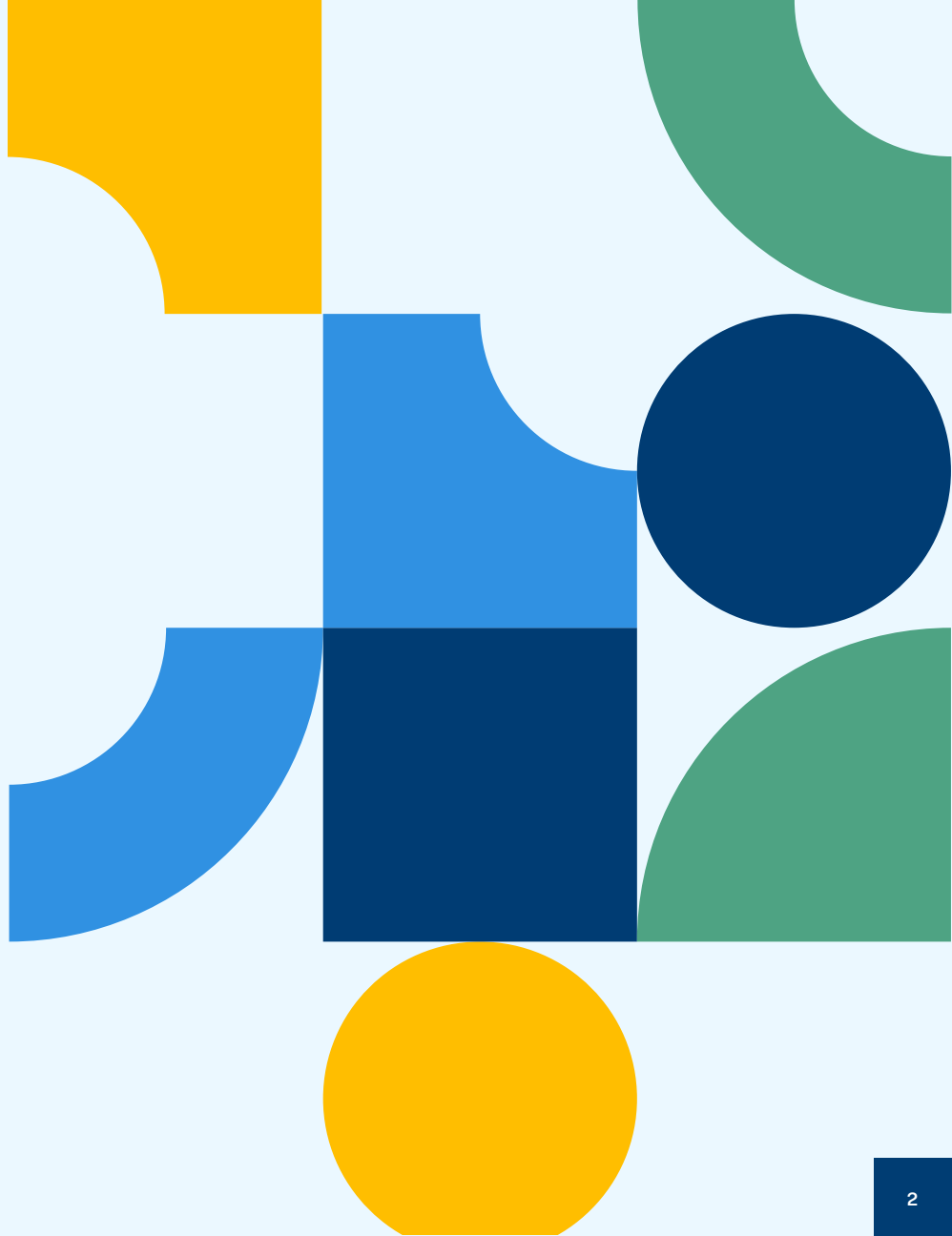
WellSpan Health

Building Healthier Communities

2025 Community Health Improvement Plan

Helping communities live longer, healthier lives.

WellSpan Medical Group
Chambersburg Hospital
Ephrata Community Hospital
Gettysburg Hospital
Good Samaritan Hospital
Philhaven
Surgery & Rehabilitation Hospital
VNA Home Care
Waynesboro Hospital
York Hospital



Contents

Introduction

WellSpan aims to be a trusted partner, reimagining healthcare and inspiring health. These principles guide our journey forward.

WellSpan is making incredible strides in advancing health and strengthening our communities. Our mission has always been clear: to enhance the well-being of every individual we serve, not just through exceptional medical care, but also through holistic support that ensures our communities can thrive. As a regional leader in high-quality care, and a mission-driven integrated health system, our team is dedicated to delivering exceptional care for all — one patient, one community, one unique health care need at a time. From supporting lifelong wellness to providing nationally recognized, advanced specialty care, to being a deeply committed community partner, we are focused on improving health across central Pennsylvania and northern Maryland.

WellSpan strives to not only take care of people when they are ill, but also to help them stay healthy. This approach means addressing health factors beyond the walls of our facilities and embracing a model of community health focused on non-medical factors.

We know we can't do this alone. That's why we work with our friends and neighbors throughout the region to identify community health needs and address them.

The 2025 Community Health Needs Assessment (CHNA) leveraged a multidimensional data collection approach to understand the most pressing needs in the community. Building on WellSpan's relentless pursuit of finding better ways to serve our communities, we are ready to put our learnings into action. Within this Community Health Improvement Plan (CHIP), we outline how we will act on the identified needs. In partnership with you, WellSpan can improve health through exceptional care for all, lifelong wellness and healthy communities.

The 2025 CHNA was conducted from the fall of 2024 to the spring of 2025. It captured ongoing health trends, while also exploring the complexities of our ever-changing communities. The Center for Opinion Research at Franklin & Marshall College in Lancaster, Penna., served as WellSpan's consultant in this work and prepared the findings. Previous CHIPs and CHNAs can be found online.

WellSpan's CHIP

Reinforces our commitment to being a trusted partner who uses diverse opinions and data sources to understand the complex health needs of our region, especially those within the WellSpan service area.

Uses health data and insights from thousands of community members in meaningful ways to reimagine health care.

Places intentional focus on reducing identified health variances and improving life expectancy within our communities. This focus includes emphasis on reducing premature death, improving the region's longevity and enhancing the quality of life for our community.

CHIP Framework

Life Expectancy

This framework serves as the foundation of WellSpan's commitment to creating impact that leads to longer, healthier lives. WellSpan's CHIP directly contributes to improving longevity, enhancing quality of life and reducing premature death of patients and community members.

Mission

Working as one to improve health through exceptional care for all, lifelong wellness and healthy communities

Objectives

Be a catalyst and leader in Care For All — collaborating with community partners to address the social, demographic, behavioral and economic/poverty issues facing our neighbors and communities, to positively impact health community indicators and to reshape our care models to understand and develop interventions to support cultural, social and behavioral issues that impact health.

Maintain and fulfill WellSpan's mission as a charitable, nonprofit organization by providing care for all, regardless of ability to pay; sponsoring services which are difficult to sustain financially, but necessary to the health and well-being of the community; and identifying unmet community health needs and developing approaches to meet them.

Care For All

Deliver on exceptional care that is accessible and affordable for all by identifying and reducing barriers to care.

FY26- FY29 Priorities

Maintain and expand strong safety net of services and programs which address access and financial barriers to care.

Transform healthcare by ensuring high-quality care is provided while balancing cost and quality simultaneously.

Leverage previous learnings to close gaps in preventive care and screenings, improve access to healthcare close to home and create personalized health experiences through exceptional care.

Children's Health

Lead the region in addressing the physical, emotional, intellectual and developmental needs of children.

FY26- FY29 Priorities

Expand the multidisciplinary Spotlight on Children's Health efforts to address identified community needs.

Reduce children's exposure to lead through universal lead testing and community collaboration.

Build on community partnerships addressing early childhood education, vaccination and management of children's health needs.

Non-Medical Factors

Collaborate with community-based organizations to impact the non-medical factors that influence the health of our patients and community.

FY26- FY29 Priorities

Advance navigation and support between our care teams and community programs.

Address housing, food and transportation barriers as system-wide health issues through community grant investment, partnership collaboration, and program development and expansion.

Leverage patient data to enhance understanding the non-medical factors influencing health as well as the impact of programs and investments WellSpan has made.

Physical Environment

Promote a healthier community by enhancing environmental sustainability efforts and building community infrastructure to support health.

FY26- FY29 Priorities

Enhance utilization of sustainable health care practices that reduce greenhouse gas emissions.

Build on understanding of the local health impacts of poor air quality and pollution and identify opportunities for improvement.

Invest in community infrastructure and partnership which fosters economic development and enhances the wellness of the community.

Chronic Disease

Improve the health and well-being of the community through strategies that promote health behaviors, support personal well-being and prioritize the management of chronic diseases.

FY26- FY29 Priorities

Foster an environment that focuses on routine care and prevention, disease management, healthy lifestyles and health education.

Promote well-being among WellSpan team members and throughout the community by making it easier to recognize and get support for mental health issues.

Continue and expand ongoing efforts to address substance misuse, while maintaining pulse on emerging trends and innovative opportunities.

Infrastructure for Improving Community Health

Infrastructure Priorities

- Develop strong community partnerships
- Serve as voice for change through policy and advocacy
- Leverage data to monitor community impact
- Evolve learning on root cause issues and strategies to build healthy communities
- Advance 2030 strategic plan including Build: Vibrant Communities pillar

Organizational Engagement & Shared Responsibility

- WellSpan Board of Directors
- WellSpan Leadership Teams
- WellSpan Community Health & Engagement
- Local, County-Based Health Coalitions
- Subject Matter Experts and Service Line Leaders

Ongoing Needs Assessment

- Community Health Survey (3 years)
- Interim data assessments
- Ongoing data monitoring
- Focus groups, listening sessions, key informant interviews

Reporting and Accountability

- Community Benefit Report
- 2030 WellSpan Strategic Plan
- Departmental Annual Plans

Our Data Process

CHNA Methodology

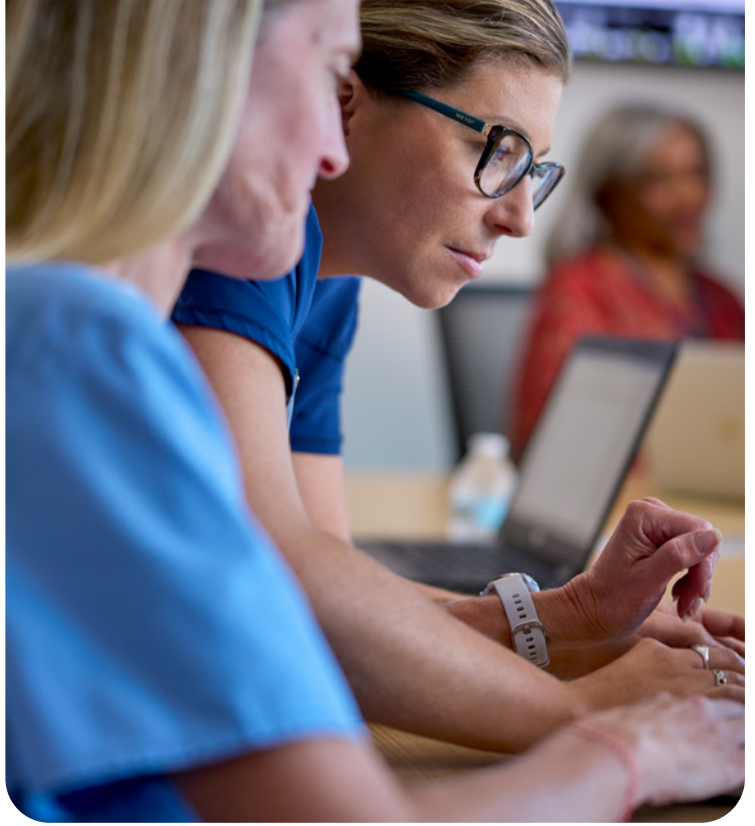
Overview Process and Scope

Assessing community health needs every three years has been instrumental to WellSpan's community health and benefit strategy since the early 1990s. Through collaboration with local health coalitions and community partners, WellSpan surveys community members about the non-medical factors influencing health, access to health care, lifestyle and health behaviors, and other topics. The 2025 CHNA provided the necessary background to create this 2026 – 2028 CHIP, which outlines WellSpan Health's response to the community's identified needs. This report also builds on learnings from the 2023-2025 WellSpan CHIP, as well as the Evangelical Community Hospital's CHIP.

