of COVID-19
- Involvement in Community Initiatives/Projects
- Awareness of Social Determinants of Health and Health Equity
- Healthcare Challenges and Issues (e.g. access, gaps, prevention/education needs, etc.).

The surveys, healthcare provider interviews, and data analysis focused on nine areas: economics, education, environment, health, housing, leisure activity, safety, social, and transportation.

Summary of the Household Survey and Results

The purpose of the household survey was to collect both subjective (opinion) and incidence data from people who live within Blair County. The household survey included questions regarding demographics, neighborhood/community strengths, community concerns, issues within the household, and healthcare challenges and needs. The household survey and cover letter are included as Appendix A.

A random sample of 3000 households (approximately six percent) was drawn from the 51,647 households in Blair County so that each zip code was represented according to its percentage of total households in the county. The services of Labor Specialties, Inc. (LSI) were utilized to obtain the database list. Three thousand surveys were mailed in June 2021, along with a cover letter and pre-paid return envelope. In addition, participants had the choice of completing the survey using survey monkey. There were 248 surveys returned for a response rate of 8.3%. Information about the household survey was publicized through a press conference, television interview, newspaper and other media releases, social media, and hospital and agency newsletters to consumers.

A link to the household survey was available on the HBCC website so that any resident had an opportunity to complete the survey (100 completed). The household survey was also administered to clients/consumers by three other groups including the Center for Independent Living of South Central Pennsylvania, Blair County NAMI, and Home Nursing Agency WIC Program (UPMC). A total of 78 surveys were returned and analyzed but were kept separate from the random household survey. Therefore, a total of 426 surveys were returned: 248 from households, 100 from responses on the website, and 78 from the agencies mentioned above.

The household survey asked recipients to state their level of agreement to questions regarding **neighborhood/community strengths**. Respondents were asked to rate the level of agreement on a Likert-type scale (Strongly Agree, Somewhat Agree, Somewhat Disagree, Strongly Disagree, and No Opinion/Don't Know).

The results in this survey indicate that 73% of respondents felt that people in their neighborhood help each other out when they have a problem. And 52.8% gather together formally or informally to participate in activities. About 23% felt they have little or no opportunity to affect how things happen in their neighborhood. In the area of voting, 86.7% reported that they vote in most elections.

Residents felt that the best things about living in Blair County are related to being close to grocery stores/shopping (73%), near highway access (64%), close to parks, recreation, and sports (64%), friendly neighbors (60%), and close to physicians and medical facilities (59%). The worse things about living in Blair County were drug use/abuse (58%), roads and alleys in need of repair (48%), and youth with nothing to do (44%). These responses were the same as results from the last needs assessment.

The household survey asked participants to identify the level of concern (Not an Issue, Minor Issue, Moderate Issue, Major Issue, or No Opinion/Don't Know) regarding 43 different **community issues**. A comparison with the 2007 responses cannot be accurately made since the options changed for respondents in the last four household surveys when health-related questions were added.

The following chart identifies the community issues for Blair County in each of the five needs assessments (identified these as a major/moderate issue).

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The following chart identifies the community issues for Blair County in each of the five needs assessments (identified these as a major/moderate issue).

Table 1: Priorities Identified in Blair County Community Needs Assessments (Community)

2007	2012	2015	2018	2021
Crime	Lack of jobs	Obesity	Alcohol and other Drugs	Overuse/addiction to cell phone, social media, internet, etc
Alcohol and other drugs	Alcohol and other drugs	Alcohol and other drugs	Obesity	Obesity
Unemployment or underemployment	Unemployment or underemployment	Lack of jobs	Overuse/addiction to cell phone, social media, internet, etc	Alcohol and other Drugs
Lack of jobs	Obesity	Poverty/lack of adequate income	Impaired/distracted driving	Impaired/distracted driving
Lack of affordable medical care	Poverty	Unemployment or underemployment	Poverty/lack of adequate income	Smoking, tobacco, and e-cigarettes/ vaping
Poverty	Crime	Smoking and tobacco	Smoking, tobacco, and e-cigarettes	Adults with mental health or emotional issues

In the next section, participants were asked whether any of the same type of issues had been a **challenge or an issue in their household**. Respondents were asked to assess whether they found each area to be: Not an Issue, a Minor Issue, a Moderate Issue, a Major issue, or No Opinion/ Don't Know.

Table 2: Priorities Identified in Blair County Community Needs Assessments (Households)

2007	2012	2015	2018	2021
Stress, anxiety, and depression	Being overweight	Being overweight	Stress, anxiety, and depression	Stress, anxiety, and depression
Not having enough money for medical needs	Stress, anxiety, and depression	Difficult to budget	Being overweight	Being overweight
Difficult to budget	Difficult to budget	Stress, anxiety, and depression	Children being bullied/harassed/ cyberbullied*	Children being bullied/harassed/ cyberbullied
Experiencing noise or pollution	Children being bullied/harassed	Not enough money to meet daily needs	Lack of activities for youth	Lack of activities for youth

In order to obtain information from residents on **health care issues affecting themselves or members of their family**, the first question in this section asked, "has of these problems ever prevented you or a

member of your family from getting the necessary health care"? High deductibles/co-pays, insurance not covering what was needed, and the wait for an appointment was too long at 21% were the top responses.

On a positive note, over 53% of households reported that none of the items prevented them from getting health care and were somewhat consistent across geographic areas. Ninety percent (91%) had seen a primary care/family physician in the past year and 72% had seen a dentist in the past year. Over 67% were able to understand the healthcare system and community resources available. Residents were asked their opinions on the **greatest gaps in health care services** and the **greatest needs in health education and prevention services** in Blair County.

Table 3: Greatest Gaps in Health Care Services in Blair County Community Needs Assessments

2012	2015	2018	2021
Dental care	Dental care	Prescription drug assistance	Inpatient and outpatient mental health services for adults
Services for low-income residents	Care for senior citizens	Dental care	Dental care
Prescription drug assistance	Services for low-income residents	Social and/or medical care for senior citizens	Outpatient mental health services for children

Table 4: Greatest Needs in Health Education and Prevention in Blair County Community Needs Assessments

2012	2015	2018	2021
Obesity prevention	Alcohol and drug abuse prevention	Mental health/ depression/suicide prevention	Obesity prevention
Alcohol and drug abuse prevention	Obesity prevention	Obesity prevention	Mental health/ depression/suicide prevention
Tobacco prevention and cessation	Mental health/ depression/suicide prevention	Alcohol and drug abuse prevention	Violence prevention
			Tobacco, nicotine, and vaping
			Alcohol and drug abuse prevention

Blair County residents were asked what keeps them from eating a healthy diet and the cost of healthy foods like fruits and vegetables was the most reason given (43%). However, when asked what keeps them from increasing their physical activity, the top reason was that they do not have the time (39%) followed by the lack of motivation (34%).

The two most common responses on how COVID-19 impacted their families was an increase in stress, anxiety, social isolation or other mental health concerns (27%) and a delay in getting routine health care or scheduling necessary surgery (26%).

Summary of the Key Informant Survey and Results

A survey was distributed to 203 key informants in Blair County (e.g. state, county, and local government officials, police chiefs, school superintendents, board presidents, hospital CEO's, media, human resource directors for major employers, executive directors of other groups such as the library, planning offices, associations, etc.) to obtain their input on strengths and issues that impact residents and neighborhoods. The key informant survey and cover letter were emailed in June 2021. Fifty-six completed surveys were received, a 24% response rate.

Eight-nine percent (89.3%) of the respondents agreed that the community is one where leaders from business, labor, government, education, religious, neighborhood, non-profit, and all other sectors come together and work productively to address critical community issues.

Out of the responses for community strengths, key informants see mainly positive strengths including 80.3% perceive leaders as having mutual respect among all sectors of the community.

Table 5: Priorities Identified by Key Informants in Blair County Community Needs Assessments

2007	2012	2015	2018	2021
Alcohol and other drugs	Alcohol and other drugs	Poverty/lack of adequate income	Poverty/lack of adequate income	Adults with mental health/ emotional issues
Crime	Unemployment or underemployment	Unemployment or underemployment	Alcohol and other drugs	Obesity
Lack of jobs	Poverty	Alcohol and other drugs	Obesity	Poverty/lack of adequate income
Unemployment or underemployment	Lack of jobs	Obesity	Adults with mental health/ emotional issues	Alcohol and other drugs
Lack of affordable medical care	Children with mental health/ emotional issues	Smoking and tobacco	Smoking, tobacco, and e-cigarettes	Smoking, tobacco, and e-cigarettes/vaping
	Smoking and tobacco	Lack of jobs	Children with mental health/ emotional issues	Use/availability of alcohol and other drugs in schools
		Adults with mental health/ emotional issues		

Table 6: Greatest Gaps in Health Care Services Identified by Key Informants

2012	2015	2018	2021
Outpatient mental health services for adults	Dental care	Outpatient mental health services for adults	Inpatient mental health services for adults
Outpatient mental health services for children/adolescents	Outpatient mental health services for children/adolescents	Inpatient mental health services for children/adolescents	Inpatient mental health services for children/adolescents
Prescription drug assistance	Inpatient mental health services for children/adolescents	Dental care	Outpatient mental health services for adults
Services for alcohol and other drug abuse	Services for low-income residents	Outpatient mental health services for children/adolescents	Outpatient mental health services for children/adolescents

Table 7: Greatest Needs in Health Education and Prevention Identified by Key Informants

2012	2015	2018	2021
Obesity prevention	Alcohol and drug abuse prevention	Mental health/ depression/ suicide prevention	Mental health/ depression/ suicide prevention
Alcohol and drug abuse prevention	Obesity prevention	Alcohol and drug abuse prevention	Obesity prevention
Mental health/ depression/ suicide prevention	Mental health/ depression/ suicide prevention	Obesity prevention	Violence prevention (e.g. workplace, family, phyisical, sexual, etc.)

Summary of Service Provider Surveys

Surveys were sent to a variety of groups to learn more about the strengths and available community assets, programs, and services as well as their opinions on the challenges and needs of the community. The survey also asked questions related to community challenges, impact of COVID-19, access to health care, gaps, and prevention/education needs. A total of 171 service providers were asked to participate with 37 responding, or 22%. The sample was characterized by both large and small agencies with an equal range serving children, youth, adults, and senior citizens.

Service providers stated that they were most involved in the following six community initiatives: health wellness/prevention (43%), employment opportunities for low income people (38%), information and referral (38%), financial assistance, education, and mental health services at 35%.

Over 64% utilized volunteers in providing services for their agency but 62% reported that they could use more volunteers. Over 81% of these organizations make an effort to purchase goods and services from local enterprises.

Table 8: Priorities Identified by Service Providers in Blair County Community Needs Assessments

2018	2021
Poverty/lack of adequate income	Adults with mental health/emotional issues
Alcohol and other drugs	Poverty/lack of adequate income
Smoking, tobacco, and e-cigarettes	Unemployment/underemployment
Adults with mental health/emotional issues	Obesity
Family violence, abuse of children, adults, or the elderly	Alcohol and other drugs
Unemployment/underemployment	Smoking, tobacco, and e-cigarettes/ vaping
	Overuse/addiction to cell phone, social media, internet, etc
	Children with mental health/emotional issues

Table 9: Greatest Gaps in Health Care Services Identified by Service Providers

2012	2015	2018	2021
Prescription drug assistance	Dental care	Out-patient mental health services for adults	Out-patient mental health services for adults
Dental care	Out-patient mental health services for adults	In-patient mental health services for children/adolescents	Out-patient mental health services for children/adolescents
Services for low-income residents	In-patient mental health services for children/adolescents	Dental care	In-patient mental health services for children/adolescents

Table 10: Greatest Needs in Health Education and Prevention Identified by Service Providers

2012	2015	2018	2021
Obesity prevention	Obesity prevention	Mental health/ depression/ suicide prevention	Mental health/ depression/ suicide prevention
Healthy lifestyles	Mental health/ depression/ suicide prevention	Alcohol and drug abuse prevention	Healthy lifestyles
Alcohol and drug abuse prevention	Healthy lifestyles	Violence prevention	Violence prevention

Summary of Faith-Based Provider Surveys

The faith community is an integral part of life in Blair County and many provide assistance and outreach to not only members of their congregations but to the community at large. Surveys were emailed to 94 faith-based organizations and 16 responded (17%).

Table 11: Priorities Identified by the Faith-Based in Blair County Community Needs Assessments

2012	2015	2018	2021
Alcohol and other drugs	Alcohol and other drugs	Poverty/lack of adequate income	Adults with mental health/ emotional issues
Unemployment or underemployment	Poverty/lack of adequate income	Alcohol and other drugs	Alcohol and other drugs
Poverty	Smoking and tobacco	Obesity	Smoking, tobacco, and e-cigarettes/vaping
Lack of jobs	Adults with mental health/ emotional issues	Impaired distracted driving (driving under the influence, texting, road rage)	Children with mental health/ emotional issues
Children with mental health/ emotional issues	Crime	Smoking, tobacco, and e-cigarettes	Obesity
Smoking and tobacco	Unemployment or underemployment	Adults with mental health/ emotional issues	Bullying/harassment/ cyberbullying
Obesity	Children with mental health/ emotional issues	Family violence	Impaired/distracted driving
Adults with mental health/ emotional issues	Family violence	Unemployment or underemployment	Unemployment or underemployment
			Suicide

Table 12: Greatest Gaps in Health Care Services Identified by the Faith-Based Community

2012	2015	2018	2021
Inpatient mental health services for adults	Outpatient mental health services for adults	Dental care	Dental care
Services for low-income residents	Services for low-income residents	Outpatient mental health services for adults	Outpatient mental health services for adults
Services for alcohol and other drug abuse	Ability to serve different languages/cultures	Family physician	Perscription drug assistance

Table 13: Greatest Needs in Health Education and Prevention Identified by the Faith-Based Community

2012	2015	2018	2021
Mental health/ depression/ suicide prevention	Alcohol and drug abuse prevention	Mental health/ depression/ suicide prevention	Obesity prevention
Teen pregnancy	Mental health/ depression/ suicide prevention	Alcohol and drug abuse prevention	Mental health/ depression/ suicide prevention
Alcohol and drug abuse prevention	Obesity prevention	Violence prevention	Violence prevention

Summary of Healthcare Provider Interviews

Interviews were conducted with 14 healthcare providers representing a variety of disciplines such as physicians, dentists, pharmacists, behavioral health, health clinics, and other agencies providing medical/behavioral health services. During the interview, participants were asked their opinions regarding healthcare needs in our county, the needs related to special populations, programs and initiatives currently underway to address those needs, changes over the past three years, and the impact of COVID-19, etc.

Healthcare providers ranked mental health concerns and the need for more providers (57.1%) as the top community health needs followed by various issues related to access to care (50%). Since the last needs assessment, over 35% of healthcare providers have seen an increase in concerns related to substance use and access to primary care. Over 21% stated obesity and behavioral health issues have also increased.

Services for the elderly was ranked as the highest need (50%) for a special population followed by mental health services especially for children/adolescents at 43%. Fifty percent reported that staff shortages in all areas is impacting the needs of patients/clients followed by the lack of mental health providers (28.6%) especially for children/adolescents.

The impact of COVID-19 was mentioned as the biggest challenge which led to hospitals and medical facilities being over capacity, staff shortages, people delaying health care needs, lack of vaccine compliance, and increased mortality of patients. For young people that had to deal with the loss of family members, their education, and routine, they are still feeling anxiety and depression.

Secondary Indicator Data

The purpose of collecting and analyzing secondary indicator data is to track changes and trends over time. It is useful to answer whether research supports or does not support the perceptions of stakeholders and the general public as reflected in survey results. Data were obtained from federal, state, and local sources, including but not limited to: U.S. Census, Center for Rural Pennsylvania, Pennsylvania Department of Education, Pennsylvania Department of Human Services, Pennsylvania Department of Health, Centers for Disease Control, County Health Ranking Report, Pennsylvania Office of Rural Health, etc.

Key Community Health Needs for Blair County

Strategy 1: Promoting a Healthy Lifestyle (Obesity, Diabetes, and Lack of Physical Activity)

The need to promote a healthier lifestyle for the residents of Blair County has remained an identified need since the first community health needs assessment. The goals for this strategy are on page 55. Accomplishments (2018 – 2021) are summarized on pages 56-58 of this report. Implementation plans and projected outcomes (2021 – 2024) can be located on pages 58-59.

Strategy 2: Alcohol and Other Substance Abuse

Although there are many proactive initiatives to address alcohol and other drugs within Blair County, it continues to adversely affect the quality of life for individuals and the community itself. In addition to the individual and population health risks, drug and alcohol use poses a significant toll on the utilization of the health care system and the economy. The goals for this strategy are on page 63. Accomplishments (2018 – 2021) are summarized on pages 63 of this report. Implementation plans and projected outcomes (2021 – 2024) can be located on page 64.

Strategy 3: Mental Health

Data from the community health needs assessment clearly indicates that mental health concerns are reflected across the population. The pandemic significantly impacted the mental health of individuals and more than ever, mental health concerns and services are a critical need (e.g. expansion of crisis services, the need for an inpatient facility for children/adolescents, access to more behavioral health providers, address workforce shortages, and additional psychiatrists, etc.). The goals for this strategy are on page 69. Accomplishments (2018 – 2021) are summarized on pages 69-70 of this report. Implementation plans and projected outcomes (2021 – 2024) can be located on pages 70-71.

Strategy 4: Smoking, Tobacco, and Use of E-Cigarettes/Vaping

Tobacco use in Blair County was highlighted as one of the areas that needed to be addressed in the County Health Rankings Report. In addition, the increased trend in the use of e-cigarettes/vaping has caused concern nationwide. The goals for this strategy are on page 73. Accomplishments (2018 – 2021) are summarized on pages 73-74 of this report. Implementation plans and projected outcomes (2021 – 2024) can be located on pages 74-75.

Strategy 5: Poverty

The underlying causes of the many of challenges identified in the needs assessment can be attributed to social determinants of health (e.g. job opportunities, poverty, lack of education, social and cultural issues, housing, transportation, etc.). The goals for this strategy are on page 80. Accomplishments (2018 – 2021) are summarized on pages 80-81 of this report. Implementation plans and projected outcomes (2021 – 2024) can be located on page 81.

Strategy 6: Youth Connections

Blair County was one of twelve counties from across the country to be chosen by the National Association of Counties (NACo) in partnership with the Robert Wood Johnson Foundation County Health Rankings & Roadmaps Programs to receive community coaching on efforts to reduce childhood poverty with an emphasis on youth connections. Financial insecurity, lack of social supports, limited transportation, mental health needs, substance abuse, and other barriers for youth cause enormous costs, decrease the overall health of our community and hinder economic growth. As a community, we need to provide pathways to opportunities for all children and youth. The goals for this strategy are on page 84. Accomplishments (2018 – 2021) are summarized on pages 84-85 of this report. Implementation plans and projected outcomes (2021 – 2024) can be located on page 86.

Tracking the Progress and Outcomes of all Strategies

Each of the three hospitals as part of the Healthy Blair County Coalition will develop, measure, and monitor outcomes and impact as a result of the CHNA. In addition, each work group/committee will develop measurable outcomes as a means of assessing the impact and effectiveness of their programs and activities.

Other Relevant Indicator Data

By collecting and analyzing indicator data, the Data Analysis Work Group was able to review strengths, trends, and challenges for our community. The intent was also to determine if the statistics supported or did not support the perceptions of key informants and the general public. For the purpose of this report, data related to the identified priorities has been summarized within each section. In lieu of providing other data, readers are directed to the Healthy Blair County Coalition's website. On the home page, there is a tab for other Blair County Data.

Conclusions

Everyone involved in this endeavor, including the Steering Committee, hospitals, members of the Healthy Blair County Coalition, community service providers, and participants is committed to strategies that demonstrate improvement in the lives of Blair County residents. This can be accomplished by creating new partnerships and by joining existing collaborations to focus on results that create a measurable impact on the challenges and issues that were identified by the CHNA and supported by indicator data.

This needs assessment process confirmed that Blair County has many assets, including community leaders, businesses, service providers, community organizations and individuals. Those individuals who took time to complete the surveys and those who dedicated many hours as members of the Coalition Steering Committee and work groups are some of what makes Blair County a great place to live. Although the pandemic limited our ability to implement some of our programs and activities, our work groups/committees continued to meet remotely and adapted as needed to maintain communications and plan for future programs.

We will continue to implement community interventions that result in the improvement of social, economic, and environmental factors. This is our fifth report, *Blair County Profile 5: Community Health Needs Assessment and Implementation Plan*.

Each of the three hospitals chose to collaborate with each other on the CHNA and each hospital board approved this joint CHNA report. Although UPMC Altoona, Conemaugh Nason Medical Center, and Penn Highlands Tyrone already have initiatives and programs aimed at addressing the community health needs that were identified in this CHNA, all three facilities have agreed to adopt a joint implementation plan as permitted by the IRS guidelines. Each hospital has chosen specific strategies that they as individual facilities will take a lead in implementing but each will also collaborate on the implementation of the strategies adopted by the Healthy Blair County Coalition Steering Committee.

Individuals and organizations from Blair County will be invited to hear the results of the most recent community health needs assessment as well as accomplishments from the last three years. They will have an opportunity to join the Healthy Blair County Coalition as we pursue other initiatives and address issues in the most recent Implementation Plan.

How to Use and Obtain Copies of This Report

This report summarizes the 2021 community health needs assessment process adopted by the Healthy Blair County Coalition and utilized by the hospitals to satisfy the requirements of the Patient Protection and Affordable Care Act. A separate community health needs assessment may have been conducted for each hospital by their parent organization and information from those reports are referenced below.

The initial stages of this effort in Blair County began in 2007 and involved various types of surveys, collection of secondary indicator data, focus groups, and community meetings. Reference to the 2007, 2012, 2015, and 2018 needs assessments and comparisons of results and trends are included in this report. The Executive Summary on pages 10-23 provides a concise overview of the findings from all the data sources. For those who want more information on methods and findings within each data type, the body of the report provides more detail as outlined in the table of contents.

References for all sources of data are included at the end of each page. Finally, the report outlines the goals, accomplishments, and future plans for the implementation of strategies chosen by the Steering Committee and each hospital.

This report will be posted on the Healthy Blair County Coalition website as well as each hospital's website. Additionally a hard copy of the CHNA Report is available at each hospital's Administration Department for public inspection during normal business hours: Monday through Friday, 8:00 AM to 5:00 PM. Public input is invited and may be provided to:

Healthy Blair County Coalition
208 Hollidaysburg Plaza
Duncansville, PA 16635
info@healthyblaircountycoalition.org
www.healthyblaircountycoalition.org

UPMC Altoona Administration
620 Howard Avenue
Altoona, PA 16601
https://www.upmc.com/about/community-commitment/community-health-needs-assessment

Conemaugh Nason Medical Center Administration
105 Nason Drive
Roaring Spring, PA 16673
814-224-2141 or 877-224-2141

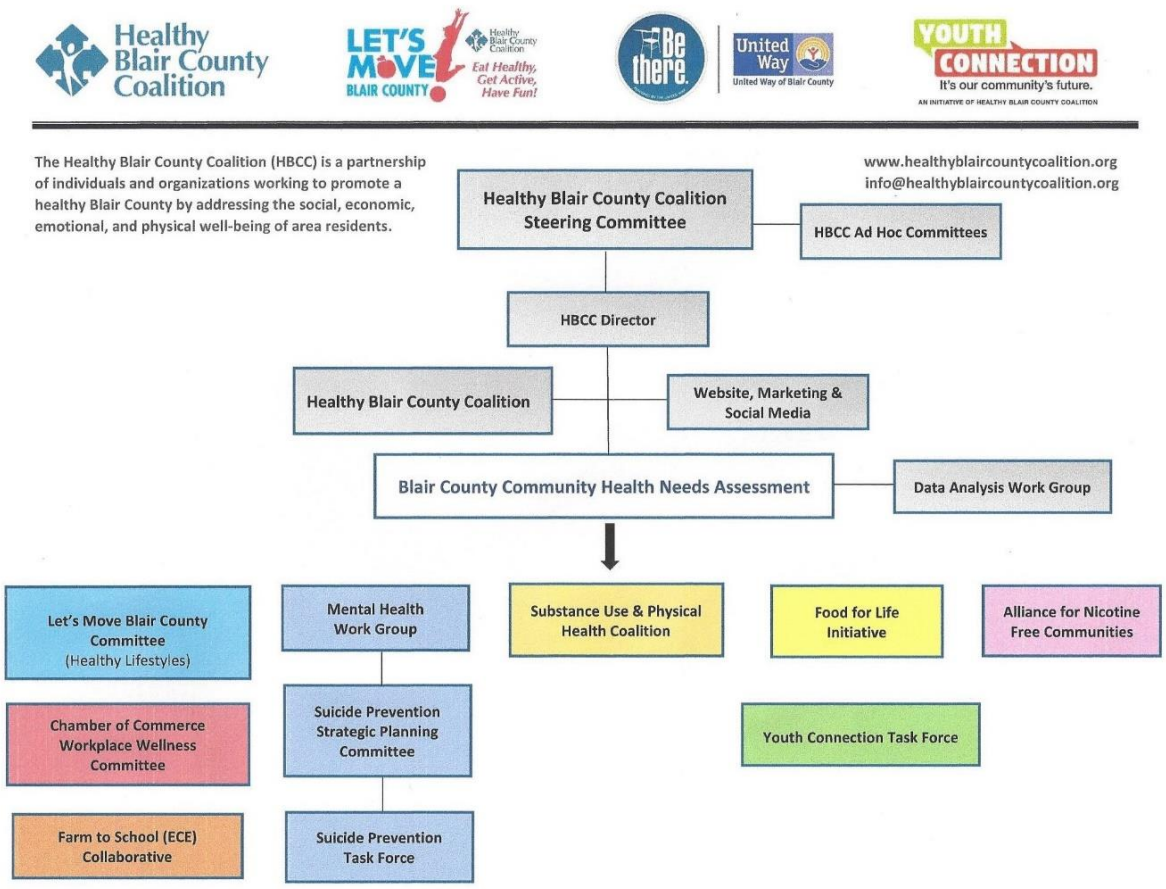
Penn Highlands Tyrone Administration
187 Hospital Drive
Tyrone, PA 16686
814-684-1255
https://www.phhealthcare.org/health-wellness/community-health-needs-assessment

Section One:
Blair County Community Health Needs Assessment

A. Collaboration and Implementation of the Community Health Needs Assessment (CHNA)

The Healthy Blair County Coalition is a community partnership that was created to provide a comprehensive community health needs assessment. Its purpose is to identify community assets, identify targeted needs, and develop an action plan to fill those needs. In 2007, the United Way of Blair County and the Blair County Human Services Office invited organizations to collaborate on a community-wide needs assessment. Then as a result of the Patient Protection and Affordable Care Act Public Law 111-148 Section 501(r)(3) which requires a hospital organization to conduct a CHNA at least once every three years and adopt an implementation strategy, the three hospitals located in Blair County chose to collaborate not only with each other but with the existing partnership. UPMC Altoona, Conemaugh Nason Medical Center, and Penn Highlands Tyrone are active participants on the Healthy Blair County Coalition Steering Committee. The organizational structure that was implemented is shown in Figure 1.

Figure 1: Healthy Blair County Coalition Organizational Chart



B. Healthy Blair County Coalition Steering Committee

The Steering Committee for the Healthy Blair County Coalition was responsible for directing the community health needs assessment, the development of the strategies to meet identified needs, and the monitoring of programs and interventions. This group meets bi-monthly and the following persons served as members during this community health needs assessment period:

Anna Marie Anna, Penn Highlands Tyrone (hospital)
Dr. Donald Beckstead, Altoona Family Physicians (health care)
Wendy Boyles, Conemaugh Nason Medical Center (hospital)
Laura Burke, Blair County Commissioner (government)
Marty Dombrowski, Center for Independent Living of South Central PA (social services)
Marcus Edwards, Altoona-Blair County Development Corporation (economic development)
Dr. Francine Endler/Jennifer Mitchell, Hollidaysburg Area School District (education)
Murray Fetzer, Penn Highlands Tyrone (hospital)
Donna D. Gority, Former, Blair County Commissioner (community volunteer)
Coleen A. Heim, Healthy Blair County Coalition Director
Lisa Hann, Family Services, Inc. (social services)
Timothy Harclerode, Conemaugh Nason Medical Center (hospital)
Kevin Hockenberry, UPMC Altoona (hospital)
Shawna Hoover, Operation Our Town (crime)
James Hudack, Blair County Department of Social Services (mental health)
Dr. Lauren Jacobson, Penn State Altoona (higher education)
Jean Johnstone, Catholic Charities, Inc. (social services)
Lannette Fetzer, PA Office of Rural Health (rural health)
Tracy Kelley, WIC Program (social services)
Amy Marten-Shanafelt, Blair HealthChoices (behavioral health)
David McFarland, Blair Planning Office (county planning)
Patrick Miller, Altoona-Blair County Development Corporation (economic development)
Mayor Matthew Pacifico, City of Altoona (government)
Clayton Rickens, James E. Van Zandt Medical Center (veterans and hospital)
Judy Rosser, Blair Drug and Alcohol Partnerships (social services)
Tom Shaffer, Penn State Altoona (higher education)
Sherri Stayer, Lung Disease Foundation of Central Pennsylvania (State Tobacco Control Provider)
Melanie Shildt/Matthew Uhler, United Way of Blair County (social services)
Bill Young, Sheetz, Inc. (business)

C. Healthy Blair County Coalition (HBCC)

The Steering Committee collaborated with a broader group of community stakeholders on whom the community decisions would have an impact, who had an interest in the effort, who represented diverse sectors of the community, and who were likely to be involved in developing and implementing strategies and activities. The Coalition is comprised of 161community partners. They represent a diverse and valuable group of individuals and organizations which include the following: social services, government, planning, public health, education, hospitals, community foundations, healthcare providers/behavioral

health, businesses, economic and workforce development, criminal justice, libraries, drug and alcohol, health insurance/managed care, media, recreation, faith-based, etc.

D. Director of the Healthy Blair County Coalition

A consultant was hired to assume the role of part-time director. This person was responsible for the day-to-day administration of the community health needs assessment; scheduling and facilitating meetings; distributing the surveys; maintaining an expense report; attending briefings/webinars on the CHNA process, supporting work groups/committees, preparing grants, updating the HBCC website and social media, and preparing the final CHNA report.

E. Work Groups and Committees

The **Data Analysis Work Group** reviews all primary indicator data such as survey results and assisted in the collection and analysis of secondary indicator data.

The purpose of the **Substance Use & Physical Health Coalition** is to enhance communication and coordination between drug/alcohol and healthcare and medical providers.

The **Pathways of Opportunity Network** was formed to develop a better understanding of poverty in Blair County and the extent to which agencies and programs provide resources and/or address poverty-related issues. Their mission also included increasing awareness of the impact of poverty on children and families. The Healthy Foods Sub-Committee specifically addressed issues related to food insecurity.

The **Youth Connection Task Force** is working to enhance collaboration and communications among organizations that can provide pathways of opportunity for youth and young adults.

The **Let's Move Blair County Committee** is implementing programs/activities to address obesity, encourage physical activity, and impact the incidence of diabetes. One of their goals is to encourage the integration of health and wellness into every aspect of community life by coordinating and collaborating with all other agencies currently working on this effort.

The **Mental Health Work Group** is addressing unmet needs and working toward establishing or enhancing programs and strategies to serve children and families more effectively. This includes creating an awareness of mental health and reducing the stigma of mental illness. Their work will be enhanced with the development of a Suicide Prevention Strategic Planning Committee.

The **Alliance for Nicotine Free Communities** is supporting programs to reduce tobacco use (e.g. smoke-free workplaces, clean air ordinances, smoking cessation programs, etc.). Another mission is to educate individuals on the impact of nicotine and the use of e-cigarettes/vaping as well as provide resources to those individuals interested in quitting.

The **Farm to Early Child Care & Education (ECE) Collaborative** is tasked with strengthening Farm to ECE practices and policies in Blair County by implementing activities and connecting local resources to early childhood centers.

In collaboration with the Healthy Blair County Coalition, the Blair County Chamber of Commerce created a **Workplace Wellness Committee**. The purpose is to encourage businesses to become part of the wellness movement and share resources to develop or enhance current workplace wellness programs.

Although there is not a formal Marketing Work Group, a variety of methods are used to provide awareness of the Healthy Blair County Coalition, inform residents and community members about the surveys and how to participate, share the results of the needs assessment, and increase collaboration and partnerships among all aspects of the community. Information is shared through the Healthy Blair County Coalition's website, Facebook page, Active Living/Let's Move Facebook page, Blair County Youth Connection Facebook page, podcasts, brochures, posters, meetings and conferences, newspaper, television, and radio.

F. Data Entry

Staff from Human Development and Family Studies at Penn State Altoona were helpful by providing the resources necessary for data entry and analysis. Data were entered using survey monkey then exported into Excel software for further analysis.

G. Funding

The community health needs assessment and HBCC are primarily funded by UPMC Altoona and Penn Highlands Tyrone. Additional funding was provided by Conemaugh Nason Medical Center, Blair County Drug and Alcohol Partnerships, Blair HealthChoices, Blair Planning, and Blair County Human Services Block Grant However, several other agencies contributed significantly to the project including Penn State Altoona and the United Way of Blair County. In-kind services such as meeting rooms, printing, use of equipment, donation of services, and volunteer hours were provided by many other organizations. In addition, grants were received from the Robert Wood Johnson Foundation, The Food Trust, Highmark, and the Thomas Jefferson University.

