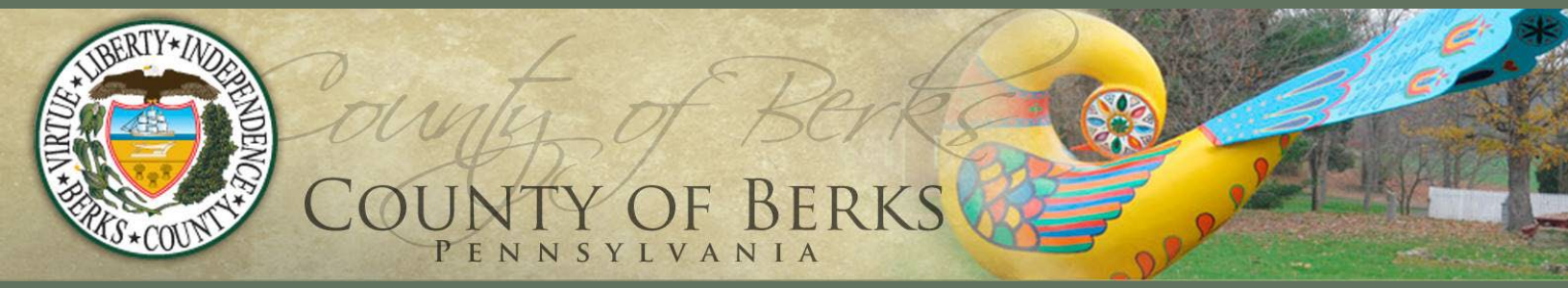

Informe final del condado de Berks

Estudio de prestación de servicios médicos y de salud pública en el condado de Berks

HEALTH MANAGEMENT ASSOCIATES

Nos gustaría reconocer a todas las personas que participaron y contribuyeron en este esfuerzo. Muchas gracias por compartir su valiosa opinión y su tiempo.

Comisionados del condado de Berks

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

Equipo principal del condado de Berks

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

Organizaciones que participaron en entrevistas

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

Organizaciones que participaron en el grupo focal

Berks Community Health Center
Berks Counseling Center
Berks County Veterans Affairs
Berks County Department of Emergency Services
Centro Hispano Daniel Torres Inc.
Co-County Wellness Services
Community Care Behavioral Health
County EMS Working Group
County Fire Working Group
County Law Enforcement Working Group
Eastern PA EMS Council
Greater Reading Chamber Alliance
Habitat for Humanity
Hope Springs Clubhouse
Mary's Shelter
Mosaic House
Muhlenberg School District
NAI Keystone
New Castle Lawn & Landscaping
Opening Doors Program Participant
Pennsylvania Department of Health
Penske Trucking
Quantitative Evaluation and Sys-Tems (QEST)
Service Access and Management, Inc
Tec Centro
Tower Health
Weaver's Hardware Company

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[1] Durante el curso del estudio, hubo un cambio en la composición de la Junta de Comisionados del condado de Berks. Cuando se autorizó este informe, el comisionado Keven Barnhardt estaba en la Junta. El comisionado Barnhardt renunció en enero de 2023. La comisionada Lucine E. Sihelnik fue nombrada por la Junta de Jueces del condado de Berks como la nueva comisionada del condado el 14 de febrero de 2023.

Además de las organizaciones mencionadas anteriormente, nos gustaría expresar nuestra gratitud a cada uno de los miembros de la comunidad del condado de Berks que participaron en conversaciones del grupo focal o en entrevistas individuales. ¡Gracias!

A. Resumen ejecutivo

La propagación del COVID-19 creó una crisis de salud pública que este país no había experimentado en el último siglo. Esta pandemia requirió que los gobiernos locales actuaran rápidamente para limitar el costo humano de esta amenaza a la salud pública. Tres años después, muchos condados están considerando cómo responder mejor cuando las necesidades comunitarias cambian. Algunos condados están examinando cómo podrían aprovechar los servicios de salud pública y las oportunidades de financiación de la Ley del Plan de Rescate de Estados Unidos para desarrollar infraestructura y sistemas que tengan un impacto duradero para mejorar las vidas de sus residentes.

Los comisionados del condado de Berks solicitaron que Health Management Associates, una empresa de investigación y consultoría con experiencia en planificación estratégica de servicios de salud pública, atención médica y servicios sociales, llevara a cabo un estudio y recibiera orientación de un equipo principal de cinco miembros de expertos de salud pública y salud del gobierno del condado, organizaciones comunitarias y un ciudadano particular con décadas de experiencia en liderazgo en el condado.

Este estudio evaluó los servicios médicos y de salud pública en el condado de Berks para identificar oportunidades para asegurar que todas las personas residentes tengan recursos y oportunidades para alcanzar sus niveles de salud más altos. Reconociendo que la salud de una comunidad se determina en gran medida por condiciones fuera de entornos de atención médica, este estudio examinó cómo el condado coordina y alinea acciones intersectoriales vinculadas a la salud pública que implican a quienes viven en el condado, negocios, escuelas, organizaciones comunitarias y sectores gubernamentales. El objetivo del estudio fue asegurar que el condado de Berks tenga información comunitaria para evaluar cómo los servicios de atención médica y de salud pública apoyan a sus residentes en mejorar los resultados y la equidad de salud. De esta manera, el estudio busca recomendar pasos que el condado pueda tomar para liderar en emergencias de salud pública como también prevenir condiciones de salud evitables y reducir desigualdades sanitarias.

Usamos un enfoque por fases para evaluar las necesidades de servicios de salud pública en el condado de Berks. En la fase uno, revisamos estadísticas de salud estatales y del condado para establecer un entendimiento base de necesidades de salud pública preexistentes. También georreferenciamos datos, revisamos evaluaciones de necesidades comunitarias de salud recientes que dos hospitales del condado completaron y comparamos el perfil de salud del condado de Berks con condados colindantes y similares. En la fase dos, profundizamos más en este punto, convocando grupos focales con un total de 81 miembros de la comunidad participantes de todo el condado. Estos grupos focales incluyeron personas que interactúan con el sistema de salud de diferentes maneras, incluyendo beneficiarios, proveedores y administradores de servicios. También llevamos a cabo entrevistas con informantes clave con líderes comunitarios y partes interesadas del sistema de salud. La información del enfoque que otros condados de Pennsylvania usan para cumplir con necesidades de salud pública también informó las recomendaciones del estudio en la fase tres.

Las partes interesadas de salud pública del condado de Berks instaron rotundamente que el condado considerara un enfoque para la salud pública que brindaría recursos para:

- Coordinar servicios de salud pública que ya se estaban implementando en el condado (organizaciones comunitarias, hospitales, planes de salud, agencias del condado y de la ciudad) y apoyar en un impacto colectivo para destinar los recursos del condado para crear sinergia entre los esfuerzos existentes y las necesidades que no se están atendiendo en otros sitios.
- Brindar una voz clara y confiable sobre amenazas, respuestas y preocupaciones de la salud pública para guiar a residentes, negocios, escuelas y organizaciones privadas y públicas del condado en emergencias de salud pública.
- Aumentar el acceso del público y socios clave de salud pública a los datos de salud pública.
- Aclarar roles y responsabilidades para cada socio público y privado y reducir duplicación de esfuerzos entre el condado, la ciudad y el estado.
- Mejorar la salud de poblaciones del condado que muestran las mayores desigualdades apoyando factores previos que afectan la salud como acceso a nutrición, vivienda, atención médica y beneficios y asegurar que la información y los recursos sobre prevención y bienestar sean accesibles en inglés y español.

Con base en nuestro análisis, recomendamos que el condado de Berks tome las siguientes acciones:

1. Crear una posición de director de salud del condado de Berks para liderar la acción colectiva y la coordinación en salud pública y que sirva como un comunicador confiable sobre información de salud pública.
2. Establecer un panel asesor de salud pública para brindar orientación clínica y de salud pública para el condado y el director de salud.
3. Apoyar el establecimiento de una coalición de salud en Berks que sirva como un órgano de coordinación para esfuerzos de salud pública en el condado.
4. Crear una posición de analista de salud del condado de Berks para mejorar la exhaustividad y precisión de datos de salud pública específicos del condado de Berks.

Estas recomendaciones le permitirán al condado tener un **amplio rango de opciones** para mejorar su capacidad de cumplir las necesidades de salud pública en el futuro. Creando una posición de director de salud pública, un panel asesor de salud pública, una coalición de salud en Berks y una posición de analista de datos de salud, el condado podrá mejorar la coordinación de servicios existentes y comunicarse con socios y el público como una voz de autoridad sobre amenazas, emergencias y riesgos de salud pública. Simultáneamente, estos pasos brindarán una **ruta para establecer un departamento de salud pública** en caso de que el condado decida hacerlo en el futuro.

B. ¿Qué es la salud pública?

La salud pública es lo que hacemos como sociedad para asegurar las condiciones en las que todas las personas puedan estar sanas. La salud pública es distinta de la prestación de atención médica o servicios sociales. Por ejemplo, los departamentos estatales y locales de salud pública monitorizan brotes de enfermedades, que van desde enfermedades transmitidas por los alimentos como *E. coli* hasta enfermedades contagiosas como COVID-19 o sarampión, para identificar la fuente del brote, diseminar información precisa para la comunidad y prevenir una mayor propagación. Sin embargo, estos departamentos no suelen prestar servicios de tratamiento médico para enfermedades contagiosas. La salud pública suele considerarse "invisible" porque su enfoque es el de prevenir que ocurran brotes, desastres, heridas y enfermedades crónicas nocivas. Sin embargo, como se evidencia por la pandemia de COVID-19, la ausencia de una infraestructura básica de salud pública puede significar que, cuando ocurre una emergencia o desastre este tipo, la respuesta puede verse severamente obstaculizada sin liderazgo de salud pública que comunice información de forma efectiva, organice los esfuerzos y coordine socios, dejando a las comunidades deplorablemente mal preparadas para responder rápidamente e implementar operaciones de aumento de capacidad.

C. Enfoque para entender las necesidades y oportunidades de salud pública en el condado de Berks

Este estudio de la prestación de servicios médicos y de salud pública en el condado de Berks se llevó a cabo desde junio de 2022 hasta marzo de 2023. Evaluó los servicios médicos y salud pública del condado desde la perspectiva de una muestra representativa de miembros de la comunidad y partes interesadas de la salud. Este estudio consideró las necesidades y servicios de salud pública del condado de Berks más de dos años después del inicio de la pandemia de COVID-19, una experiencia que moldeó las opiniones de las partes interesadas en todos los niveles. Cada paso del estudio fue guiado por un equipo central de expertos de salud pública y salud del gobierno del condado, organizaciones comunitarias y un ciudadano particular con décadas de experiencia de liderazgo en el condado.

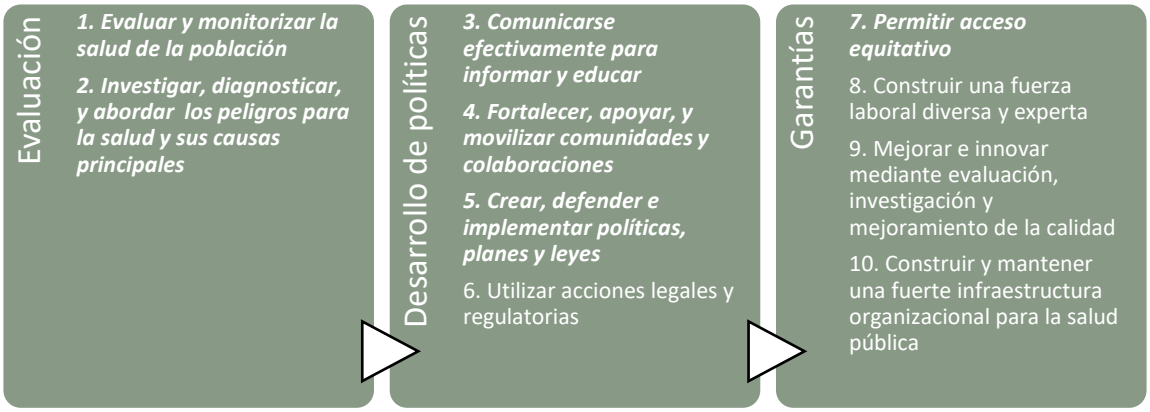
Empezamos nuestro estudio revisando dos evaluaciones previas de necesidades de salud comunitaria (CHNA, por sus siglas en inglés) llevadas a cabo en el condado de Berks. Nuestro estudio difería de una CHNA en que analizaba vacíos, oportunidades y fortalezas en relación con la prestación de servicios de salud pública. Una CHNA es un proceso sistémico para identificar necesidades y barreras comunitarias, mientras que este estudio se enfocó más en prioridades y soluciones comunitarias relacionadas a la coordinación y prestación de servicios de salud pública en el condado de Berks.

Delimitamos este estudio de los servicios médicos y de salud pública en el condado de Berks con base en los estándares nacionales para los servicios esenciales de salud pública. Los 10 servicios de salud pública esenciales se dividen en tres ámbitos: evaluación, desarrollo de políticas y garantías. Con base en las necesidades del condado de Berks identificadas en los datos y las CHNA recientes, nos enfocamos más en seis de los 10 servicios esenciales de salud pública:

- Evaluar y monitorizar la salud de la población;
- Investigar, diagnosticar y abordar los peligros para la salud y sus causas principales;
- Comunicarse efectivamente para informar y educar;
- Fortalecer, apoyar y movilizar comunidades y colaboraciones;
- Crear, defender e implementar políticas, planes y leyes; y
- Permitir acceso equitativo.

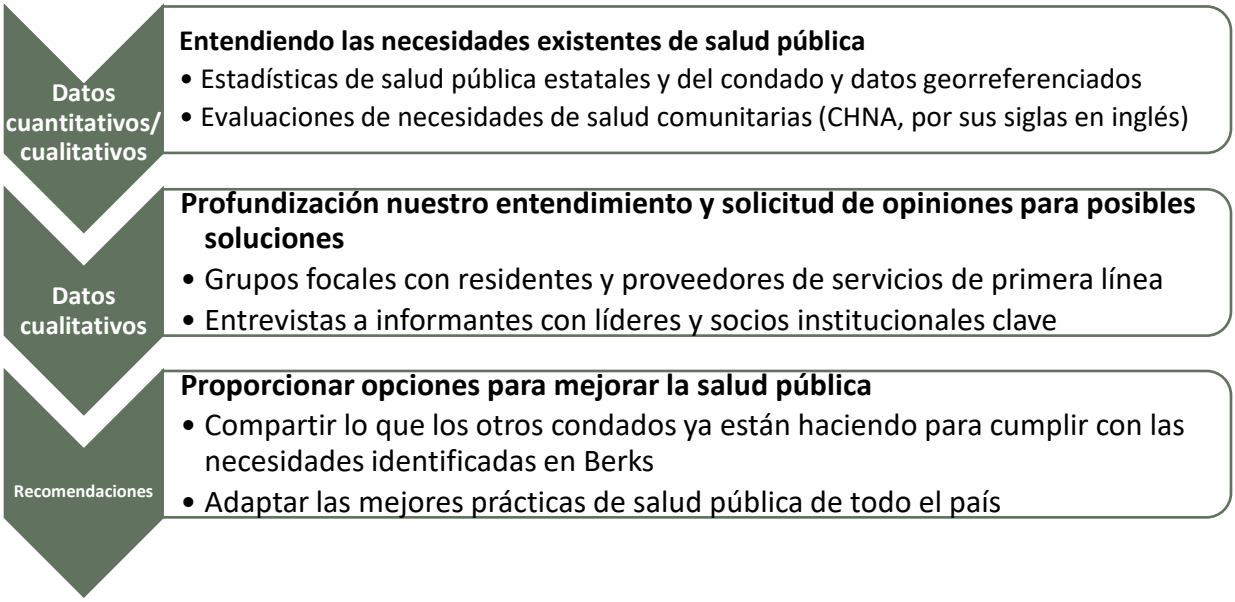
Nuestros análisis de datos, revisión de documentos, grupos focales y entrevistas examinaron el estado actual de estos seis servicios esenciales de salud pública en el condado de Berks. La **figura 1** desglosa los 10 servicios esenciales de salud pública y los seis escogidos (en negritas) para guiar nuestro estudio.

Figura 1. Servicios esenciales de salud pública



Implementamos un enfoque de tres fases para evaluar las necesidades de servicios de salud pública en el condado de Berks. En la fase uno, recibimos estadísticas de salud estatales y del condado para profundizar nuestro entendimiento de necesidades existentes de salud pública y solicitamos opiniones de posibles soluciones. También analizamos estadísticas de salud estatales y del condado, datos georreferenciados y revisamos algunas CHNA recientes. Comparamos el perfil de salud del condado de Berks a condados colindantes y similares (Chester, Lancaster, Lehigh, Montgomery y York). En la fase dos, profundizamos más en este punto, hablando con miembros de la comunidad de varias localidades del condado en grupos focales. Un total de 81 participantes de grupos focales estuvieron involucrados, tomados de residentes, trabajadores de atención médica de primera línea y personal del programa de salud. También llevamos a cabo 10 entrevistas con informantes clave con líderes comunitarios y partes interesadas clave. Nuestras conversaciones, que se llevaron a cabo tanto en inglés como en español, brindaron la base para nuestros hallazgos. La información del enfoque que otros condados usaron para cumplir con las necesidades como las del condado de Berks también informaron las recomendaciones del estudio en la fase tres. La **figura 2** ilustra nuestro proceso.

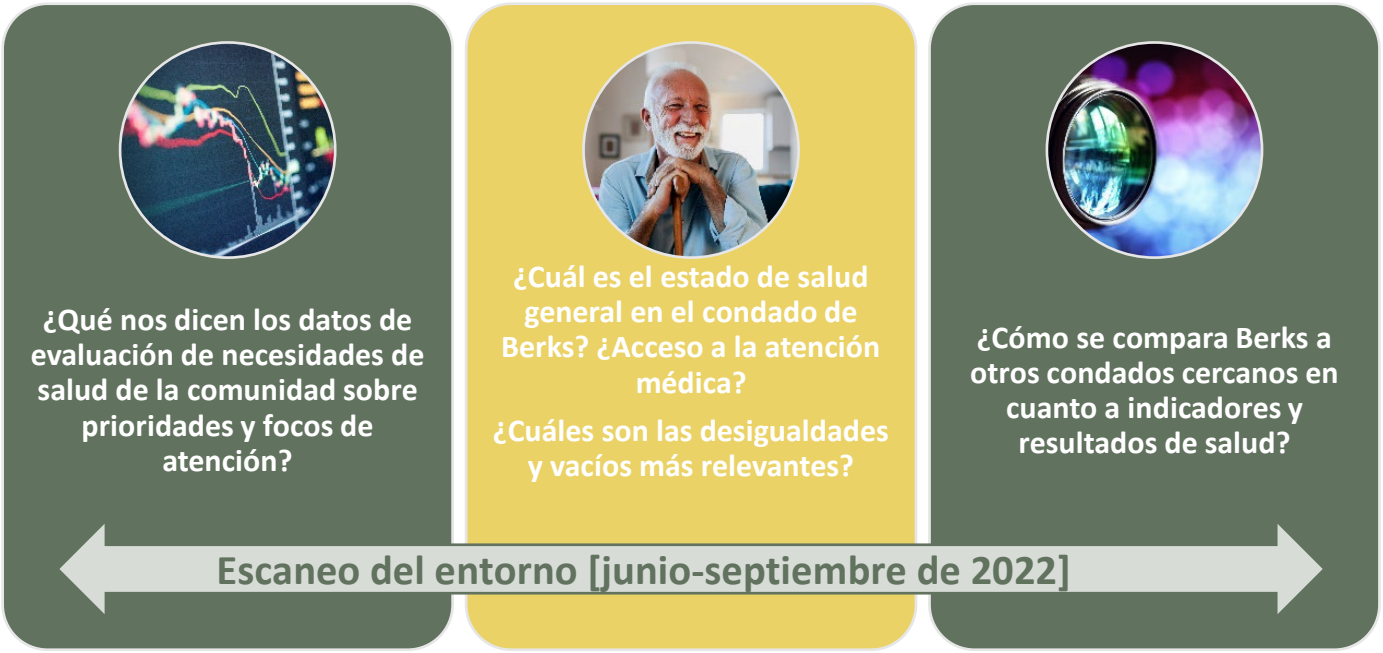
Figura 2. Proceso



D. Empezamos revisando evaluaciones recientes de necesidades de salud comunitaria y otros datos e información relevantes para crear un perfil de salud del condado de Berks

En las etapas tempranas de este proyecto, Health Management Associates (HMA) revisó fuentes de datos federales, estatales y locales, así como informes existentes y documentos para determinar lo que las organizaciones de salud y servicios sociales del condado de Berks ya habían descubierto al respecto de necesidades de salud pública de personas y familias en el condado. Delimitamos nuestro análisis en torno a las siguientes preguntas:

Figura 3. Preguntas analíticas



Al responder estas preguntas, HMA revisó una serie de datos estatales y del condado existentes incluyendo:

- Censo y datos demográficos, incluyendo composición racial/étnica, distribución etaria, socioeconómica y poblaciones especiales;
- Factores sociales y económicos incluyendo ingresos, niveles de pobreza, educación, desempleo y personas sin hogar en los cuatro condados;
- Resultados de salud en todos los condados incluyendo, principales causas de muerte, clasificaciones en materia de salud, factores y comportamientos de salud y condiciones de salud;
- Acceso a atención primaria y preventiva, cobertura de seguro;
- CHNA recientes llevadas a cabo por los hospitales Tower Reading y Penn State-St. Joseph's
- Paneles de datos nacionales y estatales incluyendo clasificación en materia de salud del condado,[2] datos de lugares de los Centros para el Control y Prevención de Enfermedades (CDC, por sus siglas en inglés),[3] panel de datos de salud de la ciudad de Reading,[4] programa Healthy People,[5] Data USA

[2] Clasificaciones en materia de salud y hoja de ruta del condado, 2022, https://www.countyhealthrankings.org/
[3] Centros para el Control y Prevención de Enfermedades: lugares, 2022, https://www.cdc.gov/places/index.html
[4] Panel de datos de salud de la ciudad, resumen de Reading PA, 2022 https://www.cityhealthdashboard.com/pa/reading/city-overview
[5] Healthy People 2023, 2022, https://health.gov/healthypeople

(página de estadísticas de Estados Unidos),[6] Word Population Review,[7] índice Future Ready PA,[8] y Oficina del Censo de los Estados Unidos[9];

- Datos del Departamento de Salud de Pennsylvania y del Departamento de Servicios Humanos, incluyendo perfiles de salud del condado y mapa de calor de desigualdades de salud; y
- Datos de United Way y 211 counts sobre necesidades de servicios sociales y uso de servicios.

A continuación, presentamos hallazgos clave vinculados a las preguntas anteriores sobre el escaneo del entorno. Las fuentes de datos y documentos fueron examinadas sistemáticamente.

Lo que aprendimos de evaluaciones de necesidades anteriores

HMA revisó dos CHNA recientes abarcando el condado de Berks preparadas por Tower Health y Penn State Health. El Servicio de Impuestos Internos requiere hospitales sin fines de lucro y planes de salud para llevar a cabo una evaluación de necesidades de salud de la comunidad al menos una vez cada tres años. Para referencia, ambas CHNA se incluyen en el **apéndice A** y **apéndice B**, respectivamente.

Las prioridades de salud clave identificadas en las dos CHNA fueron bastante similares:

1. Mejorar el acceso a atención equitativa, particularmente para poblaciones marginalizadas;
2. Brindar atención de salud de comportamiento/mental tanto a adultos y jóvenes;
3. Concentrarse en la educación y la alfabetización en materia de salud, especialmente recursos e información vinculados al bienestar y la prevención de enfermedades; y
4. Abordar las desigualdades de salud y aumentar el enfoque en la equidad de salud incluyendo factores determinantes sociales de la salud (SDOH, por sus siglas en inglés).

Ambas CHNA identificaron índices bajos de atención preventiva entre todas las personas residentes y desigualdades en atención preventiva entre minorías raciales y étnicas. Por ejemplo, 18 por ciento de las personas residentes latinoamericanas y 17 por ciento de las personas residentes afroamericanas completaron una colonoscopía en comparación con el 35 por ciento de las personas residentes blancas y el 30 por ciento de las personas residentes asiáticas. Además, las CHNA reconocieron desigualdades raciales y étnicas entre personas mayores inscritas en Medicare. En comparación con las personas blancas inscritas en Medicare, los índices de varias condiciones de salud crónicas fueron altas entre personas mayores que no eran blancas. Los índices de diabetes fueron 7 por ciento más altas entre personas hispanas, negras y asiáticas. Adicionalmente, ambos reportes resaltaron las necesidades médicas y sociales de las poblaciones hispana y latina, incluyendo el hecho de que un tercio de las personas latinas viven por debajo del nivel de pobreza federal y experimentan inseguridad alimentaria. En función de la raza y la etnia, las personas latinas en el condado de Berks tienen el índice más elevado de personas sin

[6] DataUSA, perfil de Reading PA, información de 2020, https://datausa.io/profile/geo/reading-pa/
[7] Informe sobre la población mundial, población de Reading PA, 2022, https://worldpopulationreview.com/us-cities/reading-pa-population
[8] Future Ready PA Index, 2022, https://futurereadypa.org/
[9] Datos del censo de Estados Unidos, https://data.census.gov/

seguro médico (11 %) y los índices más altos de visitas a las salas de emergencia, lo que indica una falta de acceso a atención primaria. Estos hallazgos indican la necesidad de mejorar la atención preventiva para hacer frente a las desigualdades en resultados de salud en el condado de Berks.

Las CHNA también detallaron necesidades de salud del comportamiento, incluyendo una ausencia de servicios de salud mental y trastorno de uso de sustancias (SUD, por sus siglas en inglés), una escasez de proveedores, camas de hospitalización y recursos de atención intermedios insuficientes, centros de enfermería especializada insuficientes que admitan personas con enfermedades mentales serias y una falta general de conciencia pública de los servicios de salud del comportamiento existentes.

Ambas CHNA se concentraron en la necesidad de acabar con las principales desigualdades de salud y vincularon estas desigualdades a factores sociales previos por fuera de la prestación de atención médica, incluyendo una falta de concienciación de recursos y servicios disponibles, comida, inseguridad habitacional, falta de transporte público y obstáculos culturales y lingüísticos. Estas evaluaciones también notaron una necesidad de concentrarse más en la alfabetización en materia de salud y salud preventiva, como también la necesidad de más atención a la salud del comportamiento como parte de la promoción de salud y bienestar de la comunidad.

Lo que aprendimos sobre el contexto socioeconómico para la salud en el condado de Berks

Con base en los datos del censo estadounidense de 2020, Berks es similar tanto a Pennsylvania en su totalidad como a los Estados Unidos en muchas métricas poblacionales e indicadores demográficos (véase la **tabla 1**). Los puntos clave en las que Berks es diferente en comparación con promedios estatales incluyen:

- Composición racial/étnica: Berks tiene un porcentaje mayor de residentes de las comunidades hispana/latina y porcentajes menores de residentes de las comunidades asiática, negra/afroamericana y blanca.
- Diversidad del lenguaje: Berks tiene un porcentaje mayor de hogares que hablan un idioma diferente del inglés en sus casas.
- Nivel de estudios: Berks tiene porcentajes menores de personas que hayan obtenido tanto un diploma de secundaria como un título universitario de 4 años a los 26 años.

Tabla 1. Estadísticas poblacionales, 2020

Indicador	*Condado de Berks*	*Pennsylvania*	*Estados Unidos*
Asiático	2 %	*4 %*	*6 %*
Negro/afroamericano	8 %	*12 %*	*14 %*
Hispano/latino	24 %	*8 %*	*19 %*
Multirracial	3 %	*2 %*	*3 %*
Otro	1 %	*1 %*	*2 %*
Blanco, no-hispano	69 %	*75 %*	*59 %*
Ingreso medio por hogar	$69,272	*$67,587*	*$69,021*

Porcentaje en pobreza	13 %	*12 %*	*12 %*
Porcentaje con discapacidad (menos de 65 años)	10 %	*10 %*	*9 %*
Porcentaje con menos de 18 años	22 %	*21 %*	*22 %*
Porcentaje con más de 65 años	18 %	*19 %*	*17 %*
Finalización de la secundaria	88 %	*91 %*	*89 %*
Título universitario	*26 %*	*33 %*	*34 %*
Idioma diferente al inglés hablado en el hogar	*19 %*	*12 %*	*22 %*

Lo que aprendimos sobre salud y acceso a la salud en el condado de Berks

Usando datos del Centro Nacional de Estadísticas de Salud,[10] la **tabla 2** muestra la causa principal de muertes en el condado de Berks en comparación con promedios tanto estatales como nacionales. Las causas de muerte se enumeran por orden de importancia, aparte del COVID-19 el cual representa un índice acumulativo del 2020 al 2023. En la mayoría de los indicadores, Berks tiene tasas de muerte menores en comparación con promedios estatales. Las dos excepciones son accidentes cerebrovasculares y COVID-19 (indicadas en rojo a continuación). Berks tiene índices menores en cuatro causas principales de muerte en comparación con promedios nacionales y cinco que son más altas (enfermedad cardíaca, cáncer, accidente cerebrovascular, enfermedad renal y COVID).

Tabla 2. Principales causas de muerte (tasa por 100,000), 2017

Indicador	*Condado de Berks*	*Pennsylvania*	*Estados Unidos*
Enfermedad cardíaca	172.2	176.0	165.0
Cáncer	156.9	161.0	152.5
Accidentes	48.9	70.2	49.4
Accidente cerebrovascular	**46.5**	**36.5**	**37.6**
Enfermedad crónica de las vías respiratorias inferiores	33.9	37.1	40.9
Diabetes	19.3	21.0	21.5
Alzheimer	16.7	21.7	31.0
Enfermedad renal	14.6	15.9	13.0
COVID (desde 2020)[11]	**412.9**	**387.6**	**327.3**

[10] Centros para el Control y Prevención de Enfermedades, Centro Nacional De Estadísticas De Salud, 2017 https://www.cdc.gov/nchs/pressroom/states/pennsylvania/pennsylvania.htm

[11] Casos y muertes por COVID-19 en Estados Unidos por estado, https://usafacts.org/visualizations/coronavirus-covid-19-spread-map

Usando datos de los perfiles de salud del condado de 2022,[12] la **tabla 3** muestra los indicadores de calidad de vida. Berks ocupa los puestos más bajos en salud autodeclarada y número de días de mala salud física (indicados en rojo).

Berks es similar a los promedios estatales y nacionales en cuanto a mala salud mental autodeclarada y bajo peso al nacer.

Tabla 3. Calidad de vida, 2020

Indicador	*Condado de Berks*	*Pennsylvania*	*Estados Unidos*
Salud mala o regular	**20 %**	**18 %**	**17 %**
Días de mala salud física	**4.2**	**3.9**	**3.9**
Días de mala salud mental	4.6	4.6	4.5
Bajo peso al nacer	8 %	8 %	8 %

La **tabla 4** muestra varios factores y comportamientos de salud en el condado de Berks. En comparación con datos estatales y nacionales, Berks tiene índices ligeramente mayores de adultos fumadores, inactividad física y obesidad (indicados en rojo a continuación). Berks también tiene índices mayores de nacimientos en la adolescencia e infecciones de transmisión sexual. Otros indicadores fueron similares a los índices estatales y nacionales, o mejores en el caso del acceso a comida saludable.

Tabla 4. Factores y comportamientos de salud, 2020

Indicador	*Condado de Berks*	*Pennsylvania*	*Estados Unidos*
Adultos fumadores	**19 %**	**18 %**	**16 %**
Obesidad en adultos	**34 %**	**33 %**	**32 %**
Índice de entorno alimentario (10 = mejor acceso a comida saludable)	**8.7**	**8.4**	**7.8**
Inactividad física	**28 %**	**25 %**	**26 %**
Acceso a oportunidades de ejercicio	79 %	78 %	80 %
Consumo excesivo de alcohol	19 %	20 %	20 %
Infecciones de transmisión sexual (índice por 100,000)	535.9	481.9	551.0
Nacimientos en la adolescencia (índice por 100,00)	20	15	19

Como se muestra en la **tabla 5**, Berks tiene un menor acceso a médicos de atención primaria, dentistas y salud mental en comparación con índices estatales y nacionales (indicados en rojo a continuación). Berks también tiene números mayores de estadías hospitalarias prevenibles e índices menores de mamografías que el promedio estatal. Berks obtiene mejores resultados en el porcentaje de residentes con seguro médico y tendencia a la vacunación antigripal.

[12] Clasificación en materia de salud y hoja de ruta del condado, condado de Berks, 2022, https://www.countyhealthrankings.org/explore-health-rankings/pennsylvania/berks?year=2022

Tabla 5. Acceso a atención médica/atención clínica, 2020

Indicador	*Condado de Berks*	*Pennsylvania*	*Estados Unidos*
Porcentaje de personas sin seguro	8 %	7 %	11 %
Médicos de atención primaria (índice)	**1,590:1**	**1,220:1**	**1,310:1**
Dentistas	**1,770:1**	**1,410:1**	**1,310:1**[13]
Proveedores de salud mental	**640:1**	**420:1**	**350:1**
Estadías hospitalarias prevenibles	**4,221**	**3,966**	**3,767**
Mamografías	45 %	47 %	43 %
Vacunas antigripales	55 %	54 %	48 %

Resumen de Berks con relación a otros condados cercanos

Examinamos datos de salud clave en el condado de Berks en comparación con cinco condados cercanos (Chester, Lancaster, Lehigh, Montgomery y York). Clasificamos cada condado en función de determinados indicadores de salud en una escala del uno al seis (1=mejor clasificación/resultados; 6=peor clasificación o peores resultados). La **tabla 5** a continuación resume cómo Berks se compara con otros condados cercanos.

Tabla 5. Resumen de las clasificaciones en materia de salud, mortalidad y acceso (per capita), comparación entre condados

Área	Resultados más bajos (Berks 5 o 6)	Rendimiento medio (Berks 3 o 4)	Mejores resultados (Berks 1 o 2)
Causas principales de muerte	Enfermedad cardíaca (6) Muerte por COVID (6) Accidente cerebrovascular (6) Enfermedad crónica de las vías respiratorias inferiores (6) Cáncer (5) Enfermedad renal (5)	Accidentes (4) Diabetes (4)	Alzheimer (1)
Clasificación en materia de salud	Salud mala o regular (6) Días de mala salud física (6) Muerte prematura (5) Bajo peso al nacer (5)	Días de mala salud mental (4)	
Factores y comportamientos de salud	Inactividad física (6) Nacimientos en la adolescencia (6) Adultos fumadores (5) Obesidad en adultos (5) Infección de transmisión sexual (5)	Índice del entorno alimentario (4) Consumo excesivo de alcohol (4) Acceso a ejercicio (3)	
Acceso a la atención médica/atención clínica	Médico de atención primaria (6) Dentista (5) Proveedor de salud mental (5)	% sin seguro (4)	

[13] Clasificación en materia de salud y hoja de ruta del condado, 2022, https://www.countyhealthrankings.org/ Este sitio web permite comparar a Berks con otros tres condados a la vez.

	Estadías hospitalarias prevenibles (6) Mamografía (5) Vacuna antigripal (6)		

Georreferencia de factores e indicadores de salud

Para examinar la distribución de datos de salud clave y factores relacionados a la salud en el condado de Berks, mapeamos la población del condado de Berks al nivel del código postal según los siguientes factores: índices de personas sin seguro, prevalencia de cáncer, obesidad, enfermedad cardíaca crónica, diabetes, colesterol alto, tabaquismo, asma y depresión.

Usando una herramienta federal de mapeo[14], preparamos "mapas de calor" geográficos para ilustrar la prevalencia de una condición o factor dado, llamando la atención a la ciudad de Reading en relación a las otras porciones del condado. Cuatro códigos postales (19601, 1602, 19604 y 19614) en la ciudad de Reading tienen los puntajes de índices de necesidades comunitarias (CNI, por sus siglas en inglés) más altos.[15]

Figura 4. Tasas de personas sin seguro

Condado de Berks

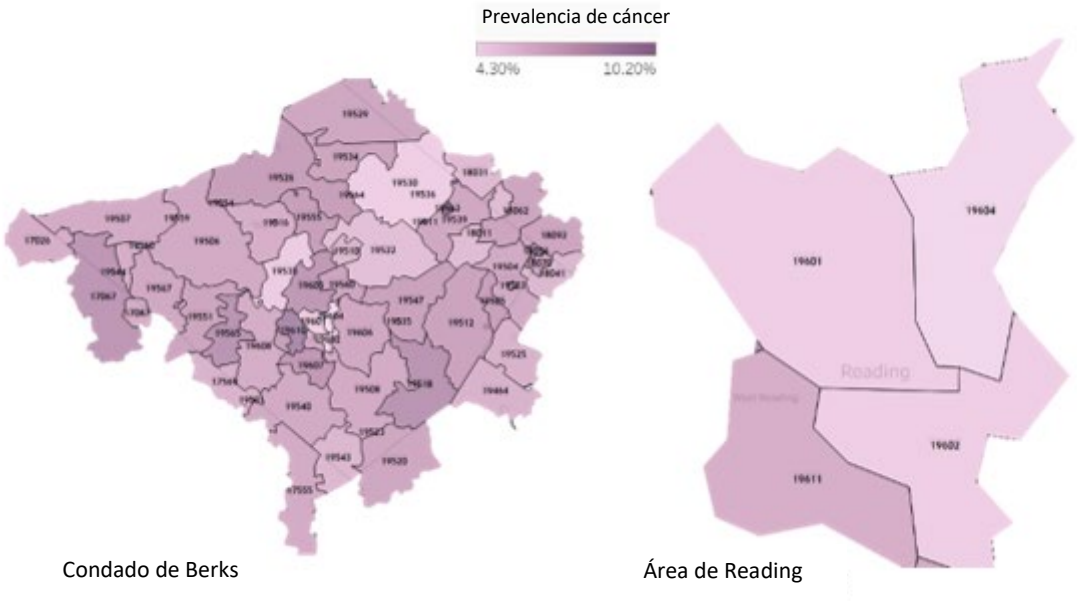
Área de Reading

Reading y las áreas colindantes están en la mitad de la escala de índices de personas sin seguro en el condado de Berks. El índice más alto de residentes sin seguro está en el código postal 19507 más al oeste del condado de Berks.

[14] Los mapas federales del condado de Berks incluyen códigos postales que podrían estar en gran parte fuera del condado de Berks.

[15] Un puntaje de CNI de 5.0 indica la necesidad socioeconómica más alta. Todos estos códigos postales tienen puntajes de CNI de 4.6-4.8.

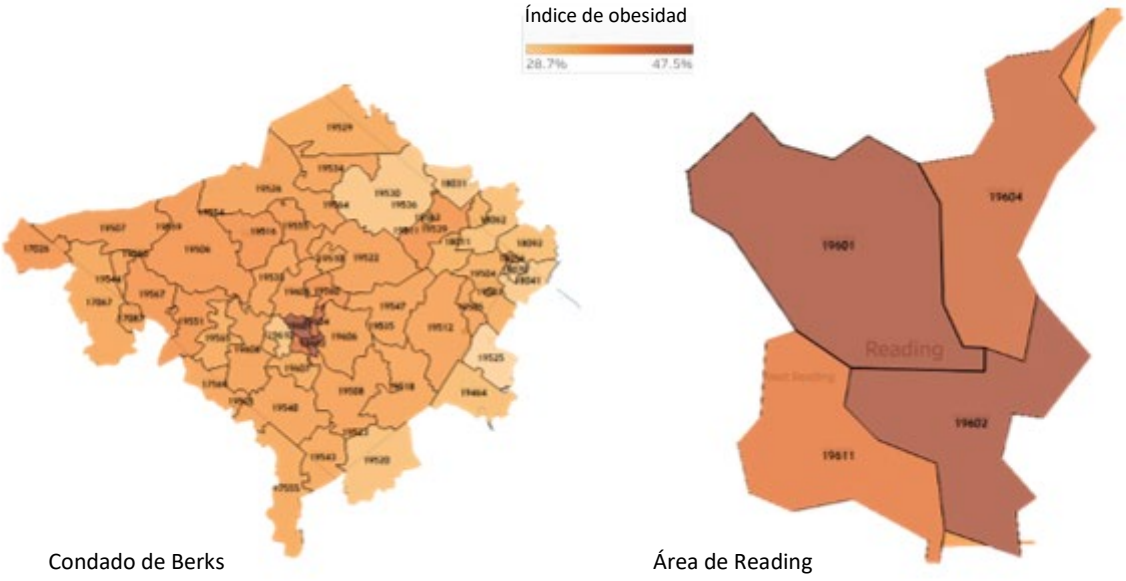
Figura 5. Prevalencia de cáncer



Condado de Berks Área de Reading

Reading y las áreas circundantes tienen una menor prevalencia de cáncer en comparación con otras áreas del condado de Berks. Los índices más altos de cáncer se extienden por el condado de Berks en diferentes códigos postales (19565, 19610, 19518 y 19562).

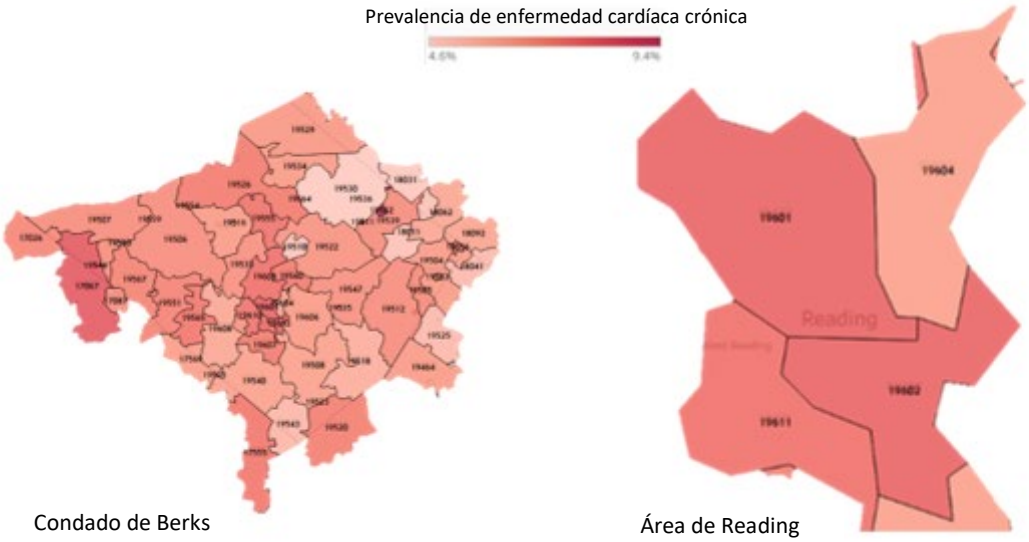
Figura 6. Prevalencia de obesidad



Condado de Berks Área de Reading

Reading y las áreas circundantes tienen una alta prevalencia de obesidad en comparación con otras áreas del condado de Berks. La menor prevalencia de obesidad en el condado de Berks se encuentra al este del condado.

Figura 7. Prevalencia de enfermedad cardíaca crónica

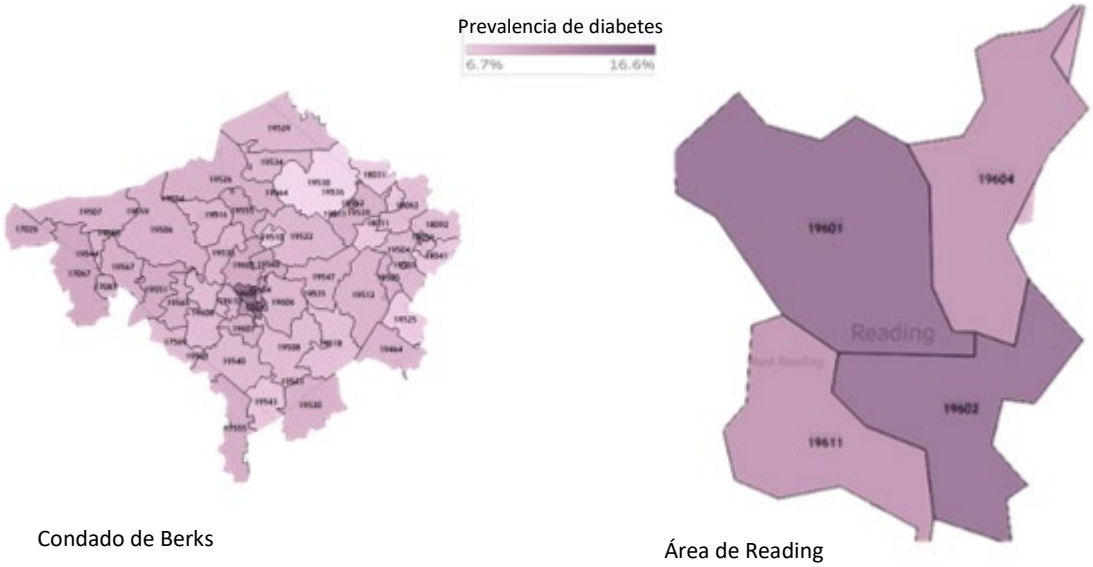


Condado de Berks

Área de Reading

Reading y las áreas circundantes están en el rango medio-alto de prevalencia de enfermedad cardíaca crónica en comparación con el resto del condado de Berks. En todo el condado de Berks hay más códigos postales con un rango medio-alto de prevalencia de enfermedad cardíaca crónica. Notablemente el código postal 19562 al noreste tiene índices altos de enfermedad cardíaca crónica.

Figura 8. Prevalencia de diabetes



Condado de Berks

Área de Reading

Reading y las áreas circundantes tienen índices altos de diabetes en comparación con el resto del condado de Berks. Los índices más bajos de diabetes están en el código postal 19530 en el área noreste del condado de Berks.

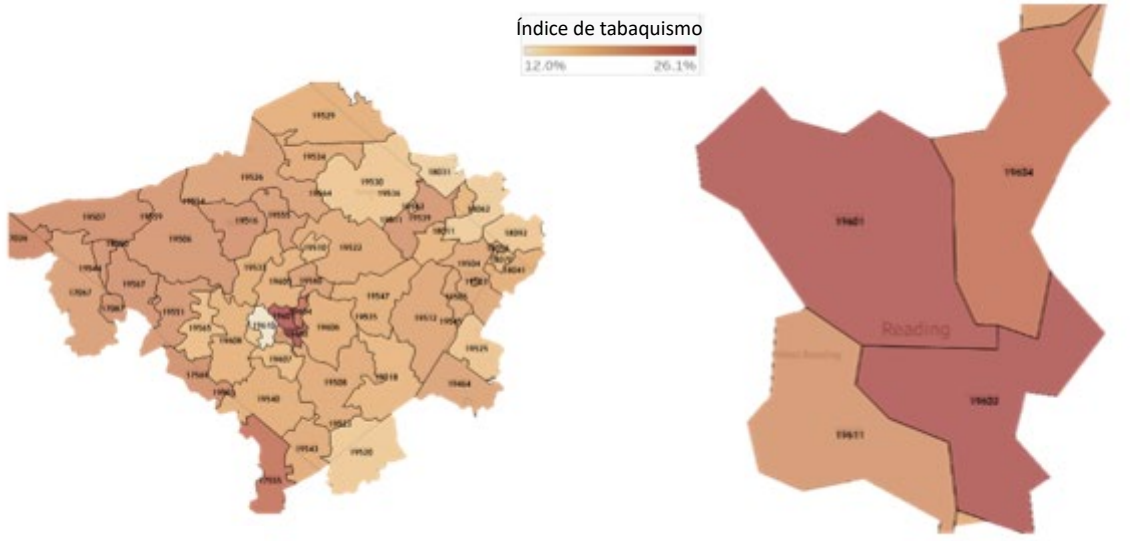
Figura 9. Prevalencia de colesterol alto

Condado de Berks

Área de Reading

Reading y las áreas circundantes tienen índices bajos a intermedios de prevalencia de colesterol alto en comparación con el resto del condado de Berks. La mayoría de residentes del condado de Berks experimentan índices notablemente altos de colesterol alto aparte de un código postal en la región noreste (19530).

Figura 10. Índice de tabaquismo



Condado de Berks

Área de Reading

Reading y las áreas circundantes tienen índices altos de tabaquismo en comparación con el resto del condado de Berks. Estos códigos postales tienen algunas de los índices de tabaquismo más altos en el

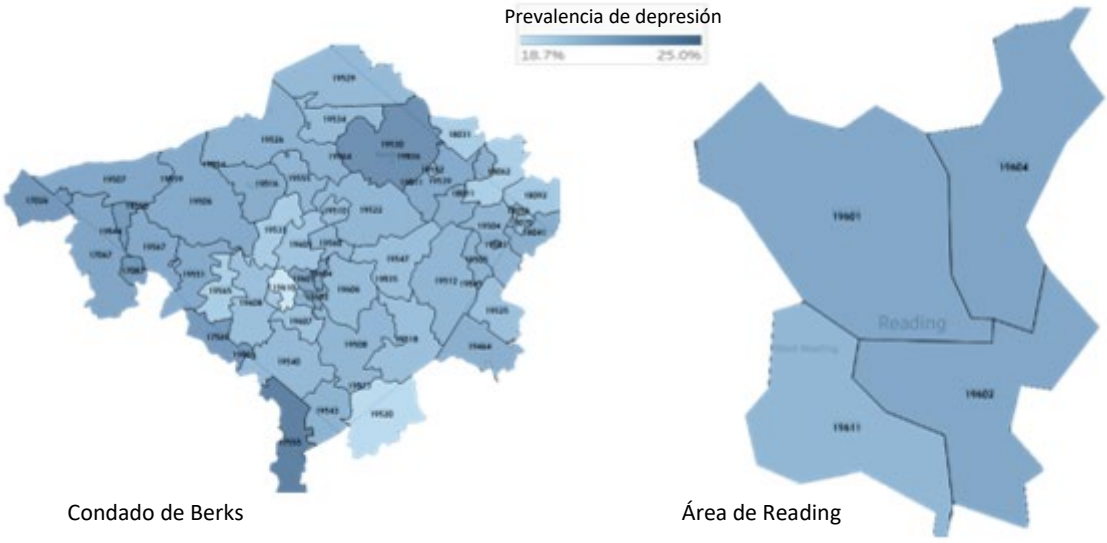
condado. En todo el condado de Berks los índices de tabaquismo son similares con índices más bajos en el este e intermedios en el sur y oeste del condado.

Figura 11. Índice de asma

Condado de Berks Área de Reading

Reading y las áreas circundantes tienen índices altos de asma en comparación con la mayoría de otras partes del condado de Berks. Se ven índices intermedios de asma en la mayor parte del condado de Berks con los índices más altos en el código postal 19530.

Figura 12. Prevalencia de depresión



Condado de Berks Área de Reading

Reading y las áreas circundantes experimentan prevalencia intermedia de depresión entre adultos en comparación con el resto del condado de Berks. Los altos índices de depresión en el condado de Berks

están en la región noreste del condado (19530). Las áreas restantes del condado de Berks experimentan índices intermedios a bajos de depresión.

Resumen

Los datos de salud existentes a nivel de condado muestran áreas de necesidad claras en el condado de Berks. En comparación con promedios estatales y nacionales, como también en relación con un subconjunto de condados de Pennsylvania cercanos, pareciera ser que Berks tiene un patrón persistente de peores comportamientos y resultados de salud en la mayoría de los indicadores cuando se controla por la población. En comparación con datos estatales y nacionales, Berks tiene mejores índices en términos del acceso a alimentos saludables e índices más bajos en la mayoría de las causas principales de muerte. También examinamos datos dentro del condado por código postal. Viendo ocho condiciones de salud clave, no detectamos ningún patrón discernible que sugiera que los resultados de salud eran peores o mejores en la ciudad de Reading en comparación con otras porciones del condado. Para tres de las ocho condiciones (tabaquismo, asma y obesidad), Reading tiene mayores índices de prevalencia. Sin embargo, Reading tiene una menor prevalencia de cáncer y está en el rango bajo a intermedio para otros dos factores de riesgo (colesterol alto y personas sin seguro). **En resumen, la salud pública es un asunto de todo el condado.**

E. Profundizamos nuestro entendimiento de carencias en la salud pública y desigualdades médicas raciales, étnicas y geográficas en el condado de Berks por medio de grupos focales y entrevistas

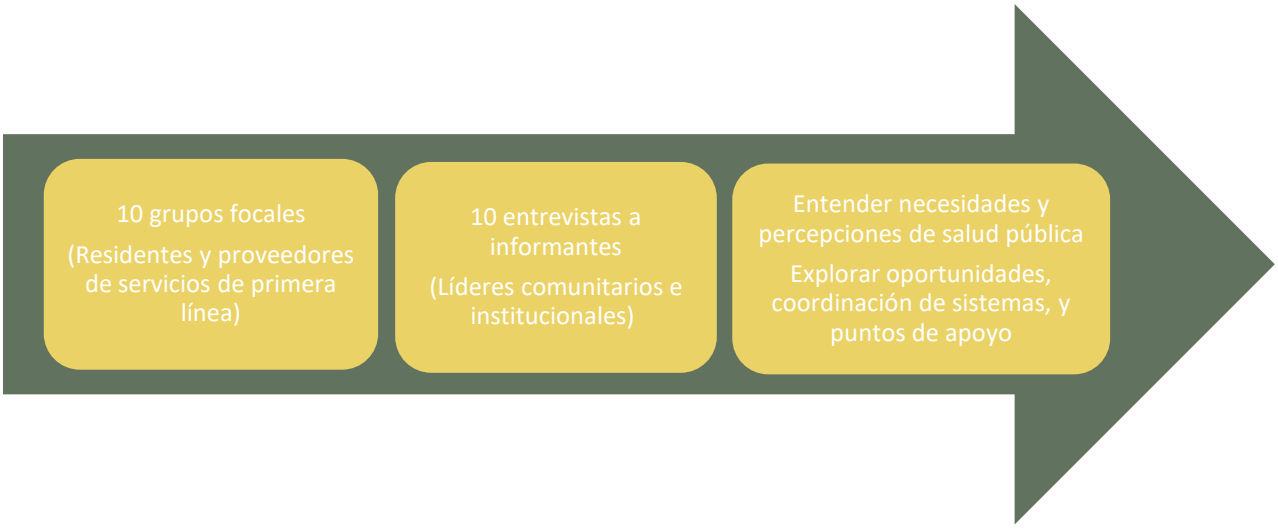
Visión general y métodos

Para entender mejor y contextualizar los datos de fuentes existentes, HMA llevó a cabo grupos focales y entrevistas con partes interesadas del condado de Berks. Los grupos focales priorizaron escuchar las opiniones de residentes del condado de Berks como también de personal involucrado en la prestación de servicios de primera línea relevantes para la salud pública incluyendo:

- Adultos mayores de comunidades rurales
- Personas adultas discapacitadas y quienes brindan servicios a personas con discapacidades
- Personas adultas de habla hispana de comunidades urbanas
- Representantes de negocios y empleadores locales
- Individuos en viviendas de transición o de emergencia
- Personal voluntario involucrado en la entrega de alimentos
- Personal de centros de salud comunitarios
- Personal de respuesta ante emergencias
- Personal de enfermería y otro personal médico escolar
- Personal de organización de base comunitaria (CBO, por sus siglas en inglés)

Como se muestra anteriormente, los grupos focales incluyeron una variedad de perspectivas para representar un continuo de áreas temáticas y circunscripciones de salud pública. De esta forma, los grupos focales buscaron solicitar opiniones sobre problemas y preocupaciones clave de quienes están directamente impactados por decisiones de salud pública. El **apéndice E** incluye una descripción detallada de métodos de los grupos focales.

Figura 13. Métodos de los grupos focales



Para las entrevistas a informantes, HMA se concentró en solicitar opiniones de líderes comunitarios e institucionales en el condado de Berks. En particular, las entrevistas a informantes se centraron en recopilar perspectivas de los programas existentes relacionados a la salud pública y coordinación de sistemas, como también preferencias para el rediseño del ecosistema de salud pública en el condado de Berks. Asignamos tiempo durante las entrevistas para discutir futuras oportunidades y puntos de apoyo para mejorar la colaboración en materia de salud pública. Las organizaciones e instituciones clave del condado de Berks representadas en las entrevistas incluyeron:

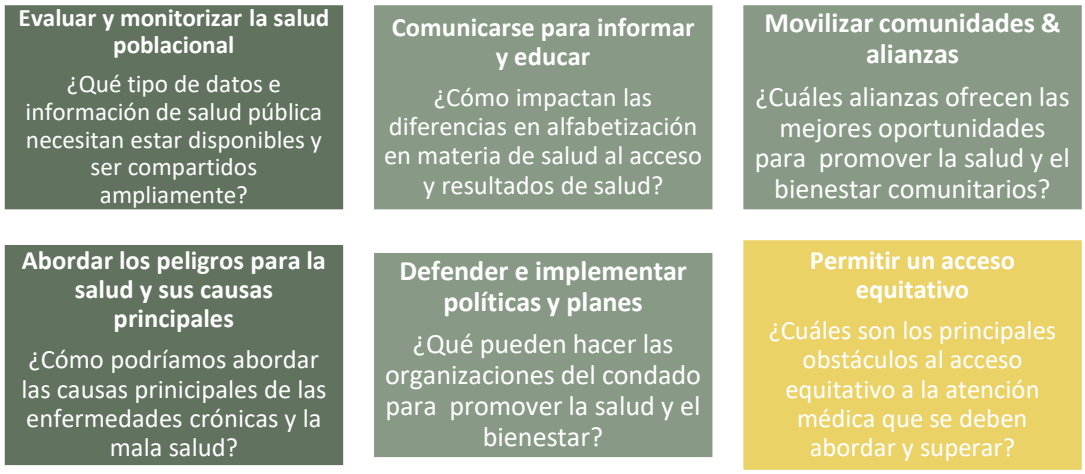
- Gobierno de la ciudad y del condado
- Organizaciones basadas en la comunidad (las CBO, por sus siglas en inglés) y fundaciones
- Hospitales, organizaciones de atención administrada y otros proveedores de atención médica
- Distritos escolares públicos

El **apéndice F** contiene una descripción detallada de los métodos de entrevistas a informantes**.**

Tanto para los grupos focales como las entrevistas, nuestras preguntas clave y áreas de investigación se centraron en los seis servicios esenciales de salud pública mostrados en la **figura 14** a continuación. Las opiniones y los comentarios sobre salud pública en el condado de Berks se filtraron desde el punto de vista de cómo mejorar, desarrollar o aprovechar un sistema existente de salud pública para: a) responder a las necesidades de salud pública de las personas en el condado de Berks y b) abordar los servicios y

funciones esenciales de salud pública. A continuación, se resumen los principales resultados de cada una de estas funciones y áreas de servicio esenciales.

Figura 14. Preguntas clave por área de servicios esenciales de salud pública



Hallazgos clave por parte del área de servicios esenciales de salud pública

A través de grupos focales y entrevistas, un tema clave fue la necesidad de que la salud pública se involucrara más en los factores previos que tienen un impacto en la salud y el bienestar. A menudo denominados determinantes sociales de la salud (SDOH, por sus siglas en inglés), estos son los factores que describen la interactividad de las condiciones en las que las personas nacen, viven, aprenden, trabajan, juegan y envejecen y que afectan a una amplia gama de resultados y riesgos para la salud y la calidad de vida. Cada SDOH se cruza a menudo con los demás para producir efectos individuales, familiares y comunitarios (véase la **figura 15**).

Figura 15. Determinantes sociales de la salud

Los entrevistados mencionaron a menudo la necesidad de que la salud pública preste más atención a las necesidades básicas (alimentación, refugio y seguridad) de residentes del condado de Berks. Así, visualizaron un sistema de salud pública más atento a los problemas de pobreza, desempleo, vivienda asequible, alimentación y nutrición, etc., como barreras considerables para la salud y el bienestar.

> *"No siempre se trata de acceder a la atención médica; tienen seguro médico. Son otras cosas. Son los determinantes sociales de la salud los que les impiden realmente tener resultados de salud positivos". Prestador de servicios*

Las personas encuestadas citaron un rol de la salud pública para **aumentar la concienciación y la aceptación del papel que desempeñan estos factores previos como impulsores de desigualdades de salud.** Del mismo modo, visualizaron un rol para la salud pública que se centra en la educación en materia de salud y la divulgación para superar obstáculos al acceso a la atención médica, especialmente el transporte, costos, falta de seguro y situación de indocumentación. En general, notaron la necesidad de

que la salud pública filtre asuntos sociales (por ejemplo, vivienda, transporte, educación, etc.) desde el punto de vista de la salud para resaltar la interdependencia y la necesidad de atención preventiva.