The CHNA is a data resource and tool for anyone who shares our mission to improve the health and well-being of the community. As our plans evolve to address the identified needs detailed here, we are reminded of our reliance on our collaborative partnerships to influence meaningful change.

CHNA Process

WellSpan leverages the American Hospital Association's Community Health Assessment Toolkit to orchestrate our needs assessment. The toolkit identifies nine key methodological tasks for a CHNA, which WellSpan consolidated into four core actions, 1) define the community in which the CHNA will take place, 2) identify the major data elements and the associated data sources that will be used, 3) analyze the data to identify core themes and areas for improvement and 4) establish an implementation plan to address identified needs. Each of these steps prioritizes the engagement of a diverse group of key stakeholders.



1. **Define** the community in which the CHNA will take place
2. **Identify** the major data elements and the associated data sources that will be used
3. **Analyze** the data to identify core themes and areas for improvement and
4. **Establish** an implementation plan to address identified needs (CHIP)

Defining the Community

The 2025 WellSpan CHNA includes the entirety of Adams, Franklin, Lebanon and York counties, as well as specific geographic areas within Lancaster County. The assessment also touches on Cumberland County health trends through secondary data. Cumberland County was outside of the target catchment area for the community survey. This geographic focus encompasses the majority of the WellSpan service area and the patients, covered lives and communities within the reach of our organization. Notably, WellSpan welcomed the Evangelical Community Hospital into the organization in the summer of 2024, well after Evangelical's CHNA and CHIP were underway. The 2024 Evangelical Community Hospital CHNA (available online at https://www.evanhospital.com/download/?id=9369), was conducted from January to December 2023, covering 18 counties across central and northeast Pennsylvania. Integration of the Evangelical Community Hospital into the WellSpan CHNA and CHIP will occur in 2028. The Evangelical Community Hospital service area is not represented in the 2025 WellSpan CHNA.

WellSpan's emphasis on local and regional data enables its seven acute care hospitals, two specialty hospitals and regional behavioral health organization to act on unique county attributes, while maintaining a regional perspective on community health issues challenging our patients, neighbors and communities. This plan describes strategies that address identified challenges locally and across WellSpan's entire service area.

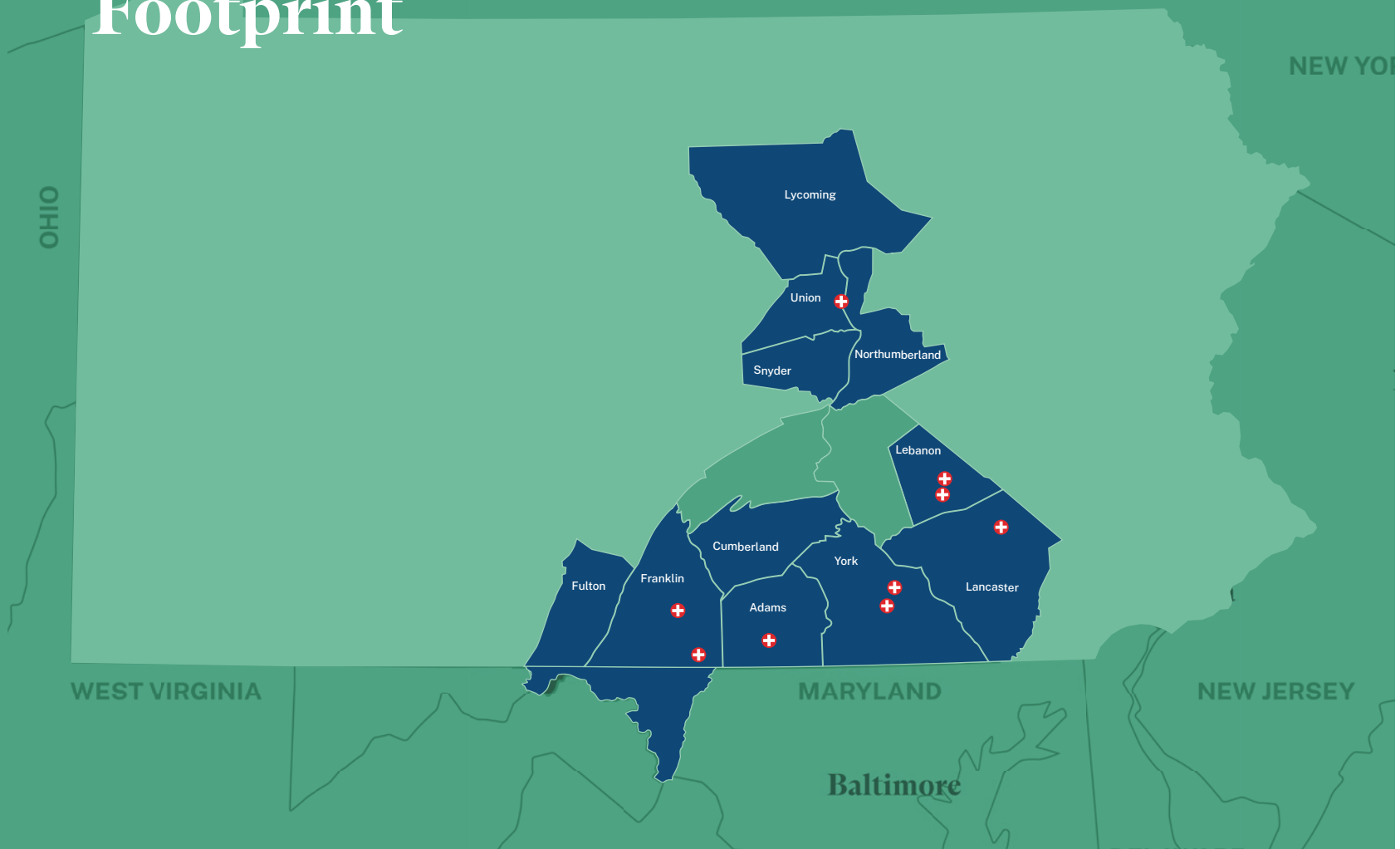
The 2025 CHNA aims to identify the needs of all residents by delivering on our commitment to a multifaceted, representative data collection strategy. Our approach, which includes primary and secondary data collection, demonstrates the themes and nuances of local geographies for residents from birth through advanced age, while also understanding the health of residents regardless of their age, gender, race, income, education or health status.

The abundance of available data in our communities has improved the CHNA processes over time, though the abundance of data has also necessitated focus. Our CHNA did not seek to explore every health indicator or behavior but rather, seeks to tell a story of our communities' health and identify core themes upon which we can act.

Many community members are disproportionately at risk of poor health outcomes. Our CHNA strategy considers the impact of a wide range of personal and financial factors in our communities, and we use our data to identify and respond to differences between segments of our community.

[1] Evangelical Community Hospital was incorporated into WellSpan Health in July 2024.

The WellSpan Footprint



Our Coalition Partners

HEALTHY ADAMS COUNTY

HEALTHY YORK
The Coaltion for a Healthier York County

COMMUNITY HEALTH COUNCIL
OF LEBANON COUNTY

HEALTHY
Franklin County

Life Expectancy Variation

Within the health system's geographic footprint, length of life varied by 20 or more years between census tracts.

Data Elements and Data Sources

The availability of data, both publicly accessible and collected through the needs assessment process, continues to improve over time. The abundance of available data today necessitates a thoughtful approach to weaving together findings in a way that tells the story of our community. WellSpan's 2025 CHNA leveraged data from multiple data sources, including:

Community Health Assessment Survey

Utilized by Franklin & Marshall to establish a statistically representative survey, this tool demonstrates the demographic distribution of the community broadly, as defined by sources like the U.S. Census Bureau. The survey was also distributed through our local health coalitions in each county and community partners to engage additional community members in our survey data collection. Broad distribution of the survey to roughly 75,000 community members was made possible by WellSpan's Communications and Innovations teams, who distributed the survey via email. For the first time, WellSpan leveraged the expertise of our Hippocratic AI partner to make outbound phone calls to patients to encourage participation in our Community Health Needs Assessment survey. Nearly 650,000 calls were made to WellSpan patients to encourage participation. The calls resulted in a measurable increase in survey completion during the two weeks they took place.

Local, State and National Data Sources

Our partner at Franklin & Marshall College extracted secondary data from local and state sources, such as the Department of Health and Behavioral Risk Factor Surveillance Survey.

WellSpan Health's Provider Survey

Created by an interdisciplinary team of physicians and leaders, this survey was administered to all physicians and advanced practice providers (Physician Assistants, Nurse Practitioners, etc.). The survey offers insight into the provider community's concerns about community health and proposed strategies for improvement.

WellSpan Health Patient Data

De-identified aggregate data from our Electronic Health Record (EHR) system, Epic, provides specific perspective on the health and well-being of WellSpan patients. This data source allows us to reinforce learnings at the local and national level by understanding consistencies among our patient population.

In addition to our routine data collection methods, focus groups, key informant interviews and off-cycle exploratory data collection have permitted an opportunity to learn about groups within our community who have been marginalized and underrepresented in similar assessments. Together, we paint a comprehensive picture of the needs of our community from birth through advanced age.

Data Collection Process

The data collection methods of the 2025 CHNA build on decades of learnings from previous assessments. Our processes strive for constant improvement, ensuring our survey sample is representative of the community, and that our processes minimize bias. Data collection was facilitated by the Center for Opinion Research at Franklin & Marshall College, led by Berwood Yost, director of the Center and project consultant. Data collection started in the spring of 2024 with an analysis of demographic indicators from secondary data sources. Simultaneously, the engagement of key stakeholders and subject matter experts helped to frame core areas of focus for further exploration.

