



# Building Healthier Communities

2025 Community Health  
Needs Assessment



# 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



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## Introduction

**W**ellSpan Health's commitment to the community extends well beyond treating illness. As an integrated health system and community change catalyst, WellSpan collaborates with partners to address social, demographic, behavioral and economic issues. This commitment requires time, determination and investment in the future. WellSpan remains steadfast in its focus on identifying community health needs and addressing them.

The 2025 Community Health Needs Assessment (CHNA) offers insights into the health of our communities throughout south central Pennsylvania and parts of northern Maryland. This report summarizes the CHNA data across the WellSpan region, including Adams, Cumberland, Franklin, Lebanon and York Counties, as well as parts of Lancaster County and northern Maryland and builds the foundation for WellSpan's Community Health Improvement Plan (CHIP).

We take pride in the comprehensiveness of this report, which helps identify health challenges and recognize the impact of non-medical factors like housing and food insecurity. This report equips decision makers with local and regional data, provides insight on emerging, trending and ongoing health-related needs in our communities, and aims to inspire impact-driven solutions that improve the health of our community. It also serves as a roadmap for WellSpan to fulfill its mission and values.

WellSpan's history of conducting localized needs assessments allows us to continuously improve our process, observe community trends and enhance our methodology as data evolves. The needs identified throughout the CHNA present an opportunity for WellSpan to continue our relentless pursuit of finding a better way. In partnership with you, WellSpan can improve health through exceptional care for all, lifelong wellness and healthy communities.



WellSpan remains steadfast in its focus on identifying community health needs and addressing them.

This report is co-authored by WellSpan Health and the Center for Opinion Research at Franklin & Marshall College. The following pages detail the methodology, findings and analysis of our assessment.

Previous Community Health Improvement Plans and Needs Assessments are available [online](#).

## Executive Summary

The 2025 WellSpan CHNA focused on the health and well-being of residents from Adams, Cumberland, Franklin, northern Lancaster, Lebanon and York counties. The following themes were identified throughout the data collected:



### Demographic Trends

The population of adults over 65 years of age is growing, as is the presence of single-female-headed households with children.

Lancaster County is the only county in the region with a birth rate that exceeds the death rate.

Population fluctuations are largely attributed to domestic and international migration.

Observations of population growth indicate the community is becoming slightly more racially and ethnically diverse.



### Access to Health Care

Most residents (92%) report having health care coverage and a personal physician (87%).

A growing number of residents report having a high-deductible plan (30%), and 9% of residents report having avoided health care in the past year because of cost.

More than 70% of insured adults across the region report having private health insurance, demonstrating a stark contrast from the payor mix observed in health care financials.

An average of 50% of households regionally report having broadband, and 96% of households report having some access to broadband.

18% of survey respondents did not have a routine check-up in the past 12 months.

Preventive cancer screenings demonstrate some improvement — 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.



### Children's Health

Uninsured rates for children under six continue to show increases and exceed the state, ranging from 2.4% in York County to 19.7% in Lancaster County.

Around 38% of children in kindergarten to 12th grade are overweight or obese.

Fewer than a third of children living in poverty have access to high-quality pre-k.

Decline in math, reading and science test scores has been consistent from 2006 to the present, with rising numbers of students testing below basic proficiency levels.

## Executive Summary

Together, the CHNA data suggests opportunities to address identified differences and provides a critical backdrop for life expectancy efforts regionally.

After compiling data and reviewing findings with top experts, community stakeholders, WellSpan leaders and the WellSpan Boards of Directors, WellSpan will look for key themes and priorities for inclusion in the Community Health Improvement Plan.



### Non-Medical Factors

Data demonstrates notable and persistent health variances across multiple geographies.

The median household income has risen significantly, though the gap between the highest income quintile and the lowest continues to grow.

More than a quarter of households are living “paycheck to paycheck,” and an additional 7% of households sometimes do not have enough money for basic items.

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, therefore increasing the likelihood of lead paint exposure for children.

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

For many residents, food purchases were cost-prohibitive (9%), while others expressed concern that their food would run out before they received more money to purchase food (10%).

For 3% of our community, utilities were shut off due to their inability to pay.



### Health Behaviors, Chronic Disease and Behavioral Health

Most adults experience high levels of stress, do not follow a balanced diet, do not exercise regularly and do not get adequate sleep.

Our communities also show rising rates of heart disease, diabetes, pulmonary disease, stroke and being overweight or obese.

Rising trends of depression, anxiety, substance use, trauma, stress and grief have been observed for the past several years.

Binge drinking and illegal drug use show modest increases.

While smoking rates have reportedly declined in recent years (from 16% in 2017 to 9% in 2025), there is concern for nearly a quarter of the community (24%) reporting marijuana use within the past month.

Nearly half of the community reports having experienced emotional trauma, 11% report unfair treatment because of their race, ethnicity or cultural background, and 10% were identified as currently depressed.

# Our Data Process

Economic Hardship  
& Financial Stress

9% of residents  
report having  
avoided health care  
in the past year  
because of cost.



## 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.



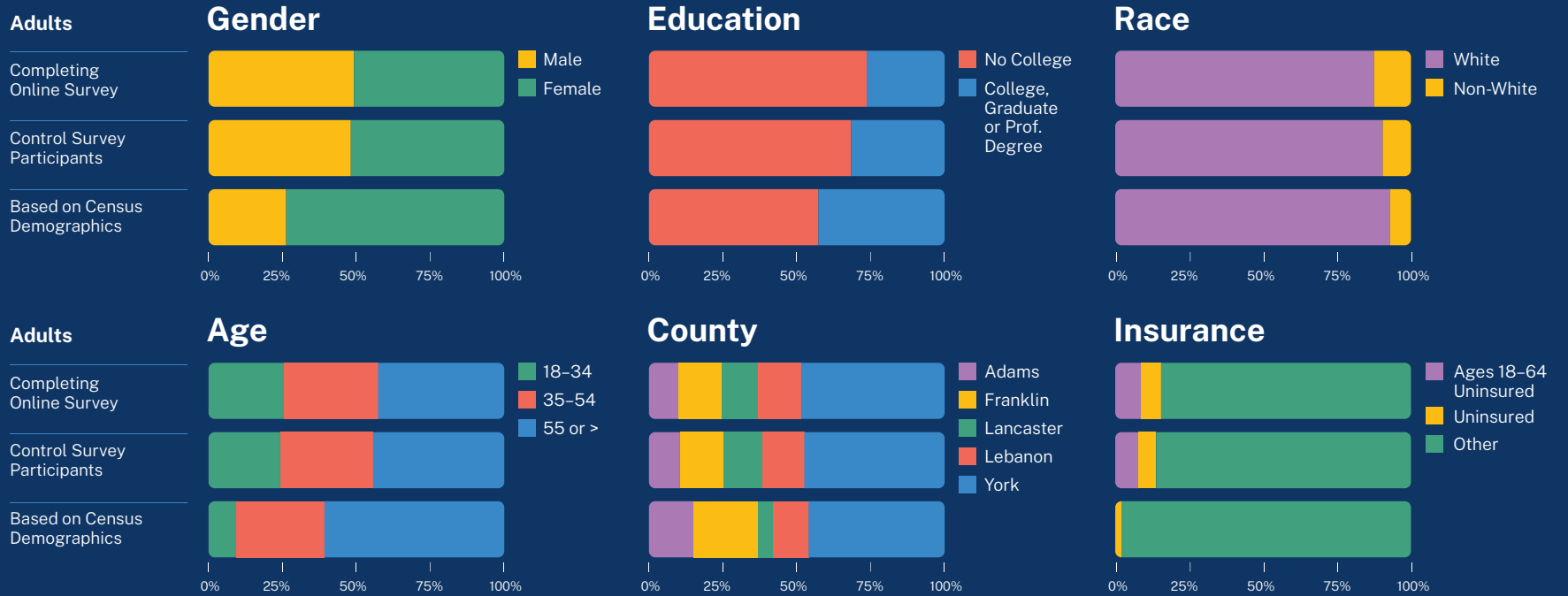
Our interest in continued learning means the needs assessment process doesn’t stop with the creation of this report. We continue to invest in community-wide assessments on focused topics like food, housing and transportation conducted externally by community partners. Ongoing qualitative

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.