Un segundo tema claro estuvo enfocado en la necesidad de más **atención a la prevención y salud preventiva**. Por ejemplo, las personas encuestadas instaron a la salud pública a que concentre la educación y comercialización social en la prevención de enfermedades crónicas comunes (por ejemplo, asma, diabetes, etc.). De igual manera, los participantes expresaron un claro acuerdo en la necesidad de **promover sensibilización sobre una nutrición sana/decisiones alimenticias**, con énfasis en el rol de la comida y la dieta como estrategias de prevención de enfermedades.

"Prioridad a facilitar y hacer equitativo el acceso a la atención preventiva". Proveedor de servicios

Finalmente, las personas encuestadas notaron la necesidad de **mejorar el acceso a proveedores de atención primaria**. En efecto, querían que se transmitieran y reforzaran continuamente los beneficios de la atención primaria, incluida la necesidad de una atención proactiva (por ejemplo, revisiones rutinarias de bienestar) y un mayor conocimiento de las opciones y acceso a Medicare.

Permitir un acceso equitativo → ¿Cuáles son los principales obstáculos para un acceso más equitativo a la atención médica que deben abordarse y superarse?

Durante los grupos focales, los participantes frecuentemente señalan problemas relacionados a mejorar el acceso equitativo a la salud y servicios relacionados. **Las barreras de lenguaje** fueron citadas frecuentemente y las personas encuestadas notaron la necesidad tanto para traducciones más consistentes como también más precisas sobre mensajes de salud pública. En efecto, quienes participan expresaron un claro acuerdo en la necesidad de **más educación de salud y promoción en español** como el idioma más comúnmente hablado además del inglés en los hogares del condado de Berks.

"Promotores que hablen mi idioma, sean bilingües y tengan la paciencia para trabajar con una persona, responder preguntas, etc.". Residente

"Las personas necesitan acceso a la educación e información en su idioma en el hospital". Residente

En relación a la equidad de salud, las personas encuestadas notaron una necesidad de que la salud pública **brinde atención culturalmente relevante y receptiva**. Varias personas encuestadas notaron la necesidad de aumentar la competencia cultural entre proveedores tanto públicos como privados, incluyendo personal con habilidades bilingües y biculturales al interactuar con residentes de habla hispana.

También surgieron preocupaciones por la equidad con relación a poblaciones especiales, quienes estaban recibiendo atención insuficiente según quienes participaron. En particular, las personas encuestadas notaron que había pocas opciones de salud disponibles para **personas sin seguro e indocumentadas**. Otro grupo mencionado explícitamente fue el de la **población con discapacidades**. Las personas encuestadas sintieron que la salud pública podría hacer más para promover un entendimiento de las necesidades de las personas con discapacidades entre médicos y otros proveedores. Adicionalmente, muchas personas encuestadas notaron una necesidad de más atención a las necesidades de **comunidades rurales** que carecen de acceso a la atención médica y también con frecuencia son reacias a aceptar mensajes de salud pública sobre enfermedades crónicas y atención preventiva.

"Las personas evitan acceder al sistema de atención médica porque están indocumentadas". Residente

Otro tema claro relacionado al acceso equitativo se centró en la necesidad de **expandir el acceso a los servicios de salud mental**. Las personas encuestadas notaron un rol para que la salud pública promueva la concienciación de servicios de salud mental, reduciendo el estigma asociado con la enfermedad mental y continuar luchando por **atención más integrada** que vincule la salud física con la mental. De hecho, las personas encuestadas abogaron por un rol por la salud pública para ayudar a avanzar la coordinación integral y única de servicios médicos y humanos, incluyendo atención de salud mental. Es importante notar que el condado de Berks ha progresado significativamente en atención integrada, incluyendo el establecimiento de sitios dedicados que apoyan la atención integrada, como también requisitos prácticos para los proveedores de servicios.

Para mejorar el acceso equitativo, las personas encuestadas de los grupos focales y las personas entrevistadas también ofrecieron una variedad de sugerencias enfocadas en **más flexibilidad y personalización** en la prestación de servicios médicos. La principal de estas recomendaciones fue la de expandir opciones tanto de **telesalud como de salud móvil**. Otras opiniones incluyeron un deseo de más servicios de navegación para pacientes, como también una necesidad general de atención y capacidad de respuesta más personalizadas de los sistemas de atención médica y de salud pública.

Comunicarse para informar y educar

¿Cómo impactan las diferencias en la alfabetización en materia de salud al acceso a la salud y sus resultados?

El rol de la salud pública en la comunicación y la educación, con frecuencia englobado en el término "alfabetización en materia de salud", fue un importante tema de discusión en los grupos focales y entrevistas. Las personas encuestadas estuvieron de acuerdo en la **necesidad de que** la salud pública **adapte y segmente la comunicación**. Dicho de otra manera, la comunicación y la divulgación se deben hacer más a medida para satisfacer las necesidades específicas de audiencias diferencias y poblaciones especiales.

"Tenemos que ser culturalmente conscientes de a quién le estamos hablando… necesitamos adaptarnos a las distintas audiencias para el mismo objetivo. El mensaje tiene que ser consciente de la audiencia". Proveedor de servicios

"Muchos pacientes de habla hispana salen de sus citas médicas con la misma confusión con la que entraron debido a la información culturalmente inadecuada que se les presenta". Proveedor de servicios

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Al igual que los hallazgos sobre acceso equitativo, las personas encuestadas notaron la necesidad de que la salud pública **adapte la comunicación y la divulgación para hacerse mucho más sensible culturalmente y receptivo lingüísticamente**. Las personas encuestadas señalaron que falta una traducción coherente al español, por lo que debe darse prioridad a esto y además que los recursos en español deben difundirse con mayor eficacia. Además, las personas encuestadas hicieron notar que la salud pública debería **difundor la información por medio de fuentes confiables y locales** tales como educadores de pares comunitarios o promotores de la salud (*promotoras*) quienes tienen más probabilidades de poseer tanto la competencia cultural como la confianza de las comunidades.

"Podemos hacer más con las escuelas, los servicios sociales, la radio, la televisión, para difundir mensajes. Las personas mueren antes de tiempo por falta de educación sobre autogestión. Se necesita más comunicación y educación a los pacientes sobre autogestión y calidad de vida". Residente

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Los participantes de los grupos focales y de entrevistas abogaron por **centrar campañas de alfabetización en materia de salud en la prevención de enfermedades crónicas generalizadas** (por ejemplo, asma, diabetes, etc.). Similarmente, las personas encuestadas notaron la necesidad de invertir en mensajes que resalten los vínculos entre hábitos y resultados de salud (por ejemplo, el vínculo entre una dieta azucarada y la diabetes o entre la obesidad y enfermedad cardíaca), a la vez de **aumentar el perfil de servicios médicos preventivos** y educación de prevención. Algunas personas encuestadas también notaron la necesidad de plantear problemas que tradicionalmente no se asocian con la salud pública (por ejemplo, seguridad vial y violencia armada) como crisis de salud prevalentes y prevenibles en el condado.

"Nos falta información y recursos y no siempre tenemos acceso a la computadora". "La gente no tiene la capacidad de navegar por Internet o la tecnología para recibir la información que necesita". Residente

Otro tema común fue la necesidad de que la salud pública **hiciera que la información y comunicación fuera más fácil de entender y absorber**. Las personas encuestadas sugirieron que los mensajes futuros de salud pública empleen infografías y otros formatos fáciles de usar. También sugirieron difusión en múltiples formatos y medios de comunicación.

La mayoría de las personas consultadas sugirieron que hay se necesita un **sistema más centralizado para desarrollar mensajes** sobre salud y luego difundir información por medio de organizaciones locales de confianza. Las personas entrevistadas describieron el estado actual de mensajes de salud como "aislado" y "fragmentado", también como "conflictivo" e "impuntual". En resumen, el acuerdo fue que el condado necesita mensajes más claros y una fuente centralizada de información de salud pública con datos oportunos y culturalmente competentes. De esta forma, las personas encuestadas anticiparon que la salud pública podría **involucrar a las comunidades, construir confianza y tener un rol claro para la salud pública de mejor manera** para mejorar la salud y el bienestar de la comunidad.

"Se trata de tener una sola voz y asegurarnos de que todas las personas difundimos la misma información". Proveedor de servicios

Movilizar comunidades y alianzas

¿Cuáles alianzas ofrecen las mejores oportunidades para fomentar la salud y el bienestar de la comunidad?

Un tema clave de grupos focales y entrevistas fue la necesidad de que la salud pública **priorice alianzas con organizaciones que ya estén trabajando con poblaciones desatendidas**. Las personas encuestadas visualizan que la salud pública lidere una coalición de agencias y organizaciones con un historial probado de compromiso y apoyo a la comunidad. Con respecto a esto, quienes participaron instaron a la salud pública a aprovechar las asociaciones existentes y a apoyar las estructuras de colaboración establecidas.

Al mismo tiempo, las personas encuestadas quieren **expandir y fortalecer alianzas adicionales** en el condado de Berks. Principalmente, escuchamos un llamado común para una **mayor coordinación y alianza con escuelas**. La educación se vio como un elemento clave para mejorar la salud; colaborar con las escuelas para abordar la salud de niños y jóvenes le permitirá a la salud pública acercarse a padres, madres y familias. Adicionalmente, muchas personas encuestadas notaron oportunidades para

profundizar alianzas existentes que busquen **integrar la salud física con la del comportamiento** para abordar las necesidades de la persona en su totalidad.

"Creo que cada persona entiende dónde están las desigualdades, pero todas las organizaciones están trabajando por separado y no están yendo a donde necesitamos ir". Proveedor de servicios

"Un paraguas que pueda apoyar a cada organización que está acá el día de hoy". Proveedor de servicios

Las personas encuestadas sugirieron una identificación de **una organización central o el desarrollo de una entidad** de salud pública **independiente** encargada de la coordinación entre organizaciones involucradas en la reducción de desigualdades de atención médica evidentes en los datos a nivel de condado. Indicaron que este organismo debería funcionar como una parte neutral que consistentemente **convoque y coordine las CBO, hospitales, agencias del condado, etc., para abordar los factores interrelacionados que están afectando a la salud pública y coordinar esfuerzos en todo el condado**.

Casi todas las personas participantes resaltaron la importancia de representación inclusiva en cualquier nueva entidad de salud pública (por ejemplo, ciudad, condado, las CBO, atención médica, etc.). También estuvieron de acuerdo en la necesidad de este organismo de apoyar alianzas capaces de trabajar colaborativamente para difundir datos oportunos de calidad e información de salud pública.

"Si tuvieras un punto único de contacto que fuera la autoridad y coordinación para asuntos de salud, foros de salud, educación sanitaria. Ese es un rol y sería un gran servicio que se concedería al condado de Berks". Proveedor de servicios

Evaluar y monitorizar la salud de la población

¿Qué tipos de datos e información de salud pública necesitan estar disponibles y ser compartidos ampliamente?

El tema central y el deseo de los grupos focales y las personas entrevistadas fue la necesidad de la salud pública de **usar mejor los datos existentes para resaltar los vacíos en la equidad de salud** y el rol de los SDOH en los resultados de salud. Les gustaría un mayor enfoque en tratamientos basados en datos para condiciones crónicas (por ejemplo, enfermedades relacionadas con la obesidad y dieta, asma, hipertensión), como también datos de los SDOH que obstaculizan el acceso (por ejemplo, acceso a alimentos sanos, transporte, tecnología, etc.).

Otro hallazgo se concentró en la necesidad de mejorar la accesibilidad a los datos. A las personas encuestadas les gustaría **más transparencia y acceso a datos a nivel de condado que puedan ser analizados** por código postal, raza/etnia, idioma principal, etc. Teniendo esos datos a su disposición, dijeron que la salud pública estaría mejor posicionada para transformar datos de salud en prioridades accionables centradas en reducir desigualdades de salud claves.

Algunas personas encuestadas también hicieron notar que la salud pública podría jugar un rol beneficioso a la hora de aprovechar y organizar conversaciones relacionadas con los datos existentes (por ejemplos, las CHNA) para **promover un mayor entendimiento del público del contexto en el que los proveedores de atención médica toman sus decisiones**. Adicionalmente, casi todas las personas participantes estuvieron de acuerdo en que una nueva entidad de salud pública sería más capaz de asegurar la integridad y eficiencia de los datos al funcionar como un punto único de contacto y comunicación.

"Para entender la salud pública, necesitamos datos que alimenten una visión final. Esto no existe en este condado. Está muy fragmentado… necesitamos datos consistentes y consolidados en toda nuestra población". Proveedor de servicios

Defender e implementar políticas y leyes

¿Qué pueden hacer las organizaciones del condado para promover la salud y el bienestar?

Las personas encuestadas y entrevistadas de los grupos focales dieron varias sugerencias sobre la manera en que la salud pública podría desempeñar un rol más importante en la defensa o implementación de leyes y políticas que mejoren la salud y el bienestar de la comunidad.

Muchas de las personas a las que consultamos querían que la salud pública acabara con la comunicación insuficiente y la competencia perjudicial dentro del sistema existente de servicios médicos y sociales en el condado de Berks. Vieron un rol para que la salud pública **aproveche los proyectos piloto e innovaciones relevantes** hacia cambios de sistemas, tales como:

- Invertir en divulgación y alfabetización en materia de salud, especialmente en trabajadores de salud comunitarios y *promotoras*
- Mejorar el acceso a datos de salud a nivel de condado a través de manifestaciones e influencia estatales
- Colaborar entre pagadores y proveedores para hacer frente al costo de la atención médica

- Promover el cumplimiento de la legislación vigente en materia de salud pública (por ejemplo, ofrecerle incentivos a los propietarios que acepten vales de vivienda, adecuar los edificios para que sean habitables, etc.).

Adicionalmente, varias personas encuestadas visualizaron un rol para la salud pública que **aumentara el acceso a servicios de salud mental**. Sintieron que la salud pública podría fomentar la integración de atención primaria y salud mental/del comportamiento y presionar para que las aseguradoras comerciales cubran los servicios de salud mental. Las personas participantes también pidieron un mayor acceso a servicios de salud mental en las escuelas, a pesar de que los programas de asistencia al estudiante (SAP, por sus siglas en inglés) que identifican a estudiantes con necesidades de salud del comportamiento están disponibles en todas las escuelas medias y secundarias del condado de Berks. En resumen, las opiniones de las personas encuestadas reflejan la necesidad de aumentar el conocimiento de los servicios ya existentes y enfocarse en áreas adicionales para su expansión o ampliación.

Finalmente, las personas participantes expresaron un deseo general de que la salud pública **abogue por una financiación que aumentaría el personal y los recursos** para satisfacer mejor las necesidades de quienes residen en el condado de Berks. Por ejemplo, las personas encuestadas identificaron la necesidad de aumentar la financiación de las clínicas de atención primaria, incluidas las clínicas escolares, para extender las horas de disponibilidad y brindar un mayor acceso a la atención primaria y preventiva basada en la comunidad.

F. Examinamos cómo otros condados en Pennsylvania aseguran la salud del público

En Pennsylvania hay una variedad de opciones disponibles para abordar las necesidades de salud pública al nivel local. Los condados pueden, por supuesto, depender del estado para estos servicios. Pueden desarrollar sus propios departamentos de salud del condado o municipales para manejar la salud pública localmente. Finalmente, pueden establecer estructuras colaborativas que reúnan esfuerzos y recursos para abordar algunas funciones de salud pública. Todos estos modelos existen en el estado.

Siete condados y cuatro municipalidades que representan más del 45 por ciento de la población del estado tienen sus propios departamentos de salud.[16] Los condados con departamentos de salud son Allegheny, Bucks, Chester, Delaware, Erie, Montgomery y Philadelphia. Adicionalmente, Allentown, Bethlehem, Wilkes-Barre y York tienen departamentos de salud municipales.

Ante la ausencia de un departamento de salud pública, varios condados en el centro de Pennsylvania han adoptado modelos alternativos para promover la salud pública por medio de alianzas que involucran proveedores de servicios médicos y sociales clave, financiadores, instituciones académicas y oficiales

[16] Datos de censos de Estados Unidos, tabla QuickFacts PA, 2022, https://www.census.gov/quickfacts/fact/table/PA/PST045222

locales. Estos modelos se enfocan en mejorar el acceso a la atención médica, efectivamente compartiendo información y recursos de salud y maximizar recursos e inversiones fiscales.

A continuación, hay algunos ejemplos de colaboraciones en materia de salud pública en los condados de York, Lebanon y Adams. Aunque cada modelo varía en estructura y visión, estos grupos tienden a trabajar juntos para evaluar y priorizar las necesidades de residentes del condado por medio de datos y evaluaciones compartidos, identificar prioridades de salud pública, asociarse para abordar prioridades y maximizar recursos, implementar estrategias de mutuo acuerdo, aumentar la visibilidad de los problemas y fomentar la comunicación entre las partes interesadas clave.

Tabla 6: Colaboraciones de salud pública

<table>
<tr><th colspan="2">Healthy York County Coalition: fundada en 1994</th></tr>
<tr><td colspan="2">Miembros: aproximadamente 45 organizaciones tienen representación en el Consejo de Liderazgo.</td></tr>
<tr><td>Comité Directivo
Family First Health
York Traditions Bank
Two Retired Physicians
York County Human Services Department
York City Health Bureau (oficial public health entity under the Pennsylvania Department of Health)
York County Community Foundation
WellSpan Health
UPMC Pinnacle
Central PA Transportation Authority
United Way of York County</td><td rowspan="2">Grupos de trabajo y comités
Acceso y empoderamiento: identifica necesidades, lleva a cabo investigación y busca soluciones para abordar problemas relacionados con el acceso a la atención médica, seguro médico y desafíos relacionados.
Defensa y política pública: identifica oportunidades de salud comunitaria; educa a legisladores, líderes comunitarios y otros; e involucra a las partes interesadas para que tomen acción y aboguen por el progreso.
Alianza para la asistencia personal a domicilio para personas de bajos ingresos (ALPHA, por sus siglas en inglés): una iniciativa importante de la coalición, ALPHA es una alianza público-privada con una muestra representativa de las partes interesadas en vivienda, salud y servicios humanos creada para identificar y aplicar soluciones sostenibles para los hogares de ALPHA.
Compromiso comunitario: apoya con comunicaciones, planificación de eventos y la construcción de relaciones estratégicas.
Prevención y bienestar: supervisa la iniciativa York County Walks, que está trabajando para promover caminatas y mejorar la accesibilidad a pie de las comunidades.
Your Life: lleva a cabo sesiones educativas para ayudar a que personas residentes entiendan opciones de atención avanzadas, fomenten las conversaciones familiares y la puesta en común de las directrices anticipadas. Las personas voluntarias de la coalición están disponibles para asistir a las</td></tr>
<tr><td>Fundadores
York County Community Foundation
United Way of York County
WellSpan Health
AARP
City of York – Bureau of Health (oficial public Health entity under the PA DOH)
Glatfelter Insurance Group
Hospice and Community Care
OSS Health
UPMC Pinnacle
Vising Nurse Association- Hanover & Spring Grove
York Area Housing Group
York County Economic Alliance
York County Literacy Council</td></tr>
</table>

<table>
<tr><td></td><td>personas residentes con documentos de directrices anticipadas.
Sitio web
http://www.healthyyork.org</td></tr>
<tr><td colspan="2">Community Health Council of Lebanon County: fundado en 1994</td></tr>
<tr><td colspan="2">Miembros: el Consejo es una organización sin fines de lucro y consiste en más de 25 comités, grupos de trabajo y eventos que involucran a más de 400 personas voluntarias de la comunidad.</td></tr>
<tr><td>Comités y grupos de trabajo actuales
Age Wave
Communities That Care
Healthy Lifestyles
Lebanon County Coalition to End Homelessness
Mentor a Mother
Teen Pregnancy Prevention & Support Network
Tobacco Prevention and Cessation
Suicide Prevention Task Force</td><td>Socios
Lebanon County Council of Human Services Agencies
REACH Project
Stronger Together Heroin Task Force
Sitio web
http://communityhealthcouncil.com/about-us/</td></tr>
<tr><td colspan="2">Junta directiva – representantes de:
Penn State College of Medicine
Area Agency on Aging
Lebanon Family Health Services (Board President)
UPMC (1st VP)
Lebanon County Drug and Alcohol
Lancaster General/Penn Medicine
Family First Health
WellSpan Philhaven
Youth Advocate Program (2nd VP)
Chamber of Commerce
WellSpan Health
Lebanon County MH/ID/EI
Child & Adolescent Service System Prog. (Secretary)
Lebanon County Children and Youth
VA Medical Center
Union Community Care
Domestic Violence Intervention
Health system physician
Lebanon Family Health Services (Treasurer)
Luthercare for Kids
YMCA
Better Together Lebanon (ex-officio)
Lebanon County Commissioner (ex-officio)
Lebanon County District Attorney’s Office (ex-officio)
Superintendent of Record(ex-officio)
Community Volunteer</td></tr>
<tr><td colspan="2">Healthy Adams County: fundado en 1996</td></tr>
<tr><td colspan="2">Miembros: aproximadamente 300 miembros prestan servicio en una variedad de comités y grupos de trabajo.</td></tr>
<tr><td colspan="2">Patrocinadores
Wellspan Health. Aloja al director ejecutivo y al asistente administrativo.
Franklin & Marshall’s College, Center for Opinion Research. Evaluaciones de salud completas.</td></tr>
<tr><td>Liderazgo
Adams County Office for Aging, Inc.
Community Representative
Gettysburg Area Recreation Authority
United Way of Adams County
YWCA Gettysburg & Adams County</td><td>Grupos de trabajo e iniciativas
Estos comités abordan las necesidades de servicios médicos y humanos y muchos se formaron como un resultado directo de necesidades identificadas mediante las CHNA:
Adams County Women’s Cancer Coalition</td></tr>
</table>

• Adams County Housing Authority • PA Interfaith Community Programs • Adams Economic Alliance • Communications Specialist • WellSpan System Communications • SCCAP, Inc. (Community Action Agency) • Gettysburg College Center for Public Service • TrueNorth Wellness Services	• Adams County Food Policy Council • Behavioral Health Task Force & Suicide Prevention Sub-Committee • Children's Health & Nutrition Task Force • Domestic Violence Task Force • End of Life Committee • Health Literacy Task Force • Latino Services Task Force • Physical Fitness Task Force • Community Wellness Connections (CWC)
Visite: https://www.healthyadamscounty.org/	

Como demuestran los ejemplos, estas colaboraciones de salud pública del condado comparten varias características clave:

- Son inclusivas y típicamente involucran múltiples organizaciones y partes interesadas en una concepción amplia de la salud pública y el bienestar.
- Están ancladas por un conjunto más pequeño de organizaciones aliadas clave que toman un rol de liderazgo, a menudo por medio de un comité directivo.
- Usan comités y grupos de trabajo más pequeños para organizar sus iniciativas y brindar oportunidades a sus miembros para que se involucren en diferentes asuntos de salud pública. Estos comités y grupos de trabajo incluyen áreas de asuntos clave, representan a las poblaciones destinatarias y a menudo se enfocan en equidad de salud y/o los SDOH.
- Usan patrocinadores y financiadores públicos y privados y para apoyar sus esfuerzos dirigidos a avanzar la salud y el bienestar de la comunidad.
- Tienen una presencia y sitio web públicos para comunicar e informar a los residentes y otros constituyentes.

G. Desarrollamos principios rectores y objetivos para un modelo de salud pública del condado de Berks

Las partes interesadas de la salud pública del condado de Berks recomiendan los siguientes principios y objetivos para desarrollar un enfoque de la salud pública en el condado de Berks. Los esfuerzos futuros se deberían enfocar en:

- Coordinar servicios de salud pública que ya se están implementando en el condado (los CBO, hospitales, condado y agencias de la ciudad) y están apoyando acciones colectivas de manera tal que los recursos del condado son dirigidos a las necesidades que no se han abordado en otro sitio para que los fondos del condado puedan tener el mayor impacto.

- Brindar una voz clara y confiable sobre amenazas, respuestas y preocupaciones de la salud pública para guiar a residentes, negocios, escuelas y organizaciones privadas y públicas del condado en emergencias de salud pública.
- Aumentar el acceso al público y socios claves de salud pública a los datos de salud pública.
- Identificar roles y responsabilidades claros para cada socio público y privado y reducir la duplicación de esfuerzos del condado, de la ciudad y del estado. Por ejemplo, el condado no asumirá roles en los que el estado tenga jurisdicción, pero establecerá un mecanismo para colaborar con el estado para asegurar que los roles de análisis de salud pública, de respuesta ante emergencias y de comunicaciones cumplan con las necesidades de residentes del condado y organizaciones del sector público y privado.
- Mejorar la salud de poblaciones del condado que muestren las desigualdades más grandes al apoyar los factores previos que afectan la salud, tales como el acceso a la nutrición, vivienda, atención médica y beneficios y asegurar que la información y recursos de prevención y bienestar sean accesibles tanto en inglés como en español.

H. Recomendaciones

Desde el principio, el equipo de HMA fue neutral en términos de si un departamento de salud sería el mejor enfoque para que el condado de Berks cumpliera las necesidades de salud pública, como lo han hecho otros siete condados de Pennsylvania, o si otro modelo sería más receptivo. Como se describió anteriormente, solicitamos opiniones de un rango de partes interesadas de la salud pública. Aunque no hablamos con todas las personas que trabajan para cumplir las necesidades de salud de quienes viven en el condado de Berks, escuchamos a líderes, miembros comunitarios demográficamente diversos, proveedores de servicio, negocios y grupos religiosos y culturales. Aprendimos que las personas y grupos más cercanos a la prestación de atención médica favorecieron fuertemente el establecimiento de un departamento de salud. Otras personas estuvieron preocupadas sobre los costos de adherirse a requisitos estatales obsoletos para departamentos de salud pública, incluida la necesidad de brindar servicios clínicos y llevar a cabo ciertas inspecciones de salud y seguridad que actualmente no son requeridas en el condado (véase el **apéndice G**).

Con base en esta información, recomendamos cuatro pasos para mejorar la coordinación de servicios existentes, analizar la salud en la zona censal y/o al nivel de código postal y tener comunicación con los socios y el público en una voz de autoridad sobre amenazas, emergencias y riesgos a la salud pública. Estos pasos prepararán al condado para que tenga una fuerte respuesta ante cualquier amenaza futura a la salud pública y beneficiará a las comunidades del condado de Berks a corto plazo y a lo largo del tiempo. También crearán una ruta para establecer un departamento de salud del condado de Berks si así se desea en el futuro.

1. Crear una posición de director de salud del condado de Berks para liderar acciones colectivas y coordinación de salud pública y servir como un comunicador de confianza sobre información de salud pública. Esta posición requiere un líder visionario y un comunicador excelente con experiencia demostrada en salud pública y atención médica. Para dos ejemplos de posiciones de director de salud pública vea el **apéndice H**.

    - Opción 1: esta posición será un empleado del condado de Berks y le rendirá cuentas a los comisionados del condado.
    - Opción 2: esta posición tendrá su sede en una organización no gubernamental de confianza enfocada en la salud pública, que le rendirá cuentas a los comisionados del condado.

2. Crear un panel asesor de salud pública

    Recomendamos que los comisionados del condado creen un panel asesor de salud pública para aconsejar al director de salud y guiar actividades de evaluaciones de salud pública, políticas y garantías. Los miembros del panel deberían aportar colectivamente una fuerte experiencia en medicina, salud pública, salud del comportamiento y los factores que le dan forma a la salud. Establecer un panel asesor de salud pública ahora ayudaría a preparar al condado de Berks para alcanzar un requisito estatal de una junta de salud en caso de que el condado decida establecer un departamento de salud del condado en el futuro. (Los requisitos del estado al respecto de la composición y obligaciones de la junta de salud bajo un departamento de salud del condado ya establecido se detallan en el **apéndice G**).

3. Apoyar el establecimiento de una coalición de salud en Berks[17] para servir como un organismo de coordinación para los esfuerzos de salud pública en el condado. El director de salud pública coordinará o cofacilitará las actividades de la coalición. Esta coalición también podría incluir liderazgo de las siguientes entidades:

    - Centros de salud con cualificaciones federales y centros de salud comunitarios
    - Hospitales Tower-Reading y Penn State St. Joseph's
    - United Way y organizaciones comunitarias, incluidos el centro hispano y la fundación comunitaria del condado de Berks
    - Grupos religiosos que brindan servicios médicos y sociales
    - Co-County Wellness Services y otras organizaciones de salud pública del condado
    - Organizaciones de salud mental, discapacidades, respuesta ante emergencias, datos y salud ambiental del condado

[17] Otros condados en Pennsylvania coordinan esfuerzos de salud pública por medio de una estructura de coalición.

- Sistemas escolares públicos, parroquiales y privados

4. Crear una posición de analista de salud del condado de Berks para mejorar la exhaustividad y precisión de los datos de salud pública específicos del condado de Berks, que reportará al director de salud. Esta posición brindará apoyo crítico para el director de salud pública identificando vacíos en los datos, brindando un seguimiento de la salud de las personas residentes del condado de Berks a nivel de zona censal y apoyando una fuerte respuesta a pandemias u otras emergencias de salud pública. Esta posición podría ser un empleado o subcontratista del condado.

Establecer posiciones de liderazgo en salud pública, un panel asesor de salud pública y una coalición de salud en Berks abordará necesidades identificadas en esta evaluación. Los beneficios inmediatos incluyen una mejor coordinación de servicios existentes, un mejor entendimiento de las necesidades y amenazas de salud pública por medio de análisis hiper locales mejorados y un mecanismo para tener comunicación con socios y el público en una voz de autoridad sobre amenazas, emergencias y riesgos de salud pública. Estos pasos también crearán una ruta para establecer un departamento de salud del condado de Berks, que es un proceso de 18 a 24 meses. En la actualidad, un departamento de salud del condado está sujeto a un cierto número de leyes y regulaciones de Pennsylvania (servicios clínicos, ciertas inspecciones) que no fueron identificadas como necesidades. Esta situación podría cambiar si Pennsylvania moderniza sus regulaciones para ajustarse a estándares de salud pública 3.0[18].

Actualmente, Pennsylvania requiere una junta de salud y un director de salud pública para establecer un departamento de salud. También exige fondos de contrapartida del condado para retirar fondos estatales destinados al departamento de salud. Las inversiones del condado en estas posiciones serían un paso significativo para proporcionar esta financiación. Las posiciones dedicadas a la salud pública también le permitirán al condado implicar al estado en las discusiones sobre actualización de regulaciones de salud pública para centrarse menos en requisitos que eran comunes hace décadas y más en el ágil liderazgo de salud pública local en el que los estados y condados están evolucionando hoy en día y que se centra en la evaluación de la salud pública, el desarrollo de políticas, asociaciones y comunicaciones que aborden las necesidades de salud y que respondan a las emergencias de salud pública, como el COVID-19.

I. Resumen

En resumen, recomendamos que el condado de Berks:

1. Cree una posición de director de salud del condado de Berks para liderar acciones colectivas y coordinación de salud pública y servir como comunicador de confianza sobre información de salud pública.
2. Establecer un panel asesor de salud pública y nombrar miembros que puedan aconsejar en cuanto a actividades de evaluación, garantías y políticas de salud pública.

[18] Centros para el Control y Prevención de Enfermedades, salud pública 3.0: un llamado a la acción para que la salud pública afronte los retos del siglo 21, 2017, https://www.cdc.gov/pcd/issues/2017/17_0017.htm

3. Apoyar el establecimiento de una coalición de salud en Berks que sirva como un organismo de coordinación para los esfuerzos de salud pública en el condado.
4. Crear una posición de analista de datos de salud del condado de Berks para mejorar la exhaustividad y precisión de los datos de salud pública específicos del condado de Berks.

Estas recomendaciones le permitirán al condado tener **un amplio rango de opciones** para mejorar su capacidad de cumplir con las necesidades de salud pública en el futuro. Con un director de salud pública, un panel asesor de salud pública, una coalición de salud en Berks y un analista de datos de salud, el condado podrá mejorar la coordinación de servicios existentes, analizar la salud en la zona censal y/o a nivel de código postal y tener comunicación con socios y el público en una voz de autoridad sobre amenazas, emergencias y riesgos de salud pública. Simultáneamente, estos pasos brindarán una ruta para tener la **opción de establecer un departamento de salud pública** si así se desea en el futuro.

APÉNDICES

Apéndice A: Evaluación de necesidades de salud comunitaria de Tower Health de 2022

CHNA completa en la página siguiente.

PennState Health

A SIX-COUNTY

Berks | Cumberland | Dauphin | Lancaster | Lebanon | Perry

COMMUNITY HEALTH NEEDS ASSESSMENT

FULL REPORT

Conducted on behalf of:

Penn State Health Milton S. Hershey Medical Center

Penn State Health Holy Spirit Medical Center

Penn State Health St. Joseph Medical Center

Penn State Health Hampden Medical Center

Pennsylvania Psychiatric Institute

Penn State Health Rehabilitation Hospital

2021

Table of Contents

Overview

Introduction – Our Commitment to Community Health

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

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

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

Thank you,

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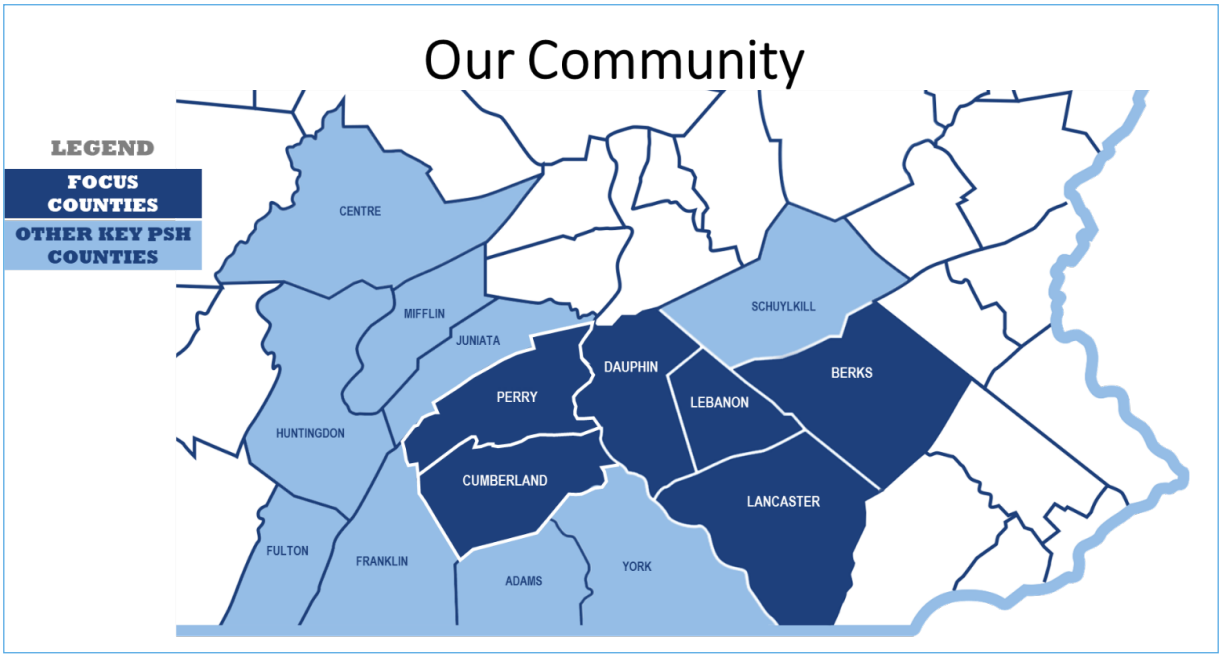
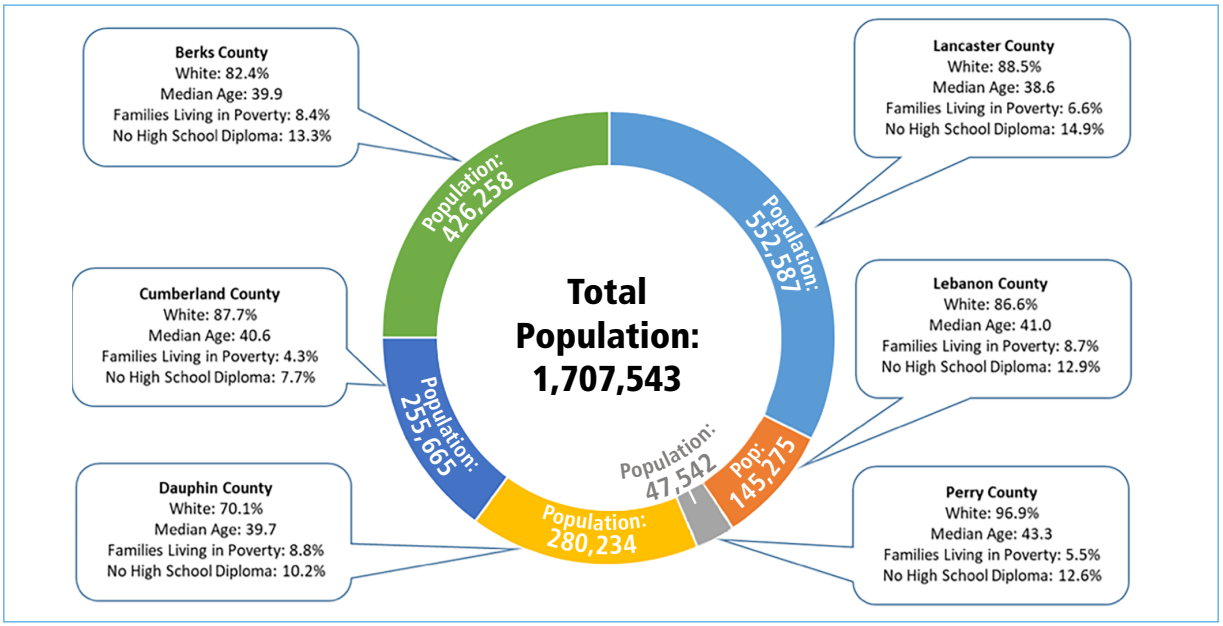
Community Description

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





CHNA Process

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

Specific CHNA steps included:

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

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

Prioritized Community Health Needs

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

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

Additional Information and Feedback

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

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

Scan:

CHNA Summary of Findings Per Priority

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

Priority 1 – Mental Health

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

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

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

Priority 2 – Health Equity

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

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

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

Priority 3 – Wellness and Disease Prevention

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

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

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

Board Approvals

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

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

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

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

Key Informant Survey

Background

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

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

Survey Participants

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

Populations Served

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

Populations Served by Key Informants

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

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

Health Perceptions

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

Top 10 Health Conditions Affecting Residents

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

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

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

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

Top 10 Contributing Factors to Health Conditions Affecting Residents

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

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

Health Perceptions – Comments by Key Informants

Ability to Afford Health Care/Poverty

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

Health Habits & Overweight/Obesity

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

Mental Health/Substance Abuse

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

Health Care Access

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

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

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

2021

Resident Health Care Access

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

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

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

Health Care Provider Availability

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

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

Primary Reason Individuals With Health Insurance Do Not Receive Regular Care

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

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

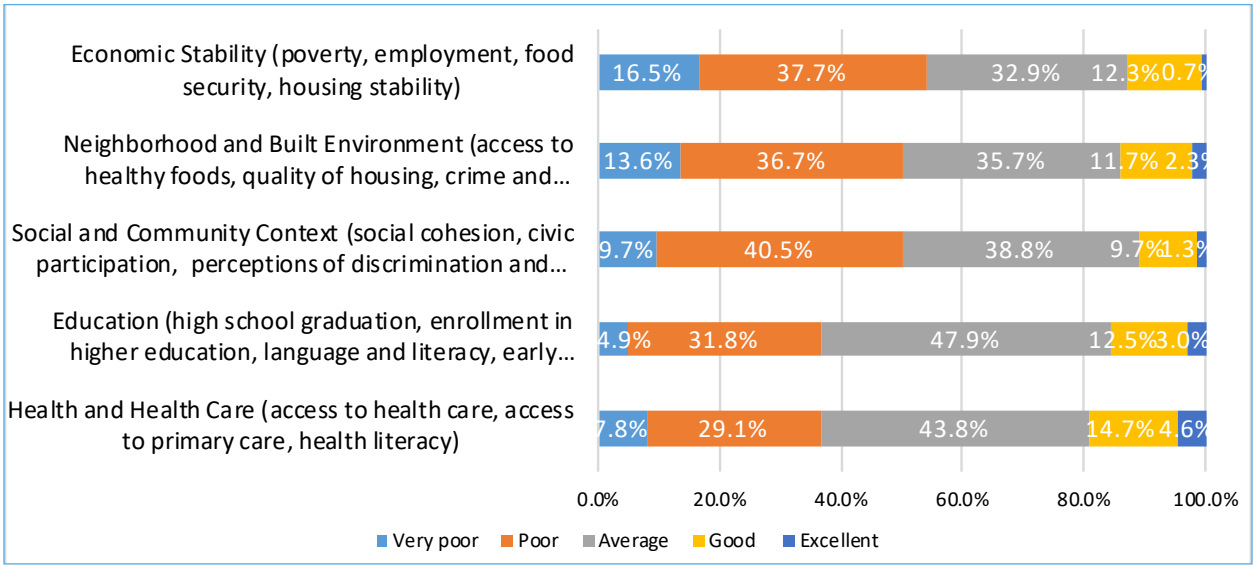
Social Determinants of Health

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

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

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

Social Determinants of Health Impacting the Community



Impact of Social Determinants on Health

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

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

Community Resources

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

Missing Resources Within the Community to Optimize Health

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

Community Member Survey

Background

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

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

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

Demographics

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

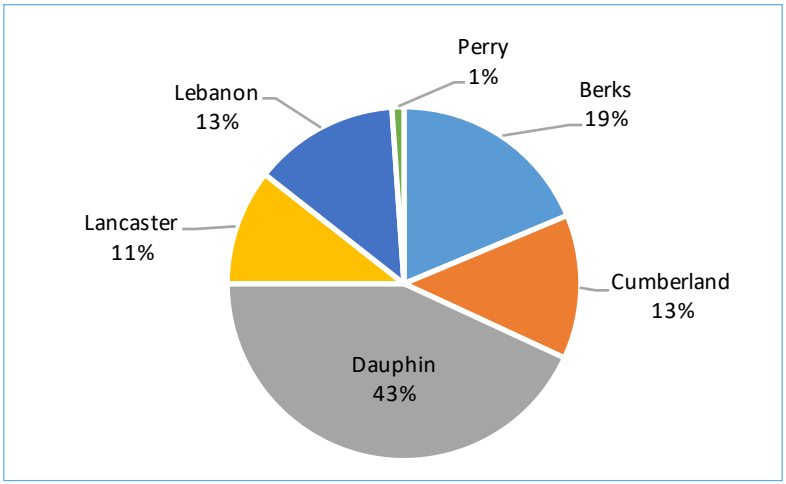
The most represented age groups were 65 to 74 (23.4%) and 55 to 64 (22.6%). Approximately 19% of respondents reported a household income of $34,999 or less. About 2.8% did not complete high school, while 15.6% graduated high school or earned a GED. Seventy-seven percent of respondents have some college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

2021

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

2021 Community Survey Respondents

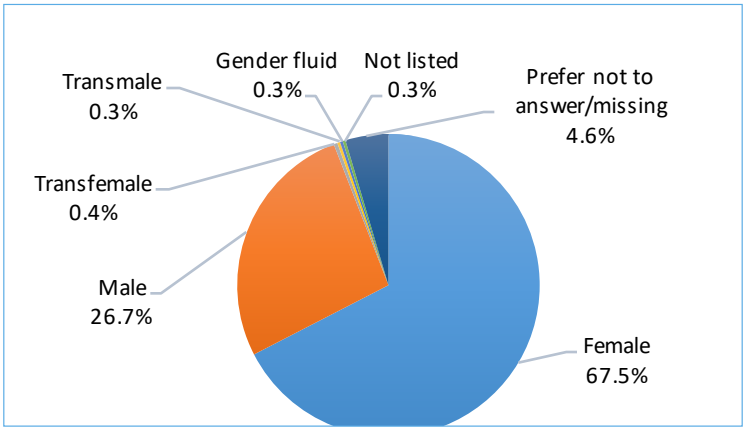
County of Residence



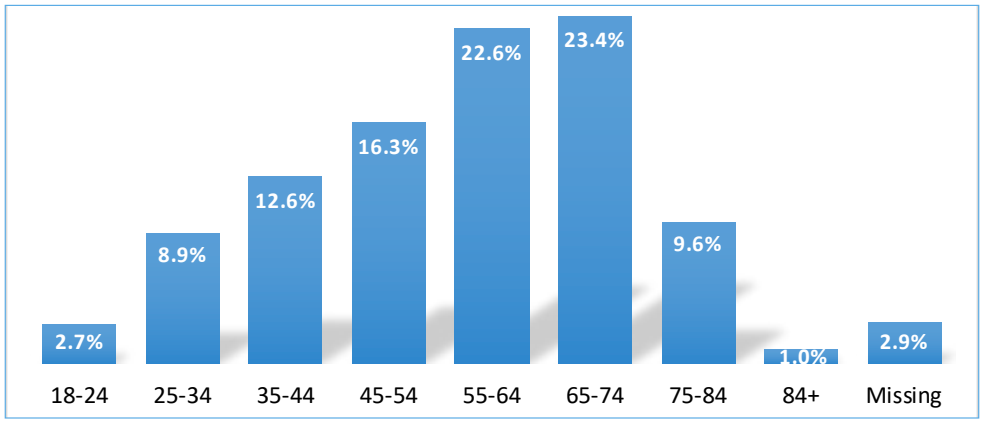
2021 Top Three ZIP Codes of Respondent Residence, by County

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

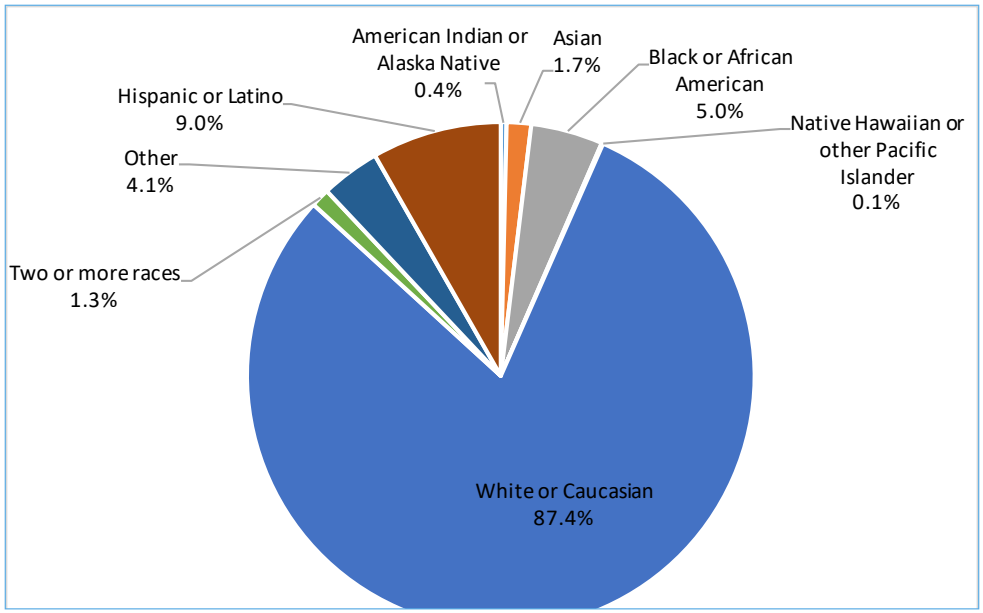
Gender of Respondents



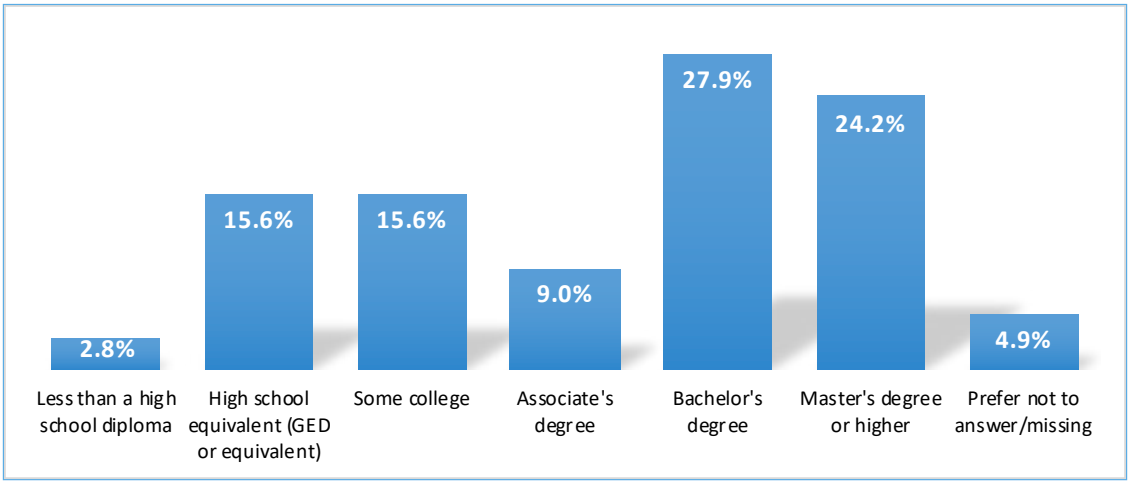
Age of Respondents



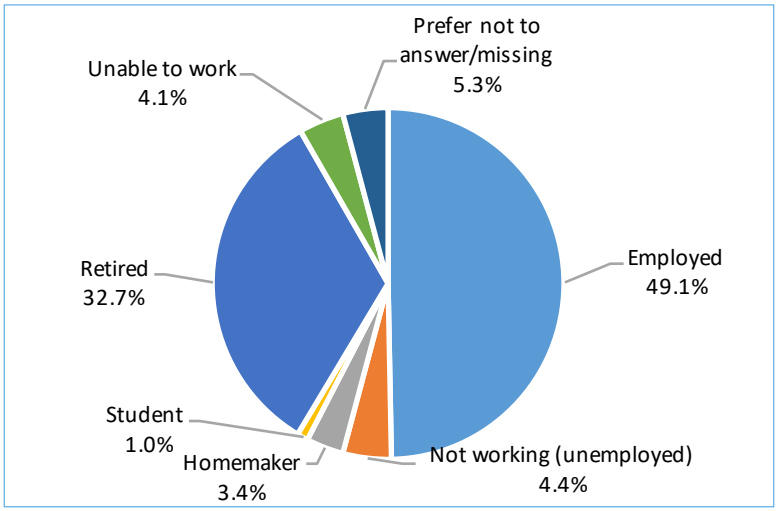
Race and Ethnicity of Respondents



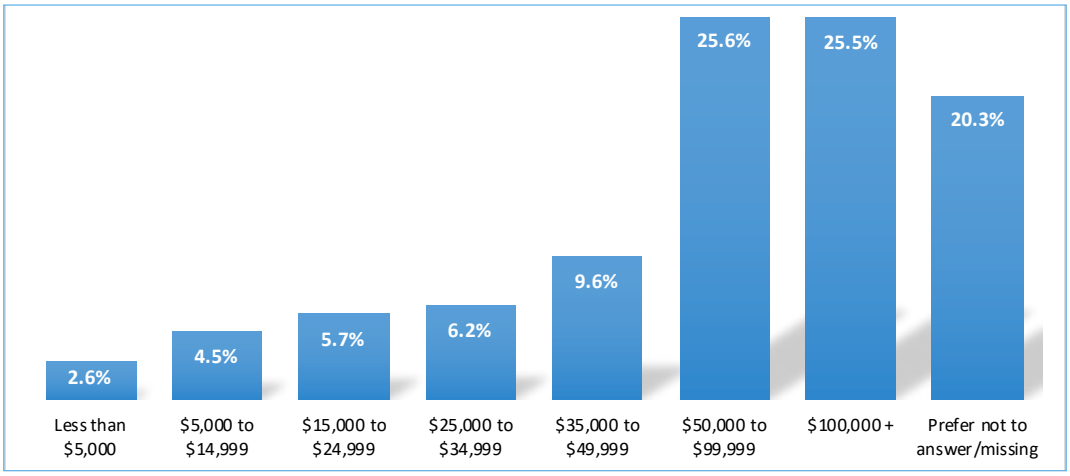
Education Level of Respondents



Employment Status of Respondents



Annual Household Income



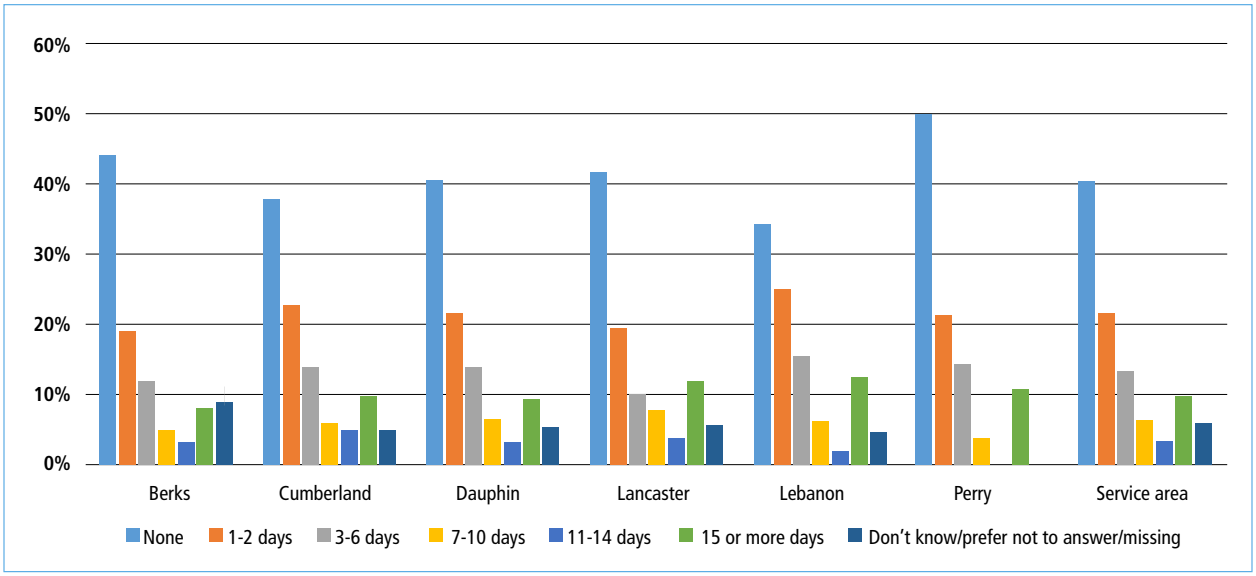
Mental Health

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

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

2021 Community Survey Respondents

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



Mental Health Services or Treatment in the Past 12 Months

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

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

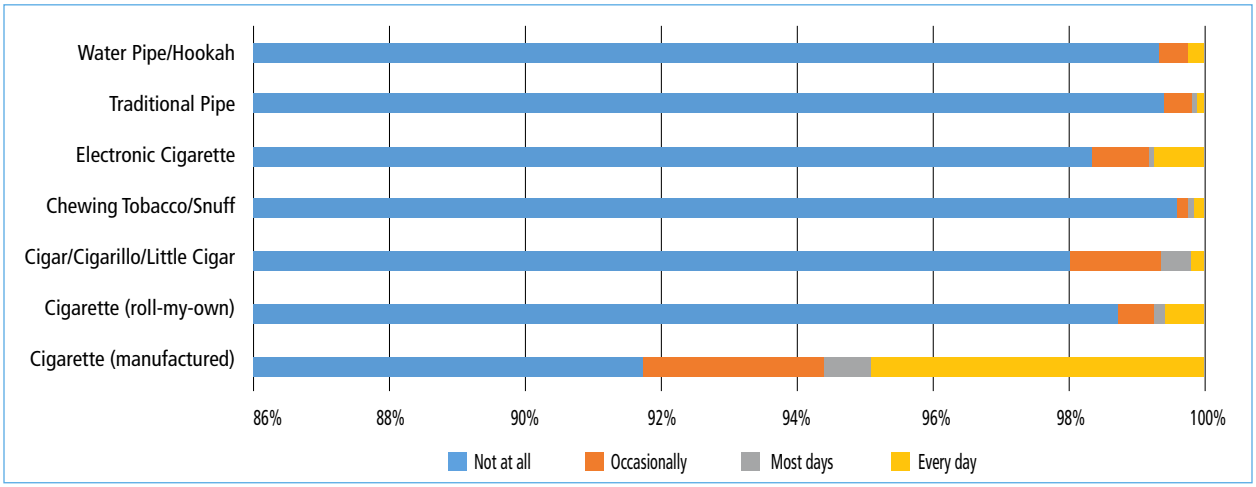
Amount of Alcoholic Drinks Consumed in an Average Week

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

Prescription and Illegal Drug Consumption

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

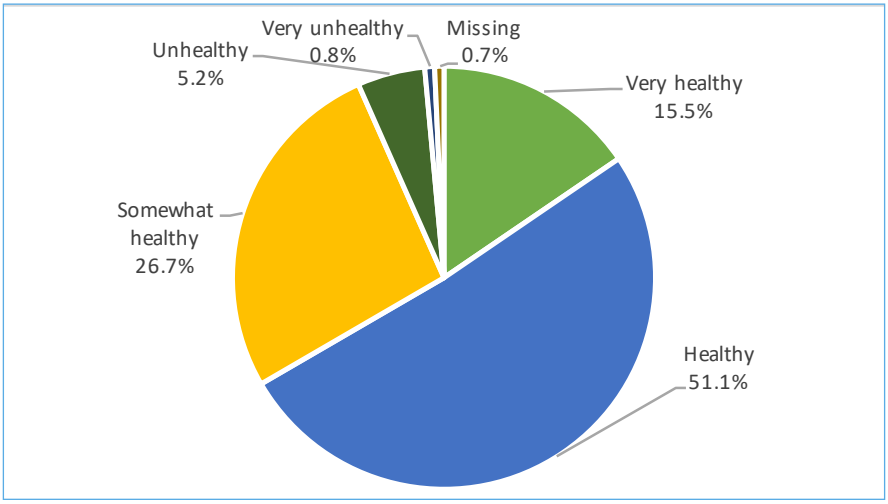
Tobacco Use in the Past 30 Days



Health Equity

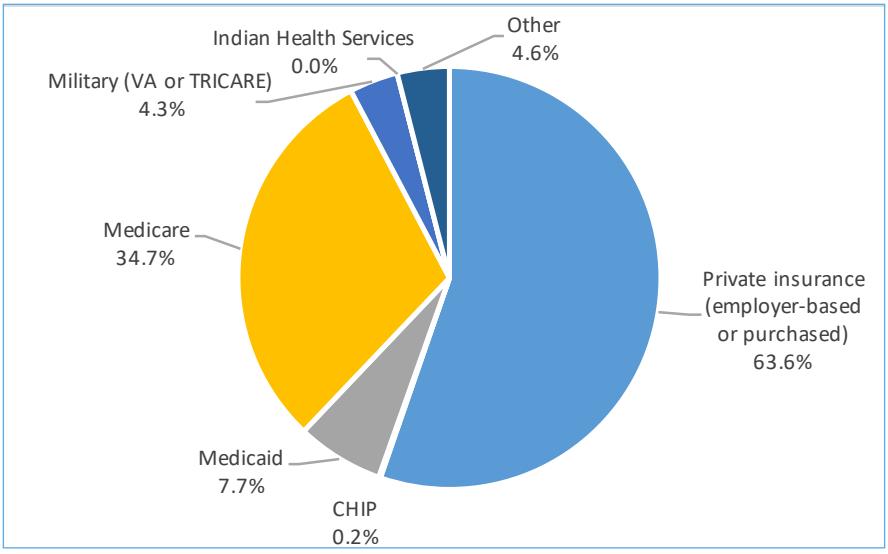
Approximately 67% of respondents reported that they are “healthy” or “very healthy,” and only 6% considered themselves to be “unhealthy” or “very unhealthy.”

How Would You Rate Your Health?



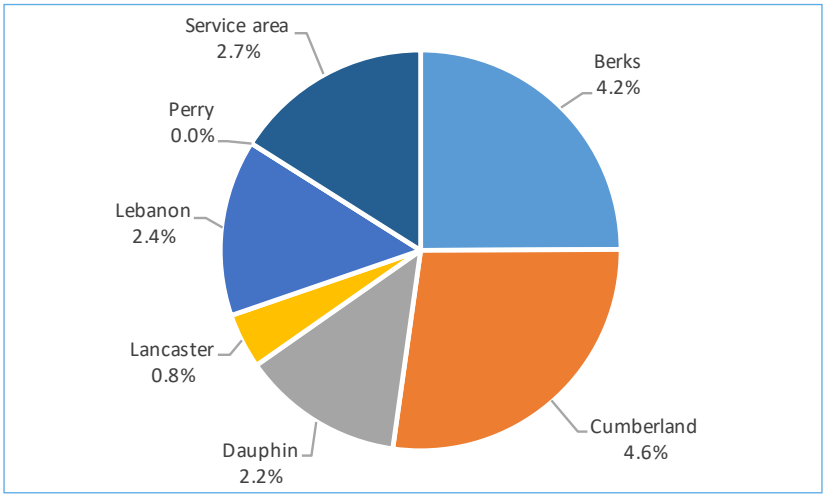
When asked about health insurance, almost two-thirds of insured respondents indicated they are covered by private insurance, while slightly more than one-third indicated they are covered by Medicare.