H. Geographic Area

Since all three hospitals involved in the collaboration primarily serve the residents of Blair County, the Steering Committee with input from the hospitals determined that the scope of the community health needs assessment would be the geographic boundaries of Blair County.

I. Input from the Community

The CHNA took into account input from persons who represent the broad interests of the community served by each of the three hospitals. This was accomplished in the following ways:

1. Each hospital has collaborated and obtained input from the Healthy Blair County Coalition Steering Committee. Their names, organizations, and entity they represent within the community are listed above in section B.
2. Members of the Healthy Blair County Coalition (the organizations involved are listed on the

HBCC website had an opportunity to be involved in the CHNA process by attending meetings, serving on work groups, administering the household survey with their clients/consumers, completing the surveys as appropriate for their organization, and providing secondary indicator data for analysis.

3. Residents of Blair County had an opportunity to complete a household survey.
4. CHNA surveys were also distributed to a variety of other community groups such as service providers and faith-based organizations.
5. A CHNA survey was distributed to key informants such as local, county, and state elected officials; school district leaders and board members; police chiefs; library presidents; media contacts; community foundations; public health entities, civic leaders; county planners; leaders of non-government funding sources; recreation commission; associations; etc. They had an opportunity to share their input and comment on community challenges as well as healthcare needs and gaps.
6. In order to obtain specific information on needs and gaps especially for certain populations within Blair County, interviews were conducted with a variety of healthcare providers, including physicians, dentists, pharmacists, behavioral health, and other agencies providing medical/ behavioral health services.
7. Three other agencies, including ones that serve income-eligible families and children and persons with disabilities conducted the CHNA household survey.

Section Two:
Methods

The Community Health Needs Assessment (CHNA) was conducted for two primary reasons. The first as a result of the Affordable Care Act Section 501(r)(3) which requires a hospital organization to conduct a CHNA at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA. The CHNA will support the overall validity of the community benefit strategy which will be used to demonstrate non-profit tax-exempt status. Another important reason is to determine whether challenges and trends have changed over the course of each needs assessment.

Each of the needs assessments are providing stakeholders as well as the community with increased knowledge of the current challenges and issues that affect residents of the county, our strengths and assets, and a better understanding of the healthcare needs. The community health needs assessment in Blair County focused on the following areas:

- Neighborhood and Community Strengths
- Community Challenges and Issues
- Household Challenges and Issues
- Impact of COVID-19
- Involvement in Community Initiatives/Projects
- Awareness of Social Determinants of Health and Health Equity
- Healthcare Challenges and Issues (e.g. access, gaps, prevention/education needs, etc.).

A. Method for Household Survey

A random sample of 3000 households (approximately six percent) was drawn from the 51,647 households in Blair County so that each zip code was represented according to its percentage of total households in the county. The services of Labor Specialties, Inc. (LSI) were utilized to obtain the database list. Three thousand surveys were mailed in June 2021, along with a cover letter and pre-paid return envelope. In addition, participants had the choice of completing the survey using survey monkey. The household survey and cover letter are included as Appendix A.

There were 248 surveys returned for a response rate of 8.3%. Information about the household survey was publicized through a press conference, television interviews, newspaper and other media releases, social media, and hospital and agency newsletters to consumers.

A link to the household survey was available on the HBCC website so that any resident had an opportunity to complete the survey (100 completed). The household survey was also administered to clients/consumers by three other groups including UPMC Altoona WIC Program, the Center for Independent Living, and NAMI Blair County. A total of 78 surveys were returned and analyzed but were kept separate from the random household survey. Therefore, a total of 426 surveys were returned: 248 from households, 100 from responses on the website, and 78 from the agencies mentioned above.

B. Method for Key Informant Survey

The purpose of this survey was to assess what community key informants believed to be the strengths, community challenges, and needs of Blair County, including health care. For the first time, there were questions related to social determinants of health and health equity. The survey was distributed to 203 key informants in Blair County (e.g. state, county, and local government officials, police chiefs, school superintendents, board presidents, hospital CEO's, media, human resource directors for major employers, executive directors of other groups such as the library, planning offices, etc.) to obtain their input on strengths and issues that impact residents and neighborhoods. The key informant survey and cover letter were emailed in June 2021. Fifty-six completed surveys were received, a 24% response rate.

C. Method for Service Provider Survey

The service provider survey was helpful in learning about the community assets, programs, and services that are already in place to serve the community. The survey also asked questions related to access to health care, gaps, prevention/education needs, social determinants of health, and health equity. An Excel spreadsheet distribution list of key service providers in the county was developed and then an email was sent in June 2021 asking participants to complete a survey on survey monkey. A total of 171 service providers were asked to participate with 37 responding, or 22%. The sample was characterized by both large and small agencies with an equal range serving children, youth, adults, and senior citizens.

D. Faith-Based Community Survey

The faith community is an integral part of life in Blair County and many organizations provide assistance and outreach to not only members of their congregations but to the community at large. They are familiar with the needs and challenges facing individuals, families, and community members. An Excel spreadsheet distribution list was developed and an email was sent in June 2021 asking the leadership of the congregation to complete a survey on survey monkey. Of the 94 faith-based organizations, 16 responded or 17%.

E. Healthcare Provider Interviews

Interviews were conducted with 14 healthcare providers representing a variety of disciplines such as physicians, dentists, pharmacists, behavioral health, health clinics, and other agencies providing medical/behavioral health services. During the interview, participants were asked their opinions regarding healthcare needs in our county, the needs related to special populations, programs and initiatives currently underway to address those needs, changes over the past three years, and the impact of COVID-19, etc.

Table 14: Blair County Community Health Needs Assessment Survey Tracker

Surveys/Interviews	Survey Sent	Surveys Returned	Percentage
Household	3000	248	8.3%
Household (website)	N/A	100	N/A
Key Informant	203	56	240%
Service Provider	171	37	22%
Faith-Based	94	16	17%
Household Surveys from Other Agencies	N/A	78	N/A
Healthcare Providers	N/A	14	N/A

F. Collection and Analysis of Secondary Indicator Data

The purpose of collecting and analyzing secondary indicator data is to track changes and trends over time for a given population. It is useful as a mechanism to answer whether research supports or does not support the perceptions of stakeholders and the general public as reflected in survey results. Data were obtained from a variety of federal, state, and local sources, including but not limited to: U.S. Census, Center for Rural Pennsylvania, Pennsylvania Department of Education, Pennsylvania Department of Human Services, Pennsylvania Department of Health, Centers for Disease Control, County Health Ranking Report, Pennsylvania Office of Rural Health, etc.

G. Data Entry and Analysis

All survey responses were entered into Survey Monkey. With the assistance of Penn State Altoona, the results were exported from Survey Monkey into Excel which was used for analysis and graphic displays.

Section Three: Household Survey

A. Blair County Demographic Data and Comparisons for Persons Completing the Household Survey

The purpose of the household survey was to collect both subjective (opinion) and incidence data from people who live within Blair County. The household survey and cover letter are included as Appendix A.

A random sample of 3000 households (approximately six percent) was drawn from the 51,647 households so that each zip code was represented according to its percentage of total households in the county. The surveys were mailed in June 2021, along with a cover letter and pre-paid return envelope. In addition, participants had the choice of completing the survey using survey monkey. There were 248 surveys returned for a response rate of 8.3%. Information about the household survey was publicized through a press conference, television interviews, newspaper and other media releases, social media, and hospital and agency newsletters to consumers.

A link to the household survey was available on the HBCC website so that any resident had an opportunity to complete the survey (100 completed). The household survey was also administered to clients/consumers by three other groups including UPMC WIC Program, the Center for Independent Living, and Blair County NAMI. A total of 78 surveys were returned and analyzed but were kept separate from the random household survey.

Therefore, a total of 426 surveys were returned: 248 from households, 100 from responses on the website, and 78 from the agencies mentioned above. As shown in Table 15, our random household survey (2021) was generally representative of Blair County.

Table 15: Comparisons of Blair County Demographics/Characteristics & Those Completing the Household Survey[1]

Characteristics	Blair County Population	Household Survey (2021)
Gender		
Male	49.0%	37.4%
Female	51.0%	62.1%
Other		0.4%
Race		
White or European American	95.6%	94.4%
Black or African American	2.0%	3.0%
Hispanic/Latino	1.3%	0.0%
Asian or Pacific Islander	0.7%	0.9%
American Indian/Alaska native	0.2%	0.0%
Two or More races in Household	1.5%	1.7%

[1] U.S Census Bureau (2020) and Blair County Household Survey (2021)

Income		
Less than $25,000	23.0%	19.5%
$25,000 - $49,999	26.2%	27.6%
$50,000 - $99,999	311%	30.8%
$100,000 - $149,999	12.9%	13.6%
$150,000 or above	6.7%	8.6%
Household Type		
Married – couple with own children	15.2%	21.6%
Married – couple without own children	30.9%	39.0%
Single parents with children under 18	9.1%	3.8 %
Single person	31.2%	24.2%
Other type of household	13.5%	11.4%

B. Neighborhood/Community Strengths

The household survey asked recipients to state their level of agreement to questions regarding **neighborhood/community strengths**. Respondents were asked to rate the level of agreement on a Likert-type scale (Strongly Agree, Somewhat Agree, Somewhat Disagree, Strongly Disagree, and No Opinion/Don't Know).

The results in this survey indicate that 73% of respondents felt that people in their neighborhood help each other out when they have a problem. And 52.8% gather together formally or informally to participate in activities. About 23% felt they have little or no opportunity to affect how things happen in their neighborhood. In the area of voting, 86.7% reported that they vote in most elections.

"People, for the most part, are very generous. In my experience, the ones most in need are the ones most willing to help another. The community really works together to meet as many needs as possible."

Residents felt that the best things about living in Blair County are related to being close to grocery stores/shopping (73%), near highway access (64%), close to parks, recreation, and sports (64%), friendly neighbors (60%), and close to physicians and medical facilities (59%). The worse things about living in Blair County were drug use/abuse (58%), roads and alleys in need of repair (48%), and youth with nothing to do (44%). These responses were the same as results from the last needs assessment.

C. Community Challenges and Issues

The household survey asked participants to identify the level of concern (Not an Issue, Minor Issue, Moderate Issue, Major Issue, or No Opinion/Don't Know) regarding 43 different **community issues** in the categories shown in Figure 2.

Figure 2: Categories of Community Challenges and Issues

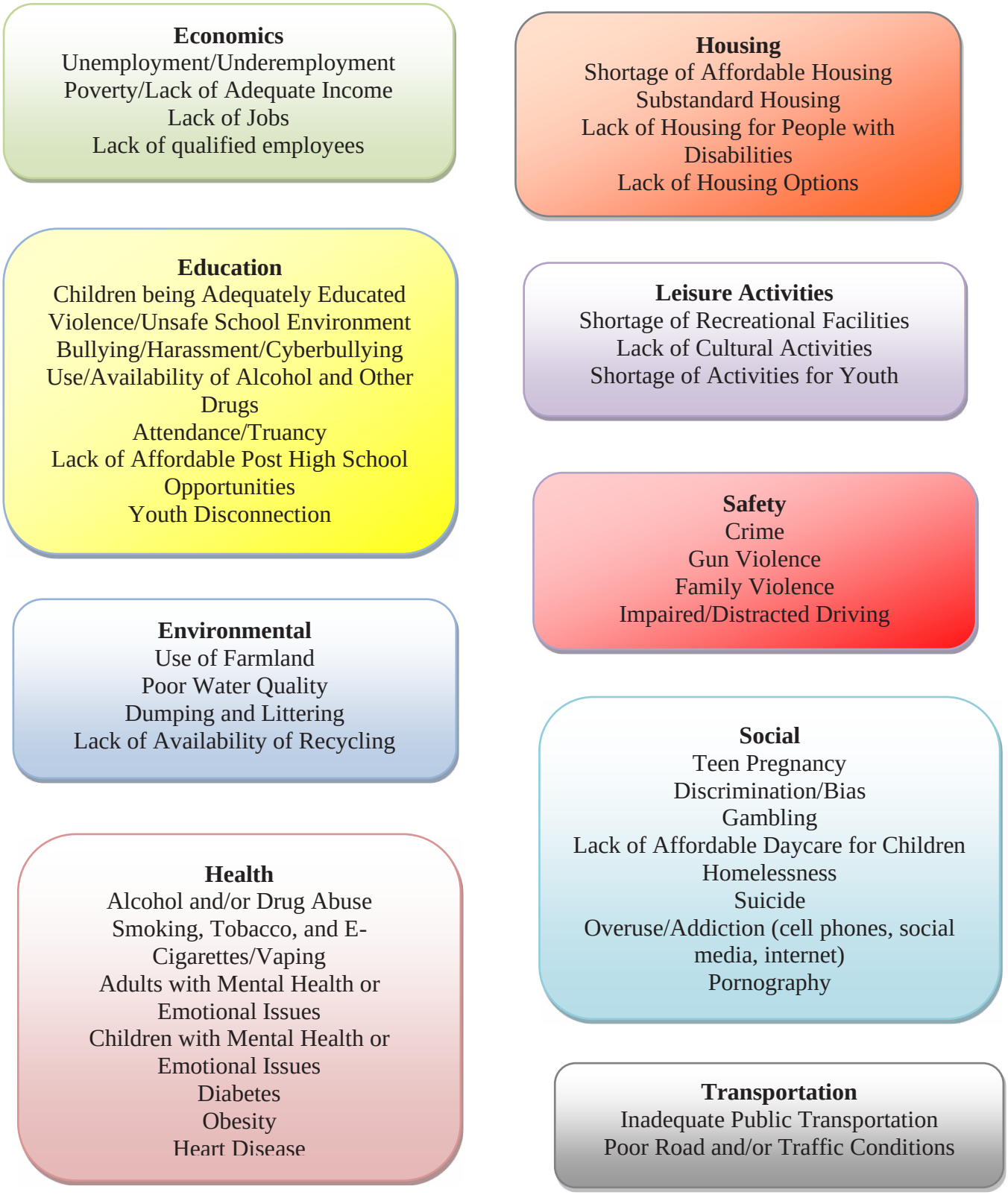


Table 16: Priorities Identified in Blair County Community Needs Assessments

2007	2012	2015	2018	2021
Crime	Lack of jobs	Obesity	Alcohol and other Drugs	Overuse/addiction to cell phone, social media, internet, etc
Alcohol and other drugs	Alcohol and other drugs	Alcohol and other drugs	Obesity	Obesity
Unemployment or underemployment	Unemployment or underemployment	Lack of jobs	Overuse/addiction to cell phone, social media, internet, etc	Alcohol and other Drugs
Lack of jobs	Obesity	Poverty/lack of adequate income	Impaired/distracted driving*	Impaired/distracted driving
Lack of affordable medical care	Poverty	Unemployment or underemployment	Poverty/lack of adequate income	Smoking, tobacco, and e-cigarettes/ vaping
Poverty	Crime	Smoking and tobacco	Smoking, tobacco, and e-cigarettes	Adults with mental health or emotional issues

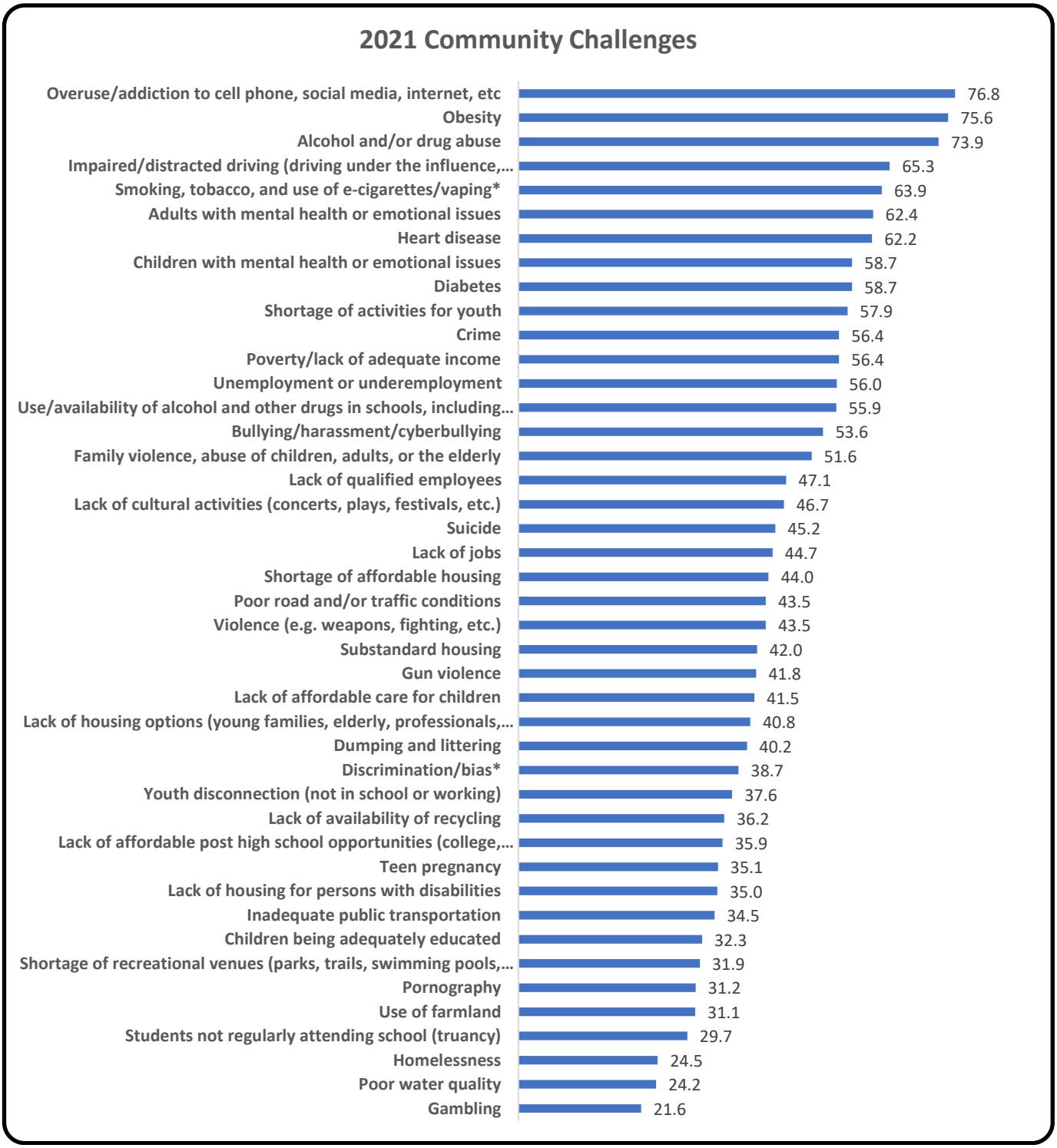
A comparison with the 2007 responses cannot be accurately made since the options changed for respondents in the 2012, 2015, 2018, and 2021 household surveys when health related questions were added.

As can be seen in Figure 3, 76.8% of respondents identified overuse/addiction to cell phone, social media, internet, etc. as the top challenge followed by obesity (75.6%) and drug and alcohol (73.9%).

The analysis based on geographic areas for the three hospitals yielded similar results with the random household survey responses. Any resident had an opportunity to complete the survey on our website and the responses were different from the random survey with alcohol and other drugs, obesity, adults with mental health issues, and bullying/harassment/cyberbullying as their top challenges (87%).

The household survey was also administered to clients/consumers by three other groups including the Center for Independent Living of South Central Pennsylvania, Blair County NAMI, and Home Nursing Agency WIC Program (UPMC). Respondents in those surveys identified poverty, housing, mental health, transportation, crime, and lack of affordable childcare as issues affecting their particular population.

Figure 3: COMMUNITY CHALLENGES & ISSUES (Ranked by percentage identified as major or moderate issue).



*Indicates new question or wording added to the survey in 2021.

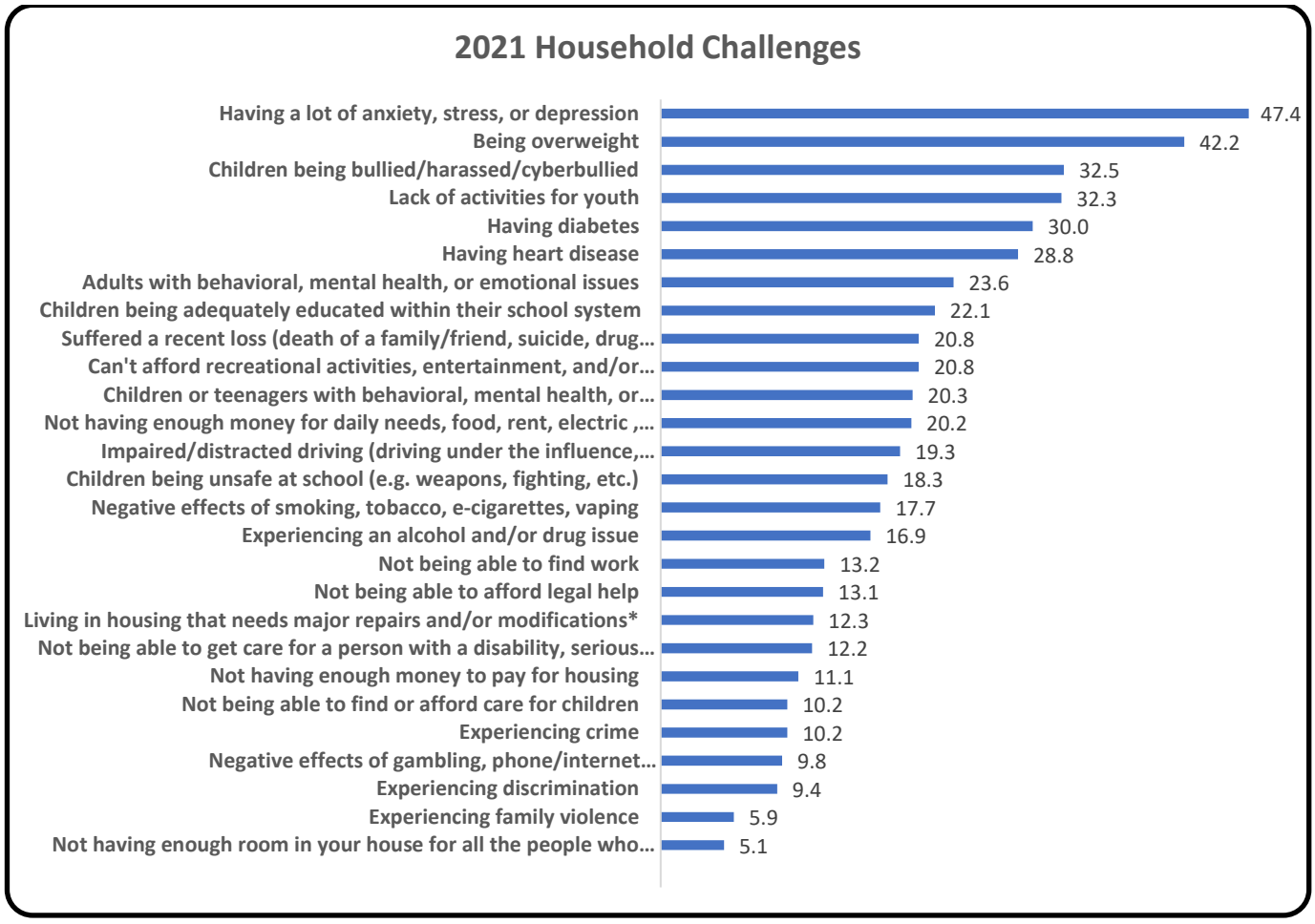
D. Household Challenges and Issues

In the next section of the household survey, participants were asked whether any of the same types of issues had been a **challenge or an issue in their household**. Respondents were asked to assess whether they found each area to be: Not an Issue, a Minor Issue, a Moderate Issue, a Major issue, or No Opinion/ Don't Know.

As Figure 4 indicates, 47.4% of respondents identified having anxiety, stress, or depression as the top challenge within their household followed by being overweight at 42.2%. The analysis based on geographic areas for the three hospitals yielded the same results with having stress, anxiety, and depression and being overweight as the highest ranking issues within households.

Respondents in surveys conducted by other organizations agreed that having anxiety, stress, or depression was among the highest ranking challenge in their households. However, the lack of activities for youth and children being bullied/harassed/cyberbullied also ranked at the top of their concerns.

Figure 4: HOUSEHOLD CHALLENGES & ISSUES (Ranked by percentage identified as major or moderate issue).



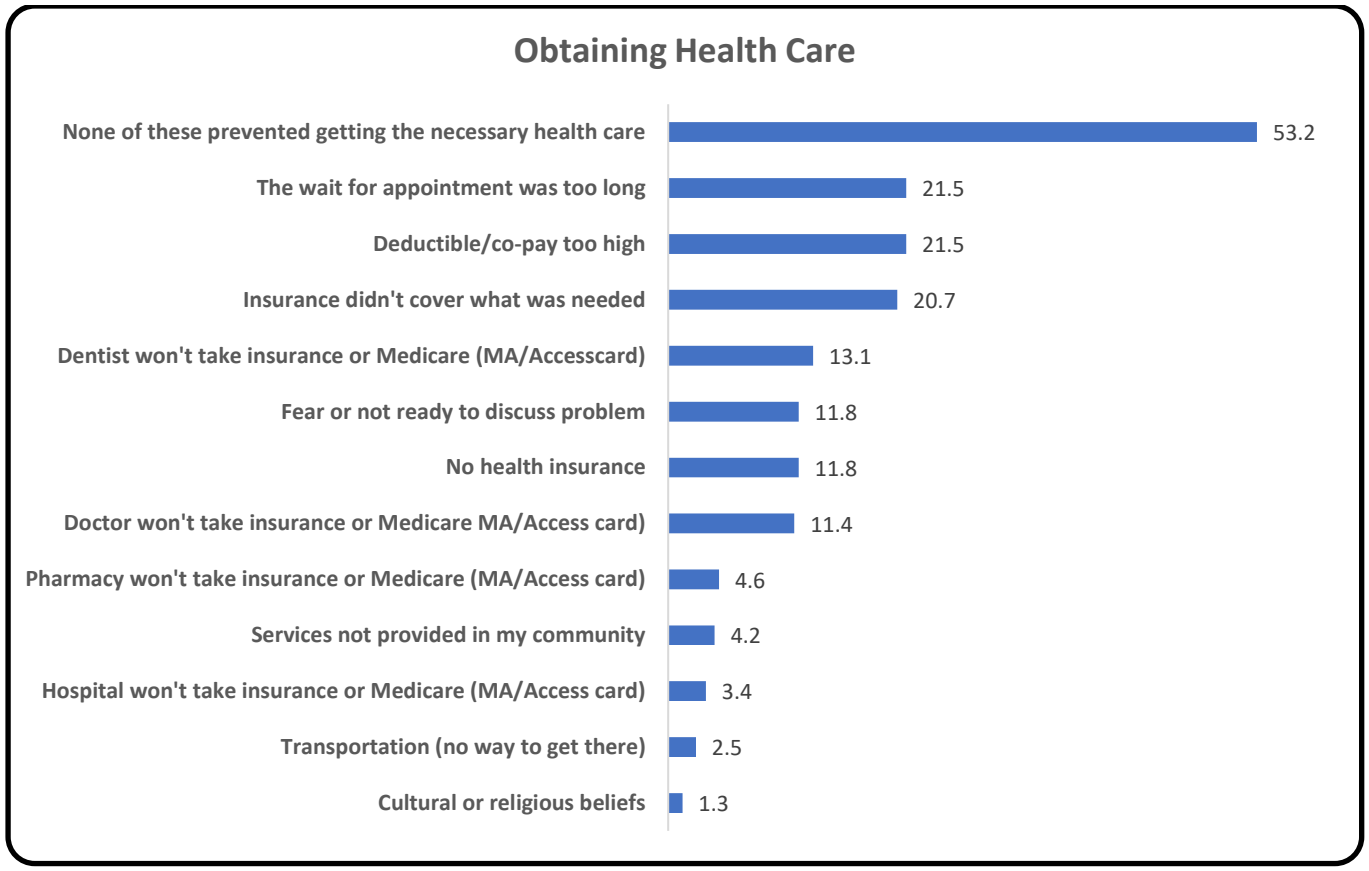
*Indicates new question or wording added to the survey in 2021.

E. Health Care Challenges and Issues

It was important to obtain information from residents on **health care issues affecting themselves or members of their families.** Survey results indicate that 90% of survey respondents have seen a primary care/family physician and 77% have seen a dentist in the last year.

Responses in Figure 5 indicate which problems prevented people from getting the necessary health care,

Figure 5: CHALLENGES & ISSUES FOR OBTAINING HEALTH CARE (Ranked by percentage identified as a major or moderate issue).



Overall, between 43% - 58% of households reported that none of the items prevented them from getting health care as reflected across geographic areas. Those responding to the survey on our website reported having no insurance at 32%. Respondents in surveys conducted by other organizations indicated more that the doctor, pharmacy, and/or dentist would not take insurance or Medicaid.

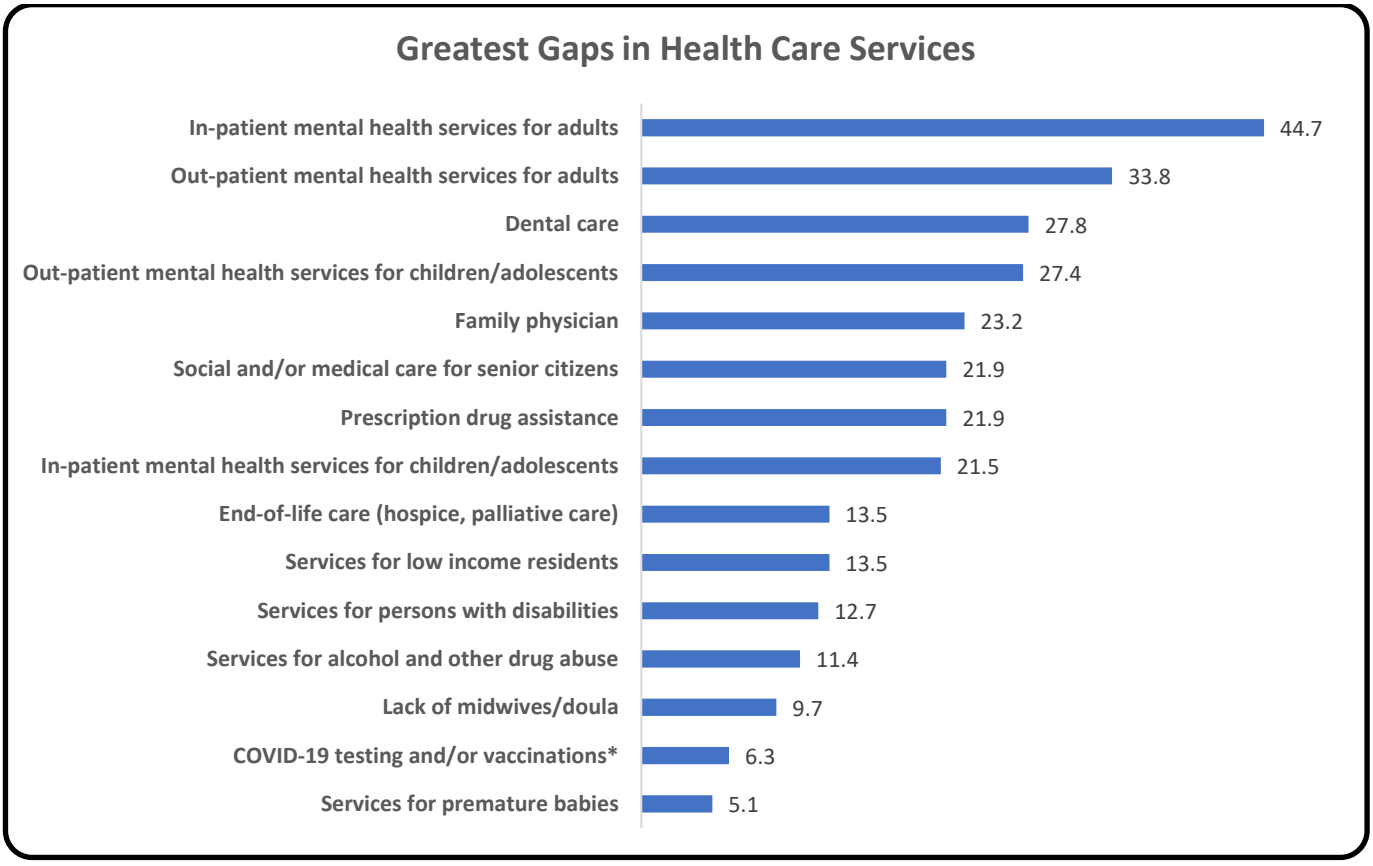
Residents about were asked their own experiences with the health care system. Table 17 summarizes their responses.

Table 17: Navigating the Healthcare System

	Yes	No	Sometimes
Do you know how to find treatment if you or someone you know needs help for an alcohol or substance use problem?	73.1%	10.9%	1.3%
When you need help are you able to navigate the healthcare system and community resources?	67.2%	12.8%	17.0%
Do you clearly understand what is going on with your healthcare?	76.5%	10.5%	12.2%
Do you feel like all of your medical care is well coordinated between different medical providers?	58.4%	18.5%	19.7%
Has the cost of any medical care you have received ever affected your ability to pay your household expenses (e.g. utility bills, food, rent)?	19.8%	70.9%	5.5%
Have you ever missed a health care appointment (e.g. doctor appointment, test, physical therapy, etc.) due to lack of transportation?	3.0%	96.2%	0.8%

Residents were asked their opinions on the **greatest gaps in health care services** in Blair County. Overall, mental health services was the greatest gap for residents.