## Acknowledgment of Limitations

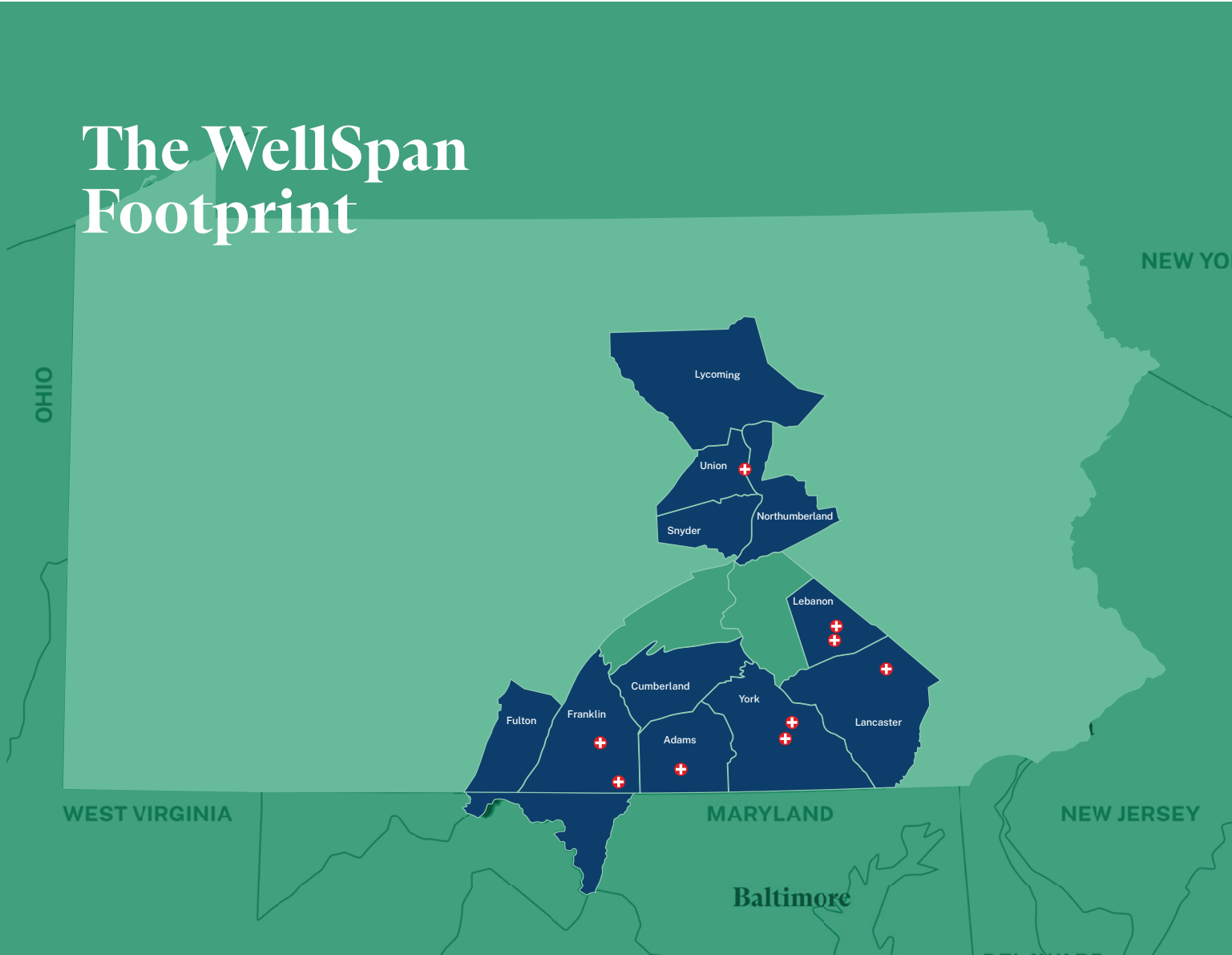
Our CHNA process is always improving — we look for opportunities to enhance the value of the data we extrapolate and appreciate the increasing availability of data. We are committed to ensuring data integrity and a sound scientific approach. Nevertheless, there are limitations to our process. We have 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 and may lack statistical significance for specific subgroups of the community, leaving a gap.
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:** Despite our efforts to engage a large portion of the community, 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.
4. **Access bias:** There is an inherent bias in survey responses due to the time and internet or phone connectivity required to complete the survey. Individuals who lack internet or phone access are most likely not represented.

Continued improvement efforts allow us to build on each needs assessment, each method utilized and each report generated. We will continue to advance ongoing 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.

# The WellSpan Footprint

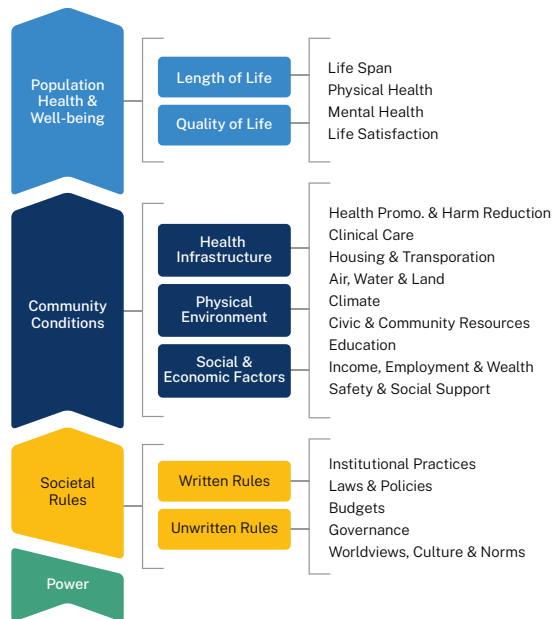
# The WellSpan Footprint



## Our Coalition Partners



# County-Specific Summaries



## 2023 Health Ranking Summaries

Table 1.

	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 ●

### Legend

- 1 = Best (statewide)
- Improved since last CHNA
- Worsened since last CHNA

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 saw improvements in Clinical Care and Health Factors but demonstrated variable results by County in most categories,

as depicted in Table 1. Improvements indicate a higher ranking among the 67 counties in Pennsylvania and therefore a lower number in the table. Notably, our region performs very poorly in physical environment indicators, which include housing and transportation, air and water quality, access to parks, and adverse climate events such as storms, droughts, floods and extreme heat. Four counties within southcentral Pennsylvania (Lancaster, Lebanon, York and Cumberland) are ranked in the lowest quartile for the state in physical environment, with Adams County near the bottom quartile as well.

Sources: Robert Wood Johnson Foundation. University of Wisconsin Population Health Institute Model of Health © 2025

# Adams County

Adams County is home to roughly 105,183 community members with a median household income of \$81,071 and 9.3% of the community living in poverty. Gettysburg typically represents the urban center of Adams County where poverty is slightly more concentrated. Racial ethnic diversity in Adams County, consisting mostly of Hispanic/Latino community members, is concentrated north of Gettysburg in the rural areas of Biglerville, Aspers and York Springs. The median age of residents in Adams County is 43.8 and roughly 21.3% of residents are over the age of 65 (higher than the state with 19.1% of state residents being over 65). Both the median age and the percentage of residents over 65 are higher in Adams County than all neighboring counties. Most housing units are owner occupied (78.1%) and the median value of homes in Adams County (\$242,800) exceeds the state, Franklin County, Lebanon County and York County median values.