Health Insurance Type Among Insured Respondents

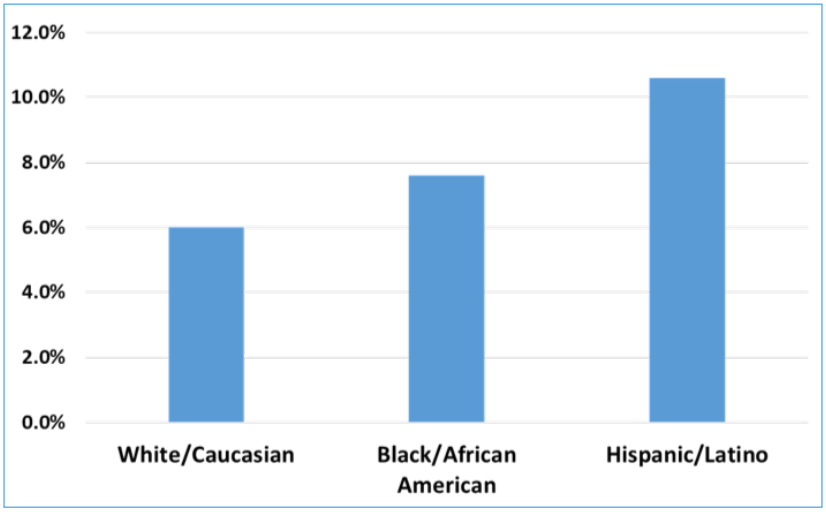


Of respondents who reported not having insurance, approximately 50% lived in Berks and Cumberland counties, and Hispanic/Latino individuals and Black/African American individuals were most likely to report being uninsured. For respondents who were uninsured, almost half indicated that they cannot afford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

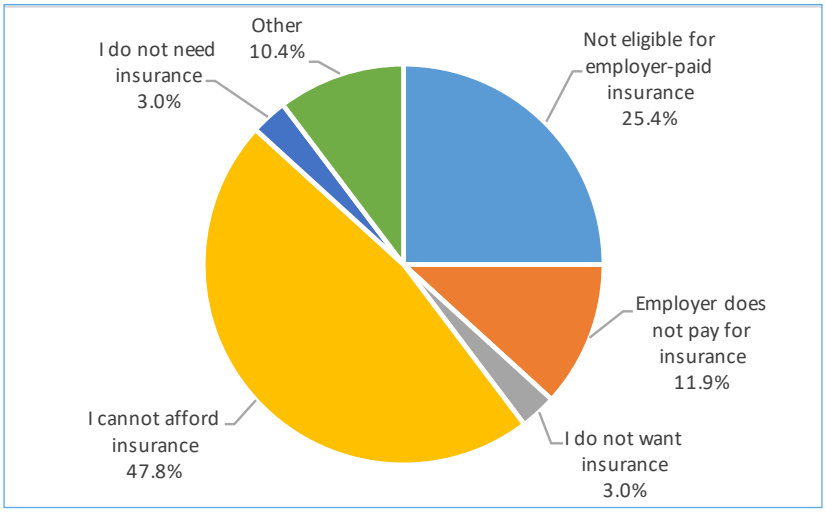
Uninsured Respondents by County



Percentage of Uninsured Respondents by Race and Ethnicity

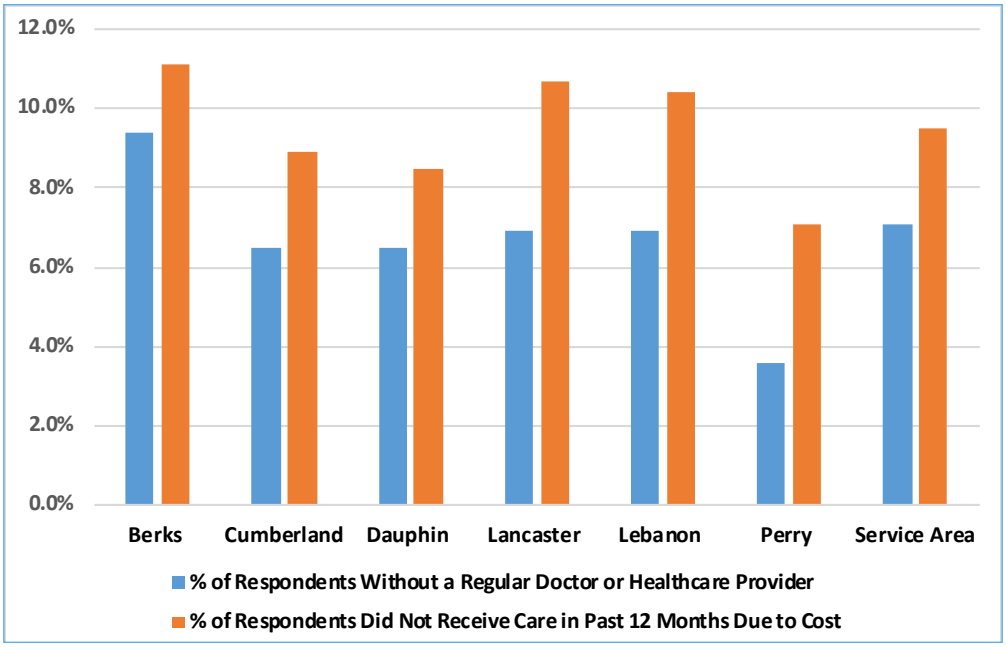


Reason for Not Having Health Insurance

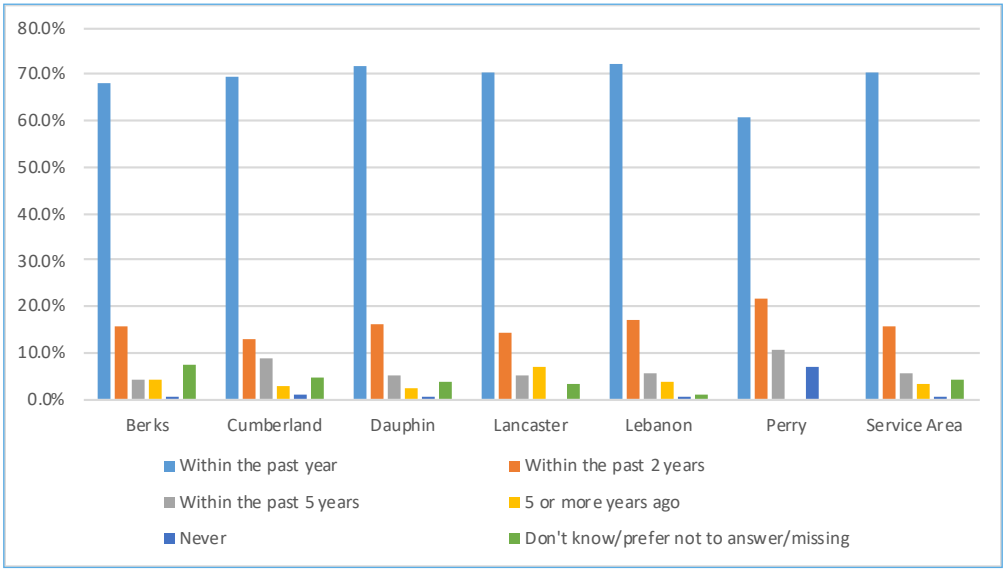


When asked about routine care and having a regular health care provider, one in 14 respondents did not have a regular doctor or health care provider and one in 11 did not receive care in the past year due to cost. Within the past year, Lebanon County respondents were the most likely and Perry County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

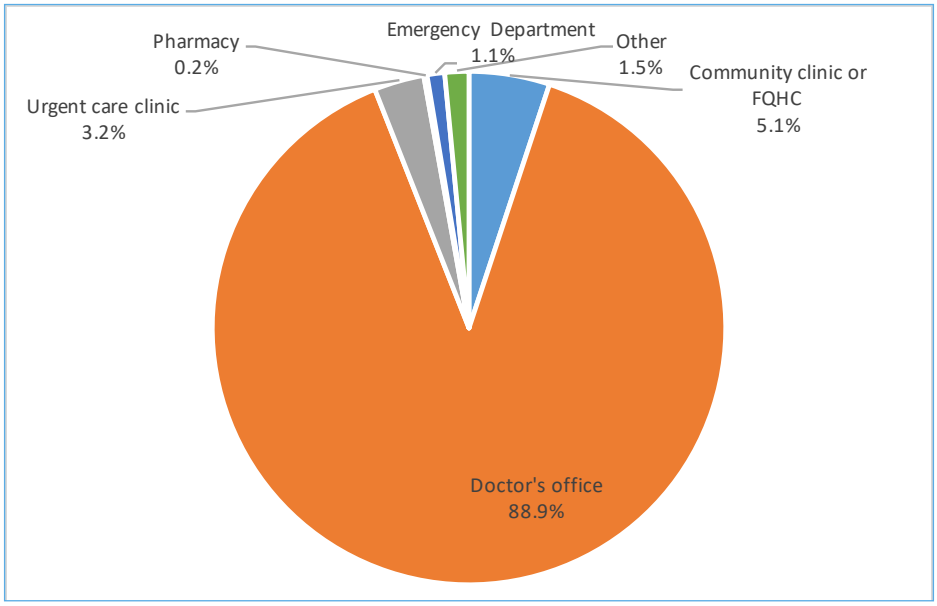
Respondents Without a Regular Provider and Those Who Did Not Receive Care in the Past 12 Months Due to Cost



Time of Last Preventive Checkup

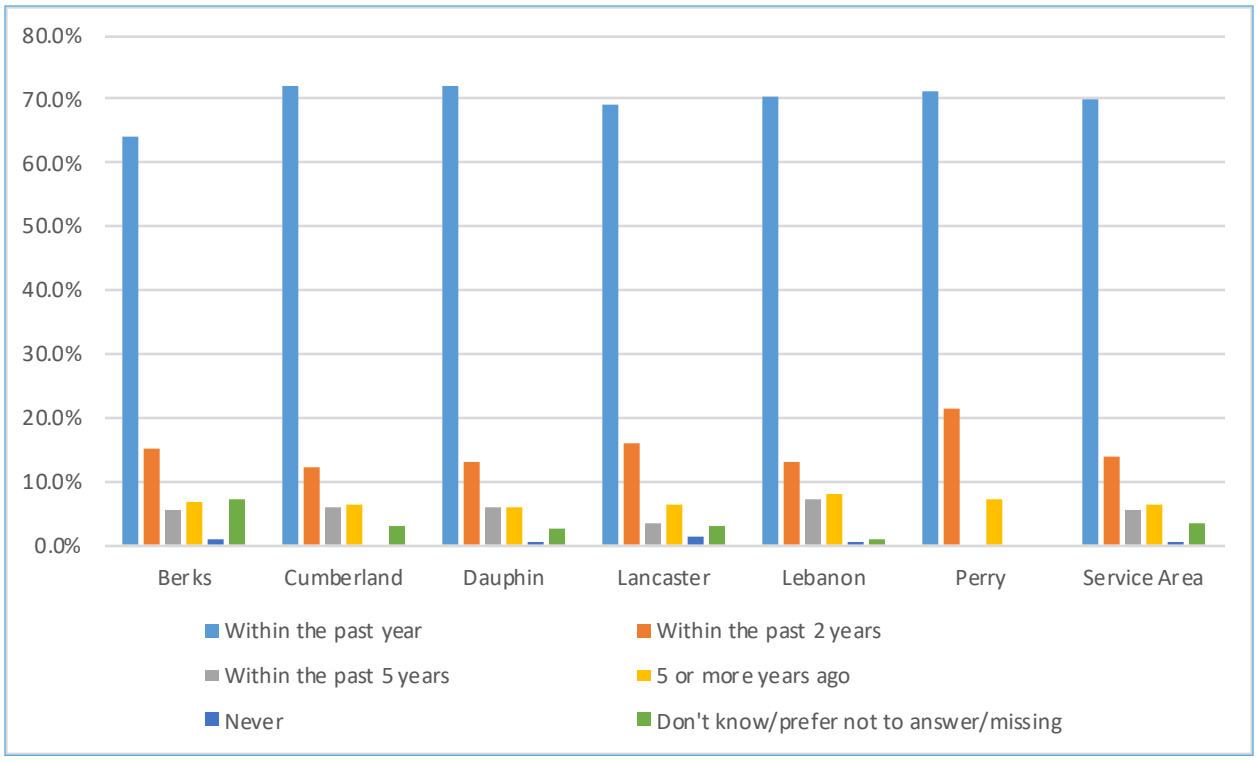


Primary Location for Seeking Medical Care

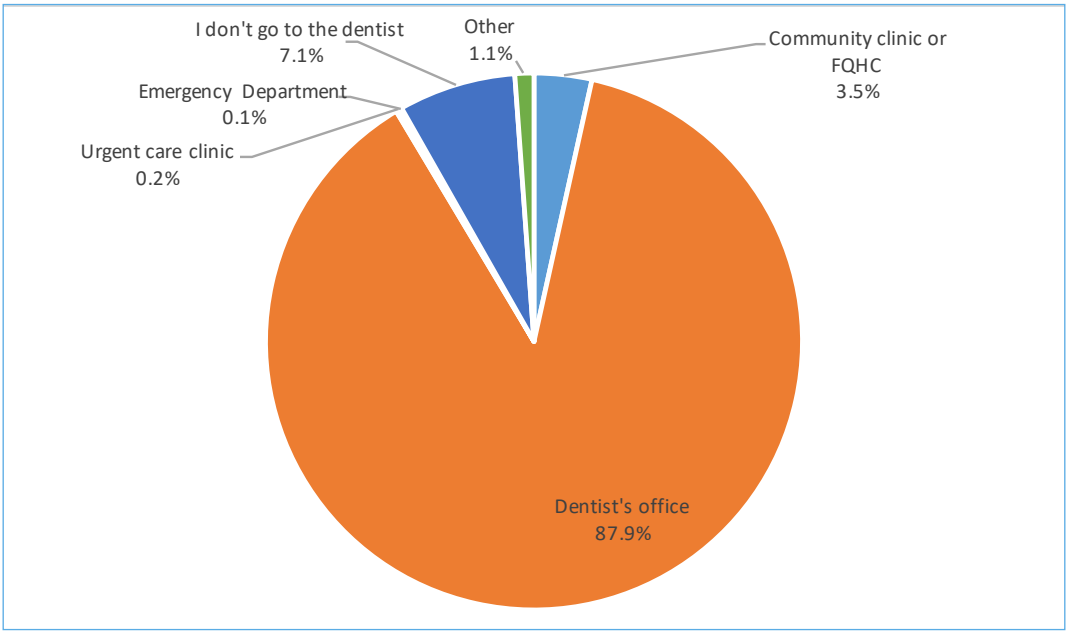


Regarding dental care, 30% of respondents across the service area had not been to the dentist within the past year, and Berks County respondents were least likely to have gone to the dentist in the past year. When asked about the primary location they sought dental care, approximately 7% of respondents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

Time of Last Dental Visit

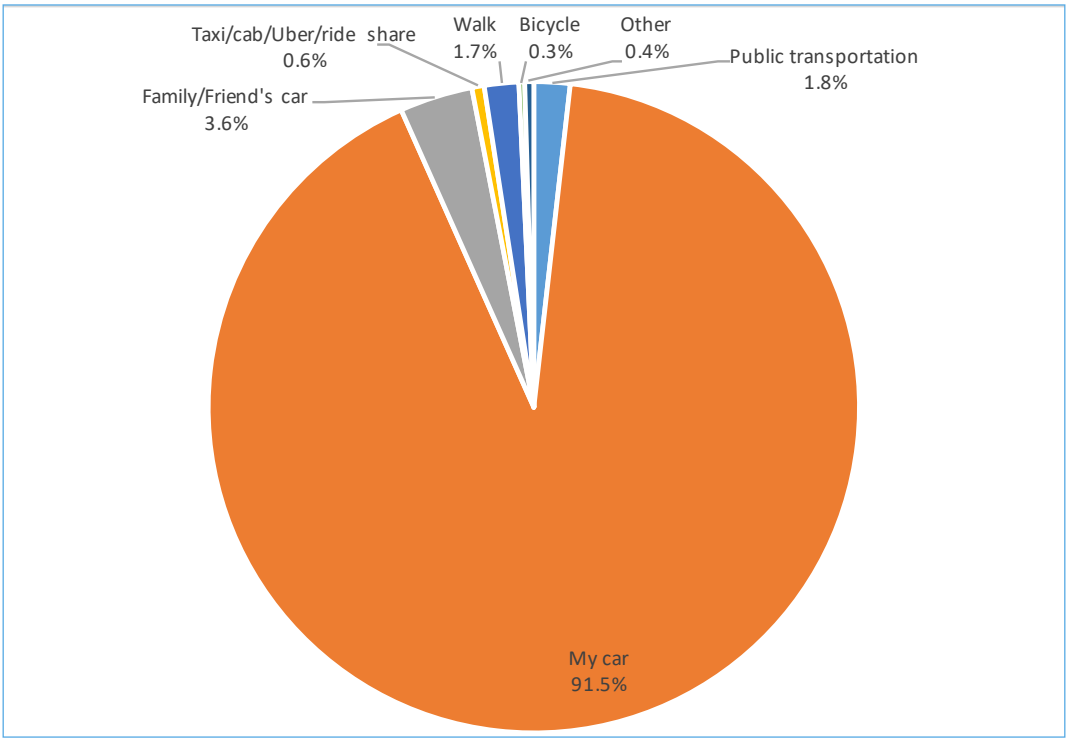


Primary Location for Seeking Dental Care



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

Main Form of Transportation



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

How Safe Do You Feel in Your Neighborhood/Community?

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

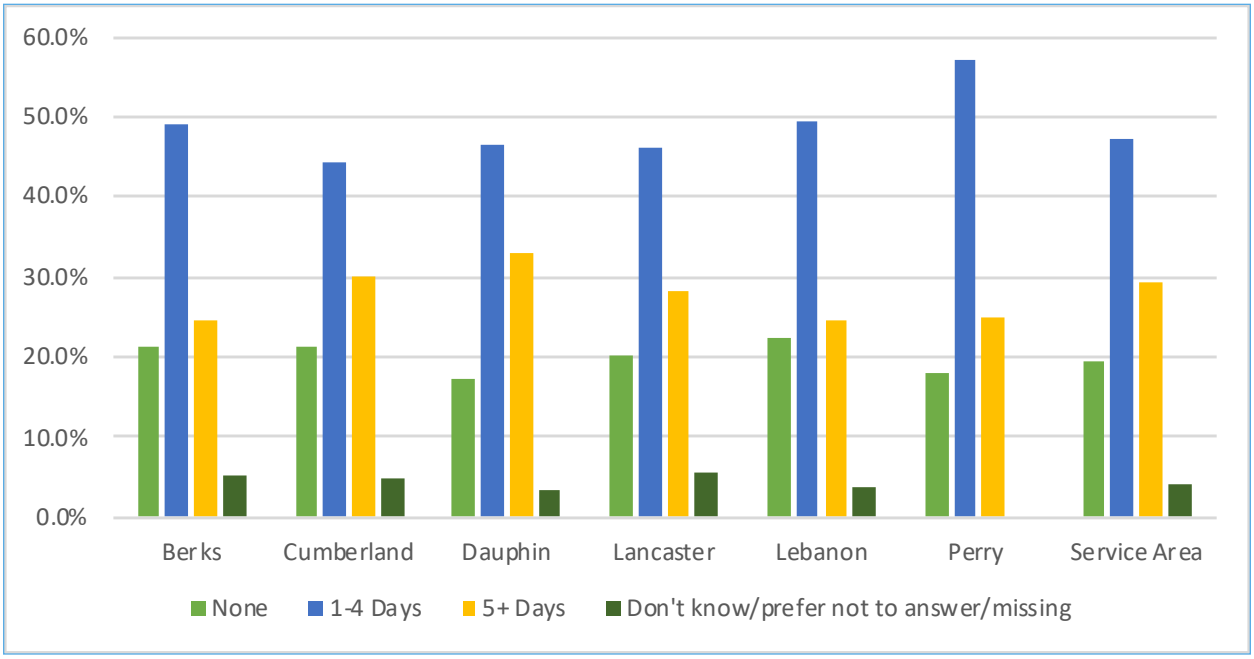
Respondents Who Feel Extremely Safe in Their Neighborhood/Community by Race/Ethnicity

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

Wellness and Disease Prevention

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

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



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

Food Insecurity by County

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

Food Insecurity by Race and Ethnicity

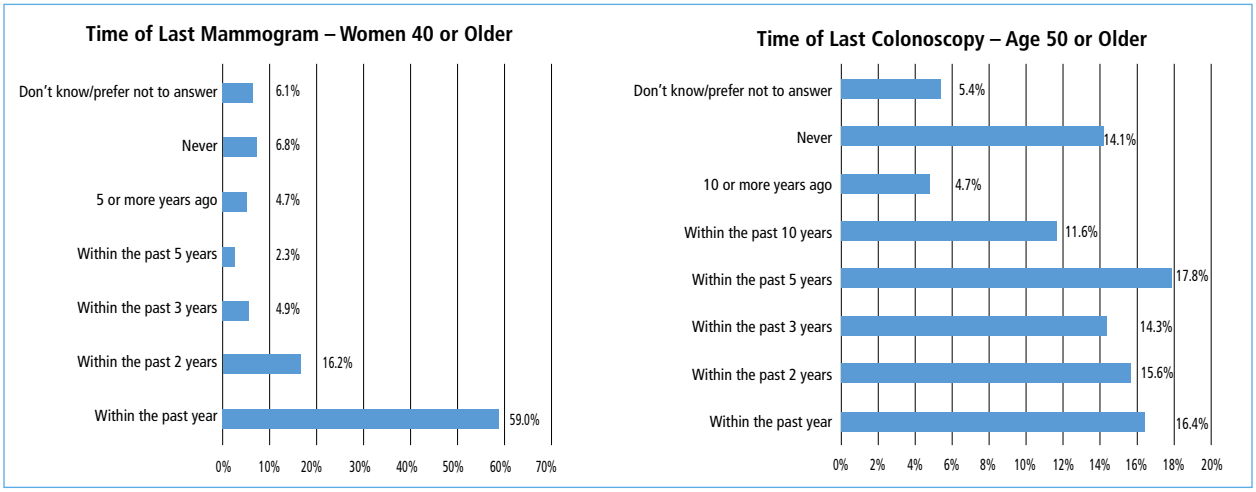
Race/Ethnicity	Within the past 12 months, I worried whether our food would run out before we got money to buy more. "Yes" Response	
	Percent	Count
Asian	22.2%	10
Black/African American	24.4%	30
Hispanic/Latino	32.1%	68
White/Caucasian	10.5%	215

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

Percentage Respondents With Chronic Condition Diagnoses, by County

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

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



Secondary Data

Background

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

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

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

Demographic Analysis and Health Equity

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

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

Population, Growth Rate and Age

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

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

Race and English Proficiency

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

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

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

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

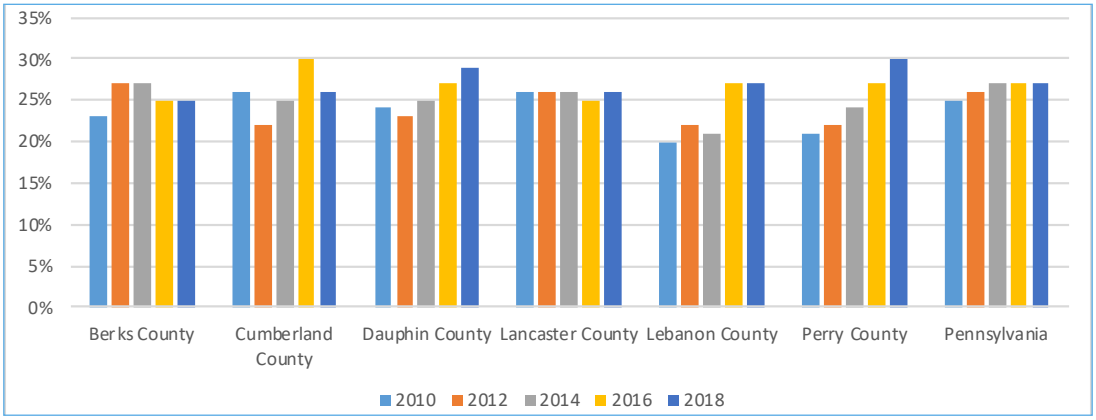
The median household income for the six-county region is $64,311, which is greater than both Pennsylvania ($61,744) and the United States ($62,843). Lebanon County has the lowest median household income ($60,281), and Cumberland County has the highest ($71,269). In the service area, 7.2% of families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

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

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

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

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



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

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

Health Insurance and Provider Access

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

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

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

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

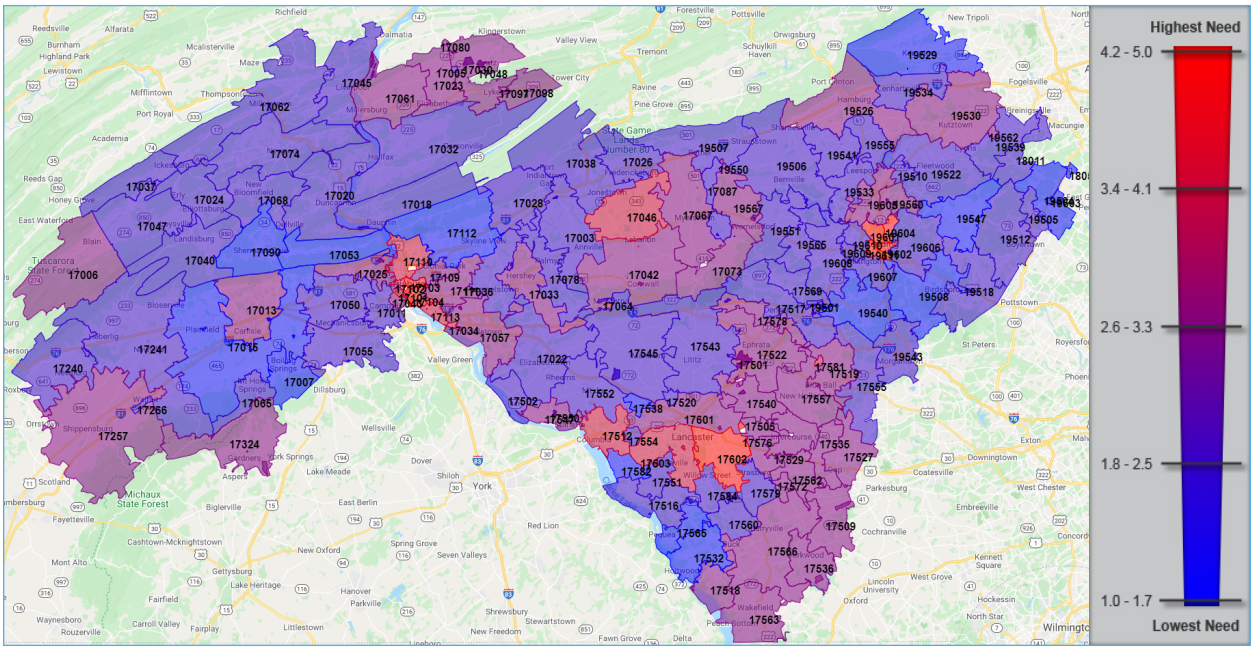
County	Housing Units That Are Overcrowded	Occupied Housing Units With One or More Substandard Conditions	Rental Households That are Cost Burdened	Owner Occupied Households With Mortgages That are Cost Burdened
Berks	2,190 (1.6%)	45,510 (29.4%)	20,844 (50.7%)	18,122 (25.7%)
Cumberland	795 (0.9%)	24,154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

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

Community Need Index

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

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



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

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

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

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

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

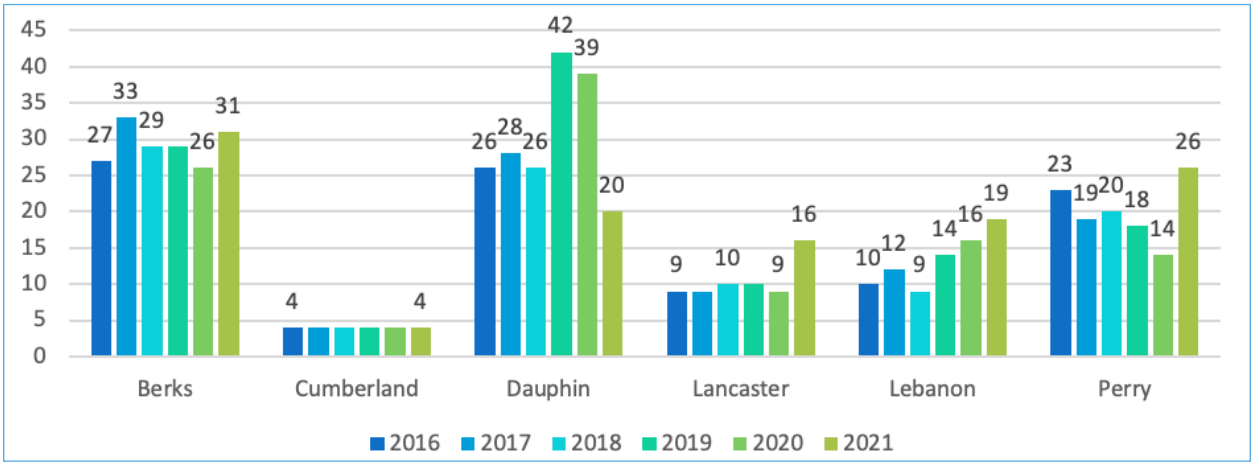
Public Health Analysis of the Six-County Region

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

County Health Rankings

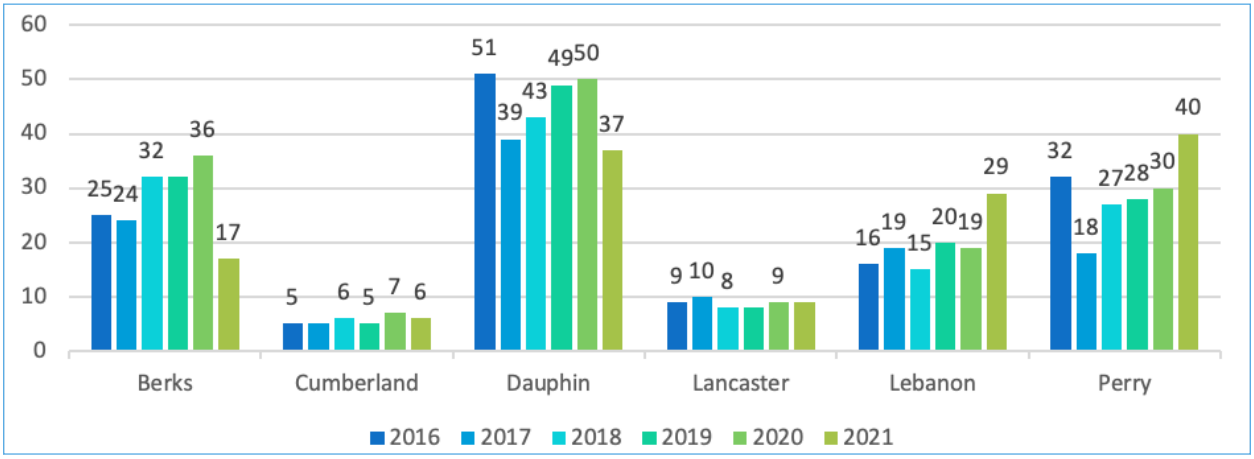
The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment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

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



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

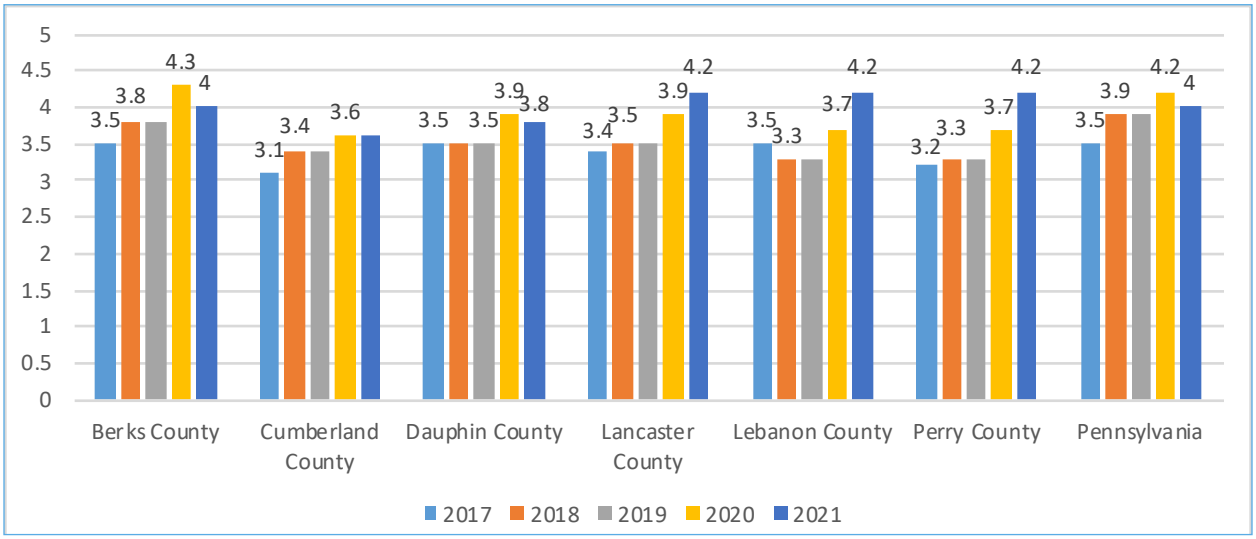
Health Outcomes Rank (out of 67 counties) – Lower = Better



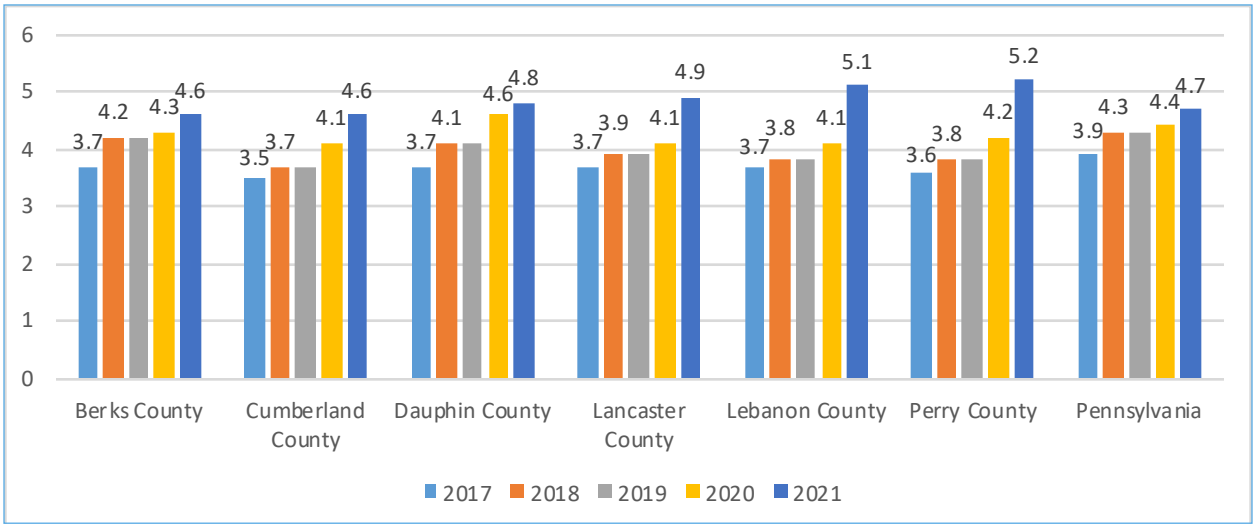
2021

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

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



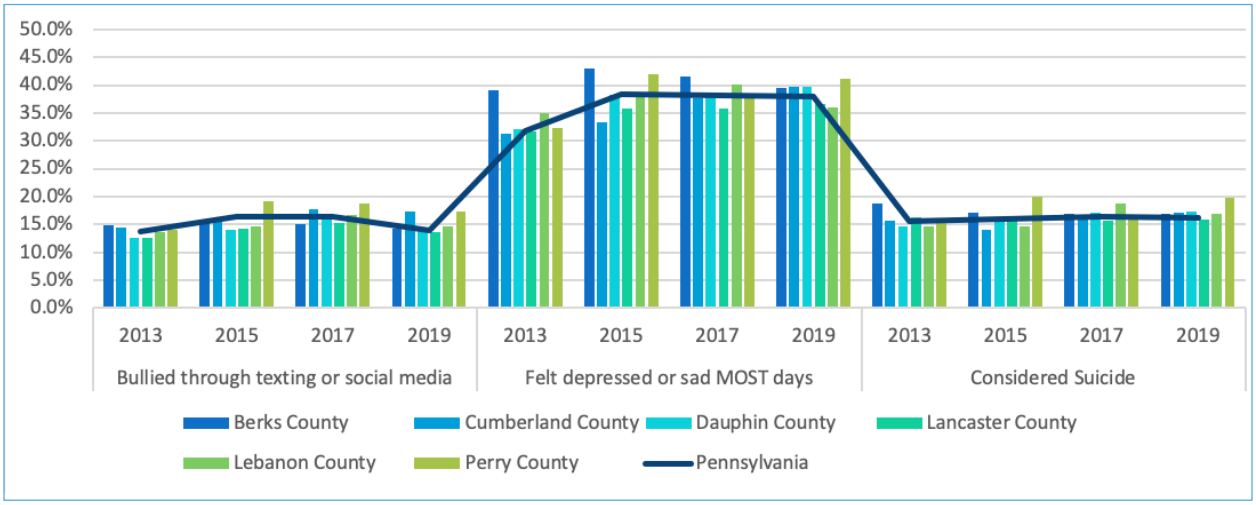
Average Number of Mentally Unhealthy Days Reported in Past 30 Days (Age-Adjusted)



Mental Health

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

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

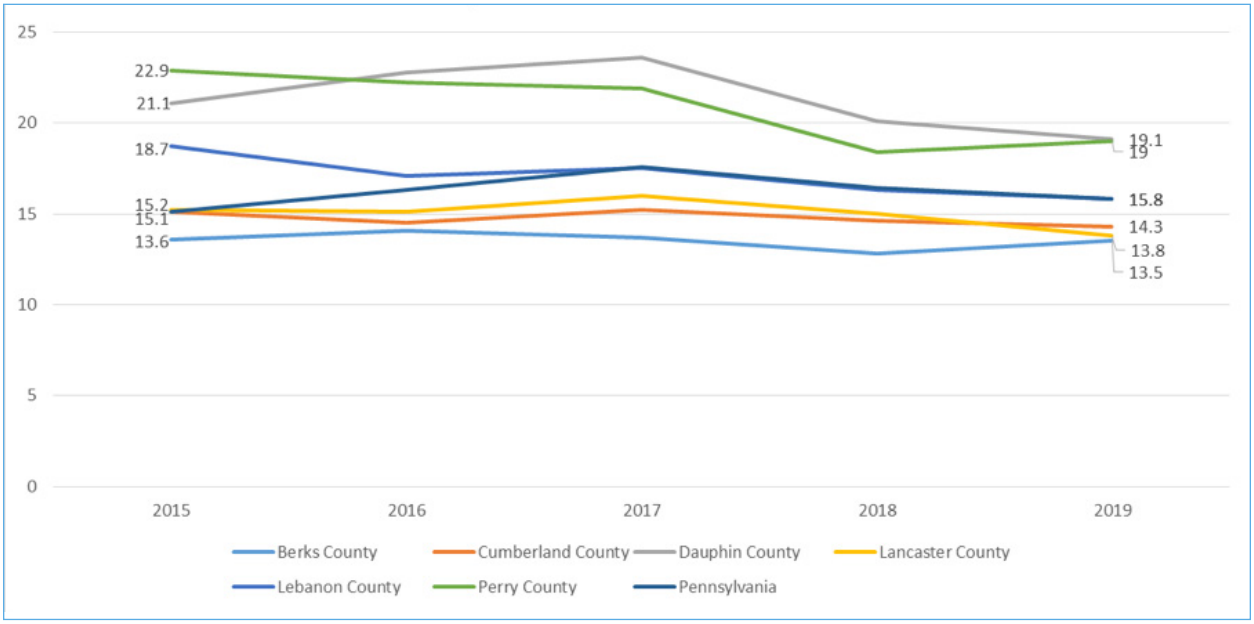


Bullying, Depression and Suicide – Past 12 months (6, 8,10 and 12 Grades)

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

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

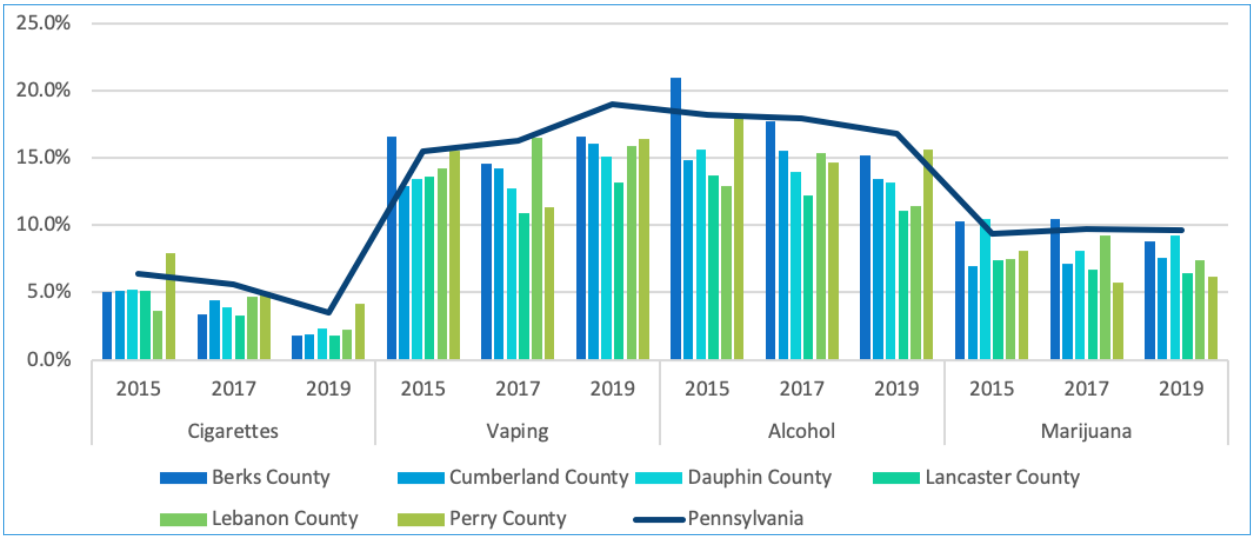
Child Maltreatment Rate Per 1,000 Children Under Age 18 – Pennsylvania Department of Human Services, 2013-2019



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

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

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



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

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

2021

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

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

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

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

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

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

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

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

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

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

Wellness and Disease Prevention

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

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

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

*One or more times in the past year

2021

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

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

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

Food Environment Index

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

2021

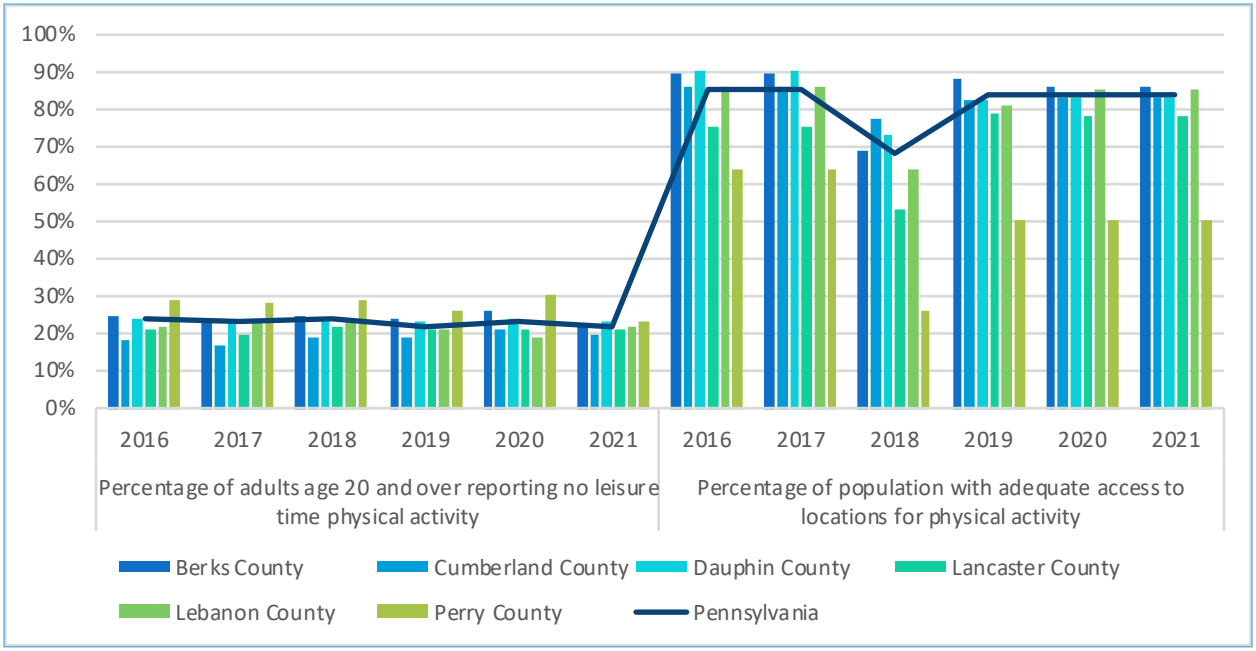
Current behaviors are determinants of future health and no leisure time physical activity may cause health issues, such as obesity and poor cardiovascular health. Access to exercise opportunities encourages physical activity and other healthy behaviors.

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

Leisure Time Physical Activity and Adequate Access

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

Physical Inactivity and Access to Exercise Opportunities



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

Overweight and Obesity – Grades K to 6

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

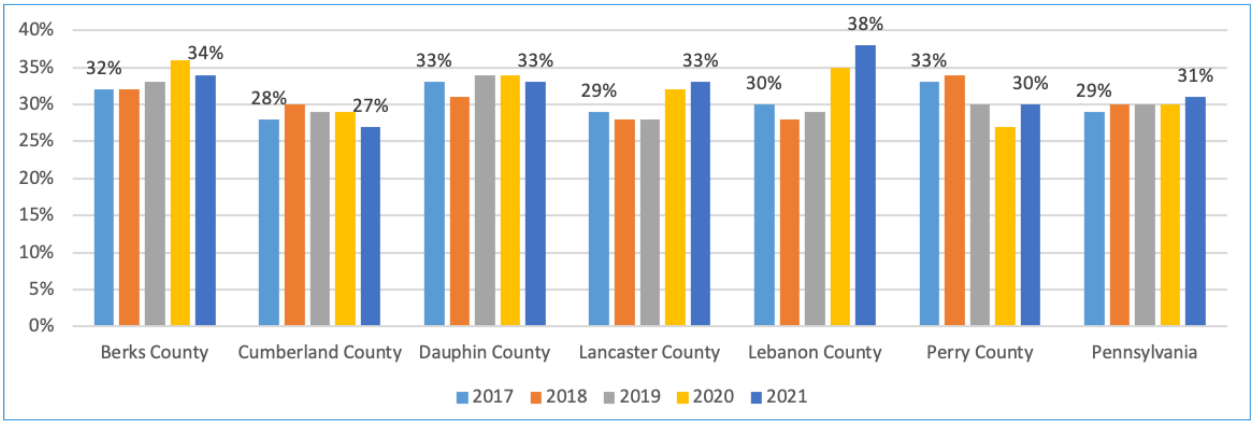
Overweight and Obesity – Grades 7 to 12

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

2021

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

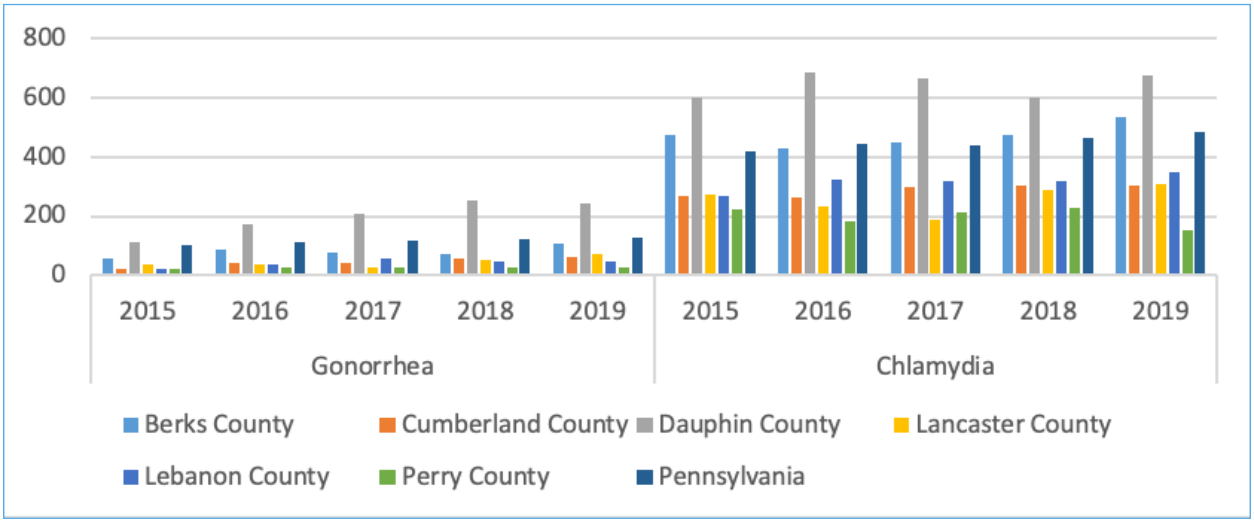
Breast and Prostate Cancer Incidence: Age-Adjusted Rates per 100,000, 2014-2018

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

2021

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

Sexually Transmitted Diseases (STDs) per 100,000



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

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

Partner Forums

Background

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

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

Prioritization Process

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

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

Scope: How many people are affected?

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

Severity: How critical is the issue?

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

Ability to Impact: Can we achieve the desired outcome?

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

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

Prioritization Results

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

Small Group Discussion

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

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

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

Mental Health

May 12

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

May 20

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

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

Access to Care

May 12

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

May 20

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

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

Social Determinants of Health

May 12

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

May 20

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

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

Chronic Disease Prevention and Management

May 12

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

May 20

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

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

Substance Use Disorder

May 12

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

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

Food Access

May 12

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

May 20

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

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

Final Determination of Prioritized Community Health Needs

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

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

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

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

Prior CHNA Implementation Plan – Evaluation of Impact and Comments Received

Evaluation of Impact

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

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

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

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

#1 Behavioral Health

Behavioral Health

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

#2 Healthy Lifestyles

Healthy Lifestyles

Nutrition

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

Oral Health

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

Physical Activity

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

#3 Disease Management

Disease Management

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

COVID-19 Response

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

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

Community Health – FY 2020

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

Community Benefit – FY 2020

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

Comments Received

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

Conclusion

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

Existing Community Assets to Address Community Health Needs

Community Benefit Inventory

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

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

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

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

Community Grants

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

Appendix A: Secondary Data References

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- United States Department of Health and Human Services, Center for Medicare & Medicaid Services. *NPI Registry*, 2020.
- United States Department of Health and Human Services, Health Resources and Services Administration. *Area Health Resource File*, 2018 and 2019.
- University of Wisconsin Population Health Institute. *County Health Rankings*, 2021.

Appendix B: Participating Community Organizations

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

Ability Prosthetics & Orthotics

AccessMatters

Adagio Health

Advance African Development, Inc.

Advanced Metrics

Aetna

A.J. Drexel Autism Institute

Alder Health Services

Allison Hill Community Center

Alzheimer's Association

American Lung Association

American Red Cross

AmeriHealth Caritas

Anchor Lancaster

Armstrong-Indiana-Clarion Drug & Alcohol Commission Inc.

ASERT Collaborative

Aspirations

Band Together

Beacon Clinic

Bell & Evans

Berks Alliance

Berks Area Regional Transportation Authority

Berks Community Health Center

Berks Counseling Center Inc.

Berks County

Berks County Area Agency on Aging

Berks County Community Foundation

Berks County Department of Emergency Services

Berks County Intermediate Unit

Berks County Office of Mental Health and Developmental Disabilities

Berks Encore

Berks Nature

Berks Teens Matter

Bethany Christian Services

Bethesda Mission

Bloomsburg University

Blue Mountain Academy Agriculture

Borough of Hamburg

Borough of West Reading

Breast Cancer Support Services of Berks County

Brethren Housing Association

Calvary United Church of Christ, Reading

Capital Area Head Start

Capital Blue Cross

Carlisle Community Area Action Network

Cathedral Parish of Saint Patrick

Catholic Health Initiatives St. Joseph Children's Health

Central Pennsylvania Food Bank

Central Pennsylvania Youth Ballet

Child Care Consultants Inc.

Church of the Good Shepherd

Church World Service-Lancaster

City of Harrisburg

City of Lebanon

City of York Bureau of Health

Cocoa Packs Inc.

Commonwealth Media Services

Communities Practicing Resiliency (CPR) of Greater Harrisburg

Community CARES

Community First Fund

Community Health Council of Lebanon County

Community Prevention Partnership

Community Services Group

Conquista Y Victoria

CONTACT Helpline 211

Contact to Care

Council on Chemical Abuse

Cumberland Area Economic Development Corporation

Cumberland County Aging & Community Services

Cumberland County Housing & Redevelopment Authorities

Cumberland/Perry County Mental Health, Intellectual & Developmental Disabilities

Cumberland Valley School District

Dauphin County Case Management Unit

Dauphin County Coroner's Office

Dauphin County Court Appointed Special Advocates

Dauphin County Drug & Alcohol Services

Dauphin County Health Improvement Partnership

Dauphin County Human Services

Dauphin County Library System

Dauphin County Medical Society Alliance

Dauphin County Prison

Derry Township

Derry Township School District

Dickinson College

Diocese of Harrisburg

Domestic Violence Intervention of Lebanon County

Domestic Violence Services of Lancaster County, Inc.

Downtown Daily Bread

Drexel University

Early Learning Resource Center

East Hanover Township

Ebenezer Baptist Church

Elizabethtown Area School District

Elizabethtown Community Housing & Outreach Services

Employment Skills Center

Epilepsy Foundation Eastern Pennsylvania

Episcopal Church of the Nativity and St. Stephen, Newport

Family Guidance Center

Family Promise of Harrisburg Capital Region

First United Church of Christ

Fishburn Church

Gateway Health

Gather the Spirit for Justice

Gemma's Angels

GLO

Grace Lutheran Church

Grantville Area Food Pantry

Greater Reading Chamber Alliance

Hadee Mosque

Hamburg Emergency Medical Services

Hamilton Health Center

HANDS of Wyoming County

Hanoverdale Church

Harrisburg Area Community College

Harrisburg Area YMCA

Harrisburg School District

Harrisburg University of Science and Technology

Healthy Family Partnership

Healthy Steps Diaper Bank

Heartshine

Hempfield recCenter

Hershey Entertainment & Resorts

Hershey Plaza Apartments

Highmark

Hill Terrace

Hope Within Ministries

Hospice of Central PA

Hoy Towers

Hummelstown Food Pantry

Hummelstown United Church of Christ

Immediate Homecare & Hospice

Jabbok Counseling

Jewel David Ministries Inc.

Jewish Family Service of Greater Harrisburg

Jewish Federation of Greater Harrisburg

Jewish Federation of Reading/Berks

Jewish Home of Greater Harrisburg

Joseph T. Simpson Public Library

Joy of Sports Foundation

Keystone Health Agricultural Worker Program

Lancaster Behavioral Health Hospital

Lancaster Family YMCA

Lancaster LGBTQ+ Coalition

Lancaster Osteopathic Health Foundation

Latino Connection

Latino Hispanic American Community Center

Lebanon County Christian Ministries

Lebanon County Mental Health /Intellectual Disabilities/ Early Intervention Program

Lebanon Diversity Social

Lebanon Family Health Services

Lebanon School District

Lebanon Valley Community Tennis Association

Lebanon Valley Family YMCA

LGBT Center of Central PA

LionReach

Literacy Council of Reading-Berks

LivingWell Institute

Lower Dauphin Communities That Care

Manna Food Pantry

Maple Terrace

Mary's Helpers Food Pantry and Clothing Store

Maternal & Family Health Services

Mechanicsburg Area School District

Merakey

Messiah Lifeways

Messiah University

Metropolitan Community Church of the Spirit

Middletown Food Pantry

MidPenn Legal Services

Milton Hershey School

Minersville Area School District

Mohler Senior Center

Monongalia County Health Department

Montgomery County Department of Health and Human Services

Mount Nittany Health

National Institute for Coordinated Health Care

New Hope Ministries

New Life Community Church

Northern Dauphin Human Services Center

Our Lady of Lourdes

PA Coalition for Oral Health

Palmyra Grace Church

Partnership for Better Health

Penn Medicine Lancaster General Health

Penn National Race Course

Penn State Addiction Center for Translation

Penn State Berks

Penn State Cancer Institute

Penn State College of Medicine

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

Penn State College of Nursing

Penn State Extension

Penn State Harrisburg

Penn State Health Medical Group

Penn State PRO Wellness

Penn Street Market

Pennsylvania Association of Community Health Centers

Pennsylvania Department of Conservation and Natural Resources

Pennsylvania Department of Health

Pennsylvania Department of Human Services

Pennsylvania Fetal Alcohol Task Force

Pennsylvania Health Access Network

Pennsylvania Link to Aging and Disability Resources

Pennsylvania Office of Vocational Rehabilitation

Pennsylvania Recovery Organizations Alliance

Pennsylvania Special Supplemental Nutrition Program for Women, Infants and Children

Pennsylvania State University

Perry County

Perry County Area Agency on Aging

Perry County Emergency Management Agency

Perry County Health Coalition

Perry Human Services

Planned Parenthood Keystone

Poplar Terrace Apartments

Prince of Peace Parish

Pyramid Healthcare

Racial and Ethnic Approaches to Community Health

Reading Farm Stand

Reading Hospital

Reading Housing Authority

Reading School District

Riverfront Federal Credit Union

Safe Berks

Safe Harbour

Safe Kids Dauphin County

Safe Kids Pennsylvania

Saint Clair Area School District

Saint Elizabeth Ann Seton Parish, Mechanicsburg

Samara

SAMBA – Susquehanna Area Mountain Bike Association

Samaritan Fellowship

Saratoga Area Senior Coordinating Council

Schaner Senior Center

Sexual Assault Resource and Counseling Center

Shippensburg Civic Club

Shippensburg Community Resource Coalition

Slippery Rock University

Southeastern Health Care at Home

South Central Transit Authority

St. Anne Catholic Church

St. John's United Church of Christ

St. Peter the Apostle Roman Catholic Church

Steelton-Highspire School District

Success Against All Odds

Susquenita School District

Tamaqua Area School District

The Caring Cupboard

The Danya Institute Inc.

The Food Trust

The Foundation for Enhancing Communities

The Hershey Company

The Kidney Foundation of Central PA

The Period Project Harrisburg

The Salvation Army

The Salvation Army Harrisburg Capital City Region

The Salvation Army of Reading

The Wyomissing Foundation

Threshold Rehabilitation Services

Tioga County Partnership for Community Health

TLR Business Solutions, Inc.

TLR Insurance

Trans Advocacy Pennsylvania

Trehab Community Action Agency

Tri County Community Action

Trinity Preschool, Harrisburg

Tri-State Advocacy Project

Tulpehocken Terrace

Unitarian Church

United Community Services for Working Families

United Way of Berks County

United Way of Carlisle & Cumberland County

United Way of Lebanon County

United Way of the Capital Region

University of Pittsburgh Medical Center (UPMC)

UPMC Harrisburg

UPMC Health Plan

Vickie's Angel Foundation

Visiting Nurse Association of Central PA

Volunteers of America of Pennsylvania

Weidenhammer

WellSpan Good Samaritan Hospital

WellSpan Philhaven

West Chester University

West Reading Borough

West Shore Chamber of Commerce

West Shore School District

West Shore YMCA

Western Berks Free Medical Clinic, Inc.