The community survey was launched in early February 2025 to gain household-level insights into non-medical factors influencing health, barriers to health care and health behaviors. The survey was developed with the expectation of taking a respondent 15–20 minutes to complete and was made available in English, Spanish and Haitian Creole. The Center for Opinion Research deployed a research engagement strategy that ensured a representative "control" sample was collected through proactive outreach using postcards, email, text and phone.

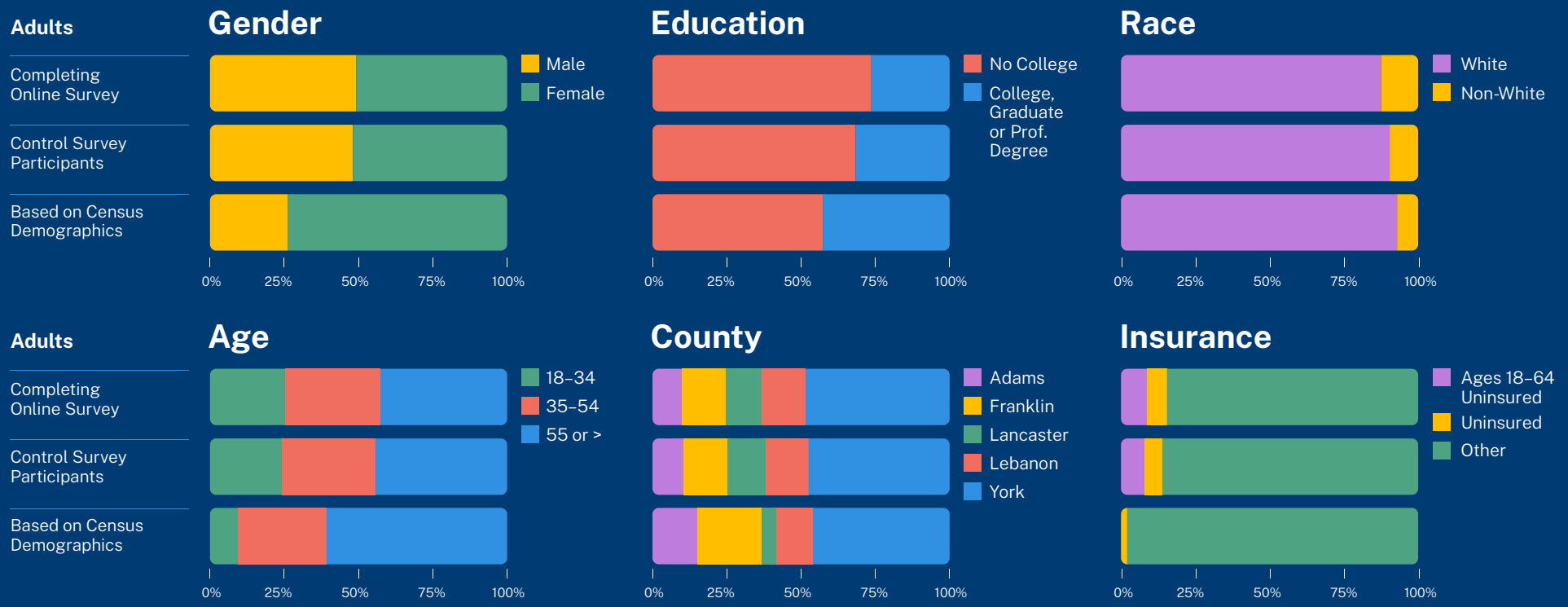
WellSpan supported the deployment of thousands of emails through community partners, as well as through our internal and external communications channels, to expand the reach of the community survey and engage a multitude of households in the online survey. Local health coalition leaders were instrumental in distributing the survey to community partners with a shared goal of collecting survey responses from all facets of the community, including racial ethnic minority groups, low-income individuals living in poverty and families who tend to engage less frequently in data collection of this type. In total, the controlled, representative survey yielded 1,646 responses, and the broadly distributed survey yielded 5,771 responses. In total, 7,417 community members made their voice heard in our 2025 Community Health Needs Assessment.

Our interest in continued learning means the needs assessment process doesn't stop with the creation of this report. We continue to invest in community-wide assessments on focused topics like food, housing and transportation conducted externally by community partners. Ongoing qualitative focus groups and key informant interviews continue to add focus and direction for action. The three-year cycle we follow for completion of the Community Health Needs Assessment provides ample opportunity to explore findings during "off-cycle years."

Selected Adult Survey Participant Characteristics

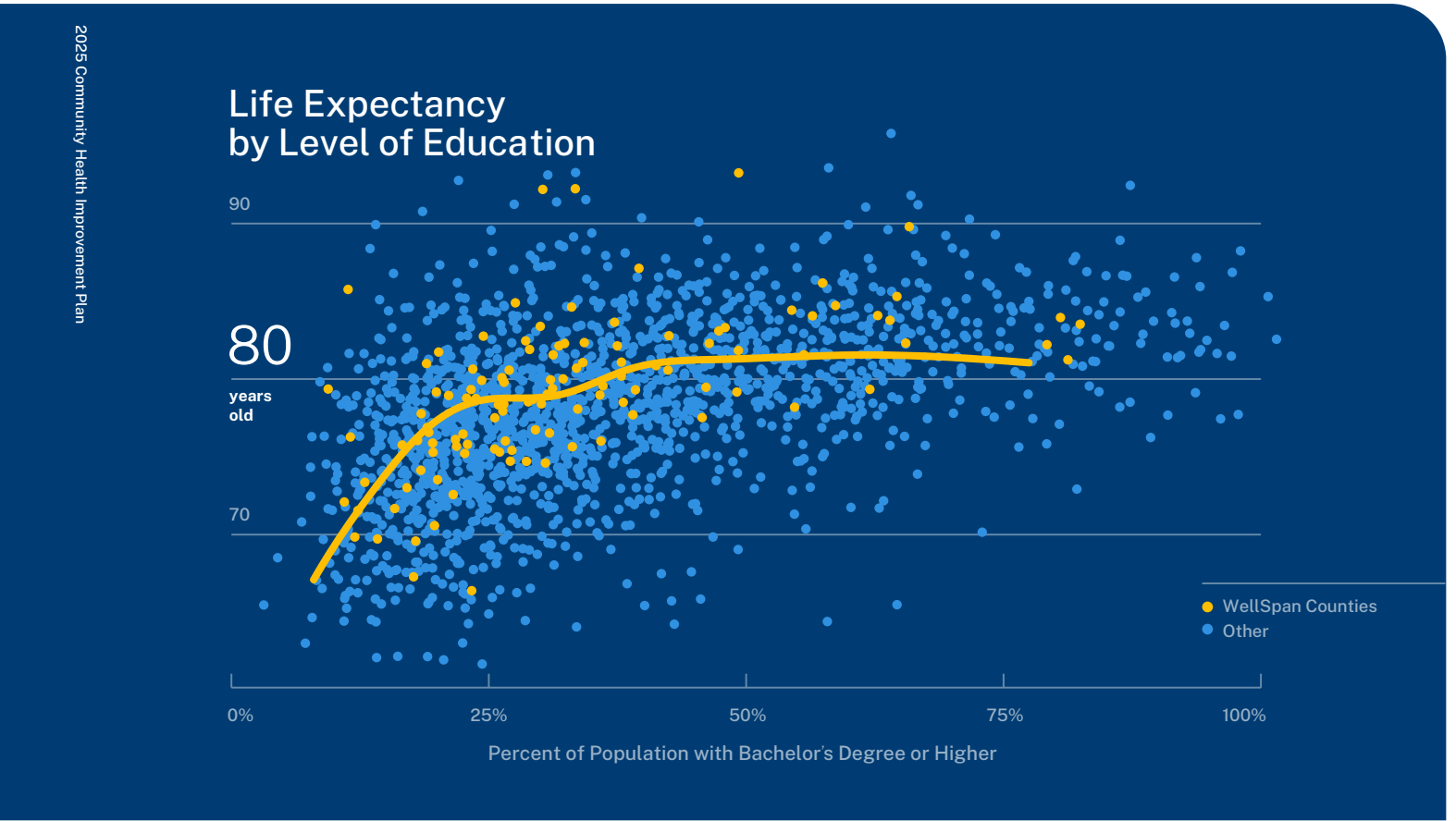
Figure 1.

Note: All estimates are from the U.S. Census Bureau, 2018-2023 American Community Survey 5-Year Estimates. Proportions are the share of adults in the study area.



Opportunity for Impact

Leveraging our CHNA to Address Life Expectancy



At WellSpan, our CHIP represents an opportunity to address needs identified in the assessment. Our CHIP aligns with the WellSpan 2030 Strategic Plan, demonstrating our relentless journey to provide exceptional health care which is easier to use.

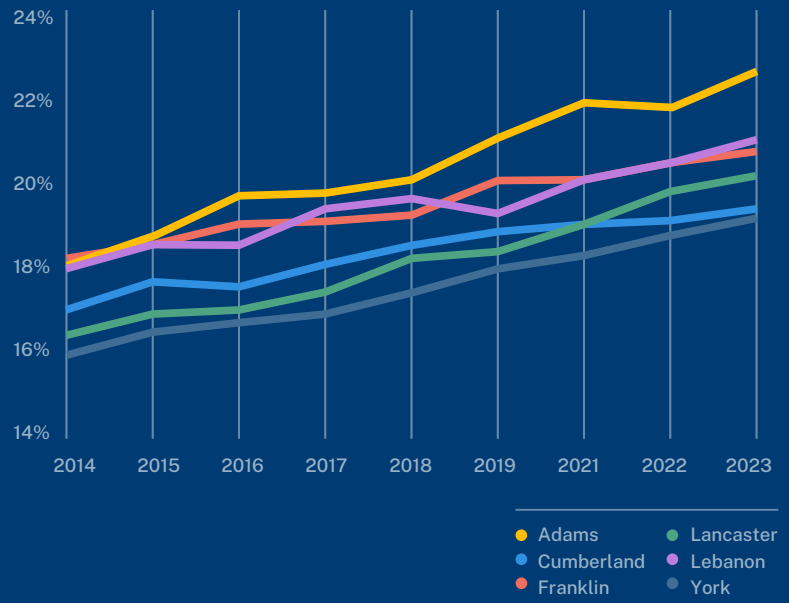
WellSpan set its sights on improving the life expectancy of our community with the realization that within the health system's geographic footprint, length of life varied by 20 or more years between census tracts. The CHIP has become a pillar of these efforts, providing community perspective on which indicators outside the walls of our facilities complement our clinical efforts to influence life expectancy.

Our CHIP priorities — Care for All, Children's Health, Physical Health, Preventing and Managing Chronic Disease, and Non-Medical Factors Influencing Health — directly contribute to improving the longevity of patients and community members, enhancing the quality of life and reducing premature death. If we are successful in advancing meaningful changes in our CHIP priority areas, it is our belief that these changes will positively influence life expectancy in our community as well.