Adams County ranks #11 in the Robert Wood Johnson's County Health Rankings, scoring #11 in Health Outcomes and #9 in Health Factors. Though comparatively this makes Adams County one of the healthier counties in our region, data shows that its residents have health issues strongly associated with obesity and associated indicators, such as poor eating, a lack of physical activities and poor mental health. Data shows that health literacy and social and emotional supports are issues for some residents. Adams County has the lowest rate of households with broadband internet access (40%) in

the region. While health access, substance use and smoking do not appear as significant problems in this community, binge drinking behavior has increased slightly since 2022. In Adams County, compared to our previous CHNA, almost 10% more survey respondents said they experienced at least one day that their physical and mental health were not good in the past month, they experienced one or more days with depressive symptoms in the past two weeks and that they have experienced trauma in their life (47%).

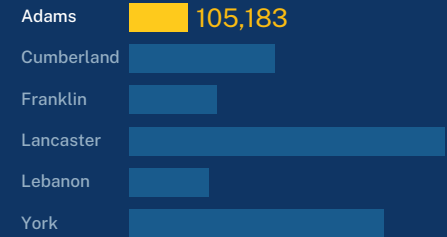
Compared to respondents in most neighboring counties, access to food and money worries have both increased since 2022, with 66% reporting they are stressed about money worries (29% increase since 2022; highest in the region) and 15% more people saying they skipped or reduced meals due to not having enough food to eat. More Adams County residents reported that they are currently depressed (16%) than the region overall (10%), and residents reporting that they used marijuana one or more days in the past month doubled from 2022 to 33%. Adams County residents are less likely to have seen a dentist within the last year (66%), with lack of dental insurance being the common reason why, and more than a quarter of residents (34%) reported one or more economic hardships.

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## County Health Ranking

Robert Wood Johnson — out of 67 PA counties

## Residential Population



## Median Household Income

**\$81,071**

## Poverty Rate

**9.9%**

# Cumberland County

Positioned in the northwest corner of WellSpan's footprint, Cumberland County is home to approximately 261,269 community members and is the fastest growing county within the region. Known for towns like Carlisle and Shippensburg, and its mix of urban and rural communities across 555 square miles, Cumberland County boasts nine school districts, six colleges and universities and 33 municipalities.<sup>1</sup> Cumberland County consistently ranks higher in the County Health Rankings than the other counties within the region and demonstrates a higher life expectancy as well. Fewer households in Cumberland County are living in poverty compared to the state and neighboring counties (4.8% compared to 8.0% for the state and a regional average of 5.8%), and the median household income is among the highest in the state at \$82,849.

The urban centers of Cumberland County (including Carlisle and Shippensburg) tend to demonstrate higher concentrations of poverty within Cumberland County, though rural poverty is also observed with 14 of the 33 municipalities defined as rural by the Center for Rural Pennsylvania. Despite the multiple assets that contribute positively to the health of Cumberland County residents, trends indicate opportunities for improvement as suicide rates and poverty rates for households with children are on the rise, for example.

Consistent with the region, high occupancy rates and rising rent costs are contributing to the challenge of cost-burdened housing. In Cumberland County, 41% of renters and 22% of homeowners are spending more than 30% of their income on housing costs alone. The median home value, \$246,200, remains high in comparison to neighboring counties and demonstrates an increase over time that is slightly lower than the nation, state and region. Additionally, the number of adults 65 and over living alone continues to increase (12.9%) and the percent of the population in the labor force remains relatively constant at 64.2%.

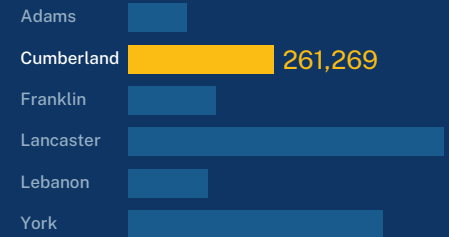
<sup>1</sup> Cumberland County Facts | Cumberland County, PA - Official Website

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## County Health Ranking

Robert Wood Johnson — out of 67 PA counties

## Residential Population



Median Household Income

**\$82,849**

Poverty Rate

**7.9%**

# Franklin County

Roughly 156,084 community members call Franklin County home. Franklin County's median household income of \$71,808 is comparable to the Pennsylvania median of \$73,170, but trails the median incomes of Adams, York and Lancaster Counties. Franklin County has fewer community members living in poverty (9.3%) than the state, Lancaster, Lebanon and York counties.

The urban centers of Chambersburg and Waynesboro demonstrate the highest concentrations of poverty within Franklin County, as well as the most racially and ethnically diverse geographic areas. Franklin County's median home value (\$222,000), median monthly rent (\$1019) and owner-occupied housing rate (61.68%) are on par with the state (\$226,200, \$1110 and 59.09%, respectively) and consistent with other counties in the region.

Franklin County ranks among the highest in the region in the Robert Wood Johnson's County Health Rankings, including #14 overall for Health Outcomes and #20 overall for Health Factors. Franklin County residents' health issues are strongly associated with obesity and associated indicators, such as poor eating, a lack of physical activities and poor mental health. The percentage experiencing one or more economic hardship (37%) is higher than all other counties surveyed in WellSpan's 2025 CHNA.

While suicide rates have decreased slightly in Franklin County, depression rates have increased (from 10% to 15%) and 71% of residents report one or more days with depressive symptoms (up from 62%), with 17% not getting the social or emotional support they need (up from 12%). Financial concerns are common: Forty-two percent of residents spend 30% or more of their income on housing, and 20% report skipped or reduced meals. Finally, school districts within Franklin County continue to demonstrate rising economic disadvantage among school-aged children; 11.6% of Franklin County children 0–6 years are uninsured.

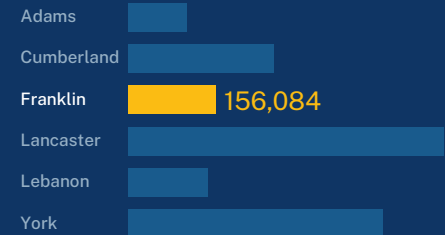
Roughly one in three Franklin County residents report living paycheck to paycheck while 57% report having enough money to go beyond each payday. On a positive note, health access, substance use, smoking and binge drinking indicators do not appear to be significant problems for people living in this community compared to other counties surveyed; these indicators were stable compared to the prior CHNA.

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## County Health Ranking

Robert Wood Johnson — out of 67 PA counties

## Residential Population



Median Household Income

**\$71,808**

Poverty Rate

**7.2%**

# Lancaster County

WellSpan's footprint in Lancaster County is largely concentrated in the northern areas of the county, including New Holland, Ephrata, Denver and Lititz. The WellSpan Community Health Needs Assessment has, for many years, been a critical tool for understanding the attributes that make northern Lancaster County the vibrant and unique community it is. The Young Center at Elizabethtown College estimates that Lancaster County is home to an estimated 42,000 Amish and plain Mennonite community members, contributing to a culture rich in agricultural history, while the entirety of Lancaster County exemplifies an evolving culture with significant population growth and increasing diversity.

Lancaster City is the urban center for the county and demonstrates more racial/ethnic diversity and more poverty than the remainder of the county. Lancaster County overall represents the largest county within the region (553,202 persons), with the highest median home value (\$263,600) and rent (\$1,221). The median household income (\$81,458) exceeds its neighboring counties and is the second highest within the WellSpan footprint, just below Cumberland County. Lancaster County also has a lower median age (39 years) compared to the neighboring Adams, Cumberland, Franklin, York and Lebanon counties and observes the most significant increase in educational attainment levels regionally. Lancaster County consistently performs well in the Robert Wood Johnson County Health Rankings and ranks #9 overall.

Lancaster ranks within the top 10 counties in the state for health outcomes (9th out of 67 counties), length of life (7th), and health behaviors (7th). Despite this, secondary data for the entirety of Lancaster County demonstrates a higher rate of uninsured adults (11.2%) than all neighboring counties, the state, and the nation and 19.7% of children 0-6 years old being uninsured in Lancaster County (more than three times the state average of 4.9%). Lancaster County has more community members speaking languages other than English compared to its neighboring counties. Lancaster County also has the highest number of homeless youth, children eligible for free or reduced school lunch, and individuals receiving WIC benefits.