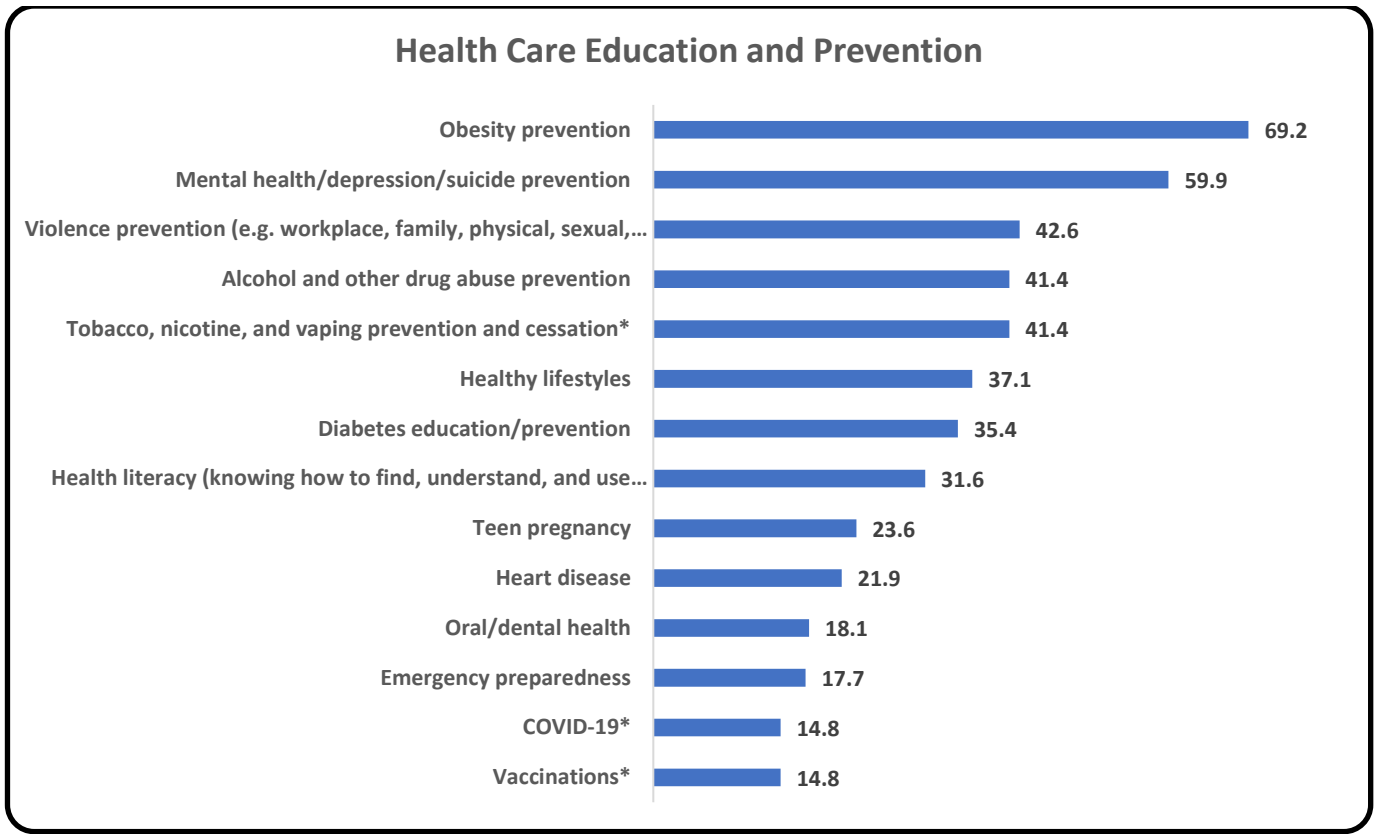
Figure 6: GREATEST GAPS IN HEATH CARE SERVICES (Ranked by percentage identified as a major or moderate issue).



*Indicates new question or wording added to the survey in 2021.

When asked "What are the **greatest needs in health education and prevention services** in Blair County", obesity prevention (69.2%) and mental health/depression/suicide (59.9%) received the highest percentages. These were consistent across all subgroups.

Figure 7: Greatest Needs in Health Education and Prevention Services (Ranked by percentage identified as a major or moderate issue).



*Indicates new question or wording added to the survey in 2021.

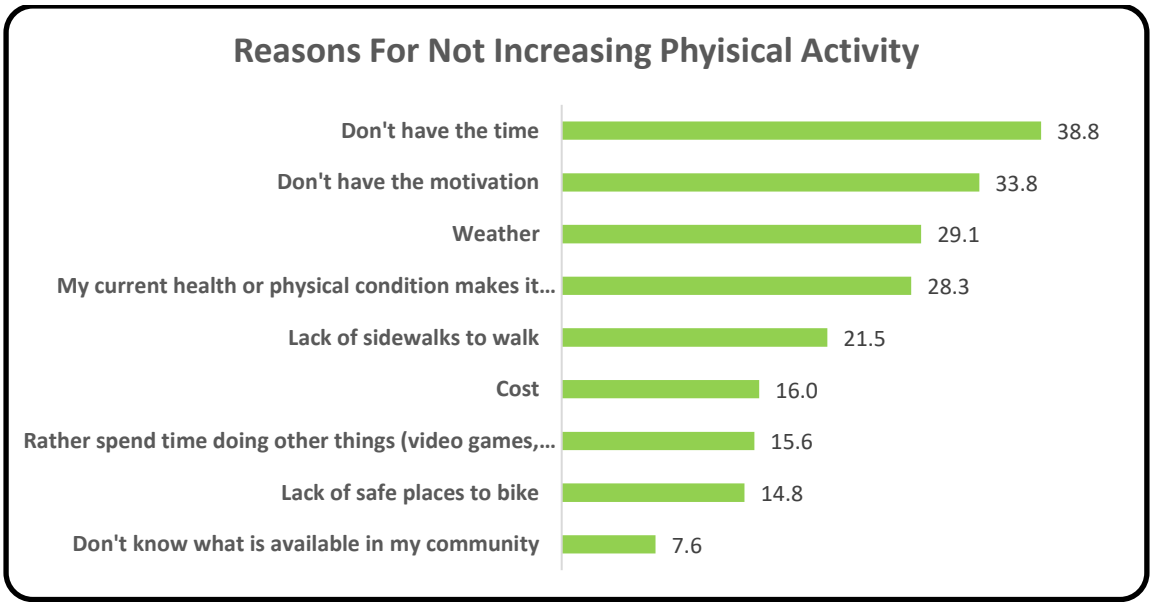
The two most common responses on how COVID-19 impacted their families was an increase in stress, anxiety, social isolation or other mental health concerns (27%) and a delay in getting routine health care or scheduling necessary surgery (26%).

When asked whether respondents or their families registered in the SMART 911 system, over 64.6% did not know what SMART 911 is. In addition, 86.9% were not familiar with the PA211 system.

Figures 8 and 9 show what Blair County residents said were what keeps them from eating a healthy diet and what keeps them from increasing their physical activity.

Figure 8: Reasons for not Eating a Healthy Diet

Figure 9: Reasons for not Increasing Physical Activity



Section Four:
Key Informant Survey, Health Care Provider Interviews Service Provider Survey, and Faith-Based Survey

A. Key Informant Survey

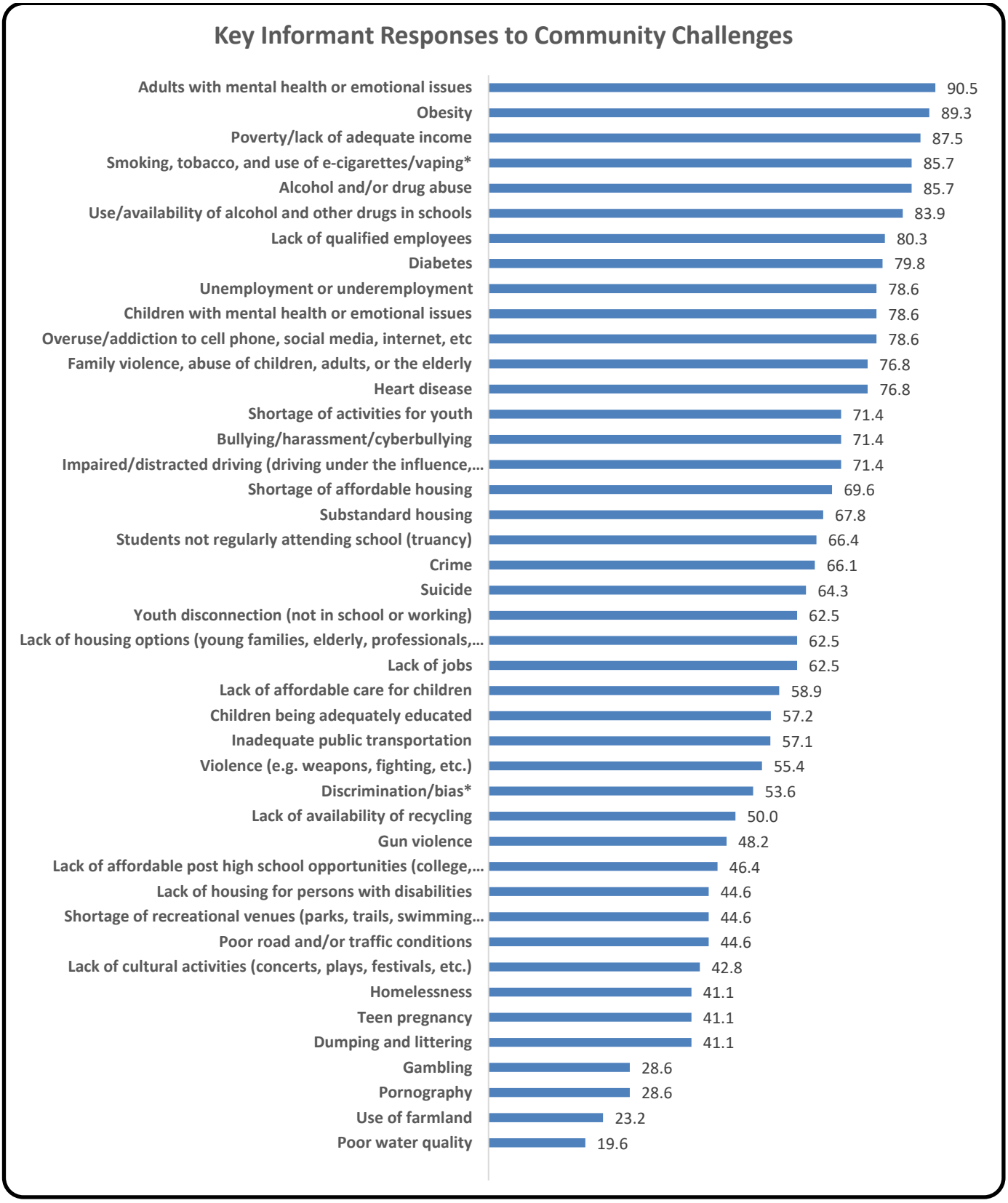
A survey was distributed to 203 key informants in Blair County (e.g. state, county, and local government officials, police chiefs, school superintendents, board presidents, hospital CEO's, media, human resource directors for major employers, executive directors of other groups such as the library, planning offices, associations, etc.) to obtain their input on strengths and issues that impact residents and neighborhoods. The key informant survey and cover letter were emailed in June 2021. Fifty-six completed surveys were received, a 24% response rate.

Out of the responses for community strengths, key informants see mainly positive strengths including 80.3% perceive leaders as having mutual respect among all sectors of the community.

Table 18: Key Informant Responses for Community Strengths

Community Strength	Strongly/Somewhat Agree
Leaders come together and work productively to address critical community issues.	89.3%
Our community actively promotes positive relations among people from all races, genders, ages, and cultures, including persons with disabilities.	69.6%
Our community is one where religious groups address pressing social concerns.	69.6%
Our community actively promotes participation in the political process from all races, genders, ages, and cultures, including persons with disabilities.	64.3%
There exists a great deal of mutual respect among leaders from all sectors of the community.	80.3%

Figure 10: Key Informant Responses for Community Challenges



Key Informant Survey Highlights, Community Strengths, and Challenges:

- When asked if you could focus on one issue, substance use and mental health tied for the most responses.

- They believe that COVID-19 has had the most negative impact on our community with regard to alcohol and other drugs (92.8%), economics (89.2%), and mental health/social isolation (87.5%), education of children (78.5%), and political climate (78.5%)..

- Over 71% were aware of social determinants of health. With regard to heath equity and how opportunities differ between neighborhoods or groups of people, over 54% felt that safe housing and transportation were very different.

- Key informant responses for the top reasons which prevented residents from getting the necessary health care were the same as those from households (e.g. deductible/co-pay was too high and insurance didn't cover what was needed).

- Key informants reported that mental health/depression/suicide prevention (92.6%) followed by obesity (64.3%) and violence prevention (62.5%) were the greatest needs regarding health education and prevention services. They listed both in-patient and out-patient mental health services for adults and children (67%) as the greatest gap in health services in the county.

- Over 77% of key informants were aware of and/or participated in Healthy Blair County Coalition initiatives.

Table 19: Key Informant Responses to the Impact of COVID-19 Pandemic

	No Impact	Positive Impact	Negative Impact
Economic/unemployment/absenteeism by employees	11%	0%	89%
Education of children/youth/young adults	12%	9%	79%
Health care resources capacity, services, etc.	28%	28%	43%
Mental health and social isolation	7%	5%	88%
Housing/homelessness	37%	2%	61%
Childcare	28%	7%	64%
Alcohol and other drug use	5%	2%	93%
Access to healthy foods	46%	18%	36%
Broadband and internet access	42%	41%	16%
Crime	23%	5%	71%
Political climate	16%	5%	78%
Transportation	54%	13%	34%
Family relationships	7%	32%	61%
Work environment (e.g. remote, use of technology, etc.)	13%	59%	29%
Utilizing outdoor/recreation opportunities	16%	71%	13%

B. Health Care Provider Interviews

Interviews were conducted with 14 healthcare providers representing a variety of disciplines such as physicians, dentists, pharmacists, behavioral health, health clinics, and other agencies providing medical/behavioral health services. During the interview, participants were asked their opinions regarding healthcare needs in our county, the needs related to special populations, programs and initiatives currently underway to address those needs, changes over the past three years, and the impact of COVID-19, etc.

Summary of Health Care Provider Interviews:

- When asked "What do you believe are the top three community health needs", healthcare providers ranked mental health concerns and the need for more providers (57.1%) as the top community health needs followed by various issues related to access to care (50%).

- Since the last needs assessment, over 35% of healthcare providers have seen an increase in concerns related to substance use and access to primary care. Over 21% stated obesity and behavioral health issues have also increased.

- When asked "What are the top needs related to special populations?" services for the elderly was ranked as the highest need (50%) for a special population followed by mental health services especially for children/adolescents at 43%.

- Fifty percent reported that staff shortages in all areas is impacting the needs of patients/clients the most followed by the lack of mental health providers (28.6%) especially for children/adolescents.

- The impact of COVID-19 was mentioned as the biggest challenge which led to hospitals and medical facilities being over capacity, staff shortages, people delaying health care needs, lack of vaccine compliance, and increased mortality of patients. For young people, that had to deal with the loss of family members, their education, and routine, they are still feeling anxiety and depression.

C. Service Provider Survey

Surveys were sent to a variety of groups to learn more about the strengths and available resources as well as their opinions on the challenges and needs of the community. We wanted to gather information and develop an understanding of the ways in which citizens and other organizations are engaged in this effort.

The survey also asked questions related to community challenges, impact of COVID-19, access to health care, gaps, and prevention/education needs. A total of 171 service providers were asked to participate with 37 responding, or 22%. The sample was characterized by both large and small agencies with an equal range serving children, youth, adults, and senior citizens.

Figure 11: Service Provider Responses for Community Challenges

Service Provider Survey Highlights, Community Initiatives/Projects, and Assets:

- Service providers stated they were most involved in the following six community initiatives: health wellness/prevention (43%), employment opportunities for low income people (38%), information and referral (38%), and financial assistance, education, and mental health services at 35%.

- Over 64% utilized volunteers in providing services for their agency but 62% reported that they could use more volunteers. Over 81% of these organizations make an effort to purchase goods and services from local enterprises.

- When asked if you could focus on one issue, substance use, mental health, and the economy tied for the most responses.

- They believe that COVID-19 has had the most negative impact on our community with regard to alcohol and other drugs (97.3%), mental health/social isolation (84.6%), political climate (91.9%), and education of children (89.2%). Service providers did their best to continue services remotely as financial and emotional stressors for families and clients increased exponentially.

- Over 76% were aware of social determinants of health. With regard to heath equity and how opportunities differ between neighborhoods or groups of people, they agreed with ley leaders that safe housing and transportation were very different.

- Only 21.6% feel that there is collaboration among and/or between physical and behavioral health providers. Fifty-nine percent (59.4%) say sometimes.

- Transportation (81%) was the top reason which prevented residents from getting the necessary health care followed by no insurance, deductible/co-pay was too high, and insurance didn't cover what is needed.

- Service providers reported that mental health/depression/suicide prevention (86%) was the greatest need regarding health education and prevention services. They listed both in-patient and out-patient mental health services for adults and children (46% - 68%) as the greatest gap in health services in the county. Dental care was also high on the list at 48.6%.

- Over 65% of service providers were aware of and/or participated in Healthy Blair County Coalition initiatives.

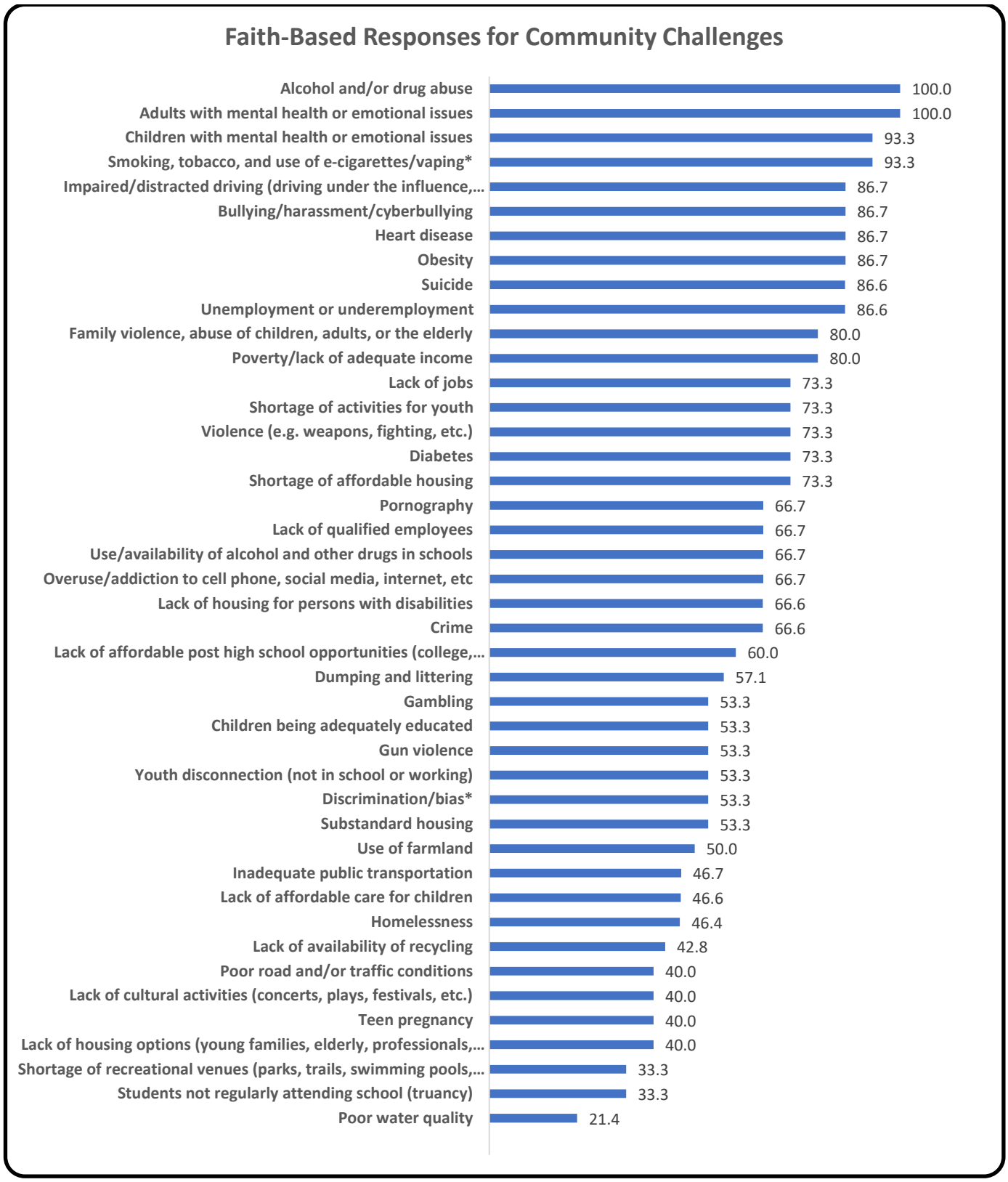
Table 20: Service Providers Responses to the Impact of COVID-19 Pandemic

	No Impact	Positive Impact	Negative Impact
Economic/unemployment/absenteeism by employees	8%	5%	86%
Education of children/youth/young adults	3%	8%	89%
Health care resources capacity, services, etc.	14%	27%	60%
Mental health and social isolation	0%	5%	95%
Housing/homelessness	17%	6%	78%
Childcare	14%	8%	77%
Alcohol and other drug use	0%	3%	97%
Access to healthy foods	32%	19%	49%
Broadband and internet access	31%	42%	28%
Crime	25%	6%	69%
Political climate	8%	0%	92%
Transportation	50%	8%	42%
Family relationships	8%	38%	54%
Work environment (e.g. remote, use of technology, etc.)	8%	51%	41%
Utilizing outdoor/recreation opportunities	11%	76%	13%

D. Faith-Based Surveys

The faith community is an integral part of life in Blair County and many organizations provide assistance and outreach to not only members of their congregations but to the community at large. They are familiar with the needs and challenges facing individuals, families, and community members. Surveys were emailed to 94 faith-based organizations and 16 responded (17%).

Figure 12: Faith-Based Responses for Community Challenges



Faith-Based Survey Highlights, Community Initiatives/Projects, and Assets:

- Ninety-three percent of the respondents agreed that the community is one where leaders from business, labor, government, education, religious, neighborhood, non-profit, and all other sectors come together and work productively to address critical community issues. They also believe that our community is one that promotes positive relations among people from all races, genders, ages, and cultures, including persons with disabilities.

- Ninety-two percent agreed that our community is one where religious groups address pressing social concerns.

- The faith-based community provides a wide variety of services to both members of their congregations and to the community itself.

- They believe that COVID-19 has had the most negative impact on our community with regard to economy (86.6%). Over 80% listed alcohol and other drugs, mental health/social isolation, and crime.

- Over 71% were aware of social determinants of health. With regard to heath equity and how opportunities differ between neighborhoods or groups of people, they also agreed that safe housing and transportation were very different.

- Eight percent responded that deductible/co-pay was too high and insurance didn't cover what is needed were the top reasons which prevented residents from getting the necessary health care.

- They reported that obesity (86.6%) and mental health/depression/suicide prevention (73.3%) were the greatest needs regarding health education and prevention services. Dental care, out-patient mental health services for adults, and prescription drug assistance all at 46.6% as the greatest gaps in health services in the county.

- Fifty percent of the congregations reported having a youth group.

- Over 53% were aware of and/or participated in Healthy Blair County Coalition initiatives.

Section Five:
Demographics of Blair County

Blair County is located in south-central Pennsylvania and covers a land area of 526 square miles. The County includes the City of Altoona, fifteen townships, and eight boroughs. It also includes a portion of another borough, which is split between Blair County and Cambria County.[1] Blair County sits at the heart of the I-99 Corridor and is the crossroads for Route 22 and I-99 covering all points north, south, east, and west. Blair County is the 43rd largest county and the 28th most populated county in the state of Pennsylvania out of 67 counties.

Table 21: Demographic Data for Blair County[2]

Characteristics	Blair County	Pennsylvania
2020 Population	122,822	13,002,700
2019 Veterans	9,111 (9.6%)	759,474 (7.2%)
2019 Persons with a Disability (all ages)	10.0%	14.4%
2020 Number of Households	51,647	5,053,106
2017 Average Household Size	2.30	2.45
2020 Population by Age		
Age <5	5.1%	5.5%
Ages <18	20.2%	20.8%
Ages 18+	79.6%	79.3%
Ages 65+	21.3%	18.7%
2019 Population by Marital Status		
Never married	28.4%	33.5%
Married, spouse present	48.7%	48.3%
Married, separated	2.5%	2.0%
Divorced	11.0%	9.7%
Widowed	8.08%	6.6%
2019 Housing Ownership	70.6%	69%
2019 Median Value of Owner-Occupied Housing	$123.600	$180,200
2019 Median Gross Rent	$722	$938
2019 Households with a Computer	84.8%	88%
2019 Households with a Broadband Internet	78.4%	81.5%
2020 Median Household Income	$50,856	$63,627
2020 Per Capita Income	$29,336	$34,352
2019 Unemployment Rate	4.4%	5.4%
2020 Unemployment Rate[3]	17.7%	15.1%

[2] U.S. Census Bureau (2019-2020)
[3] U.S. Bureau of Labor Statistics

2012 Unemployment Rate	5.4%	5.4%
2019 Population 25+ with High school Graduation	91.4%	90.5%
2019 Population 25+ with a Bachelor's Degree	23.1%	31.4%

Blair County Health Care Resources

There are three acute care hospitals in Blair County: UPMC Altoona, Conemaugh Nason Medical Center, and Penn Highlands Tyrone.

UPMC Altoona is a nonprofit, 375 bed acute care teaching hospital located in Blair County, Pennsylvania. In operation since 1886, the hospital became affiliated with UPMC in 2013 and now serves as its regional hub in central Pennsylvania. UPMC Altoona offers more than 200 years of health care experience, over 300 talented and highly recognized physicians, nearly 4,000 specialized and experienced caregivers, and 600 supportive volunteers. The health system serves more than 20 counties throughout Central Pennsylvania.

UPMC Altoona Partnership for a Healthy Community provides access to dental care for income-eligible children and adults. The mission of UPMC Altoona Partnership for a Healthy Community is to provide accessible, comprehensive, dental care to the community's economically disadvantaged, uninsured, and underinsured, enabling these patients to live healthier lives.

Since 1954, the Tyrone Hospital has been serving the surrounding communities with personalized healthcare. The hospital, now **Penn Highlands Tyrone**, has grown from serving a small number of individuals in Tyrone, to offering many services to surrounding communities in neighboring counties. Penn Highlands Tyrone is a twenty-five bed community hospital with three primary care physician offices which include Tyrone Rural Health Center, Pinecroft Medical Center and Houtzdale Rural Health Center. Its services include the Breast Cancer & Women's Health Institute, an orthopedic clinic, Company Healthcare, and the Tyrone Fitness and Wellness Center.

Conemaugh Nason Medical Center is a forty-five bed facility serving a suburban and rural area of Blair, Bedford, and Huntingdon Counties. Conemaugh Nason Medical Center is part of LifePoint Health®, a leading healthcare company dedicated to Making Communities Healthier®. LifePoint owns and operates 65 community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in 29 states.

In addition, there is the **James E. Van Zandt Veteran's Medical Center** with 51 operating beds and 973 employees. In 2020, they served 24,970 veterans in their 14-county service area.

There are other Freestanding Ambulatory Surgery Centers, Freestanding Imaging, Urgent Care, Physical Therapy Centers, long term care providers, twelve nursing homes, and nineteen assisted living facilities.

In Blair County, there are 118 primary care physicians (96.1 per 100,000 residents), 53 active dentists (43.2 per 100,000 residents), 15 pediatric physicians (12.2 per 100,000 residents), and 184 physician assistants (149.8 per 1000,000 residents).[4]

[4] 2019 U.S. Health and Human Services Administration (HRSA)

Section Six:
Strategy 1: Promote a Healthy Lifestyle

Findings and Documented Need

The need to promote a healthier lifestyle for the residents of Blair County remains an identified need in every community health needs assessment.

What did everyone say about obesity?

76% greatest community challenge (household survey)
87% greatest community challenge (website household survey)
42% greatest challenge in households
89% greatest community challenge (key informants)
92% greatest community challenge (service providers)
87% greatest community challenge (faith community)
28.5% greatest community health need (healthcare providers)

69% greatest education/prevention need by households
64% greatest education/prevention need (key informants)
62% greatest education/prevention need (service providers)
87% greatest education/prevention need (faith community)

A further analysis based on geographic area (Northern, Central, and Southern Blair County) and the three organizations that conducted the survey with their clients indicated similar results.

The overall ranking for Blair County in the County Health Rankings Report has improved significantly as shown in Table 21.[5] There are factors such as changes in indicators or indicator sources that affected the annual rank. Each county is encouraged to study individual indicators as opposed to the ranking from the previous year.

Table 22: Blair County Health Rankings

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
63	62	56	56	51	48	46	47	45	51	43	39

According to that same report, 32% of the adult population in Blair County is considered obese. This is in comparison to Pennsylvania at 31%. Obesity is often a result of poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, stroke, etc. In terms of potential life lost (YPLL) before age 75 per 100,000 population, the measure in Blair County is 8,000 as compared to Pennsylvania at 7,500. The report indicates the ranking for physical inactivity among adults in Blair County is 25% again comparing that with Pennsylvania at

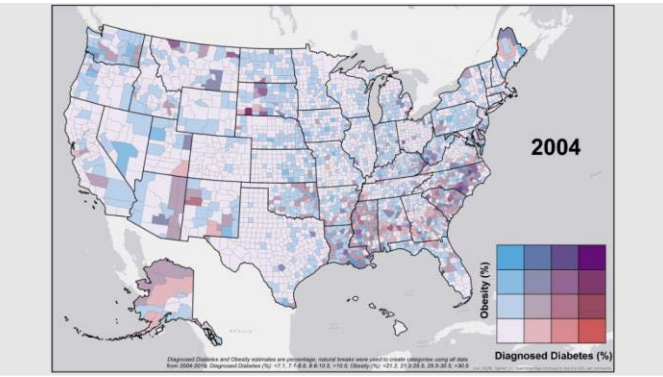
[5] 2021 County Health Rankings Report for Blair County

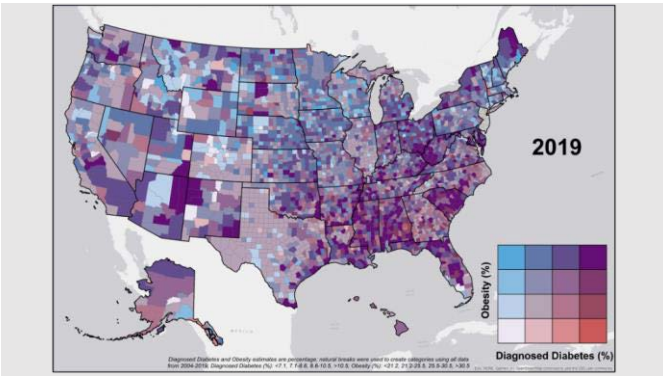
22% and the national benchmark at 20%. It is important to state that 75% of residents in Blair County have access to exercise opportunities.[6]

According to the Center for Disease Control, obesity rates in Blair County increased from 25.3% to 36.3% from 2004 – 2019. Reports of physical inactivity increased from 26.9% to 29.7% while reported diagnoses of diabetes rose from 9.3% to 11.5%. The two maps below illustrate the increase across the nation in diagnosed diabetes and obesity estimates.[7] In Blair County, 34.7% of K-6 students and 38.9% of students in grades 7-12 are considered overweight or obese.[8] The Healthy People 2030 national health target is to reduce the proportion of children and adolescents with obesity is 15.5%.

Over 26% of the Blair County population live more than one mile (urban area) or ten miles (rural area) from the nearest supermarket.[9] Food insecurity is an economic and social indicator of the health of a community. Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. In Blair County, 13% (about 16,000 people) of the population experienced food insecurity at some point during the year. The child food insecurity rate is even higher at 17.5%[10]

The 2019 Blair County Health Profile Report indicates diseases of the heart as the major cause of death. The rate for Blair County is 206.3 (per 100,000) as opposed to Pennsylvania at a rate of 175.3 (per 100,000).[11]





Goals: Let's Move Blair County

- Implement Programs/Activities to Address Obesity, Encourage Physical Activity, and Impact the Incidence of Diabetes
- Encourage the integration of health and wellness into every aspect of community life.
- Coordinate and collaborate with other agencies currently working on this effort.