Sources: https://www.cdc.gov/nchs/data-visualization/life-expectancy/index.html and https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html. Tract-level census data from the American Community Survey 2021 five-year estimates were merged to compare life expectancy with education data.

Overall Findings/Themes

65 and Over Population Growth

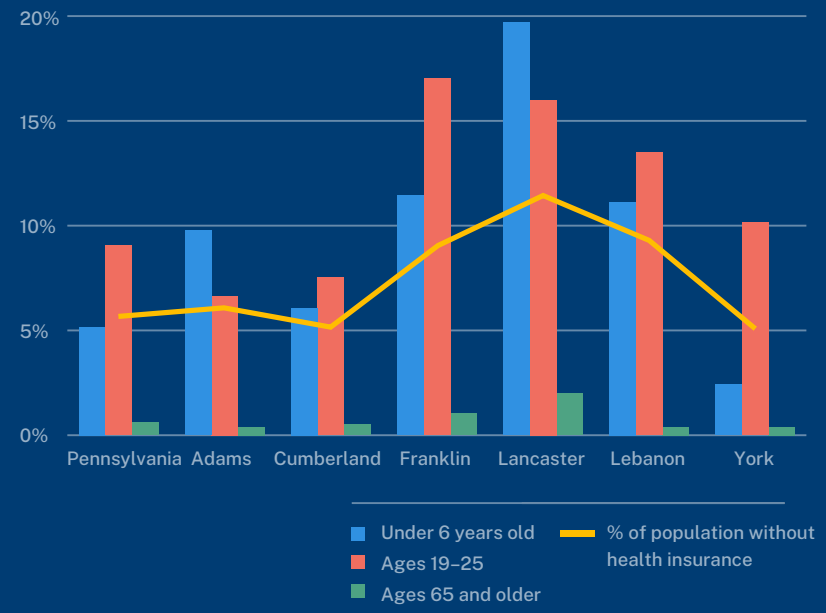


The 2025 WellSpan CHNA focused on the health and well-being of residents from Adams, Cumberland, Franklin, northern Lancaster, Lebanon and York counties. The CHNA paints a picture of the health of our communities, identifies concerning trends across the region and compares the counties WellSpan Health services with others throughout the state and across the nation. The health indicators measured by the CHNA have remained mostly stable over time, though circumstances such as COVID-19 and other influences have impacted the trends observed.

The growing population of adults over the age of 65 years has been consistently observed within the WellSpan footprint and is slightly above the national and state trends. The region has also observed an increasing presence of single-female-headed households with children. Observations of population growth indicate the community is becoming slightly more racially and ethnically diverse. The birth rate currently falls below the death rate for every county except for Lancaster County, where a higher than usual birth rate is attributed to the Plain Community there.

Care For All

Uninsured by Age



The 2023-2025 CHIP prioritized "Care For All" due to indicators such as the increasing number of residents with high-deductible health insurance plans, delays in care largely attributed to COVID-19, the identification of cost as a barrier to care and pronounced variances in access to health care by geography, age, race, gender and income. Though successful efforts have emerged to reduce gaps in care, improve quality and address the cost of care, the 2025 CHNA indicates ongoing challenges in health care affordability, access and quality.

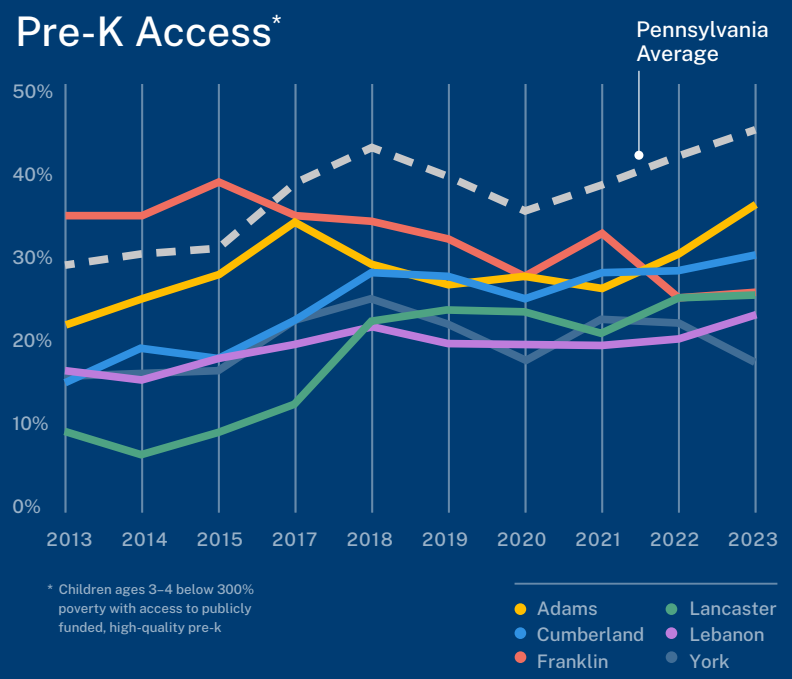
Indicators related to health care access are generally favorable, with most residents (92%) reporting they have health care coverage and a personal physician (87%). A growing number of residents report having a high-deductible plan (30%) however, and 9% of residents report having avoided health care in the past year because of cost. Of those insured across the region, more than 70% are identified as having private health insurance, demonstrating a stark contrast from the payor mix observed in health care financials. The emergence of telehealth has elevated concerns for broadband access — an average of 50% of households report having broadband within the home and 96% of households report having some access to broadband, whether at home or in the community.

Despite many favorable trends, variances among uninsured community members demonstrate variability, and concerns about health care cost, economic hardships and stress associated with household finances disproportionately affect some individuals in the community.

Data suggests an improvement in previously declining preventive care trends (e.g., routine care), delays which were influenced by COVID-19. In 2025, an estimated 18% of survey respondents did not have a routine check-up in the past 12 months (down from 25% in 2022). Though WellSpan focused efforts have been successful in exponentially increasing the number of patients completing cancer screenings such as mammography and colonoscopy as recommended, 24% of adults meeting the criteria for these screenings have delayed them because of cost. Our needs assessment data suggests 24% of community members who are recommended for colorectal cancer screenings received them and 94% of women over 40 years of age have had a mammogram.

Source: www.census.gov

Children's Health



The 2025 CHNA provided data specific to the health of children and families within WellSpan's footprint. High uninsured rates, rising economic disadvantage, vaccine hesitancy among caregivers and climbing obesity rates continue to affect the health of children across the region.

The WellSpan geographic footprint demonstrates higher uninsured rates for children under 6 than the state average, ranging from 2.4% in York County to 19.7% in Lancaster County. Though it is believed that the Plain Community's avoidance of health insurance influences these numbers in part, every county except for York County demonstrates uninsured rates higher than the state and nation. Additionally, more than 38% of children in kindergarten to 12th grade within the WellSpan geography are overweight or obese.

Children living in poverty are disproportionately impacted by poor health indicators across the region. Fewer than a third of children living in poverty have access to high-quality pre-k, well below the state average of 46.1%, and households with children are more likely to live in poverty than households without children.

Half of the children in WellSpan's footprint are eligible for free or reduced lunch, and although public assistance programs like Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP) and Medicaid have demonstrated modest increases, many eligible individuals are not utilizing these important resources.

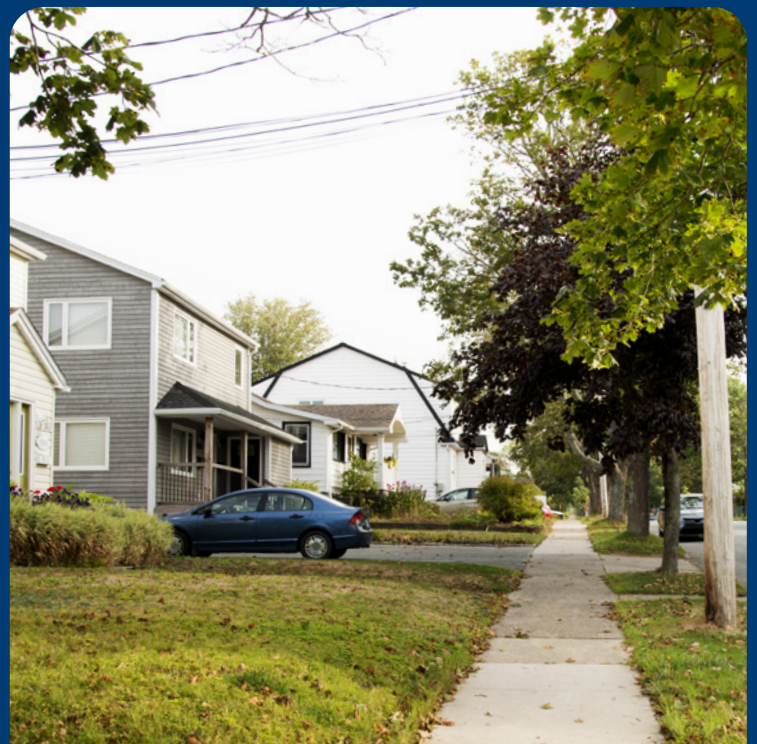
An evaluation of standardized Pennsylvania education testing for math, reading and science scores demonstrates consistent decline in test scores from 2006 to present with rising numbers of students testing below basic proficiency levels in English Language Arts (9.8% of students), Math (28.9% of students) and Science (13.0% of students).

Source: https://datacenter.aecf.org/data/tables/8036-children-ages-3-to-4-with-access-to-publicly-funded-high-quality-pre-k?loc=40&loct=2#detailed/5/5399/false/1771,1740,871,573,869,36/4201/17812,17814

Economic Hardship & Financial Stress

Roughly 32% of residents are currently experiencing one or more economic hardships, and 53% are stressed about money.

Non-Medical Factors



The CHNA data found notable and persistent health variances within all of the Central Pennsylvania counties served by WellSpan. These differences are largely attributable to a set of factors often referred to as non-medical factors or social drivers of health.

The median household income of the region has risen significantly over the past decade, though the gap between the highest income quintile and the lowest continues to grow over time. More than a quarter of households are living “paycheck to paycheck,” while an additional 7% of households sometimes do not have enough money for basic items like food, housing and transportation. Household characteristics support local conversations related to housing insecurity — nearly half of renters and nearly a quarter of homeowners are spending more than 30% of their income on rent or mortgage expenses. Over half of the housing inventory across the region was built before 1979, and occupancy rates across the region exceed the state and the nation.

Our community survey findings demonstrate resounding financial concerns across the region — concern for costs associated with health care, housing, food and transportation. Across the region, roughly 32% of residents are currently experiencing one or more economic hardship, 53% are stressed about money and 26% pinpointed food, shelter, health care and transportation worries specifically. For some, food purchases were cost prohibitive (9%) and they were forced to go without, while others expressed concern that their food would run out before they received more money to purchase food (10%) and, for 3% of our community, utilities were shut off because of an inability to pay.

Health Behaviors, Chronic Disease and Behavioral Health

Households within the WellSpan footprint demonstrate consistency with national, state and local trends related to health behaviors. Most adults experience high levels of stress, while not eating healthy foods, not exercising regularly and not getting adequate sleep. Perhaps not surprising, our communities also observe rising rates of heart disease, diabetes, pulmonary disease, obesity and stroke.