Residents of northern Lancaster County are, like the residents of other counties in WellSpan's service area, primarily dealing with health issues associated with obesity and associated indicators such as poor eating and a lack of physical activity, limited social and emotional support, and poor mental health.

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## County Health Ranking

Robert Wood Johnson — out of 67 PA counties

## Residential Population



Median Household Income

**\$81,458**

Poverty Rate

**8.4%**

# Lebanon County

Despite being the smallest county in land area in the WellSpan footprint, Lebanon County is one of the fastest growing at 2.5%, with a current population of 143,258. The Hispanic/Latino community continues to expand and now represents 14.5% of the county's population—one of the highest proportions in the region. Lebanon City, the county's urban center, is home to a 45% Hispanic population, highlighting the city's significant role in the county's demographic diversity.

Lebanon County has the lowest percentage of working-age adults (ages 18–64) in the footprint at 55%, falling below both the Pennsylvania average (57.8%) and the national average (58.7%). It also has the second-lowest median household income in the region at \$72,532—trailing both state and national levels. Economic variances are particularly evident within the Latino community, where the median household income is just \$46,780. Additionally, 7.8% of families in Lebanon County live below the federal poverty level, the highest rate among counties in the WellSpan footprint.

While there has been a slight improvement in the percentage of children under 18 living in poverty (down from 16.5% to 16.2%), this remains the highest child poverty rate in the region. Lebanon County also has the lowest median home value (\$211,400) and an average median rent

of \$1,022—making housing costs more affordable than in neighboring counties, though still reflective of broader affordability challenges.

Encouragingly, Lebanon County has improved in several County Health Rankings metrics. The county's rank for physical environment improved from 65th to 59th, while overall health outcomes rose from 29th to 26th, and health factors improved from 19th to 17th. Regardless, poor air quality remains a concern due to the county's geographic features, which contribute to persistent environmental health challenges.

Findings from the 2025 Community Survey underscore several health concerns. Residents reported higher rates of depression, increased financial stress and ongoing poor health habits. Sadly, 85% of respondents said they did not get the recommended amount of exercise in the past week. Lebanon also had the highest percentage (16%) of survey participants reporting experiences of unfair treatment due to race, ethnicity or cultural background.

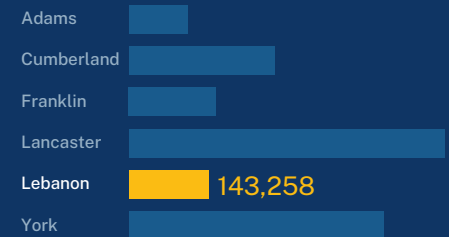
Fortunately, preventive care and coverage are trending upward. More residents reported having a regular check-up in the past 12 months, and the rate of adults with health insurance continues to improve across the county.

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## County Health Ranking

Robert Wood Johnson — out of 67 PA counties

## Residential Population



## Median Household Income

**\$72,532**

## Poverty Rate

**7.5%**

# York County

York County, the largest service area within WellSpan, is home to approximately 457,051 residents and has experienced a 2.5% population growth since 2019. The median age in the county is 41.0, which is higher than both the state and national averages and comparable to neighboring counties. York County is one of the most racially diverse areas within WellSpan's footprint, with 8.3% of residents identifying as Black/African American and 8.5% identifying as Hispanic/Latino. The county features a mix of urban and suburban communities, including the city of York at its center and a smaller urban hub in Hanover. Diversity is most concentrated in York City and extends into surrounding suburban areas such as Red Lion, Manchester and Mount Wolf.

Housing affordability remains a challenge for many residents, with the median home value reaching \$220,700 — an increase of \$43,600 since 2022. More than 24% of households in the county allocate more than 30% of their income to housing costs, and the median monthly rent of \$1,094 mirrors the state median. The median household income in York County is \$79,183, which exceeds the state median of \$73,140 and is higher than in Adams, Franklin and Lebanon counties. However, economic variances persist, with Black/African American households reporting a median income of \$53,391 and Latino households at \$50,802. While York County's poverty rate of 6.0% for families is lower than the state average, financial strain continues to impact certain populations.

York County's health rankings have declined in recent years, dropping from 19th in 2021 to 31st overall in 2023. Despite this, the county ranks 8th in clinical care, the highest in the region. Its physical environment ranking, which considers factors such as air pollution, housing challenges, commuter traffic and drinking water violations, places 50th. Additionally, York City continues to experience high per capita gun-related assaults, surpassing other counties in the region and cities of similar size. Drug-induced death rates and suicides have remained consistent with 2019 levels. The 2023 community survey indicates that residents face significant health concerns related to obesity, poor nutrition, lack of physical activity and mental health struggles. Many adults in the county report being less physically active and experiencing heightened stress due to financial hardships.

While York County's health insurance coverage figures outperform regional, state and national averages — 5% of residents and just 2.4% of children ages 0–6 lack insurance — this data was collected prior to adjustments to pandemic-related insurance thresholds. Employment trends in the county show a shift away from manufacturing and toward health care and social assistance. Education access remains a concern, as only 12.5% of children in York County have access to high-quality pre-k, the lowest rate among neighboring counties and the state.

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## County Health Ranking

Robert Wood Johnson — out of 67 PA counties

## Residential Population



## Median Household Income

**\$79,183**

## Poverty Rate

**8.4%**

## Incorporation of North Region into Process

The alignment of core values and commitment to community are one of many reasons we were delighted to welcome Evangelical Community Hospital into WellSpan Health in the summer of 2024.

As a nonprofit hospital with a shared commitment to community, Evangelical Community Hospital has also been conducting CHNAs for decades with consistent delivery of the reports to the public every three years. The Evangelical Community Hospital cycle for the CHNA, prior to integration with WellSpan, was one fiscal year ahead of all other hospitals within WellSpan. Therefore, the 2024 Evangelical Community Hospital's CHNA and CHIP were implemented in July of 2024.

It was completed along with local partners, stakeholders and neighboring health systems, Geisinger and Allied Services Integrated Health System. The needs assessment covers the shared geographic footprint of all three health systems, which includes 18 counties across four regions in central and northeast Pennsylvania.

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. Access to care, chronic disease prevention and management, and mental health (including substance use disorder) were prioritized as the most pressing needs identified in the CHNA. The graphic (right) identifies key contributing factors driving these top priorities:

Thoughtful consideration of the best approaches to align WellSpan's needs assessment process across the entirety of its footprint remains a priority. WellSpan is committed to learning the needs of the community at a local, county-focused level while also understanding core themes and trends across the WellSpan service area. As such, we will integrate Evangelical Community Hospital into our regional CHNA process by focusing on local data collection and reporting. The full integration of the North Region into the broader WellSpan CHNA/CHIP process will take place in 2028 when the methodology is expanded to include a primary survey and Epic data extraction.

## Consistent Community Priorities & Contributing Factors

Access to Care	Chronic Disease Prevention & Management	Mental Health & Substance Use Disorder
Ability to afford care	Aging, rural population	Availability of providers
Availability of providers	Comorbidities	Comorbidities
Cultural competence	Disparities in disease, mortality	Depression and stress
Digital access	Early detection, screening	Impact of COVID pandemic
Healthcare navigation	Health education	Opioid and alcohol use
Health insurance	Healthy food access	Social isolation
Medical home	Physical activity	Stigma
Transportation	Tobacco use	Suicide attempts, death

← **Focus on Non-Medical Factors Influencing Health** →

For the complete 2024 Evangelical Community Hospital CHNA, visit: <https://www.evanhospital.com/download/?id=9369>. You can find an Executive Summary of Evangelical Community Hospital's Community Health Implementation Plan in Appendix 3.