Wilkes-Barre City Health Department

Willow Terrace Senior Apartments

YMCA Center for Healthy Living

YMCA of Reading and Berks County

York College of Pennsylvania

YWCA Carlisle & Cumberland County

Zion Lutheran Church, Union Deposit

Appendix C: Feedback Comments for Past CHNAs and Implementation Plans

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- *"Excellent"*

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

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

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

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

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

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

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

PennState Health

2021

Apéndice B: Evaluación de necesidades de salud comunitaria de PennState Health de 2021

CHNA completa y sus conclusiones en la página siguiente.

COMMUNITY HEALTH NEEDS

2022 ASSESSMENT

HEALTH IS WHERE WE LIVE, LEARN AND WORK

Reading Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

Reading.TowerHealth.org

TABLE OF CONTENTS

LETTER FROM THE CEO

OUR MESSAGE TO THE COMMUNITY

Charles Barbera,
MD, MBA, MPH, FACEP

President and Chief Executive Officer,
Reading Hospital

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

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

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

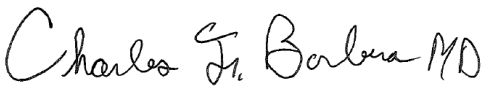
Reading Hospital is committed to advancing health and transforming lives throughout Berks County. As a leading health care provider, we strive to positively impact the health and well-being of our patients, as well as the broader communities we serve. Many of our programs and services have been developed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

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

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

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

Sincerely,



Charles Barbera,
MD, MBA, MPH, FACEP

President and Chief Executive Officer,
Reading Hospital

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

ABOUT
THIS REPORT

COMMUNITY HEALTH NEEDS ASSESSMENT INTRODUCTION

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

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

IRS MANDATE

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

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

CONSULTANT INFORMATION

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

CHNA PROCESS – COMMUNITY ENGAGEMENT

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

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

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

Figure 1: Community Engagement

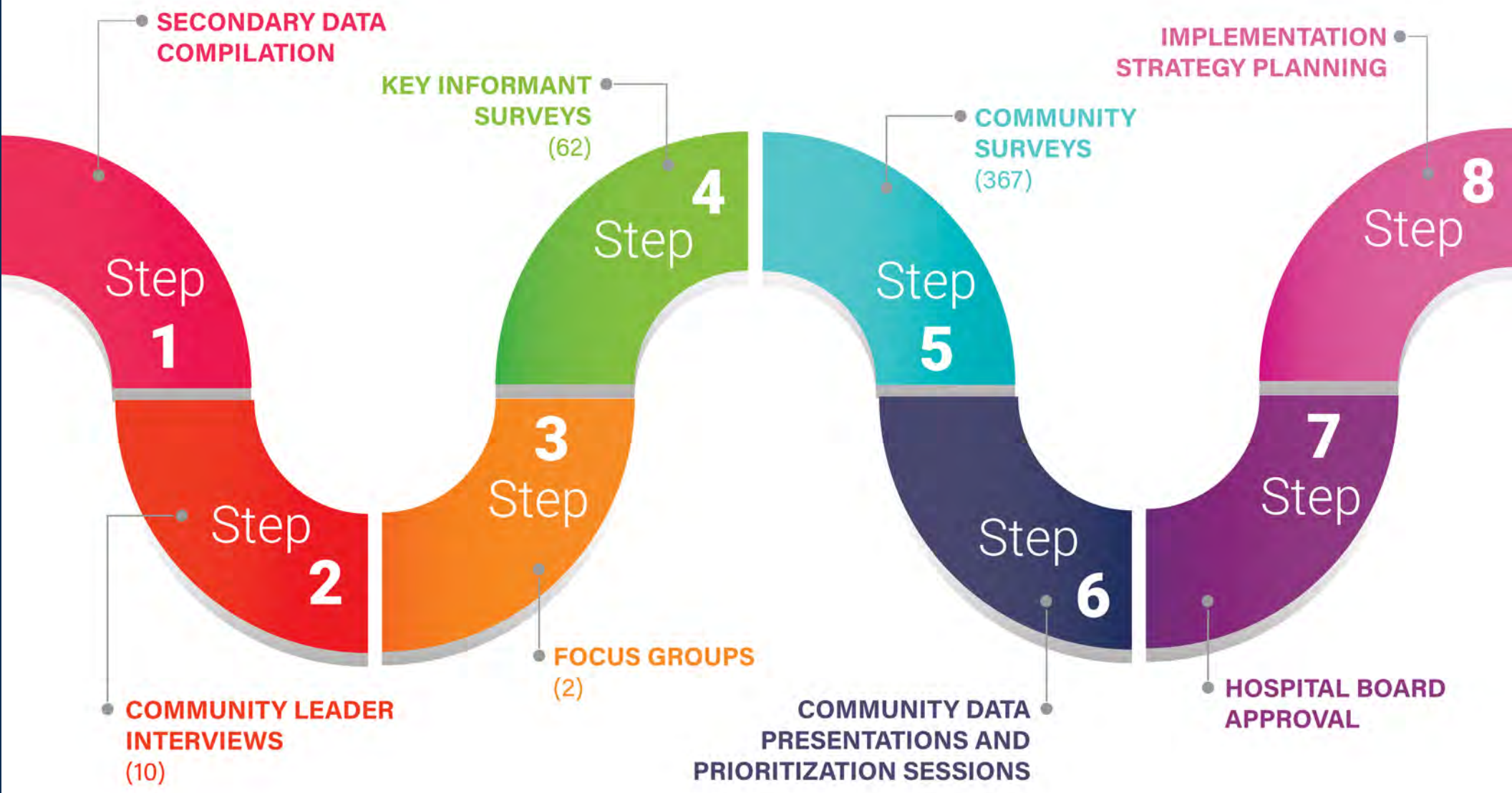
[1] Members of the working group consisted of Desha Dickson, Associate Vice President Community Wellness, Reading Hospital; Tanieka Mason, Senior Manager SDOH & Analytics, Reading Hospital; Courtney Powers, Program Manager, Community Wellness, Reading Hospital; Ha T. Pham, Senior Principal, Tripp Umbach;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

2021-2023 COMMUNITY HEALTH REGIONAL PRIORITIES

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

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

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



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

READING HOSPITAL

WHO ARE WE?

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

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

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

MISSION

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

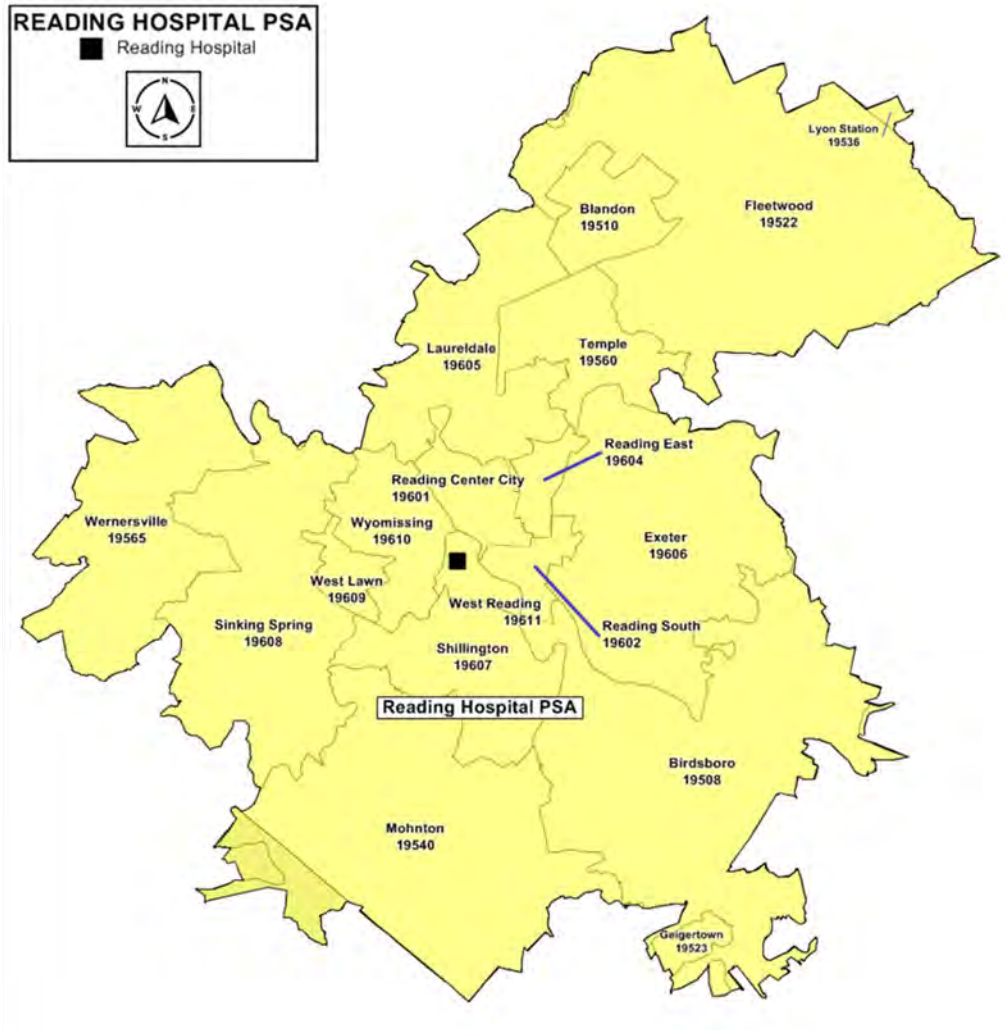
VISION

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

REPORT SERVICE AREA

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

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



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

EVALUATION OF
2019 CHNA IMPLEMENTATION STRATEGY

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

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

1 HEALTH PRIORITY: ACCESS TO HEALTH CARE

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

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

2 HEALTH PRIORITY: SOCIAL DETERMINANTS OF HEALTH (SDOH)

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

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

3 HEALTH PRIORITY: DISEASE PREVENTION AND MANAGEMENT

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

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

4 HEALTH PRIORITY: ACCESS TO BEHAVIORAL HEALTH SERVICES

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

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

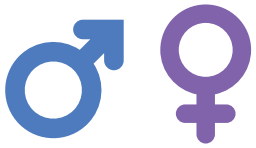
COMMUNITY AT A GLANCE

THE COMMUNITY WE SERVE

POPULATION

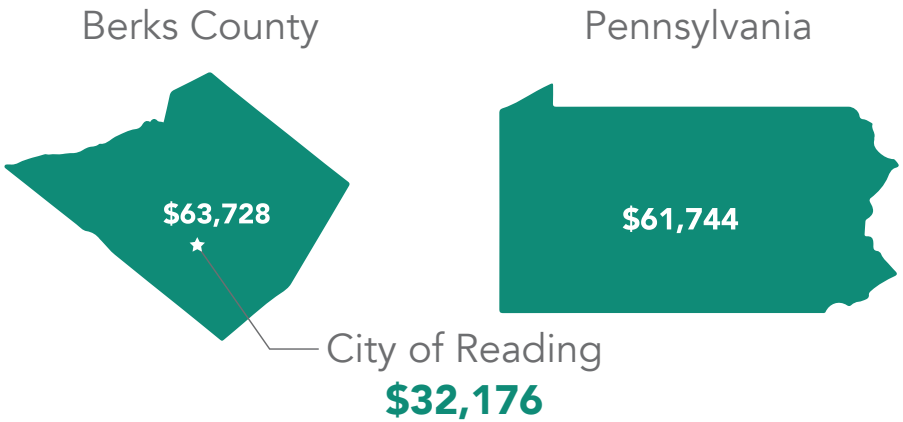
Source: U.S. Census Bureau 2020

GENDER



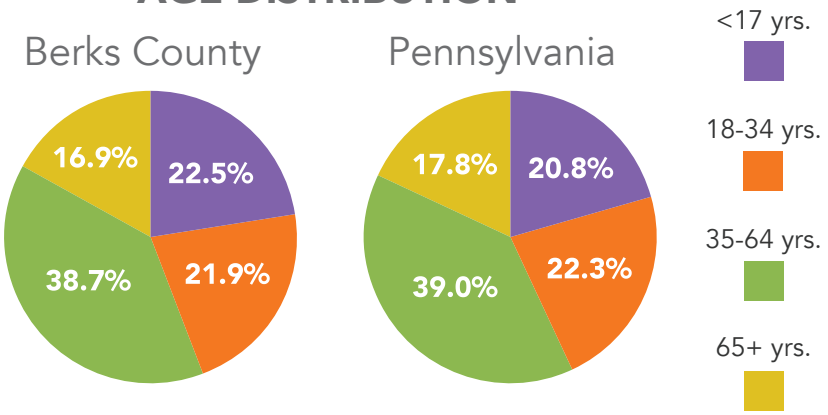
Source: U.S. Census Bureau 2019

MEDIAN HOUSEHOLD INCOME



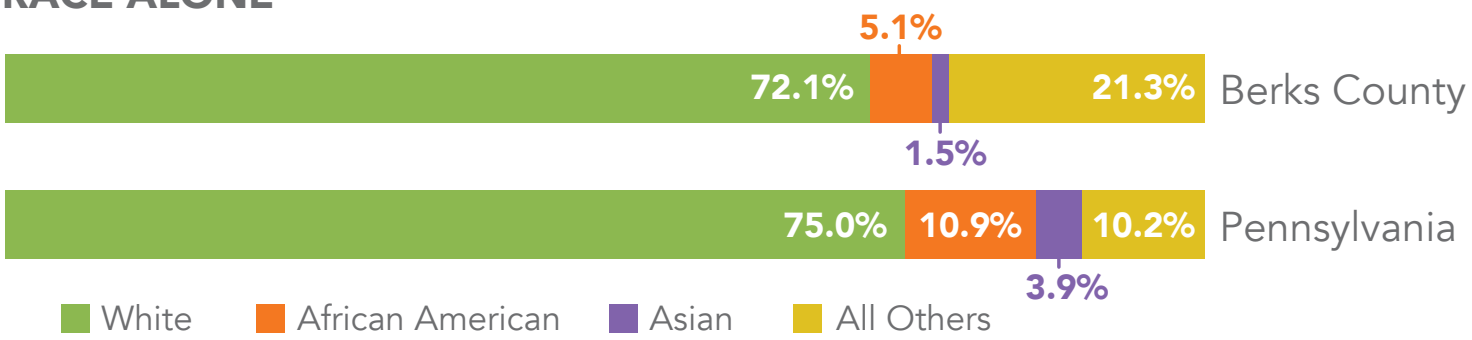
Source: U.S. Census Bureau 2019

AGE DISTRIBUTION



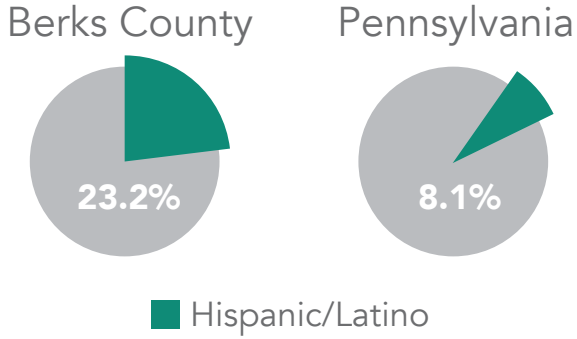
Source: U.S. Census Bureau 2019

RACE ALONE



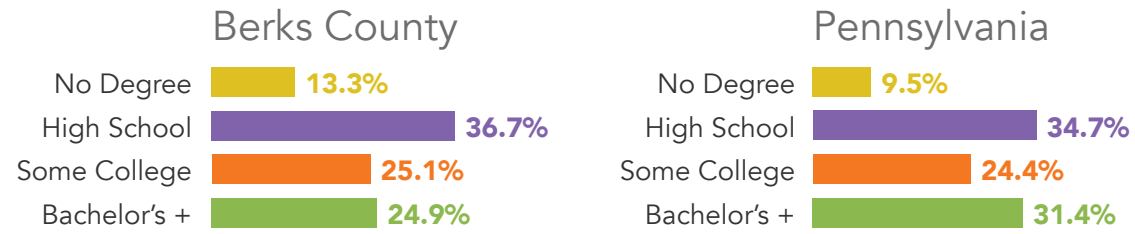
Source: U.S. Census Bureau 2020

ETHNICITY



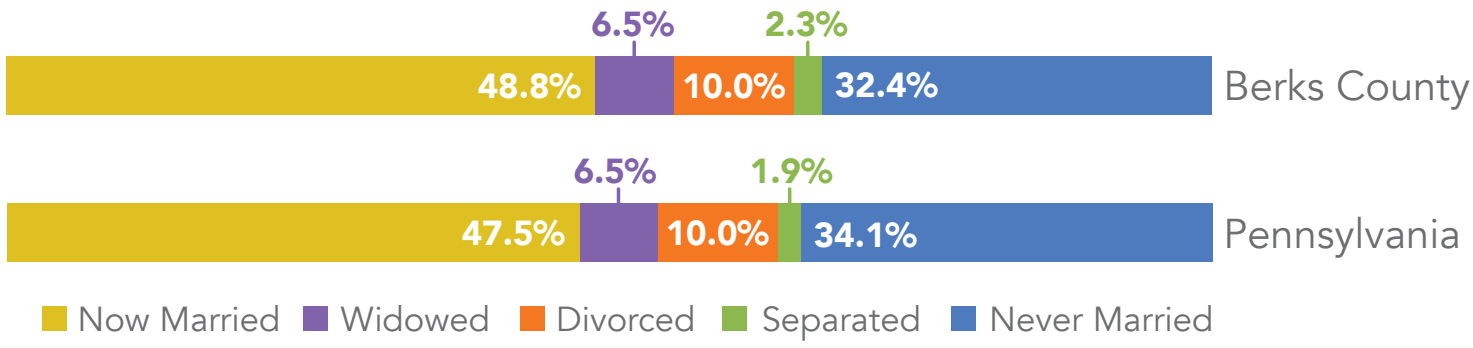
Source: U.S. Census Bureau 2020

EDUCATION



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

MARITAL STATUS



Source: American Community Survey 2019

OUR ENVIRONMENT

VIOLENT CRIME

(per 100,000 population)

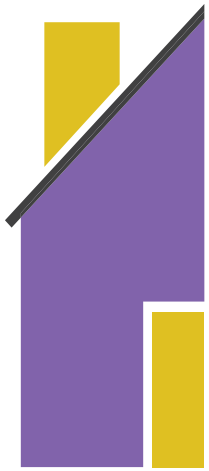
Berks County

299.9

Pennsylvania

315.6

Source: FBI Uniform Crime Reports 2020



HOUSING COST BURDEN

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

Berks County

29.5%

Pennsylvania

28.1%

SUBSTANDARD HOUSING

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

Berks County

29.4%

Pennsylvania

28.1%

Source: U.S. Census Bureau 2019

HOUSING OCCUPANCY BY RACE

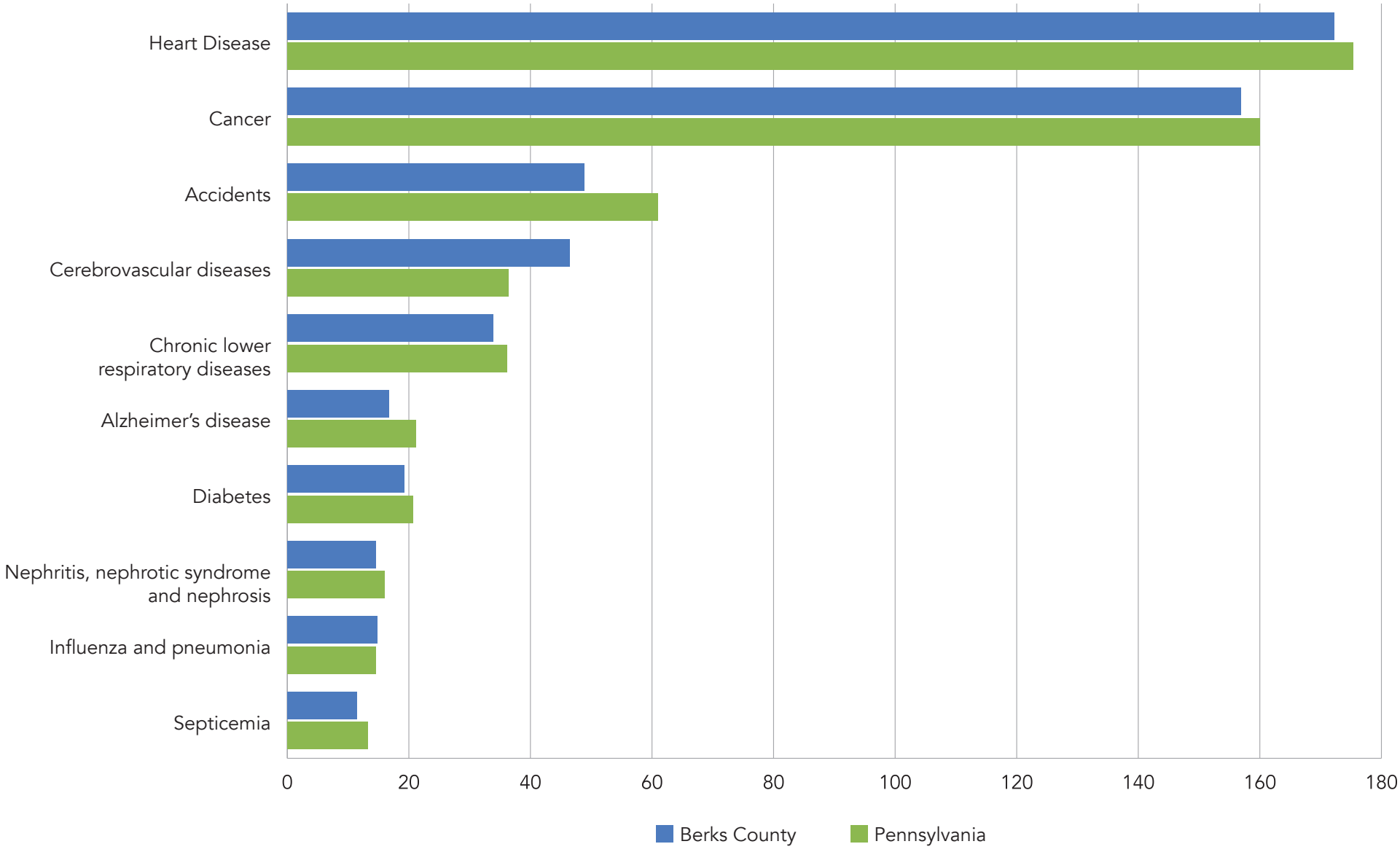
	Owner-Occupied Housing			Renter-Occupied Housing		
	Berks County	**Pennsylvania**	**U.S.**	**Berks County**	**Pennsylvania**	**U.S.**
White	75.6	73.3	69.5	24.4	26.7	30.5
Black	41.7	43.2	41.8	58.3	56.8	58.2
Asian	71.3	58.4	59.6	28.7	41.6	40.4
Native American or Alaska Native	40.1	52.3	54.3	59.9	47.7	45.7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

Source: U.S. Census Bureau 2019

KEY HEALTH FINDINGS

TOP CAUSES OF DEATH

(per 100,000 population)



Source: Pennsylvania Department of Health 2014-2019

OVERALL DISEASE DEATHS BY RACE/ETHNICITY IN BERKS COUNTY

(ages 35 years+ per 100,000 population)

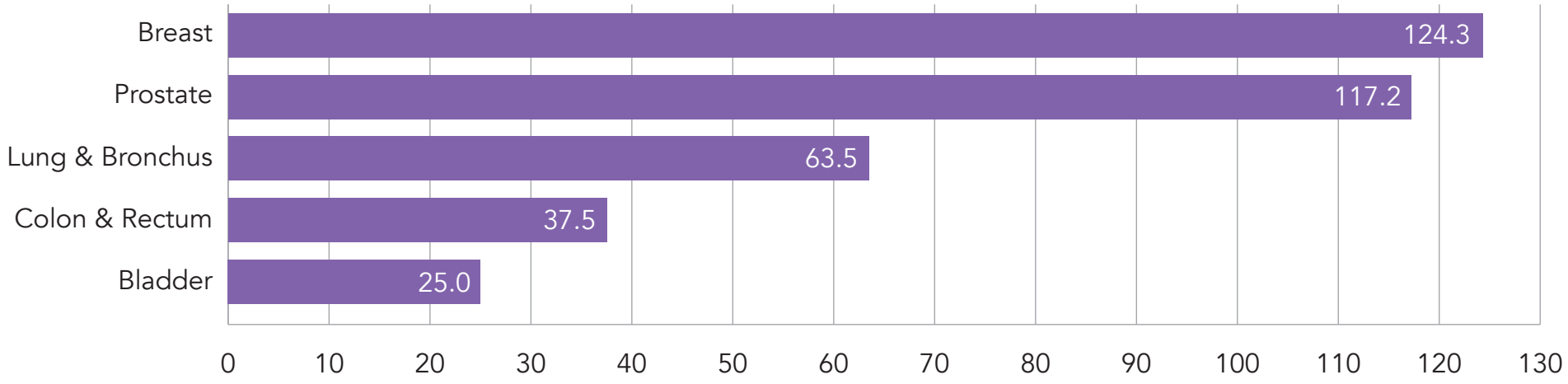
	Heart Disease	Stroke
White	336.0	105.0
Black	445.0	80.0
Asian/Pacific Islander	121.0	67.0
Hispanic	226.0	77.0

Source: Pennsylvania Department of Health 2019

OVERALL COMMON CANCERS IN BERKS COUNTY

MOST COMMONS CANCERS IN BERKS COUNTY

(per 100,000 population)

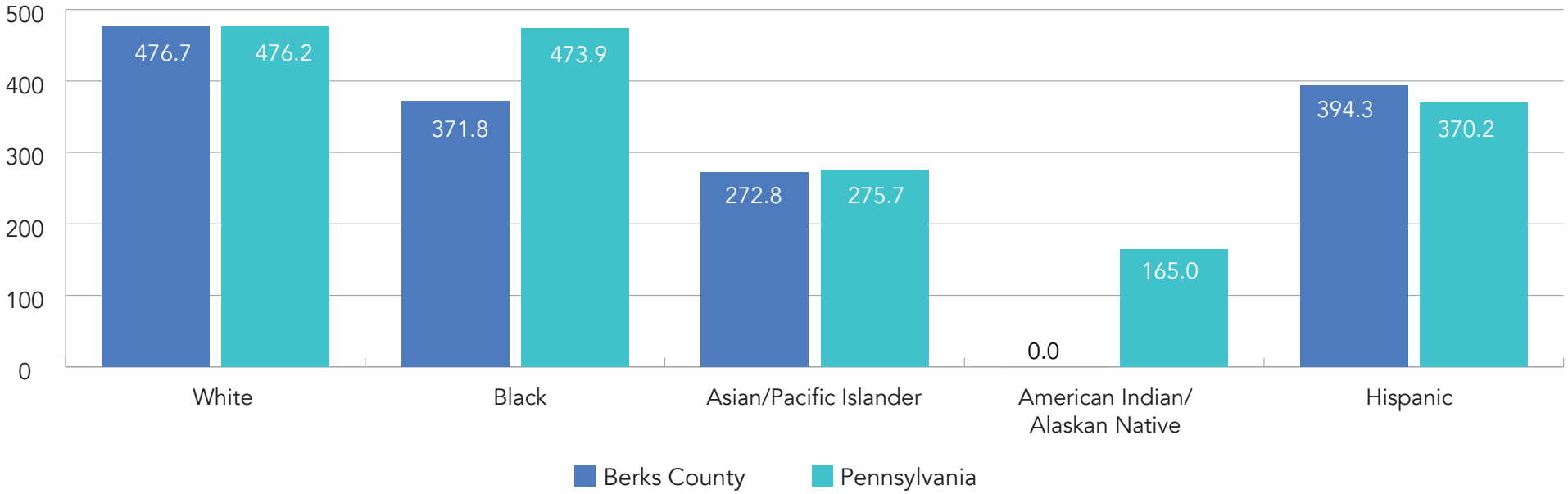


Source: Pennsylvania State Cancer Profiles 2014-2018

OVERALL CANCER INCIDENCE

CANCER INCIDENCE RATES BY RACE

(per 100,000 population)



CANCER INCIDENCE RATES IN BERKS COUNTY BY RACE

(per 100,000 population)

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

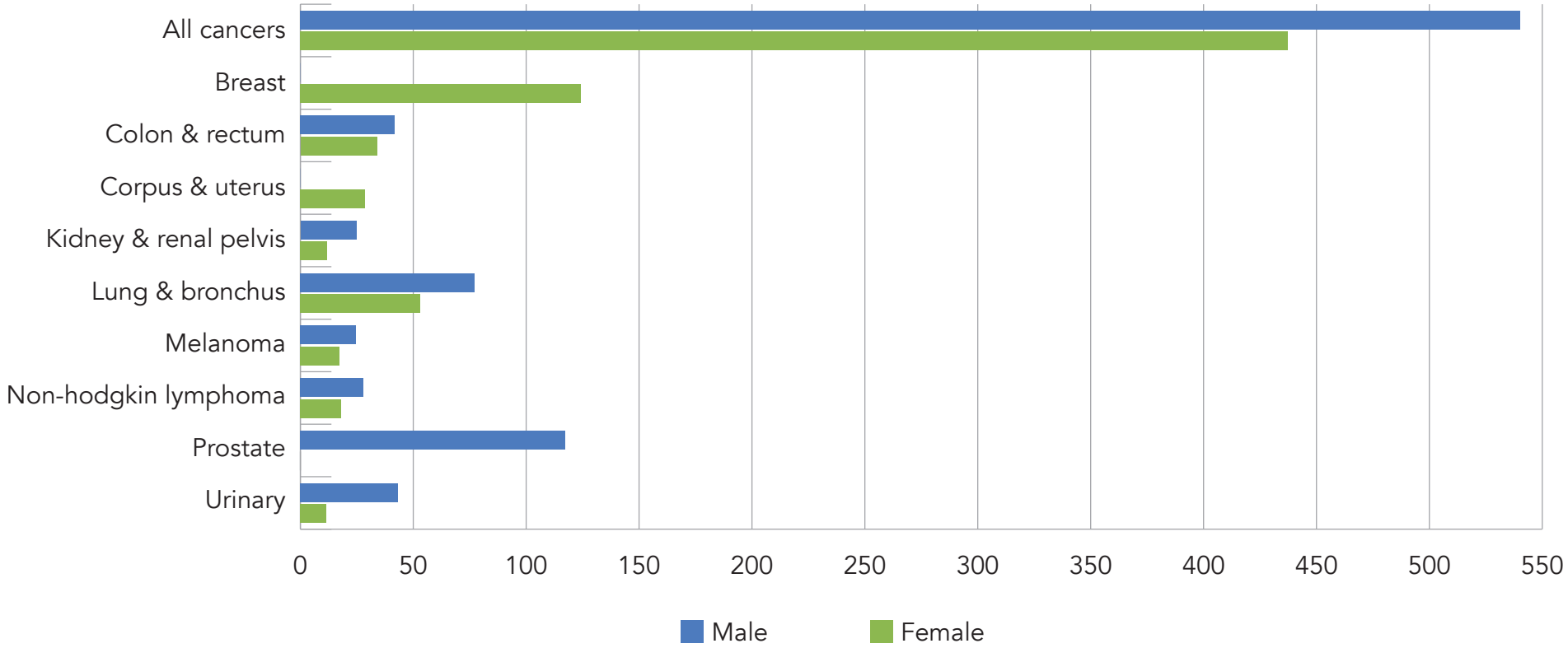
Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.

Source: Pennsylvania State Cancer Profiles 2014-2018

CANCER BY GENDER

CANCERS BY GENDER IN BERKS COUNTY

(per 100,000 population)



Source: Pennsylvania State Cancer Profiles 2014-2018

CANCER INCIDENCE RATES AND DEATH BY RACE AND ETHNICITY

(per 100,000 population)

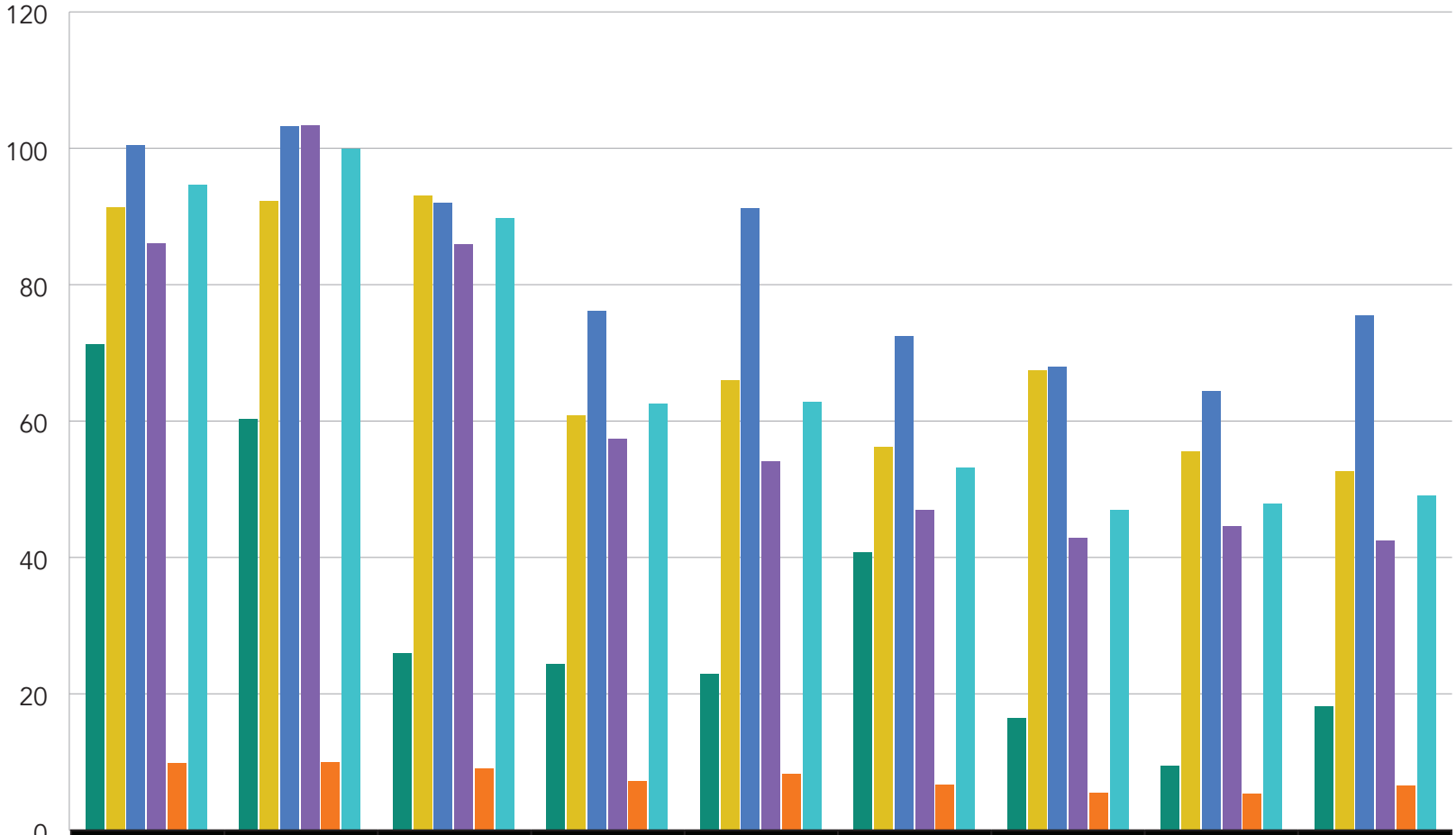
All Cancer Incidence by Race/Ethnicity			
	Berks County	Pennsylvania	U.S.
White	476.7	476.2	451.0
Black	371.8	473.9	444.9
Asian/Pacific Islander	272.8	275.7	291.7
American Indian/Alaskan Native	-	165.0	285.8
Hispanic	394.3	370.2	345.0

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

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

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

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



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

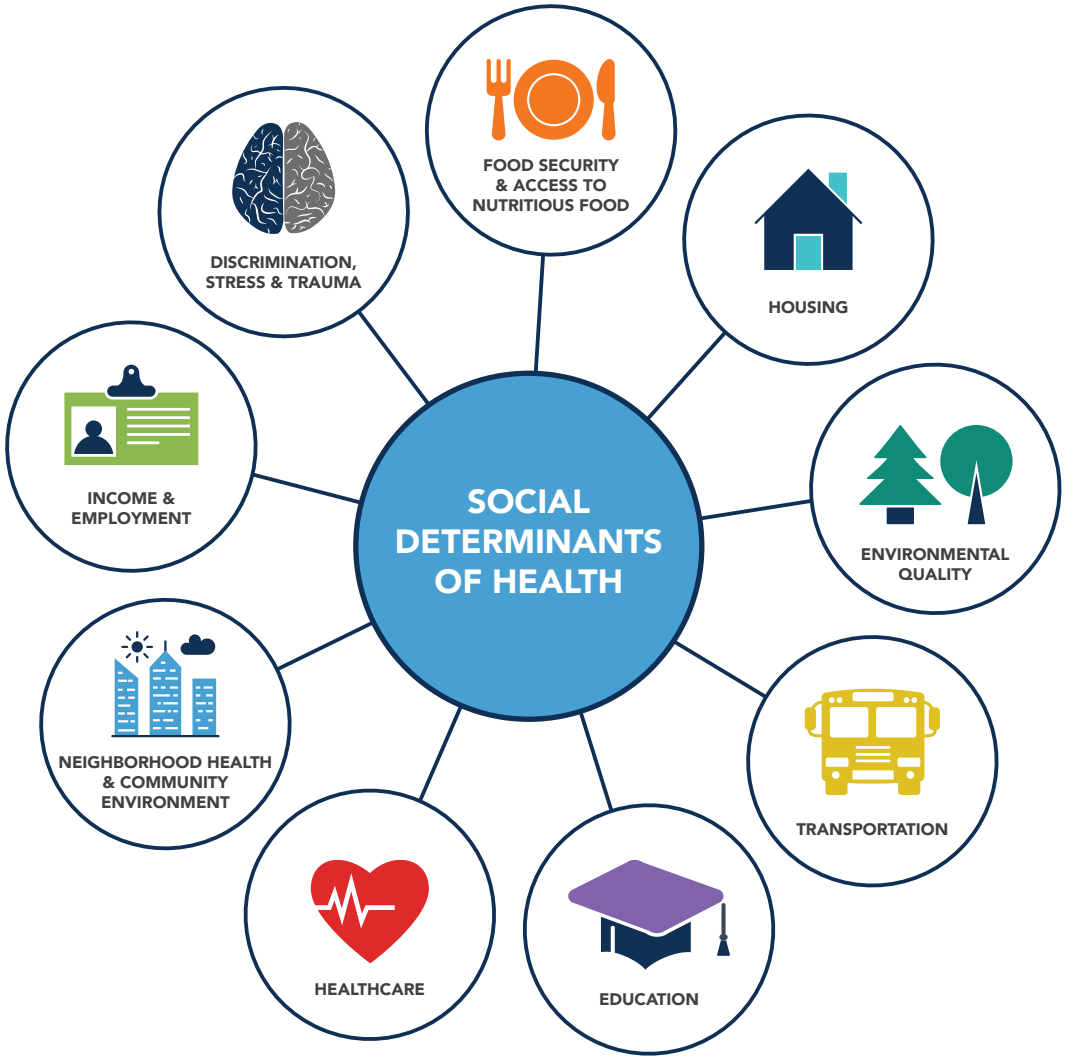
Note: The figures in red indicate high emergency room visits when compared to the benchmarked data of all adults within the specific ZIP code.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services


EMERGENCY

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

Figure 3: Influential Factors



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

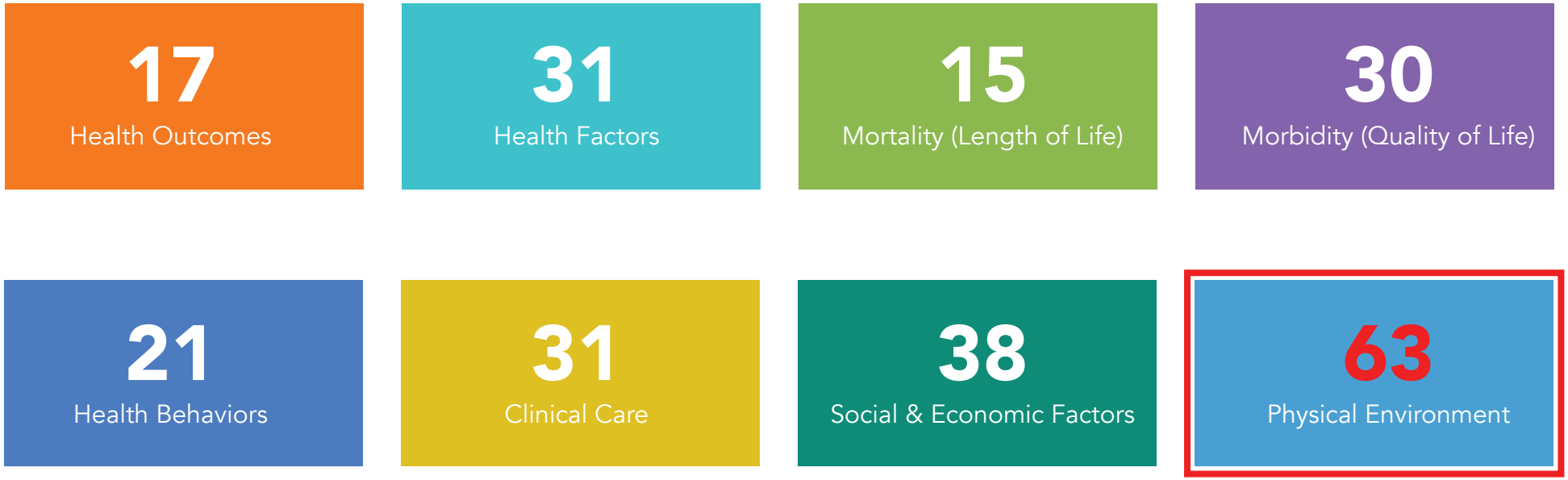
According to the Robert Wood Johnson Foundation, social inequalities such as poverty are linked to unhealthy behaviors like smoking, poor diet, and lack of exercise. However, community investments in proven programs and policy changes can reduce disparities, allowing residents to make it easier to make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

FACTORS THAT INFLUENCE OUR HEALTH

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

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

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



Source: County Health Rankings and Roadmaps 2021

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

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

HEALTH RELATED SOCIAL NEEDS

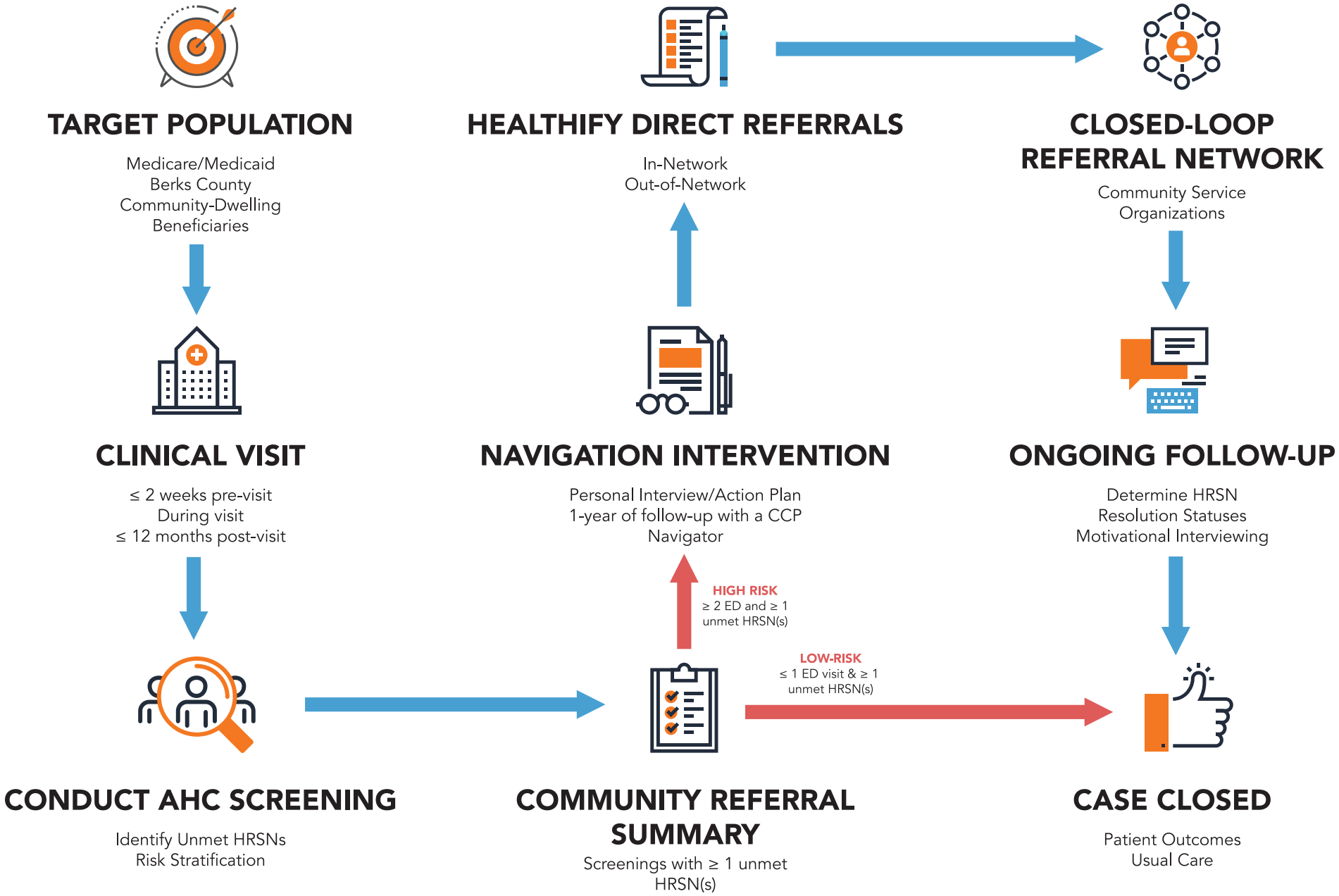
In past CHNA cycles at Reading Hospital, the community has identified barriers such as SDOH impeding their access to health care. As a response, Reading Hospital began to address SDOH through the CCP. The CCP is funded by the Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities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

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

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

CCP OVERVIEW

Figure 5: CCP Screening, Referral, Navigation Workflow

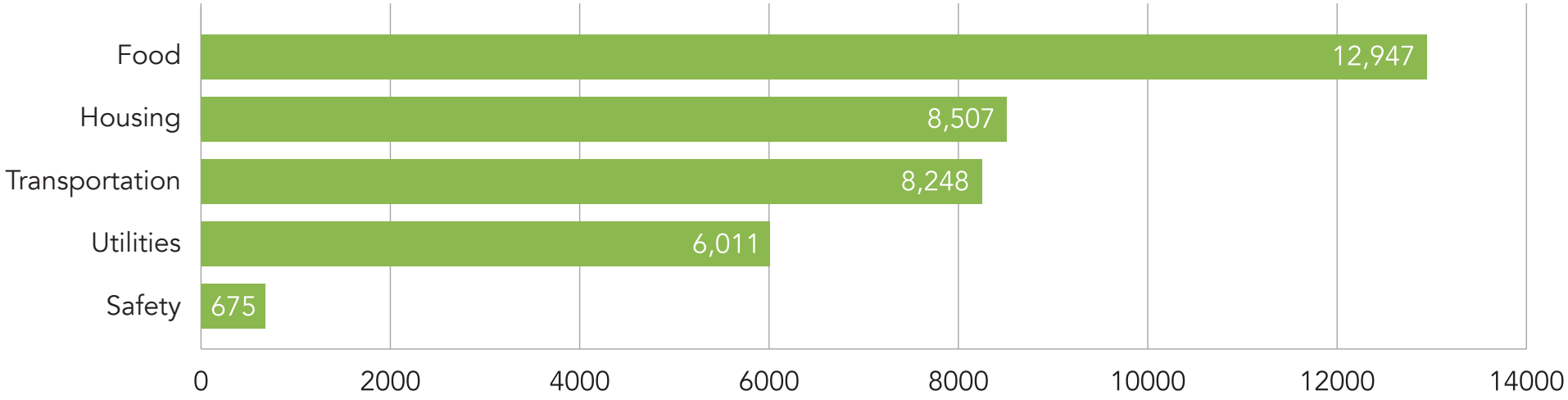


IMPLEMENTATION OUTCOMES/IMPACT

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

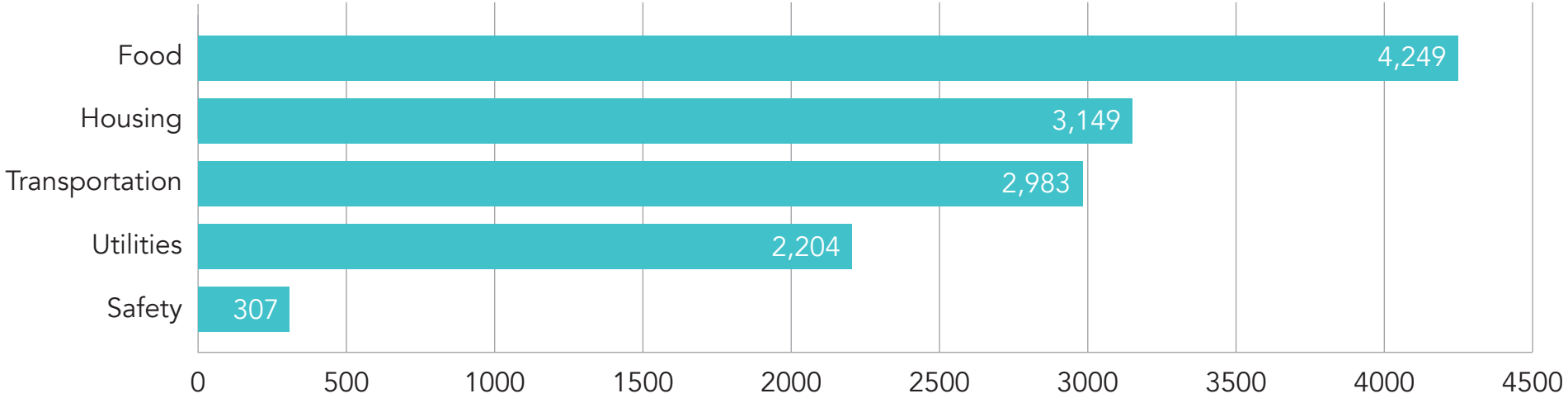
As of June 2021, Reading Hospital has completed 130,215 screenings for 49,221 beneficiaries. Figure 6 shows a breakdown of positive completed screenings by the HRSN identified. A third (n=42,646) of these screenings were high-risk, resulting in 6,184 unique navigation cases. HRSNs identified by unique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

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



Source: CMS AHC Data System

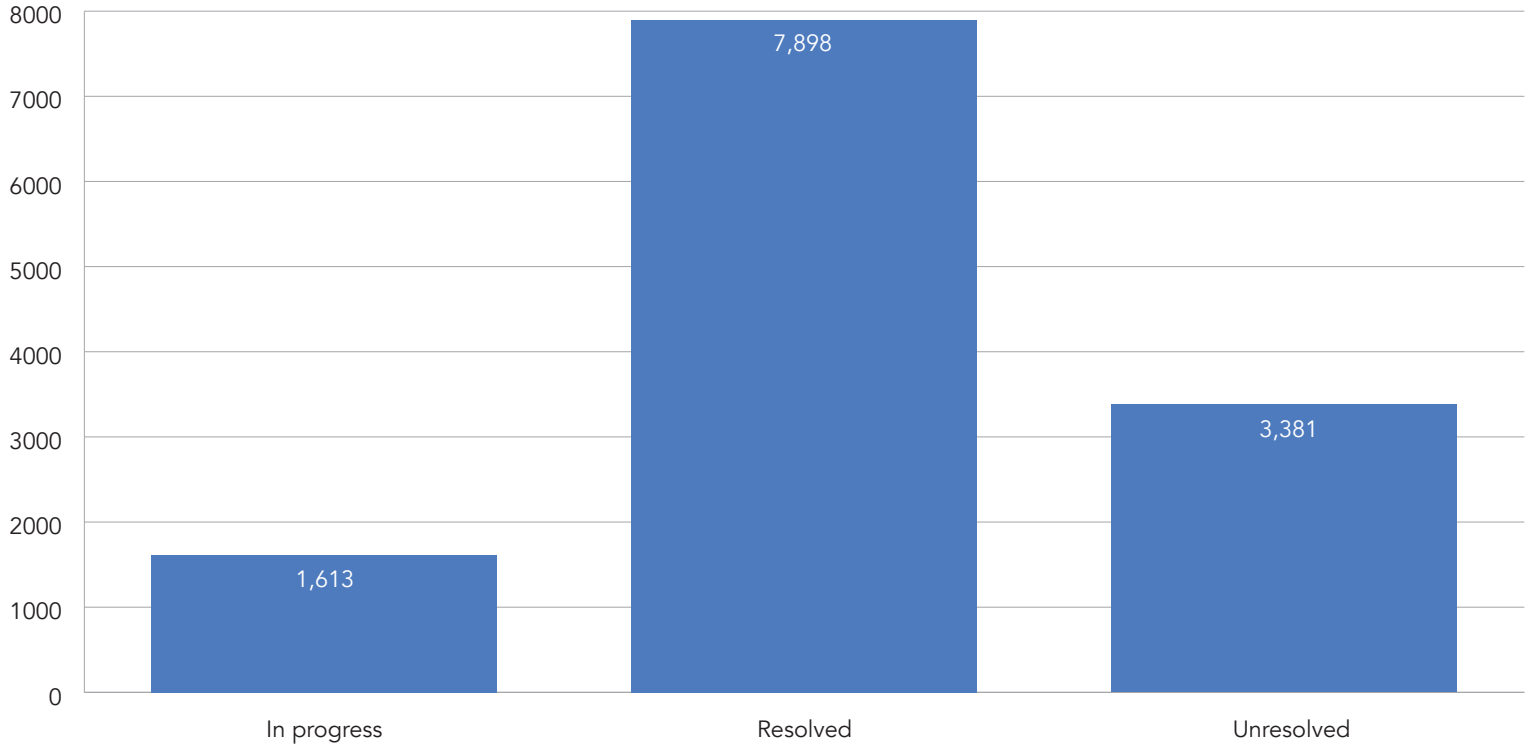
Figure 7: Number of Navigation Cases by HRSN May 2018-June 2021



Source: CMS AHC Data System

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

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



Source: CMS AHC Data System

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

EQUITY LENS: DEMOGRAPHICS SUMMARY

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

Table 9: Number of Unique Beneficiaries with a Completed Screening

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

Table 10: Number of Unique Beneficiaries Who Accepted Navigation

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

Source: AHC Monthly Monitoring Dashboard Report July 2021

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

Table 11: Demographic Disparities of Unique Beneficiaries in CCP

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

IMPACT ON THE PATIENT

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

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

PULLING IT TOGETHER

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

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

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

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

A) ACCESS TO EQUITABLE CARE

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

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

WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 13: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

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

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

"Why are People Treated Differently?"

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

COMMUNITY STAKEHOLDER INTERVIEWS

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

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

"What are the Barriers to a Quality Life"

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

KEY INFORMANT SURVEYS

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

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

"What are the Barriers to a Quality Life?"

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

COMMUNITY SURVEYS

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

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

"What are the Most Important Health Issues?"

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

"What are the Barriers to a Quality Life?"

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

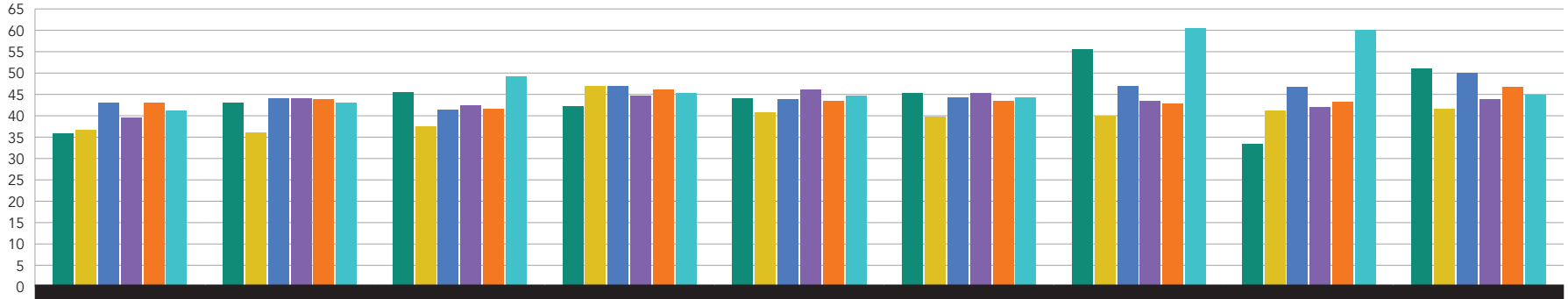
Figure 14 shows Berks County residents who have no health insurance coverage or coverage via Medicare. Over the last few CHNA cycles, we have seen the percentage of insured people steadily rise; however, efforts to improve access to care must continue.