[6] 2021 County Health Rankings Report for Blair County
[7] Centers for Disease Control and Prevention
[8] Pennsylvania Department of Health. Bureau of Community Health Systems. Division of School Health
[9] USDA Economic Research Service. 2019
[10] Feed America. 2019
[11] Pennsylvania Department of Health. County Health Profile Report for Blair County (2019)

Progress and Accomplishments (2018 – 2021)	
Let's Move Blair County Committee	The Committee which adopted the national **Let's Move** Initiative continues to provide and participate in educational and physical activities promoting the overall message of eating healthy, getting active, and having fun. The **Facebook** page which has 2,001 followers has been sharing tips for healthy eating and getting active, including posting events and activities. Visit us at facebook.com/healthyblaircountycoalition.
Active Living Brochure/Map	In collaboration with the South Hills School of Business & Technology, an interactive Active Living Brochure/Map was developed and 30,000 copies are being distributed. It includes resources and activities in Blair County.
Let's Move Blair County	The Committee sponsored an annual Let's Move Blair County Day in collaboration with the Altoona Curve Baseball Team and now Lakemont Park. This event includes a health fair, children and family wellness activities, Workplace Wellness Corporate Challenge winner presentations, fun games and the overall message about making healthier choices about food, nutrition, and physical activity.
Corporate Wellness Challenge	In 2014, Tyrone Regional Health Network (TRHN) and the Northern Blair County Recreation Center organized the Corporate Wellness Challenge. Our partners at Blair Regional YMCA, Conemaugh Nason Medical Center, Northern Blair County Recreation Center, Tyrone Regional Health Network, and UPMC Altoona expanded this into a countywide challenge. Area companies were invited to participate giving their employees an opportunity to work on weight loss to support good health. In 2018, there were 24 companies and 480 participants that lost a total of 4,948 pounds.
Active Living/Steps Challenge	From 2018 – 2021, we sponsored five eight-week Active Living/Steps Challenges for teams and individuals. In total, our community walked 514,840,143 million steps.
Chamber of Commerce's Workplace Wellness Committee	In collaboration with the Blair County Chamber of Commerce's Workplace Wellness Committee, a Workplace Wellness Toolkit was developed. The purpose was to assist businesses and organizations in assessing and implementing workplace wellness initiatives. The toolkit was distributed to 65 attendees attending a Wake Up To Wellness event. The Committee also hosted virtual monthly Chamber Chats with a presenter and discussion focusing on health and wellness topics. There were 15 Chamber Chats with a total of 286 participants.
Blair Planning Commission	Blair Planning has included Public Health and Safety as a priority and included an action plan in the 2018 Comprehensive Plan for Blair County. HBCC supported the efforts of the Blair Planning Commission to increase opportunities for physical activity by creating sixteen walking routes in twelve communities through a project called WalkWorks. In addition, the Blair Planning adopted a complete streets policy to encourage sidewalk and bicycle facility construction; supported the development of a trail system and outdoor recreation in Antis Township; is working with various trail groups to create a trail along the western county line; promoted the Trail Town concept in Williamsburg; conducted presentations on public health; is undertaking a radon

	awareness and mitigation program through its hazard mitigation planning program; and participated in a variety of community events such as the Blair County Home, Garden, and Healthy Living Showcase, the Healthy Resolutions Expo and Healthy Blair County Coalition's Let's Move Day, etc.
Collaboration with Partners	Our three local hospitals as well as other community agencies provides classes/programs on healthier eating, physical activity, diabetes education, and stress reduction.
Born Learning Trails	The United Way of Blair County in collaboration with Penn State Altoona's Sheetz Fellows Program created two outdoor, interactive, early learning trails. The trail includes learning activities for adults to play with young children to help boost language and literacy development and to help caregivers support early learning.
UPMC Altoona	UPMC Altoona continued with hosting the Diabetes Day at The Casino at Lakemont Park in November 2018 and 2019 with over 200 people attending in total. UPMC Altoona offered many free educational health events and continues to participate in activities sponsored through the UPMC Health Plan, including the National Senior Health and Fitness Day, Coffee Connection Wednesdays held at the Logan Valley Mall health plan kiosk and Check Your Fit First Fridays at the Logan Valley Mall monthly. During the continued pandemic, some classes have continued, but through a virtual platform. Regarding staff activities and events, UPMC offers incentives through Active and Fit Direct, as well as Take a Healthy Step Credits with questionnaires and activities to lower health plan deductibles paid out of pocket.
Penn Highlands Tyrone (formerly Tyrone Regional Health Network)	Professionals from TRHN/Tyrone Hospital participated in an assortment of community events where information and screenings were incorporated into event offerings. Events attended included but were not limited to the Healthy Blair County Coalition's Let's Move Day. The hospital continues to provide the Tyrone Fitness and Wellness Center. The Center offers adults a variety of exercise options to support good health. Community members continue to have access to walking trails located on the hospital campus. Penn Highlands Tyrone identified health literacy as an important area to address by training all staff and managers to understand the concept and how to provide information to patients to ensure compliance with health care regiments.
Conemaugh Nason Medical Center	Staff from Conemaugh Nason conducted on-site wellness programs for local businesses with over 100 employees participating. They attended local community events and offered blood pressure screenings, hands only CPR demonstrations, AED training, and Stop the bleed training programs for local schools, farmers, first responders, and the community. Conemaugh Nason also conducted Healthy Lifestyle outreach programs for area senior citizens and Diabetes Management Programs for community members. They provided sponsorships and donations to local food banks, Blue Knob Ski Patrol, Blair County Library systems, Nason Foundation, the United Way of Blair County, and Let's Move Blair County.

Farm to ECE Collaborative	In 2020, Blair County was selected by The Food Trust to be a part of a Pennsylvania Farm to ECE Initiative. The Food Trust, in partnership with the Pennsylvania Head Start Association, was granted funding from the W.K. Kellogg Foundation to work across the state, with local advisory boards to explore ways to increase Farm to Early Care and Education (ECE) activities. Based on the input shared from the first community meeting, a needs assessment was distributed to ECE providers in Blair County. Subsequently, two meetings and a webinar were conducted with ECEs and community partners to provide ideas for program activities, resources, and mini-grants to support implementation. However, facility closures and staff shortages because of the pandemic impacted the implementation of this project on a countywide basis.

Implementation Plans (2021 – 2024)

Program	Intended Outcomes	Anticipated Impact	Lead Organizations
Let's Move Blair County	Promote obesity prevention, such as eating healthier and engaging in physical activity throughout the community.	Increase the number of children, parents, employees, and community members engaging in programs to encourage healthy eating, physical activity, and limiting screen time.	Healthy Blair County Coalition Conemaugh Nason Medical Center Penn Highlands Tyrone UPMC Altoona
SparkBlair County	Promote the SparkAmerica Fit City Challenge to encourage residents to attain their optimal state of health.	Increase the number of individuals, organizations, businesses, and employees engaging in programs to encourage healthy eating and becoming more physically active	Healthy Blair County Coalition
Active Living Steps Challenge	Develop and promote an Active Living Steps Challenge.	Encourage individuals and teams in Blair County to improve their physical health by documenting a total of 200,000,000 steps from September – November 2021.	Healthy Blair County Coalition
WalkWorks	Continue to promote and expand walking routes in communities throughout Blair County.	Increase social interaction among individuals using the WalkWorks routes.	Blair Planning Commission Healthy Blair County Coalition
Community Education Programs	Provide classes on healthier eating, physical activity, diabetes education, and stress reduction.	Increase the number of children, parents, employees, and community members	Healthy Blair County Coalition Conemaugh Nason Medical Center

		engaging in programs to encourage healthy eating and becoming more physically active.	Penn Highlands Tyrone UPMC Altoona
National Diabetes Day Health Fair	Host health fair and offer screenings, educational classes, and cooking demonstrations.	Increase diabetes education and awareness	UPMC Altoona
Tyrone Fitness and Wellness Center	Provide exercise classes, cardio equipment, treadmills, and other state-of-the-art fitness equipment.	Increase the number of community members engaging in activities to become more physically active.	Penn Highlands Tyrone
Penn State Altoona	Research and address food insecurity in Penn State communities.	Increase the use of the food pantry at Penn State Altoona	Penn State Altoona
Public Health and Safety	Market, promote, and preserve local trails, pedestrian routes/facilities and other recreational destinations/ facilities.	Increase the use of trails and routes to improve the health of residents.	Blair Planning Commission
Health Literacy	Develop a health literacy presentation/curriculum to support better understanding for patient self-care.	Improve the capacity of individuals to obtain, process, and understand basic health information needed to make appropriate health decisions.	Penn Highlands Tyrone Healthy Blair County Coalition's AmeriCorps Member
Community Wellness Hospital Trail	Promote overall wellness in the Tyrone area community through educational signage along a walking trail.	Increase the use of the trail to improve the health of residents.	Penn State Altoona: Community-Based Studies Blair Planning Penn Highlands Tyrone

Section Seven:
Strategy 2: Alcohol and Other Substance Abuse

Findings and Documented Need

Although there have been many proactive initiatives to address alcohol and other drugs within Blair County, it continues to adversely affect the quality of life for individuals and the community itself. In addition to the individual and population health risks, drug and alcohol use poses a significant toll on the utilization of the health care system and the economy.

What did everyone say about alcohol and other drugs?

74% greatest community challenge (household survey)
89% greatest community challenge (website household survey)
17% greatest challenge in households
86% greatest community challenge (key informants)
92% greatest community challenge (service providers)
100% greatest community challenge (faith community)
35.7% greatest community health need (healthcare providers)

41% greatest education/prevention need by households
59% greatest education/prevention need (key informants)
59% greatest education/prevention need (service providers)

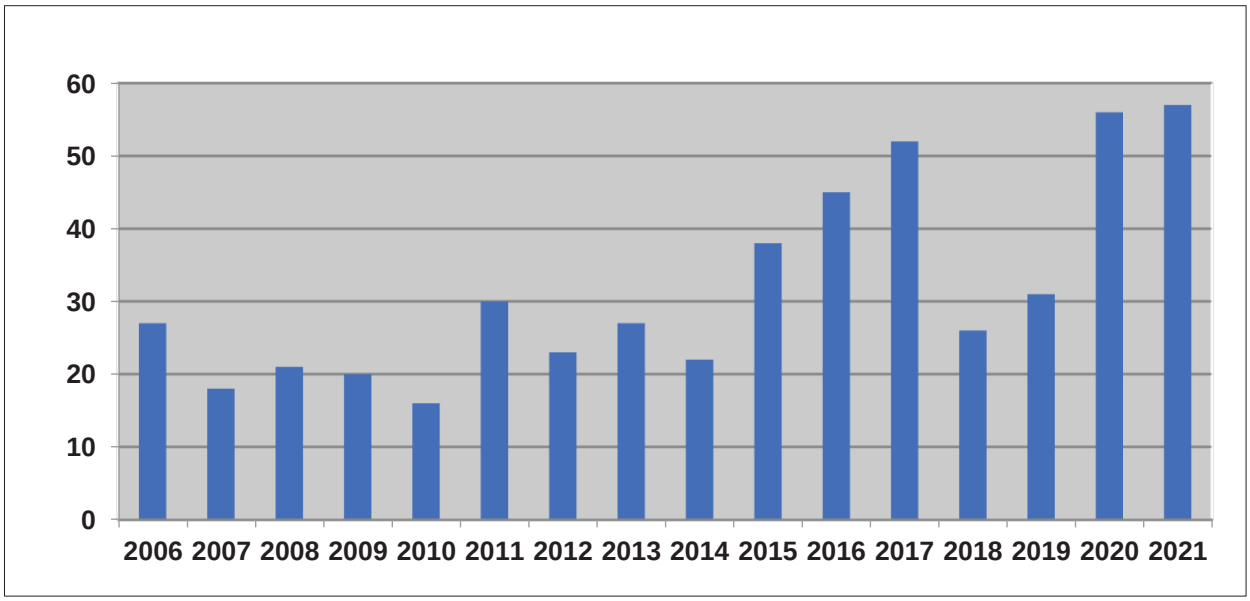
An analysis based on geographic areas indicated differences in where residents ranked alcohol and other drugs with the central part of the county ranking it the top challenge at 78%. Responses from the three other organizations ranged from 75% - 100%. On a positive note, over 73.1% of people in the household survey stated they would know how to find treatment if they or someone they knew needed help for an alcohol or substance abuse problem.

The Blair Drug and Alcohol Partnerships (BDAP) is the SCA (Single County Authority) for Blair County which is the agency designated by the Department of Drug and Alcohol Programs to plan, fund and administer drug and alcohol activities. BDAP operates a central point of contact to support and navigate individuals into treatment. In addition, BDAP has developed wrap around services of case management and recovery supports to address social determinates of health that impact early recovery for those they serve. Since July 2018, BDAP has assessed an average of 1800 individuals a year. They work with the local partners in our community to support overdose prevention, primary prevention through our schools and the communities and ongoing work that addresses stigma of substance use disorder and interventions needed to support and facilitate support to the individual and their families.

According to 2020 – 2021 data the drugs of choice in the county for adults are opioids, alcohol, amphetamines. For adolescents, the drugs of choice are cannabis, alcohol, and opioids In 2019-2020, Medicaid data showed 2624 distinct members admitted for substance use disorders and 1687 admissions 64% had an opioid use disorder. One group of individuals who are underserved and less likely to receive an intervention is our older populations (less than 20% of admissions are age 44 and above). This is of concern because data shows they are at risk based on prescribing data and overdose data.

The state prescription drug data identified the population ages 44-70 as receiving the highest volume of opioid prescriptions for Blair County in the second quarter of 2021. In conjunction, the overdose data for Blair County shows 20+% of fatal overdoses are for persons over the age of 50.[12] In the second quarter of 2021, there were 22,587 dispensations for opioids, 17,491 for benzodiazepines, and 11,301 for stimulants in Blair County.[13]

Table 23: Blair County Drug Overdose Deaths[14]



Drug trends have changed in the last three years. Methamphetamine has increase due to the change in production of this substance. Super labs in Mexico are producing mass quantities that are widely distributed in the Commonwealth and Blair County. In the last 2 years, there has been an increase in clandestine produced fentanyl being cut into heroin, methamphetamine, and cocaine emerging on our streets.

In 2020, 9,097 members were served in behavioral health services (both mental health and substance use disorders) in Blair County. Of those members, 2,427 utilized substance use disorders services with a total expenditures of $10,133,037. Fifty-five percent of the 2,477 members had a opioid use disorder. Total behavioral health expenditures during 2020 was $35,276,985.[15]

[12] Blair Drug and Alcohol Partnerships
[13] Pennsylvania Office of Drug Surveillance and Misuse Prevention
[14] Blair County Coroner's Office
[15] Blair HealthChoices

In 2020, 32.1% (766) of new criminal cases in Blair County were drug-related which was a 120% increase since 2011.[16]

Table 24: Blair County Drug/Alcohol Arrests (juveniles and adults)[17]

Offense	2018	019	2020	2021
Drug Abuse Violations	740	688	793	636
Driving Under The Influence	435	368	263	176
Liquor Law Violations	148	115	59	13
Drunkenness	186	174	99	114

The *Pennsylvania Youth Survey* data provides use history in the past 30 days, lifetime and onset of use. As shown in Table 22, Blair County has seen declines in the percentage of youth engaging in most drugs for lifetime use but an increase in vaping/e-cigarettes and marijuana.[18]

Table 25: Pennsylvania Youth Survey Results for Blair County (Percent of Lifetime Use for Students in Grade 12)

	2001	2003	2005	2007	2009	2011	2013	2015	2017	Blair County 2019	State 2019
Alcohol	86.6	82.2	82.0	77.8	66.0	60.7	72.7	65.1	57.6	58.0	63.0
Marijuana				30.8	29.0	38.7	31.9	33.8	29.4	30.8	37.5
Inhalants				11.1	10.8	5.2	7.1	7.0	3.5	3.9	4.7
Cigarettes	61.6	55.2	50.3	47.7	47.5	49.3	40.9	37.2	31.1	23.7	21.9
Smokeless Tobacco	0.4	28.5	27.7	30.6	30.1	35.8	29.4	21.8	14.6	11.4	11.8
Vaping/E-Cigarettes (past 30 days not lifetime)	-	-	-	-	-	-	-	29.9	28.1	35.2	33.1
Narcotic Prescription Drug	-	-	-	-	-	12.3	12.7	12.1	7.1	7.1	5.0
Prescription Tranquilizers	-	-	-	-	-	2.6	6.1	6.1	4.0	3.5	3.3
Prescription Stimulants	-	-	-	-	-	7.4	9.4	10.6	8.4	4.5	4.2
Steroids	3.3	1.3	1.1	2.4	0.5	1.3	1.7	1.3	0.6	0.6	0.9
Cocaine	7.4	6.4	5.6	6.9	2.9	2.6	3.1	2.5	2.8	1.5	2.1
Methamphetamines	6.6	5.0	3.9	0.6	0.8	0.4	2.1	0.7	0.5	0.5	0.4
Heroin	3.1	3.3	2.6	0.3	0.9	0.6	1.7	1.3	0.2	0.5	0.3
Hallucinogens	12.7	9.0	5.9	9.3	3.7	7.2	6.4	8.0	6.9	5.6	5.9
Ecstasy	11.1	5.4	3.3	2.7	2.2	2.0	1.7	1.7	1.0	1.4	2.1

[16] Pennsylvania Judicial System
[17] PA State Police Uniform Crime Report
[18] Pennsylvania Youth Survey. 2001 - 2019 Blair County Survey.

Since 2007, Operation Our Town has raised over $4,3000,000 and provided over $3,800,000 in grant funding to support law enforcement, prevention, and treatment programs to combat crime and substance abuse in Blair County. They have awarded prevention grants to 70 non-profits and served over 104,000 youth and families. In 2021, the majority of drug buys were for heroin or methamphetamine, much of it laced with fentanyl. In 2021, local police departments collected over 1,494 pounds of drugs through the Blair County Drug Collection Boxes.[19]

Goals: Substance Use and Physical Health Coalition

- Enhance collaboration and communications between behavioral and physical health care providers.
- Continue the implementation of the evidenced-based SBIRT (Screening, Brief Intervention, and Referral to Treatment) which would include substance abuse as an area screened during routine healthcare.
- Continue to implement evidenced-based early intervention programs for those with substance use disorders.

Progress and Accomplishments (2018 – 2021)	
SBIRT (Screening Brief Intervention and Referral to Treatment)	SBIRT is a comprehensive and integrated approach to the delivery of early intervention and treatment services through universal screening. Since initiation of the SBIRT: Empower 3 Clinic, Pregnancy Care Clinic, and Altoona Family Physicians (AFP) have conducted over 60,843, over 3,439 brief interventions, and 930 patients were referred to treatment (drug/alcohol and mental health). The grant ended in September 2021 but all facilities will expand and/or sustain the project. Seven pharmacies in Blair County have implemented the program. There have been 3,500 screenings and 40 brief interventions. BDAP received a federal grant to provide SBIRT training and Stigma Reduction/Addiction training to emergency responders. 78 EMS responders from AMED and Hollidaysburg and 63 police officers from Altoona and Logan Township were trained. So far, 2059 patients were screened by EMS, 255 brief interventions, and 42 referrals to specialized care were offered. [20]
Warm Handoff for Substance Abuse Disorders	In 2019, the Emergency Department Certified Recovery Specialist (CRS) program was developed with 24/7 warm handoff in all Blair County hospitals. There were 736 individuals engaged at UPMC by the CRS, another 258 were engaged by the UPMC staff on days/times the CRS was not present for a total of 994 contacts. 300 clients attended their first treatment episode.

[19] Operation Our Town 2022 Annual Report
[20] Blair Drug and Alcohol Partnerships 2020 – 2021 Annual Report

Implementation Plans (2021 – 2024)			
Program	**Intended Outcomes**	**Anticipated Impact**	**Lead Organizations**
SBIRT (Screening, Brief Intervention, and Referral to Treatment)	Improve the early identification of an evidence-based intervention on substance use disorders by the medical community, pharmacies, EMS, and law enforcement.	Reduce the impact of substance use disorders on the criminal justice system and community.	Blair Drug and Alcohol Partnerships Altoona Family Physicians PeopleOne Health Pregnancy Care Center
Warm Handoff for Substance Abuse Disorders	Improve the early identification and intervention of substance use disorders by the medical community.	Increase the number of individuals who have early access to treatment services	Blair Drug and Alcohol Partnerships Blair County Hospitals
Education and Training	Increase the knowledge base on the use of methamphetamine/ fentanyl for the physical health care system.	Improve outcomes for those patients with substance use disorders	Blair Drug and Alcohol Partnerships
Access to Care	Improve access to primary care those individuals with substance use disorders.	Improve both physical and behavioral health outcomes for those patients with substance use disorders	Blair Drug and Alcohol Partnerships Healthcare Providers

Section Eight:
Strategy 3: Mental Health Needs

Findings and Documented Need

Perhaps in part attributed to the pandemic, data from the community health needs assessment clearly indicates that mental health concerns are reflected across all population.

What did everyone say about mental health?

62% greatest community challenge (household survey)
87% greatest community challenge (website household survey)
47% greatest challenge in households
90% greatest community challenge (key informants)
95% greatest community challenge (service providers)
100% greatest community challenge (faith community)
57.1% greatest community health need (healthcare providers)

60% greatest education/prevention need by households
93% greatest education/prevention need (key informants)
86% greatest education/prevention need (service providers)

Table 26: Household Responses to the Impact of COVID-19 Pandemic

Increase in depression, anxiety, social isolation, or other mental health concerns	Yes	No	Sometimes
Household Survey	27%	40%	26%
HBCC Website	58%	18%	22%
WIC	49%	20%	31%
NAMI	57%	14%	29%
Center for Independent Living	100%	0%	0%

In responding to the question “What are the greatest needs regarding health education and prevention services in Blair County”, mental health/depression/suicide prevention was ranked number in every survey.

As part of their interview, healthcare providers ranked mental health services as the top community health need (57.1%). Many believe that mental health services especially for children and adolescents is a critical need (e.g. the awareness of mental health/suicide, the need for an inpatient facility, access to more behavioral health providers, and additional psychiatrists, etc.).

In 2020, 9,097 members were served in behavioral health services (both mental health and substance use disorders) in Blair County. Of those members, 2,427 utilized substance use disorders services with a total expenditures of $10,133,037. Fifty-five percent of the 2,477 members had a opioid use disorder. Total behavioral health expenditures during 2020 was $35,276,985. In 2021, the number of members served increased to 9,385. There were 2,498 utilizing SUD services with 63.1% having an opioid use disorder. Total behavioral health expenditures for that year was $32,473,154.[21]

Blair County residents have an average of 5.2 poor mental health days in the last 30 days which compares to the state at 4.7. The County Health Rankings Report looked at the ratio of the population to mental health providers. This measure represents the ratio of the county population to the number of mental health providers. For Blair County, that ratio was 400:1 as compared to Pennsylvania at 450:1.[22] In addition, Blair County is designated as a Health Professional Shortage Area for mental health care.[23]

Suicide is the tenth-leading cause of death in the United States. It is the fourth-leading cause of death for adolescents ages 15-19 globally. In 2019, there were an estimated 3.5 million people who planned a suicide, 1.4 million suicide attempts and 47,511 deaths by suicide. When someone dies by suicide, as with any cause of death, the loss is felt by many people and even people the deceased did not know.

Mental health and substance use disorders are the most significant risk factors for suicidal behaviors. In addition, environmental factors such as stressful life events and access to lethal means such as firearms or drugs may increase the risk of suicide. Previous suicide attempts and a family history of suicide are also important risk factors. [24] One person every eleven minutes in the United States dies by suicide. The national annual suicide rate is 13.9 per 100,000, 14.8 for Pennsylvania and 13.2 for Blair County. [25]

Table 27: Suicide Statistics in Blair County 2004-2021[26]

	2004	2005	2006	2007	2008	2009	2010	2011	2012
Number of Suicides	25	20	17	20	16	15	14	16	13
Male	21	16	13	17	14	9	9	13	12
Female	4	4	4	3	3	6	5	3	1
Age									
0-15	0	0	0	0	0	1	0	0	0
16-25	4	1	0	5	3	2	4	2	1
26-35	3	2	1	3	2	2	2	2	3
36-45	5	4	7	8	6	6	3	1	3
46-55	7	2	2	3	2	2	1	7	1
55-65	3	6	4	1	2	1	4	1	4
66-75	2	1	1	0	1	1	0	3	0
75 and older	1	4	2	0	1	0	0	1	1

[21] Blair HealthChoices
[22] 2021 County Health Rankings Report for Blair County
[23] Bureau of Health Planning. Department of Health
[24] American Association of Suicidology (2019)
[25] Center for Disease Control (2019)
[26] Blair County Coroner

	2013	2014	2015	2016	2017	2018	2019	2020	2021
Number of Suicides	17	14	27	14	21	22	20	24	30
Male	15	14	24	11	19	20	16	17	22
Female	2	0	3	3	2	2	4	7	8
Age									
0-15	0	0	0	0	1	0	0	0	0
16-25	2	1	4	5	5	4	6	2	4
26-35	4	2	7	2	2	2	1	6	3
36-45	2	2	3	1	4	3	3	2	6
46-55	2	1	4	4	3	6	4	0	8
55-65	5	4	4	0	3	3	3	9	7
66-75	1	0	2	0	1	3	1	2	1
75 and older	1	4	3	1	2	1	2	3	1

In 2021, the HBCC Mental Health Work Group began gathering data to update the 2015 feasibility study to determine whether there was a need for a children/adolescent in-patient facility in Blair County. Between 2017 - 2019, 440 Blair County residents ages 0-18 received in-patient behavioral health care at UPMC Altoona. Another 465 individuals ages 0-18 received in-patient services in one of nine referral facilities located outside of Blair County.

A review of the Student Assistance Program (SAP) implementation in Blair County identified many strengths including the commitment by school districts, funding provided by both mental health and drug/alcohol administrators, willingness of providers to devote resources, and parent permission for SAP services. The number of referrals in the county has increased yearly as districts added elementary SAP teams.[27] However, the lack of credential staff, insurance issues, the lack of an in-patient facility in the county and/or available beds in other facilities, waiting lists, and the impact on workforce shortage were identified as weaknesses in our child/adolescent mental health services system.

The death of friends or family members, personal injury, moving homes, and worrying about having enough food are stressful events that can negatively affect a student's life. In Blair County, 41.9% of students in this county reported the death of a close friend or family member in the past twelve months, compared to 40.3% at the state level. 12.1% of students reported changing homes once or twice within the past 12 months, and 5.7% of students reported being away from parents or guardians because they were kicked out, ran away, or were abandoned.

[27] Pennsylvania Department of Education. Student Assistance Program Data (1996-2021)

Table 28: Summary of Blair County Student Assistance Program Data[28]

School Year	Total Number of SAP Referrals	Number of Referrals for Suicide Ideation, Gestures, or Attempts	Number of Referrals for Suffered Recent Loss
1996-1997	1151	36	-
1997-1998	973	48	-
1998-1999	964	54	-
1999-2000	1023	65	-
2000-2001	1010	43	-
2001-2002	949	44	-
2002-2003	912	35	183
2003-2004	998	37	51
2004-2005	1055	34	73
2005-2006	1008	27	87
2006-2007	1018	19	69
2007-2008	1116	13	57
2008-2009	1206	14	106
2009-2010	1359	22	83
2010-2011	1478	51	96
2011-2012	1358	30	64
2012-2013	1368	33	55
2013-2014	1569	40	63
2014-2015	1647	37	64
2015 - 2016	1767	29	88
2016 - 2017	2050	60	89
2017 - 2018	2352	90	89
2018 - 2019	2224	70	77
2019 - 2020	2149	46	74
2020 - 2021	1716	49	-

(Student Assistance Programs have been established to identify and assist students who may be experiencing problems with school performance or behavior. These problems may be related to mental health concerns, or alcohol and other drug use. The decrease in the number of referrals is most likely due to school closures/remote learning because of the pandemic).

Table 29: Blair County Youth Reporting Symptoms of Depression (2019)[29]

	6th	7th	8th	9th	10th	11th	12th	Overall
In the past year, felt depressed or sad most days	35.9%	-	37.8	-	44.7%	-	42.0%	40.0%
Sometimes I think that life is not worth it	19.7%	-	22.8%	-	28.6%	-	25.8%	24.2%
At times I think I am no good at all	33.2%	-	36.4%	-	41.4%	-	37.9%	37.2%
All in all, I am inclined to think that I am a failure	19.3%	-	24.2%	-	28.1%	-	25.0%	24.1%

Note: The symbol "--" indicates that data is not available because only students in grades 6, 8, 10, and 12 were surveyed as part of the Pennsylvania Youth Survey.

[28] Pennsylvania Department of Education. Student Assistance Program Data (1996 – 2021)
[29] Pennsylvania Youth Survey. 2019 Blair County Survey

As shown in Table 29 above, 40.0% of students felt depressed or sad most days as compared to 30.1 % in 2011. Preliminary data from the 2021 Pennsylvania Youth Survey indicated that on average 30% of students felt so sad or hopeless most days for two weeks or more that they stopped doing some usual activities. Over 17% of students seriously considered suicide in the past year with 14.5% made a plan on how they would attempt suicide.[30]

Bullying and harassment often lead to depression and suicide, especially among young people. Students in Blair County (grades 6, 8, 10, and 12) reported on the 2019 Pennsylvania Youth Survey that 27.3% experienced bullying in the past 12 months (compared to 25.1% of students at the state level).[31] Although not ranked as high as other issues, 53.7% of participants in the household survey considered bullying/ harassment/cyberbullying a major/moderate issue with approximately 33.9% reported having children who were being bullied/harassed/cyberbullied. This was the third highest concerns within their households. Responses generated from the HBCC website had bullying tied as their second highest ranked community challenge at 86.6% and 52.5% reported children being bullied. Responses on bullying concerns from surveys conducted by other organizations ranged from 64.6% - 88.9% as a community challenge. But, within their own households, responses ranged from 44.4% - 100%.

Goals: Mental Health Work Group

- Explore unmet needs and work toward establishing or enhancing programs and strategies to serve children and families more effectively.
- Develop a better understanding of the services available to identify, intervene, and provide treatment to children and adolescents within the county.
- Build awareness of mental health and mental illness in Blair County.
- Increase the capacity for residents and community members to identify whether someone is at-risk for suicide.

Progress and Accomplishments (2018 – 2021)	
Addressing Gaps in Services for Children and Adolescents	Committee members began gathering data to update the feasibility study for a child/ adolescent in-patient mental health facility. Service providers continue to discuss short-term options for youth in lieu of in-patient and how to enhance communications between schools and UPMC Crisis Center based on confidentiality regulations (what information can be shared from crisis so schools know the status of the students who is returning to school).
Student Assistance Program (SAP)	A strategic planning session was held in 2020 and an annual review of data on the implementation of Student Assistance Programs in Blair County schools is conducted. School districts and the UPMC Altoona Foundation provide funding for staff from UPMC Western Behavioral Health of the Alleghenies to facilitate summer support groups for students identified by school SAP teams. Regular meeting were held with local school districts, agency providers, and PNSAS

[30] Pennsylvania Youth Survey. 2021 Preliminary Blair County Survey Results
[31] Pennsylvania Youth Survey, 2019 Blair County Survey

	staff to encourage the fidelity of the SAP model and provide training/ networking opportunities. An analysis was done to explore the need and staffing for year round services.
Columbia Suicide Risk Assessment Tool	The work group developed a training based on the Columbia-Suicide Assessment Tool. The Columbia-Suicide Severity Rating Scale (C-SSRS) supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs. During this time period, there were 5 trainings conducted with 240 school and agency staff attending. Under the leadership of the Blair County Department of Social Services, an app was developed for Blair County as well as nationwide in conjunction with the developers of the program. From April 2019 – March 2022, over 241 individuals accessed the Columbia protocol app.
UPMC Altoona's Mobile Crisis Team	UPMC Altoona's Mobile Crisis Team provides on-site, face-to-face mental health services for individuals and families experiencing a mental health crisis. Over the last three years, the hospital has expanded the program to better meet the needs of its community.

Implementation Plans (2021 – 2024)

Program	Intended Outcomes	Anticipated Impact	Lead Organizations
Develop a Comprehensive Suicide Prevention Strategic Plan	Improve communications, coordination of suicide prevention practices and resource-sharing across systems.	Decrease suicide risk among all ages in Blair County.	Blair County Suicide Prevention Strategic Planning Committee Blair County Department of Social Services
Feasibility study for an inpatient behavioral health facility	Determine the demand and feasibility of establishing an inpatient behavioral health unit for children and adolescents.	Updated assessment of inpatient behavioral health needs in Blair County.	UPMC Altoona Healthy Blair County Coalition's Mental Health Work Group
Access to behavioral health services	Improve service coordination, cooperation, and communications among and between service providers and school districts.	Enhanced communications between mental health providers and local school districts in order to address the needs of children and adolescents in Blair County.	Healthy Blair County Coalition's Mental Health Work Group Blair County Department of Social Services UPMC Altoona Crisis Center Behavioral Health Providers
Community Conversations about Mental Health	Build awareness of mental health and mental illness.	Conduct community conversations about mental health to break down misperceptions of mental illness and promote recovery and healthy communities.	Healthy Blair County Coalition's Mental Health Work Group

Columbia Suicide Risk Assessment Tool	Increase screening efforts/improve screening protocols within organizations to provide a method to identify whether someone is at risk for suicide, assess the severity/ immediacy of that risk, and gauge the level of support that the person needs.	Decrease suicide risk among all ages in Blair County.	Blair County Department of Social Services Healthy Blair County Coalition's Mental Health Work Group Suicide Prevention Strategic Planning Committee Behavioral Health Providers
Student Assistance Programs	Monitor the implementation of Student Assistance Programs	Assure that K-12 students are being identified, referred, and provided services as required by Act 211 and Chapter 12.	Blair County SAP Coordination Team
Summer SAP Support Groups	Increase access to summer support programs.	Provide support during the summer for students who were identified as having school performance and school behavior issues due to substance abuse and/or mental health concerns.	Blair County Student Assistance Programs Blair County Department of Social Services UPMC Western Behavioral Health of the Alleghenies
Develop services and address system issues to meet current service/program gaps.	Expand capacity for child psychiatry and tele-psychiatry Address issues related to insurance and lack of credentialed agency staff Improve reentry procedures and protocols (post care)	Decrease future re-admissions	Blair County Department of Social Services UPMC Western Behavioral Health of the Alleghenies Blair County Behavioral Health Providers
Marketing	Promote and market suicide prevention events, training, resources, etc.	Increase awareness of mental health and suicide prevention in Blair County.	Suicide Prevention Strategic Planning Committee Suicide Prevention Task Force

Section Nine:
Strategy 4: Smoking, Tobacco, and E-cigarettes/Vaping

Findings and Documented Need

According to the County Health Ranking Report, 18.0% of the adult population in Blair County currently smoke. The Healthy People 2030 national health target is to reduce the proportion of adults who smoke to 5.0%. This is an area designated for our county to address in the county health ranking report.[32] More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.[33] Cigarette smoking is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions.