Trending data for mental and behavioral health indicators over time have demonstrated rising trends of depression, anxiety, substance use, trauma, stress and grief for the past several years. Nearly half of the community reports having experienced trauma, 11% reporting unfair treatment because of their race, ethnicity or cultural background and 10% were identified as currently depressed. Virtually every indicator that has been observed over time indicates consistent, increasing incidence of mental illness and substance misuse. Binge drinking and illegal drug use show modest increases, while smoking appears to demonstrate some improvement despite nearly a quarter (24%) of the community reporting marijuana use within the past month.

Healthy Communities

The Robert Wood Johnson Foundation provides an annual ranking of all 67 counties in Pennsylvania. The ranking has become a measure of progress compared to the rest of the state and has been long used to appeal to the competitive nature of counties seeking to improve their residents' health. The rankings indicate the top-ranked county as performing the best and the 67th county as performing the worst in the state for eight core domains including Health Outcomes, Health Factors, Length of Life, Quality of Life, Health Behaviors, Clinical Care, Social and Economic Factors, and Physical Environment. The WellSpan footprint demonstrated improvements in Clinical Care and Health Factors but demonstrated variable results by county in most categories, as depicted in the chart (right).

2023 Health Ranking Summaries

Legend

1 = Best (statewide)

- Improved since last CHNA
- Worsened since last CHNA

	Health Outcomes	Health Factors	Length of Life	Quality of Life	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Adams	11 ●	9 ●	9 ●	11 ●	15 ●	16 ●	7 =	46 ●
Franklin	14 ●	20 ●	16 =	25 ●	31 ●	49 ●	10 ●	38 ●
Lancaster	9 =	12 ●	8 ●	8 ●	10 ●	24 ●	9 ●	66 ●
Lebanon	26 ●	17 ●	19 =	37 ●	21 ●	18 ●	16 ●	59 ●
York	31 ●	16 ●	22 ●	40 ●	29 ●	8 ●	15 ●	57 ●
Cumberland	5 ●	4 =	6 ●	7 ●	5 ●	5 ●	4 =	56 ●

Source: Robert Wood Johnson Foundation

Priority Areas

Identifying Priority Areas

After compiling data and reviewing findings with top experts, community stakeholders, WellSpan leaders and the WellSpan Boards of Directors, key themes and priorities emerged. The themes and priorities were considered in comparison with national benchmarks to ensure evidence-based impact alignment.

The analysis of the CHNA data helped provide recommendations that are theoretically justifiable, practical, understandable and a good fit for the community and WellSpan by considering:

- The influence of identified themes on the life expectancy of the community
- The scope of the problem in terms of how many residents are affected, trends and comparisons to other communities
- The community-level effects attributed to the problem by thinking specifically about wasted dollars, reduced quality of life and lives lost
- The community resources available to implement change
- The alignment of these problems with local health systems' goals, missions and resources

WellSpan and community leaders considered the following questions as they prioritized their focus areas:

- What are the most pressing needs WellSpan should be addressing?
- Are there issues that are more important than others?
- What would success look like in 2028?

WellSpan partners with patients, neighbors, community organizations and policymakers to tackle community health priorities by balancing our understanding and applying the principles of the Socio-Ecological Model. Complex issues identified in the needs assessment cannot be solved by WellSpan alone and requires coordination of efforts at many levels. This builds on an understanding that health is affected by the interaction between individuals, groups/community and physical, social and political communities.

This model is used by health professionals, researchers and community leaders to identify factors at different levels (the individual, the interpersonal level, the community, society) that contribute to poor health and to develop approaches to disease prevention and health promotion that include action at those levels. Through community-engaged partnerships, we can develop coordinated strategies to produce and reinforce change on all levels.

Socio-Ecological Model

The Spotlight on Children's Health initiative

One example of how WellSpan has already applied this model is our work in addressing children's lead exposure and poisoning. WellSpan's Spotlight on Children's Health initiative launched in 2022 to address a multitude of pediatric topics. The ongoing exposure of children in our region to lead, mostly attributed to the aging stock of houses, puts children at risk for developmental delays and permanent cognitive and behavioral deficits.

There is no safe blood lead level in children, and yet, most children in the region are not tested. To address this issue, WellSpan committed to a universal lead testing policy, partnered with community organizations to create innovative programs to support patients, defined measurable performance indicators to track impact and has been actively advocating for policy changes to support children throughout Pennsylvania.

Exceptional healthcare, simplified.

Deliver: Exceptional, Equitable Health Outcomes

Seek excellence for all who experience WellSpan's care.

Innovate: Personalized Care and Experiences

Pioneer solutions to create tailored experiences, easier processes and safer, more reliable care.

Thrive: Accessible, Affordable Care

Transform the health care value proposition for patients to access and afford care.

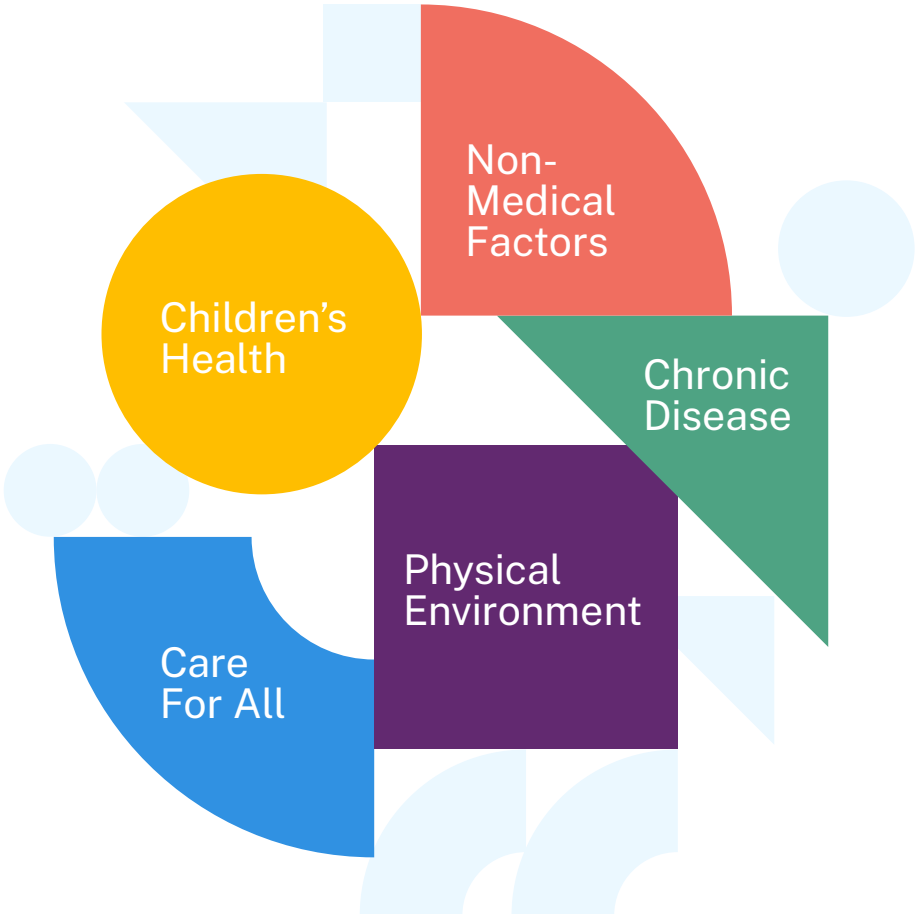
Engage: Thriving Team Members

Cultivate a culture of curiosity and learning where every team member can excel.

Build: Vibrant Communities

Foster economic development and enhance wellness for all by addressing social determinants of health, engaging supporters in our mission, focusing on prevention and promoting a healthier community.

2025 WellSpan Community Health Priorities



Based on the CHNA results, WellSpan's three-year strategies and priorities within its CHIP will include:

Care for All

Deliver exceptional care that is accessible and affordable for all by identifying and reducing barriers to care.

Children's Health

Lead the region in addressing the physical, emotional, intellectual and developmental needs of children.

Physical Environment

Promote a healthier community by enhancing environmental health efforts and building community infrastructure.

Chronic Disease

Improve the health and well-being of the community through strategies that promote health behaviors, support personal well-being and prioritize the management of chronic diseases.

Non-Medical Factors

Collaborate with community-based organizations to impact the most pressing non-medical factors (often called social drivers of health) affecting our patients and community like food, housing and transportation.

Inevitably, the impact of the health needs identified and prioritized differs slightly across each community in our region. A multifaceted, local approach involving health coalitions, WellSpan subject matter experts and community partners will address the county-level intricacies of how we advance each priority area. Several county and population-specific needs were significant enough to highlight in the CHIP.

Each of these priorities contribute to WellSpan's commitment to improving longevity, enhancing quality of life and reducing premature deaths in our community. Additionally, these priorities demonstrate alignment and consistency with WellSpan Strategic 2030 Plan, a testament to our organizational commitment to building vibrant communities.

Care For All

A Trusted Partner. Reimagining Healthcare. Inspiring Health. Our WellSpan vision exemplifies our commitment to building trusted relationships with each other, individuals, organizations and communities to achieve more together while leading the way through innovation, expert clinical care and personalized experiences for our patients. As we strive for our community to be their healthiest, access to affordable and equitable health care is necessary.

Our needs assessment demonstrates that some community members face challenges accessing affordable, quality health care when they need it. Ensuring that every resident can afford and obtain health care is a necessary step toward building a healthy and productive community. WellSpan desires to improve ease of use by addressing ongoing and emerging barriers experienced by community members so they can seek and receive care they need in a manner that is reliable, tailored to them, accessible and affordable. Understanding the needs and barriers in our community is an important first step.

The findings of our needs assessment point to concerns in our community related to health care, housing, food and transportation throughout our region. With more than half our adult population currently experiencing stress related to money, roughly a third of our population reports one or more economic hardships, and 9% of our community avoided health care in the last year because of cost. Knowing that the rate of individuals in our community with a high-deductible plan or no insurance is also increasing, the need for WellSpan to deliver on their commitment to providing accessible and affordable care is heightened.

WellSpan desires to eliminate barriers, improve access to affordable care and create a personalized experience for every person in our community to access the exceptional care they need to be healthy.

Reward healthier outcomes to make health care more affordable	→ Expand and diversify financial models to support value-based care options for our patients. → Increase proportion of patients who receive necessary preventative screenings.
A strong safety net of services and programs that address access and financial barriers to care for all	→ Provide easy access to WellSpan's Financial Assistance Policy and patient support programs. → Increase price transparency for out-of-pocket expenses. → Partner with local Federally Qualified Health Centers to deliver comprehensive care to our community's at-risk and historically underrepresented groups (HUGs). → Enhance the proactive engagement of patients to improve ability to pay for necessary health care.
Improve life expectancy by identifying and addressing observed gaps	→ Utilize quality measures in premature death rates to prioritize efforts that will close the gap on life expectancy variation. → Improve HEDIS measures that are directly correlated with years of life preserved by increasing screenings for cancer, testing of children for lead and identification of genetic conditions, among others.