Figure 14: Percentage of Population with No Health Insurance Coverage

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

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

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



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

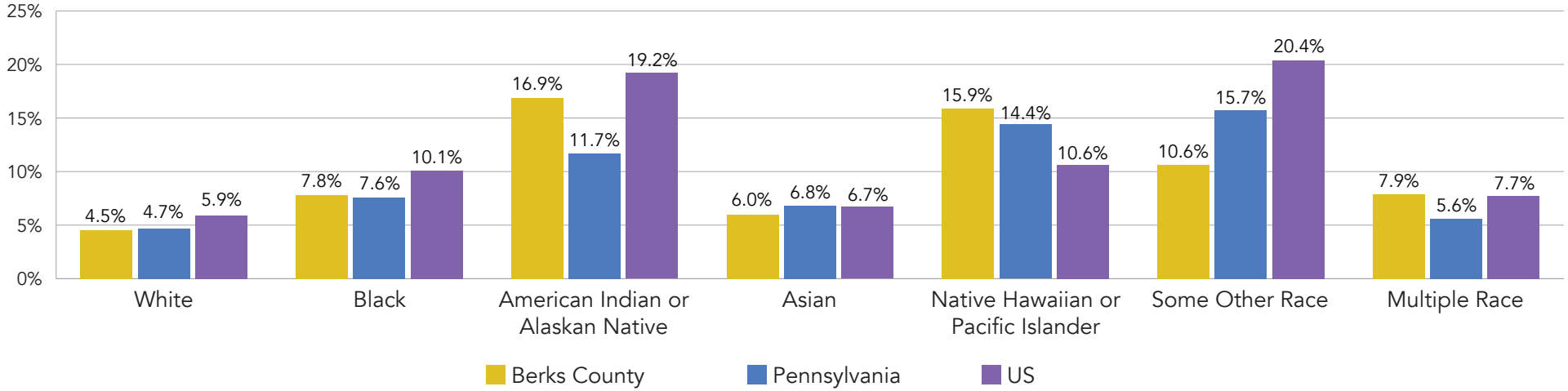
Note: The figures in red indicate low percentages of adults with primary care physician visits when compared to the benchmarked data of all adults within the specific ZIP code.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

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

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

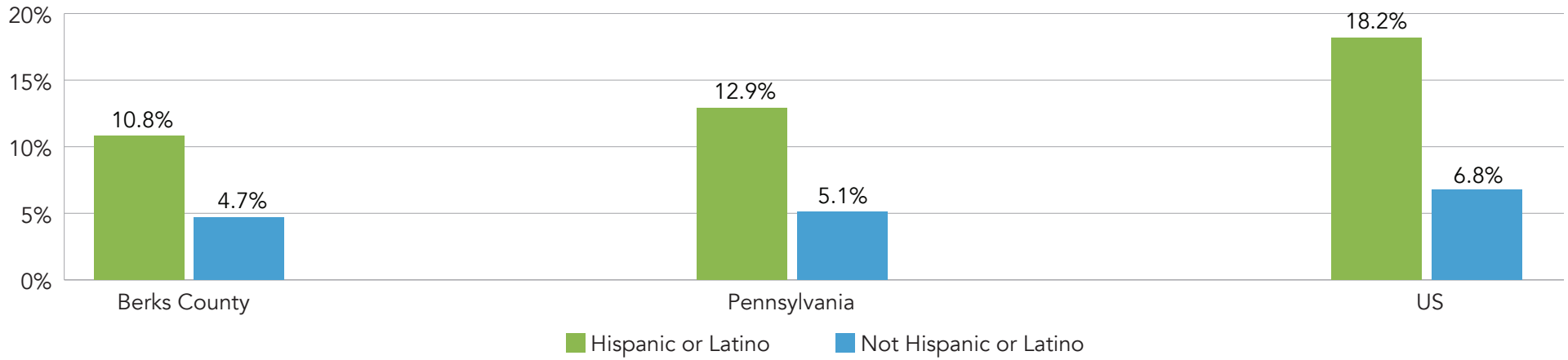
Figure 16: Percentage of Uninsured Population by Race



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

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

Figure 17: Percentage of Uninsured Population by Ethnicity

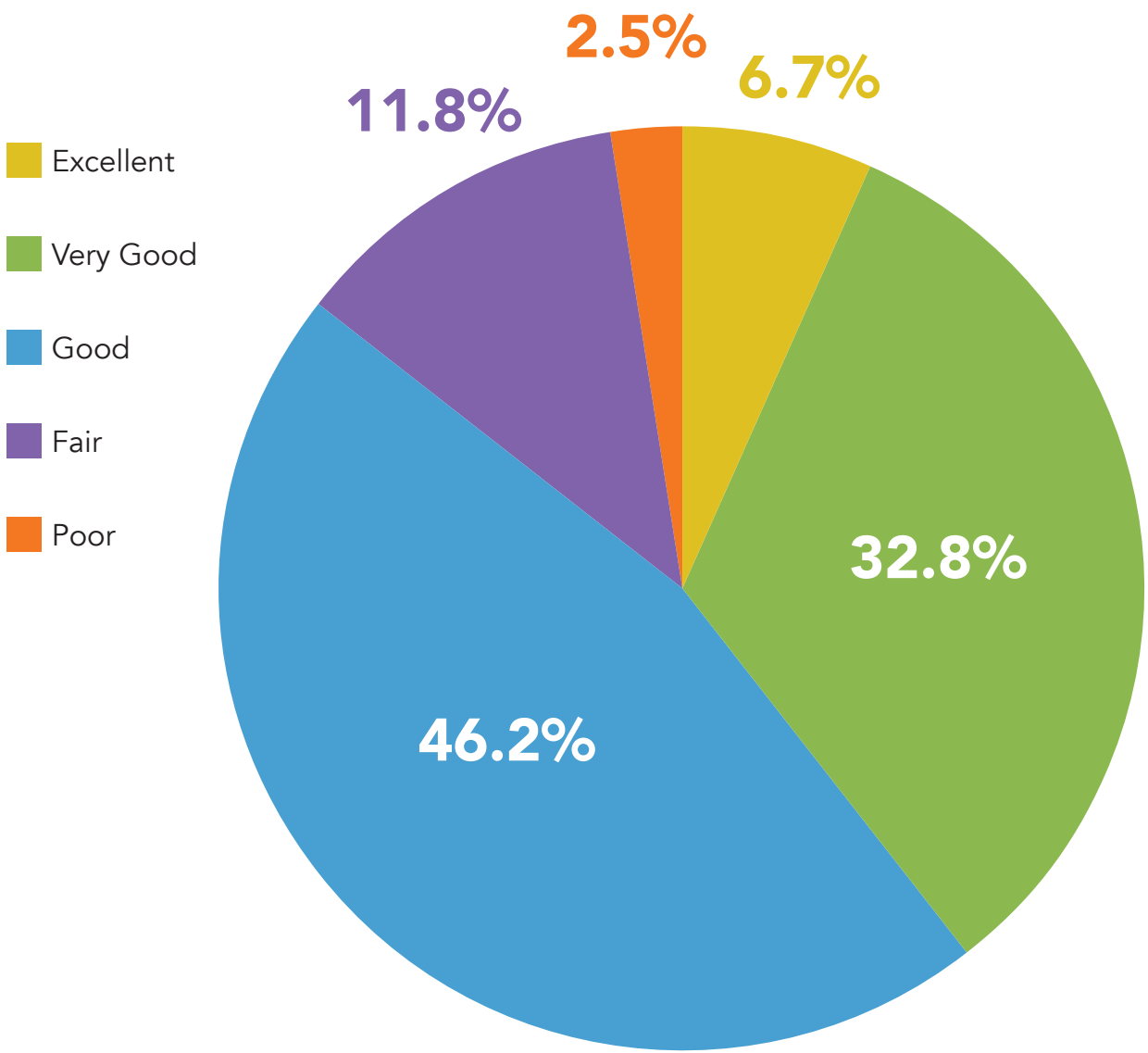


Source: U.S. Census Bureau, American Community Survey 2019

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

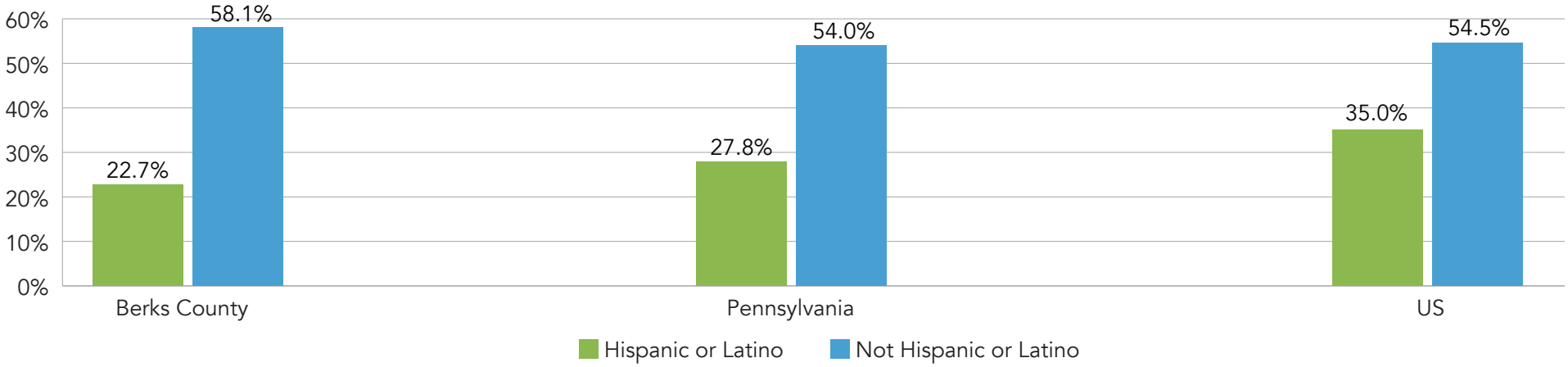
Figure 18 reported how respondents described their overall health.

Figure 18: Description of Overall Health



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

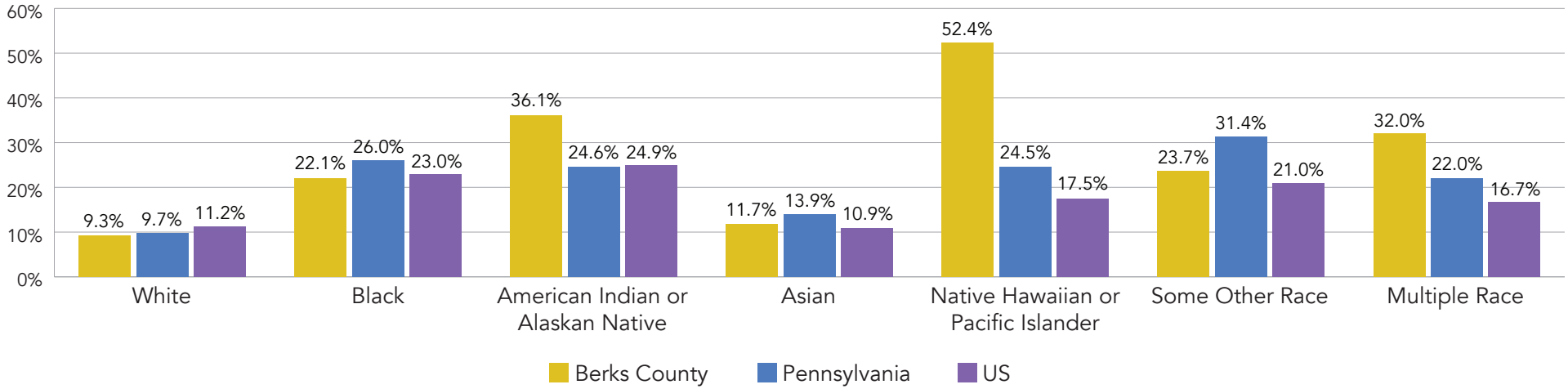
Figure 19: Families Earning More Than $75,000 by Ethnicity



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

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

Figure 20: Population Below 100% FPL by Race

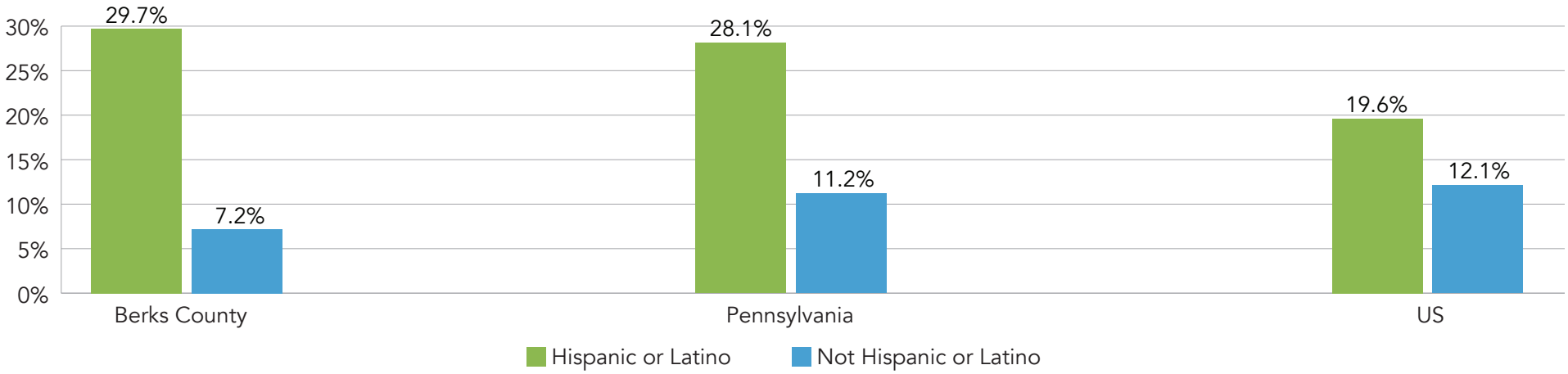


Source: U.S. Census Bureau, American Community Survey 2019

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

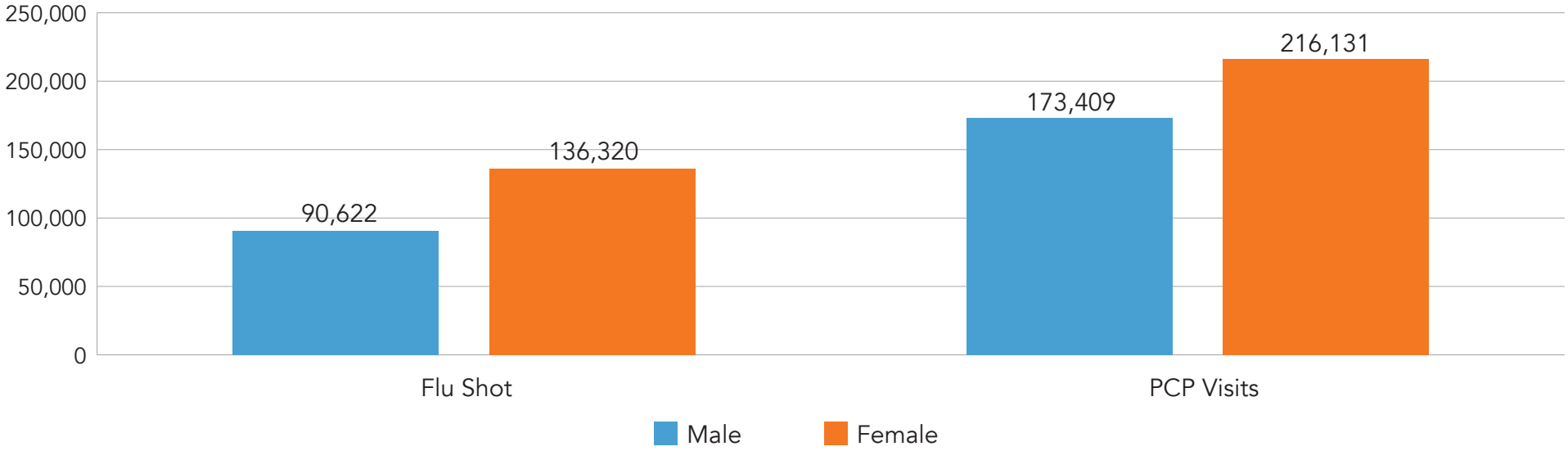
Figure 21 reports the percentage of the population below 100% of the federal poverty line by ethnicity.

Figure 21: Population Below 100% FPL by Ethnicity



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

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



Source: Epic Clarity

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

Table 23: Overall Mammography Screenings 2018- 2020

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

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

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

Table 24: Mammography Screenings by Race 2018 – 2020

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

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

Source: Epic Clarity

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

Table 25: Mammography Screenings by Ethnicity 2018 – 2020

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

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

Source: Epic Clarity

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

Table 26: Colonoscopy Screenings 2018- 2020

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

Source: Epic Clarity.

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

Table 27: Colonoscopy Screenings by Race 2018 – 2020

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

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

Source: Epic Clarity

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

Table 28: Colonoscopy Screenings by Ethnicity 2018 – 2020

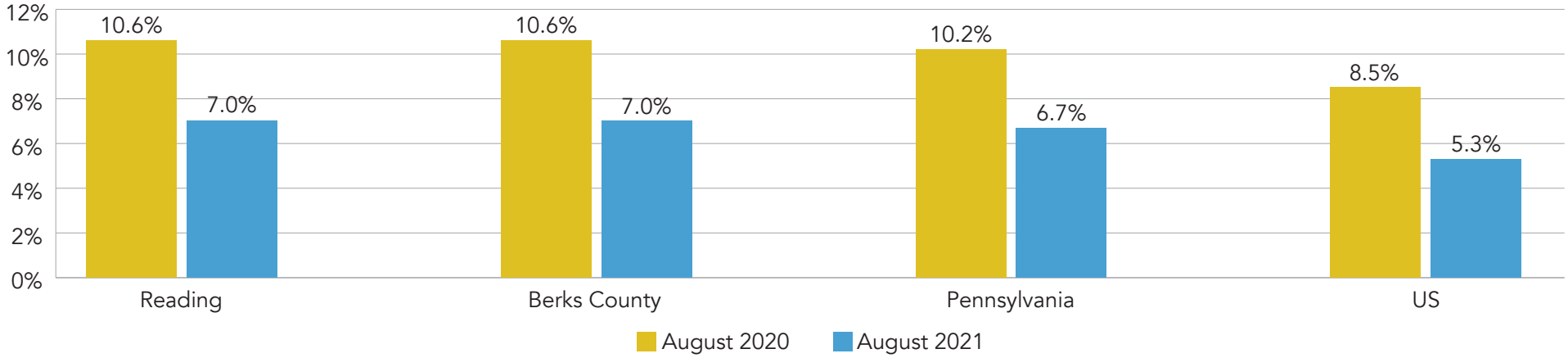
	Colonoscopy Completed	Colonoscopy Eligible	Completion Rate
Hispanic or Latino	8,980	49,371	18.2%
Not Hispanic or Latino	149,084	445,401	33.5%
TOTAL	**158,064**	**494,772**	**31.9%**

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

Source: Epic Clarity

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

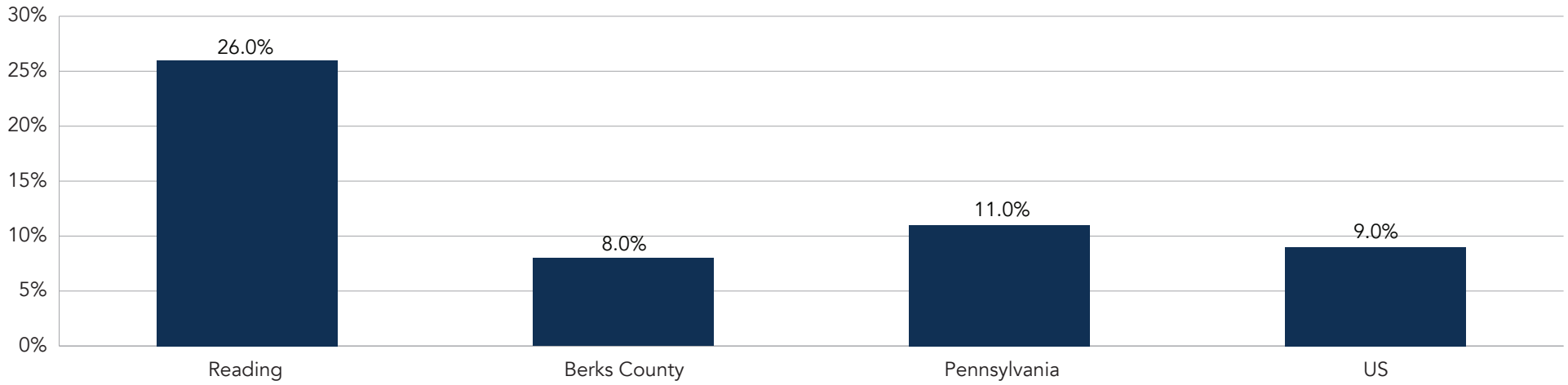
Figure 29: Unemployment Rates



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

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

Figure 30: Households with No Motor Vehicle



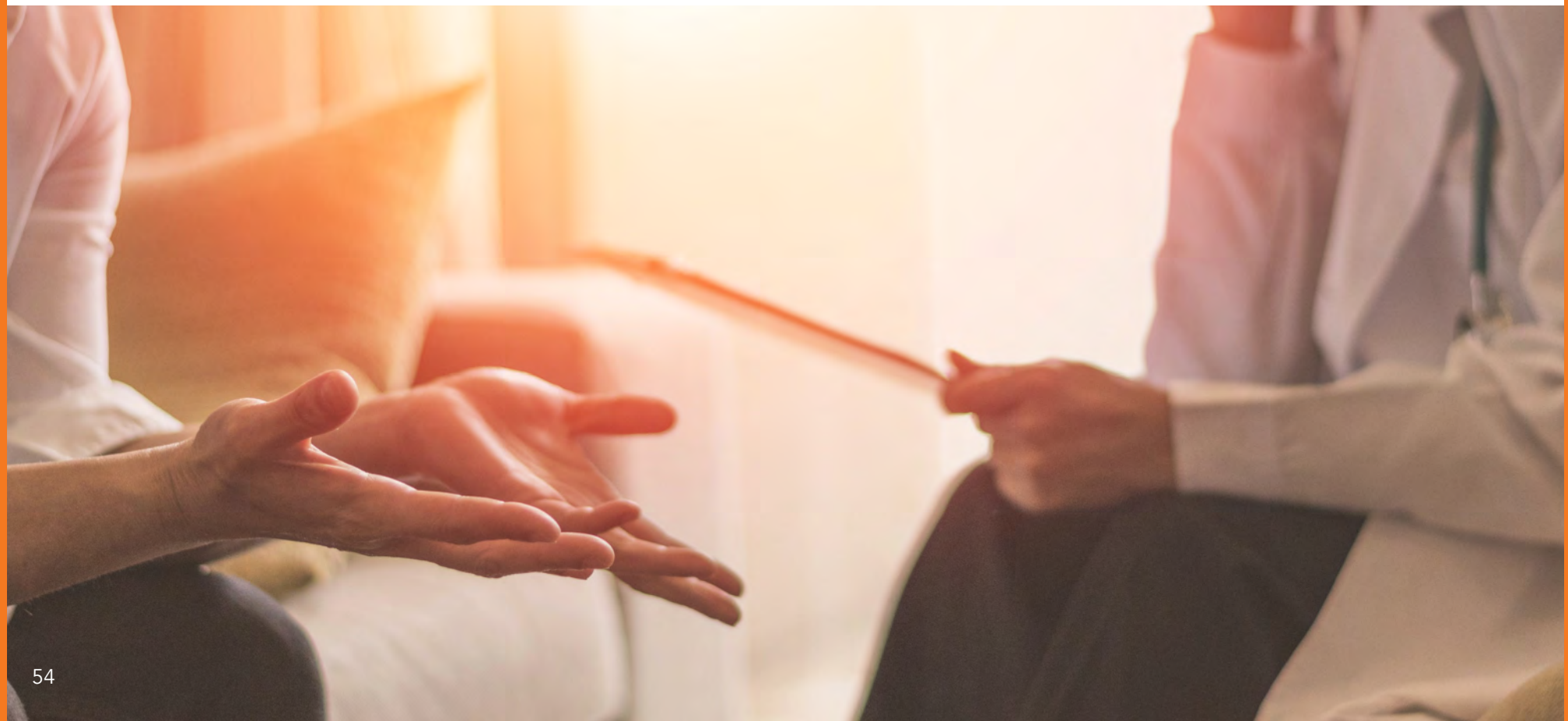
Source: Berks Vital Signs 2015-2019

B) BEHAVIORAL HEALTH

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

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

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



WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 31: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

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

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

KEY INFORMANT SURVEYS

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

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

COMMUNITY STAKEHOLDER INTERVIEWS

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

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

COMMUNITY SURVEYS

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

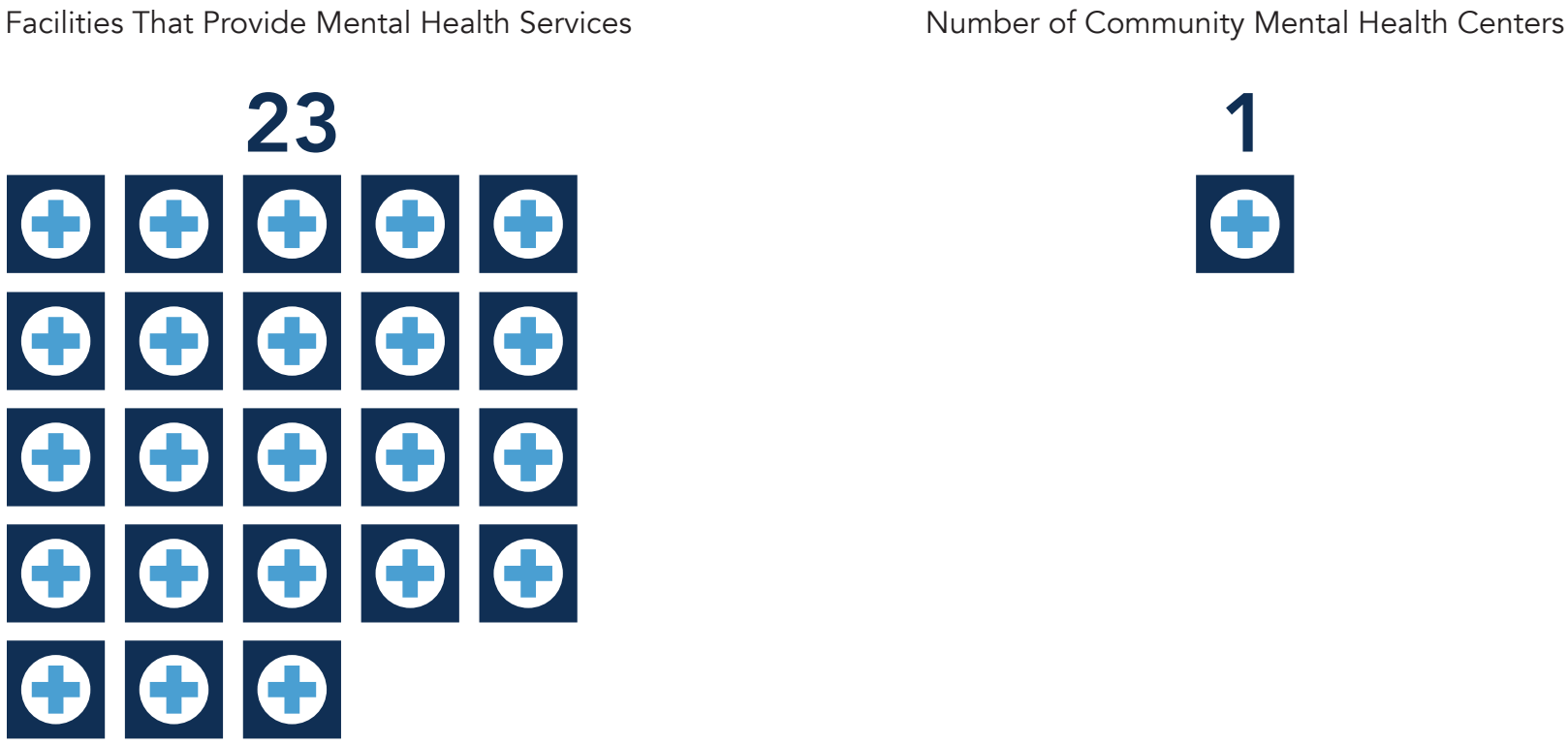
- Lack of access to behavioral health/mental health services
- Drug/alcohol use
- Awareness of available behavioral health/mental health services

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

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

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

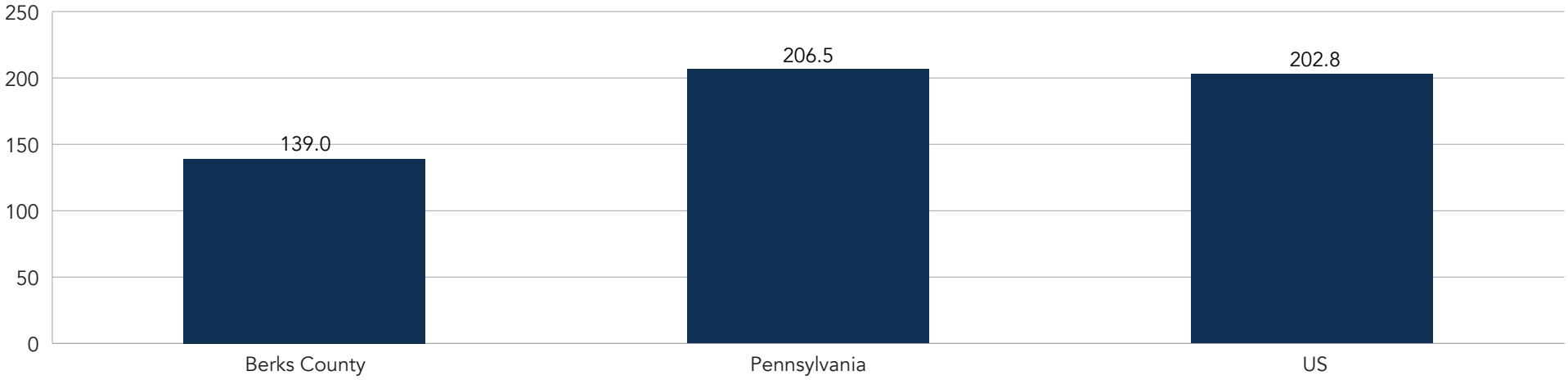
Figure 32: Mental Health Facilities and Centers in Berks County



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

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

Figure 33: Mental Health Providers

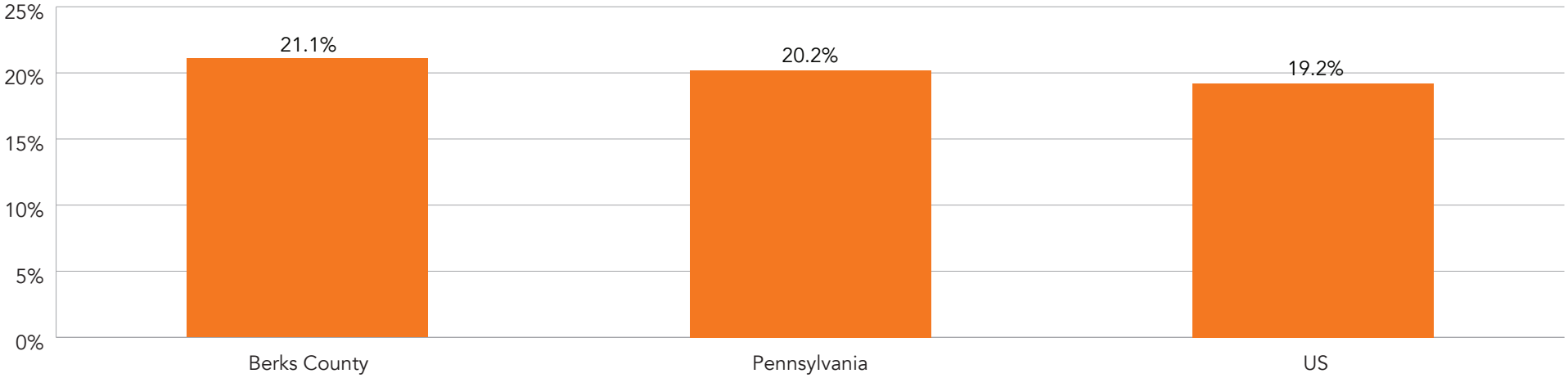


Source: County Health Rankings & Roadmaps 2019

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

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

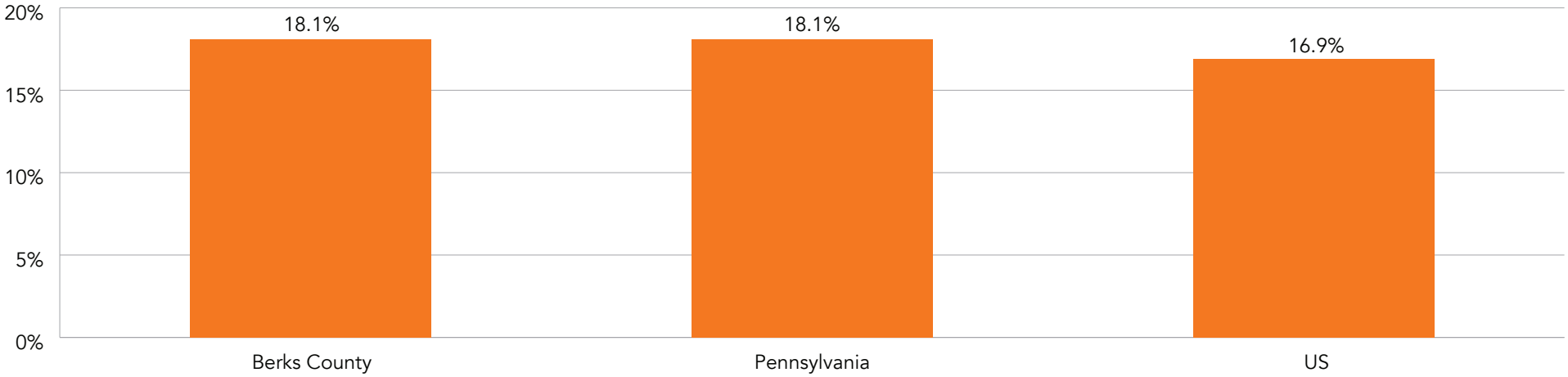
Figure 34: Alcohol Consumption (18 years and older who are Heavy Drinkers)[7]



Source: County Health Rankings & Roadmaps 2018

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

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

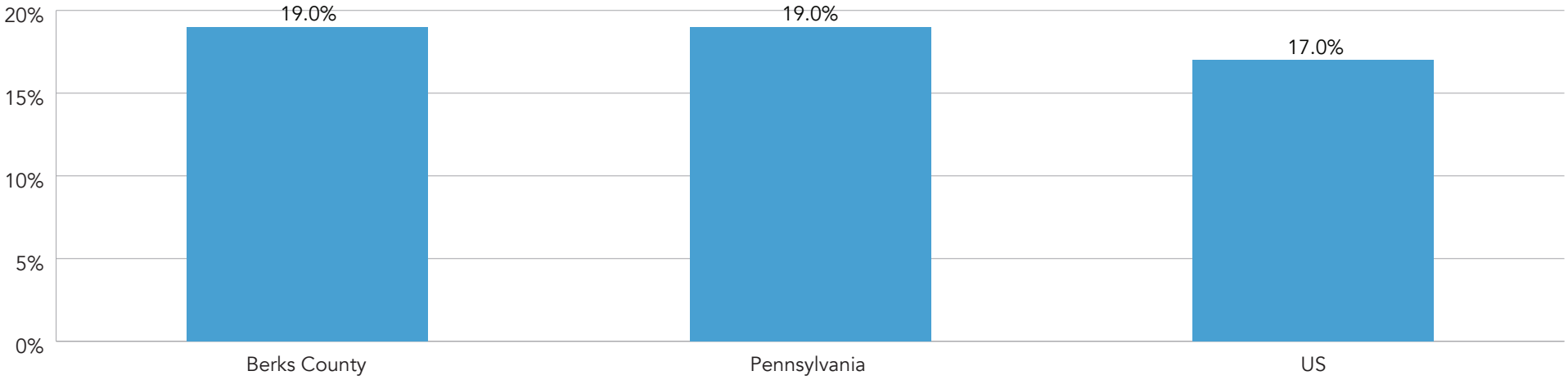


Source: CDC, Behavioral Risk Factor Surveillance System 2018

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

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

Figure 36: Tobacco Usage - Current Smokers[9]



Source: CDC, Behavioral Risk Factor Surveillance System 2018

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

C) HEALTH EDUCATION AND PREVENTION

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

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

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

WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 37: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

Discussions related to Health Education

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

KEY INFORMANT SURVEYS

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

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

COMMUNITY STAKEHOLDER INTERVIEWS

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

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

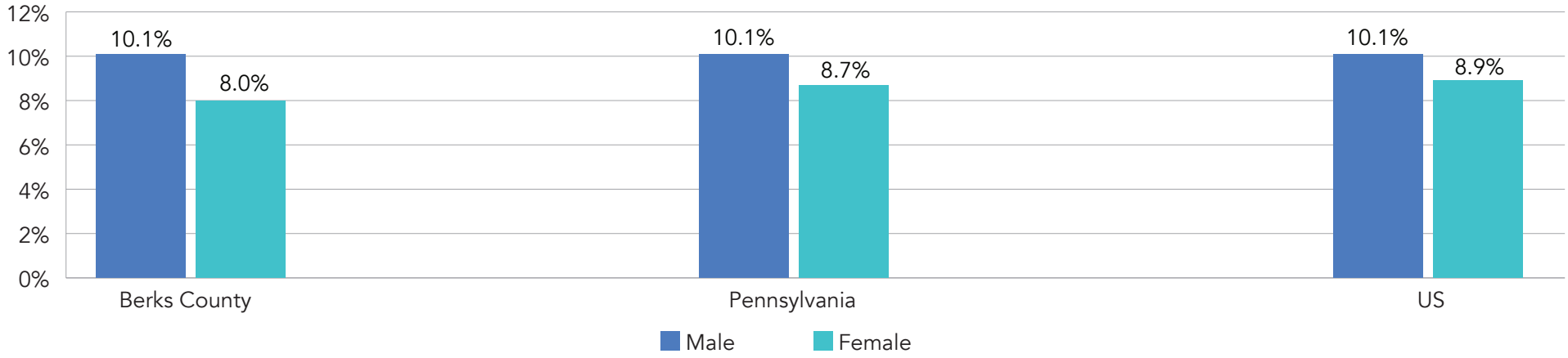
COMMUNITY SURVEYS

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

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

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

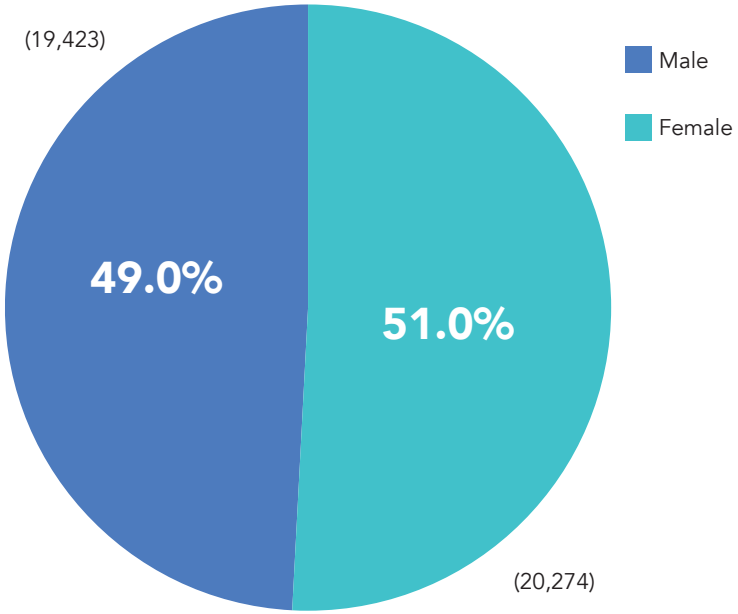
Figure 38: Diabetes by Gender



Source: U.S. Census Bureau 2017

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

Figure 39: Diabetes Registry Patients by Gender



Source: EPIC Clarity

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

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

Source: Epic Clarity

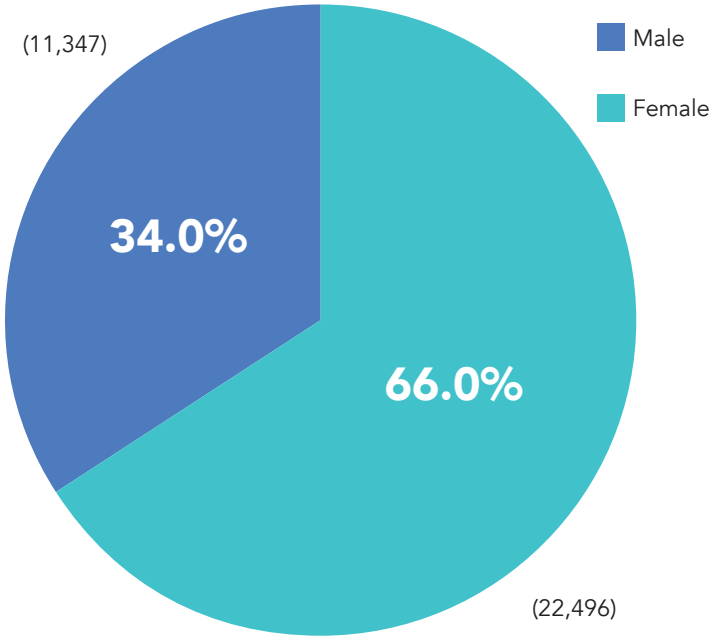
Table 41: 2021 Diabetes Registry Patients at Reading Hospital by Race

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

Source: Epic Clarity

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

Figure 42: Asthma Registry Patients by Gender



Source: EPIC Clarity

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

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

Source: Epic Clarity

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

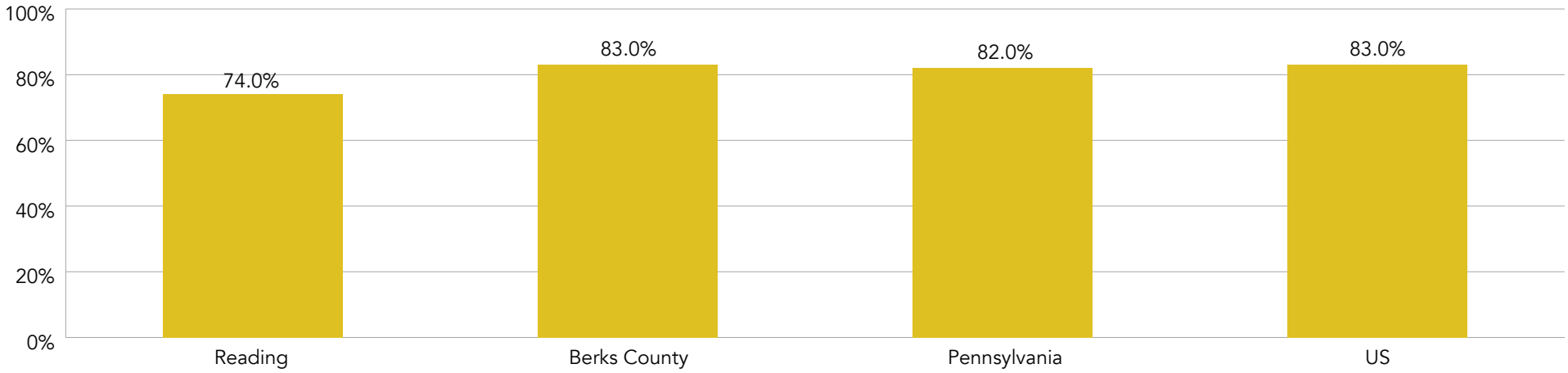
Race	Asthma Registry Patients
American Indian or Alaska Native	42
Black or African American	3,650
Hispanic	3
Native Hawaiian or Other Pacific Islander	37
Other	6,182
Other Asian	190
Patient Refused	316
Unknown	813
White or Caucasian	22,604
Total	**33,837**

Source: Epic Clarity


Patient Prescription Information

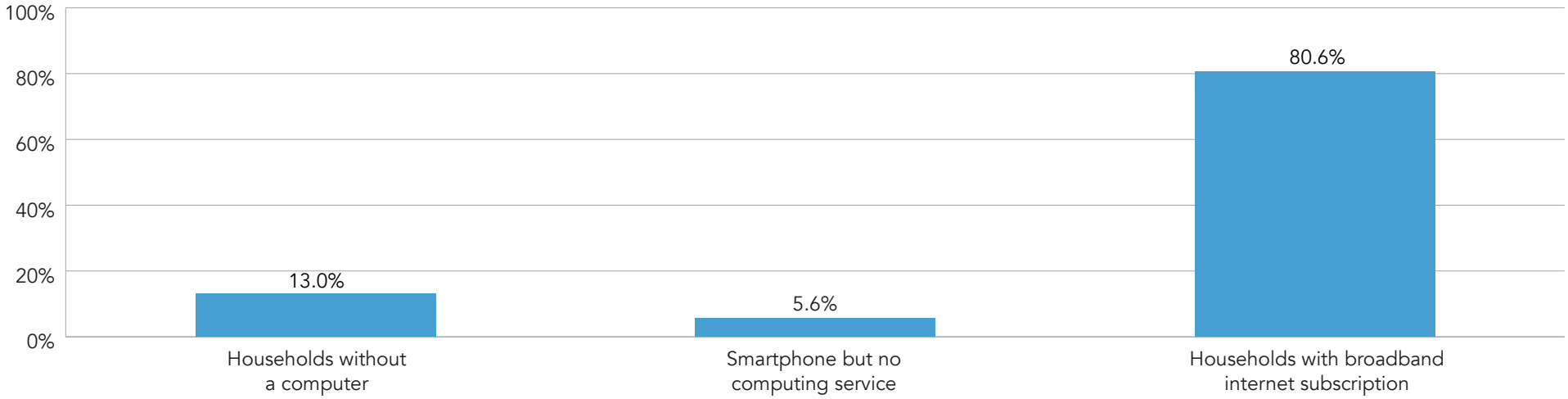
Figure 45 illustrates the percentage of residents in Berks County with/without internet or a computing device. Primary data indicated a lack of access to the internet among minorities and seniors. With the advent of virtual applications and programs, more health centers and professionals are utilizing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

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



Source: Berks Vital Signs 2015-2019

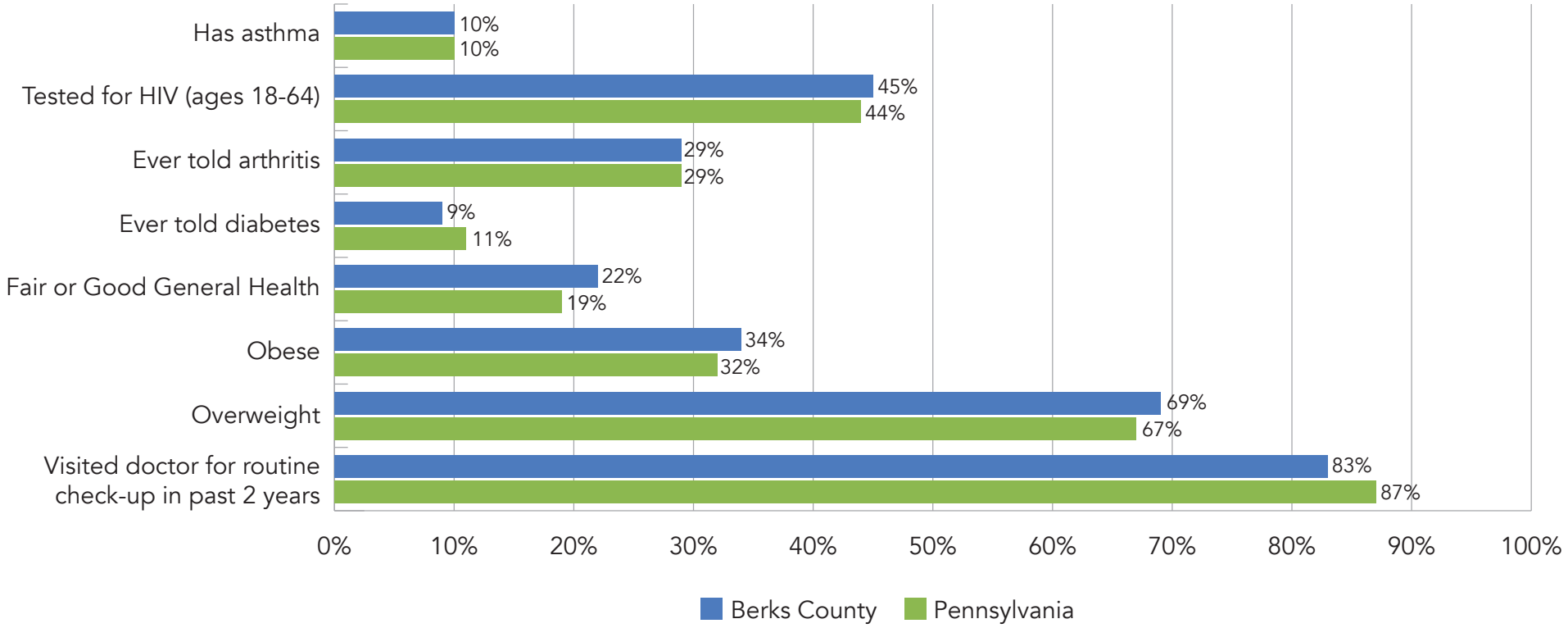
Figure 46: Percentage of Households in Berks County with Limited Technology



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

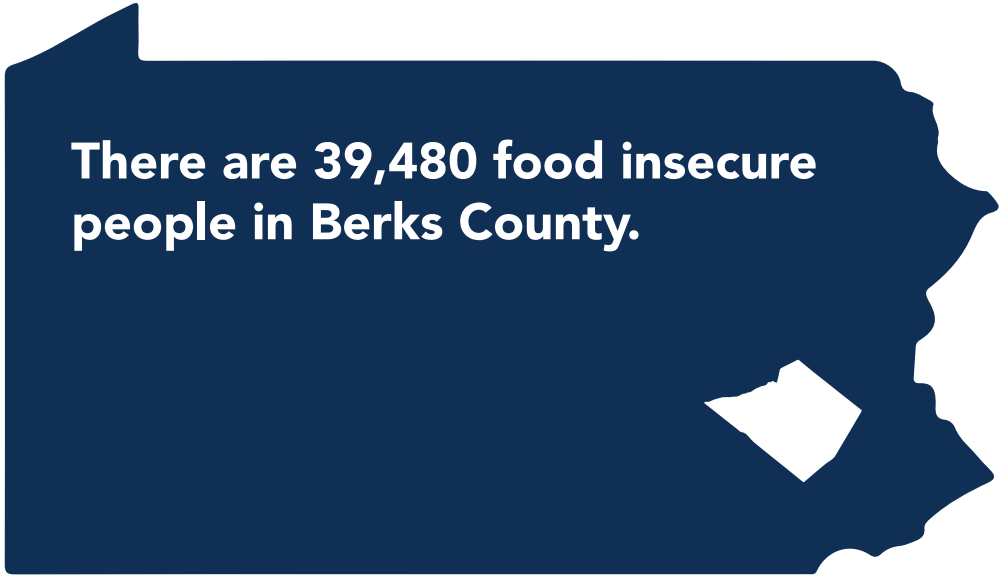
Figure 47 shows adult health risk behaviors, health outcomes, and general health in Berks County and Pennsylvania. Specifically, the graph depicts the obesity/overweight rate of individuals in Berks County exceeding the state rate.

Figure 47: Overall Adult Health Risks



Source: Pennsylvania Department of Health 2017-2019

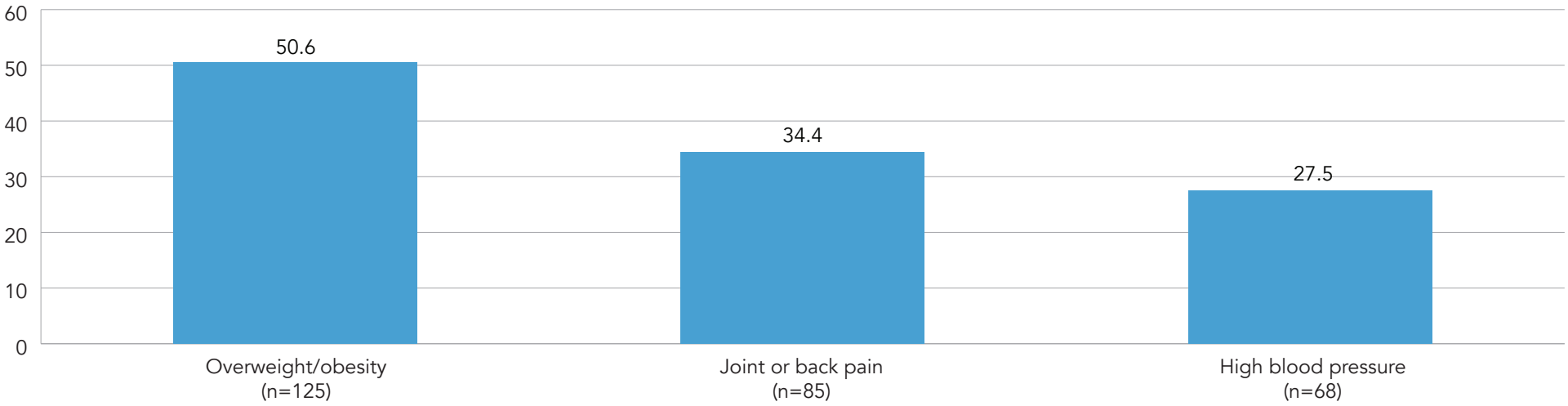
The USDA refers to food insecurity as the lack of access (periodically) to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food insecurity may reflect a household's need to make trade-offs between important basic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



Source: Feeding America 2019

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

Figure 48: Top Three Challenges Currently Faced



SM SNAP Supplemental Nutrition Assistance Program

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

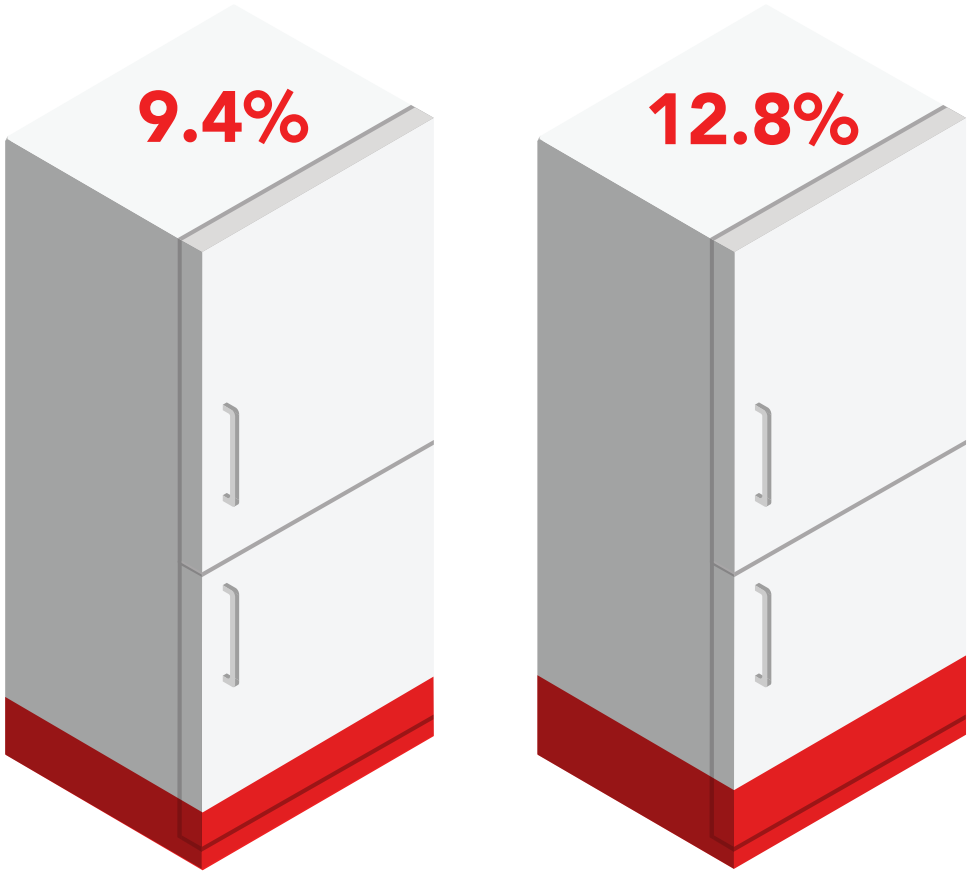
- 59,288 Berks County residents received $7,163,720 in SNAP benefits to help make ends meet in December 2018.
- 66% of those receiving SNAP are children, seniors, and persons with disabilities.
- 97% of benefits are redeemed by the end of the month.
- Low-income SNAP participants spend $1,400, or nearly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

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

COVID-19 AND THE IMPACT ON FOOD INSECURITY

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

Figure 49: Food Insecurity in Berks County



Source: Feeding America 2019

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

Jay Worrall

President
Helping Harvest

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

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

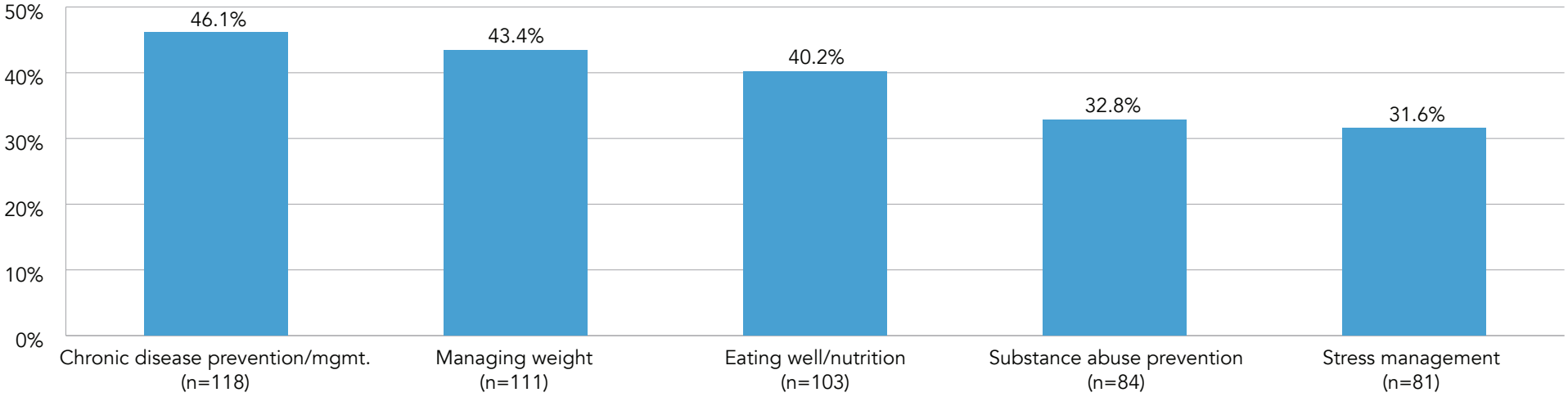
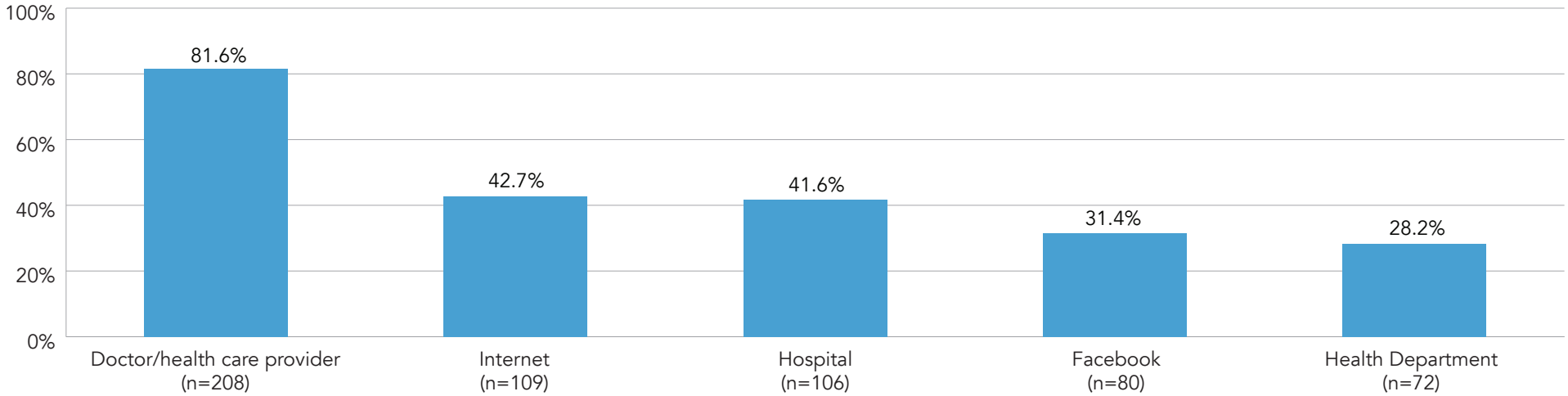


Figure 51 from the community survey reports how the community wants to receive health information.