Lack of Physical Activity  
& Healthy Behaviors

Health issues are strongly associated with obesity and other indicators such as poor eating, and a lack of physical activities.

# Opportunity for Impact

# Overview of Identified Needs

In addition to the CHNA survey conducted for this project, this needs assessment also uses data from numerous publicly available sources. Data used to understand non-medical factors influencing health and demographics, including statistics related to population growth, employment, income, expenses, income supports, poverty, housing, transportation, the environment, education, social integration and stress, come primarily from government sources (e.g., American Community Survey, the Pennsylvania Department of Health and other similar government-supported data collection systems).

Data used to profile health-related indicators, such as health care access, mortality, morbidity and health behaviors, also come primarily from publicly available sources that include the Census Bureau's American Community Survey, the Pennsylvania Department of Health and the County Health Rankings. Data about deaths and disability are based on the University of Washington's Institute for Health Metrics and Evaluation

data. Life expectancy data came from the Center for Disease Control's Small-Area Life Expectancy Estimates Project (USALEEP). Data about deprivation was downloaded from the School of Medicine and Public Health at the University of Wisconsin.

The CHNA process, including all data elements collected, concludes with the analysis of data and identification of core findings and themes. The abundance of data collected and analyzed for the CHNA necessitates the summarization of findings in a meaningful way rather than an attempt to include every data point in this report. The following elements were summarized to provide aggregate perspective of data findings.



# Demographics

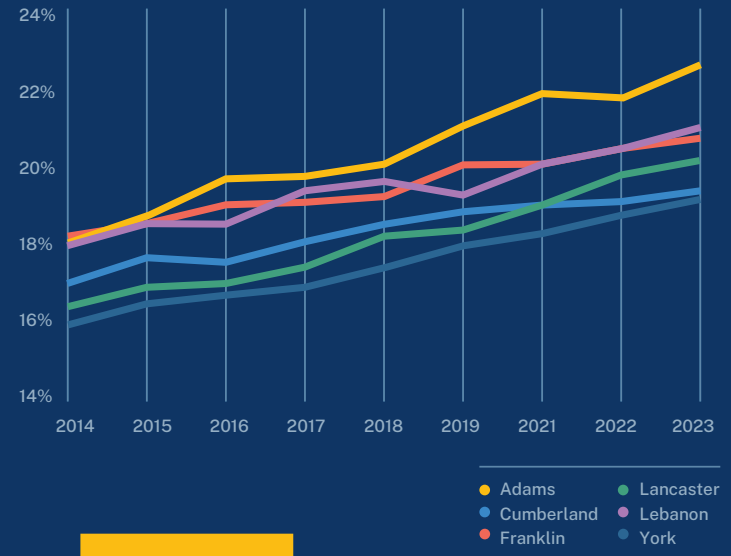
**M**onitoring the demographic attributes of the community requires consideration of the current, previous and future composition of the community. The demographic attributes of the community have remained relatively stable for the past decade, with most residents identifying as White (87%) and the median age (41.3 years) gradually increasing over time. Notably, the growing population of adults over the age of 65 years is consistent but slightly above national and state trends. An additional demographic shift of note in the region is the increasing presence of single-female-headed households with children.

Observations of population growth indicate the community is becoming slightly more racially and ethnically diverse, and the birth rate falls below the death rate currently for every county except for Lancaster County. This is attributed largely to high birth rates observed among Mennonite and Amish

(Plain) communities and the increased presence of Plain community members in Lancaster County.<sup>1</sup>

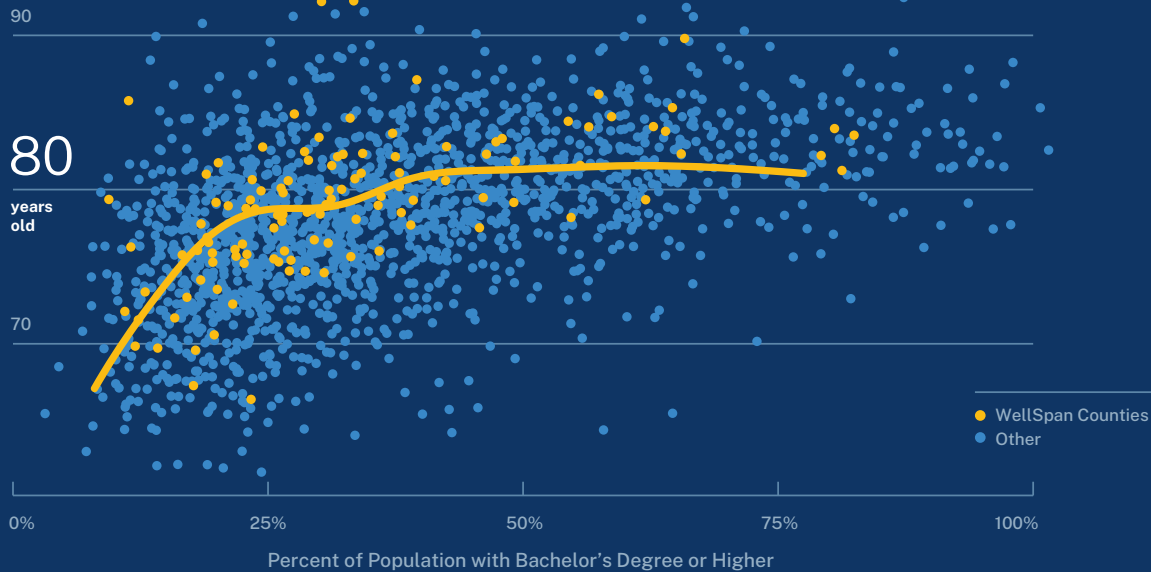
The regional population distribution by age is expected to continue to demonstrate an increasing number of older adult residents — older adults are projected to represent more than 20% of the population by 2040 due to the aging of the baby boomer generation and observed increases in life expectancy over time.<sup>2,3</sup> Beyond the aging population, changes in population are most consistently observed among domestic and international migration in all counties in the footprint except for Lancaster, demonstrating growing rates of individuals moving into the region from domestic and international locations. This upward growth from domestic migration is observed most drastically in York County. Figure 2 demonstrates the observed population changes over time for the region.

### 65 and Over Population Growth



# Life Expectancy

## Life Expectancy by Level of Education



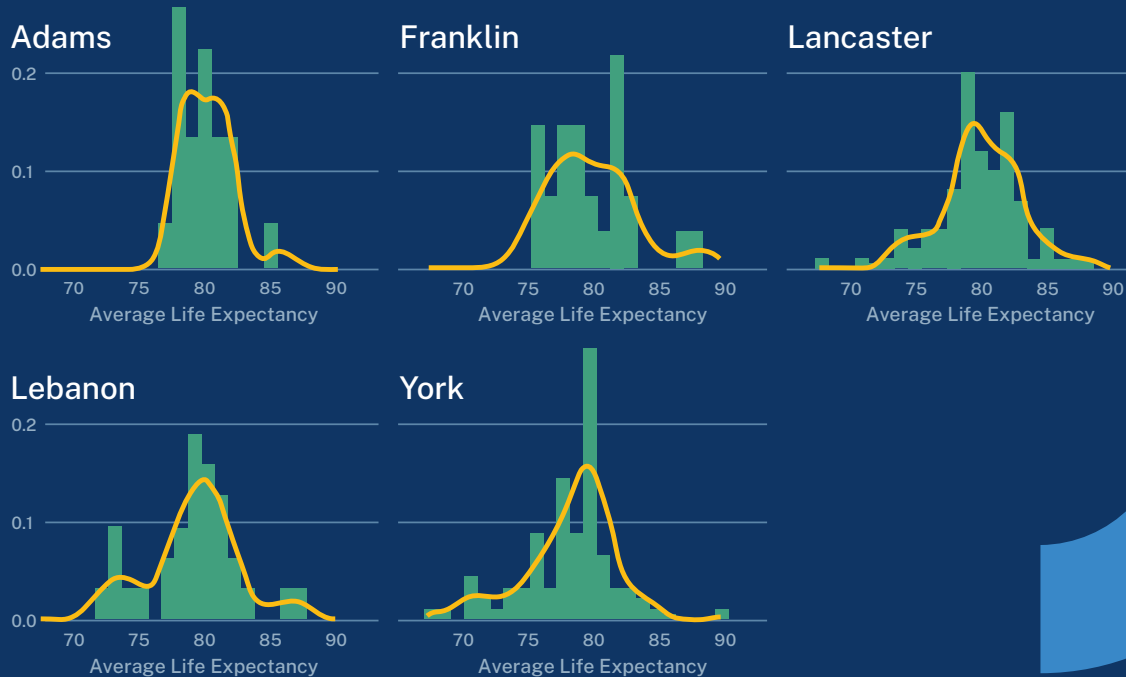
Life expectancy is a helpful data tool because it succinctly captures the overall health status of a population. Life expectancy data also identifies differences across and within geographic areas and demographic subgroups. Understanding which groups are most at risk for poor health helps efficiently direct resources to improve health.