Children's Health

WellSpan is committed to fostering the health and well-being of children by ensuring they grow up in safe, stable and nurturing environments. Through strong partnerships and community-based initiatives, WellSpan works to build systems of support that promote healthy development and long-term success. The launch of the Spotlight on Children's Health Initiative in 2022 serves as evidence of WellSpan's commitment to leading the region in addressing the physical, emotional, intellectual and developmental needs of children.

Evidence points to the significance of the first years of life as a precursor of lifelong health and wellness. Adverse childhood experiences, trauma and living in poverty are demonstrated to decrease life expectancy, impact childhood development, increase the risk of chronic conditions and increase the risk of poor health in adulthood. Ensuring our youngest community members have a healthy start is a way to influence the community's health and to ensure our next generation is equipped for success.

WellSpan will engage in focused and impactful opportunities to advance children's health. We understand that the health of a community is dependent upon collaboration with diverse stakeholders. Together, we can strategically partner to build a safe environment for our current neighbors and future generations to thrive.

Ensure children (ages 0–6) get a healthy start and are ready to thrive as they approach kindergarten.	→ Actively engage caregivers of patients to ensure more children receive well visits on time and school-required vaccinations. → Continue to partner with the community to support early childhood education access. → Ensure school readiness through standardized developmental screening and promotion of early literacy (for example, Read Out and Read program expansion). → Explore opportunities to support families with uninsured children. → Partner with the community to address non-medical factors and safety issues for families with young children.
Improve access to pediatric health care resources.	→ Simplify access to preventive care for children during primary care visits (for example, RSV vaccine, point of care bilirubin measurements and universal lead testing). → Increase pediatric online urgent care usage as appropriate. → Enhance access to resources and education related to breastfeeding.

Non-Medical Factors

Factors such as housing insecurity, food insecurity, transportation barriers and economic hardship continue to impact health outcomes across our region. These non-medical factors, also called social drivers of health (SDoH), not only influence access to care, but also contribute to increased levels of chronic stress, mental health concerns and worsening overall well-being. To date, we have screened over one million patients for housing, food insecurity and transportation challenges across our ambulatory and inpatient settings. These screenings have deepened our understanding of patient and community needs, revealed critical resource gaps and informed the development of more equitable, responsive care models.

Our CHNA demonstrates that roughly 14% of residents across the region have skipped or reduced meals in the past year because of cost, 7% have fallen behind in paying their rent or mortgage and 3% were unable to get to a health care appointment in the last year because of a lack of transportation. Individuals with children under 18, living in poverty and/or experiencing depression disproportionately report challenges with food, housing and transportation. Our data underscores a consistent pattern: concerns about cost are pervasive and impact non-medical factors such as housing, food and transportation, as well as contribute to delays in care and avoidance of preventive health.

Addressing the intersectionality of medical and non-medical factors is essential to improving long-term health outcomes and the health of our community. Through strategic partnerships, targeted investments and innovative programming, WellSpan is leading efforts to collaborate with community-based organizations to mitigate social barriers and strengthen the overall health and resilience of our communities. WellSpan remains focused on supporting patients in removing non-medical barriers that impact health and delivering more holistic, person-centered support.

Demonstrate improvements in the navigation of patients between care teams and community programs.	→ Strengthen HeretoHelpAll social service referral network for patients and community members. → Demonstrate outcome measures associated with closed loop navigation system to identify opportunities for improvement.
Enhance organizational commitment to non-medical drivers of health such as food, housing and transportation infrastructure in our communities.	→ Build capacity and strength of community-wide food, housing and transportation eco-system through partnership, advocacy and program innovation. → Expand reach of WellSpan's social programs and build community partnerships for projects addressing non-medical factors such as food, housing and transportation insecurity for patients and community members. → Monitor the impact of organizational investment in food and housing infrastructure.
Address housing insecurity as systemwide health issue.	→ Support community-level initiatives addressing housing affordability, access, safety and infrastructure. → Demonstrate increased investment in community partnerships focused on housing projects. → Explore innovative housing opportunities for WellSpan to collaborate with community partners for transformational solutions.

Chronic Disease

Chronic diseases are among the leading causes of death and disability in our region and are often driven by preventable risk factors. Health behaviors such as diet, exercise, substance use and sleep are powerful predictors of long-term health — but many community members face barriers to maintaining healthy routines. According to our CHNA, 80% of adults did not engage in regular physical activity, nearly one in four report marijuana use and many residents are not getting enough sleep to support their overall well-being.

The consequences of these trends are clear. Nearly three out of four adults in our region are overweight or obese, and half report at least one recent day of poor physical or mental health — a significant increase compared to previous assessments. Behavioral risk factors like high BMI and substance use are also the leading contributors to chronic conditions such as cancer, cardiovascular disease, diabetes and chronic respiratory illnesses. When reflecting on the leading causes of death in our communities, we understand that chronic disease contributes to premature death, reduces the longevity of our community and diminishes the quality of life for our community. Reducing the incidence of, and better management of, chronic disease would improve life expectancy.

To address these challenges, WellSpan is committed to improving health and well-being through proactive, people-centered strategies that focus on prevention, early intervention and chronic disease management. Our approach emphasizes both physical and mental wellness, recognizing the strong connection between the two. By empowering individuals to take charge of their health, and by aligning clinical, behavioral and community resources, WellSpan is working to reduce the burden of chronic disease and ensure more people in our region can live longer, healthier lives.

Improve management of chronic conditions for patients and community members to avoid preventable hospitalizations.	→ Partner with community-based organizations to promote healthy lifestyles and mental well-being through nutrition, physical activity, sleep hygiene and tobacco cessation. → Monitor patient data to proactively identify opportunities to improve chronic condition outcomes that correlate with life expectancy.
Enhance education and clinical care coordination to improve chronic disease management	→ Explore opportunities to address maternal health through pre-, peri-, postnatal education and chronic disease management. → Personalize the experience of managing a patient's chronic condition through education and clinical care coordination.
Decrease the number of community members experiencing poor mental health in our community.	→ Advance innovative clinical pathway models that improve access and provide evidence-based practices to patients experiencing anxiety and depression. → Evolve depression monitoring to manage patient progress through functional assessment tools.
Provide consistent access to comprehensive and coordinated treatment services for substance use disorders.	→ Maintain commitment to optimal pathways for patients and community members seeking treatment services for substance use disorder. → Foster collaborations among community providers to reduce the burdens of mental illness and other mental health challenges in our community.

Transportation Barriers to Healthcare

3% were unable to get to a health care appointment in the last year because of a lack of transportation.

Physical Environment

Environmental factors play a critical role in shaping the health and well-being of individuals and communities across our region. Elements such as air and water quality, access to green spaces and safe, supportive built environments significantly influence chronic disease risk, mental health and overall quality of life. Recognizing this, WellSpan is committed to advancing environmental health efforts and investing in the physical conditions that promote healthy living.

Our priority is clear: to foster a healthier, more resilient community by improving our environmental health and collaborating to strengthen community infrastructure. This work is grounded in a core belief: a healthy environment is not a luxury — it is a necessity for long-term community health. By embedding environmental health within health care and aligning with public health and regional planning efforts, we are helping to build a stronger, healthier future for all who live and work in our region.

Together with our partners, we are creating a physical environment where health can truly flourish — supporting not just clinical outcomes, but the overall well-being of our communities and enhancing the life expectancy of the region.

Advance WellSpan's organizational commitment to environmental health and enhance our reporting of outcomes.	→ Expand organizational commitment to planning and measuring progress with development of Sustainability and Strategic Energy Management plans as well as enhanced emissions reporting. → Strengthen community collaboration for climate risks that pose a health challenge for our community.
Leverage local community and agricultural assets to invest in local and healthy food.	→ Continue to advance the Good Food, Healthy Hospitals initiative by increasing local food purchases and using source reduction methods to reduce food waste. → Evolve WellSpan's Food as Medicine model to align food insecurity tactics with sustainability practices and local food procurement.
Strengthen our community's infrastructure and built environment through thoughtful investment to support healthy living.	→ Leverage grant investments to support development of safe and active community spaces that promote healthy living. → Engage in and convene community efforts that will advance the economic development of our communities in meaningful ways that reduce the impact of non-medical factors on health. → Support the advancement of transportation focused infrastructure changes that will improve access to care for the community while simultaneously improving air quality.

Moving to Action

Addressing the identified priorities will not be easy and will require collaboration with our local community partners across the region. We are fortunate that this work isn't new, but rather, builds on our decades-long commitment to our community. Through our experience carrying out mission-focused community work, we've learned that each of the priorities we have identified connects to the other. Together, the priorities offer a glimpse of the complex factors that impact our community's health. We are poised and ready to advance this work and look forward to sharing our progress along the way.

Incorporation of the North Region

Despite unique local attributes, the communities within WellSpan's footprint tend to be more similar than they are different. That's why the identification of county-level themes and priorities from WellSpan's needs assessment data often point to themes across multiple counties and communities. It's also why many of the health systems within Pennsylvania identify similar priority areas in our CHNA and CHIP reports, providing a collaborative opportunity to tackle regional, shared health priorities as a community rather than on our own.

WellSpan was delighted to welcome Evangelical Community Hospital into WellSpan Health in the summer of 2024 when their CHNA and CHIP development was already well underway.

The consistency of core data findings and themes prioritized and primed for action was evident when comparing Evangelical Community Hospital's CHNA and CHIP reports with the remainder of the WellSpan footprint. Despite Evangelical Community Hospital's CHIP plan operating one fiscal year ahead, the two plans integrate well and speak to shared priorities regionally. The two CHIP plans demonstrate unique efforts to address needs in a community-focused way, while sharing a common goal of improving the health of the community.

WellSpan is advancing this CHIP plan along with the 2025-2028 Evangelical Community Hospital Community Health Implementation Plan until both cycles are integrated. You can find an Executive Summary of Evangelical Community Hospital's Community Health Implementation Plan in the appendix. For the complete 2025-2028 Evangelical Community Hospital CHIP, visit: https://www.evanhospital.com/download/?id=9624.

We look forward to a shared report in the future and embrace the opportunity to maintain community-focused plans that impact the most pressing needs, regardless of where along the Susquehanna River or within the Lebanon Valley the community lies.

Food Insecurity & Affordability

Roughly 14% of residents across the region have skipped or reduced meals in the past year because of cost.

Acknowledgement of Limitations and Topics Not Addressed

WellSpan has evolved its CHNA process over time and remains committed to ensuring data integrity and a sound scientific approach. Nevertheless, there are limitations to our process. We have minimized the risk of incomplete or inaccurate data whenever possible but remain cognizant of the following limitations:

1. Lagging data: Utilizing secondary data sources means embracing the limitations of those sources. For example, data may not be reported within the last year, may lack statistical significance for specific subgroups of the community and may not update the indicator for a year or more.
2. Internal patient data: Utilizing WellSpan patient data may have an inherent bias of not including those who cannot afford care and are therefore not captured in our records.
3. Survey sample sizes: For a variety of reasons, we are not able to survey every member of our community. Though we maintain a commitment to statistically significant sample sizes, our sample sizes may limit our ability to draw conclusions about certain subsets or very specific groups of the community. For the 2025 CHNA we are proud to have increased our sample sizes by more than 200%, demonstrating our commitment to ensuring as many households as possible are represented in our data collection strategies.