Figure 51: Top Ways Community Wants to Receive Information



D) HEALTH EQUITY

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

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

SYSTEM POLICIES

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

LANGUAGE/CULTURE

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

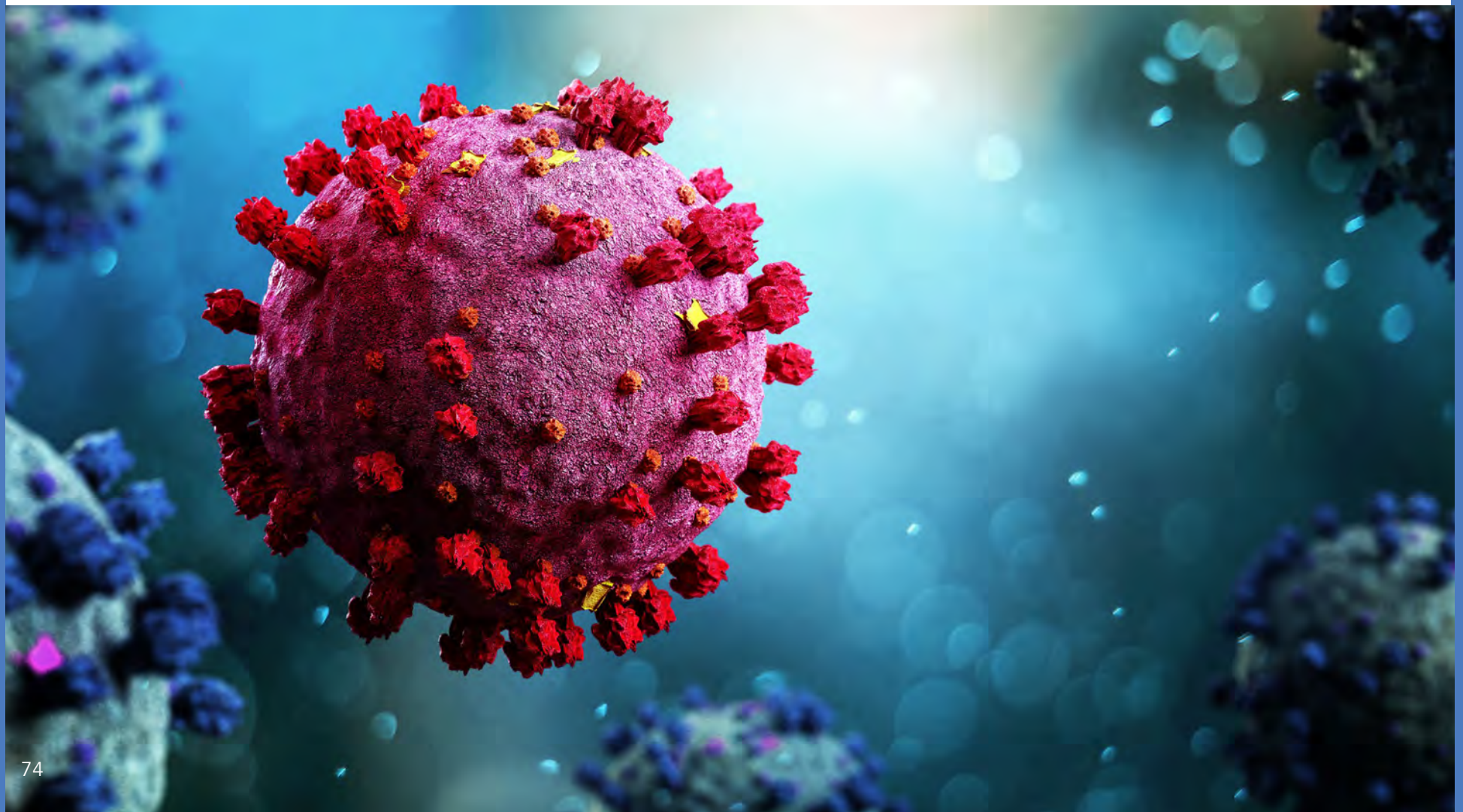
SOCIAL DETERMINANTS OF HEALTH

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

LESSONS LEARNED FROM COVID-19 AND HEALTH EQUITY

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

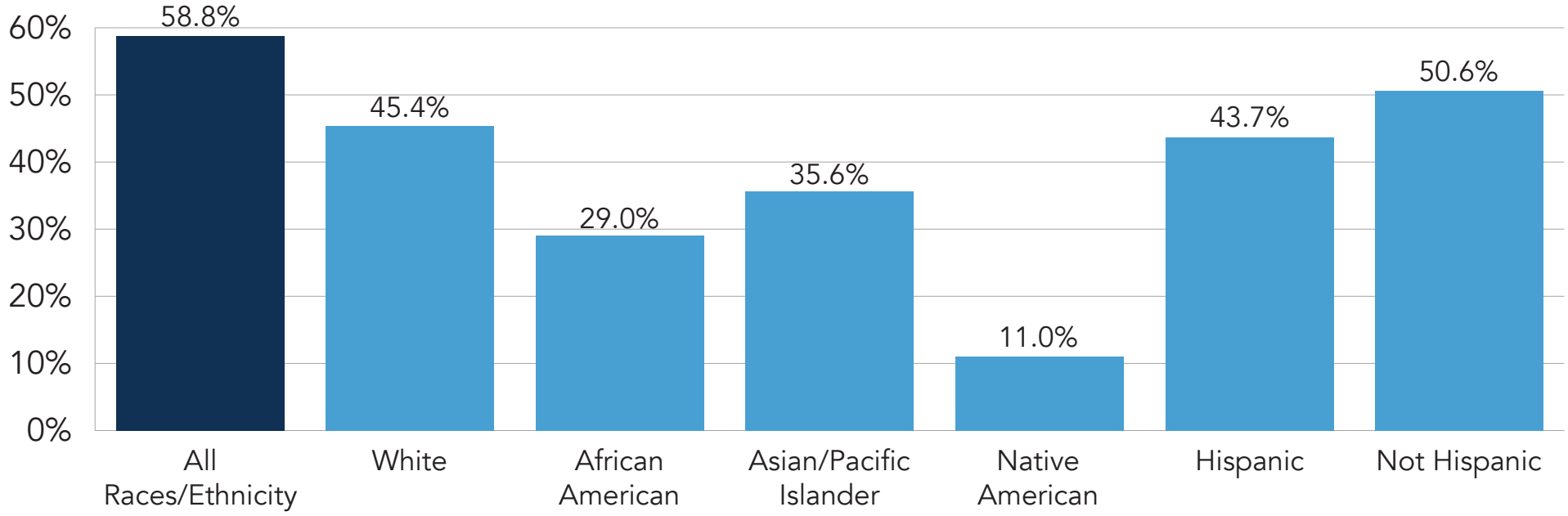
Race and ethnicity are markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased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



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

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

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



Source: The PA Department of Health

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

DRIVERS OF DISEASE INEQUITIES

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

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

DISCRIMINATORY POLICIES

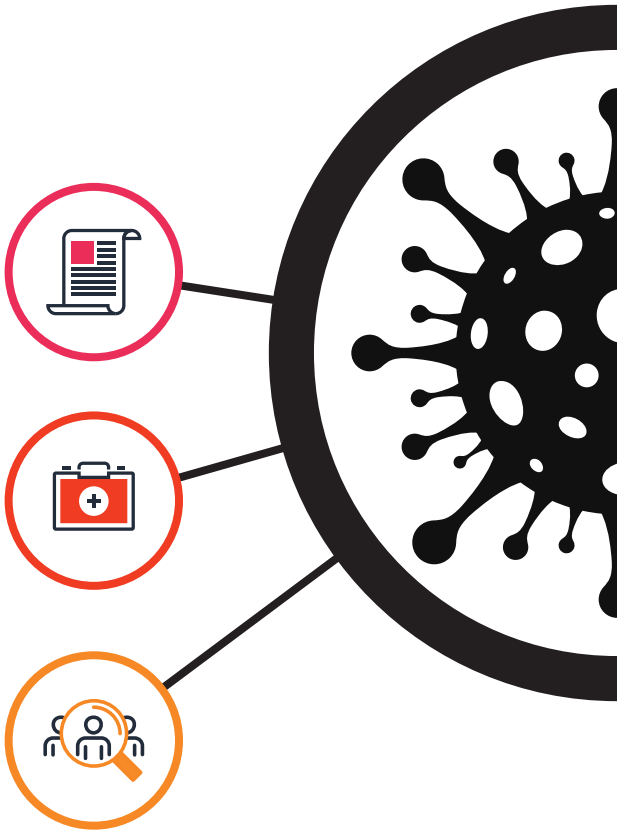
Policies impacting healthcare, education, finance, criminal justice, and other formative systems which should serve to protect communities can lead to stress as well as act as barriers towards proper healthcare.[11]

LIMITED ACCESS TO ESSENTIAL SERVICES AND RESOURCES

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

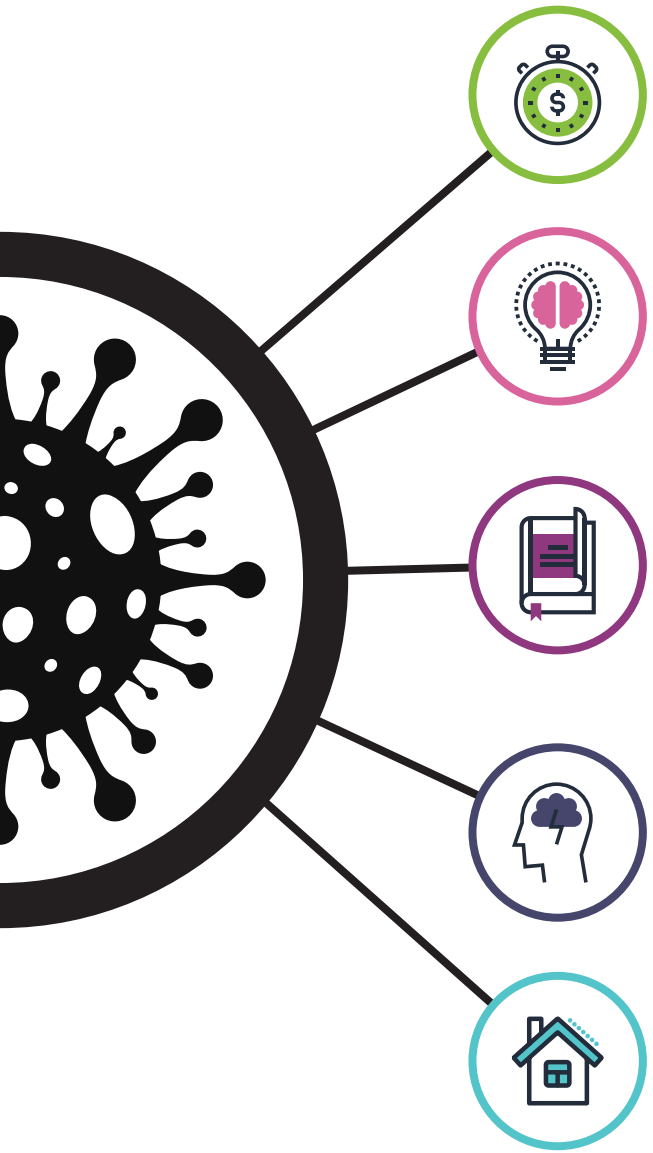
HISTORY OF RACISM & SOCIAL DISCRIMINATION

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



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

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



POVERTY

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

MISTRUST

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

LOW HEALTH LITERACY & MISINFORMATION

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

CHRONIC STRESS

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

OVERCROWDED LIVING CONDITIONS

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

Source: The Health Equality Initiative 2020

WHAT DID WE LEARN FROM THE COMMUNITY?

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

Figure 54: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

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

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

KEY INFORMANT SURVEYS

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

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

COMMUNITY STAKEHOLDER INTERVIEWS

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

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

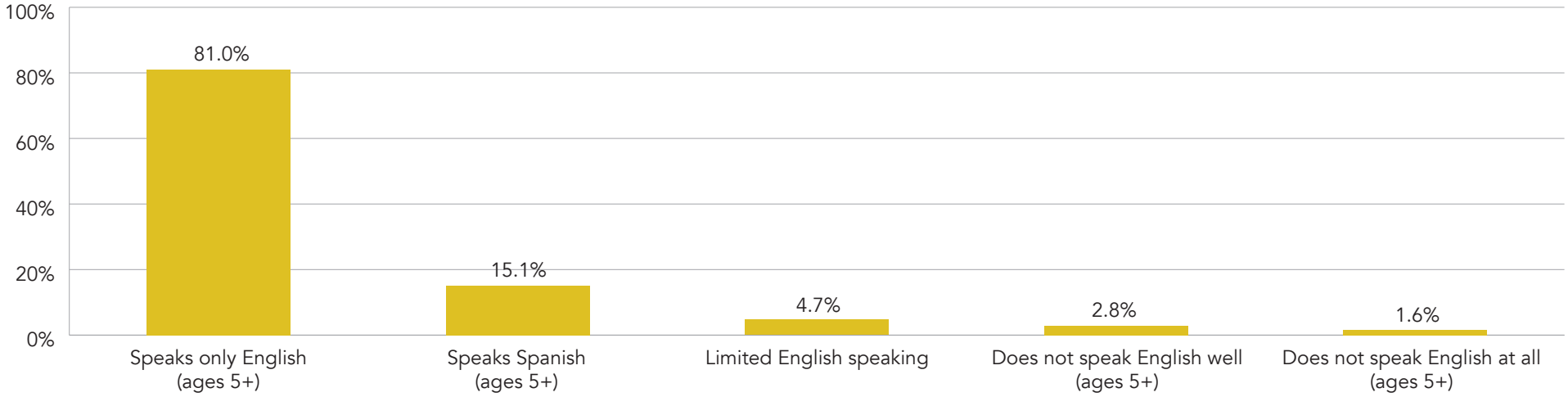
COMMUNITY SURVEYS

"What are the Barriers to Overall Health"

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

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

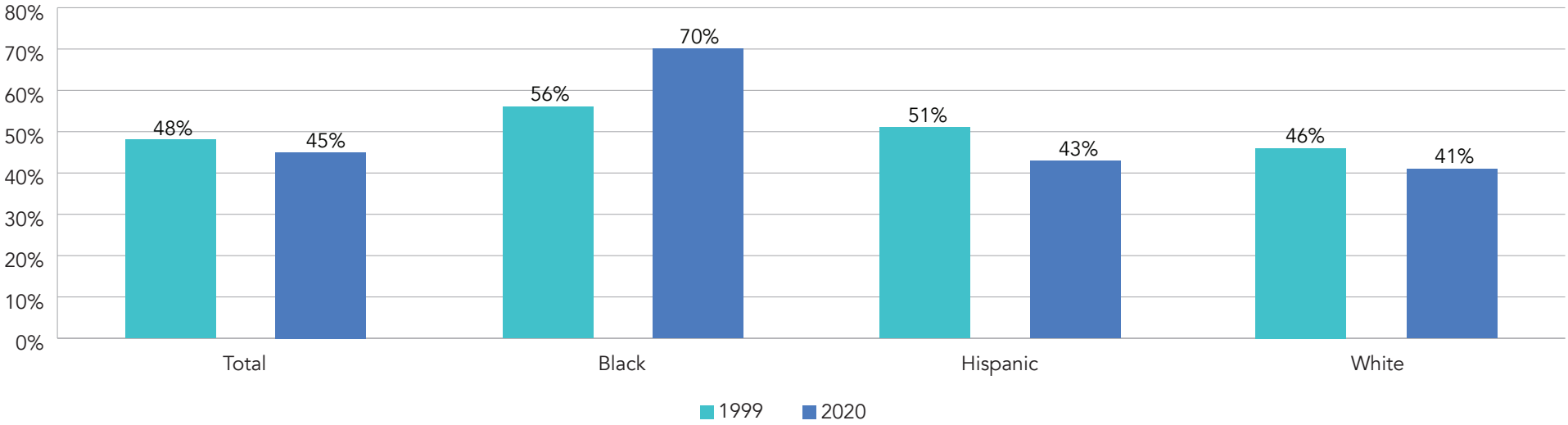
Figure 55: Households with Residents Speaking English Only, Spanish, and Limited English



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

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

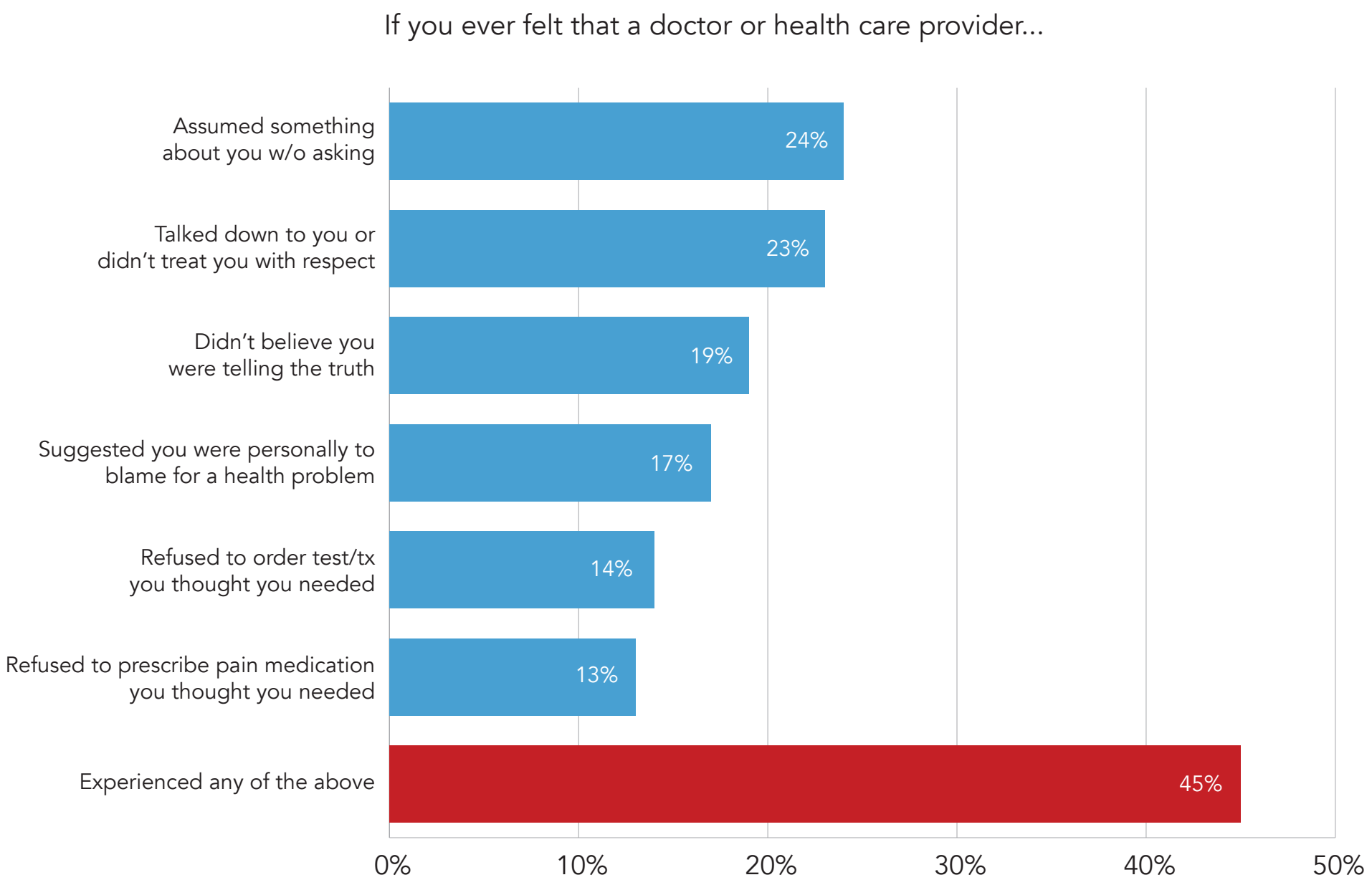
Figure 56: Percentage That Thinks the Health Care System Mistreats People Based on Race/Ethnic Background Very Often or Somewhat Often



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

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

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

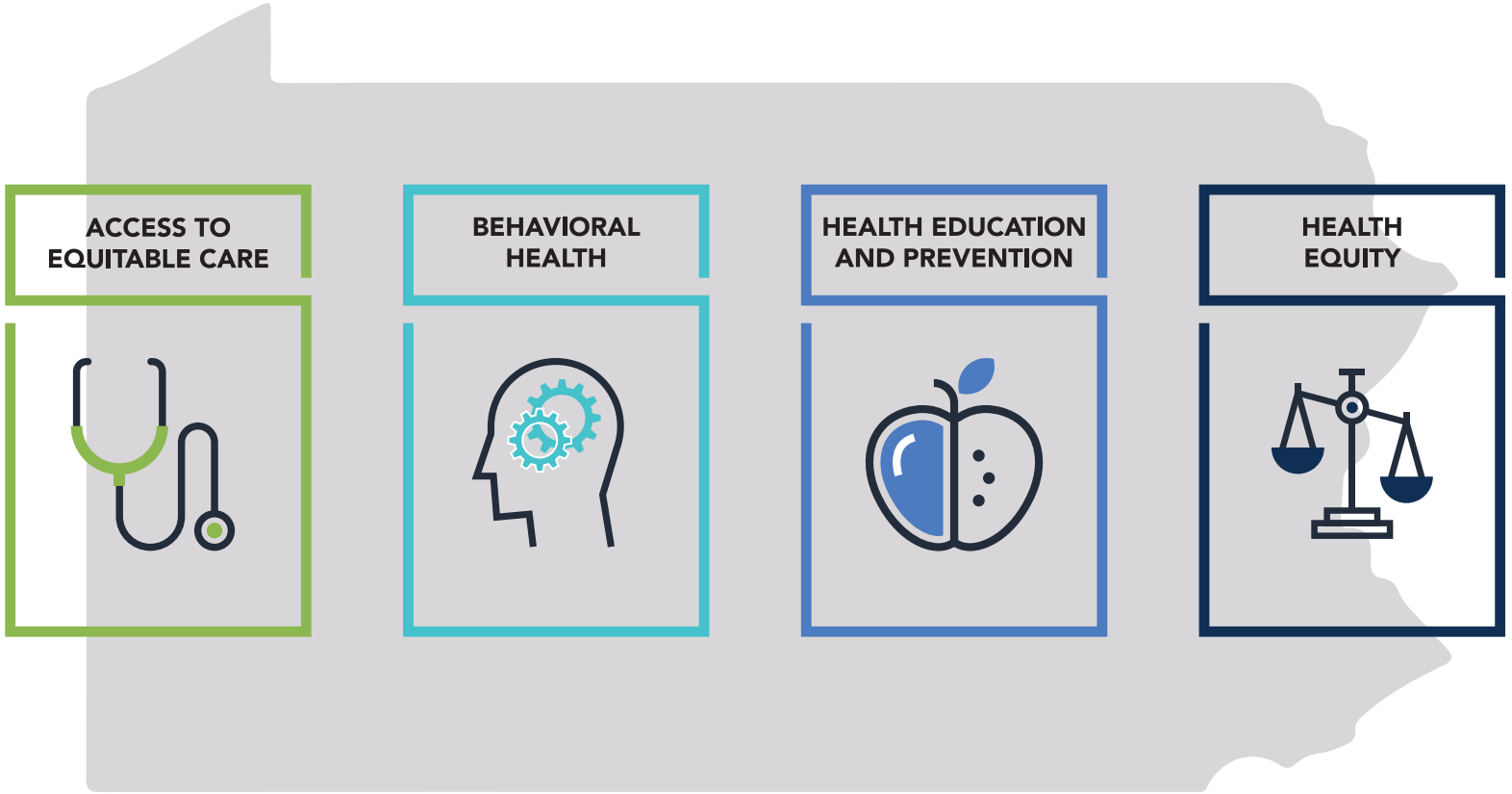


Source: KFF/The Undefeated Survey on Race and Health 2020

CHNA FOCUS AREAS FOR
READING HOSPITAL 2022

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

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



CONCLUSION

WHAT'S NEXT … IT'S COMPLICATED

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

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

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

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

CONTACT//

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www.**towerhealth**.org

Reading Hospital

TOWER HEALTH

Advancing Health. Transforming Lives.

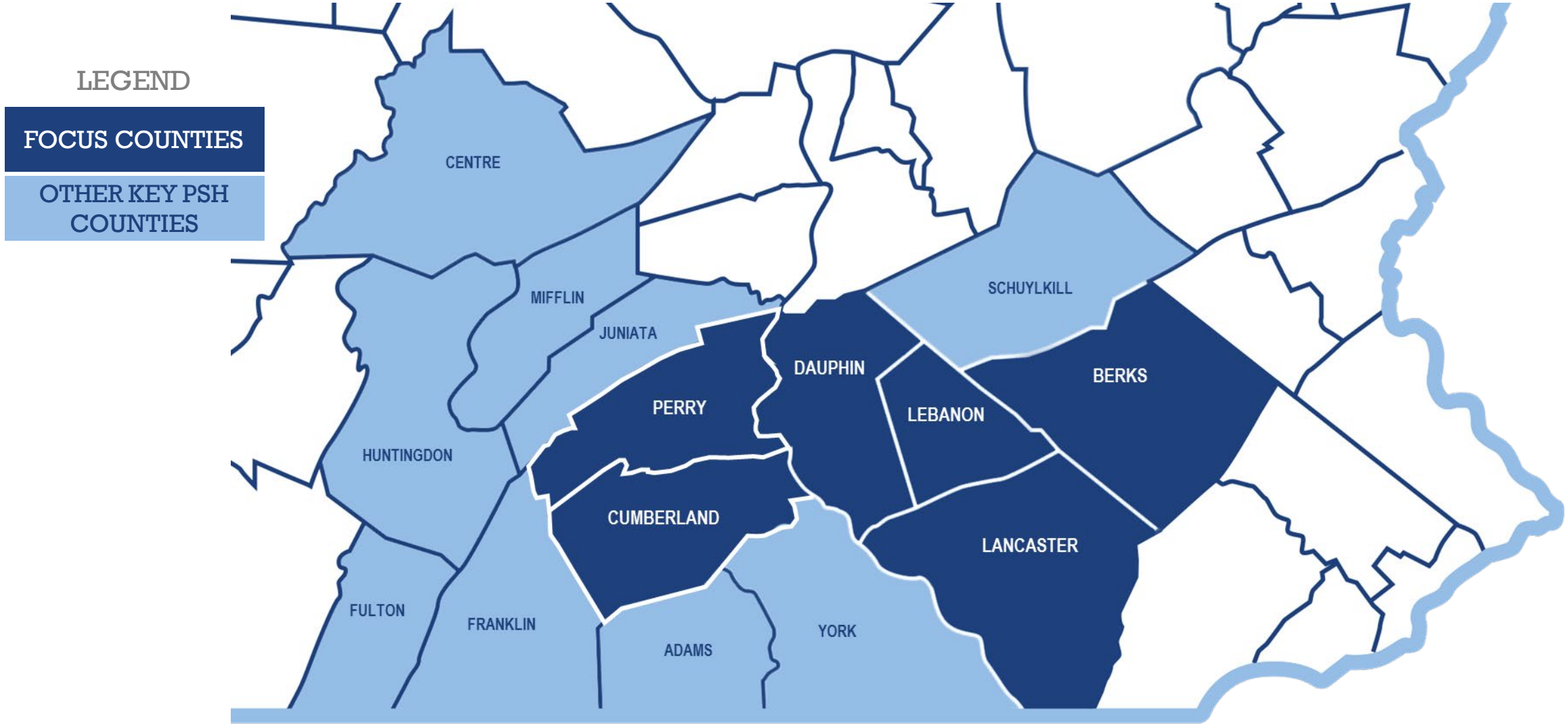
Penn State Health

Community Health Needs Assessment (CHNA)

Partner Forums – May 2021

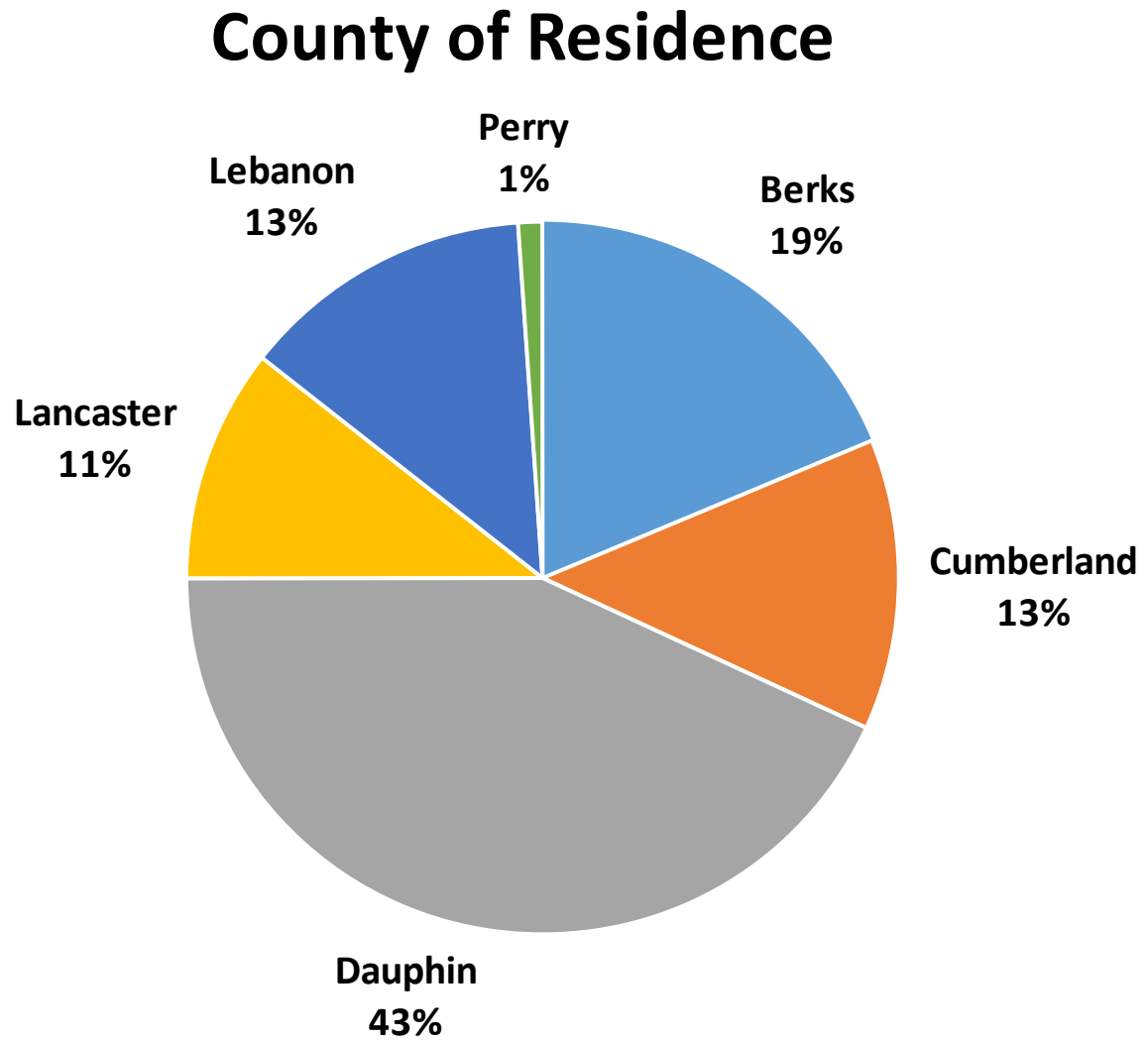
CHNA Findings

Our Community



County and ZIP Code Representation

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

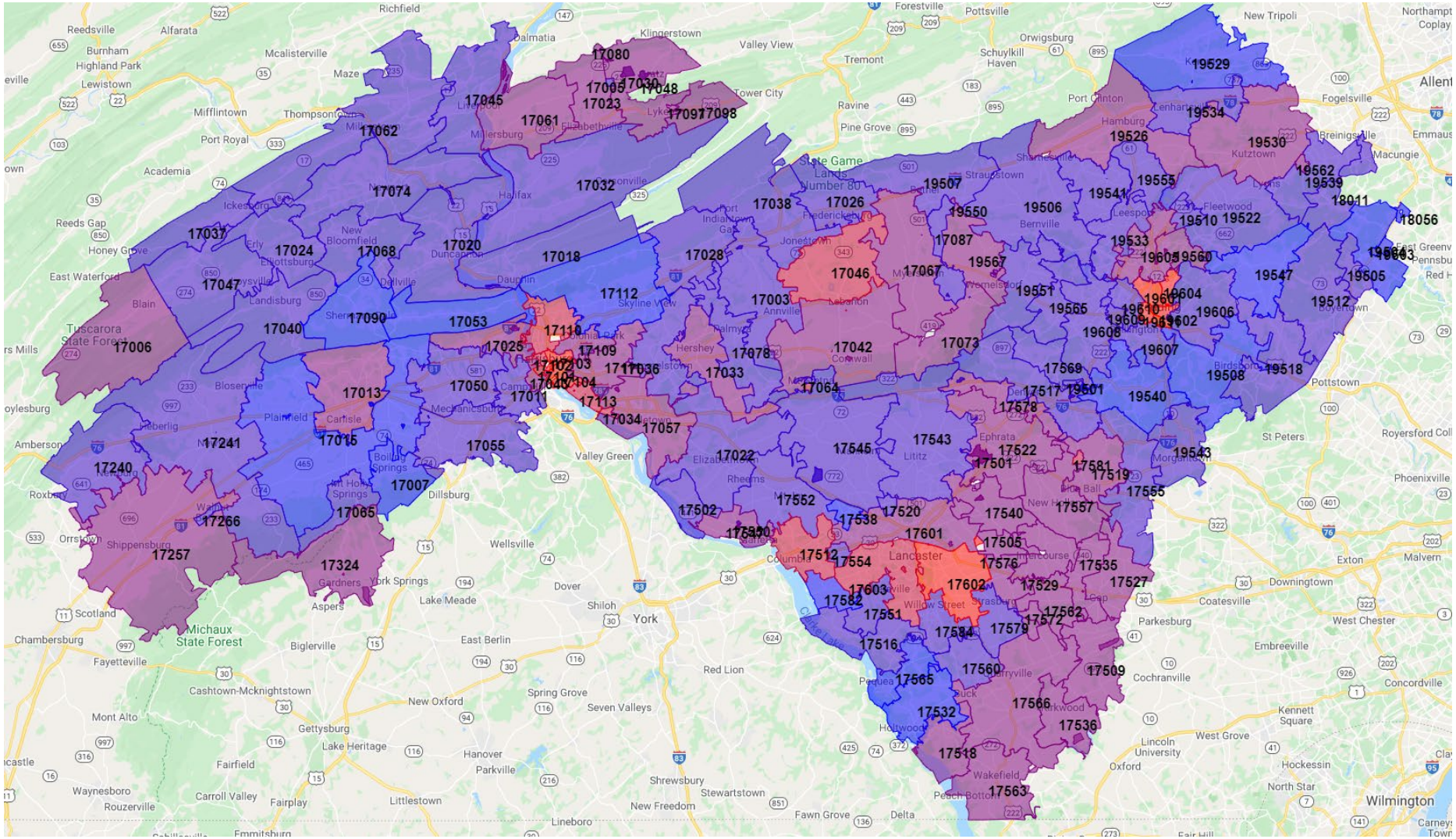


County and ZIP Code Representation Cont.

Top Three Zip Codes of Community Member Residence by County

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

Community Need Index



Service Area - Demographics

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

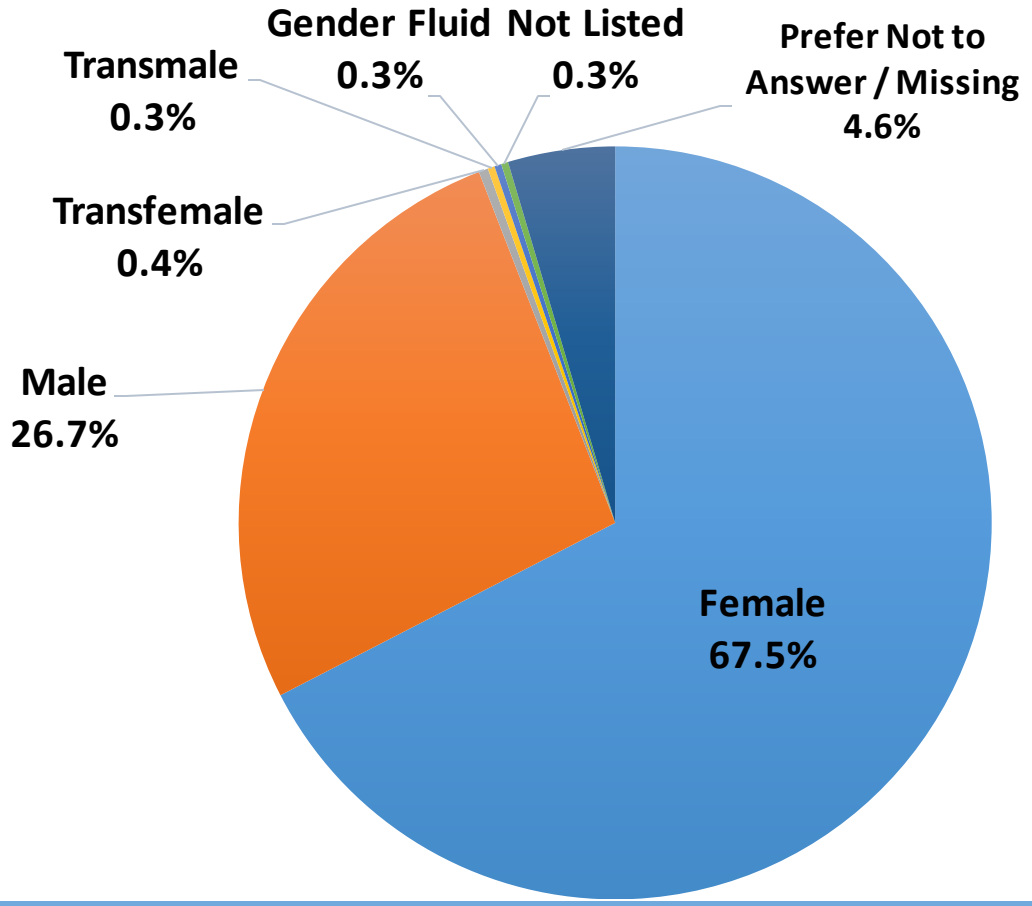
Population, Growth Rate, and Age

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

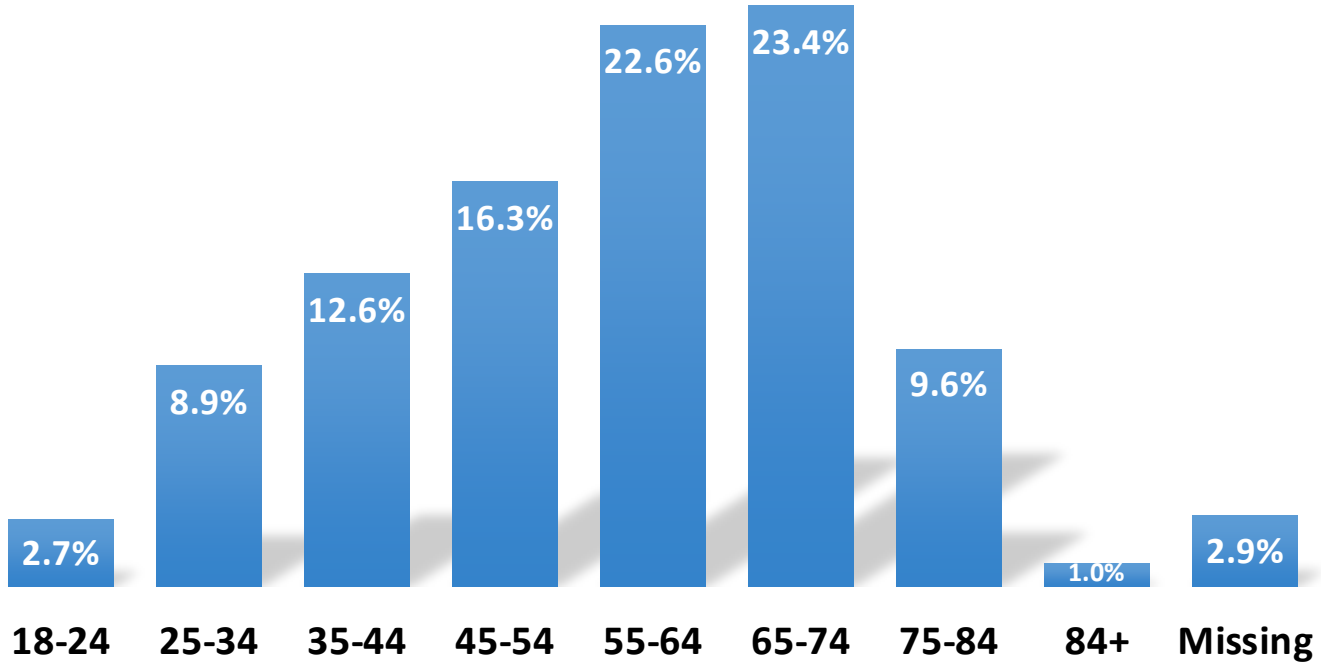
Age and Gender

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

Gender of Respondents



Age of Respondents



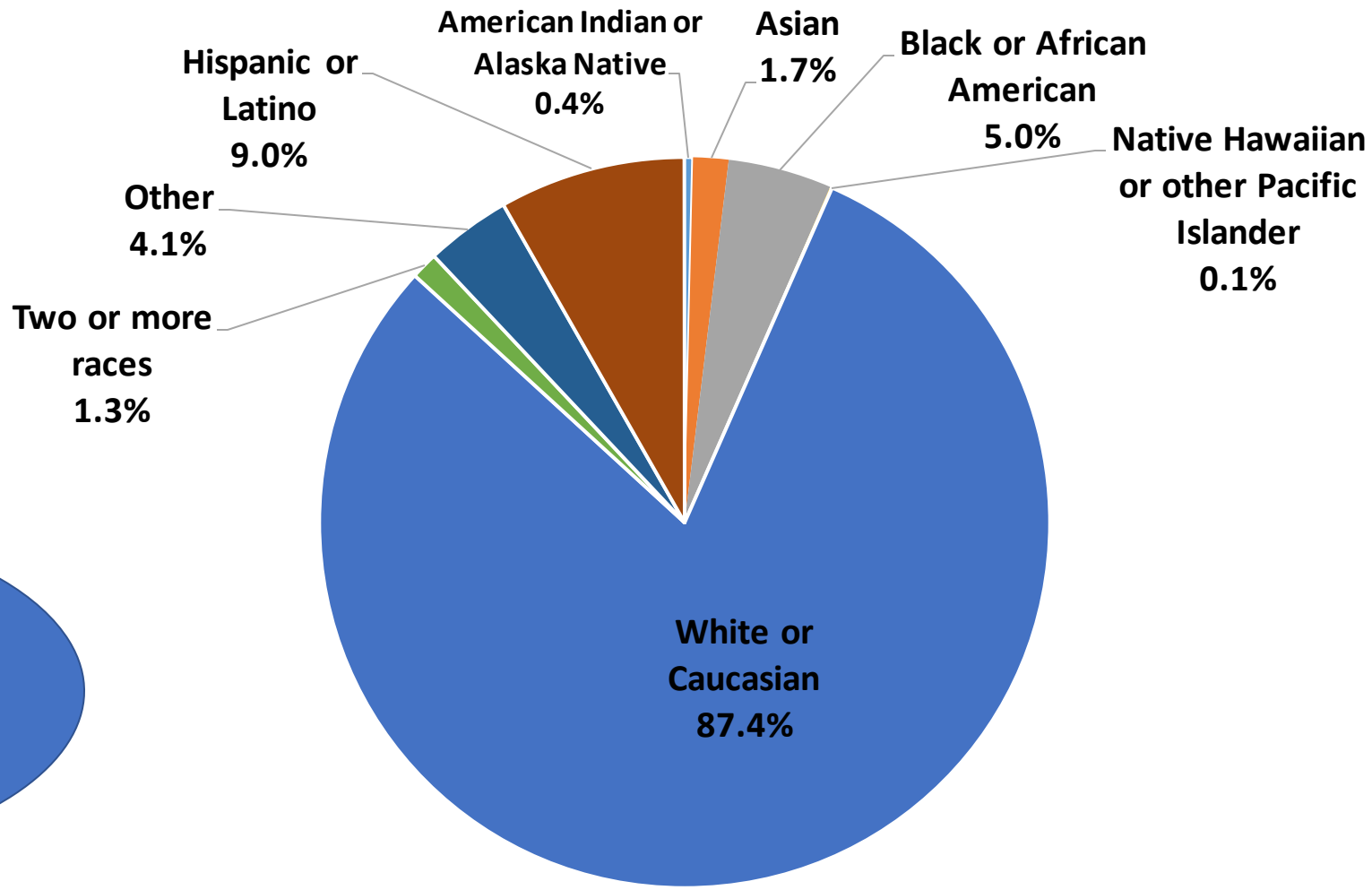
- The median age of the population in the service area is 40 years old (ACS, 2015-2019).

Race and Ethnicity

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

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

Race & Ethnicity of CMS Respondents



Race and Ethnicity Cont.

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

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

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

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

Education, Income, & Employment

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

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

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

Employment

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

Education, Income, Poverty

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

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

Top Health Concerns

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

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

KIS – Health Concerns/Contributing Factors

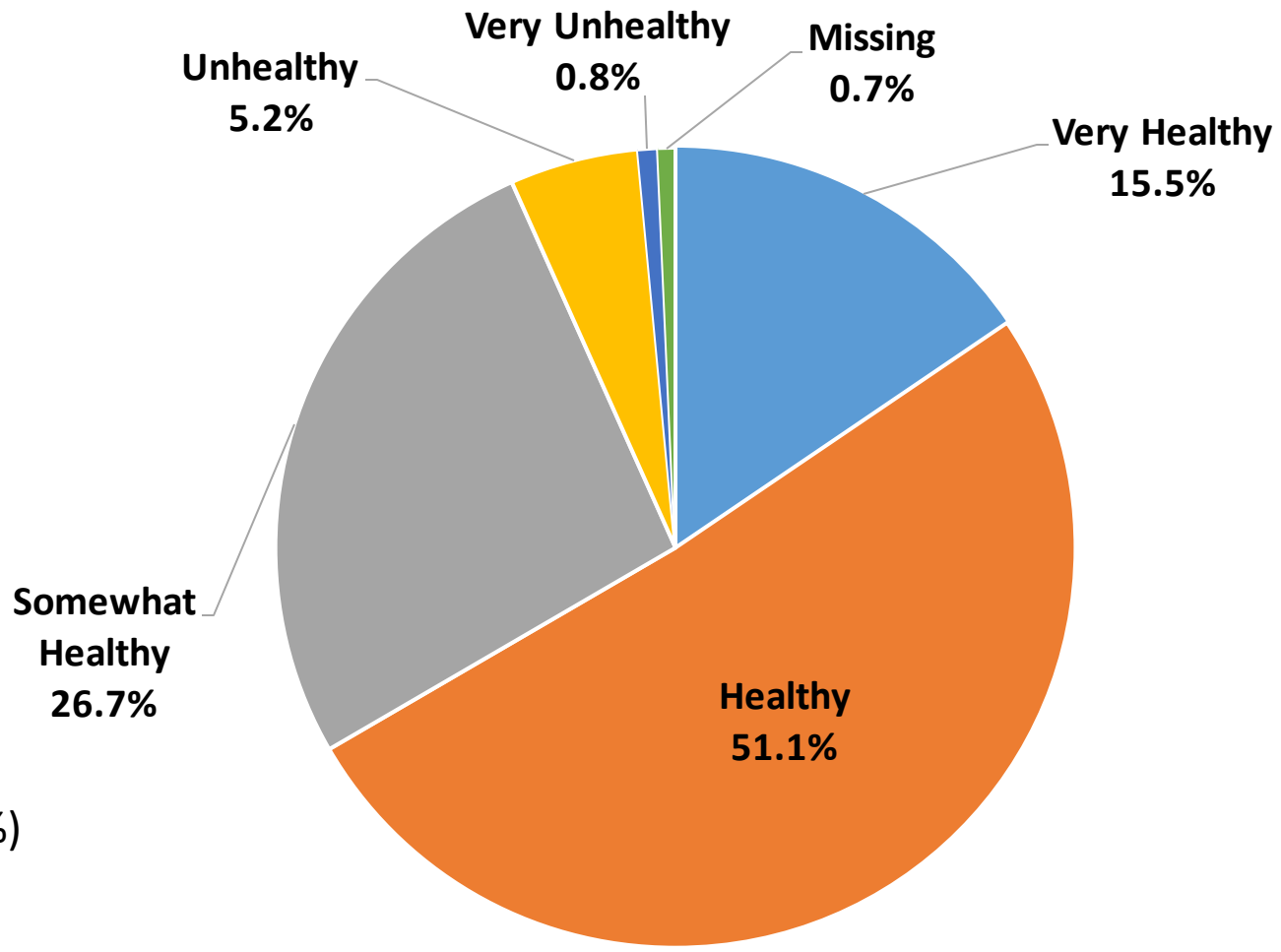
Overall Health

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

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

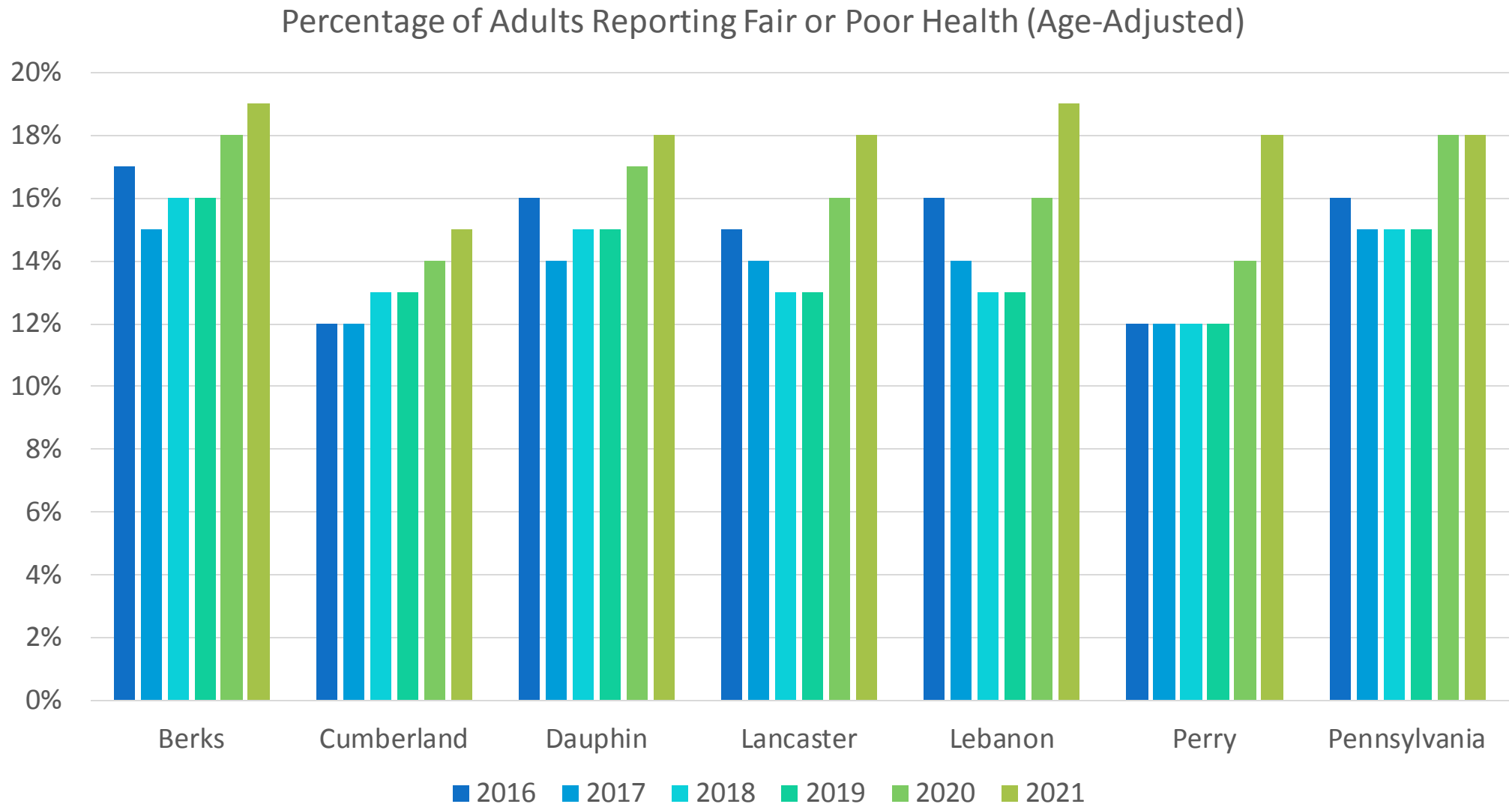
- Just over half (51.1%) of KIS respondents disagreed that their community is healthy.

How Would You Rate Your Health?

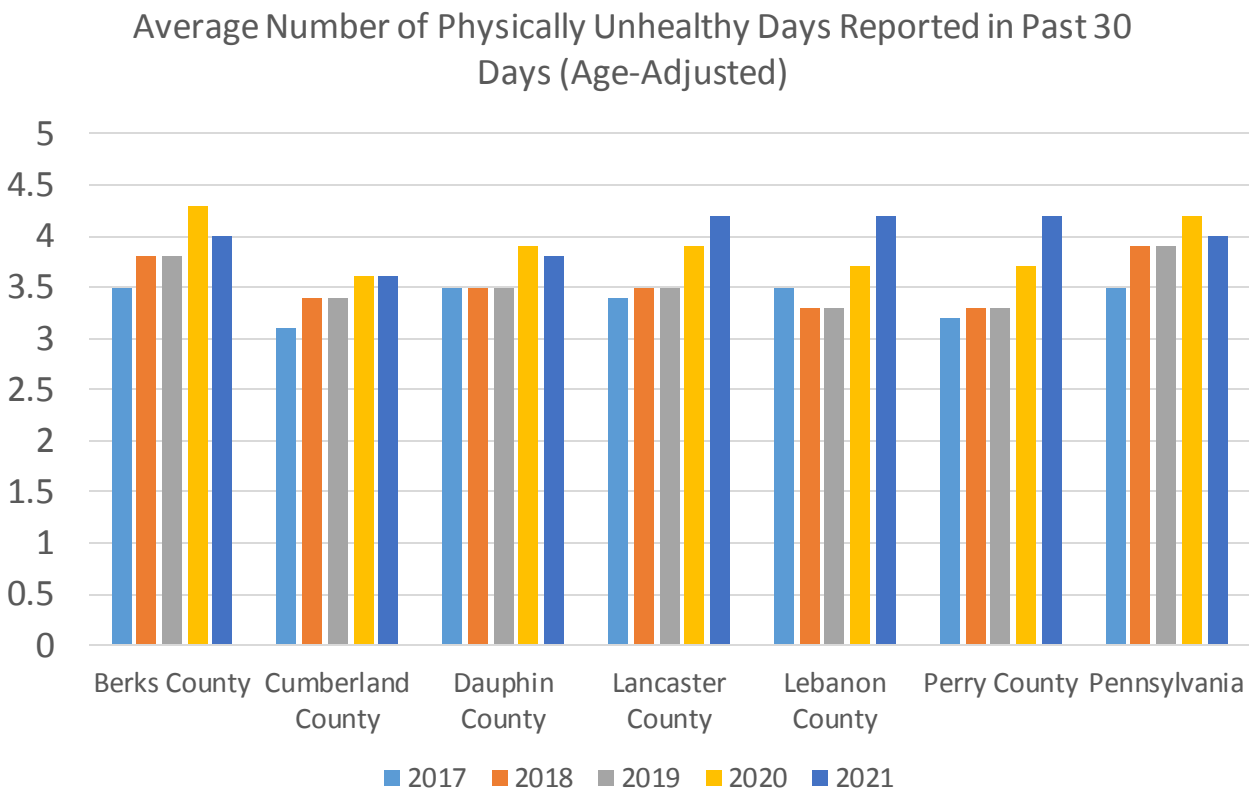


Overall Health Cont.

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

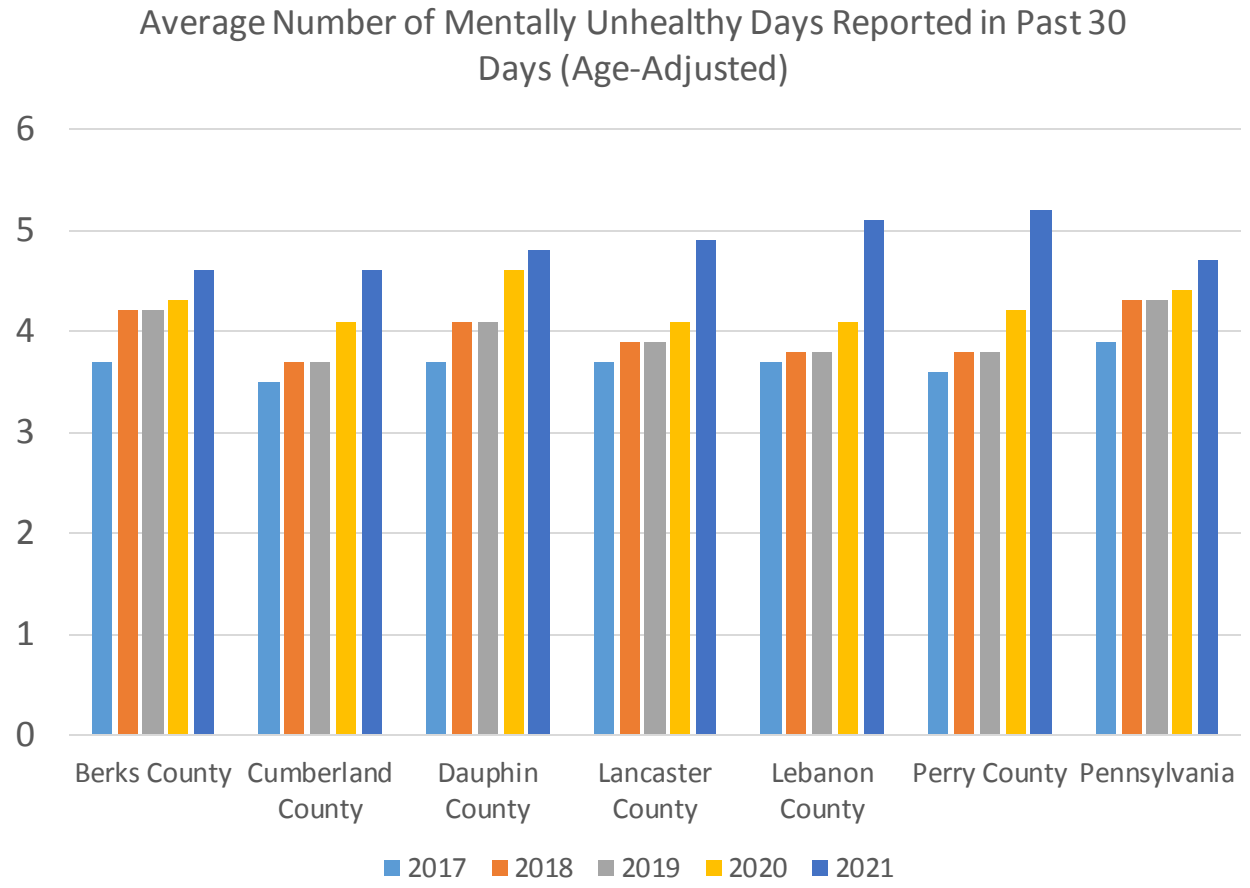


Physically and Mentally Unhealthy Days



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

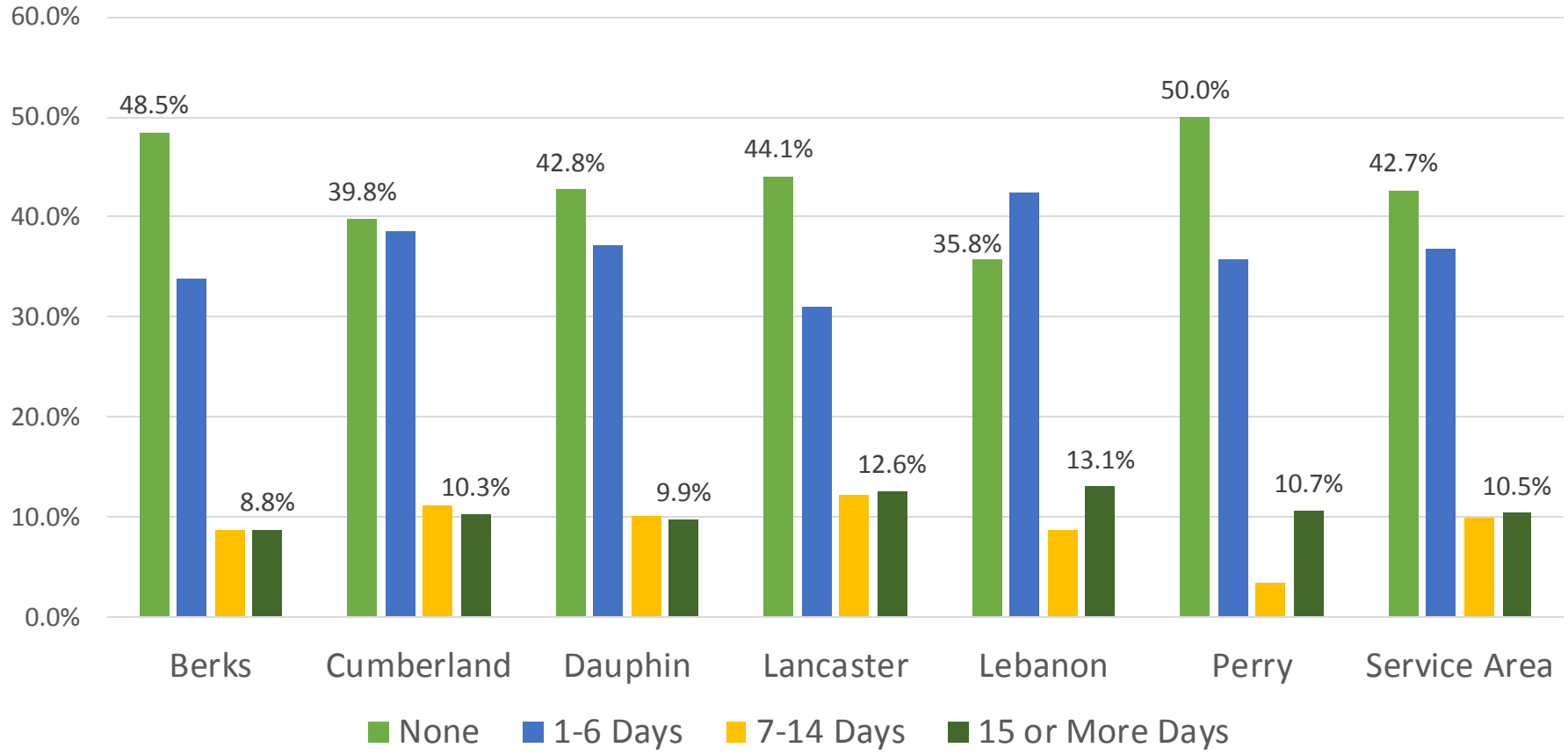
- More mentally unhealthy days are reported than physically unhealthy days (BRFSS, 2018).