The surge in deaths from COVID-19 reduced U.S. life expectancy in 2021 compared to prior years. But declining life expectancy has also been related to an increase in premature death, including deaths caused by unintentional injuries.<sup>2</sup> Comparatively, residents of the U.S. tend to have shorter lifespans than residents of other developed nations, with deaths due to overdose, violence and injury being more common.<sup>3</sup> Deaths from COVID-19 were greater in the U.S. than in other peer nations, in part, because the U.S. has higher rates of heart disease, obesity and diabetes.

Estimates of life expectancy by census tract show that there is significant variability in life expectancy across and within counties.<sup>4</sup> For instance, life expectancy in WellSpan's service area ranges from a low of 67.7 years to a high of 89.8 years — a 22-year difference — depending on the census tract where

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.

## Life Expectancy by Census Tract



someone lives. The images in the graphic (next page) show variable life expectancy at birth by census tract, with bluer tracts having longer lives. The large differences in life expectancy within a compact geographic area like WellSpan's footprint are striking.

These differences are the natural implication of non-medical factors that influence health — attributes like income, wealth, poverty, education and other characteristics, which are discussed later in this summary. The social characteristics that define each census tract, such as differences in income, educational attainment, or race and ethnicity, are strongly associated with life expectancy.<sup>5</sup>

One of the many ways we've aligned our CHNA findings with our organizational strategy is by setting our sights on improving life expectancy in our community.

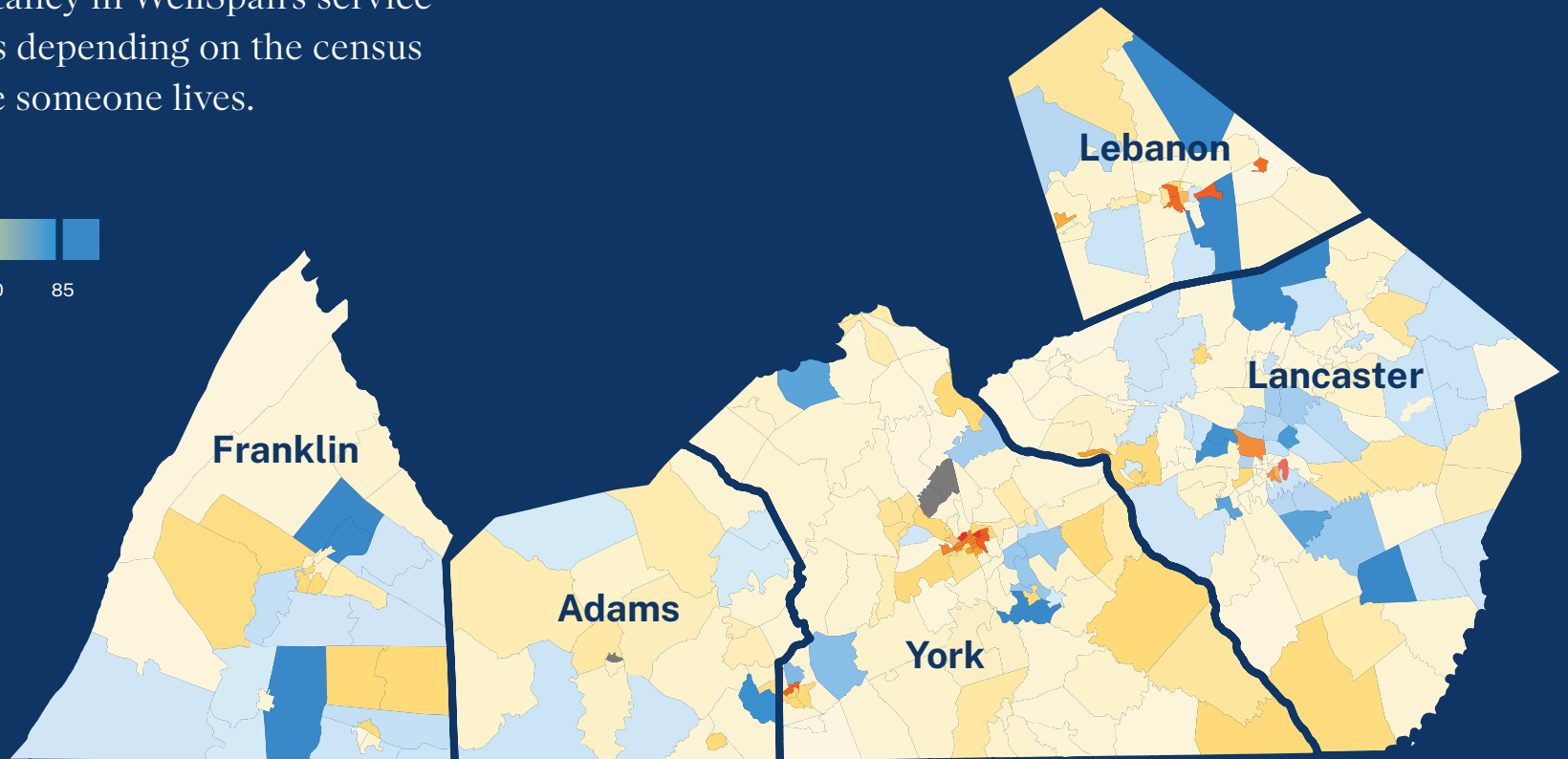
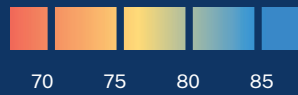
WellSpan's commitment to life expectancy includes focused attention on improving the longevity of patients and community members, enhancing the quality of life and reducing premature death. This work necessitates an appreciation for the multitude of factors that influence life expectancy — both in and out of the control of WellSpan as an integrated health system. As such, WellSpan's needs assessment data provides a critical backdrop for life expectancy efforts regionally.

Source: National Center for Health Statistics, <https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html>.

# Life Expectancy in the Region

Life expectancy in WellSpan's service area ranges depending on the census tract where someone lives.

Source: Centers for Disease Control and Prevention, <https://www.cdc.gov/nchs/data-visualization/life-expectancy/index.html> and <https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html>.



# Death and Disability

**N**ine of the 10 leading causes of death in Pennsylvania and the nation reflect the ongoing burden of chronic health conditions (more specifically, non-communicable disease). COVID-19 represents the lone communicable disease among the leading causes of death (Table 2). The top 10 causes of death in Pennsylvania are the same as the top 10 leading causes of death in the U.S., although deaths from drug use disorders rank higher as a cause of death in Pennsylvania than in the U.S.

The rates of change in death rates between 2011 and 2021 in Pennsylvania were generally below the rates of change in the U.S., either growing more slowly or declining at a faster rate for eight of the 10 causes. Death rates for heart disease, lung cancer, colorectal cancer and diabetes all declined in Pennsylvania, while only the rate of death from heart disease declined nationally during the same period. Changes in death rates were higher in the state for drug use disorders than they were nationally. Deaths rates from chronic kidney disease and Alzheimer's also had notable increases.