WellSpan understands the unique and diverse community health needs of each county we serve. The WellSpan team is comprised of more than 23,000 employees whose families live, work and/or play in our community. WellSpan believes that through partnership and collaboration we can positively influence many factors affecting health, even those not prioritized in this plan. We are well positioned to impact change through partnership and collaboration at the local and regional levels. WellSpan's support of local health coalitions in each county also speaks to the value of collaboration and the commitment WellSpan has made to building an infrastructure that supports community-driven partnerships.

While this plan includes an array of goals and objectives for broad priority areas, it does not address all health-related issues identified through the CHNA process. WellSpan uses the following criteria to determine when NOT to address an identified need in our formal CHIP:

1. Efforts specific to an issue are already underway and will continue, therefore a callout in the CHIP is unnecessary.
2. Issue appears to be emerging and warrants monitoring, but is not affecting the community in a manner that requires immediate action.
3. A community-wide or partner-specific approach would be more effective in addressing the need.

Our health system and community continue to experience hardships as a result of workforce shortages, challenging financial times and health care expenses. Despite these challenging times, WellSpan remains focused on our mission-driven commitment to the communities we serve. We will continue in our relentless goal of building vibrant communities and will advance efforts that promote healthy living, collaborate with partners to address issues important to each local community and monitor emerging trends that may warrant action in the future.

Reflecting on WellSpan's 2023-2025 Community Health Improvement Plan

At the completion of our 2022 CHNA when we launched the 2023-2025 CHIP there was still uncertainty and chaos as our communities were challenged by living through a pandemic. Conversations about pressing needs pointed to a shared concern about the mental well-being of our community, including the threat of grief, anxiety, social isolation, paused social opportunity for children, compassion fatigue and the epidemic of depression.

WellSpan has not hesitated in its relentless pursuit of exceptional care for all and its commitment to healthy communities. As a result, we launched our CHIP in July 2022 and have not slowed down in our effort to achieve the identified objectives. We've taken a multifaceted, local approach involving our local health coalitions, WellSpan subject matter experts and community partners to address the priority areas of Care for All, Mental Well-Being, Non-Medical Factors and Healthy Communities. We are proud of the progress we've made in advancing our latest CHIP, and we're excited to celebrate the work of the thousands of dedicated team members and community partners who make it possible.

Along our journey, we've acknowledged the need to explore opportunities to improve the life expectancy of our community. Our commitment to care for all continues to evolve as we strive to not only close the gap of life expectancy variability by geography, race and gender, but also aim to improve the life expectancy for all community members across our footprint. This work began with evolving our understanding of the factors that influence the length of our community members' lives. We've built on this understanding by prioritizing the reduction of premature death, improvement in longevity and enhancement of quality of life as core goals that will move the mark on life expectancy.

Our life expectancy efforts were just beginning when we launched the 2023–2025 CHIP and are instrumental to the future direction of our community health aspirations. Together, we will build on lessons learned in the last three years to continue to grow vibrant communities.

Below you will find a summary of WellSpan's 2023–2025 CHIP accomplishments.

2023- 2025 CHIP Summary of Accomplishments

Non-Medical Factors

More than 67,000 searches for resources on our white label #Heretohelpall strong social service referral network

Develop and implement new approaches for collaborating with community-based organizations to impact the most pressing non-medical factors affecting our patients and community

- More than 1 million patients screened for non-medical factors, also called social drivers of health
- Partnered with Giant Foods for a six-month fruit and vegetable voucher pilot program which demonstrated a 110% increase in produce purchases for participants
- $2.2 million awarded in community grants for 57 projects addressing non-medical factors influencing health
- Three transformational food insecurity projects supported by $1.5 million investment
- Received more than $10 million in grants to address non-medical factor needs
- Achieved Good Food, Healthy Hospitals distinction across WellSpan hospitals by demonstrating an increase in healthy options for patients and visitors
- More than 6,600 shelf-stable meals distributed to patients in need
- Supported over 600 housing-insecure patients in need of medical and social support through the Arches to Wellness Recuperative Care Program by leasing 22 shelter beds, with 97% of participants being placed in temporary or permanent housing, 96% having resolved acute medical issues, and 100% having a primary care physician at program completion

Mental Well-being

Through county health coalitions, distributed more than 7,000 resource guides and window clings encouraging better navigation to local mental health resources

Support personal well-being and whole person health by making it easier for people to recognize and get support for mental health and addiction issues

- Invested $627,151.32 in grants to support mental well-being programs in the community
- Achieved a 19% decrease in waitlist length to improve patient care access to behavioral health services
- Launched expansion of behavioral health unit at York Hospital, which will add 56 patient beds and 30,000 sq. feet
- WellSpan crisis counselors began responding to 911 calls for mental health emergencies
- Provided support for nicotine cessation and drug treatment for youth
- Recognized for our commitment to a supportive and inclusive work environment by Mental Health America
- More than 2,000 community members trained to address mental well-being
- Demonstrated a 10% decrease in emergency room visits for behavioral health patients by expanding mobile crisis teams, incorporating peer support and addiction recovery specialists into crisis services and expanding walk-in crisis center access
- Expansion of walk-in crisis centers improved access to immediate care for behavioral health crisis and realized a 21% increase in visits
- Reduced the average length of stay in emergency rooms for patients seeking behavioral health care by 50%, from 34 hours to 16 hours
- Received $9 million in grant funds to address mental well-being

Healthy Communities

Serving as a community convener by financially supporting the Executive Director positions for four local health coalitions

Create healthy, safe communities and ensure our youngest community members and next generation can thrive and grow

- $667,565.21 community grant dollars awarded to community partners for 17 programs
- Received $2.5 million in grant funds to address Healthy Community topics
- Encouraged healthy living through programs like Winter STREAK, which reaches more than 1,300 participants annually
- Invested more than $100,00 annually in Group Violence Interventions (GVI), resulting in a dramatic decline in gun violence in York City — over 100 days without gun violence in 2024
- Provided hands-on cooking demonstrations for children resulting in 93% of participants reporting development of a new, applicable skill

Care for All

$646.6 million invested in charity care and medical subsidies, with an additional $691,082 given to support patient needs through multiple health-topic-specific Patient Support Funds

Ensure access and quality of care for patients by identifying and reducing variances and barriers to care

- Provided free community health education to more than 110,000 community members
- Broke ground or opened at least 10 new sites, including the Critical Care Tower in York
- Launched a new communication platform called Hello World for improved patient experience
- Leveraged state-of-the art mobile units to provide patient screenings, including mammography
- Improved health care outcomes by integrating genetic insights through Helix, a program that has already served more than 400,000 patients
- Increased mammogram screening for women needing an interpreter provided an estimated cost savings for early detection of $370,225
- Bringing innovation — and prescriptions — straight to your doorstep with the help of Zipline
- Securing future clinical staff through partnerships with Temple University, Jersey College School of Nursing and the MA Training program through HACC
- Launched hypertension pilot program that has reached more than 700 patients, 48% with stage II hypertension
- The Special Projects Nurse team has screened over 1500 community members for blood pressure, providing referrals and follow-up as needed, with a estimated $64,000 savings realized in avoided emergency department visits and $910,000 savings in admissions avoided
- Partnering with Emerus to build three “micro hospitals” in central Pennsylvania

Children’s Health

$1.2 Million raised for the Spotlight on Children’s Health Fund

Support the opportunity for all children in our regions of care to develop in safe, stable, nurturing relationships and environments

- Optimized policies for RSV immunization, resulting in reduced infant hospitalizations, with more than 5,800 infants protected by immunization in two years
- Optimized care for opiate-exposed newborns
- Promoted literacy to our youngest patients by distributing more than 6,000 books annually though the Reach Out and Read program
- Maintained commitment as the lead agency of Safe Kids York County, which recently expanded to Safe Kids South Central PA
- Implemented point of care dried blood spot testing to screening 5,420 children for lead poisoning, over 400 of which demonstrated abnormal results
- Improved breastfeeding rates
- Encouraged physical activity and reading for over 25,000 children and families annually across six counties through Get Outdoors program

Conclusion

WellSpan has been and will always remain a steadfast community partner with a commitment to the communities we serve. We have made great strides in addressing the community's health — both with medical advancements and care that occurs inside the walls of our hospitals, medical group practices and ancillary services, and with our strong engagement and partnership within the community.

WellSpan wishes to extend our gratitude to the many invaluable partners who assisted with the planning and completion of the CHNA and the CHIP. Thank you to our local health coalitions, Healthy Adams County, Healthy Franklin County, Healthy York Coalition and the Community Health Council of Lebanon County, as well as to our consultants, Berwood Yost and Scottie Thompson Buckland, at the Center for Opinion Research at Franklin & Marshall College — your expertise and commitment to the community is instrumental in this work.

As we move forward, we will engage in focused and impactful opportunities to advance the health of our community and improve the lives of those we serve. We know our work depends on collaboration with diverse stakeholders, coordinating efforts and implementing strategies to address the prioritized needs. We are excited to move forward with our neighbors on a quest to further live out our mission: working as one to improve health through exceptional care for all, lifelong wellness and healthy communities.

Regulatory Note

The 2025 WellSpan Health Community Health Needs Assessment represents the communities served by WellSpan Chambersburg Hospital, WellSpan Waynesboro Hospital, WellSpan Gettysburg Hospital, WellSpan York Hospital, WellSpan Surgery and Rehabilitation Hospital, WellSpan Ephrata Community Hospital, WellSpan Good Samaritan Hospital and WellSpan Philhaven. It aligns with Evangelical Community Hospital, who completed their assessment in 2024. The Community Health Needs Assessment and associated Community Health Improvement Plan are in compliance with all mandates outlined in the 2010 Affordable Care Act and follow the guidance of the Catholic Health Association and other similar organizations to ensure all requirements are met.

Appendix

Evangelical CHNA Summary

2024 Evangelical Community Hospital Community Health Needs Assessment and Implementation Plan

Executive Summary

Methodology

The 2024 Evangelical Community Hospital CHNA was conducted from January to December 2023. Quantitative and qualitative methods, representing both primary and secondary research were used to illustrate and compare health and social trends and variances across each region and hospital service area.

The 2024 CHNA was built upon the Hospitals' previous CHNAs and subsequent Implementation Plans. The CHNA was conducted in a timeline to comply with IRS Tax Code 501(r) requirements to conduct a CHNA every three years as set forth by the Affordable Care Act (ACA). The research findings will be used to guide community benefit initiatives for the hospital and engage local partners to collectively address identified health needs.