Mental Health

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

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



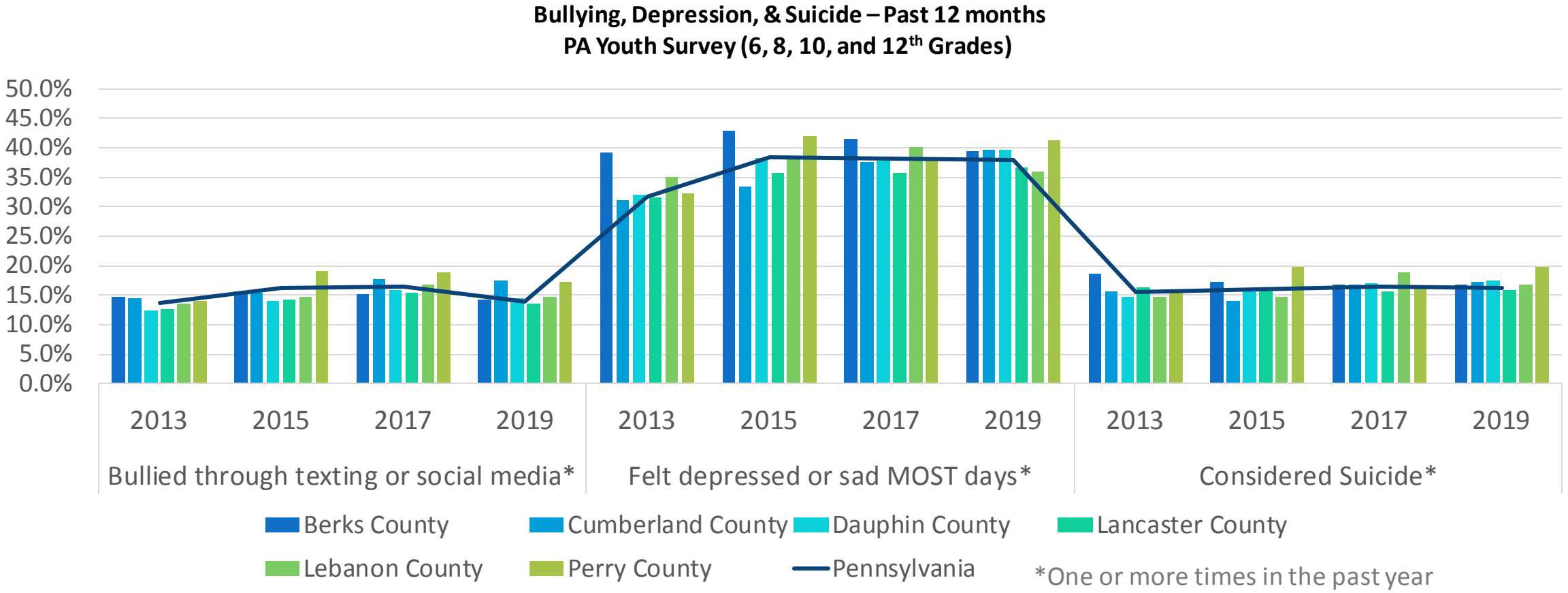
- 63% of the LGBTQ population said depression was a top 3 health concern (LGBTQ Health Needs Assessment, 2020).
- 18% of respondents received mental health services in the past year.
- Approximately 1 in 11 respondents needed mental health services but did not receive them.

Mental Health Cont.

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

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

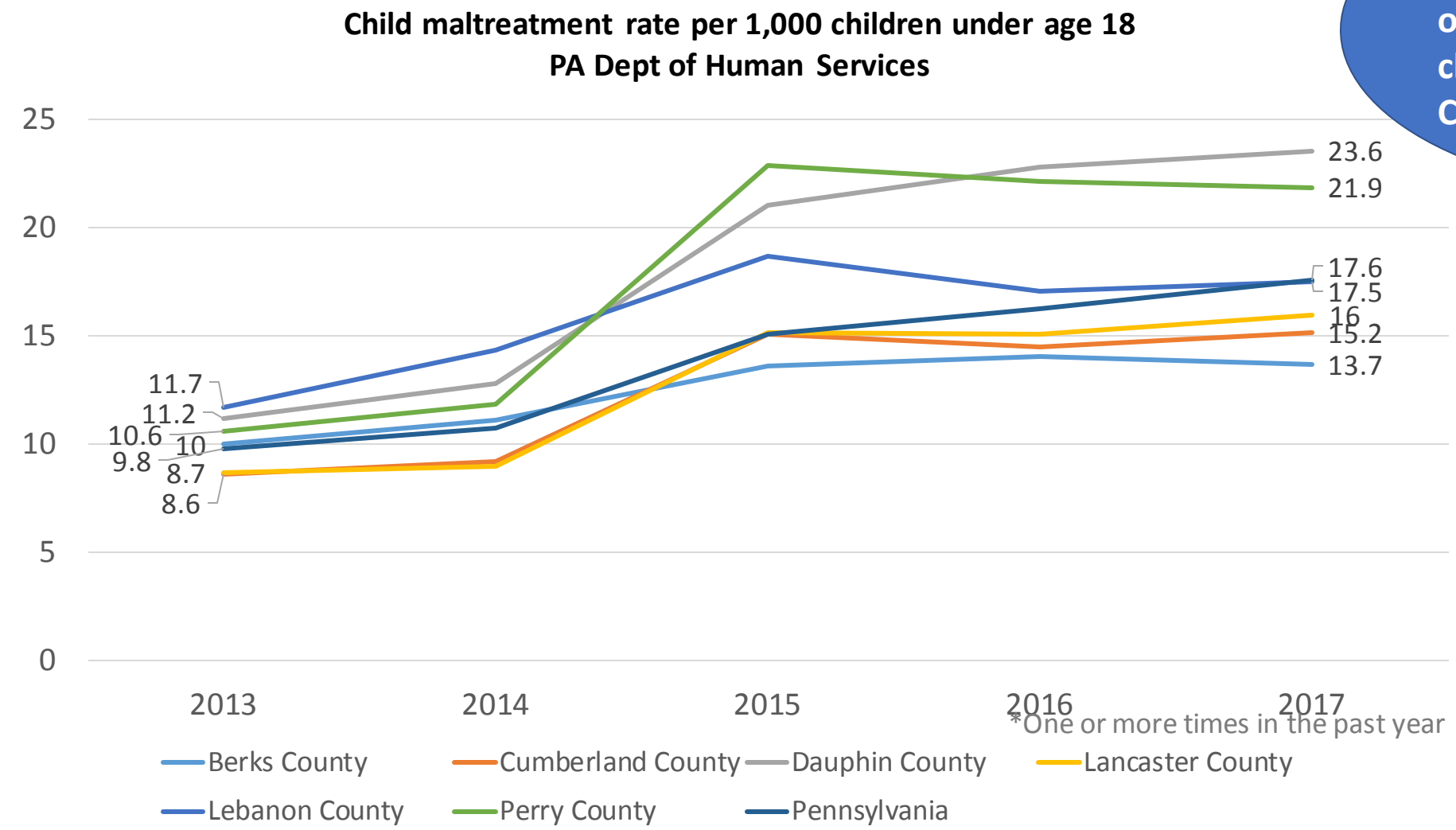
Mental Health – Children



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

Mental Health – Children Cont.

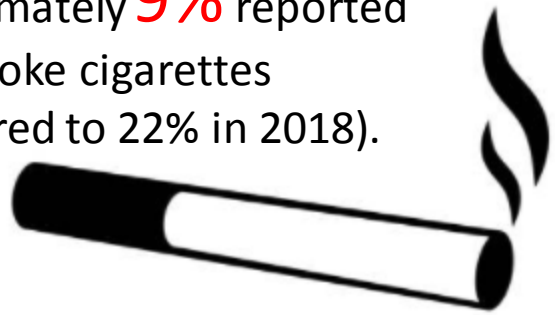
"I think that our largest community health issue, which is of epidemic proportions, is childhood trauma/Adverse Childhood Experiences (ACEs)."
-Community Member



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

Tobacco and Alcohol

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



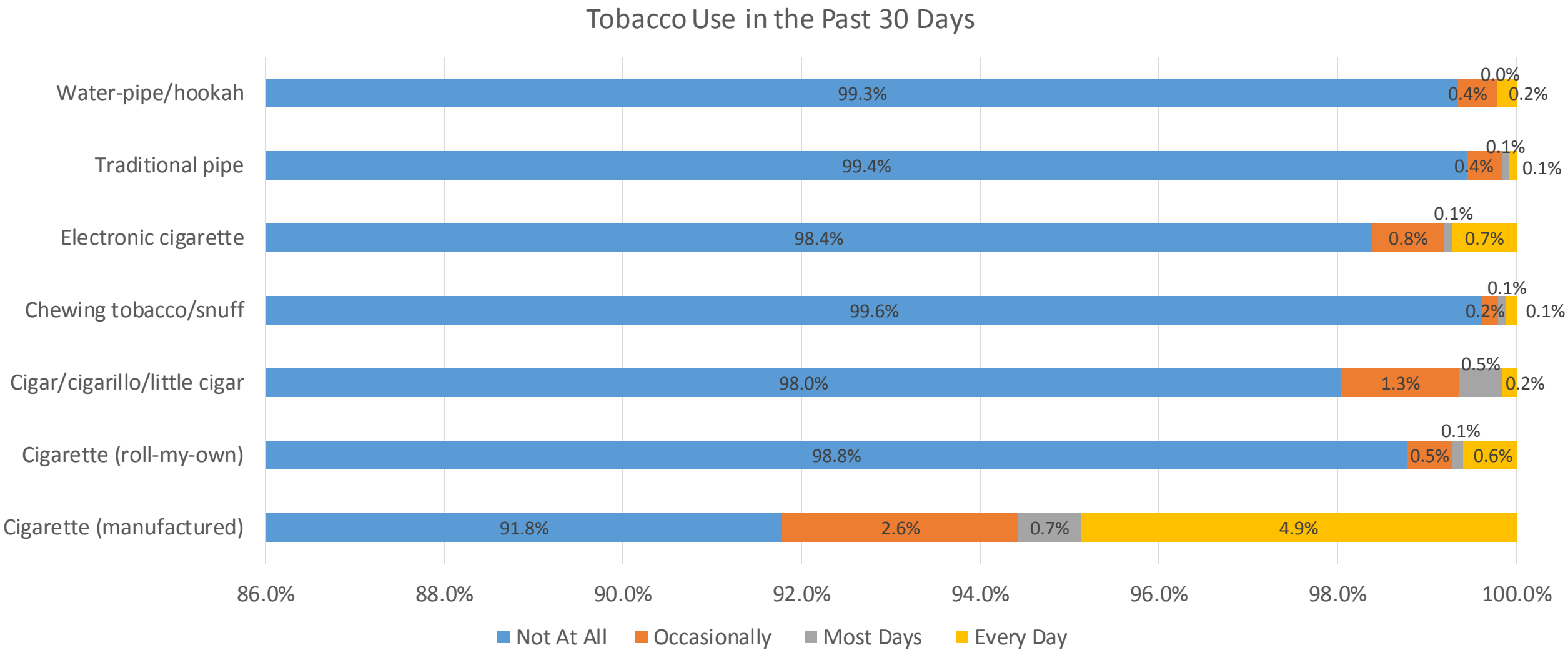
- 16% of Black/African American respondents reported smoking cigarettes compared to only 8% of White respondents.
- 12% of the LGBTQ population reported that they smoke cigarettes (LGBTQ Health Needs Assessment, 2020).
- According to 2018 BRFSS data, 18% of Pennsylvania adults smoke and 20% report excessive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

Amount of Alcoholic Drinks Consumed in an Average Week

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

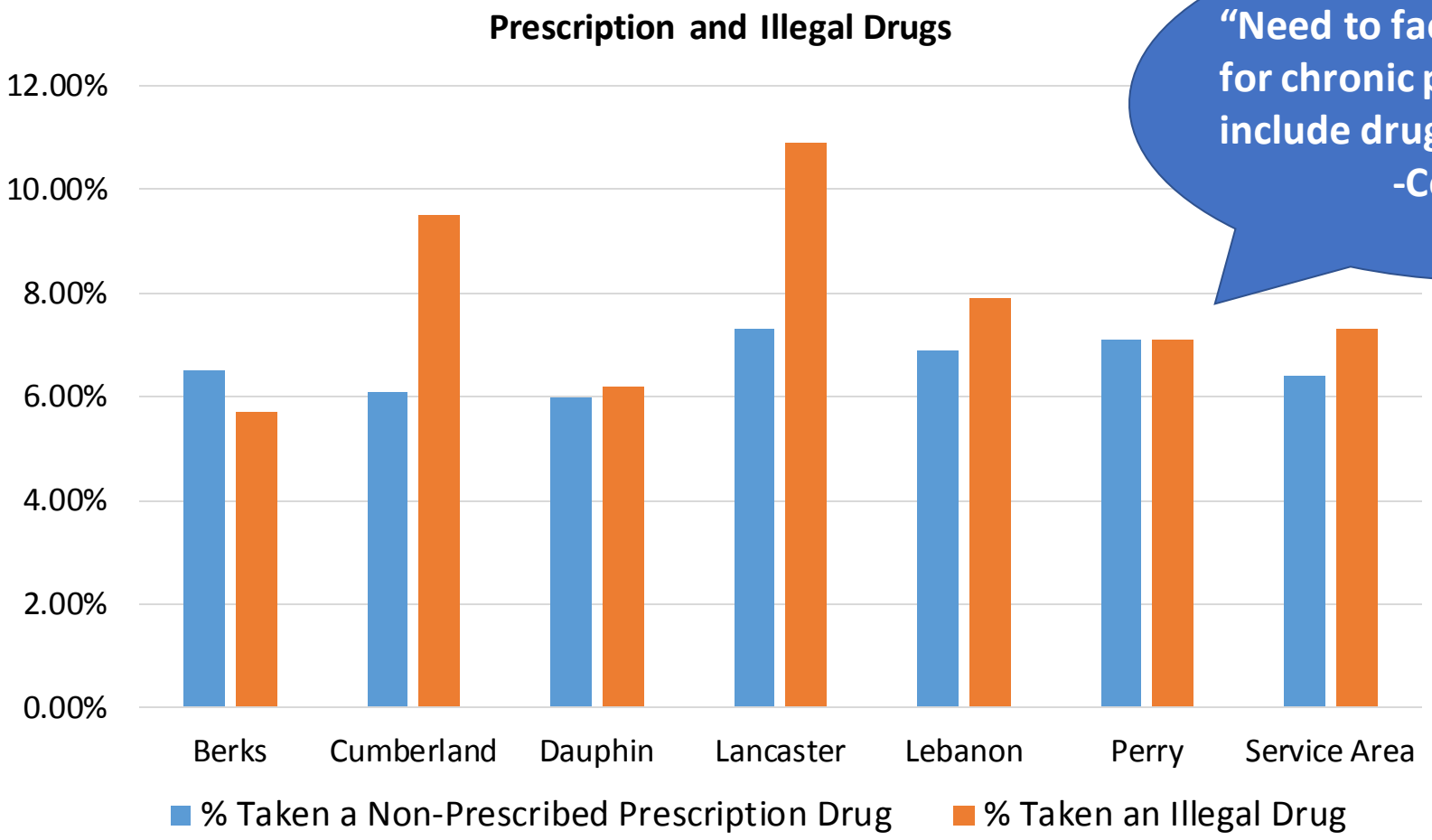
- Approximately 1 in 12 respondents had 7 or more drinks per week.

Tobacco and Alcohol Cont.



Prescription and Illegal Drugs

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



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

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

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

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

Prescription and Illegal Drugs Cont.

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

Perceptions of Ease of Accessing Recreational Drugs

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

Overdose Deaths

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

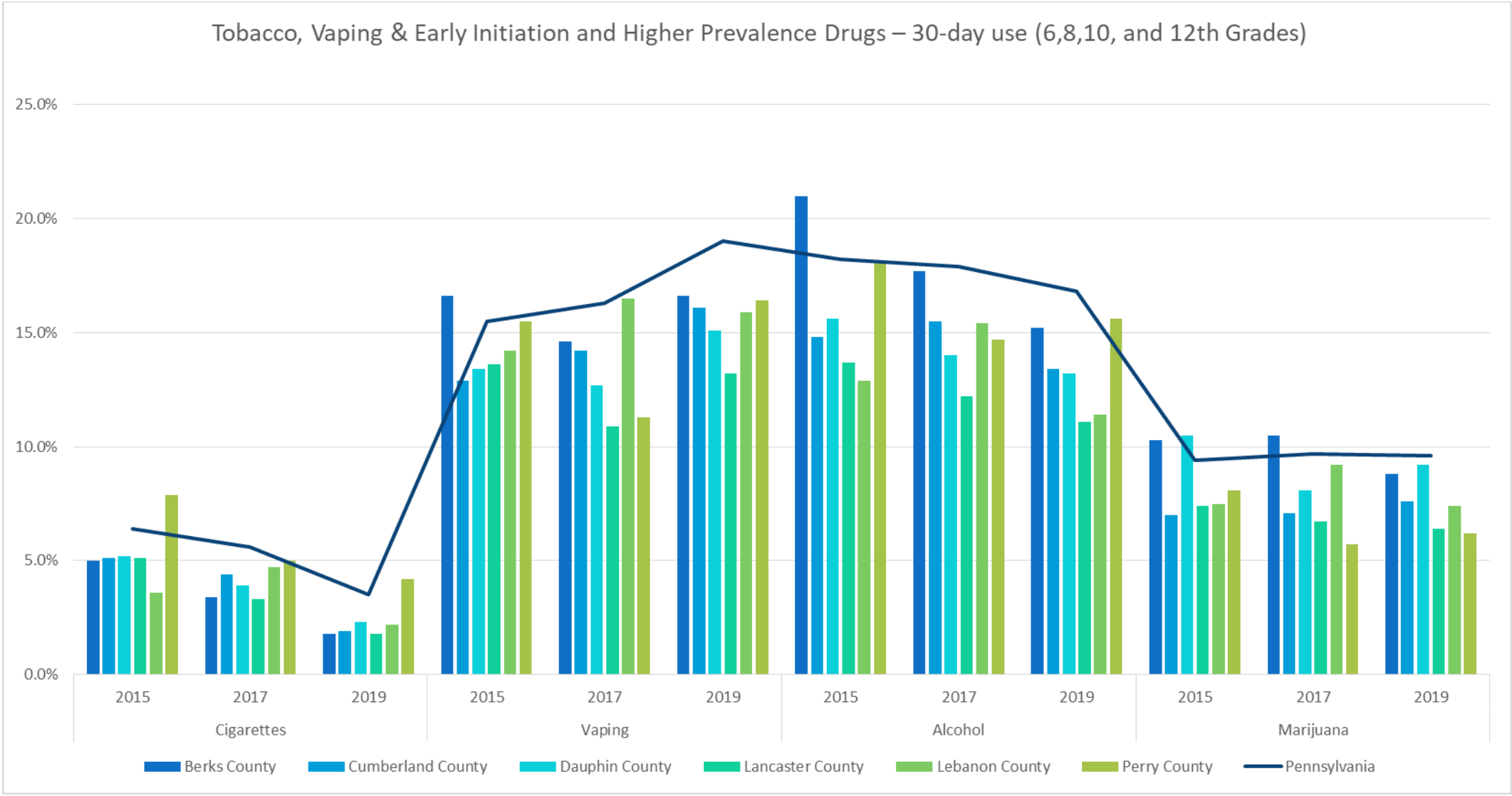
	2015 Rate (Count)	2016 Rate (Count)	2017 Rate (Count)	2018 Rate (Count)	2019 Rate (Count)
Berks County	16 (69)	27 (117)	27 (111)	23 (100)	28 (117)
Cumberland County	15 (41)	23 (58)	30 (74)	19 (52)	16 (41)
Dauphin County	29 (82)	30 (84)	35 (97)	44 (128)	36 (101)
Lancaster County	14 (80)	22 (116)	30 (165)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

Source: DEA Philadelphia Field Division

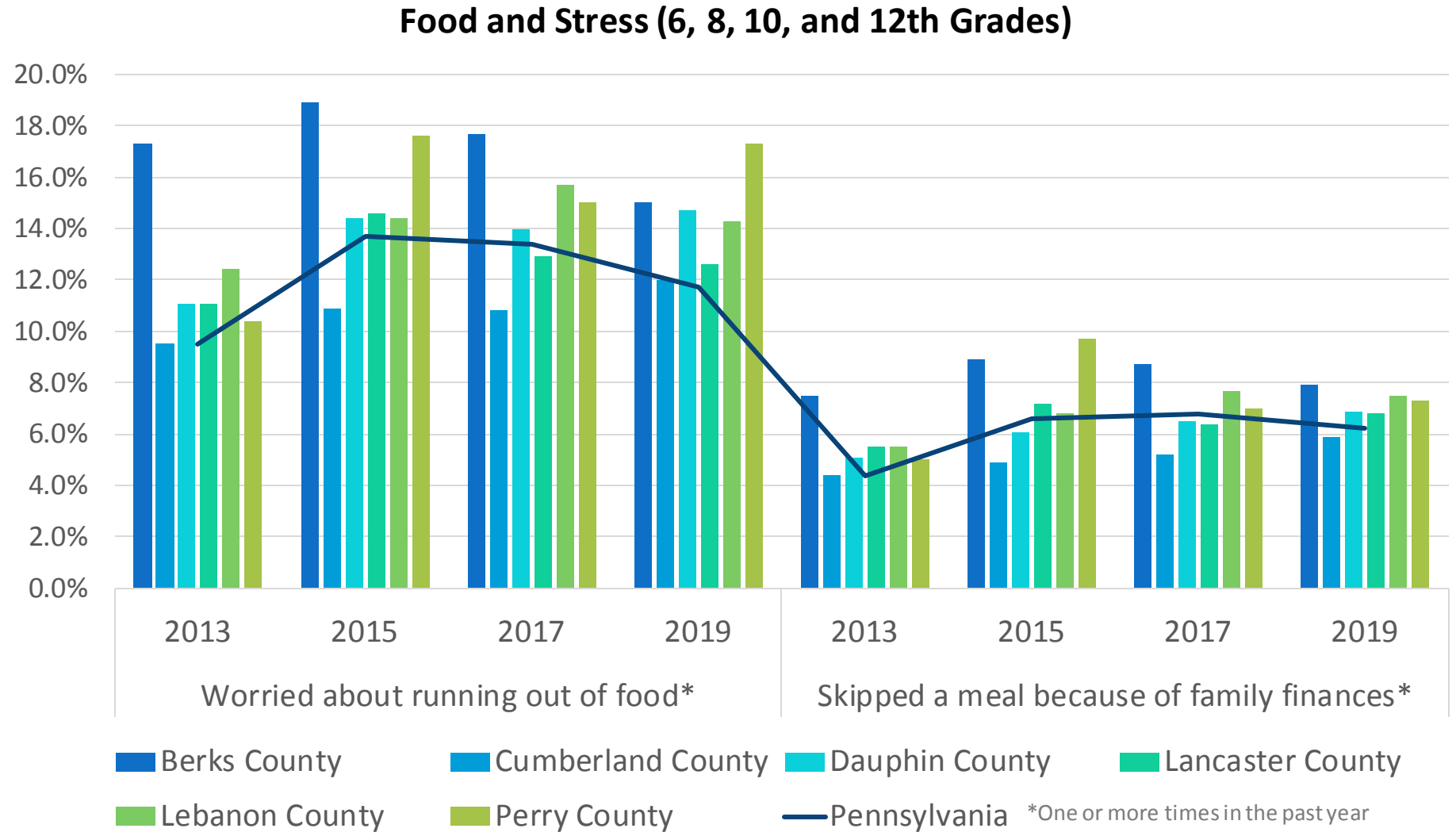
*Counties with overdose death counts between 1 and 9 are suppressed.

Substance Use – Children (PAYS, 2019)

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

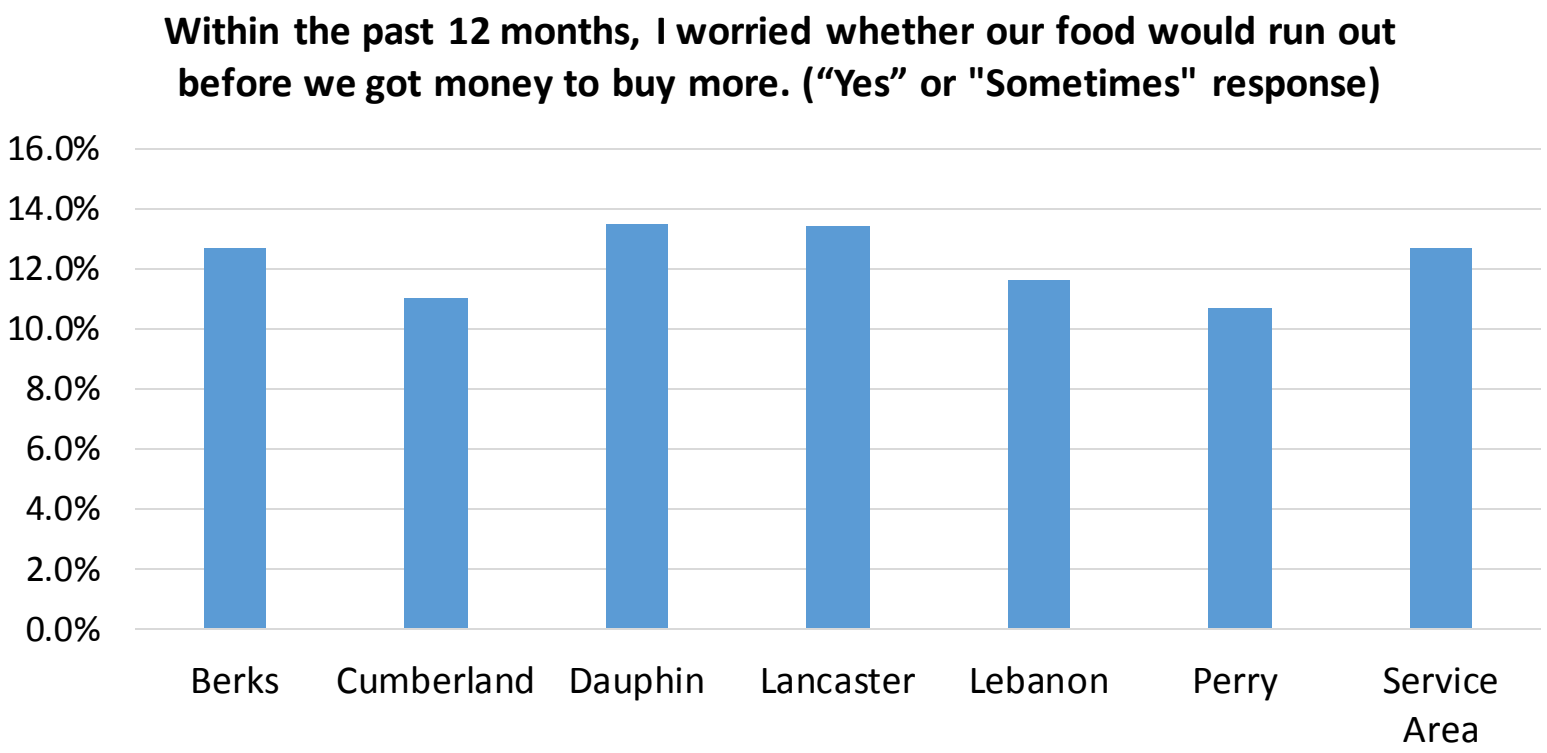


Mental Health and Food – Children (PAYS, 2019)



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

Food



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

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

Worried About Running Out of Food By Race/Ethnicity

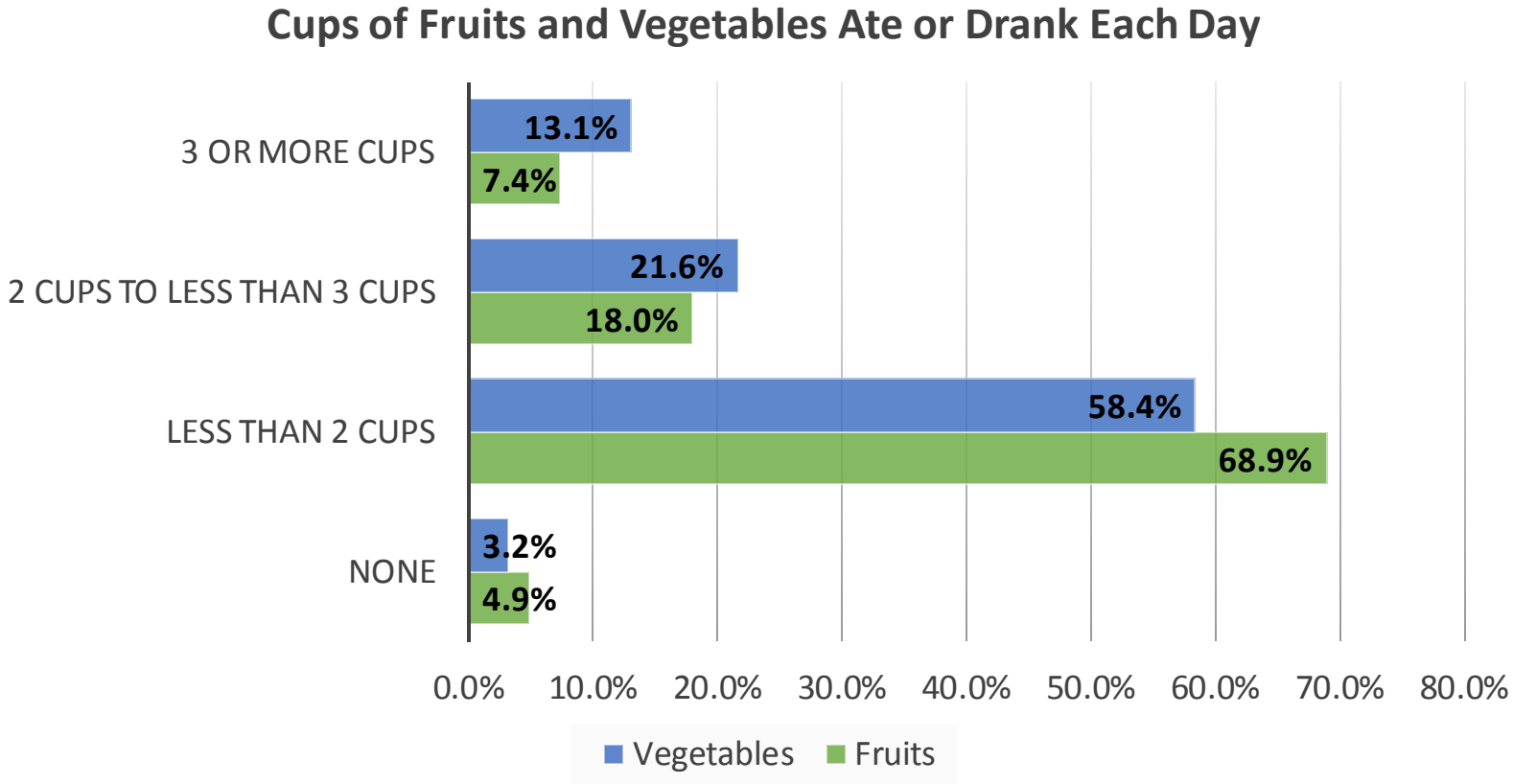
Race/Ethnicity	%	N
Asian	22.2%	10
Black/African American	24.4%	30
Hispanic/Latino	32.1%	68
White/Caucasian	10.5%	215

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

Food Cont.

Food Access

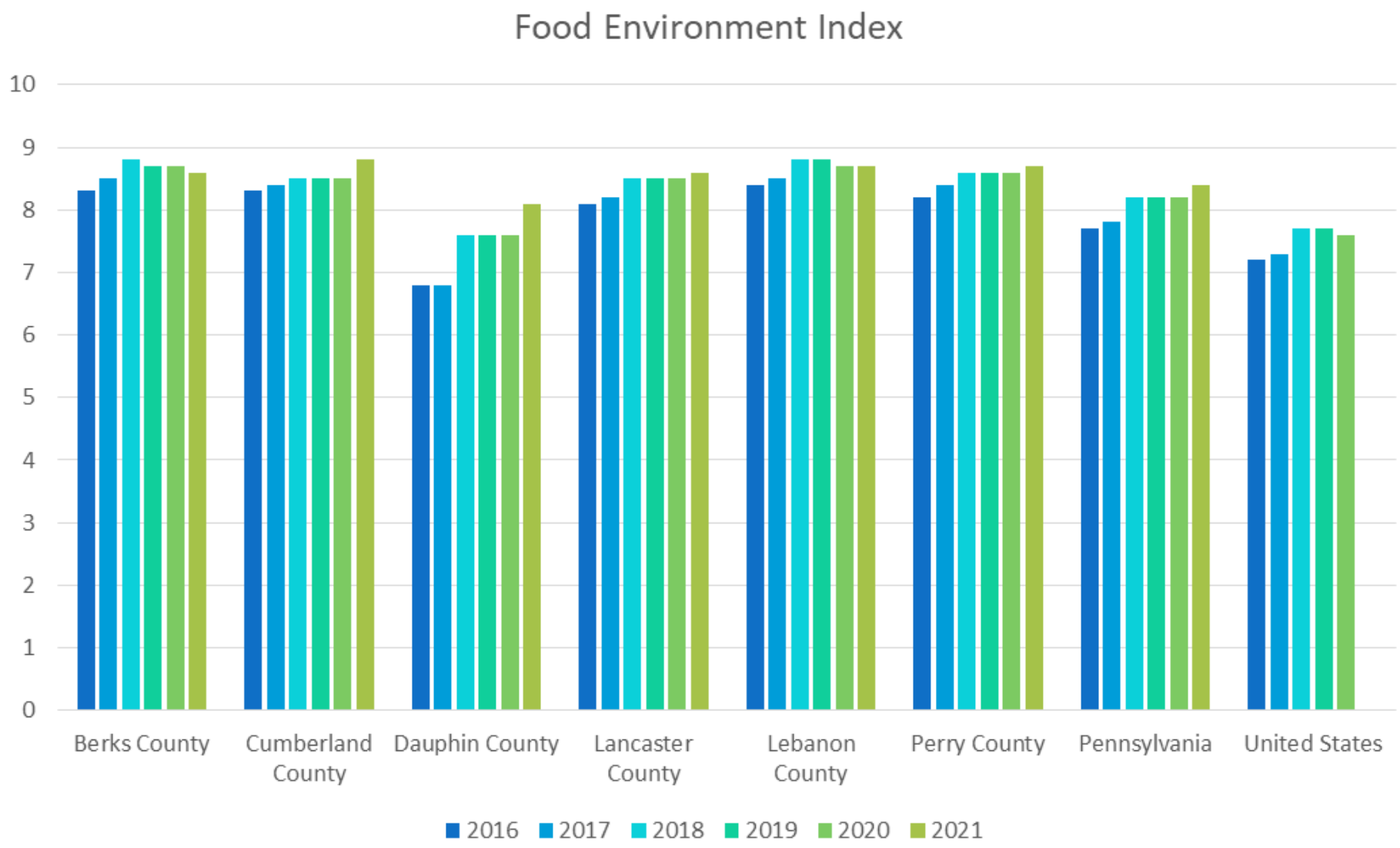
County	Are you able to have fresh, healthy foods (fruits/vegetables) when you want them? ("No" response)
Berks	2.5%
Cumberland	2.4%
Dauphin	1.7%
Lancaster	3.7%
Lebanon	1.5%
Perry	7.1%
Service Area	2.2%



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

Food Cont.

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



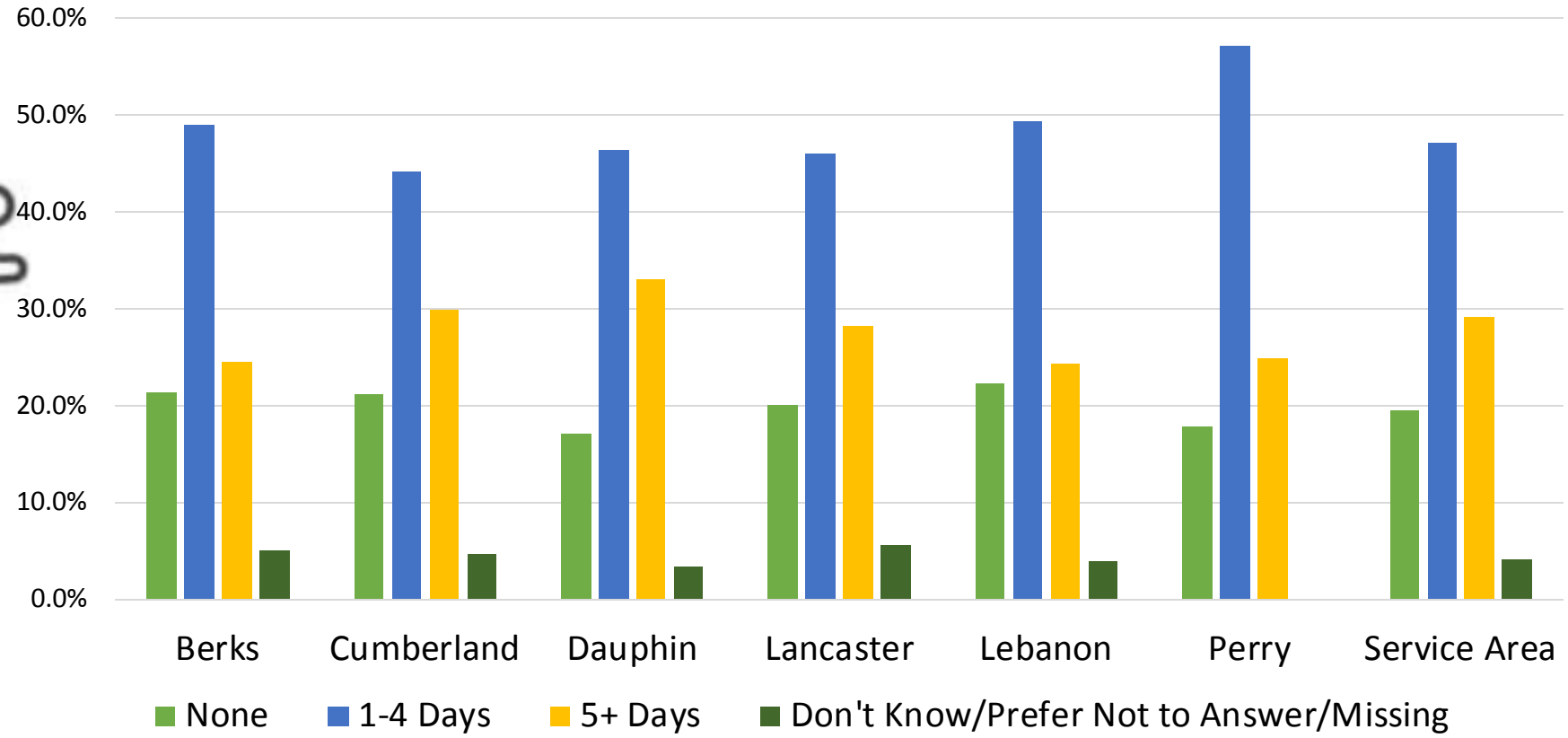
Physical Activity

"More free community exercise programs"
-Community Member

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

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

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

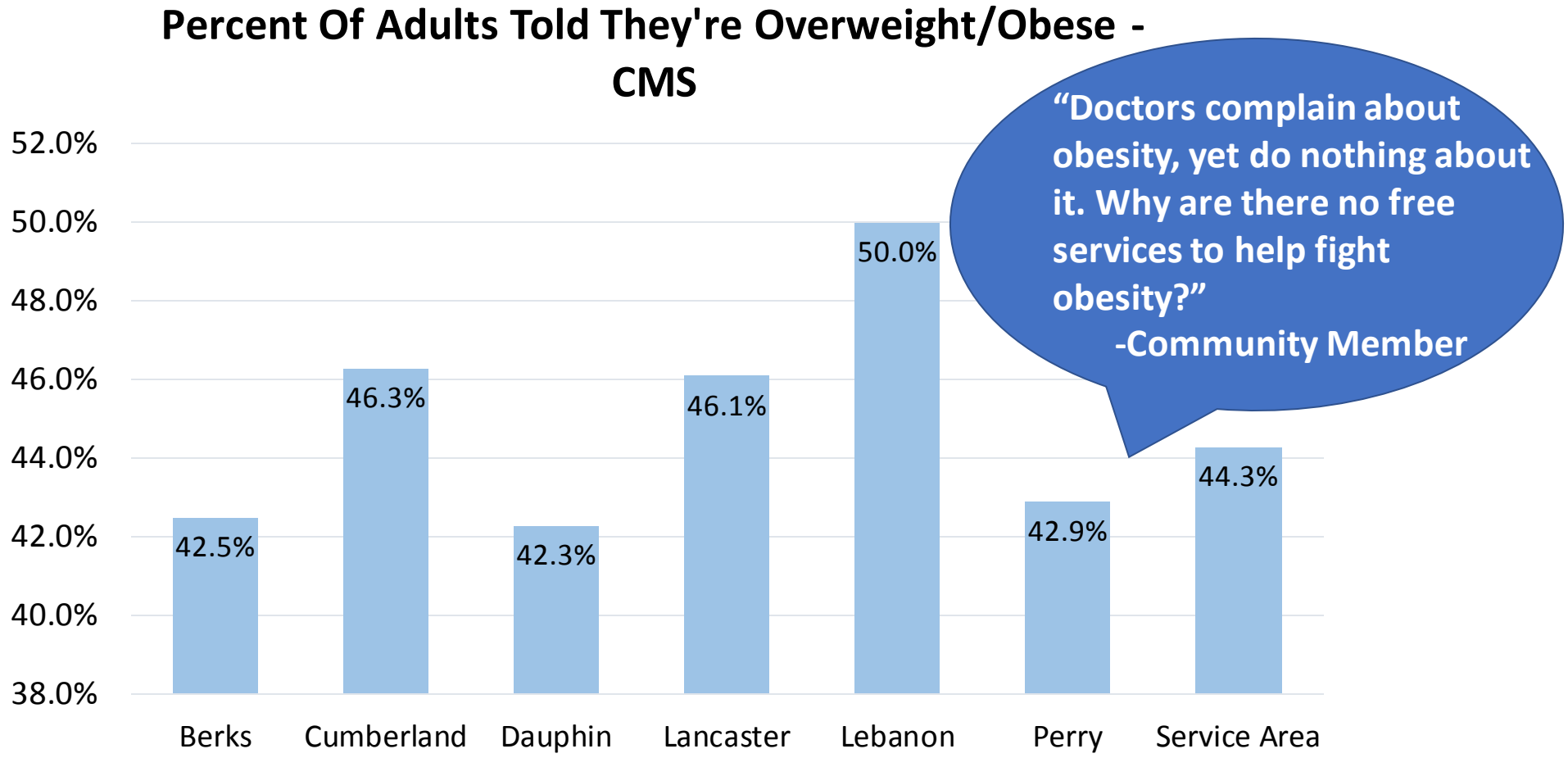


- Only 50% of the population in Perry County had adequate access to exercise opportunities (County Health Rankings, 2021).
- Access to exercise opportunities is decreasing within all counties.

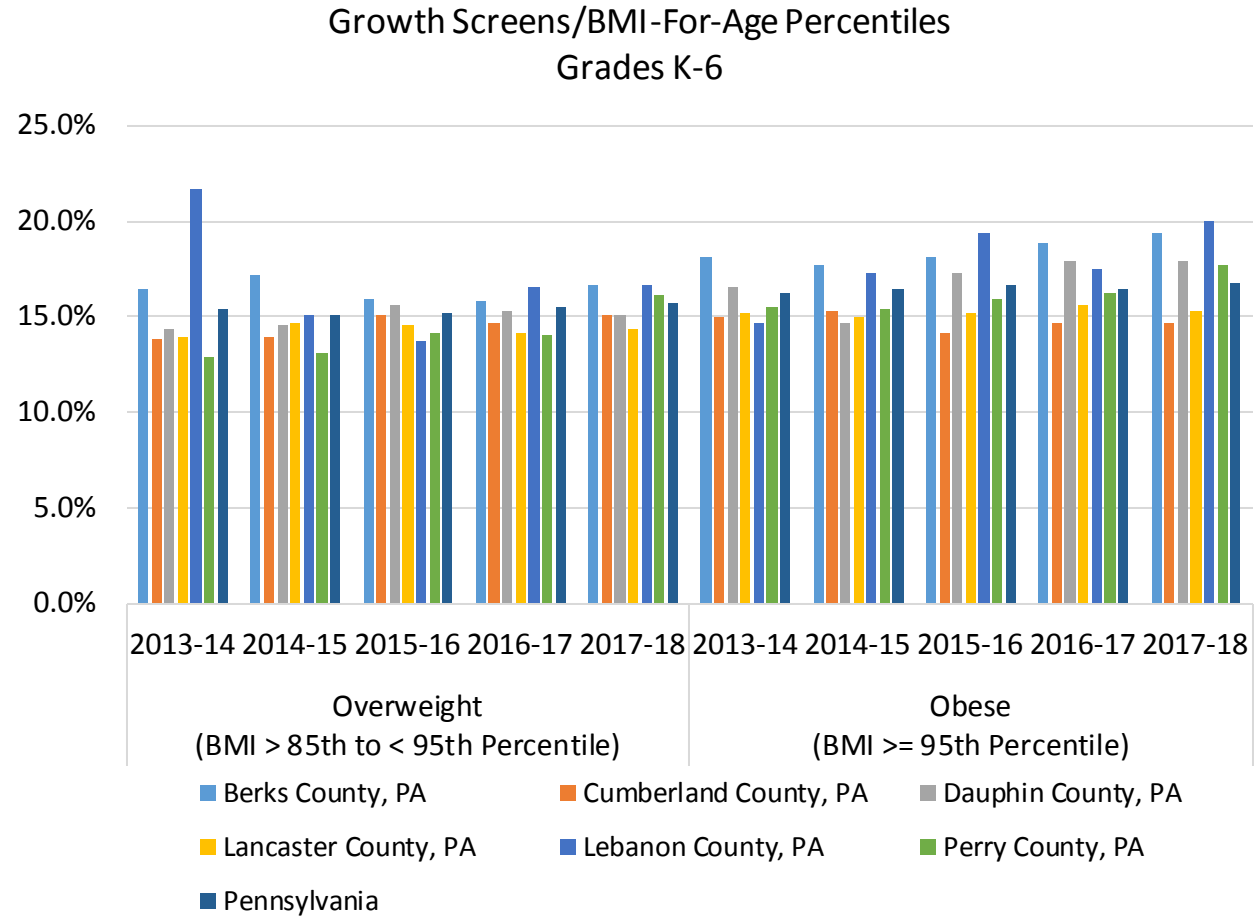
Overweight/Obesity

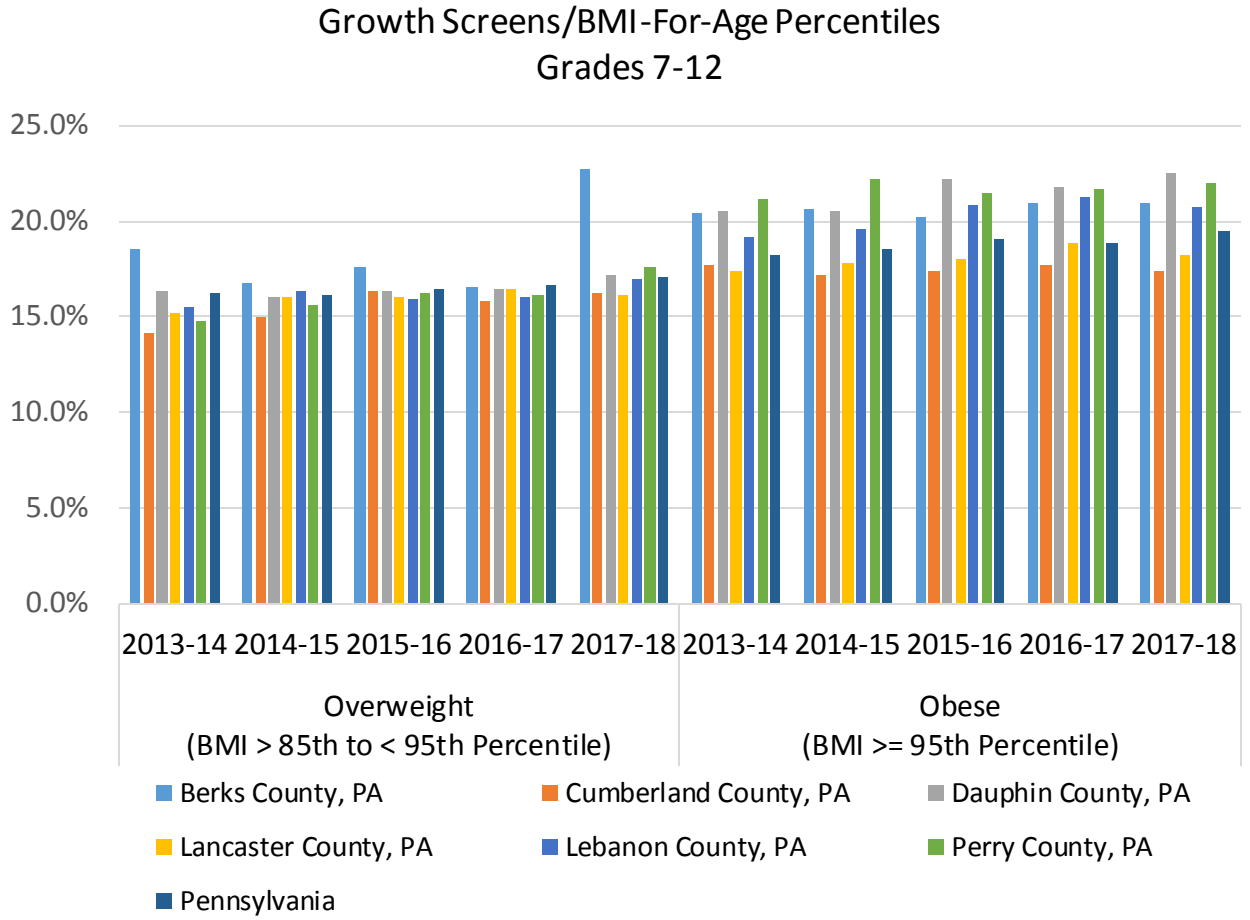
- 44% of CMS respondents reported being told that they're overweight or obese (41% in 2018).

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



Overweight/Obesity Cont.





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

Chronic Conditions

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

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

Chronic Condition Diagnoses by County

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

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

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

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

Chronic Conditions Cont.

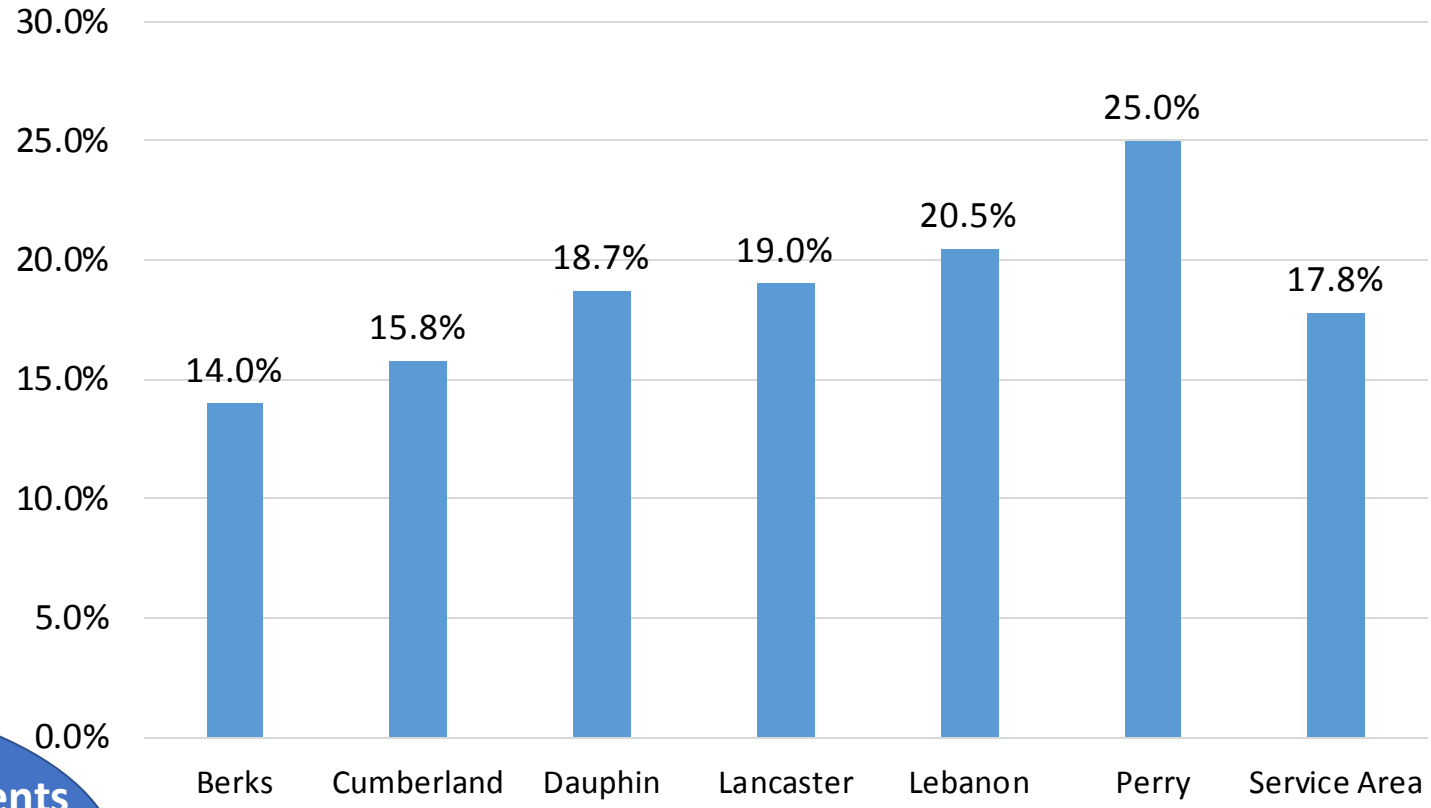
Medicare Beneficiaries with Diabetes, High Cholesterol, High Blood Pressure, and Heart Disease, 2017

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

Cancer

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

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



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

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

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

Cancer Cont.

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

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

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

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

Safety and Housing

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

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

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

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

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

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

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

Safety and Housing Cont.

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

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

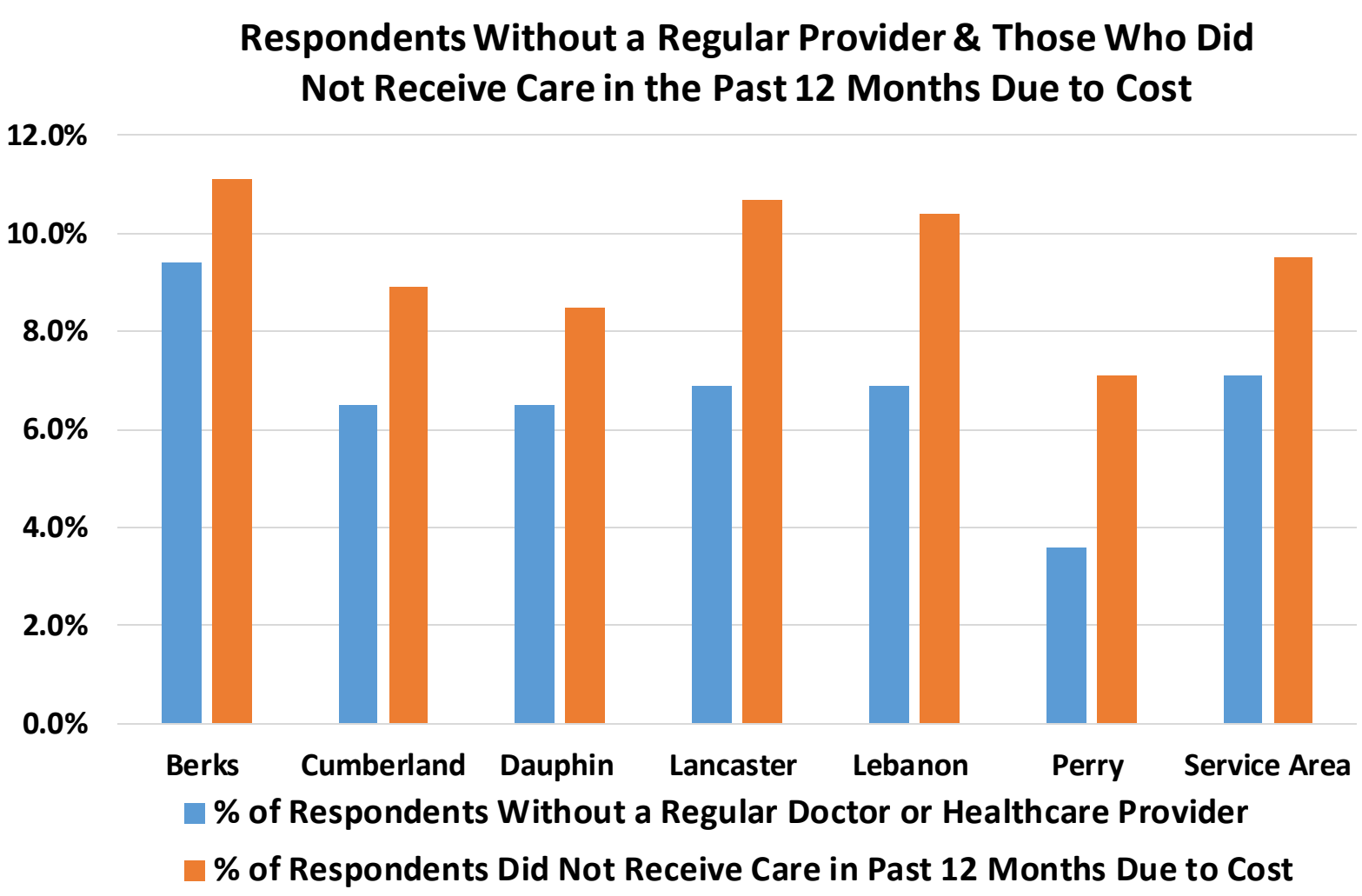
Transportation

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

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

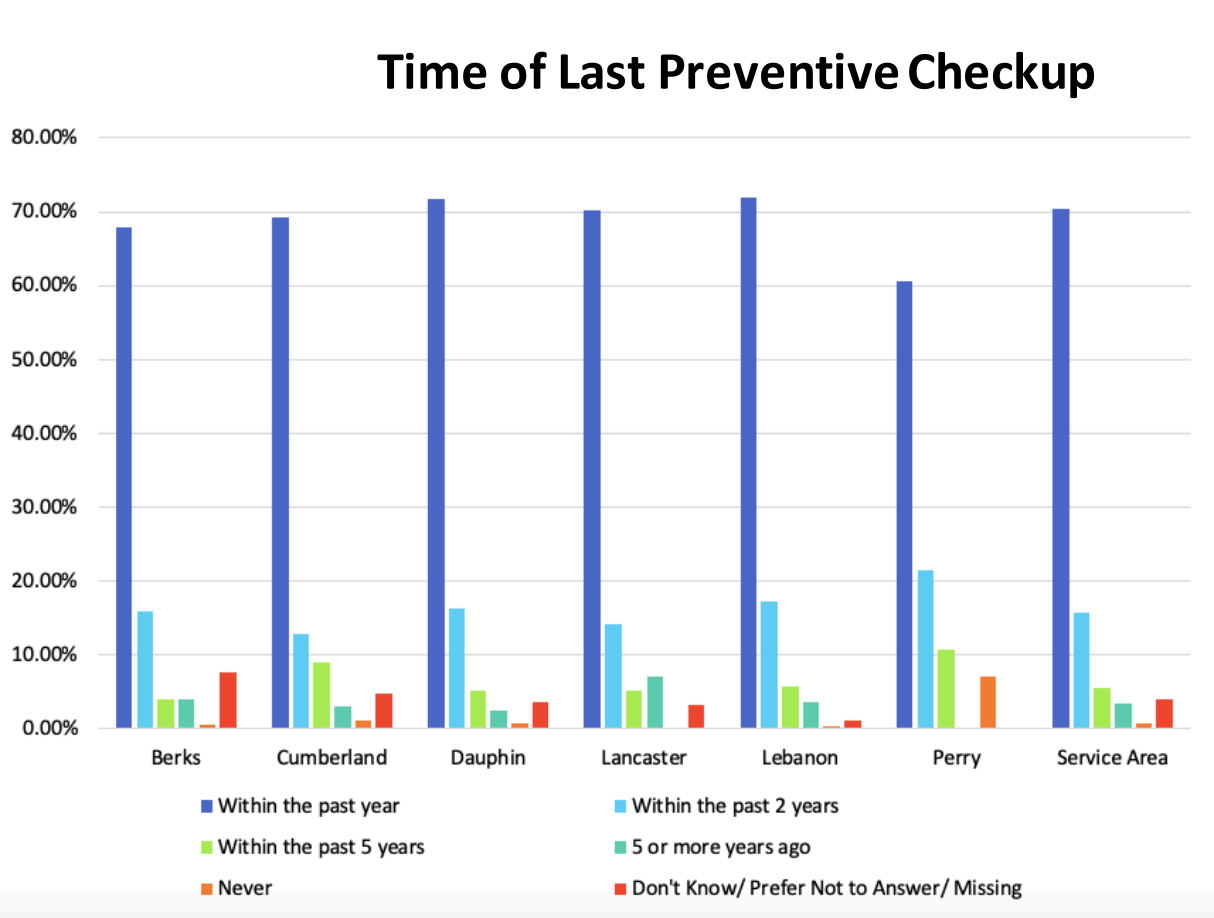
- 1 in 15 respondents indicated that they or their family needed transportation services but were not able to access them.
  - Key Informants listed "lack of transportation to healthcare services" as their number 3 reason as to why individuals with health insurance still do not seek routine care.