Focusing on the conditions that lead to the most deaths is not helpful if it focuses attention on those specific outcomes without considering and remedying the underlying causes that lead to death and disability. Instead, a public health focus on reducing disability-adjusted life years (DALYs) prioritizes the prevention of disease for an entire population instead of focusing on the treatment of individual conditions. The use of DALYs also serves as a reminder that disability is consequential to quality of life. The World Health Organization defines DALYs for a disease or health condition, "as the sum of the years of life lost due to premature mortality and the years lived with a disability due to the disease or health condition in a population."<sup>6</sup> One DALY represents the loss of one year of full health.

The risk factors that account for the most disease burden in the U.S. and Pennsylvania are behavioral risks related to diet, such as high BMI, and to tobacco, drug and alcohol use (Table 3). These risks contribute to cancer, cardiovascular and circulatory disorders, chronic respiratory diseases and diabetes.



## Top 10 Causes of Death per 100k

	Pennsylvania			U.S.	
	2011 Rank	2021 Rank	Change in Deaths	2021 Rank	Change in Deaths
Ischemic Heart Disease	1	1	= -12.5	1	-1.3
COVID-19	-	2	▲ 159.7	2	145.4
Alzheimer's Disease	2	3	▲ 5.3	3	7.7
Stroke	4	4	= 0.4	5	7
COPD	5	5	= 1.6	4	6.5
Lung Cancer	3	6	▲ -7.2	6	4.5
Chronic Kidney Disease	6	7	▲ 12.2	7	13.2
Drug Use Disorders	13	8	▼ 19.7	10	10.2
Colorectal Cancer	7	9	▲ -2.0	8	0.5
Diabetes	8	10	▲ -0.9	9	1.1

Table 2.

Six of these 10 leading risks increased over the last decade, producing increased risk of disability. The greatest increases in disability come from high BMI, high fasting glucose, drug use, kidney dysfunction, high blood pressure and high alcohol use.

The CHNA survey results highlight how common these risk factors are within WellSpan's community. Health behaviors —

things like diet, exercise, substance use and sleep — are important behavioral risk indicators. Few residents exercise regularly (Table 4), too few residents get enough sleep and an increasing number (close to one in four) use marijuana.

Not coincidentally, mental health indicators show that an increasing share of adults, more than 70%, exhibited some depressive

## Top 10 Risks to DALYs\* per 100k

	Pennsylvania			U.S.	
	2011 Rank	2021 Rank	Change in Deaths	2021 Rank	Change in Deaths
High Body-Mass Index (BMI)	2	1	▲ 502	1	661.3
High Fasting Plasma Glucose	3	2	▲ 621.2	2	736.6
Tobacco Use	1	3	▼ -394.5	3	-184.5
Drug Use	6	4	▲ 1,567.5	6	1,011.4
Dietary Risks	4	5	▼ -57.5	4	140.6
High Blood Pressure	5	6	▼ 97.1	5	316.5
Kidney Dysfunction	7	7	= 200.4	7	276.9
High Alcohol Use	8	8	= 50.8	8	143.8
High LDL	9	9	= -78.9	9	-16.6
Occupational Risks	10	10	= -54.1	10	-23.2

Table 3.

symptoms, and an increasing number also say they do not get sufficient social and emotional support. A major source of stress for many people comes from their economic circumstances, with more than half of residents saying they are stressed about money.

Finally, health status indicators are increasingly bad. Nearly 3 in 4 adults are overweight or obese, and half report having at least one day in the past

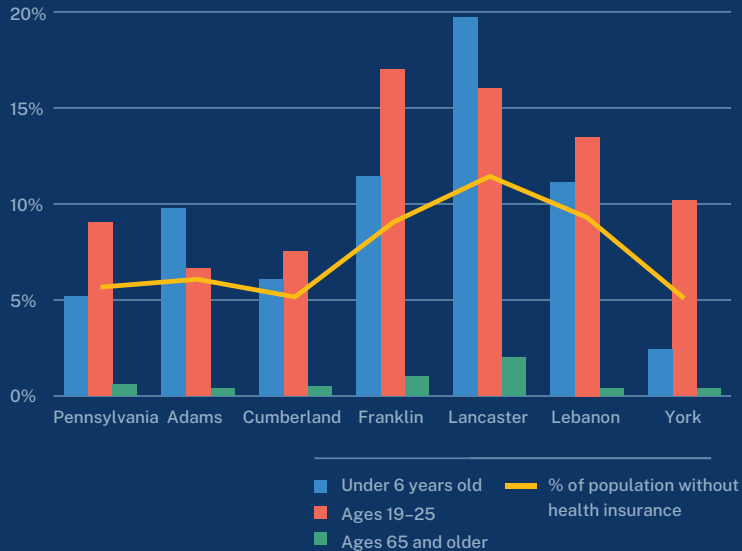
month when their physical or mental health was “not good.” The number of adults who experienced poor physical and mental health days is a good bit higher than in prior health needs assessments.

Source: <https://www.neighborhoodatlas.medicine.wisc.edu/>

\* Disability-Adjusted Life Years

# Care for All

## Uninsured by Age



The exacerbation of health care access and affordability concerns over time in the community have shaped WellSpan's comprehensive and innovative policies. WellSpan's commitment is evident in its generous Financial Assistance Policy, throughout its strategic 2030 Plan and beyond. Though successful efforts have emerged to reduce gaps in care, improve quality and address the cost of care, the CHNA indicates ongoing challenges in health care affordability, access and quality. Additionally, feedback from WellSpan providers pointed to access and affordability of care as a core concern throughout their interactions with patients.

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.

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.

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.

Source: [www.census.gov](http://www.census.gov)

Housing Insecurity & Affordability

Nearly half of renters and nearly a quarter of homeowners are spending more than 30% of their income on rent or mortgage expenses.

# Non-Medical Factors Influencing Health



**D**ata suggests notable and persistent health variances within all the Central Pennsylvania counties served by WellSpan.

These variances 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 concern for costs 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.

Researchers know that the social characteristics that define each census tract, such as differences in income, educational attainment or race and ethnicity, are strongly associated with life expectancy.<sup>6</sup> In addition to the many types of data we’ve described, our needs assessment also presents community-level data from a composite indicator that includes 17 education, employment, housing-quality and poverty measures. This Area Deprivation Index (ADI) is a tool that identifies neighborhoods with significant social disadvantages.<sup>7</sup>

The ADI shows that social conditions within our area vary considerably, with some community deprivation scores revealing neighborhoods that are among the most disadvantaged places in the entire nation. Recognizing these neighborhood gaps will be important for planning interventions.



# Preventing and Managing Chronic Disease

**H**ouseholds in the WellSpan footprint are on par with national, state and local trends related to health behaviors. Health behaviors—diet, exercise, substance use and sleep—are important behavioral risk indicators. According to our survey, few residents exercise regularly (80% did not exercise 30 minutes on five days in the past week), and most adults are not eating the recommended healthful foods, are experiencing high levels of stress and are not sleeping enough. Perhaps not surprising, our communities also observe rising rates of heart disease, diabetes, pulmonary disease, weight gain/obesity and stroke.

Trending data for mental and behavioral health indicators over time revealed 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% reported 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.