What did everyone say about smoking, tobacco, and e-cigarettes/vaping?

72% greatest community challenge (household survey)
81% greatest community challenge (website household survey)
17% greatest challenge in households
86% greatest community challenge (key informants)
92% greatest community challenge (service providers)
93% greatest community challenge (faith community)

41% greatest education/prevention need by households
48% greatest education/prevention need (key informants)
30% greatest education/prevention need (service providers)

According to the 2019 Blair County Health Profile Report, cancer is the second leading cause of death in Blair County. The rate is 160.4 (per 100,000) which is comparable to Pennsylvania at a rate of 160.0 (per 100,000). The number of mothers in Blair County who report smoking during pregnancy was 19.6% as compared to Pennsylvania at 89%.[34]

E-cigarettes are now the most commonly used tobacco product among youth. In 2021, 2.06 million U.S. middle and high school students used e-cigarettes in the past 30 days, including 2.8% of middle school students and 11.3% of high school students. Among youth who currently used e-cigarettes, 43.6% of high school students and 17.2% of middle school students reported using e-cigarettes on 20 or more of the past 30 days. Also among current users, more than 1 in 4 (27.6%) high school students and about 1 in 12 (8.3%) middle school students who used e-cigarettes used them daily. As of February 2020, there were 2,807 hospitalizations and 68 deaths due to use of these products. High rates of frequent and daily use

[32] 2021 County Health Rankings Report for Blair County
[33] U.S. Department of Health and Human Services
[34] Pennsylvania Department of Health. County Health Profile Report for Blair County (2019)

suggests many teens have a strong dependence on nicotine. In 2018. it is estimated that 8.1 million adults were current e-cigarette users.[35]

In Blair County, 35.2% of students in grade 12 reported vaping/e-cigarette use in the last 30 days (as compared to 28.1% just two years earlier). Vaping substances used by those students ranged from flavoring (43.1%), nicotine (69.7%), marijuana or hash oil (24.4%), and didn't know the substance (5.9%).[36] The use of nicotine and marijuana almost doubled from the previous two years. The amount of nicotine in one Juul pod is equivalent to a pack of cigarettes. Since teens often use multiple pods in one sitting, they can unknowingly become exposed to unsafe levels of nicotine.[37]

Goals: Alliance for Nicotine Free Communities

- Identify and support the implementation of policies and programs that promote a smoke-free community (e.g. smoke-free workplaces, clean indoor ordinances, smoking cessation programs, etc.).
- Educate young people and the community on the dangers of tobacco, nicotine, and e-cigarettes/ vaping.

Progress and Accomplishments (2018 – 2021)	
Healthy Resolutions Expo	A Healthy Resolutions Expo was conducted in order to provide education and encourage residents to sign-up and pledge to work on a healthy resolution. This went beyond the typical health fair by selecting vendors that would engage residents to learn about and commit to a healthy resolution such as getting more exercise, quitting tobacco use, drinking more water, eating healthier, scheduling important preventive health care checkups, etc. Over 100 residents signed pledge cards at the 2019 event.
State Tobacco Control Grant	The Lung Disease Foundation of Central Pennsylvania is the tobacco control grant provider in Blair County. In collaboration with the American Lung Association of Pennsylvania, they offer resources and programs related to tobacco control. From July 2018 to June 2021, 24 smoking cessation classes were conducted with 126 smokers. Two Tobacco resistance Unit (TRU) groups were created and 15 students participated in a Day at the Capital to advocate for tobacco control programs. Staff from the Lung Disease Foundation provided a variety of resources and education presentations to schools, businesses, healthcare providers, social services agencies, community organizations, etc. They also participated in major health fairs and related community events. From 2018 to 2021, Blair County Drug and Alcohol Partnerships provided the Blair County community with 123 presentations that address tobacco issues and 106 individuals completed classes (multiple sessions) that included tobacco education.

[35] Centers for Disease Control. 2021 National Youth Tobacco Survey
[36] Pennsylvania Youth Survey. 2017 Blair County Survey
[37] National Center for Health Research

Vaping/E-Cigarette Initiative	Staff from the Lung Disease Foundation conducted 23 vaping/e-cigarette presentations to 653 students, parents, educators, healthcare providers, social services staff, community leaders, etc. HBCC, the Lung Disease Foundation, and Blair Drug and Alcohol Partnerships developed a Training of Trainers vaping/e-cigarette curriculum for students in grades 6-12. Two trainings were conducted for 17 school and agency personnel. The Lung Disease Foundation secured a grants from the Ronald McDonald Charity and the UPMC Altoona Foundation to purchase 30 vaping sensors to be installed in restrooms and locker rooms at the Hollidaysburg and Altoona Area School Districts. Staff from the Lung Disease Foundations are implementing the Vape Free School Initiative. Trained staff are conducting the InDepth Program which is an alternative to suspension for students caught vaping. They are also offering NOT for those students who want to quit.
Every Smoker, Every Time	Staff from UPMC Partnering for Dental Services received training on integrating nicotine dependence treatment with oral health. The Lung Disease Foundation provided resources to address nicotine use with the dental patients and encouraged them to refer patients to smoking cessation classes.

Implementation Plans (2021 – 2024)

Program	Intended Outcomes	Anticipated Impact	Lead Organizations
Education and Resources	Implement or strengthen tobacco-free policies	Create tobacco-free environments	Lung Disease Foundation of Central Pennsylvania
Smoking Cessations Programs	Increase the number of smoking cessation programs offered in Blair County.	Increase the number of individuals who participate in smoking cessation programs and commit to quitting.	Lung Disease Foundation of Central Pennsylvania
Promote the PA Free Quitline.	Increase the number of individuals who commit to quitting.	Increase the number of individuals who participate in smoking cessations programs and commit to quitting.	Lung Disease Foundation of Central Pennsylvania
TRU Groups	Educate young people about the dangers of tobacco and nicotine addiction and marketing/advertising tactics.	Increase the number of youth who are tobacco and nicotine free.	Lung Disease Foundation of Central Pennsylvania
E-cigarettes and Vaping	Educate the community about the dangers of e-cigarettes and vaping	Decrease the number of youth and adults using e-cigarettes and vaping products. Decrease the number of pregnant women who use nicotine products.	Healthy Blair County Coalition's Alliance for Nicotine Free Communities Lung Disease Foundation of Central Pennsylvania Blair Drug and Alcohol Partnerships

Vape Free Schools Initiative	Implement the InDepth Program to provide an alternative to school suspension for policy violations	Decrease the number of youth and adults using e-cigarettes and vaping products.	Lung Disease Foundation of Central Pennsylvania Local School Districts
Every Smoker, Every Time	Encourage dental providers to implement interventions and promote effective tobacco dependence treatments.	Increase the number of individuals who have early access to smoking cessation programs.	Lung Disease Foundation of Central Pennsylvania
Synar Coverage Study	Conduct annual inspections of tobacco outlets to determine whether outlets are selling tobacco products to individual under age 21.	Reduce the percentage of youth who purchase tobacco products at retail outlets.	Blair Drug and Alcohol Partnerships

Section Ten:
Strategy 5: Poverty

Findings and Documented Need

The underlying causes of the many of challenges identified in the community health needs assessment can be attributed to other circumstances within a community such as social determinants of health (e.g. unemployment, poverty, lack of education, social and cultural issues, housing, transportation, etc.).

What did everyone say about poverty?

56% greatest community challenge (household survey)
84% greatest community challenge (website household survey)
20% greatest challenge in households
88% greatest community challenge (key informants)
95% greatest community challenge (service providers)
80% greatest community challenge (faith community)

27% gap in healthcare for low income persons (key informants)
30% gap in healthcare for low income persons (service providers)
26% gap in healthcare for low income persons (faith community)

Over 20% of households reported that they didn't have enough money to meet daily needs/food and it was as high as 52% in the subgroups (other organizations that conducted the survey).

Table 30: Economic and Social Data for Blair County[38]

Characteristics	Blair County	Pennsylvania
2020 Median Household Income	$50.856	$61,744
2019 Per Capita Income	$29,336	$34,352
2019 Unemployment Rate	4.4%	5.4%
2020 Unemployment Rate	17.7%	15.1%
2021 Unemployment Rate[39]	5.4%	5.4%
Poverty Rate	13.7%	12.2%
Poverty Rate for Children Under 18	19%	17%
Receiving Medical Assistance	27.1% (35,278)	22.1%
Receiving Medical Assistance Under Age 21	11.3%	9.35%
Receiving Food Stamp Assistance	16.5% (20,550)	13.6%
Adults 65 and over Enrolled in PACE[40]	15.2% (3,811 people)	12% (256,219 people)

[38] U.S. Census Bureau 2020
[39] U.S. Bureau of Labor Statistics
[40] PA Department of Human Services

Without Health Insurance	5.1%	5.6%
Without Internet Subscription	17.7%	15.5%

The cost of living in Blair County is 87 (less than Pennsylvania at 96 and the U.S. average at100). The reason Blair County's cost of living is less is due to the lower cost of housing as compared to the rest of the nation. However, Blair County has a higher cost of living when comparing groceries, utilities, transportation, clothing, and other services.[41]

Table 31: Percent of Children Enrolled in Free and Reduced Lunch Programs (2019 – 2020)[42]

School District	Percent of Children
Altoona Area	61.1%
Bellwood-Antis	37.5%
Claysburg-Kimmel	63.9%
Hollidaysburg Area	38.2%
Spring Cove	42.2%
Tyrone Area	46.0%
Williamsburg Community	53.8%

Preliminary data from the 2021 Pennsylvania Youth Survey indicated that on average 22.5% of students were worried about running out of food before their family got money to buy more. Twelve percent reported they skipped a meal because their family didn't have money to buy food.[43]

With regard to childhood obesity across the country, there are significant differences based on household income. In 2019 – 2020, obesity rates ranged from 8.6% among youth in the highest income group to 23.1% among youth in the lowest income group.[44]

When reviewing education indicator data, the high school graduation rate for Blair County is 90% as compared to the state at 87%. However, those earning a bachelor's degree or higher is much less than the state at 31.4% compared to Blair County at 21.3%.[45] The percentage of unserved children eligible for publicly funded Pre-K in Blair County is 53% which is lower than the state percentage of 64%. In 2019-2020, 69% of children ages 3 and 4 (2010 children) were not enrolled in high-quality Pre-K programs[46].

The 2019 SocioNeeds Index is a measure of socioeconomic need that is correlated with poor health outcomes. Table 27 shows the areas of highest need in Blair County. The selected locations are ranked from 1 (low need) to 5 (high need) based on their Index Value.

[41] Altoona Blair County Development Corporation
[42] Pennsylvania Department of Education. Data and Statistics.
[43] Pennsylvania Youth Survey. 2021 Preliminary Blair County Surveys Results
[44] National Survey of Children's Health
[45] American Community Survey
[46] PA Partnership for Children

Table 32: SocioNeeds Index for Blair County Zip Codes[47]

Zip Code	Ranking
16625 - Claysburg	5
16601 - Altoona	5
16602 - Altoona	4
16637 – East Freedom	4
16693 - Williamsburg	4
16673 – Roaring Spring	3
16662- Martinsburg	2
16686 - Tyrone	2
16635 - Duncansville	2
16617 - Bellwood	2
16648 - Hollidaysburg	1

In 2019, child abuse and neglect reports indicate 605 reports of child abuse in Blair County with 75 being substantiated. The total substantiated reports per 1000 children is at 3.0% which is higher than the state percent at 1.8%. In addition, there 2,553 reported concerns of general neglect that resulted in 647 validated. In 2020, the number of child abuse and neglect reports decreased substantially with 490 reports of child abuse in Blair County with 91 being substantiated. However, there is a concern that the decrease probably reflects children not being in school because of the pandemic and remote learning. The number of general protective services for that year was 2,192 and 584 validated.[48] There were 133 children in foster care in Blair County in 2020.[49]

The Center for Child Justice is Blair County's Children's Advocacy Center (CAC). The Center provides a child-friendly, neutral place for the forensic interview and forensic medical evaluation of child victims of abuse, neglect or exploitation. Use of a CAC reduces trauma to child victims by minimizing duplication of interviews and examinations and improves the ability of investigators to uncover facts and evidence. The CAC model is an internationally recognized, evidence-based practice. From 2018 - 2021, there were 530 forensic interviews with 319 interviews for victims of sexual abuse and 133 interviews for victims of physical abuse.[50]

The Victim Services Program of Family Services, Inc. sheltered an additional 95 persons experiencing domestic abuse for a total of 1825 days and assisted 164 individuals fleeing domestic abuse with permanent housing. The program also assisted Blair County victims and survivors of abuse in filing 1,180 Protection Orders such as Protection From Abuse Orders(PFA), Protection from Intimidation Orders (PFI), and Sexually Violent Protection Orders (SVPO). The Victim Services 24/7 Helpline answer 2446 hotline calls during that time, assisting people experiencing domestic abuse, sexual assault, or child abuse.[51]

[47] Conduent Healthy Communities Institute (2019)
[48] Pennsylvania Department of Human Services (2017)
[49] Pennsylvania Partnership for Children 2021
[50] Blair County Center for Child Justice
[51] Family Services, Inc.

According to the 2016-2017 Reach and Risk Report, children in Blair County are at a moderate-high risk of school failure. When children experience risk factors such as living in economically stressed families, poor or no prenatal care for the mother, parents with low educational levels, abuse and neglect, and entering a poorly performing school system, they are more likely to enter school behind, and fail in school. Data shows that 29.7% of children under the age of five live in economically high-risk families. In addition, 12.8% of children in Blair County are born to young, single mothers. Over 39% children were below proficient in English and language arts on the 3rd grade PSSA while 49% were below proficient in math. This data indicates that 6,823 children in Blair County fall into this category.[52]

Between 2015 – 2019, there were 379 teen births in Blair County (less than 19 years of age) and Medicaid was the principal source of payment for 66%[53]

Data taken from the 2021 County Health Rankings Report indicate 7% of people ages 18-64 in Blair County are without health insurance which is comparable to Pennsylvania.[54] Without health insurance, people do not have the means to pay for office visits, diagnostic tests, or prescription medications. The result is often no treatment, overall poor health, or inappropriate emergency room use. In 2019, there were 1,973 children in the county receiving health coverage through the Children's Health Insurance Program (CHIP). In addition, 11,805 low-income children receiving health coverage through Medical Assistance (MA).[55] Eighteen percent of the Blair County population lives in a HRSA-designated Medically Underserved Area (MUA).[56]

Homelessness and affordable housing have continued to be a significant concern in the county. In 2017-2018, Blair Senior Services provided 975 consumers emergency help through rental assistance, motel stays, and utility payments. Blair County Community Action assisted 162 households who were homeless or in danger of becoming homeless and Family Services served 177 individuals in their homeless shelter, turning away 366 due to lack of available beds. The Family Services Victim Services Program sheltered an additional 39 persons and assisted 15 with permanent housing. There has been an increase in rental opportunities in Blair County but not those that are affordable for low to moderate income households and the wait list for access to subsidized housing continues to be two years or longer. Employment in the area has increased but mostly in the service industry with jobs that provide no benefits or a livable wage for families.[57]

Community resilience is the capacity of individuals and households to absorb and recover from the health, social, and economic impacts of a disaster such as the pandemic. Risk factors from the 2019 American Community Survey include: income to poverty ratio, communications barriers, disability, unemployment, no health insurance, age 65+, no vehicle access, no broadband internet access, etc. For Blair County, 39.1% of the population had no risk factors. However, 38.6% had one-two risk factors and 22.3% had three or more. This equates to over 73,500 residents.[58]

[52] Pennsylvania Office of Child Development and Early Learning Program Reach and Risk Report
[53] Pennsylvania Department of Health
[54] 2021 County Health Rankings Report for Blair County
[55] Pennsylvania Department of Public Welfare
[56] UPMC Altoona
[57] Family Services, Inc.
[58] 2019 American Community Survey

Goals: Pathways of Opportunity Network & Healthy Foods Sub-Committee

- Identify and address issues related to poverty in Blair County as well as provide training and increase awareness of the impact of poverty on children and families.
- Address food insecurity and promote eating healthy foods in collaboration with community partners.

Progress and Accomplishments (2018 – 2021)	
Poverty Simulations	A sub-committee sponsored a Poverty Simulation for 50 participants and volunteers.
Rural Impact County Challenge (housing)	HBCC was invited to apply for a second Rural Impact County Challenge in cooperation with the National Association of Counties (NACo) and Robert Wood Johnson's County Health Rankings and Roadmaps. We were one of twelve counties across the country chosen to focus on strategies to improve housing, the built environment, and health. The Blair County Team participated in several webinars and two on-site visits with a coach. This initiative provided an opportunity for networking with other communities on best practice for addressing housing needs.
Center for Independent Living of South Central PA (CILSCSPA)	Operation Five Loaves (O5L) was a program started in April 2020 after a study showed a service gap in food security for individuals who did not have easy access to food distribution sites due to lack of transportation, physical limitations, or fear of leaving their homes due to the covid-19 pandemic. The program was created to address nutrition insecurity, especially for individuals with disabilities. Each box of food that was delivered was an opportunity for CILSCPA to connect with individuals and help them to improve their immunity and wellness. At each delivery, individuals were provided food, recipes, and information about food safety. After a drop off, the individual could choose to provide his/her information, and a follow up was made to provide education on how to connect to local food pantries and food banks. Another outcome of O5L was a collaboration with Altoona Family Physicians and the UPMC Altoona Dental Clinic. Community volunteers distributed boxes of food at the Diabetes and Dental Clinics. Patients were offered these boxes filled with fresh produce. Opportunities were offered that included discussions about the effects of healthy food choices and good nutritional practices on patient's overall health. This program also helped to address social isolation because it allowed employees at CILSCPA to connect with individuals receiving food and invited them to participate in other activities, such as weekly zoom calls featuring a variety of guests, educational topics and events designed to offer opportunities to engage with others in the community. Additionally, every individual participating in O5L received a wellness check twice a month, at minimum. The individuals who benefited from this program included people with disabilities, especially those who identify as older adults and those who are economically underserved. Over 400 Blair County families were served during this program.

UPMC Altoona Partnership for Healthy Community Dental Clinic	UPMC Altoona's Partnership for a Healthy Community which provides dental services for income-eligible children and adults: In 2019, there were 4,394 adult patients and 2,989 pediatric patients seen. In 2020, there were 2,939 adult patients and 1,680 pediatric patients seen. There was a 30-32% decrease in patients seen related to COVID-19. From April – October 2019, there were 3,725 adult patients and 1,925 pediatric patients seen. The dentist from UPMC Dental Clinic had conducted exams/fluoride varnishes at the largest Head Start Center which resulted in a 25% increase in screenings for that agency. However, strict COVID-19 protocols prohibited continuation of services.

Implementation Plans (2021 – 2024)

Program	Intended Outcomes	Anticipated Impact	Lead Organizations
Food for Life Initiative*	Address food insecurity and promote eating healthy foods in collaboration with community partners.	Increase the number of individuals who have access to healthy foods.	Center for Independent Living in South-Central PA Altoona Family Physicians Partnering for Dental Services
Community Produce Cookbook	Provide individuals with simple and healthy recipes for the specific produce they are receiving	Increase knowledge of how to properly prepare and store produce, therefore increase vegetable consumption.	Penn State Altoona: Community-Based Studies Healthy Blair County Coalition St. Vincent de Paul Monastery Gardens
Nutrition Security of Backpack Program	Assess nutritional value of food provided to students through the backpack program and increase knowledge of more nutritious alternatives	Increase the nutritional quality of donated items	Penn State Altoona: Community-Based Studies
Patient Navigators	Provide patients with information on resources for social determinants of health such as food, housing and transportation	Increase patient knowledge of local resources so that they know where to go and who to contact for services they need.	Penn State Altoona: Community-Based Studies Altoona Family Physicians

* Was formerly called the Healthy Foods Sub-Committee

Section Eleven:
Strategy 7: Youth Connections

This strategy was developed when Blair County was one of twelve counties from across the country chosen by the National Association of Counties (NACo) in partnership with the Robert Wood Johnson Foundation County Health Rankings & Roadmaps Programs to receive community coaching on efforts to reduce childhood poverty with an emphasis on youth connections. A Rural Impact County Coaching Team was created (now called the Youth Connection Task Force).

What did everyone say about youth disconnections?

46% greatest community challenge (household survey)
66% greatest community challenge (website household survey)
63% greatest community challenge (key informants)
65% greatest community challenge (service providers)
53% greatest community challenge (faith community)

30% youth not attending school (household survey)
66% youth not attending school (key informants)
69% youth not attending school (service providers)
33% youth not attending school (faith community)

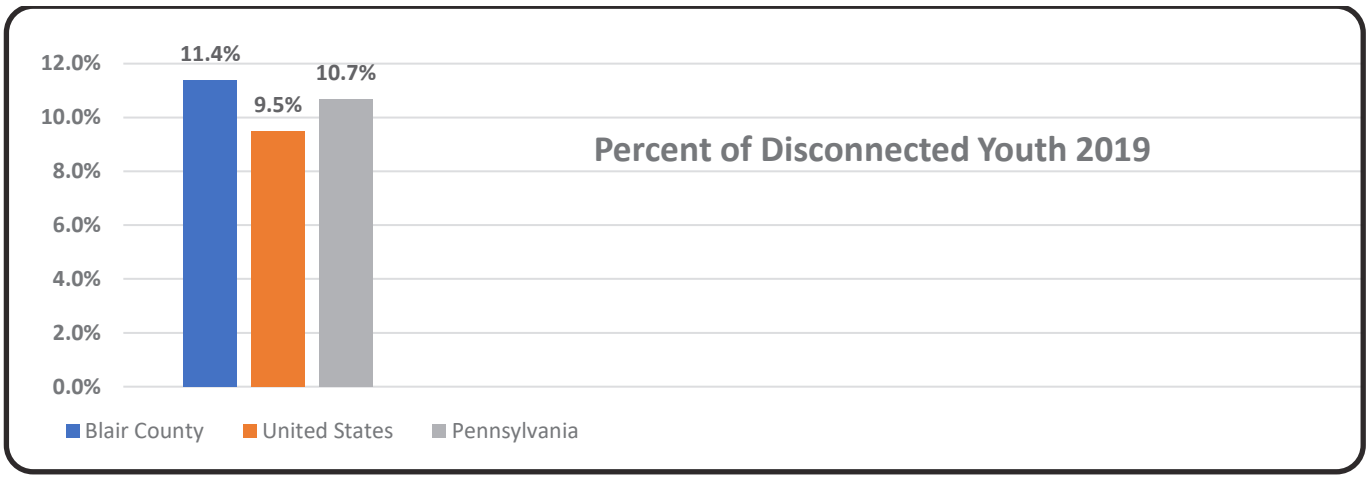
58% shortage of activities for youth (household survey)
71% shortage of activities for youth (key informants)
70% shortage of activities for youth (service providers)
73% shortage of activities for youth (faith community)

Based on the most recent Measure of America Report, 10.7% of youth and young adults ages 16-24 across the country are not in school or working. In Pennsylvania, that number was 9.5%. These young people are cut off from the people, institutions, and experiences that would otherwise help them develop the knowledge, skills, maturity, and sense of purpose required to live rewarding lives as adults. And the negative effects of youth disconnection affect the economy, social sector, criminal justice system, and the political landscape. Disconnected young people are more than three times as likely to have a disability of some kind.

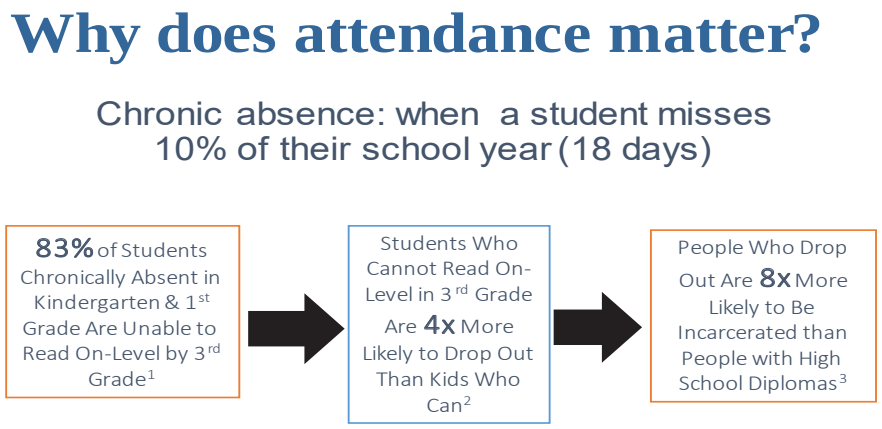
The data for Blair County indicates that over 1400 youth and young adults (11.4%) are disconnected from school, the workforce, and our community. Overall, there was a decline in youth disconnection rates since 2015; however, it clear that the COVID-19 pandemic will erase these gains and cause the 2020 youth disconnection rate to spike even higher.[59] From 2018 – 2021, there were 243 runaways in Blair County.[60]

[59] Measure of America of the Social Science Research Council Attendance Works
[60] Police Uniform Crime Reports

Chart 1: Percent of Disconnected Youth



Nationwide about 7.5 million students miss nearly a month of school each year and 7,000 students drop out every day in our country about 1.2 million a year. Students from communities of color as well as those with disabilities are disproportionately affected. This isn't simply a matter of truancy or skipping school. Many of these absences, especially among our youngest students, are excused. Often absences are tied to health problems, such as asthma, diabetes, and oral and mental health issues. Other barriers including lack of a nearby school bus, a safe route to school or food insecurity make it difficult to go to school every day. This isn't just a problem in high school, this starts as early as preschool and is very prevalent among kindergarten students.[61]



Currently in the Blair County Prison, there are 291 people incarcerated and 79 did not graduate from high school or obtain a GED (27%). 130 individuals did complete their GED, 66 completed high school, and

[61] Attendance Works

another 16 have additional education beyond high school[62] High school dropouts account for 67% of inmates in state prisons and 56% of federal prisons.[63] A dropout will cost taxpayers $292,000 over a lifetime due to the price tag associated with incarceration and other factors such as how much less they pay in taxes.[64]

Goals: Youth Connection Task Force

- Build public awareness about the need to address truancy and chronic absenteeism by fostering partnerships across systems to improve school engagement and expand the use of best practices.
- Enhance collaboration and communications among organizations that can provide pathways of opportunity for youth and young adults.
- Understand the impact of bullying and support bullying prevention efforts.

YOUTH CONNECTION
It's our community's future.
AN INITIATIVE OF HEALTHY BLAIR COUNTY COALITION

Progress and Accomplishments (2018– 2021)	
Marketing and Awareness of Youth Disconnection	The following materials were developed and distributed: • An infographic • A series of eight podcasts • Youth Connection logo • Youth Connection brochure • The **Blair County Youth Connection Facebook** page which has 199 followers posts events and activities.
School Attendance and Truancy	The School Attendance Task Force met monthly to address the challenges associated with chronic absenteeism and truancy. Accomplishments included the following: • Developed a marketing plan to support and encourage school attendance. • Communicated with the medical community on health and school attendance, including the need to decrease unnecessary medical excuses. • Enhanced communications between School Districts, Blair County Children, Youth, and Families, and the Truancy Court by reviewing policies and procedures related to school attendance and truancy. • Supported and assisted in the implementation of the Be There School Attendance Challenge and Be There Buddy mentoring Program.
Be There School Attendance & Be There Buddy Mentoring Program	In collaboration with the United Way of Blair County and the School Attendance Task Force, Blair County adapted the Be There Program (developed by the United Way of Southwestern Pennsylvania). A training was held for 65 school and agency representatives. The following materials were developed and distributed: • Be There School Attendance Challenge Toolkit

[62] Blair County Prison (2022)
[63] Public School Review
[64] Northwestern University

	• Be There Mentoring Program Toolkit • Be There posters with all Blair County school district logos • Be There videos (one for adults and one representing students in all Blair County school districts) • Student Pledge cards • Parent Tip cards • Two Healthcare Provider posters (one for families and one for providers)
Workforce Development	As a result of the Workforce Development Committee, several organizations were willing to commit funds to provide employment opportunities for at-risk students and several businesses provided co-op and/or job shadowing opportunities. As a result of the collaboration, youth and young adults have been connected with and/or obtained employment through CareerLink in the Tyrone Area School District, Altoona Area, and Teen Center.
Robert Wood Johnson Foundation Collaborative Learning Grant	HBCC applied for and secured a $20,000 Robert Wood Johnson Foundation grant to support replication of the Graduation Initiative (GI) Program. This program began by identifying students in the Tyrone Area School District who were at risk of dropping out but had potential if the school/community provided academic and/or behavioral support to them and their families. Building on the success of that program,, the Central Pennsylvania Graduation Initiative and Blair Family Solutions (mental health service provider), led efforts to replicate the program in the Altoona Area School District. Specific activities included training of the GI team, training staff, development of materials, direct funding to support youth involved in the program, and conducting a Youth Connection Summit for community leaders and stakeholders. With funding from the grant, a Standard Operating Procedures (SOP) document was developed for initiating, implementing, and monitoring the GI Program in other interested school districts.
TEAM Builders	The Center for Independent Living in South-Central PA (CILSCSPA) was one of six sites worldwide to adapt the Olweus Bullying Prevention Program as an out of school time program, TEAM Builders. This bullying prevention experience is a collaboration with Dorman's Sports Performance and CILSCPA. Participating Blair County youth meet in the gym and are offered time to physically work out and get some great exercise. Afterward, certified staff offer a brief activity that promotes good citizenship, social and developmental growth, and skills to build relationships. To date, over 80 youth have participated in the TEAM Builders Program. The overall health of the participants is notable. On the physical side, physicians and health care professionals have stated at annual appointments that their "young patients are stronger and developing good habits". These young people have also indicated that they feel "stronger and more confident" in their relationships with others. Guidance counselors have shared with staff that they "have noticed small changes with decision making and increased rates of positive actions".

Implementation Plans (2021 – 2024)			
Program	**Intended Outcomes**	**Anticipated Impact**	**Lead Organizations**
Youth Connection Summit 2	Obtain feedback from stakeholders regarding current challenging facing youth in our community.	Increase opportunities for youth	Healthy Blair County Coalition's Youth Connection Task Force
Be There Attendance Challenge & Be There Mentoring Program	Implement an attendance challenge in Blair County schools. Identify and establish positive and caring relationships with students who are at risk of being chronically absent.	Decrease in chronic absenteeism.	United Way of Blair County Healthy Blair County Coalition Youth Connection Task Force Blair County Chamber of Commerce BASIC Youth Attendance Committee School Districts
Resource Directory	Develop an up-to-date Resource Directory to enhance awareness of programs and services for children and youth.	Increase in access to programs and services.	Healthy Blair County Coalition's Youth Connection Task Force Local Interagency Coordinating Council (LICC)
Workforce Development	Enhance collaboration and communications among organizations that can provide pathways of opportunity for youth people	Increase the number of at-risk youth and young adults that have access to employment and/or career services.	CareerLink Blair County Chamber of Commerce BASIC Youth Attendance Committee
Bullying Prevention	Develop and conduct training and presentations for after-school and youth serving organizations to incorporate bullying prevention into their program.	Decrease incidents of bullying/harassment/cyber bullying among youth.	The Center for Independent Living in South-Central PA Healthy Blair County Coalition
TEAM Builders	Continue and/or expand the out of school time bullying prevention program.	Decrease incidents of bullying/harassment/cyber bullying among youth.	The Center for Independent Living in South-Central PA

Section Twelve: Implementation

Action Steps toward Implementation

The following action steps toward implementation of strategies will be taken by the Healthy Blair County Coalition, UPMC Altoona, Conemaugh Nason Medical Center, Penn Highlands Tyrone and community partners:

1. The Steering Committee will provide each work group or other entity with a specific charge, including outlining goals and general timeline based on IRS 990 requirements for the implementation of interventions.

2. Based on survey results and secondary indicator data, the following work groups will research, select, and implement programs/activities to address their strategy, including determining a target population, funding needed, and a timeline. In certain areas, the work group will continue and/or expand current initiatives.