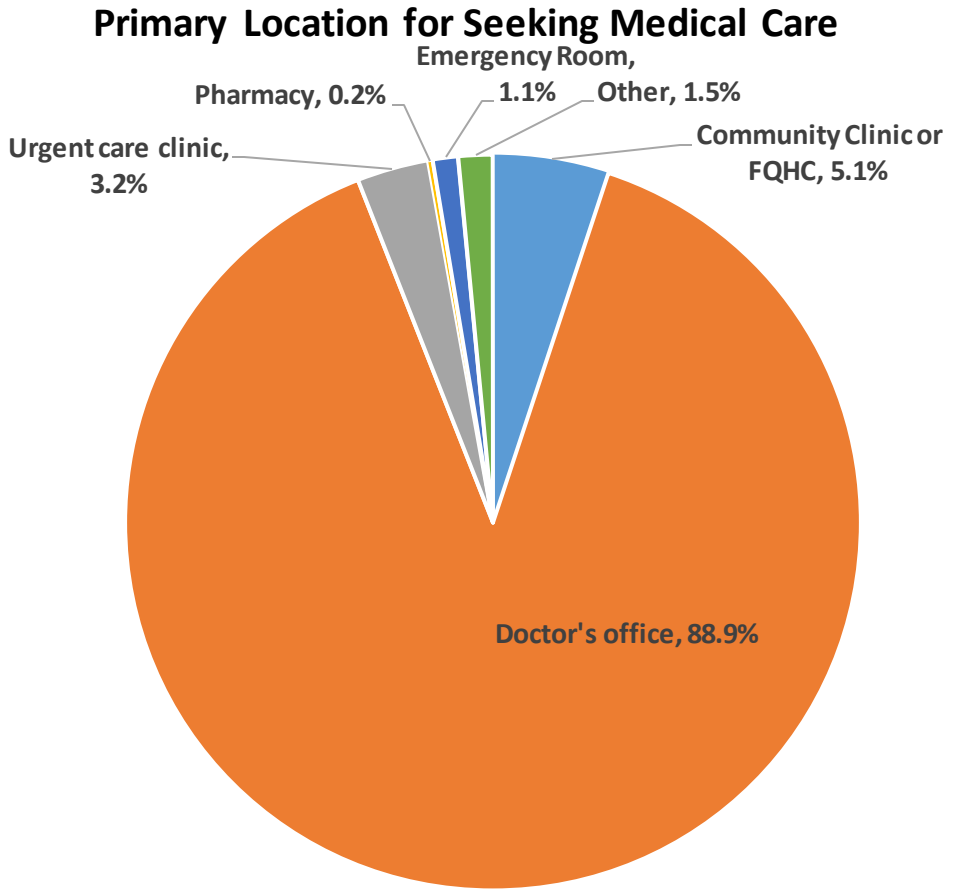
Regular Provider/Routine Care



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

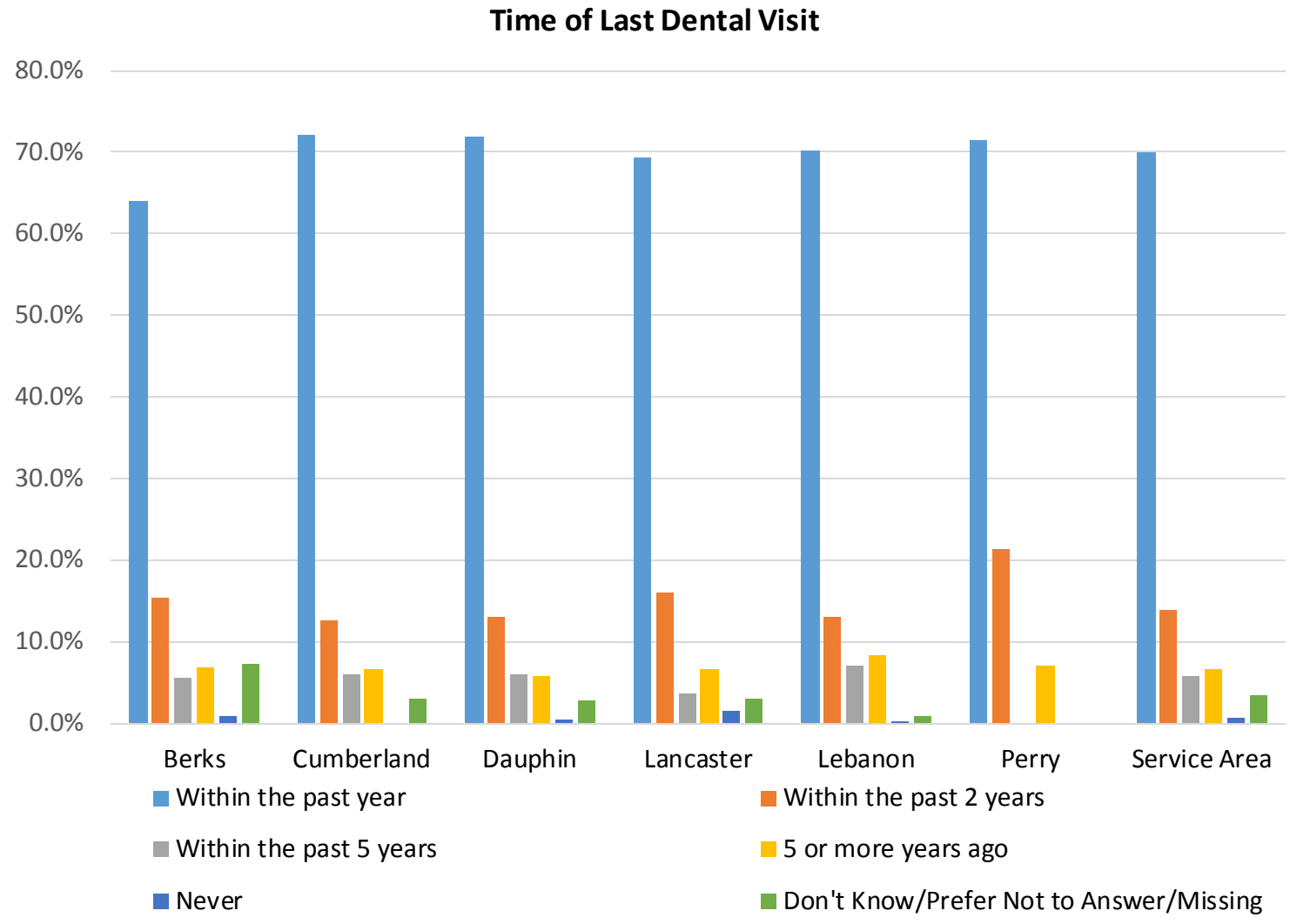
Time and Location of Medical Care

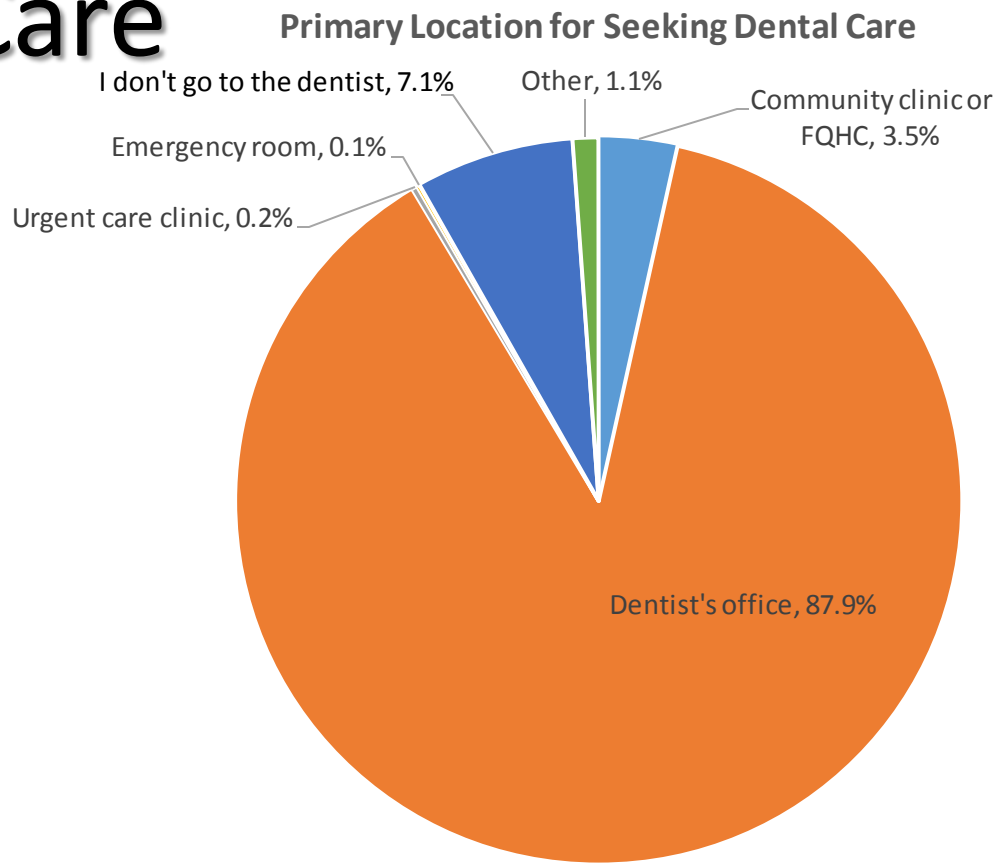




- Within the past year, Lebanon County respondents were the most likely to receive a preventive checkup, while Perry County residents were least likely to receive a preventive checkup.

Time and Location of Dental Care





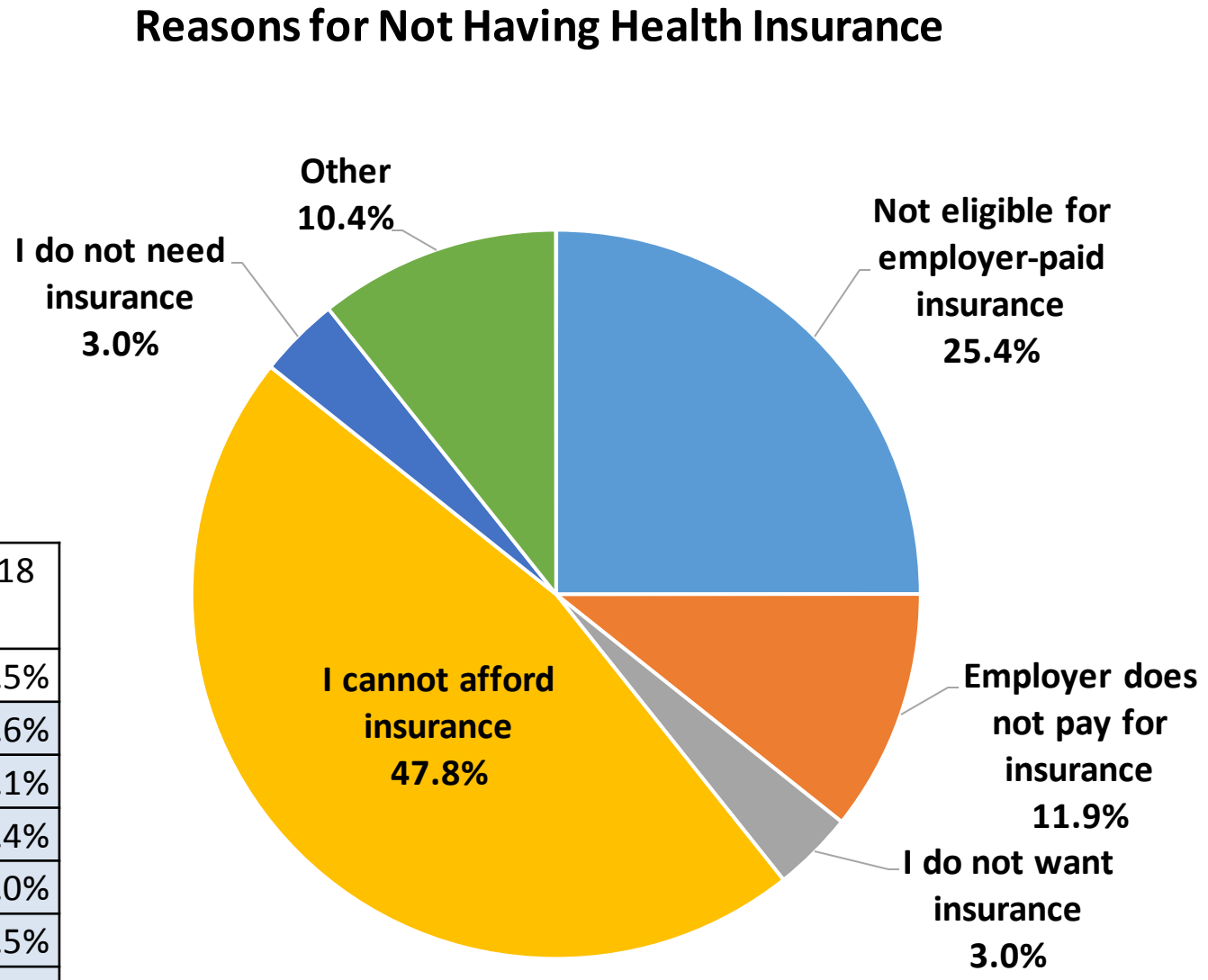
- 1 in 14 respondents indicated that they do not go to the dentist.
- 30% of respondents had not been to the dentist within the past year.

Health Insurance

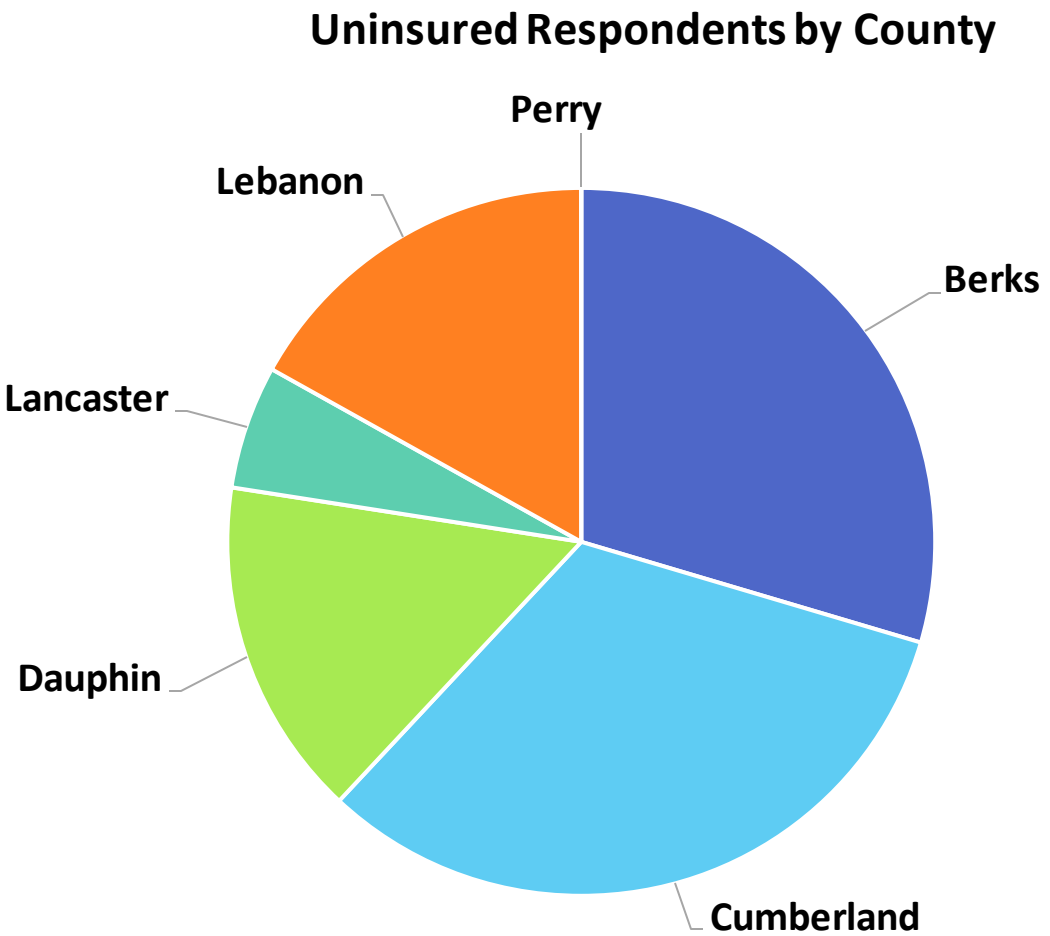
- 97% of respondents reported having some type of health insurance.
- For respondents who are uninsured, almost half indicated that they cannot afford insurance, while one-quarter indicated they are ineligible for employer-paid insurance.

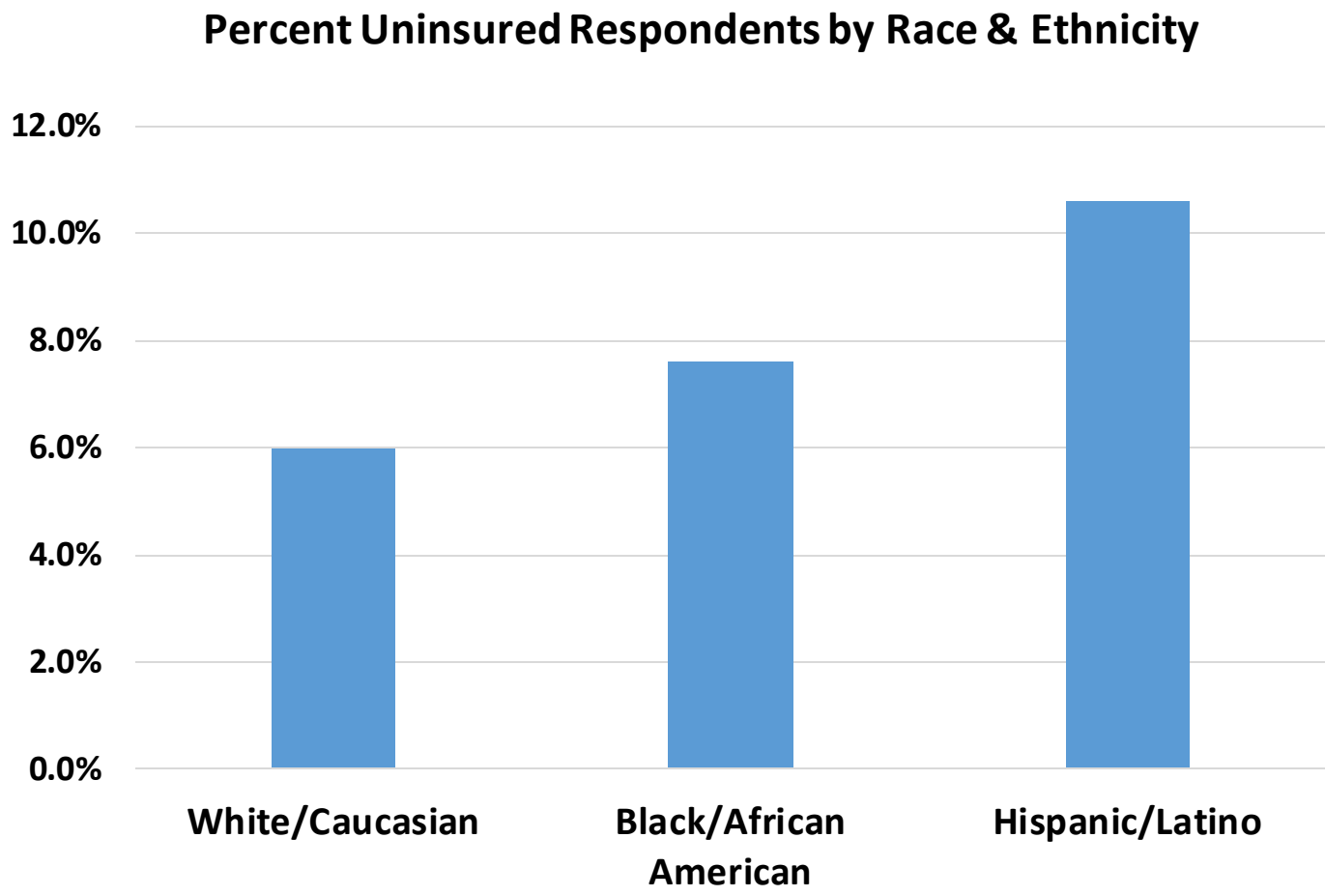
Child Health Insurance – ACS 2015-2019 5-Year Estimates

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



Health Insurance Cont.





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

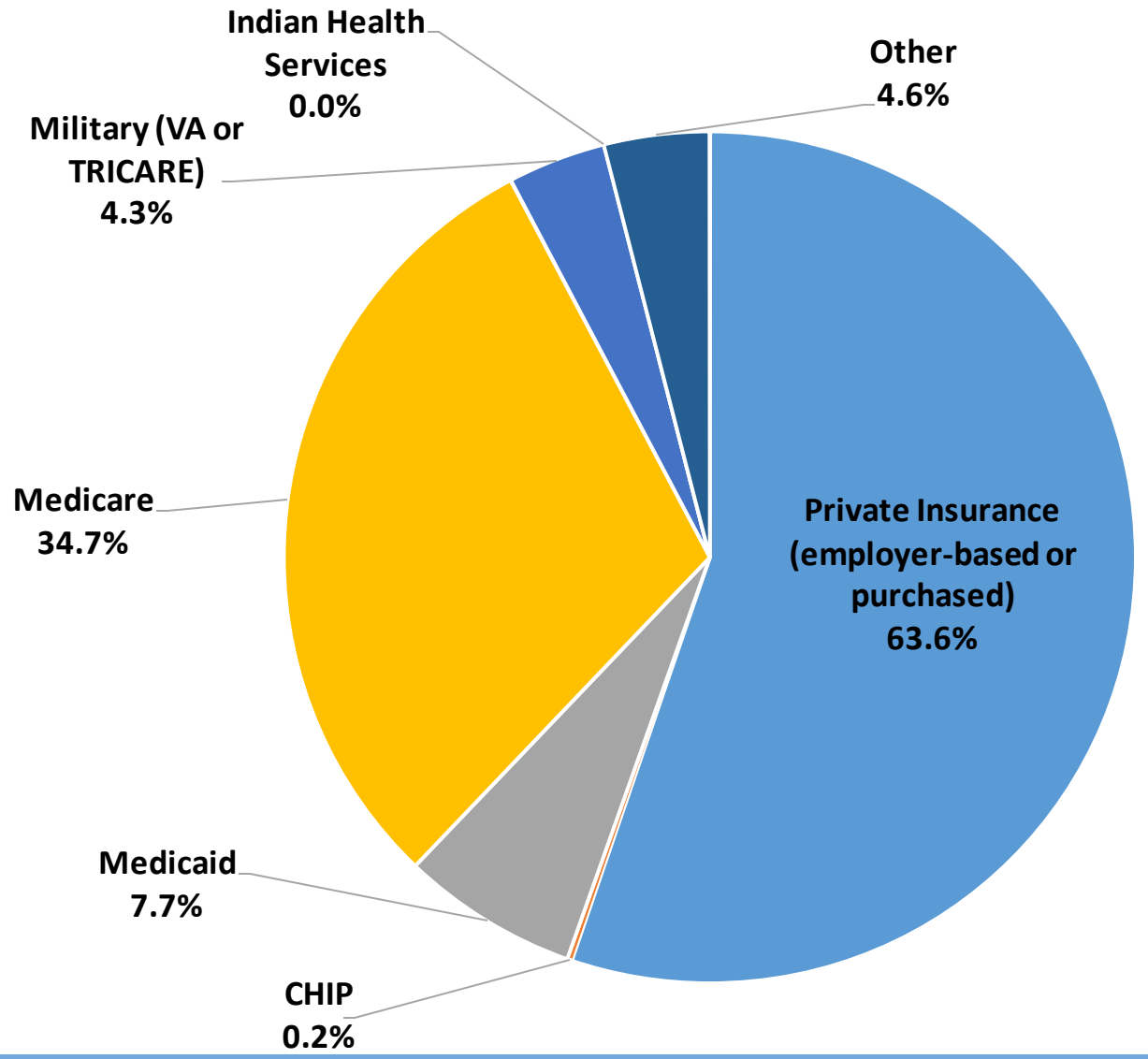
Health Insurance Cont.

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

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

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

Health Insurance Type Among Insured Respondents



KIS – Open-Ended Reasons Not Seeking Care

Questions Regarding Findings?

CHNA@pennstatehealth.psu.edu

Apéndice C: Datos de United Way y de 211 counts sobre principales necesidades de los SDOH en áreas rurales del condado

HMA examinó los **datos de United Way y de 211 counts en PA desglosados por distritos escolares en zonas rurales.**[19]

Los puntos de datos a continuación están basados en 211 solicitudes en total entre septiembre de 2021 y agosto de 2022 de personas en los siguientes distritos escolares rurales:

- Distrito escolar del área de Hamburg
- Distrito escolar del área de Kutztown
- Distrito escolar de Oley Valley
- Distrito escolar del área de Tulpehocken
- Distrito escolar de Twin Valley

Tabla 7: Datos de 211 Counts

PRINCIPALES NECESIDADES DE LOS SDOH EN ÁREAS RURALES		
Área	**% de solicitudes totales**	**Necesidades específicas principales**
#1 – Vivienda	47 %	• Ayuda para el alquiler (39 %) • Refugio (30 %) • Vivienda de bajo costo (20 %)
#2 – Ayuda con los servicios públicos	17 %	• Luz (59 %) • Internet/teléfono (12 %)
#3 – Alimento	7 %	• Despensas (57 %) • Ayuda para comprar comida (23 %)
#4 – Empleo e ingresos	6 %	• Ayuda financiera (71 %) • Búsqueda de trabajo (15 %)

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

Apéndice D: Servicios esenciales de salud pública

Los 10 servicios esenciales de salud pública brindan un marco de trabajo para guiar a los profesionales de la salud pública en su trabajo con el objetivo de promover y proteger estratégicamente la salud de todas las personas en todas las comunidades. Los servicios esenciales de salud pública buscan alcanzar la equidad promoviendo activamente las políticas, sistemas y condiciones comunitarias generales que facilitan la salud óptima para todas las personas que viven en el condado y con miras a retirar obstáculos sistémicos y estructurales. Los 10 servicios esenciales de salud pública buscan abordar obstáculos a la salud óptima tales como pobreza, racismo, discriminación de género, capacitismo y otras formas de opresión. Los 10 servicios esenciales de salud pública se dividen en tres categorías: evaluación, desarrollo de políticas y garantías. La puesta en marcha de estos servicios es cíclica: se evalúa y vigila la salud de la población y se investigan los problemas; luego, se inicia la elaboración de políticas, en la que tienen lugar la comunicación, las asociaciones, la aplicación de políticas y la acción reguladora. Seguido de las garantías en las que se realizan esfuerzos para mejorar y mantener las iniciativas, incluidas la promoción de la diversidad y la equidad, la investigación y la evaluación, la mejora de la calidad y la creación de una infraestructura organizativa sólida. Véase la **figura 16** para más detalles.

Figura 16: 10 servicios esenciales de salud pública[20]

[20] Servicios esenciales de salud pública, https://phnci.org/uploads/resource-files/EPHS-English.pdf

Apéndice E: Métodos y preguntas de los grupos focales

Los grupos focales se llevaron a cabo desde septiembre de 2022 hasta diciembre de 2022. Típicamente organizados como pequeños grupos de hasta 10 participantes, HMA facilitó los grupos focales, los que tuvieron conversaciones semiestructuradas explorando una selección de temas vinculados a los servicios y funciones esenciales de salud pública.

A propósito, los grupos focales buscaron contar con la participación de personas no especializadas y profesionales "más cercanos al terreno" en cuanto a la prestación y recepción de servicios de salud pública. Buscamos opiniones de quienes viven en el condado y de trabajadores de primera línea que prestan servicios médicos y humanos en el condado de Berks. Desarrollamos las categorías de personas encuestadas en los grupos focales en conjunto con el equipo central de planificación de este proyecto.

Como muestra la **tabla 8**, 81 personas participaron en los grupos focales. Mientras que HMA buscó reunir de 6 a 10 participantes por grupo focal, el tamaño final de los grupos focales varió mucho.

Tabla 8: Participantes de los grupos focales por categoría

Categoría de grupos focales	Número de participantes
Adultos hispanos/latinos de comunidades urbanas	15
Personal de respuesta ante emergencias	9
Personas en viviendas de transición o de emergencia	7
Grupo de negocio/empleador	5
Personal de salud escolar	10
Grupo voluntario de entrega de alimentos	5
Personal de CBO	3
Personas que acceden o brindan servicios a personas con discapacidades	11
Adultos mayores de comunidades rurales	11
Personal del centros de salud comunitarios	5
Total	**81**

Nuestro objetivo al formar los grupos focales fue el de entender las percepciones y perspectivas en cuanto a las necesidades de salud pública en el condado de Berks. Las áreas de investigación exploraron cómo los participantes entendieron el estado actual, a la vez de solicitar opiniones sobre las oportunidades y sugerencias para mejorar la calidad y respuesta de servicios de salud pública en el condado. Para alentar la honestidad, nos comprometimos a proteger la confidencialidad de quienes participaron en los grupos focales y a presentar los resultados únicamente en conjunto por temas.

Nuestras preguntas y áreas de investigación se basan en los servicios y funciones esenciales de la salud pública. La tabla 9 presenta la distribución de los temas por grupo focal.

Table 9: Asignación de los grupos focales a los servicios y funciones de salud pública

Participantes de grupos focales	**Servicios y funciones de salud pública** *¿Cómo podemos diseñar una entidad de salud pública para prestar los siguientes servicios y funciones clave?*					
	Evaluar y monitorizar la salud de la población *¿Qué tipo de datos e información se necesita que estén disponibles y ser compartidos ampliamente?*	***Abordar peligros de salud y sus causas principales*** *¿Cómo podríamos abordar las causas principales de enfermedades crónicas y mala salud?*	***Comunicarse para informar y educar*** *¿Cómo impactan las diferencias en alfabetización en materia de salud al acceso y resultados de salud?*	***Movilizar comunidades y colaboraciones*** *¿Cuáles alianzas ofrecen las mejores oportunidades para promover la salud y el bienestar de la comunidad?*	***Permitir acceso equitativo*** *¿Cuáles son los obstáculos clave para tener un acceso más equitativo a la atención médica que se deben abordar y superar?*	***Defender e implementar políticas y leyes*** *¿Qué pueden hacer las organizaciones del condado para fomentar la salud y el bienestar?*
Adultos mayores de comunidades rurales		✓	✓	✓		
Las personas que acceden o brindan servicios a personas con discapacidades	✓		✓	✓	✓	✓
Adultos hispanos/latino que viven en una comunidad de bajos recursos (en español)		✓	✓		✓	
Grupo de negocios/ empleadores	✓		✓	✓		✓
Personas en viviendas de transición o emergencia		✓	✓		✓	
Grupo voluntario de	✓	✓		✓		

entrega de alimentos						
Personal de centros de salud comunitarios	✓		✓		✓	
Personal de CBO	✓	✓	✓	✓		✓
Personal de respuesta ante emergencias		✓	✓	✓	✓	
Personal de salud escolar	✓	✓	✓		✓	

Dos colegas de HMA llevaron a cabo los grupos focales, uno facilitando el grupo focal y el otro tomando notas detalladas. Unos pocos grupos focales se reunieron en persona, pero la mayoría se reunieron virtualmente.

A continuación, se ofrece un resumen de las preguntas que usamos para guiar estas conversaciones.

Abordar peligros a la salud y causas principales: ¿Cómo podríamos abordar las causas principales de enfermedades crónicas y mala salud?

- ¿Qué necesita usted o su comunidad para manejar mejor una vida con enfermedades crónicas (por ejemplo, cáncer, enfermedad cardíaca, diabetes, accidente cerebrovascular, Alzheimer)?
    - Si tuviera los recursos, ¿qué haría para reducir el número de personas que viven con enfermedades crónicas y mala salud?
- ¿Cuáles recursos financieros o comunitarios son necesarios?

Permitir acceso equitativo: ¿Cuáles son los obstáculos principales para tener un acceso más equitativo a la atención médica que deben ser abordados y superados?

- ¿Cuáles son obstáculos que usted ha experimentado personalmente para acceder a la atención médica?
- ¿Cuáles son los obstáculos más comunes que ve en mejorar la salud y el bienestar comunitarios?
    - ¿Cuáles poblaciones tienen más probabilidad de experimentar dificultades? ¿Cuáles grupos necesitan apoyo y asistencia adicionales?
- ¿Qué haría que la atención médica fuera más fácil de acceder para usted/en su comunidad?

Comunicarse para informar y educar: ¿Cómo impactan las diferencias en alfabetización en materia de salud al acceso de salud y sus resultados?

- ¿Qué podría hacer diferente el condado de Berks para mejorar las comunicaciones de salud para su comunidad?
    - ¿Cuáles poblaciones necesitan una estrategia de comunicación diferenciada? ¿Por qué?

    - ¿Cuáles sugerencias tiene sobre cómo dirigir o segmentar la comunicación a estas poblaciones?
- ¿Dónde cree que el condado de Berks (todas las agencias públicas y privadas) debería enfocarse para educar mejor e informar a las personas residentes sobre la salud (alfabetización en materia de salud) de aquí en adelante?
    - ¿Cuáles cambios podrían hacerse a las comunicaciones de salud para mejorar su entendimiento e impacto en su salud?
- [Solo de ser necesario] ¿Hay alguna lección que usted haya aprendido de la pandemia de COVID-19 que ilustre lo que se puede hacer mejor de aquí en adelante?

Evaluar y monitorizar la salud de la población: ¿Qué tipos de datos e información deben estar disponibles y compartirse ampliamente?

Una función clave de la salud pública es usar datos para: a) crear conciencia sobre necesidades de salud específicas; b) sugerir la reasignación de recursos a poblaciones o comunidades específicas; y c) mostrar el progreso a la hora de mitigar o mejorar la salud de la comunidad.

- ¿En qué medida se utilizan los datos de alguna de las formas que se acaban de describir?
- ¿Qué tipos de datos o recursos de información le ayudaría a servir mejor a su comunidad?

Movilizar comunidades y colaboraciones**:** ¿Cuáles alianzas ofrecen las mejores oportunidades para promover la salud y el bienestar de la comunidad?

- ¿Cuáles alianzas comunitarias han ayudado a promover la salud y el bienestar de la comunidad? ¿En su comunidad? ¿Con sus empleados?
- ¿Cuál rol le gustaría ver que sea brindado por agencias del condado de Berks (sin fines de lucro y otras agencias no gubernamentales) para promover la salud y el bienestar?
- ¿Cuáles alianzas comunitarias le gustaría que se mantuvieran y promovieran, tanto si existen actualmente como si es necesario desarrollarlas?

Defender e implementar políticas y leyes: ¿Qué pueden hacer las organizaciones del condado para promover la salud y el bienestar?

- ¿Cómo puede el gobierno del condado de Berks apoyar o promover la salud y el bienestar para su comunidad?
    - ¿Cuáles políticas o leyes apoyarían mejor a la salud comunitaria?
    - ¿Cuáles políticas o leyes podrían reforzar o apoyar el rol de las agencias comunitarias (por ejemplo, las CBO) como proveedoras de servicios e intermediarias mejorando la salud pública?

Apéndice F: Métodos y preguntas para las entrevistas

Llevamos a cabo entrevistas con informantes desde noviembre de 2022 hasta enero de 2023, después de finalizar con la mayoría de los grupos focales elegidos. Las entrevistas se centraron en solicitar la opinión de los líderes comunitarios e institucionales clave que representan a múltiples grupos de partes interesadas. La selección de los entrevistados se basó en las recomendaciones del equipo principal de planificación establecido para este proyecto.

La **tabla 10** muestra que se realizaron un total de 10 entrevistas con informantes, en las que participaron entre una y cuatro personas en cada sesión. Un colega de HMA realizó las entrevistas de manera virtual.

Tabla 10: Entrevistas con los informantes

Categorías de la entrevista	Número de participantes
Organizaciones comunitarias	2
Líderes gubernamentales de ciudades y condados y jefes de agencias	4
Hospitales, atención médica administrada y otros proveedores de atención médica	3
Líderes de los distritos escolares involucrados en la comunicación sobre la salud y familia	1
Total	**10**

Las entrevistas se enfocaron en recopilar perspectivas sobre el nivel de coordinación dentro de los programas y sistemas existentes relacionados con la salud pública. Además, le preguntamos a los entrevistados sobre sus sugerencias y preferencias para rediseñar el ecosistema de salud pública del condado de Berks. Durante las entrevistas, dedicamos tiempo para debatir las futuras oportunidades y los puntos de apoyo para mejorar la colaboración en el área de la salud pública. Para fomentar la confianza, prometimos proteger la confidencialidad de los participantes en las entrevistas y presentar los resultados únicamente en conjunto por temas.

En el caso de los grupos focales, las preguntas de las entrevistas y las áreas de investigación se basaron en los servicios y funciones esenciales de la salud pública. A continuación, se encuentran las preguntas utilizadas para guiar estas entrevistas semiestructuradas.

Abordar los peligros para la salud y las causas principales:
Aprendimos mucho sobre las necesidades de salud del condado de Berks con la ayuda de los grupos focales. Algunos de los temas que escuchamos fueron: la dificultad para encontrar alimentos, falta de vivienda y el aumento de los costos de viviendas. En otras palabras, pudimos aprender sobre los factores determinantes sociales de la salud. También aprendimos que es necesario brindar atención más integrada y holística. Por ejemplo, una atención que trate tanto la salud física como la mental.

- ¿Cómo podría una organización de salud pública del condado ayudar o apoyar el trabajo que está realizando para abordar las necesidades de salud de la comunidad?
    - ¿Existen oportunidades para trabajar en colaboración con campañas o iniciativas específicas relacionadas con la salud pública? ¿Y abordar los factores mencionados previamente, también conocidos como los SDOH?
    - ¿Cómo sería ese apoyo o colaboración? (financiación/subvenciones, recursos, datos, información, educación).
- ¿Cómo podría una organización de salud pública del condado apoyar la integración de la salud física y mental?
    - ¿Tiene alguna sugerencia sobre cómo podría proceder el condado en este aspecto?

Permitir un acceso equitativo:

Actualmente, existe la sensación de que hay muchas personas en el condado de Berks que están atravesando por momentos difíciles cuando se trata de la atención médica y los servicios sociales. Existen disparidades y desigualdades en el sistema. Hemos observado que muchos de ustedes se esfuerzan por llegar a estas personas y ayudarlas, pero a menudo no hay suficiente tiempo, recursos o medios para todos.

- Tomando en cuenta el sistema actual de salud pública del condado de Berks, ¿quiénes son los más afectados?
    - ¿Qué podría hacer una organización de salud pública del condado para aumentar el apoyo a estas personas y comunidades?
- Tomando en cuenta a los pacientes más vulnerables o los que sufren disparidades de salud, ¿cómo podría una organización de salud pública del condado apoyar a estas personas y comunidades?

Movilizar a comunidades y colaboraciones:

Hemos sido informados de la existencia de muchas colaboraciones importantes en el condado de Berks que han sido esenciales para el trabajo de salud pública, especialmente durante la pandemia de COVID-19. Hemos observado el deseo de que estas colaboraciones continúen y se expandan. También nos han comentado que las colaboraciones necesitan más coordinación y coherencia, sobre todo si van a ser reforzadas y apoyadas.

- En el condado de Berks, ¿qué colaboraciones funcionan bien?
    - En su opinión, ¿qué hace que esta colaboración tenga éxito y/o sea duradera?
- Para ampliar la colaboración para el beneficio de la salud pública, ¿quiénes deberían participar de su organización?
    - ¿Cuál es la mejor manera de relacionarse con ellos o llamar su atención?
- ¿Cómo sugiere que organicemos o coordinemos las colaboraciones de salud pública del condado?
    - ¿Cómo se ve colaborando con una organización de salud pública del condado?

Comunicarse para informar y educar:

Muchas personas con las que hemos hablado han dicho que el condado de Berks necesita una estrategia de comunicación unida y enfocada, las personas utilizaron el término "una sola voz". También nos han comentado la necesidad de crear mensajes personalizados para dirigirse mejor a las diferentes poblaciones y comunidades, así como mensajes procedentes de múltiples fuentes (en línea, en persona, a través de proveedores, en la escuela, etc.).

- ¿Sobre qué temas le gustaría que el condado organizara los mensajes?
    - ¿Se trata de mensajes en los que ya está trabajando? (Es decir, que le gustaría que se reforzara) o ¿representan un área que, en su opinión, no se ha abordado lo suficiente?
- ¿Cuál sería el mayor obstáculo a la hora de personalizar los mensajes para las distintas comunidades? (Traducción, fuente, tecnología, formato)
    - ¿Cómo abordaría este tema?
- ¿Qué otras sugerencias tienen para abordar la alfabetización en materia de salud en el condado?
- ¿Cómo podría una organización de salud pública del condado involucrar a su organización en este trabajo?

Evaluar y monitorizar la salud de la población:

En este momento, la mayoría de los datos sobre la salud de la población proceden del estado. Solo hay pocos datos disponibles a nivel del condado. Tras la pandemia de COVID-19, ha quedado claro que los datos a nivel del condado no están disponibles cuando se necesitan. Una organización de salud pública a nivel del condado podría ser capaz de llenar este vacío.

- ¿Qué datos de salud pública del condado de Berks necesita su organización?
    - ¿Qué datos no están presentes? ¿O no están disponibles desglosados? ¿O no se facilitan a tiempo?
- ¿Sería útil disponer de un lugar donde se puedan consultar todos los datos de salud pública del condado de Berks?
    - ¿Qué datos le gustaría que estuviesen disponibles?
    - ¿De dónde procederían estos datos?
    - ¿Qué le permitirían hacer estos datos que no esté haciendo actualmente?

Apéndice G: Resumen de las autoridades legales de Pensilvania

En Pensilvania, los departamentos de salud de un solo condado pueden ser autorizados, por resolución o por referéndum, conforme a la Ley 315. [21] Antes de promulgar una resolución o de presentar la propuesta en unas elecciones, los comisionados de los condados deben solicitar un certificado de aprobación al secretario de salud del estado. Inmediatamente después de la autorización del establecimiento de un departamento de salud de un solo condado (por resolución adoptada o referéndum aprobado), los comisionados del condado deben notificar por escrito al secretario de salud del estado. Los departamentos de salud financiados por la Ley 315 deben ofrecer programas de salud pública en las áreas de servicios administrativos y de apoyo, servicios de salud personal y servicios de salud ambiental. La Ley 315, que otorga una subvención del estado, fue modificada en 1976 por la Ley 12 para brindar apoyo a las iniciativas de salud ambiental, incluyendo, pero no limitada a, la protección de los alimentos y el suministro de agua, el control de la contaminación del agua, la salubridad de los lugares de baño público, el control de vectores, la gestión de residuos sólidos y la inspección del entorno institucional, recreativo y de la vivienda.

Cada departamento de salud del condado/municipio (CMHD, por sus siglas en inglés) tiene una junta de salud que designa a un director. Los comisionados del condado nombran a cinco ciudadanos residentes para la junta, incluidos dos médicos con licencia para ejercer en Pensilvania, los cuales deben prestar servicio sin remuneración. El director de salud es responsable de la administración del departamento de salud del condado/municipio y tiene otros poderes enumerados. Las funciones del CMHD son muy similares a las del Departamento de Salud de Pensilvania (DOH, por sus siglas en inglés). Según el código, los departamentos de salud del condado/municipio deben prestar servicios administrativos, de salud personal y de salud ambiental. Estos servicios se describen en el Código de Pensilvania: título 28: capítulo 15. El capítulo 17 incluye más detalles sobre los servicios de salud ambiental y el capítulo 13 describe la administración del personal. Los departamentos de salud del condado/municipio (CMHD) prestan estos servicios a través de programas exhaustivos de detección de enfermedades, vigilancia e investigación de brotes, así como de programas ambientales.

Generalmente, la jurisdicción del CMHD se limita a los límites geopolíticos de la entidad que forma el departamento, concretamente, el condado de Berks. Un municipio puede quedar exento de la jurisdicción del departamento de salud del condado/municipio si: (1) tenía su propio departamento o junta de salud en el momento en que se creó el departamento de salud del condado/municipio, 2) el DOH lo aprueba, y 3) el municipio exento no ha optado, mediante ordenanza, por quedar sujeto a la jurisdicción del departamento de salud del condado/municipio. La estructura específica de cada autoridad de salud local se determina por los reglamentos y ordenanzas locales.

Fondos suplementarios de la Ley 12

[21] https://www.health.pa.gov/topics/Documents/Administrative/County%20Muni%20HD%20ACT315.pdf

La ley 12 establece un conjunto de expectativas complementarias que de cierta manera se superponen, (normas para los servicios de salud ambiental) para un CMHD. Y el estado pagará una subvención anual adicional a través de la Ley 12 para los servicios ambientales que incluyen, pero no se limitan a:

- Control de la contaminación acústica y del aire
- Inspección de restaurantes y ventas mayoristas de alimentos
- Control de roedores y de vectores
- Inspección de aguas y alcantarillado
- Cumplimiento de las normas de vivienda
- Otros servicios similares además de otras subvenciones de salud local para servicios de salud pública.

Código de PA, capítulo 13: administración de personal en los departamentos de salud del condado [22]

El director de salud del condado ejerce el poder conferido por el departamento de salud del condado para emplear personal, aunque la junta de salud del condado no nombrará a un director de salud del condado hasta que el departamento certifique primero que el candidato postulado posee las cualificaciones mínimas requeridas establecidas en el plan de clasificación del puesto. Como condado de tercera clase, el condado de Berks también necesitará un oficial de salud que deberá ser un médico con licencia para ejercer la medicina o la osteopatía, o elegible para la licencia mencionada, en el estado. No es necesario que la persona que ocupe el cargo de director de salud y de oficial de salud sea la misma persona. A la hora de contratar personal para el CMHD, se dará preferencia al personal profesional y técnico contratado por los departamentos o juntas de salud municipales, en caso de que se hayan disuelto y al personal profesional y técnico contratado por el DOH cuyos puestos en el condado o condados en los que presta servicios el departamento de salud del condado puedan haber finalizado como consecuencia de la instauración de un CMHD.

Código de PA, capítulo 15: asistencia estatal al departamento de salud local [23]

Las solicitudes del CMHD para las subvenciones del estado deben presentarse en un plazo de 30 días una vez aprobado el presupuesto del departamento de salud local. La solicitud inicial debe incluir una declaración que describa las funciones de las subdivisiones del CMHD. Las solicitudes posteriores solo deben describir los cambios en las funciones. Cada solicitud debe contener toda la información que se indica a continuación:

1) Un presupuesto detallado de los gastos propuestos para los programas de salud pública

[22] Código y Boletín de Pensilvania, capítulo 13, http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter13/chap13toc.html&d=reduce

[23] Código y Boletín de Pensilvania, capítulo 15, http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter15/chap15toc.html&d=reduce

2) Las subdivisiones del departamento local de salud (pueden incorporarse al presupuesto)
3) Título, salario anual e importe de cada puesto (puede incorporarse al presupuesto)
4) Los montos asignados a gastos de equipamiento, vehículos, alquileres, viaje y otros (pueden incorporarse al presupuesto)
5) Una estimación de los ingresos previstos
6) Copias de las resoluciones pertinentes
7) Copias de los contratos pertinentes de los servicios a prestar
8) Un plan del programa que indique los objetivos medibles de cada programa financiado y los criterios de evaluación que se utilizarán para medir los resultados
9) Un resumen presupuestario completado en un formulario prescrito por el departamento. Este formulario se utilizará también como resumen de gastos para acompañar la declaración certificada de gastos de final de año

El capítulo 15 describe los requisitos para los departamentos de salud del condado en tres áreas: (1) servicios administrativos y de apoyo, (2) servicios de salud personal y (3) servicios de salud ambiental. Estas áreas comprenden los siguientes programas generales que un departamento de salud del condado de Berks estaría obligado a proporcionar:

1. Los servicios administrativos y de apoyo incluyen, pero no se limitan a: administración y dirección de programas; presupuesto; contabilidad; administración de personal, incluyendo la supervisión del sistema de méritos; educación en materia de salud pública, estadísticas de salud pública, servicios de laboratorio de salud pública. El personal administrativo deberá incluir un director y el personal profesional, técnico y administrativo que sea necesario.

2. Los servicios de salud personal incluyen, pero no se limitan a: enfermedades crónicas; control de enfermedades transmisibles, incluyendo el control de la tuberculosis y de las enfermedades venéreas; servicios de salud materna e infantil; y servicios de enfermería de salud pública.

3. Los servicios de salud ambiental incluyen, pero no se limitan a: protección alimentaria, suministro de agua, control de la contaminación del agua, lugares de baño, control de vectores, residuos sólidos, ambiente institucional, ambiente recreativo y ambiente de la vivienda.

Personal

Cada departamento de salud local está administrado por un director a tiempo completo. El director debe ser un médico con mínimo de 2 años de experiencia administrativa o de supervisión en el campo de la salud pública, con licencia para ejercer la medicina o la osteopatía en este estado, o sea elegible para obtener la licencia en el plazo de 1 año a partir de su nombramiento, o, si no es médico, una persona con al menos 4 años de experiencia administrativa o de supervisión en el campo de la salud pública complementada con una maestría en salud pública, administración hospitalaria, administración pública o una disciplina relacionada. El CMHD debe emplear al menos a un médico a tiempo completo, que puede, pero no está obligado a ser el director del departamento de salud local. El CMHD también debe emplear a

un director de enfermería de salud pública y a un director de servicios de salud ambiental que trabajen bajo la supervisión del director del CMHD.

Código de PA, capítulo 17: normas para los servicios de salud ambiental [24]

Este capítulo va dirigido a todos los departamentos de salud locales que reciben subvenciones del estado en virtud de la ley y establece las normas mínimas de rendimiento para esos departamentos en los programas obligatorios en el ámbito de los servicios de salud ambiental. El CMHD es responsable de llevar a cabo evaluaciones de los programas ambientales que realizan y de informar puntualmente los resultados de estas evaluaciones al secretario. Estas regulaciones describen las actividades mínimas del programa, la capacitación y los procedimientos de evaluación para el control de vectores, de la contaminación del agua y la gestión de residuos sólidos

Código de PA, capítulo 27: enfermedades transmisibles y no transmisibles [25]

Este capítulo describe las responsabilidades de un CMHD y del departamento de salud cuando se trata de enfermedades transmisibles y no transmisibles. El capítulo 27 delimita la autoridad de un departamento de salud local para establecer cuarentena o aislamiento, incluida la vigilancia, la separación, la cuarentena o la cuarentena modificada de una persona o un animal con una enfermedad o infección transmisible. Otras medidas de control de enfermedades también pueden ser consideradas si el CMHD opina que son apropiadas para la vigilancia de enfermedades, cuando la medida de control de enfermedades es necesaria para proteger al público de la propagación de agentes infecciosos. La autoridad de salud local determinará la medida de control de la enfermedad adecuada en función de la enfermedad o infección, las circunstancias del paciente, el tipo de centro disponible y cualquier otra información disponible relacionada con el paciente y la enfermedad o infección. La autoridad de salud local podrá investigar cualquier caso o brote de enfermedad que considere una amenaza potencial para la salud pública, incluida la revisión confidencial de los historiales médicos.

Cumplimiento progresivo de la Ley 315

La regulación estatal puede distinguir cuando se crea un CMHD y cuando se establece un CMHD. Para crear un CMHD es necesario solicitar un certificado de aprobación al secretario de salud y un referéndum/resolución local. Una vez que se crea un CMHD, los comisionados del condado deben trabajar para cumplir con las regulaciones de la Ley 315.

Los comisionados del condado deben crear una junta de salud.

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[24] Código y Boletín de Pensilvania, capítulo 17, http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter17/chap17toc.html&d=reduce

[25] Código y Boletín de Pensilvania, capítulo 27, http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter27/chap27toc.html&d=reduce

- Los comisionados del condado nombrarán a cinco ciudadanos residentes, dos de los cuales deberán ser médicos con licencia para ejercer en Pensilvania.
- En la reunión de la organización se elegirá un presidente por un periodo de un año
- Se debe nombrar un director de salud
- El director de salud será el secretario de la junta, pero no será un miembro.
- Los miembros de la junta ejercerán sus funciones sin compensación,

Los requisitos administrativos incluyen:

- Plan anual de los programas y
- Requisitos del sistema de méritos para la administración de personal.

El secretario de salud del estado determina cuando un departamento de salud de condado propuesto está preparado para ejercer sus poderes y obligaciones. Esa determinación solo se realiza cuando (1) se han asignado fondos locales, (2) se ha completado la organización del departamento de salud del condado, (3) se ha contratado personal de acuerdo con la regulación del departamento de salud del estado, (4) se han obtenido las instalaciones y el equipo necesarios y (5) la junta de salud ha preparado las normas y reglamentos necesarios en la medida en que el departamento de salud del condado podrá lograr los propósitos de esta ley. Luego es secretario remite un certificado de su decisión a los comisionados del condado. Treinta (30) días después de que los comisionados del condado hayan notificado a los ejecutivos de todos los municipios del condado de Berks, el departamento de salud del condado se considerará como establecido y comenzará a ejercer sus poderes y obligaciones.

Los comisionados del condado presentan al secretario de salud del estado, en los formularios prescritos por el DOH, una estimación inicial de los gastos para cubrir el funcionamiento del departamento de salud del condado desde la fecha de su creación hasta el final del año natural en el que se establece. La estimación inicial de gastos deberá indicar los nombres de los municipios exentos que no hayan decidido quedar sujetos a la jurisdicción del departamento de salud del condado. La estimación deberá presentarse dentro de los treinta (30) días anteriores a la fecha de establecimiento.

Ningún departamento de salud del condado comenzará a recibir subvenciones anuales hasta el año natural después de su creación.

Apéndice H: Ejemplo de descripción del puesto de director de salud [26]

EJEMPLO #1

Descripción ilustrativa del puesto de director de salud pública

Es responsable de supervisar los programas y actividades de salud pública en un condado. Esto incluye el desarrollo y la implementación de políticas de salud pública, la organización y realización de encuestas de salud pública y la educación en materia de salud pública.

Es responsable de mantener la salud y el bienestar de la comunidad proporcionando liderazgo y dirección en el campo de la salud pública. Trabaja con otros miembros de la comunidad para identificar y prevenir problemas de salud y promover estilos de vida saludables. Las responsabilidades del oficial de salud pública incluyen garantizar que las comunidades tengan acceso a alimentos, agua y aire saludables; desarrollar y aplicar políticas de salud pública y prestar servicios de salud pública.

El trabajo del oficial de salud pública consiste en proteger la salud pública mediante la vigilancia y la promoción de la salud y la seguridad, la detección y prevención de brotes y la promoción de la educación en salud pública.

Destrezas, conocimientos y aptitudes

- Título de educación superior en salud pública o un campo relacionado.
- Comprensión de la política de la salud, cómo se elabora e implementa.
- Comprensión de los determinantes sociales, económicos y políticos de la salud.
- Capacidad para trabajar con personas de diferentes culturas y orígenes.
- Buena organización y destrezas para resolver problemas.
- Capacidad para utilizar datos y pruebas en la toma de decisiones.
- Buenas destrezas de gestión de proyectos e investigación.
- Capacidad de pensamiento crítico y creativo.

EJEMPLO #2

El Departamento de Salud del condado de Prince George busca un ejecutivo con visión a futuro para dirigir sus programas de salud pública que afectan al condado, que incluyen salud del comportamiento, salud ambiental, prevención y control de enfermedades transmisibles, servicios de salud familiar y salud y bienestar. La persona seleccionada se desempeñará como oficial de salud del condado bajo la autoridad del Departamento de Salud de Maryland y del ejecutivo del condado de Prince George.

El Departamento de Salud del condado de Prince George es un departamento de salud local completo con un personal de más de 500 empleados y un presupuesto anual de aproximadamente $75 millones. Este puesto es ideal para un profesional de la salud motivado, altamente competitivo y con deseo de desempeñar un papel clave y tener un gran impacto en una comunidad dinámica. El oficial de salud

[26]Descripción del puesto de oficial de salud pública, https://www.leadlake.com/post/public-health-officer-job-description-duty-skill-requirement-tips/

asesorará y/o consultará al ejecutivo del condado, a la junta del condado de Prince George y al Departamento de Salud del estado. El oficial de salud desempeñará un papel fundamental en la protección y mejora de la salud del condado de Prince George y en el posicionamiento del condado como uno de los lugares más saludables para vivir en los Estados Unidos.

El oficial de salud es responsable de la formulación, desarrollo y ejecución de programas de salud pública que reflejen las necesidades estatales y locales y de la aplicación y/o cumplimiento de las leyes y reglamentos estatales apropiados del secretario del Departamento de Salud de Maryland y del condado de Prince George.

Entre las funciones esenciales del puesto y las tareas asignadas se incluyen las siguientes:

Se encarga de administrar los programas de salud pública del condado de Prince George, incluyendo la gestión del personal, los fondos, las instalaciones y todos los activos del departamento. Administrar el presupuesto operativo del departamento, de casi $75.000.000, compuesto por la financiación básica de salud pública; las subvenciones del condado, federales y estatales; y los ingresos derivados de la recaudación de tarifas. Reasignar los recursos presupuestarios y departamentales dentro del departamento para maximizar el rendimiento del servicio.

Es responsable del desarrollo, la promoción y la gestión de programas de salud pública para el condado de Prince George, incluyendo la evaluación de las necesidades de la comunidad y la iniciación de nuevos programas según se considere necesario para cumplir los objetivos estatales y del condado para lograr tener una población saludable. Además, se encarga de supervisar desde el punto de vista clínico los programas de salud pública del departamento.

Hace cumplir las leyes, normas y regulaciones federales, estatales y del condado para proteger la salud pública y la seguridad de la población, incluidas las normas de salud ambiental. Ejecuta las políticas y los procedimientos establecidos por el estado y el condado en lo que respecta a los asuntos relacionados con la salud que son aplicables al condado de Prince George. Dirige el desarrollo y la revisión de las políticas y procedimientos del departamento de acuerdo con estas normas y regulaciones.

Coordina o combina los recursos de instituciones de salud, organizaciones de servicios sociales, personal de seguridad pública u otros organismos para mejorar la salud de la comunidad.

Propone leyes, normas y regulaciones federales, estatales y del condado relacionadas con la administración de los servicios de salud. Presenta testimonio ante la legislatura estatal y la junta del condado, según corresponda, en relación con la legislación nueva o modificada que afecte al departamento.

Diseña o utiliza herramientas de seguimiento, como pruebas de detección, registros de laboratorio e información vital, para identificar los riesgos para la salud.

Desarrolla herramientas para abordar las causas conductuales de las enfermedades.

Decide el mantenimiento, la ampliación o la eliminación de servicios de programas y otros recursos departamentales.

Integra los planes, actividades, y se encarga de la contratación de personal de las divisiones y programas del departamento.