Data Findings

Demographic and Priority Population Trends

- The Evangelical service area is within the Central Region of the CHNA study area and is comprised of six rural Pennsylvania counties: Columbia, Montour, Northumberland, Schuylkill, Snyder and Union.
- Population growth over the past decade was stagnant in Montour and Snyder counties and declined in all other counties.
- The growth of older adult populations will challenge communities to provide adequate support for aging residents, many of whom live alone and choose to age in place.
- Central Region counties are aging, but children comprise approximately 1 in 5 residents, reinforcing the potential for upstream, preventive action. Critical to these upstream efforts is addressing non-medical factors that have historically disproportionately affected children.
- Top health concerns for children in the Central Region, and statewide, include mental health issues. Child mental health was a growing concern before the pandemic, and in 2021, approximately 2 in 5 students reported feeling consistently sad or depressed, and 1 in 10 reported an attempted suicide.
- Commitment to school, measured by factors like how important students feel school is to later life or how much they enjoy the experience, can be protective for youth, reducing the likeliness of health concerns. School commitment has declined statewide; the percentage of youth who feel school is important for their later life fell from 57.5% in 2017 to 41.8% in 2021.
- The Central Region is a majority white community, but consistent with state and national trends, people of color are the only growing populations. This demographic shift is slow across counties, accounting for a one-to four-percentage-point change over the last decade. Growth among populations of color was most evident for individuals who identify as multiracial and/or Latinx.
- While populations of color are growing, they comprise a small proportion of the total population, limiting local-level data and often masking their community experience.

Non-Medical Factors Influencing Health

The Key Stakeholder Survey was completed by 180 Central Region representatives. As part of the survey, respondents were asked to share the top five priorities their community should address to improve health and well-being of the populations they serve. While most respondents selected mental health conditions, the majority of the top five identified priorities were SDoH, such as lack of transportation, housing, substance use disorder and child care.

Feedback from key stakeholders and others addressed the need to better serve the working poor or ALICE (Asset Limited Income Constrained Employed) households. Households that are designated as ALICE have incomes that are above the federal poverty level, but below the threshold necessary to meet all basic needs.

Recommendations to Improve Health

Community representatives were engaged throughout the CHNA to reflect on health and social needs for the region and offer recommendations for improvement. These conversations were anchored in building on identified community strengths, including access to health care, good schools and safe neighborhoods. These strengths can be drawn upon to improve the quality of life for all people.

Key Stakeholder Survey respondents and Community Forum participants shared feedback on what the community can do differently to address health and social concerns, better serve community members, and facilitate cross-sector collaboration. Consistent themes included addressing SDoH barriers, efforts to increase the capacity and quality of health care and social service providers, and improved community partnerships to collectively affect health.

For the complete 2024 Evangelical Community Hospital CHNA, visit: https://www.evanhospital.com/download/?id=9369

CHIP Prioritized Community Health Needs

From the review and analysis of key data sources, the following health needs were identified as top priorities:

- Access to Care
- Chronic Disease Prevention and Management
- Mental Health and Substance Use Disorder

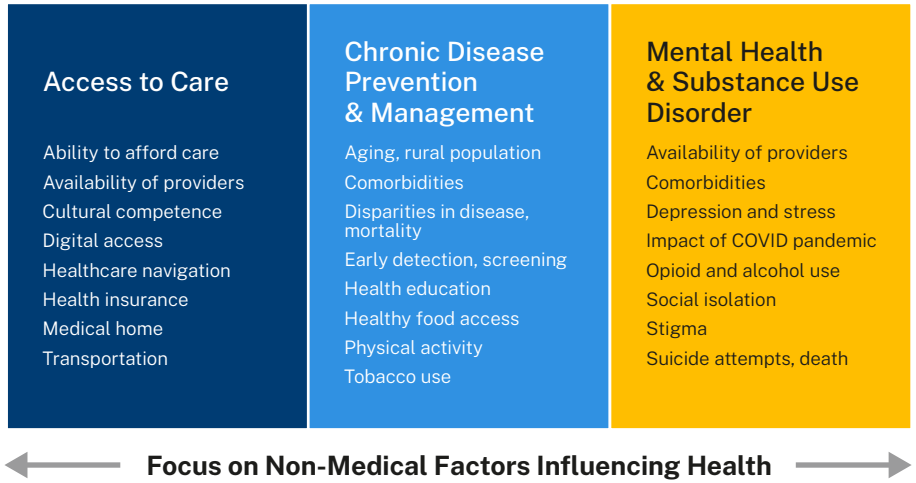
The chart below identifies key contributing factors driving these top priorities:

Access to care and chronic disease prevention and management are consistent with those needs determined in the previous 2021 CHNA and reflect complex needs requiring sustained commitment and resources. Mental health and substance use disorder is a more specific identified need than the broader 2021 CHNA behavioral health need.

Access to Care

Through several programs and resources, Evangelical will continue to focus on vulnerable areas of need for improvement to access to care.

Consistent Community Priorities & Contributing Factors



- Continue to expand Evangelical Regional Mobile Medical Services (ERMMS) to support access to quality emergency medical services throughout the ECH service area.
- Evangelical Community Health and Wellness/Mobile Health of Evangelical will continue to offer free or reduced-fee health screenings, focused on screenings that identify risk or prevalence of chronic disease.
- Continue offering free or reduced-fee preventive programs such as Freedom from Smoking through Evangelical Community Health and Wellness.
- Cancer Services in collaboration with Mobile Health of Evangelical will partner to offer community based clinical breast exams and skin cancer screenings throughout the hospital's service area.
- Serve as a community advocate for increasing use of closed loop referral resources. Continue to collaborate with external community organizations to increase awareness of these resource portals (i.e. PA Navigate, 211).
- Continue screening patients for food insecurity and providing free food boxes to patients through Care Coordination, Infusion, Hospital to Home and the Union County Food Hub at The Miller Center.

- Continue leveraging and building on collaborations and partnerships through The Miller Center joint venture to increase awareness and access to lifestyle-based resources such as the Phase III Cardiac Rehabilitation Program, Parkinson's Disease Programs, Fitness Classes, Personal Training Services and access to the amenities of the facility through membership and program participation.
- Pulmonary Services will seek to Incorporate a phase III pulmonary rehabilitation program in partnership with The Miller Center joint venture.
- Utilize Mobile Health of Evangelical to reach populations with known care gaps in areas such as dental care and diabetes education, screening and management.
- Evangelical will continue participating in the Nurse-Family Partnership Program for at-risk young expectant women.
- Care Coordination will continue to collaborate and strengthen relationships with community agencies that focus on addressing non-medical factors that influence health and disease-specific management and treatment.
- Evangelical Community Health and Wellness will seek opportunities to collaborate with medical students on youth mentorship opportunities within Evangelical's service area, in an effort to build tomorrow's health care provider workforce.
- Identify an approved vendor for implementation of a remote therapeutic rehabilitation monitoring platform.
- Continue marketing efforts focused on improving patient use and ease of access to the hospital's digital patient portal.
- Evangelical will seek to identify opportunities to expand and improve ease of patient access to telehealth and virtual care platforms in both inpatient and outpatient care settings.
- Evangelical will continue to provide patients with easy access to financial assistance resources, while also increasing price transparency for out-of-pocket expenses.

Chronic Disease Prevention and Management

Continue to focus on education, healthy lifestyle programming, and prevention screenings.

- Utilize Mobile Health of Evangelical to deploy chronic disease care through Evangelical's specialty care services in areas of need.
- Offer diabetes education and screening internally and through partnerships with local agencies.
- Collaborate with community organizations such as schools, YMCAs and youth camps to offer healthy lifestyle programming focused on priority topics of need as identified in the CHNA.
- Utilize the Evangelical Community Health and Wellness health coaching program to address chronic disease management through lifestyle-based approaches in collaboration with internal and external partners.
- Continue offering healthy lifestyle programming to the adult and senior population both in community and worksite settings with a focus on referrals from clinical service lines such as metabolic and bariatrics as well as primary care service lines.
- Continue coordination of services to address health and variances with various community health agencies.
- Continue to expand the Evangelical Fresh Local Food Project, which involves school-based education as well as employee and community access to fresh and local food options through partnership with local farms.
- Continue efforts to expand the Low Dose Lung Screening program through the work of two designated lung screening coordinators and seek Accreditation of American College of Radiology.
- Cardiovascular services will implement a Cardiac Calcium Score Screening program for patients who do not qualify for the service as medically necessary but wish to have an early cardiac screening.

Mental Health and Substance Use Disorder

Specifically targeting mental health concerns like depression and anxiety, which can be linked to non-medical factors like income, employment and environment, and can pose risks of physical health problems by complicating an individual's ability to keep up other aspects of their health and well-being.

- Continue to offer stigma training to all Emergency Department (ED) staff to improve care and compassion for patients who present to the ED with medical conditions exhibiting behavioral health and substance use disorder characteristics.
- Continue providing Naloxone reversal kits and fentanyl/xylazine test strips to community organizations as directed through funding from The Pennsylvania Overdose Prevention Program (POPP).

- Expand collaboration with Columbia Montour Snyder and Union (CMSU) Behavioral Health and Developmental Services and continue warm hand-off referral process to connect patients with Certified Recovery Specialist (CRS) to provide access to services.
- Continue to serve on the Susquehanna Valley Recovery Coalition, which covers a five-county region focusing on addressing issues and challenges related to substance use disorder, stigma reduction and reentry into the community.
- Continue offering community-based educational programming on the topics of stress management, resiliency and burnout.
- Continue to facilitate Plans of Safe Care for mothers who deliver children identified as substance-affected.
- ERMMS will begin participating in the First Responder Addiction and Connection to Treatment Program, which includes naloxone leave-behind kits for incidents involving opioid overdose.
- Explore opportunities to incorporate facility and programming changes in an effort to improve care pathways to better serve the behavioral health needs of the community.
- Departments across the organization are implementing processes for SDoH screening with patients as a routine component of inpatient and outpatient visits.

Evangelical's efforts to improve the health and well-being of our community are not limited to the previously mentioned action items. We are committed to focusing our expertise and resources in areas of greatest need and where we see we can make the greatest impact. Along with our internal providers and educators we will look to community agencies for collaboration to move the needle on our key identified needs.

Evangelical will focus on the following identified needs. Below are our main goals and how we will work to meet these need objectives:

1. Evangelical aims to expand the Wellness 360 program to older adults within Evangelical's service area with the goal of increasing outreach and access to community resources, to improve the quality of life for the older adult population by June 30, 2027.
2. The identified population at risk will be the aging, rural population within Evangelical's service area. Aligning resources and effort with this project will aim to improve access to resources for our patients, thus managing the progression, preventing or reversing the effects of chronic disease and improving access to care.
3. Evangelical aims to increase awareness and improve knowledge of mental health and substance use and contributing factors through the hospital's school-based programming targeting children kindergarten through grade 12 by June 30, 2027.
4. The identified population at risk will be the youth (kindergarten through grade 12) within Evangelical's service area. Aligning resources and effort with this project will aim to increase awareness and improve knowledge of mental health and substance use issues and contributing factors for youth within Evangelical's service area.

Approved by the board.