    - Let's Move Blair County Committee
    - Substance Use & Physical Health Coalition
    - Mental Health Work Group
    - Alliance for Nicotine Free Communities
    - Youth Connection Task Force
    - Food for Life Initiative
    - Farm to ECE Collaborative

3. The work group will gather baseline data and select one or two outcome measurements that will be used to measure outcomes.

4. Each of the three hospitals as part of the Healthy Blair County Coalition will develop, measure, and monitor outcomes and impact as a result of the CHNA.

Resources and Support from Hospitals

UPMC Altoona is, and has been, an active member of the Healthy Blair County Coalition and will continue to provide financial support for the Coalition. In addition, representatives of UPMC Altoona have been members of the Steering Committee and various work groups/committees. UPMC Altoona has provided a variety of in-kind services such as meeting space, designing and printing of documents, printing of the household survey, marketing, etc. UPMC Altoona plans to commit the necessary staff, financial support, staff time and coordination of strategies to ensure successful implementation of the strategies, programs, and services. Additionally, they will provide all the educational material that will be used for the programs.

Conemaugh Nason Medical Center is, and has been, an active member of the Healthy Blair County Coalition and various work groups/committees. As needed, Conemaugh Nason Medical Center has provided sponsorships for specific HBCC events plans. They plan to commit the necessary staff, financial support, staff time and coordination of strategies to ensure successful implementation of the strategies, programs, and services. The hospital will provide all the educational materials that will be used for the programs.

Penn Highlands Tyrone is, and has been, an active member of the Healthy Blair County Coalition and will continue to provide financial support for the Coalition. In addition, representatives of Penn Highlands Tyrone have been members of the Steering Committee and various work groups/committees. The hospital plans to commit the necessary staff, financial support, staff time and coordination of strategies to ensure successful implementation of the strategies, programs, and services. They will provide all the educational materials that will be used for the programs.

Partnering with Other Organizations to Address Identified Needs

In addition to the above-identified health needs that will be specifically addressed by UPMC Altoona, Conemaugh Nason Medical Center, and Penn Highlands Tyrone, each of the three hospitals will as part of the Healthy Blair County Coalition work with other coalition members to address other identified needs. Those organizations are identified in the implementation plans under each strategy. Blair County is fortunate to have many other organizations that will continue to address challenges that are beyond the scope and resources of the Healthy Blair County Coalition and/or the hospitals.

Additional Comments or Implementation Plans

Since 2011, HBCC has maintained a **poverty work group** (Bridges Network and then the Pathways of Opportunity Network) to address poverty because it was identified as a significant community challenge in the CHNA. Over that time period, partnerships have been formed and many activities were conducted. Various community organizations are addressing issues related to poverty, including social determinants of health. Groups are meeting to address food insecurity, others are conducting poverty simulations, and there is a group looking specifically at a shelter for the homeless. Given all of the work these different groups are doing, the HBCC steering committee agreed that it is time to discontinue the Pathways of Opportunity Network.

Dental care was identified as one of the gaps in health services on the CHNA so a Dental Care Work Group was created in 2016. As a result of this work group, partnerships were formed that increased access to dental care especially for children. We will continue to promote oral health initiatives but the HBCC steering committee agreed that there isn't a need for an ongoing work group.

There were two challenges in this community health needs assessment that were identified as major/ moderate challenges in all surveys conducted. The first is **overuse/addiction to cell phone, social media, internet, etc.** This issue ranked first in the household survey (76.8%). An analysis based on geographic

areas indicated that residents in northern and central Blair County also responded that it was a major/ moderate issue with similar rankings and percent. Those responding to the survey on our website ranked it lower than other challenges but still at 81.4%. Responses form other organizations ranged from 68% - 89%. It was also a concern for key informants (78.8%), service providers (91.6%), and the faith-based community (86.7%) as a major/moderate issue.

When deciding how to prioritize our needs and strategies, we considered the extent of the problem, the capacity to address the problem, the ability to have a measurable impact, and existing interventions within our community. Based on those conditions, the HBCC Steering Committee determined that our ability to impact overuse/addiction to cell phone, social media, and internet would be limited. However, we can provide education programs to at least enhance the awareness of the dangers associated with overuse and misinformation. Therefore, we will explore options for community education programs in 2022.

The second challenged was **impaired/distracted driving (driving under the influence, texting, road rage, etc.)** which ranked fourth with 74% of respondents in the household survey identifying it as a major/moderate issue. An analysis based on geographic areas indicated that residents in northern, central, and southern Blair County also responded that it was a major/moderate issue with similar rankings and percent. Impaired/distracted driving (DUI, texting, road rage, etc.) was identified by key informants (71.4%), service providers (81.1%), and the faith-based community (86.7%) as a major/moderate challenge. It was not a significant concern for those responding from other organizations.

In 2020, there were 38,824 fatal crashes in the United States which was a 6.8 % increase from the previous year. The estimated number of people injured on our roadways 2.28 million. There were 3,142 fatal crashes that occurred on U.S. roadways in 2019 that involved distraction (9% of all fatal crashes). Nine percent of drivers 15 to 20 years old involved in fatal crashes were reported as distracted. This age group has the largest proportion of drivers who were distracted at the time of the fatal crashes. In 2019 there were 566 non-occupants (pedestrians, bicyclists, and others) killed in distraction-affected crashes. Almost eight percent of all drivers at any given time are using their phones while driving.[65]

In 2019, there were 13,776 distracted driver crashes in Pennsylvania, resulting in 62 fatalities. Preliminary data for 2021 shows deaths increased by as much as ten percent.[66] In Pennsylvania all drivers are prohibited from texting while driving, which includes sending, reading or writing a text-based message or e-mail, and from wearing or using headphones or earphones while the car is in motion.

The HBCC Steering Committee discussed the Coalition's ability to impact this issue and decided that there are already national and state campaigns and resources to address driving under the influence, distracted driving, etc. Therefore, we will support those initiatives but will not establish a work group or specifically address this strategy

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[65] National Highway Traffic Safety Administration
[66] Pennsylvania Department of Transportation 2017

Section Twelve:
Blair County Indicator Data

By collecting and analyzing indicator data, the Data Analysis Work Group was able to review strengths and issues related to many other areas. The intent was also to determine if the statistics supported or did not support the perceptions of key informants and the general public. For the purpose of this report, data related to the identified priorities have been summarized within each section. In lieu of providing other data in this section, readers are directed to the Healthy Blair County Coalition's website. On the home page, there is a tab for Blair County Data which includes the following:

County Health Rankings Reports (2010 – 2021)
County Health Profiles (1998 – 2019)
PA Office of Rural Health Population Health Data for Blair County

The Robert Wood Johnson Foundation County Health Rankings measures two types of health outcomes (mortality and morbidity). These outcomes are a result of a collection of health factors and health behaviors. The County Health Rankings are based on weighted scores of seven types of factors: health outcomes, quality of life, health factors, health behaviors, clinical care, social and economic, and physical environment. In the 2021 report, Blair County ranked 39 out of 67 counties (one being the healthiest and 67 being the unhealthiest county). Criteria may change slightly from year to year as some indicators are added or deleted, data sources may be different, and how another county does can affect another's ranking. Regardless of those factors, Blair County's health ranking impacts quality of life, outlook for families, demand for health care, and workforce and economic stability. A complete summary of County Health Rankings indicator trends for Blair County from 2010 – 2021 is included in Appendix C.

The Blair Planning Commission participated in a Comprehensive Plan for the Southern Alleghenies Region in 2018.[67] The plan includes information, data, and priorities for broadband and cell phone, collaboration and coordination, agriculture, housing and blight, and public health and safety. Specific action items under public health and safety include:

- Develop a mobile farm market/coop to bring locally grown healthy food to county residents.
- Explore with law enforcement to develop a regional mobile prescription drug take-back/collection program.
- Complete a county active transportation plan or bicycle and pedestrian master plan.
- Develop model land development regulations and public health policies.
- Markey, promote and preserve local trails, pedestrian routes/facilities, and other recreational destinations/facilities.
- Ensure the sustainability of the Healthy Blair County Coalition and its efforts.

[67] Alleghenies Ahead: Comprehensive Plan for the Southern Alleghenies 2018

Section Fifteen:
Charge to the Community

This community health needs assessment confirmed that Blair County has many assets, including community leaders, businesses, service providers, community organizations and individuals. Those individuals who took time to complete the surveys and those who dedicated many hours as members of the Healthy Blair County Coalition are some of what makes Blair County a great place to live. But there are significant challenges, many of which are impacting the quality of life and health of our local community and the nation.

Our goal is to promote healthy living through community interventions that result in the improvement of social, economic, and environmental factors. The County Health Rankings Model describes population health and emphasizes that if other factors are improved, communities can be healthier places to live, work, and play (Appendix B). The challenge is to motivate community leaders and citizens to use this information to understand the issues and to work collaboratively toward resolving them.

We will continue to utilize the "collective impact" concept as we move forward in which a highly structured collaborative effort can achieve a substantial impact on large scale social problems.[68]

Figure 13: Collective Impact Model

The five conditions for collective impact are:

- A common agenda
- Shared measurement
- Mutually reinforcing activities
- Continuous communications
- Backbone support

[68] Stanford Social Innovation Review: Channeling Change: Making Collective Impact Work 2012

This is our fifth community needs assessment and we will use the information contained in this report to continue the progress that has been made thus far. Individuals and organizations from Blair County will be invited to hear the results of the community health needs assessment and join the Healthy Blair County Coalition and the 161 community partners in developing and assisting with the Implementation Plan.

Once again, we thank everyone who was involved in the community health needs assessment process and welcome those who are willing to work on improving their community.

For those who want electronic access to the information contained in this report, please visit the website of the Healthy Blair County Coalition (www.healthyblaircountycoalition.org). This report is also posted on the three participating hospital websites.

Appendices

Appendix A: Household Cover Letter and Survey

Appendix B: County Health Rankings Model

Appendix C: Matrix of Priority Issues and Supporting Data/Survey Results

Appendix D: 2010 – 2021 Blair County Health Rankings

Appendix A: Household Cover Letter and Survey

Dear Neighbor:

As part of the effort to build a healthier community in Blair County, we are conducting a Household Survey in collaboration with our partners listed below to learn more about strengths and issues in neighborhoods and households. We believe your insights will help improve all aspects of a healthy Blair County (e.g. social, economic, physical, emotional, etc.). The results of your survey as well as others will provide us with information on what you think is most important so our work groups can develop programs and activities that are most beneficial.

Your address has been randomly selected and there is no way to identify you or your household when the survey is returned. We would like an adult (18 years of age or older) in your household to complete this survey and return in the enclosed self-addressed stamped envelope as soon as possible, but no later than **July 15, 2021.**

When you are completing this survey, please keep in mind:
Community means your municipality, township, borough, or city.
Household means members of your family and others living in your house.

Your participation will help ensure that this is a successful effort. Thank you in advance for your support in making this a better community.

Instead of mailing the survey back, you may go to the link below and complete the survey on the internet through Survey Monkey. Again, there will be no way to track who completed the survey.

https://www.surveymonkey.com/r/SHXNQHR

If you have questions or need more information, please call Coleen Heim, Director of the Healthy Blair County Coalition (HBCC) at 814-317-5108 ext. 305. To learn more about the HBCC, visit our website at www.healthyblaircountycoaliton.org or our Facebook page.

Sincerely,
Coleen Heim, Director
Healthy Blair County Coalition

***Household Survey* – Start Here**

A. COMMUNITY STRENGTHS, CHALLENGES, AND ISSUES

Communities have strengths that help people make their community a better place to live. Here is a list of common strengths. For each one, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree that the strength exists in your community.

CHECK ONE NUMBER IN EACH ROW.

1. Community Strength	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	No Opinion/ Don't Know
1a. People in your community gather together formally or informally (for example at picnics or meetings).	❑1	❑2	❑3	❑4	❑5
1b. People and groups in your community help each other out when they have a problem.	❑1	❑2	❑3	❑4	❑5

2. What are the best things about where you live in Blair County? **CHECK ALL THAT APPLY.**

❑1 Close to parks, recreation, and sports
❑2 Close to library/cultural activities
❑3 Quiet
❑4 Close to bus stops/lines
❑5 Variety of people
❑6 Near highway access
❑7 Affordable housing
❑8 Friendly neighbors
❑9 Close to grocery stores/shopping
❑10 Places of worship
❑11 Close to work
❑12 Opportunity to volunteer
❑13 Good schools
❑14 Low crime/safe place to live
❑15 Good sidewalks/places to walk
❑16 Family friendly/good place to raise kids
❑17 Close to physician and medical facilities
❑18 Other _____

3. What are the worst things about where you live in Blair County? **CHECK ALL THAT APPLY.**

❑1 Crime/not feeling safe
❑2 Issues with housing
❑3 Traffic/speeding cars and trucks
❑4 Youth with nothing to do
❑5 No opportunity to volunteer
❑6 Dirt, trash, and litter
❑7 Too many rental properties/changing renters
❑8 Not enough police coverage
❑9 Not enough activities in neighborhood
❑10 Poor street lighting
❑11 Roads and/or alleys in need of repair
❑12 Drug use/abuse
❑13 Far from schools, stores, medical facilities, libraries, grocery stores
❑14 Too many bars
❑15 Too many fast-food restaurants
❑16 Racism, prejudice, hate, discrimination
❑17 Lack of regional public transportation
❑18 Other _____

4. Do you vote in most elections? **CHECK ONE.**

❑1 Yes ❑2 No

5. I feel that I have an opportunity to affect how things happen in my community. **CHECK ONE.**

❑1 Strongly agree ❑2 Agree ❑3 Neutral ❑4 Disagree ❑5 Strongly Disagree

---

People experience challenges and issues sometimes in the community where they live. Here is a list of common issues. For each one, please describe whether you believe it is not an issue, is a minor issue, is a moderate issue or is a major issue for **people in your community (e.g. township, borough, or city).**

CHECK ONE NUMBER IN EACH ROW.

Community Issue ECONOMICS	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Unemployment or under-employment	❑1	❑2	❑3	❑4	❑5
Poverty/lack of adequate income	❑1	❑2	❑3	❑4	❑5
Lack of jobs	❑1	❑2	❑3	❑4	❑5
Lack of qualified employees	❑1	❑2	❑3	❑4	❑5

Community Issue EDUCATION	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Children not being adequately educated	❑1	❑2	❑3	❑4	❑5
Violence (e.g. weapons, fighting, etc.)	❑1	❑2	❑3	❑4	❑5
Bullying/harassment/cyberbullying	❑1	❑2	❑3	❑4	❑5
Use/availability of alcohol and other drugs in school, including nicotine and vaping	❑1	❑2	❑3	❑4	❑5
Students not regularly attending school (truancy)	❑1	❑2	❑3	❑4	❑5
Lack of affordable post high school opportunities (college, community college, technical school, etc.)	❑1	❑2	❑3	❑4	❑5
Youth disconnection (not in school or working)	❑1	❑2	❑3	❑4	❑5

Community Issue ENVIRONMENTAL	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Loss of farmland	❑1	❑2	❑3	❑4	❑5
Poor water quality	❑1	❑2	❑3	❑4	❑5
Dumping and littering	❑1	❑2	❑3	❑4	❑5

Lack of availability of recycling	❑1	❑2	❑3	❑4	❑5

Community Issue HEALTH	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Alcohol and/or drug abuse	❑1	❑2	❑3	❑4	❑5
Smoking, tobacco, and use of e-cigarettes/vaping	❑1	❑2	❑3	❑4	❑5
Adults with mental illness or emotional issues	❑1	❑2	❑3	❑4	❑5
Children with mental illness or emotional issues	❑1	❑2	❑3	❑4	❑5
Diabetes	❑1	❑2	❑3	❑4	❑5
Obesity	❑1	❑2	❑3	❑4	❑5
Heart Disease	❑1	❑2	❑3	❑4	❑5

Community Issue HOUSING	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Shortage of affordable housing	❑1	❑2	❑3	❑4	❑5
Substandard housing	❑1	❑2	❑3	❑4	❑5
Lack of housing for people with disabilities	❑1	❑2	❑3	❑4	❑5
Lack of housing options (young families, elderly, professionals, downsizing, etc.)	❑1	❑2	❑3	❑4	❑5

Community Issue LEISURE ACTIVITIES	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Shortage of recreational venues (parks, trails, swimming, etc.)	❑1	❑2	❑3	❑4	❑5
Lack of cultural activities (concerts, plays, festivals, etc.)	❑1	❑2	❑3	❑4	❑5
Shortage of activities for youth	❑1	❑2	❑3	❑4	❑5

Community Issue SAFETY	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Crime	❑1	❑2	❑3	❑4	❑5
Gun violence	❑1	❑2	❑3	❑4	❑5

Family violence, abuse of children, adults, or the elderly	❑1	❑2	❑3	❑4	❑5
Impaired/distracted driving (driving under the influence, texting, road rage, etc.)	❑1	❑2	❑3	❑4	❑5

Community Issue SOCIAL	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Teen pregnancy	❑1	❑2	❑3	❑4	❑5
Discrimination/bias	❑1	❑2	❑3	❑4	❑5
Gambling	❑1	❑2	❑3	❑4	❑5
Lack of affordable daycare for children	❑1	❑2	❑3	❑4	❑5
Homelessness	❑1	❑2	❑3	❑4	❑5
Suicide	❑1	❑2	❑3	❑4	❑5
Overuse/addiction to cell phone, social media, internet, etc.	❑1	❑2	❑3	❑4	❑5
Pornography	❑1	❑2	❑3	❑4	❑5

Community Issue TRANSPORTATION	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Inadequate public transportation	❑1	❑2	❑3	❑4	❑5
Poor road and/or traffic conditions	❑1	❑2	❑3	❑4	❑5

Are there other issues in the community that are not listed?

_____

_____.

B. HOUSEHOLD CHALLENGES AND ISSUES

Here is a list of questions about challenges and issues for which people and families often look for help. These challenges and issues affect people of all ages. The questions ask whether any one of the following has been a challenge or an issue for you or anyone **IN YOUR HOUSEHOLD over the past 12 months**. If it has been a challenge or an issue, please describe it as either a minor issue, moderate issue, or major issue.

CHECK ONE NUMBER IN EACH ROW.

Household Issue ECONOMICS	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Not having enough money for daily needs, food, heat, electric, etc.	❑1	❑2	❑3	❑4	❑5
Not being able to find work	❑1	❑2	❑3	❑4	❑5

Household Issue EDUCATION	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Children not being adequately educated within their school system	❑1	❑2	❑3	❑4	❑5
Children being unsafe at school (e.g. weapons, fighting, etc.)	❑1	❑2	❑3	❑4	❑5
Children being bullied/ harassed/cyberbullied	❑1	❑2	❑3	❑4	❑5

Household Issue HEALTH	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Having a lot of anxiety, stress, or depression	❑1	❑2	❑3	❑4	❑5
Experiencing an alcohol and/or drug issue	❑1	❑2	❑3	❑4	❑5
Negative effects of smoking, tobacco use, e-cigarette use, vaping	❑1	❑2	❑3	❑4	❑5
Adults with behavioral, mental health, or emotional issues	❑1	❑2	❑3	❑4	❑5
Children or teenagers with behavioral, mental health, or emotional issues	❑1	❑2	❑3	❑4	❑5
Being overweight	❑1	❑2	❑3	❑4	❑5
Having diabetes	❑1	❑2	❑3	❑4	❑5
Having heart disease	❑1	❑2	❑3	❑4	❑5

Household Issue LEISURE ACTIVITIES	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Can't afford recreational, entertainment, and or cultural activities	❑1	❑2	❑3	❑4	❑5
Lack of activities for youth	❑1	❑2	❑3	❑4	❑5

Household Issue HOUSING	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Not having enough room in your house for all the people who live there	❑1	❑2	❑3	❑4	❑5

Living in housing that needs major repairs and/or modifications	❑1	❑2	❑3	❑4	❑5
Not having enough money to pay for housing	❑1	❑2	❑3	❑4	❑5

Household Issue SAFETY	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Experiencing crime	❑1	❑2	❑3	❑4	❑5
Experiencing family violence	❑1	❑2	❑3	❑4	❑5
Impaired/distracted driving (driving under the influence, texting, road rage, etc.)	❑1	❑2	❑3	❑4	❑5

Household Issue SOCIAL	Not an Issue	Minor Issue	Moderate Issue	Major Issue	No Opinion/ Don't Know
Not being able to afford legal help	❑1	❑2	❑3	❑4	❑5
Not being able to get care for a person with a disability or serious illness, or for an elder	❑1	❑2	❑3	❑4	❑5
Experiencing discrimination	❑1	❑2	❑3	❑4	❑5
Suffered a recent loss (death of a family/friend, suicide, drug overdose, etc.)	❑1	❑2	❑3	❑4	❑5
Negative effects of gambling, phone/internet overuse/addiction, pornography, etc.)	❑1	❑2	❑3	❑4	❑5
Not being able to find or afford day care for children	❑1	❑2	❑3	❑4	❑5

Are there other issues in your household that are not listed? Please specify _____
_____.

Has the COVID-19 pandemic made any of these more difficult for you or your immediate family?
CHECK ONE NUMBER IN EACH ROW.

	Yes	No	Sometimes	Not Applicable
1. Housing (e.g. paying rent, facing eviction, foreclosure, maintenance, etc.).	❑1	❑2	❑3	❑4
2. Job security (e.g. employed, got fired or laid off, less work to do than before, less income, etc.).	❑1	❑2	❑3	❑4
3. Transportation (e.g. getting places you need to go, riding public transit, carpooling, etc.).	❑1	❑2	❑3	❑4
4. Access to food (e.g. affording groceries, getting SNAP benefits, feeding family or loved ones, etc.).	❑1	❑2	❑3	❑4
5. Utilities (e.g. facing gas, water, or electric shutoffs or difficulty paying for them, etc.).	❑1	❑2	❑3	❑4

6. Paying bills (e.g. medical or other).	❑1	❑2	❑3	❑4
7. Increase in depression, anxiety, social isolation, or other mental health concerns.	❑1	❑2	❑3	❑4
8. Education (e.g. negative effect on child(s) academics, school attendance, etc.).	❑1	❑2	❑3	❑4
9. Resources needed to work or for school (e.g. laptop, internet, IPad, space in home, etc.)	❑1	❑2	❑3	❑4
10. Difficulty getting a COVID test if wanted or needed it.	❑1	❑2	❑3	❑4
11. Difficulty getting the COVID vaccine.	❑1	❑2	❑3	❑4
12. When contacted by an official about exposure to COVID, are you willing to comply with reporting and quarantining (contact tracing)?	❑1	❑2	❑3	❑4
13. Delayed getting routine health care or scheduling necessary tests/surgery.	❑1	❑2	❑3	❑4

C. HEALTHCARE CHALLENGES AND ISSUES

CHECK ONE NUMBER IN EACH ROW.

	Yes	No	Sometimes	Not Applicable
14. Have you seen a primary care/family physician in the past year?	❑1	❑2	❑3	❑4
15. Have you seen a dentist in the past year?	❑1	❑2	❑3	❑4
16. Do you know how to find treatment if you or someone you know needs help for an alcohol or substance use problem?	❑1	❑2	❑3	❑4
17. When you need help are you able to easily understand the healthcare system and community resources available?	❑1	❑2	❑3	❑4
18. Do you clearly understand what is going on with your healthcare?	❑1	❑2	❑3	❑4
19. Do you feel like all of your medical care is well coordinated between different medical providers?	❑1	❑2	❑3	❑4
20. Has the cost of any medical care you have received ever affected your ability to pay your household expenses (for example: utility bills, food, rent)?	❑1	❑2	❑3	❑4
21. If you are 50 years of age or older, have you ever had a colorectal cancer screening?	❑1	❑2	❑3	❑4
22. Have you ever missed a health care appointment (e.g. doctor appointment, test, physical therapy, etc.) due to lack of transportation?	❑1	❑2	❑3	❑4

23. Have any of these problems ever prevented you or someone in your family from getting necessary health care? **CHECK ALL THAT APPLY.**

- ❑1 No health insurance
- ❑2 Insurance didn't cover what I/we needed
- ❑3 My/our deductible/co-pay was too high
- ❑4 Doctor would not take insurance or Medicaid (MA/Access Card)
- ❑5 Hospital would not take insurance or Medicaid (MA/Access Card)
- ❑6 Pharmacy would not take insurance or Medicaid (MA/Access Card)
- ❑7 Dentist would not take insurance or Medicaid (MA/Access Card)
- ❑8 Transportation (no way to get there)
- ❑9 Fear or not ready to face or discuss health problem
- ❑10 The wait for an appointment was too long
- ❑11 Services were not provided in my community
- ❑12 Cultural or religious beliefs
- ❑13 None of the above prevented getting the necessary health care

24. Are you and your family registered in the SMART 911 system? (www.smart911.org)

❑1 Yes ❑2 No ❑3 Don't know what it is

25. Are you familiar with the 211 system? (www.pa211.org)

❑1 Yes ❑2 No

26. What are the greatest gaps in health care services for Blair County?
CHECK ALL THAT APPLY.

- ❑1 Dental care
- ❑2 Social and/or medical care for senior citizens
- ❑3 Services for premature babies
- ❑4 End-of-life care (hospice, palliative care)
- ❑5 In-patient mental health services for adults
- ❑6 Out-patient mental health services for adults
- ❑7 In-patient mental health services for children/adolescents
- ❑8 Out-patient mental health services for children/adolescents
- ❑9 Prescription drug assistance
- ❑10 Family physician
- ❑11 Services for low-income residents
- ❑12 Services for alcohol and other drug abuse
- ❑13 Services for persons with disabilities
- ❑14 Lack of midwives/doula
- ❑15 COVID-19 testing and/or vaccinations
- ❑16 Other, please specify: _____

27. What are the greatest needs regarding health education and prevention services in Blair County?
CHECK ALL THAT APPLY.

- ❑1 Tobacco, nicotine, and vaping prevention and cessation
- ❑2 Mental health/depression/suicide prevention
- ❑3 Violence prevention (e.g. workplace, family, emotional, physical, sexual, etc.)
- ❑4 Obesity prevention
- ❑5 Diabetes education/prevention
- ❑6 Oral/dental health
- ❑7 Healthy lifestyles
- ❑8 Health literacy (knowing how to find, understand, and use information and services to make informed health-related decisions)
- ❑9 Alcohol and other drug abuse prevention
- ❑10 Teen pregnancy
- ❑11 Heart disease

❑12 Emergency preparedness
❑13 Vaccinations
❑14 COVID-19
❑15 Other, please specify: _____

28. Where do you get health-related information? **CHECK ALL THAT APPLY.**

❑1 Family and friends
❑2 Doctor and/or other healthcare provider
❑3 Television/newspapers/magazines/newsletters
❑4 Pharmacist
❑5 Veteran's Health System
❑6 Public library/books
❑7 Telephone helplines (PA 211, hospital physician referrals, etc.)
❑8 Holistic providers (e.g. massage, acupuncture, aroma therapy, etc.)
❑9 Health department
❑10 School
❑11 Employer
❑12 Places of worship
❑13 Internet/social media
❑14 Health food stores/vendors

29. Do you have a Blair County Library System card?

❑1 Yes ❑2 No

30. What keeps you from eating a healthy diet? **CHECK ALL THAT APPLY.**

❑1 Cost of healthy foods like fruits and vegetables
❑2 Healthy foods are not available
❑3 Don't have the time
❑4 Don't know how to prepare healthier foods
❑5 Too much trouble to prepare healthier foods
❑6 Don't have the motivation to eat better
❑7 Not sure what to eat to be healthier
❑8 Lack of education about healthy diet

31. What keeps you from increasing your physical activity? **CHECK ALL THAT APPLY.**

❑1 Cost
❑2 Lack of sidewalks to walk
❑3 Lack of safe places to bike
❑4 Don't have the time
❑5 Don't know what is available in my community
❑6 Don't have the motivation
❑7 Rather spend time doing other things (video games, watching TV, being with friends, etc.)
❑8 My current health or physical condition makes it hard for me to get more exercise
❑9 Weather

E. The following questions will help us be certain we have included a valid sampling of people.

1. What is your postal Zip code? _____

2. Are you… ❑1 Male ❑2 Female ❑3 Other

3. Are you a veteran?

❑1 Yes ❑2 No

4. Which of the following, including yourself, live in your household? **CHECK ONE.**

❑1 Married – couple with own children (under 18)
❑2 Married – couple with no children
❑3 Single parents (male/female, no spouse, with children under 18)
❑4 Single person
❑5 Other type of household

5. How old are you (in years)? _____

6. What do you consider to be your primary racial or ethnic group? **CHECK ONE.**

❑1 American Indian/Alaska Native
❑2 Asian or Pacific Islander
❑3 Black or African American
❑4 White or European American
❑5 Hispanic/Latino
❑6 Two or more races

7. What is your primary source of transportation? **CHECK ONE.**

❑1 Car
❑2 Family/friends
❑3 Taxi
❑4 Bus
❑5 Walk
❑6 Bike
❑7 Uber/Lyft
❑8 Other, please specify _____.

8. Does anyone in your household receive public assistance such as Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (food stamps), Supplemental Security Income (SSI), or Social Security Disability (SSD)? **CHECK ONE.**

❑1 Yes ❑2 No

9. What type of health insurance do you have? **CHECK ONE.**

❑1 No insurance
❑2 UPMC
❑3 Aetna
❑4 Highmark (Blue Cross/Blue Shield)
❑5 Medicaid (Medical Assistance/Access)
❑6 Medicare
❑7 Empower360
❑8 Tricare/VA
❑9 Geisinger
❑10 Other _____

10. Where do you get your insurance? **CHECK ONE.**

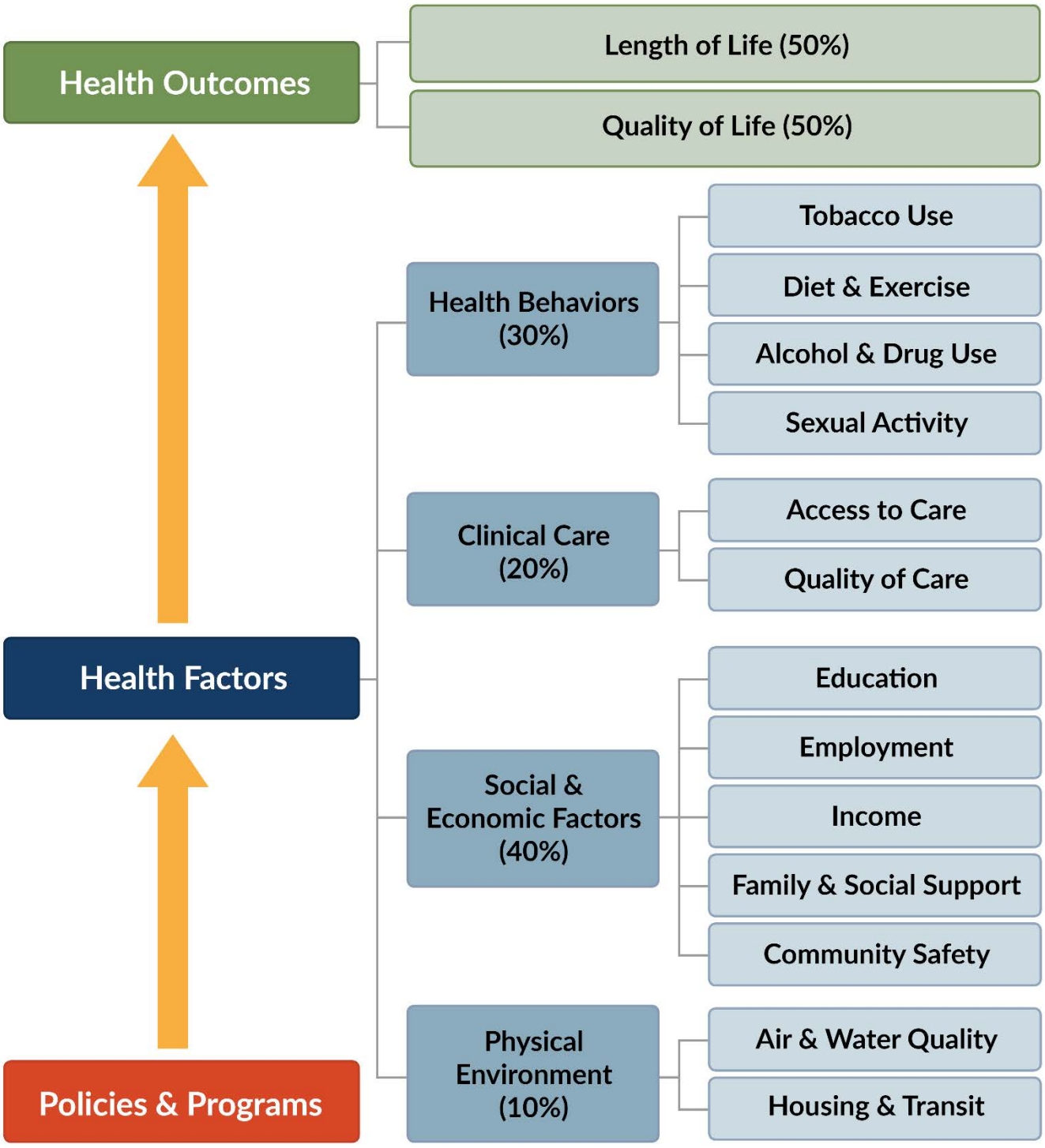
- ❑1 Large employer
- ❑2 Small employer (50 people or less)
- ❑3 Private (Marketplace/Obamacare)
- ❑4 Government (e.g. Medicaid, Medicare, Veterans)

11. Counting income from all sources (including all earnings from jobs, unemployment insurance, disability, workers' compensation, pensions, public assistance, etc.) and counting income from everyone living in your home, which of the following ranges did your household income fall into last year? **CHECK ONE.**

- ❑1 Less than $25,000
- ❑2 $25,000 – $49,999
- ❑3 $50,000 - $99,999
- ❑4 $100,000 - $149,999
- ❑5 $150,000 and higher

THANK YOU FOR HELPING OUR COMMUNITY BY COMPLETING THIS SURVEY!
Please visit our website at www.healthyblaircountycoalition.org and like our Facebook page

Appendix B: County Health Rankings Model



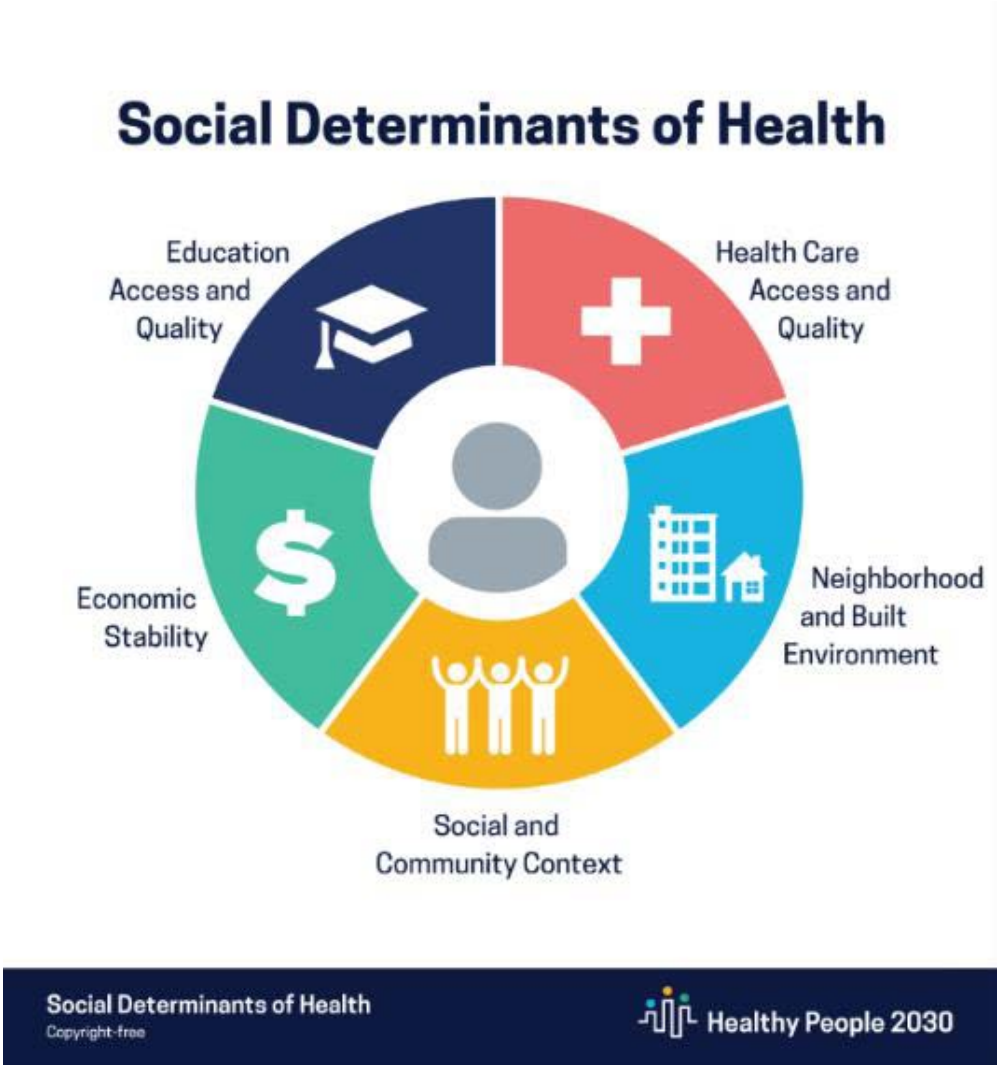
Appendix C: Blair County Health Rankings 2010 - 2021

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Health Outcomes (Overall Ranking)	**63**	**62**	**56**	**56**	**51**	**48**	**46**	**47**	**45**	**51**	**43**	**39**
Length of life	65	60	52	47	47	42	47	43	46	53	46	
Premature death	8693	8350	7869	7387	7387	7182	7500	7400	7700	8700	8300	8000
Quality of Life	56	58	60	61	50	51	38	45	38	36	36	
Poor or fair health	20%	20%	21%	21%	20%	20%	15%	14%	15%	15%	16%	18%
Poor physical health days	5.1	5.1	5	4.9	4.2	4.2	3.7	3.6	3.8	3.8	4.1	4.2
Poor mental health days	3.8	3.9	4	4.2	3.7	3.7	4.1	4	4.1	4.1	4.5	5.2
Low birth weight	6.9%	6.9%	7.2%	7.2%	7.4%	7.4%	7%	7%	7%	7%	7%	7%
Health Factors	33	42	29	37	36	37	30	39	32	37	37	
Health Behaviors	51	61	42	46	49	47	51	62	48	40	40	
Adult smoking	23%	23%	22%	23%	23%	23%	20%	19%	17%	17%	19%	24%
Adult obesity	31%	34%	32%	32%	33%	33%	34%	33%	32%	30%	31%	32%
Food environment index					8.2	7.8	7.6	7.7	7.7	7.7	7.7	7.7
Physical inactivity		28%	31%	31%	31%	31%	29%	27%	25%	24%	26%	25%
Access to exercise opportunities					79%	76%	75%	75%	60%	73%	75%	75%
Excessive drinking	13%	12%	14%	13%	15%	15%	17%	17%	19%	19%	20%	21%
Motor-vehicle crash deaths	18%	17	17	15	15	13	13	14				
Alcohol-impaired driving deaths					33%	35%	32%	34%	32%	29%	23%	23%
Sexually transmitted infections	159	117	165	211	275	245	313	251	219	247	290	311
Teen births	36	36	36	33	33	33	32	31	28	27	24	23
Clinical Care	18	27	21	25	19	27	21	24	25	38	49	
Uninsured	10%	12%	12%	12%	11%	11%	11%	9%	6%	6%	6%	6%
Primary care phyisicans		1188 to 1	1188 to 1	1144 to 1	1155 to 1	1177 to 1	1190 to 1	1210 to 1	1160 to 1	1230 to 1	1190 to 1	1220 to 1
Dentists			2190 to 1	2117 to 1	1956 to 1	1885 to 1	1880 to 1	1820 to 1	1780 to 1	1670 to 1	1610 to 1	1620 to 1
Mental health providers		3229 to 1	3229 to 1	3736 to 1	639 to 1	491 to 1	460 to 1	490 to 1	480 to 1	470 to 1	420 to 1	400 to 1
Preventable hospital stays	80	73	70	68	71	69	58	54	60	5349	5953	5192
Diabetes monitoring	84%	83%	86%	86%	85%	86%	87%	84%	84%			
Mammography screening		58.60%	63.90%	59.50%	57%	55.90%	54%	57%	57%	37%	39%	41%
Flu Vaccinations										43%	43%	43%
Social & Economic Factors	45	34	24	30	30	28	29	28	29	25	26	
High school graduation	82%	84%	85%	88%	88%	88%	87%	88%	88%	90%	90%	90%
Some college		51.90%	52.70%	52.60%	52.60%	54.20%	53%	54%	55%	56%	57%	58%
Unemployment	5.0%	7.2%	7.7%	7.0%	7.2%	6.7%	5.6%	5.0%	5.3%	4.8%	4.2%	4.5%
Children in poverty	20%	21%	20%	22%	20%	24%	21%	23%	21%	19%	19%	22%
Income inequality						4.3	4.3	4.4	4.5	4.5	4.6	4.5
Inadequate social supports	24%	25%	25%	25%	25%							
Children in single-parent households		30%	31%	33%	33%	33%	33%	32%	33%	32%	34%	23%
Social associations						17.5	17.5	17.5	17.8	17.6	18.1	18.5
Violent crime	277	290	294	274	263	252	252	232	232	224	224	224
Injury deaths					71	70	70	75	80	85	84	88
Physical Environment	1	13	50	57	22	30	40	32	32	48	52	
Air pollution -ozone days	4	2	2									
Air pollution-particular matter	0	0	0	13.8	13.3	13.3	13.3	10.4	10.4	11.2	11.2	8.2
Drinking water violations					0	2%	yes	yes	yes	yes	yes	no
Severe housing problems					11%	12%	12%	12%	13%	13%	13%	14%
Driving alone to work		82%	82%	83%	83%	83%	83%	83%	83%	82%	83%	83%
Long commute - driving alone					18%	18%	18%	19%	19%	20%	20%	21%
Access to healthy foods	63%	67%	67%									
Access to recreational facilities		10	8	8								
Limited access to healthy foods			11%	6%	6%	6%	6%	6%				
Fast food restaurants			53%	54%								

Appendix D: Social Determinants of Health

Social determinants of health (SDOH) have an impact on people's health, well-being, and quality of life. This includes issues such as safe housing, transportation, discrimination, education, job opportunities, access to nutritious foods and physical activity opportunities, polluted air and water, etc.

SDOH contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity and even lowers life expectancy relative to people who do have access to healthy foods. Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners need to take action to improve the conditions in people's environments.[69]



[69] Healthy People 2030, US Department of Health and Human Services

Community Health Improvement Progress and Plan

2019 – 2022 Progress Report and

2022 – 2025 Implementation Plan

UPMC | WESTERN MARYLAND

DRAFT

Caring for the Community

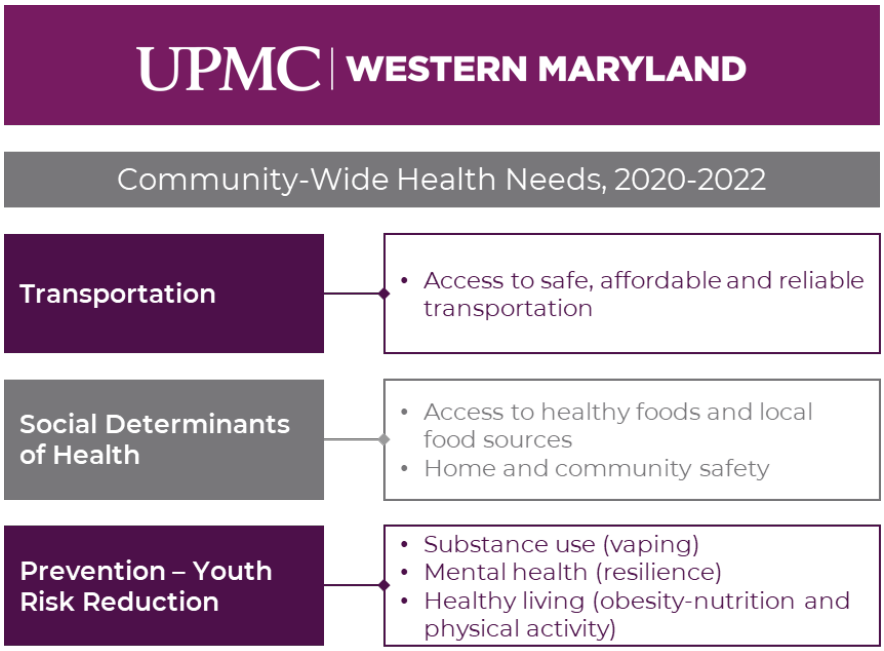
UPMC Western Maryland is a nonprofit, acute-care hospital located in Cumberland, Maryland, that serves residents in Allegany County and the surrounding counties in Maryland, West Virginia, and Pennsylvania. The hospital offers a wide range of inpatient and outpatient services through its accredited cancer center, robotic surgery program and cutting-edge neurosurgery operating suite. UPMC Western Maryland is also recognized for having an award-winning cardiac surgery program and offers the only open-heart surgery in the state, west of Baltimore. In addition, UPMC Western Maryland has received the following designations from the Maryland Institute for Emergency Medical Services Systems: Designated Cardiac Interventional Center, Primary Stroke Center, and Level III Adult Trauma Center.

UPMC Western Maryland has been at the forefront of value-based care and is continuously working to improve the overall health of the community through a variety of population health initiatives.

VITAL STATISTICS Calendar Year 2020		JOBS AND STRENGTHENING THE LOCAL ECONOMY	
Licensed Beds	224	Employees	2,131
Hospital Patients	12,850	Community Benefits Contributions	$68.0 million
Emergency Dept. Visits	37,044	Free and Reduced Cost Care	$17.0 million
Total Surgeries	5,904	Total Economic Impact of Hospital Operations	$690.1 million

Addressing the Community's Significant Health Needs

When the Fiscal Year 2020 CHNA was conducted, UPMC Western Maryland affirmed the following significant health needs:



Advancing Community Health Initiatives While Navigating the COVID-19 Pandemic

Beginning in March 2020, the COVID-19 pandemic disrupted Maryland's communities, economy, and health care organizations. To help slow the spread of COVID-19 throughout the region, state and local governments issued community mitigation and social distancing measures, impacting UPMC Western Maryland's ability to implement planned community health improvement initiatives. As a result, UPMC Western Maryland temporarily suspended or modified in-person programs to promote social distancing, educated the community about the health risks of COVID-19, increased access to telehealth services, established COVID-19 testing sites, and worked with state and local leaders to deliver COVID-19 vaccines. While UPMC Western Maryland navigated the complexities of the pandemic, the hospital continued to address identified health needs by developing innovative approaches and strategies to engage with its communities.

Access to Care and Navigating Resources

Transportation: Access to Safe, Affordable, and Reliable Transportation

UPMC Western Maryland continues to work to reduce the percent of patients without transportation or faced with transportation barriers when trying to access care or return home. Though not a direct connection, by increasing access to needed care, it is anticipated that medically unnecessary visits to the ED and readmissions will be reduced. Transportation also allows patients to receive more timely care and identify health issues earlier.

GOAL:

Increase access to safe, affordable, and reliable transportation

STRATEGY:

Provide underserved residents with rides to health and human service appointments when no other resources are available thereby improving access to care

ACTIONS:

- ✓ Educate at least 100 transportation users or service providers and the transportation options and system changes
- ✓ Identify existing transportation alternatives and seek at least one new option to reduce the transportation barrier

TARGET POPULATION:

- Seniors
- Individuals with disabilities
- Low-income residents

PROGRAMS:

- Mobility Management Program
- AllTrans
- On-Demand Transportation/Taxi Service Arrangement
- Taxi Vouchers
- One Call Click System

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2020-2022)

121
Total Rides Provided to Patients for Appointments
(January 2020 – April 2021)

3,905
Rides Required Wheelchair Transportation
(January 2020 – April 2021)

$150-200k
Annual Cost Savings Based on Projected Ambulance Spend
(2020 – 2021)

PROGRAM HIGHLIGHTS:

Improving Access to Care with Transportation Assistance

Since 2012, UPMC Western Maryland has worked to improve access to care by helping to coordinate rides to health and human services appointments for underserved residents. By increasing access to needed care, the hospital aims to reduce medically unnecessary visits to the Emergency Department and readmissions. By helping to provide appropriate transportation to preventive care and services, the hospital is helping patients to receive more timely care, identifying health issues earlier and reducing the potential need for high levels of care.

- **Partnering with Allegany County Human Resources Development Commission (HRDC):** UPMC Western Maryland collaborates with several community agencies to help coordinate transportation for patients. Hospital staff are trained to assess a patient's need for transportation when scheduling a patient's appointment or discharging a patient from the hospital. When transportation assistance is needed, hospital staff enter a request into the Trip Master portal monitored by Allegany County Human Resources Development Commission (HRDC). HRDC determines the most appropriate mode of transportation based on the request. If a patient qualifies for the Mobility Management Program or AllTrans, those services will be used. When a request does not fit the criteria for other services, HRDC provides the On-Demand transportation or arranges for a taxi. If the patient uses a wheelchair, walker, or is unsteady and needs assistance, HRDC assists the patient to the front door or across the threshold of a provider's office or their residence. UPMC Western Maryland partners with HRDC to provide walkers, wheelchairs, and other needed equipment to aid patients. When HRDC cannot provide a ride, UPMC Western Maryland also uses taxi vouchers.

  Community Partnership to Provide Continuum of Care

  > Between January 2020 and April 2021, the hospital helped provide 14,466 total rides. Of all rides, about 27 percent required wheelchair transportation.

- UPMC Western Maryland continues to work with the partners in Mobility Management to identify ways to improve transportation coordination in the area. There is still an interest in developing a One Call One Click system for transportation, but a lead agency has not been found. Other efforts included a blending of policy across agencies, targeted education, and an examination of routes to outlying areas.

COMMUNITY PARTNERS:

Transportation Committee, UPMC Western Maryland Mobility Mgmt.-HRDC Med Trans- NEMT ACHD or Statewide vendor, All Trans- County Transit Taxi (Crown, Yellow, QCity) County Medical Transport, Bay Runner, Garrett Transit, Mineral County Logisticare, PVTA, CUW, Communities for Life, Service Providers, Human Resource Development Commission, Alleghany County Health Department-Behavioral Health Systems Office, Alleghany Transit, Committed to Change, Progressive PT, BACHS, Devlin Manor and Mountain City Nursing and Rehab, County Medical Transport, CTS -Trip Master, and other transportation providers

Prevention and Community-Wide Healthy Living

Social Determinants of Health: *Access to Healthy Foods and Home and Community Safety*

UPMC Western Maryland continues to address social determinants of health, focusing on access to healthy foods and improved home and community safety, by leveraging support from the hospital's Center for Clinical Resources (CCR). In addition to providing evidence-based programs for diabetes, heart disease, and nutrition and weight status, the CCR engages patients in chronic disease self-management and addresses unemployment, poverty, health literacy, and other social determinants of health.

GOAL:

Increase access to healthy foods and local food sources, improve home and community safety (fire, security, safety), and help to address other social determinants of health

STRATEGY:

Identify key strategies to help close the gap for food insecurity and safe, affordable housing/ home sharing

ACTIONS:

- ✓ Utilize information obtained through food system mapping to identify and establish five sites per cycle year where healthy food choices or local food sources will be increased
- ✓ Provide education and assessment process focused on improving home and community safety for 100 or more people
- ✓ By June 2023, assess and assist 100 individuals with home or community safety need

TARGET POPULATION:

- Seniors
- Low-income individuals with chronic conditions

PROGRAMS:

- Community gardens
- Farmers Market vouchers
- Wellness Ambassadors
- Center for Clinical Resources (CCR)
- PATH2HELP
- Bridges to Opportunity

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2020-2022)

6,760
Patient Encounters in the Center for Clinical Resources
(June 2019 – July 2020)

266
Referrals to Resources through Path2Help
(July 2019 – May 2021)

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PROGRAM HIGHLIGHTS:

Addressing Social Determinants of Health

The UPMC Western Maryland Center for Clinical Resources (CCR) is a source of support for patients managing chronic medical conditions such as diabetes, heart failure, and lung disease, or taking anticoagulation medication. CCR's goal is to effectively co-manage at-risk patients who have a chronic disease in an outpatient setting to help improve their health.

- **Improving access to healthy foods:** Over the past three years, the hospital has worked with local farmers to provide access to fresh, local food within food deserts and address chronic disease and obesity associated with lack of access to fresh food. Since 2018, the hospital and several organizations adopted a platform to provide community organizations and community members access to resources through an online resource guide and referral system.
  - > **Leveraging technology to increase access to resources:** Path2Help is an online tool that makes it easy for people to find appropriate programs and services for food, shelter, health care, work, financial assistance and more.

- **Assisting with home and community safety:** The hospital's Bridges to Opportunity initiative strives to help move individuals from poverty to self-sufficiency, reduce social costs related to crime, poor health, and welfare, strengthen educational attainment and job skills, enhance economic development, and revitalize neighborhoods.
- **Addressing chronic disease to help reduce hospital readmissions:** UPMC Western Maryland continues to help patients manage their health conditions and barriers to let them live the life they want and in turn reduce potentially avoidable readmissions and Emergency Department visits. Since 2019, the hospital has worked with medical staff, area providers and community partners to provide assistance, resources and education to those dealing with chronic diseases. By addressing the social determinants of health and self-management, the impact has saved more than $600,000 in hospital utilization.

COMMUNITY PARTNERS:

Bridges to Opportunity, SunLife Partners, Aramark, Western Maryland Food Council, Western Maryland Food Bank, Allegany College of Maryland, Area Health Education West, Associated Charities, Allegany County Human Resources Development Commission, UPMC Western Maryland., University of Maryland Extension., Frostburg State University, Allegany County Health Department, Funders-CareFirst, Singer, Cumberland Housing Authority and Alliance, Human Resources Development Commission, Allegany County Health Department , local Law Enforcement and Fire Dept. Home Care and CHW, FSU, AHEC Committee, Aunt Bertha, Western Maryland Food Council

Prevention and Community-Wide Healthy Living

Prevention – Youth Risk Reduction: Substance Use, Mental Health, and Healthy Living

UPMC Western Maryland embraces a community-oriented approach to promoting healthy behaviors and supporting at-risk populations.

GOAL:
Improve the mental and physical health of youth

STRATEGY:
Focus prevention and risk reduction efforts on substance use (vaping), mental health (resilience), and healthy living (obesity-nutrition and physical activity)

ACTIONS:
- ✓ By June 2023, engage 500 or more youth in mind body skills groups and targeted prevention programs in the community
- ✓ Each cycle year host at least three cross sector forums regarding identified risk behaviors of youth and potential prevention strategies for our community

TARGET POPULATION:
- Children and adolescents

PROGRAMS:
- Mind and Body Skills Groups
- Vaping Prevention Program
- Stigma – Distorted Prevention Program
- Family Needs and Trauma-Informed Care
- Physical Activity Programs
- After School Programming

PROGRESS:

MAKING A MEASURABLE IMPACT IN THE COMMUNITY (2020-2022)

22
School Partnerships
(July 2019 – May 2021)

Launched New Local Hiking Program
(July 2021 – August 2021)

PROGRAM HIGHLIGHTS:

Engaging Allegany County Youth in Prevention Education Programs

Over the last two years, UPMC Western Maryland has worked with local organizations and the surrounding school districts to provide health education by certified trainers.

- **Vaping Prevention Program:** This initiative takes a community-based approach to decrease the number of Allegany County youth who engage in vaping or tobacco use to educate as early as elementary aged youth and their guardians.
- **Mind and Body Skills Groups:** This effort reaches out to local youth through Allegany and Mineral County schools to provide wellness programs and activities surrounding the mind and the body.

UPMC Western Maryland primary care practices screened 94 percent of the Maryland Primary Care Program (MDPCP) patients using the SBIRT tool and provided a follow-up plan — exceeding Maryland's state benchmark by 24 percent in 2021.

Encouraging Active Lifestyles with Happy Feet Youth Hiking

In June 2021, UPMC Western Maryland Wellness Center and Rocky Gap State Park teamed up to offer a fun youth hiking series to parents and youth as part of the Healthy Parks Healthy People program. Through the Happy Feet Youth Hiking program, Allegany County families can join a hike led by UPMC Western Maryland staff every Thursday to engage in the outdoors and explore local trails.

COMMUNITY PARTNERS:

Allegany County Health Department, Frostburg Coalition, Allegany County Public Schools, Local Management Board, Department of Juvenile Services, Allegany College of Maryland, Center for Mind-Body Medicine, Area Health Education Center West, Families First, Family Junction, 4H, University of Maryland Extension, Allegany County Public Libraries

UPMC Western Maryland Is Addressing High Priority Health Issues:

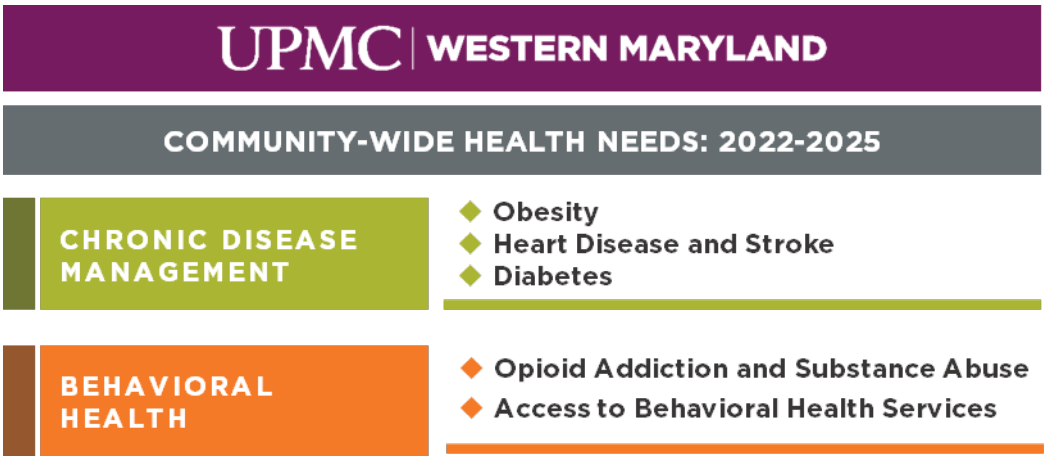
Adoption of the Implementation Plan

On March 24, 2022, the UPMC Western Maryland Board of Directors adopted an implementation plan to address the significant health needs identified:

- Chronic Disease Management
- Behavioral Health

UPMC Western Maryland Is Leveraging UPMC and Community Resources

By providing a comprehensive suite of programs, UPMC Western Maryland plays an important role in addressing the community health needs that were identified in the recent Community Health Needs Assessment. The hospital will support the priority areas with internal resources, through grants, and by strengthening collaborations with numerous community partners.



Working to Advance Health Equity

UPMC Western Maryland recognizes that a broad range of efforts both within and beyond health care will be instrumental in addressing issues that contribute to health disparities. UPMC Western Maryland's 2022-2025 Implementation Plan includes health equity-promoting programs and initiatives, which aim to help address socioeconomic and other factors that may contribute to health disparities. Efforts include:

- **Advancing Access to Behavioral Health Programs for Vulnerable Populations:** Creating approaches and implementing strategies to help improve access to behavioral health care in rural communities, including embedding behavioral health specialists in primary care offices and offering local access to a residential crisis service facility.

COMMUNITY HEALTH NEED

CHRONIC DISEASE MANAGEMENT

UPMC Western Maryland is taking a community-based approach to address obesity by providing a range of community health improvement programs that promote healthy behaviors and support at-risk populations. The hospital will continue to collaborate with local organizations, including the Allegany County Health Planning Coalition, to increase programming that encourages healthy eating and physical activity.

HEALTH PRIORITY #1

Obesity

GOAL

Increase awareness of obesity prevention and management and encourage healthy behaviors

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Take a comprehensive approach to help reduce obesity within the community, by providing education and promoting healthy eating and physical activity.	• Provide education about achieving and maintaining healthy lifestyles, including methods to prevent chronic illnesses • Engage in community outreach events to raise awareness about the links between obesity and chronic diseases • Encourage physical activity by promoting fitness classes and events

TARGET POPULATION

General community

PLANNED COLLABORATIONS

Allegany County Health Department, Allegany County Public Schools, Rocky Gap State Park, Wellness Ambassadors, Allegany County Human Resources Development Commission (HRDC Senior Centers), Area Health Education Center West (AHEC West), Allegany County Public Library System, Western Maryland Food Council, Allegany College of Maryland, Frostburg State University, local municipalities

COMMUNITY HEALTH NEED

CHRONIC DISEASE MANAGEMENT

UPMC Western Maryland will focus on heart disease and stroke through prevention, education, awareness, and management, while seeking new and innovative strategies to help ensure residents can receive the best care close to home.

HEALTH PRIORITY #2

Heart Disease and Stroke

GOAL

Increase awareness of disease prevention and management and encourage healthy behaviors

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Host a suite of services to promote heart failure and stroke awareness, prevention, and management within the community.	• Provide chronic disease education and support in the community • Continue to offer a cardiac rehab program to help lower the risk of death, complications, and risk for readmission for patients who have had a cardiac event or procedure • Provide interventions and screenings for community members • Monitor symptoms of heart failure and connect patients with a source of support for managing chronic medical conditions, such as diabetes, anticoagulation medication, heart failure, and chronic obstructive pulmonary disease (COPD)

TARGET POPULATION

General community

PLANNED COLLABORATIONS

Allegany County Health Department, Allegany County Public Schools, Wellness Ambassadors, Allegany Human Resources Development Commission (HRDC Senior Centers), faith-based institutions, Area Health Education Center West, Heart Institute at UPMC Western Maryland, Stroke Center

COMMUNITY HEALTH NEED

CHRONIC DISEASE MANAGEMENT

UPMC Western Maryland will address diabetes with a focus on awareness, prevention, and management through a suite of offerings, including community outreach, preventive screenings, and evidence-based interventions that link diabetic patients to specially-trained educators.

HEALTH PRIORITY #3

Diabetes

GOAL

Increase awareness of diabetes prevention and management and encourage lifelong healthy behaviors

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Increase awareness of diabetes prevention and management within the community.	• Provide diabetes education and training • Leverage referring providers to increase awareness and promote participation in diabetes management programs • Offer preventive screenings to identify and treat potential health problems before they develop or worsen • Increase community engagement through outreach events and health fairs • Offer medical nutrition therapy to support behavioral or lifestyle changes and provide individualized meal planning

TARGET POPULATION

General community

PLANNED COLLABORATIONS

UPMC Primary Care Practices, local primary care practices, Mountain Laurel Medical Center, Human Resources Development Commission (HRDC), Area Health Education Center West (AHEC), Allegany County Health Department

COMMUNITY HEALTH NEED

BEHAVIORAL HEALTH

UPMC Western Maryland will address the community's needs relating to opioid addiction and substance use disorders through multiple channels, including linking individuals to the right levels of care, outreach initiatives, and partnerships with community-based behavioral health services organizations.

HEALTH PRIORITY #1

Opioid Addiction and Substance Abuse

GOAL

Increase awareness and access to substance misuse resources and interventions

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Further augment current behavioral health programs to address addiction and substance abuse.	• Improve coordination and communication between service providers with embedded behavioral health specialists at primary care locations • Continue to offer a residential crisis service facility to provide support for adults with mental health illnesses and addictions • Increase awareness throughout the community to help reduce the stigma of addiction • Partner with local community organizations to provide education and training • Develop and support programming to address substance misuse and addiction recovery • Provide early intervention and treatment to people with substance use disorders and those at risk of developing these disorders

TARGET POPULATION

General community

PLANNED COLLABORATIONS

Allegany County Health Department, Archway Station, Potomac Behavioral Health, Allegany County Sheriff's Department, Maryland State Police, Cumberland City Police Department, Frostburg State University Police, Department of Social Services, Allegany County Human Resources Development Commission, Healing Allegany, local nursing homes, Frostburg State University, Allegany College of Maryland, Allegany County Drug and Alcohol Abuse Council and Overdose Prevention Task Force, Prescribe Change

COMMUNITY HEALTH NEED

BEHAVIORAL HEALTH

UPMC Western Maryland will continue to address access to behavioral health services in the community by embedding behavioral health specialists in primary care offices, enhancing telehealth capabilities, and collaborating with local organizations.

HEALTH PRIORITY #2

Access to Behavioral Health Services

GOAL

Improve access and coordination of care for behavioral health services

STRATEGY AND INTENDED ACTIONS

Strategy	Intended Actions
1. Improve access to behavioral health services by increasing access points for individuals to be connected to the right level of care across the continuum.	• Embed behavioral health services into primary care settings • Offer telehealth services for behavioral health care • Track and improve access to care through provider referrals • Provide education and training to community members on how to offer initial help to individuals with the signs and symptoms of mental illness or in a crisis, and connect them with the appropriate professional, peer, social, or self-help care

TARGET POPULATION

General community, adults

PLANNED COLLABORATIONS

Allegany County Health Department, Archway Station, Potomac Behavioral Health, Allegany County Sherriff's Department, Maryland State Police, Cumberland City Police Department, Frostburg State University Police, Department of Social Services, HRDC, Healing Allegany, local nursing homes, Frostburg State University, Allegany College of Maryland, Allegany County Drug and Alcohol Abuse Council and Overdose Prevention Task Force, Prescribe Change

UPMC is addressing important community needs.

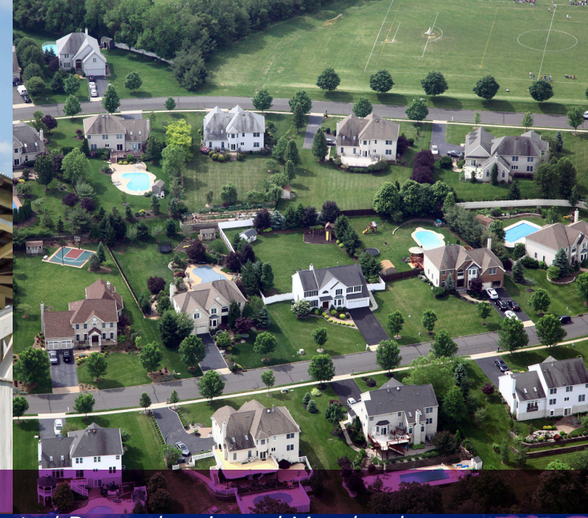
CHRONIC DISEASE MANAGEMENT
- Diabetes
- Heart Disease and Stroke

BEHAVIORAL HEALTH
- Access to Behavioral Health Services

ACCESS TO CARE AND NAVIGATING RESOURCES
- Primary Care
- Specialty Care
- Care Coordination / Transportation

PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING
- Community Prevention and Wellness Initiatives / Youth Risk Reduction
- Health-Related Social Needs / Social Determinants of Health

UPMC Somerset and UPMC Western Maryland were welcomed into the UPMC hospital network to ensure high-quality patient care for generations to come. UPMC has committed to enhance services and upgrade facilities, such as expanding clinical programs, recruiting and retaining outstanding medical staff, and updating information technology capabilities.



West Central Pennsylvania and Maryland

Enhancing the Health of Our Communities

Bedford, Blair, and Somerset Counties in Pennsylvania, and Allegany County in Maryland

COMMUNITY HEALTH NEEDS ASSESSMENT UPDATE COVERING

UPMC ALTOONA

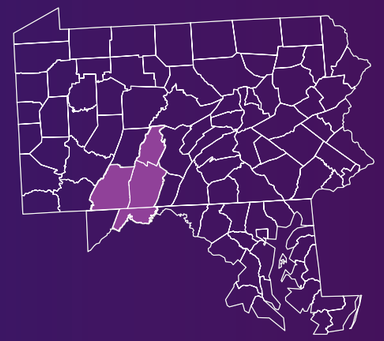
UPMC BEDFORD

UPMC SOMERSET

UPMC WESTERN MARYLAND

UPMC
LIFE CHANGING MEDICINE

SYS521833d LGH/CD 0821S



2019-2022 REGIONAL PROGRESS REPORT

UPMC is committed to improving the health and wellbeing of communities in Bedford, Blair, and Somerset counties in Pennsylvania, and in Allegany County in Maryland. Working with community partners and engaging system-wide resources, UPMC hospitals are making measurable progress to address community health needs.

INCREASING LOCAL ACCESS TO WORLD-CLASS CARE

UPMC is taking steps to make health care more accessible.

- **Working Together to Recruit Physicians:** UPMC Altoona, UPMC Bedford, and UPMC Somerset continue to assess the community's needs for primary and specialty care, and collaborate to attract new physicians to the region.

UPMC Altoona, UPMC Bedford, and UPMC Somerset recruited 90+ physicians.

- **Connecting with Patients through Telemedicine:** Due to the COVID-19 pandemic, UPMC hospitals' rapidly expanded telemedicine capabilities in outpatient locations, including primary care, urology, and orthopaedics. UPMC hospitals also use teleconsult centers to link patients with specialists in Pittsburgh, while on-site staff help perform exams. In 2020, UPMC Bedford's Teleconsult Center adapted its service, leveraging the MyUPMC app, and in 2021, UPMC Somerset's newly established Outpatient Telemedicine Center began offering endocrinology and neurosurgery services, and will offer rheumatology in 2022.

ADDRESSING ACCESS TO BEHAVIORAL HEALTH SERVICES

UPMC hospitals in the four-county region continue to expand services to address behavioral health needs.

- **Reaching Out to Community Members in Crisis:** UPMC Altoona's Mobile Crisis Team provides on-site, face-to-face mental health services for individuals and families experiencing a crisis, such as police calls, deaths, and suicides. The program continues to see an increased need for mobile crisis intervention. In 2020, the program served 600-700 individuals.
- **Training Providers to Recognize the Signs and Symptoms of Addiction:** UPMC Somerset is training providers in the use of Screening Brief Intervention and Referral to Treatment (SBIRT), a model that encourages mental health and substance use screenings as a routine preventive service.

MANAGING CHRONIC DISEASE

UPMC offers education and high-quality treatment options for people impacted by chronic disease.

- **Improving Control of Diabetes:** Embedded within a primary care office, UPMC Bedford's diabetic educator assists patients with the latest management tools, including apps, glucose monitoring, and insulin pumps.
- **Supporting Patients with Heart Disease:** UPMC Somerset offers an expansive interventional cardiology program — with more than 700 visits to the cardiac cath lab each year. In addition, the hospital's cardiac rehabilitation program offers personalized treatment plans, which help keep patients out of the hospital, help prevent future cardiac events, and encourage patients to be active and independent.
- **Providing Resources for a Healthier Life:** The UPMC Western Maryland Center for Clinical Resources (CCR) supports patients managing chronic conditions, such as diabetes, heart failure, and lung disease, as well as patients taking anticoagulation medication. The CCR's goal is to effectively co-manage patients with chronic disease in an outpatient setting to help improve their health.

PROMOTING PREVENTION AND COMMUNITY-WIDE HEALTHY LIVING

UPMC hospitals work with local organizations to encourage community participation in health education and screening events, as well as healthy activities.

- **Educating the Community about Cancer, Heart Disease, and Stroke:** To help raise awareness of the signs and symptoms of cancer, heart disease, congestive heart failure, and stroke, UPMC Altoona provides free education at community events, senior centers, and churches. Between July 2019 and March 2021, UPMC Altoona hosted 21 in-person and virtual events, with more than 450 participants.
- **Addressing Social Determinants of Health:** UPMC Western Maryland is using Path2Help, an online tool, to help connect people with community programs and services for food, shelter, health care, work, financial assistance, and more.

PARTNERING WITH ALLEGANY COUNTY HUMAN RESOURCES DEVELOPMENT COMMISSION

UPMC Western Maryland collaborates with Allegany County Human Resource Development Commission to help coordinate transportation for patients. Hospital staff assess a patient's transportation needs when scheduling an appointment or discharging a patient from the hospital. The hospital also provides walkers and wheelchairs.

UPMC Western Maryland helped provide 14,000+ rides to patients in 2020-2021.

CARING FOR OUR COMMUNITIES DURING THE COVID-19 PANDEMIC

UPMC is committed to keeping our patients, staff, and communities safe during this challenging time.

ADMINISTERING VACCINES

UPMC is proud to partner with community organizations to offer convenient and accessible COVID-19 vaccine clinics.

39,000+
Vaccine Doses Administered in the West Central Region*

PROTECTING VULNERABLE POPULATIONS

UPMC is dedicated to health equity in all vaccination efforts and is committed to vaccinating as many people as possible. Staff members at UPMC Altoona, UPMC Bedford, UPMC Somerset, and UPMC Western Maryland are volunteering their time and expertise to ensure the most vulnerable populations are protected from the virus.

LAUNCHING ONLINE PROGRAMS

UPMC expanded telemedicine capabilities to enable patients to receive care from the safety of their homes. In addition, UPMC hospitals adapted programs to allow community members to access health education, support, and resources through webinars, virtual discussions, and social media platforms.

OFFERING TESTING SITES

UPMC established seven regional collection centers to expand local testing. In addition, UPMC hospitals offer testing to patients before certain in-hospital procedures.

**Vaccine data as of November 22, 2021*

Itemized List of PhysicianType/Specialty Subsidized	Subsidy Type	DIRECT COST($)	INDIRECT COST($)
Urgent Care Centers	Physician Recruitment to Meet Community Need	$6,408,859.67	$2,593,622.98
Hospice	Physician Recruitment to Meet Community Need	$2,731,359.65	$1,316,885.20
Hospitalists	Non-Resident House Staff and Hospitalists	$676,313.70	$443,188.37
Psychiatric Physicians	Physician Recruitment to Meet Community Need	$2,659,348.35	$1,344,887.66
Obstetric Physicians	Physician Recruitment to Meet Community Need	$5,882,157.94	$2,756,956.16
Nephrology	Physician Recruitment to Meet Community Need	$1,782,746.46	$919,961.02
Infectious Disease	Physician Recruitment to Meet Community Need	$862,012.65	$462,822.49
Endocrinology	Physician Recruitment to Meet Community Need	$1,664,074.32	$920,910.06
Pulmonary Physicians	Physician Recruitment to Meet Community Need	$4,174,190.15	$2,170,162.38
Cardiology Physicians	Physician Recruitment to Meet Community Need	$11,938,936.19	$6,374,246.65
GI Physicians	Physician Recruitment to Meet Community Need	$5,381,607.62	$2,679,611.30
Wound Care Physicians	Physician Recruitment to Meet Community Need	$706,655.18	$383,366.78
Primary Care Physicians	Physician Recruitment to Meet Community Need	$8,259,107.65	$4,014,706.16
Outpatient Dialysis and Peritoneal Dialysis	Non-Resident House Staff and Hospitalists	$13,336,567.37	$2,831,116.66
Population Health	Physician Recruitment to Meet Community Need	$557,922.14	$364,900.40
Center for Clinical Resources	Physician Recruitment to Meet Community Need	$2,151,241.62	$1,278,554.51
Anesthesia	Non-Resident House Staff and Hospitalists	$982,816.74	$644,039.81
Oncology Phys	Physician Recruitment to Meet Community Need	$2,522,725.16	$1,398,200.70

HSCRC GRANTS/RATE SUPPORT	OTHER OFFSETTING REVENUE($)	NET COMMUNITY BENEFIT
$0.00	$7,911,109.07	$1,091,373.58
$0.00	$2,668,267.33	$1,379,977.52
$0.00	$0.00	$1,119,502.07
$0.00	$1,860,143.89	$2,144,092.12
$0.00	$5,270,092.06	$3,369,022.04
$0.00	$1,305,389.00	$1,397,318.48
$0.00	$446,505.88	$878,329.26
$0.00	$836,264.00	$1,748,720.38
$0.00	$2,488,542.84	$3,855,809.69
$0.00	$6,204,844.69	$12,108,338.15
$0.00	$3,251,600.69	$4,809,618.23
$0.00	$422,552.00	$667,469.96
$0.00	$7,640,061.36	$4,633,752.45
$0.00	$10,602,116.00	$5,565,568.03
$0.00	$4,634.13	$918,188.41
$0.00	$539,401.50	$2,890,394.63
$0.00	$0.00	$1,626,856.55
$0.00	$1,288,251.71	$2,632,674.15

UPMC WESTERN MARYLAND Business Office Policy Manual	**Department\Division:** Business Office	**Policy Number:** 400-04
	Effective Date: November 12, 2010	**Reviewed/Revised:** 4/11, 12/11, 5/12, 10/12, 8/13, 6/14, 4/15, 7/15, 4/2015, 6/2016, 2/2017, 6/2019, 4/2020, 12/2021,4/2022

FINANCIAL ASSISTANCE POLICY

This policy is intended as a guideline to assist in the delivery of patient care or management of hospital services. It is not intended to replace professional judgment in patient care or administrative matters.

PURPOSE:
UPMC Western Maryland is committed to providing quality health care for all patients regardless of their ability to pay and without discrimination on the grounds of race, color, national origin or creed. The purpose of this document is to present a formal set of policies and procedures designed to assist hospital Patient Financial Services personnel in their day to day application of this commitment. The procedures describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications.

This policy is intended to comply with Section 501(r) of the Internal Revenue Code and the Code of Maryland Regulations 10.37.10.26 and has been adopted by "UPMC Western Maryland' Board of Directors.

POLICY:
This policy applies to all patients seeking emergency or other medically necessary care at UPMC Western Maryland. This policy also applies to patients seeking treatment at any UPMC Western Maryland owned physician practice. These entities are hereinafter collectively referred to as "UPMCWM."

The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under available Federal, State and Local Medical Assistance Programs, but whom outstanding "self-pay" balances exceed their own ability to pay. The underlying theory is that a person, over a reasonable period of time can be expected to pay only a maximum percentage of their disposable income towards charges incurred while in the hospital. Any "self-pay" amount in excess of this percentage would place an undue financial hardship on the patient or their family and may be adjusted off as Financial Assistance.

PROCEDURE:
OVERVIEW

1. Financial assistance can be offered before, during, or after services are rendered. After applying, the hospital will send an acknowledgment letter to the patient.
   a. For purposes of this policy, "financial assistance" refers to healthcare services provided without charge or at a reduced charge to qualifying patients.
      i. A list of our health care service providers is available at. https://www.wmhs.com/find-a-provider. Only providers employed by UPMCWM are covered under this policy and are indicated on the provider list.
   b. If a provider is not covered under this policy, patients should contact the provider's office to determine if financial assistance is available.
   c. Should a patient need assistance applying for Financial Assistance; help is available at our physical location 12500 Willowbrook Road, Cumberland, MD 21502. Patients can also call 240-964-8435 with any inquiries regarding the Financial Assistance application process.

2. Notice of the Availability of Financial Assistance:
   a. UPMCWM will make available brochures informing the public of its Financial Assistance Policy. Such brochures will be available-at UPMCWM' locations.

b. Notices of the availability of financial assistance will be posted at appropriate admission areas, the Billing Office, website, and other key patient access areas.
c. A statement on the availability of financial assistance will be included on patient billing statements.
d. A Plain Language Summary of UPMCWM' Financial Assistance Policy will be provided to patients receiving inpatient services with their Summary Bill and will be made available to all patients upon request.
e. UPMCWM' Financial Assistance Policy, a Plain Language Summary of the policy, and the Financial Assistance Application are available to patients upon request at UPMCWM or via mail as well as on UPMCWM' website at https://www.wmhs.com/patients-and-visitors/patients/financial-assistance
f. UPMCWM' Financial Assistance Policy, Plain Language Summary, and Financial Assistance Application are available in a different language upon request.

3. Availability of Financial Assistance: UPMCWM' retains the right, in its sole discretion, to determine a patient's ability to pay, in accordance with Maryland and Federal law.
   a. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.
   b. All patients presenting for emergency services will be treated regardless of their ability to pay.
      i. For emergent services, applications for financial assistance will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

4. Limitation of Charges: Individuals eligible for reduced-cost care under this policy will not be charged more than the hospital's standard charges, as set by Maryland's Health Services Cost Review Commission (HSCRC).
   a. UPMCWM' rate structure is governed by the HSCRC rate setting authority. As an "all-payer system", all patient care is charged according to the resources consumed in treating them regardless of the patient's ability to pay.
   b. Charges are developed based on a relative predetermined value set by the HSCRC at the approved unit rate developed by the HSCRC.

5. Payment plans are available to patients with family income between 200 and 500 percent of the Federal Poverty Level for those patients who request assistance, regardless of their insurance status.

PROGRAM ELIGIBILITY

1. UPMCWM strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. UPMCWM reserves the right to grant Financial Assistance without formal application being made by patients. These patients may include the homeless or returned mailed with no forwarding address.
2. Patients who are uninsured, under insured, ineligible for a government program, such as Medicaid, or otherwise unable to pay for medically necessary care may be eligible for "UPMCWM' Financial Assistance Program.
3. Services Eligible under this Policy. Health care services that are eligible for financial assistance include:
   a. Emergency medical services provided in an emergency room setting.
   b. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the individual.
   c. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
   d. Medically necessary services.

4. Exclusions from Financial Assistance: Specific exclusions to coverage under the Financial Assistance program include the following:
   a. Patients whose insurance program or policy denies coverage for the services received (e.g., HMO, PPO, Workers Compensation, or Medicaid)

i. Exceptions to this exclusion may be made, in UPMCWM' sole discretion, considering medical and programmatic implications.

b. Unpaid balances resulting from cosmetic or other non-medically necessary services;

c. Patient convenience items.

5. Ineligibility: Patients may become ineligible for financial assistance, for a specific date of service, for the following reasons:

a. After being notified by UPMCWM, refusal to provide requested documentation or information required to complete a Financial Assistance Application within the 240 days after the patient receives the first post-discharge billing statement (approximately 8 months).

b. Unless seeking emergency medical services, having insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to UPMCWM due to insurance plan restrictions/limits.

c. Failure to make appropriate arrangements on past payment obligations owed to UPMCWM (including those patients who were referred to an outside collection agency for a previous debt).

d. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program, unless UPMCWM can readily determine that the patient would fail to meet the eligibility requirements.

6. Patients who become ineligible for the program may be required to pay any open balances and may be submitted to a bad debt agency if the balance remains unpaid in the agreed upon time periods.

7. Patients who indicate they are unemployed and have no insurance coverage may be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance (See Section C.2 below)

a. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums may be reviewed by appropriate personnel and recommendations may be made to Senior Leadership for approval.

b. Individuals with the financial capacity to purchase or receive government sponsored health insurance may be encouraged to do so as a means of assuring potential coverage for health care services.

8. Coverage amounts will be calculated using a sliding scale fee scale based on federal poverty guidelines. An example of the sliding scale included in this policy.

9. A 25% discount will be extended for all Amish and Mennonite patients. For religious reasons the Amish and Mennonite community are opposed to accepting Medicare, Medicaid, public assistance or any form of health insurance coverage.

PATIENT ASSISTANCE GUIDELINES

1. Services eligible under this Policy will be made available to the patient on a sliding fee scale as described in this section; additionally, payment plans based on patient's ability to pay are available on an individual basis.
2. In determining the family income, the following individuals, at a minimum, must be used in the definition of household size:
    1. A spouse, regardless of whether the patient and spouse expect to file a joint federal or state tax return.
    2. Biological children, adopted children, or stepchildren
    3. Any person for whom the patient claims a personal exemption in a federal or state tax return.
3. For a patient who is a child, the household size must consist of the child and the following individuals:
    1. Biological parents, adoptive parents, stepparents, or guardians.
    2. Biological siblings, adopted siblings or stepsiblings.
    3. Any person for whom the patient's parents or guardians claims a personal exemption in a federal or state tax return.

4. Payment plans for patients, regardless of their insurance status are available for all patients with family income between 200% and 500% of the Federal Poverty Level who request assistance.

5. US Federal Poverty guidelines are updated annually by the Department of Health and Human Services at https://aspe.hhs.gov/poverty-guidelines. Below is an example of the sliding scale UPMCWM shall use to determine patient eligibility for financial assistance.
   a. Patients whose family income is at or below 200% of the Federal Poverty Level (FPL) are eligible to receive free care.
   b. Patients whose family income is above 200% but not more than 250% of the FPL are eligible to receive a discount of 80% of their account balance.
   c. Patients whose family income is above 250% but not more than 300% of the FPL are eligible to receive a discount of 60% of their account balance.
   d. Patients whose family income is above 300% but not more than 350% of the FPL are eligible to receive a discount of 40% of their account balance.
   e. Patients whose family income is above 350% but not more than 400% of the FPL are eligible to receive a discount of 20% of their account balance

PRESUMPTIVE FINANCIAL ASSISTANCE

1. Patients may be eligible for financial assistance on a presumptive basis. There are instances when a patient may appear eligible for financial assistance, but there is no Financial Assistance form and/or supporting documentation on file. Often there is adequate information provided by the patient or other sources that is sufficient for determining financial assistance eligibility.
   a. In the event there is no evidence to support a patient's eligibility for financial assistance, UPMCWM reserves the right to use outside agencies, or propensity to pay modeling information in determining Financial Assistance eligibility.
   b. Patients who are determined to satisfy presumptive eligibility will receive free care.

2. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
   a. Active Medical Assistance pharmacy coverage;
   b. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low-Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums);
   c. Homelessness;
   d. Maryland Public Health System Emergency Petition patients;
   e. Participation in Women, Infants and Children Programs ("WIC");
   f. Food Stamp eligibility;
   g. Eligibility for other state or local assistance programs;
   h. Patient is deceased with no known estate; and
   i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.

3. Patients deemed to be presumptively eligible for financial assistance based on participation in a social service program identified above must submit proof of enrollment within 30 days of such eligibility determination. A patient, or a patient's representative, may request an additional 30 days to submit required proof.

4. Exclusions from consideration for presumptive eligibility include:
   a. Purely elective procedures (e.g., cosmetic procedures).

FINANCIAL HARDSHIP

1. Patients falling outside of conventional income or who are not presumptively eligible for financial assistance are potentially eligible for bill reduction through the Financial Hardship program.
   a. Patients may qualify under the following circumstances:
      ii. Combined household income less than 500% of Federal Poverty Guidelines; or

iii. Financial Hardship is having incurred collective family hospital medical debt exceeding 25% of the combined household income during a 12-month period.

2. UPMCWM applies the criteria above to a patient's balance after any insurance payments have been received.

3. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines. An example of this sliding scale is provided at our website; https://www.wmhs.com/patients-and-visitors/patients/financial-assistance

4. If determined eligible, patients and their immediate family are certified for a reduced-cost medically necessary care, for a 12-month period effective on the date the medically necessary care was initially received.

5. In situations where a patient is eligible for both Financial Hardship and the standard Financial Assistance programs, UPMCWM is to apply the greater of the two discounts.

6. Patient is required to notify UPMCWM of their potential eligibility for this component of the financial assistance program.

ASSISTANCE BASED ON INDIVIDUAL CIRCUMSTANCES:
UPMCWM reserves the right to consider individual patient and family financial circumstances to grant reduced-cost care in excess of State established criteria.

1. The eligibility, duration, and discount shall be patient-situation specific.

2. Patient balance after insurance accounts may be eligible for consideration.

3. Cases falling into this category require management level review and HSCRC approval.

ASSET CONSIDERATION

1. Assets are generally not considered as part of Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient's responsibility without causing undue hardship. When assets are reviewed, individual patient financial circumstances, such as the ability to replenish the asset and future income potential may be taken into consideration.

2. The following assets are exempt from consideration:
   a. The first ~~$10,000~~ $10,600 of monetary assets for individuals, and the first ~~$25,000~~ $26,500 of monetary assets for families.
   b. Up to ~~$150,000~~ $159,000 in primary residence equity.
   c. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal.
   d. One motor vehicle used to transport the patient or any family member of the patient.
   e. Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act.
   f. Prepaid higher education funds in a Maryland 529 program account.

APPEALS

1. Patients whose financial assistance applications are denied have the option to appeal the decision. Appeals should be made in writing and mailed to: UPMCWM Willowbrook Office Complex Attn: Financial Counseling Team P.O Box 539 Cumberland, MD 21502.
2. Patients are also permitted to request that UPMC Western Maryland reconsider the denial of free or reduced cost care by contacting the Health Education and Advocacy Unit of the Maryland Attorney

General's office which can assist the patient or their authorized representative in filing and mediating a reconsideration request:

Maryland Attorney General
200 St. Paul Place, Baltimore, MD 21202
www.marylandattorneygeneral.gov

3. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

4. Appeals are documented and reviewed by the next level of management for additional reconsideration.

5. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.

6. Appeals can be escalated up to the Chief Financial Officer who will render the final decision.

PATIENT REFUND

1. If, within a two (2) year period after the date of service, a patient is found to be eligible for free care under UPMCWM' Financial Assistance Program, for that date of service, the patient shall be refunded payments in excess of their financial obligation where such refund is greater than $5.00.
   a. The two (2) year period may be reduced to 30 days after receipt of the first post-discharge billing statement where UPMCWM' documentation demonstrates a lack of cooperation by the patient, or guarantor, in providing documentation or information necessary for determining patient's eligibility.

2. If a patient is found to be eligible for financial assistance after UPMCWM has initiated extraordinary collection actions (ECA), such as reporting to a credit agency, liens, or lawsuits, UPMCWM will not take any further ECA and will take all reasonable steps available to reverse any ECA already taken.

OPERATIONS

1. UPMCWM will designate a trained person or persons who will be responsible for taking Financial Assistance Applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, or other designated trained staff.

2. Every effort will be made to determine eligibility prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request financial assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the applicable state Medicaid program to determine whether patients have current coverage or may be eligible for coverage where appropriate.
      i. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations).
   b. UPMCWM will provide patients with the Maryland State Uniform Financial Assistance Application and a checklist of what paperwork is required for a final determination of eligibility.
      i. In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:
         a) A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income);
         b) Proof of disability income (if applicable);
         c) A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income or documentation of how they are paying for living expenses;
         d) Proof of social security income (if applicable);

e) A Medical Assistance Notice of Determination (if applicable);
f) Reasonable proof of other declared expenses; and
g) If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

3. If a patient has not submitted a completed Financial Assistance application or any required supporting documentation within 30 days after a formal request, this will result in a denied application.
   a. A deadline for submission, prior to initiation of collection actions, will be included in the letter. Such deadline will be no earlier than 30 days after the date the reminder letter is provided.
   b. No extraordinary collection actions, such as reporting to a credit agency, liens, or lawsuits, will be taken prior to 120 days after the first post-discharge billing statement (approximately 4 months).
   c. If documentation is received after collection actions have been initiated, but within the 240 day after patient receipt of the first post discharge billing statement, UPMCWM shall cease all collection actions and determine whether the patient is eligible for financial assistance.

4. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UPMCWM guidelines.
   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.
   b. For complete applications, the patient will receive a letter notifying them of approval/denial within 30 days of submitting the completed applications.
   c. If an application is determined to be incomplete, the patient will be contacted regarding any additional required documentation or information
      i. If a patient is determined to be ineligible prior to receiving services, efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
      ii. If a patient is determined to be ineligible after receiving services, efforts to obtain a payment arrangement will be made, subject to UPMCWM' approval, on any balance due by the patient.

5. Except as noted below, once a patient is approved for financial assistance, such financial assistance shall be effective eight (8) months prior to date eligibility determined and the following twelve (12) calendar months.
   a. For those who qualify for reduced-cost care due to financial hardship, such qualification will apply for a twelve (12) month period.
   b. If additional healthcare services are provided beyond the approval period, patients must reapply to continue to receive financial assistance.

6. The following may result in the reconsideration of Financial Assistance approval:
   a. Post approval discovery of an ability to pay; and
   b. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to UPMCWM.

7. UPMCWM will track patients' qualification for financial assistance or financial hardship. However, it is ultimately the responsibility of the patient to inform UPMCWM of their eligibility status at the time of registration or upon receiving a statement.
8. The Health Service Cost Review Commission establishes a process for a patient or a patient's authorized representative to file with the Commission a complaint against a hospital for an alleged violation of 19-214.1 or 19-214.2 of this subtitle. The email address for the Health Service Cost Review Commission patient complaint (hscrc.patient-complaints@maryland.gov)

CREDIT & COLLECTION POLICY

1. UPMCWM maintains a separate Credit & Collection Policy that outlines what actions UPMCWM may take in the event a patient fails to meet their financial responsibility.

2. A copy of the Credit & Collection policy may be obtained by requesting a copy from UPMCWM staff, or by visiting UPMCWM website

3. UPMCWM maintains a list of all non-UPMCWM providers who may care for patients while at UPMCWM. Non-UPMCWM providers bill separately for their services and not all participate in UPMCWM' Financial Assistance Program.

4. A copy of this list may be obtained by requesting a copy from UPMCWM staff or by visiting UPMCWM' website at https://www.wmhs.com/find-a-provider

APPROVAL PROCESS:
Manager, PFS Hospital (editor)
Director, Revenue Cycle
Chief Financial Officer
UPMCWM Board of Directors

~~2021~~ 2022 SLIDING SCALE ADJUSTMENTS

UPMCWM FINANCIAL ASSISTANCE PROGRAM

Patient Responsibility Percentages

Size of Family Unit	0%	20%	40%	60%	80%
1	$0.00 - $ 27,180.00	$ 27,181.00 - $ 33,975.00	$ 33,976.00 - $ 40,770.00	$ 40,771.00 - $ 47,565.00	$ 47,566.00 - $ 54,360.00
2	$0.00 - $ 36,620.00	$ 36,621.00 - $ 45,775.00	$ 45,776.00 - $ 54,930.00	$ 54,931.00 - $ 64,085.00	$ 64,086.00 - $ 73,240.00
3	$0.00 - $ 46,060.00	$ 46,061.00 - $ 57,575.00	$ 57,576.00 - $ 69,090.00	$ 69,091.00 - $ 80,605.00	$ 80,606.00 - $ 92,120.00
4	$0.00 - $ 55,500.00	$ 55,501.00 - $ 69,375.00	$ 69,376.00 - $ 83,250.00	$ 83,251.00 - $ 97,125.00	$ 97,126.00 - $ 111,000.00
5	$0.00 - $ 64,940.00	$ 64,941.00 - $ 81,175.00	$ 81,176.00 - $ 97,410.00	$ 97,411.00 - $ 113,645.00	$ 113,646.00 - $ 129,880.00
6	$0.00 - $ 74,380.00	$ 74,381.00 - $ 92,975.00	$ 92,976.00 - $ 111,570.00	$ 111,571.00 - $ 130,165.00	$ 130,166.00 - $ 148,760.00
7	$0.00 - $ 83,820.00	$ 83,821.00 - $ 104,775.00	$ 104,776.00 - $ 125,730.00	$ 125,731.00 - $ 146,685.00	$ 146,686.00 - $ 167,640.00
8	$0.00 - $ 93,260.00	$ 93,261.00 - $ 116,575.00	$ 116,576.00 - $ 139,890.00	$ 139,891.00 - $ 163,205.00	$ 163,206.00 - $ 186,520.00
FPL Range	Thru 200%	201% - 250%	251% - 300%	301% - 350%	351% - 400%

From: Ruble, Amber R
To: Hilltop HCB Help Account
Cc: Perrin, Scott M; Morton, Cody
Subject: RE: Clarification Required - FY 22 UPMC Western MD Financials
Date: Monday, October 2, 2023 1:46:30 PM
Attachments: image001.png
CBR Initiative and Data Observed-UPMC WMD-FY22.xlsx
CBR Narrative-UPMC Western Maryland-FY22.docx

The attached files are in response to the two emails we received about the FY22 Community benefit report asking for clarification. I have pasted the second email below in red so you can see both requests in one email. It is our intent that the two attachments provide clarification. Should you have further questions, please reach out. We are attempting to include this detail in our FY23 reporting as well.

Thank you.

Amber

Amber Ruble
Chief Financial Officer
p: 240-964-8032
rublear@upmc.edu
UPMC Western Maryland
12500 Willowbrook Road
Cumberland, MD 21502

UPMC
LIFE CHANGING MEDICINE

Thank you for submitting the FY 2022 Hospital Community Benefit Narrative report for UPMC Western Maryland. In reviewing the narrative, we encountered an item that requires clarification. Your answer to Question 80 on page 40 was very brief and did not describe why a subsidy was needed for each provider type selected in Question 79. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed for the physician types or services listed below:

- Anesthesiology
- Cardiology
- Endocrinology, diabetes & metabolism
- Internal medicine
- Obstetrics & gynecology
- Oncology-cancer

- Preventive medicine
- Psychiatry
- Urgent care centers
- Hospice
- Nephrology
- Infectious disease
- Wound care physicians
- Outpatient dialysis and peritoneal dialysis
- Population health
- Center for Clinical Resources

Please provide your clarifying answer as a response to this message.

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Monday, April 24, 2023 10:48 AM
To: Ruble, Amber R <rublear@upmc.edu>
Cc: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Subject: Clarification Required - FY 22 UPMC Western MD Financials

Good morning. In reviewing the financials sheet submitted for UPMC Western MD, we encountered an issue that needs clarification. No information was entered in the Initiative Outcomes Observed or Data Used to Measure Initiative Outcomes columns. Please provide details on the initiative outcomes observed and the data used to measure outcomes for each initiative or explain why these fields are not applicable.

Please provide your clarifying answer as a response to this message.

Each physician subsidy selected is a result of needs identified during our Community Health Needs Assessments.

For many subsidies selected, including Cardiology, Endocrinology, Oncology-Cancer, Psychiatry, Infectious Disease, Wound Care and Dialysis (OP & Peritoneal) we are the only provider of care within our primary service area. The next closest care option is at least 45-60 minutes away from our community, representing a significant barrier to our community to get the care they need if we don't offer it. Some of these subsidies selected have additional barriers. For Oncology-Cancer subsidy, the next closest care option that is 45 minutes away only has 1 clinician available for medical oncology and doesn't provide radiation therapy, not allowing enough additional capacity to meet the needs of our community. For Psychiatry, this is an area with increasing demand for services as behavioral health care needs continue to increase. For Dialysis, similarly to Oncology-cancer, the next closest care option that is 45 minutes away only has 7 chairs available, not producing enough additional capacity to address the needs of our community. As you can see, in many instances, the next closest care site doesn't produce adequate additional capacity to address the needs of our community, leaving us to create the capacity to meet the need.

For other subsidies selected, including Obstetrics & Gynecology and Nephrology, limited community services are available in our service area which doesn't allow the need of the community to be met. An additional barrier exists for Obstetrics & Gynecology, where we have an FQHC and one other community provider to provide care, but the other community provider doesn't accept Medicaid, which is a huge barrier since 49% of our patients in this subsidy are covered by Medicaid. For Nephrology, only one other community provider is available, which doesn't provide adequate capacity to meet the community need.

For Anesthesiology, over 73% of our patients are covered by governmental payors, which the reimbursement rates under FFS for governmental payors do not allow the Anesthesiology group to cover their expenses by their billings, creating a funding gap we must cover in order for the services to be available to our community.

The Population Health and Center for Clinical Resources subsidies are unique in our service area and are addressing chronic conditions, such as COPD, CHF, Diabetes (in conjunction with our Nephrology specialty), as well as social determinants of health. We also have a Sepsis clinic to address the clinical condition to improve the well-being of our community.

Our Internal Medicine subsidy covers our investment in primary care, and we carry the HRSA MUA designation. Also related is our Urgent Care subsidy, which covers our investment in this area to address the community needs in the areas they reside to provide more appropriate care and in a more appropriate and cost efficient setting.