# Children's Health

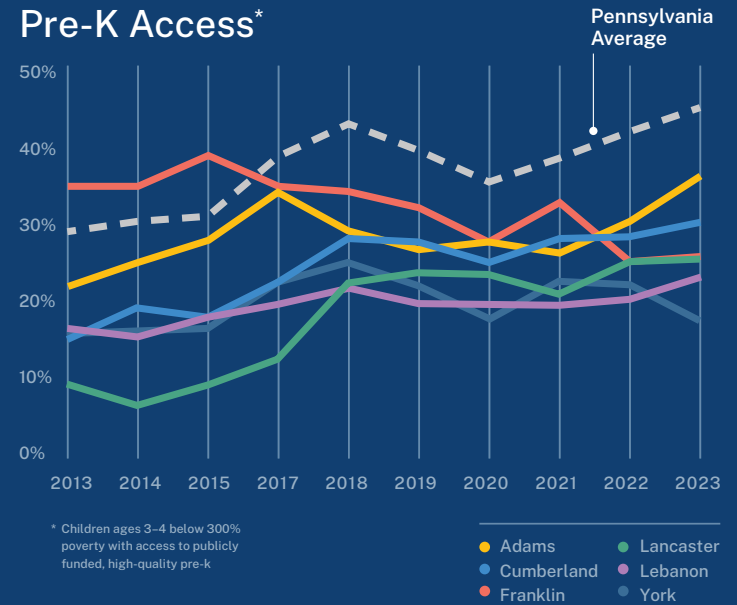
Incorporation of children's health measures into the CHNA began in 2022, with key findings emphasizing the increasing economic disadvantage in every school district across the region, high uninsured rates for children under 6 years, limited access to high quality pre-k for children living in poverty, rising childhood obesity and declining vaccination rates. The 2025 CHNA once again provided data specific to the health of children and families within WellSpan's footprint with many of the same identified concerns observed.

The WellSpan geographic footprint demonstrates higher uninsured rates for children under 6 than the state, 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 ranks higher for uninsured rates than the state and nation. Additionally, approximately 38% of children in kindergarten through 12th grade in the WellSpan service area 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 (28.0% of students) and Science (13.7% of students).

## Pre-K Access\*



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

# Analysis & Prioritization

## New and Emerging Trends

WellSpan has been delivering a CHNA to the community every three years for decades with many of the same trends observed each cycle. There are observed changes in the demographic attributes of the community as the population continues to age and more single-female-headed households emerge. Additionally, the impact of COVID-19 and rising poverty rates over the past three years present challenges to the community. There has been notable improvement in the smoking rates regionally for the past decade, however the number of residents reporting marijuana use demonstrates an alarming recent trend with nearly one in four residents reporting

use within the last month. Children's health insurance rates and concerns about the affordability of health care, food, housing and transportation will be crucial indicators to watch in the near future, with trends demonstrating concerning findings in 2025.

WellSpan has been delivering a CHNA to the community every three years for decades with many of the same trends observed each cycle, as shown in Table 4.



Table 4.

Indicator	Adams			Franklin			Lancaster			Lebanon			York			Total		
	2017	2022	2025	2019	2022	2025	2018	2022	2025	2018	2022	2025	2017	2022	2025	2017	2022	2025
Did not receive health care because of a lack of transportation	5%	2%	2%	5%	3%	4%	6%	0%	1%	4%	2%	2%	6%	4%	3%	5%	2%	3%
Adult e-cigarette vaping (% current vapers)	6%	6%	4%	7%	2%	3%	5%	5%	3%	4%	5%	5%	6%	4%	5%	6%	4%	4%
Used illegal drugs in past year	4%	3%	4%	4%	4%	3%	4%	5%	5%	3%	2%	3%	7%	4%	6%	4%	4%	5%
Fell behind paying rent or mortgage		3%	7%		6%	7%		3%	5%		2%	5%		5%	8%		4%	7%
Did not receive health care in past year because of cost	9%	3%	8%	8%	6%	12%	7%	6%	4%	6%	4%	9%	12%	9%	10%	8%	6%	9%
PHQ-8 current depression indicator-currently depressed	10%	7%	16%	11%	10%	15%	7%	5%	6%	8%	8%	7%	13%	10%	9%	10%	8%	10%
Skipped or reduced meals		7%	19%		8%	20%		10%	16%		5%	9%		11%	13%		8%	14%
Experienced any unfair treatment b/c of race, ethnicity or cultural background		6%	13%		10%	9%		8%	5%		6%	16%		12%	13%		8%	11%
Uninsured (% of pop. under age 65 without health insurance)	12%	4%	7%	14%	13%	14%	16%	22%	12%	12%	15%	9%	10%	5%	5%	13%	12%	8%
No health insurance any time during past year (ages 18-64)	15%	13%	10%	19%	10%	19%	17%	11%	8%	14%	9%	10%	14%	9%	10%	16%	10%	11%
Ate fast food three or more days in past week	4%	7%	15%	12%	9%	14%	9%	7%	9%	9%	9%	6%	14%	12%	7%	10%	9%	9%
Does not get needed social and emotional support	5%	16%	11%	8%	12%	17%	6%	11%	10%	8%	8%	12%	7%	10%	14%	7%	11%	13%
Experienced a reduction in pay		10%	17%		13%	17%		16%	12%		9%	15%		13%	14%		13%	15%
Adult smoking (% current smokers)	18%	14%	12%	16%	13%	9%	15%	7%	5%	12%	9%	11%	19%	15%	8%	16%	12%	9%
Binge drinking behavior	16%	12%	15%	12%	14%	9%	14%	12%	15%	11%	11%	13%	19%	14%	16%	14%	13%	14%
Does not have a personal physician	14%	9%	14%	13%	17%	14%	13%	18%	15%	16%	14%	13%	16%	12%	11%	14%	14%	13%
Poor or fair health	15%	18%	15%	18%	13%	18%	14%	14%	15%	17%	16%	24%	16%	16%	16%	16%	15%	17%
Needs help reading health materials at least occasionally		19%	22%		16%	12%		14%	9%		19%	18%		16%	12%		17%	14%
Used marijuana one or more days in past month		12%	33%		21%	19%		25%	23%		18%	22%		17%	24%		19%	24%
Does not believe vaccines are generally safe and effective		21%	14%		22%	19%		29%	17%		17%	22%		13%	15%		20%	17%
Ever experienced trauma			47%			43%			41%			49%			49%			46%
Has a high-deductible health plan	19%	28%	32%	18%	16%	26%	20%	22%	37%	27%	19%	23%	25%	23%	31%	22%	22%	30%
Economic hardships (one or more)	31%	26%	34%	32%	28%	37%	31%	27%	27%	24%	22%	35%	37%	27%	31%	31%	26%	32%
No routine check-up with doctor in past 12 months	21%	16%	25%	31%	24%	14%	26%	36%	31%	26%	24%	14%	24%	27%	15%	26%	25%	18%
Has not seen a dentist in past year	32%	34%	34%	28%	31%	28%	28%	32%	28%	24%	32%	32%	27%	25%	24%	28%	31%	28%
Stressed about recent loss of a loved one		25%	39%		32%	30%		37%	27%		37%	33%		38%	34%		32%	31%
Did not participate in physical activities or exercise in past month		31%	39%		37%	35%		37%	31%		24%	35%		33%	26%		28%	33%
At least one day mental health was not good in past month		34%	42%		34%	40%		35%	34%		35%	40%		44%	40%		36%	48%
At least one day physical health was not good in past month		43%	43%		44%	45%		35%	39%		40%	34%		45%	45%		41%	49%
Stressed about money worries		38%	66%		46%	51%		42%	57%		36%	46%		44%	52%		46%	53%
No strength training in past month		53%	70%		60%	57%		45%	63%		45%	57%		53%	61%		51%	55%
One or more days with depressive symptoms in past two weeks		59%	61%		62%	62%		56%	64%		55%	67%		64%	65%		59%	71%
BMI: Overweight and Obese		72%	82%		73%	71%		63%	61%		73%	68%		72%	73%		71%	72%
Experienced any symptoms of not getting enough sleep		76%	70%		72%	65%		75%	58%		74%	59%		71%	68%		74%	65%
Did not exercise 30 minutes on five days in past week		81%	84%		80%	80%		85%	83%		83%	77%		84%	82%		83%	82%

# Observed Demographic Differences

Public health researchers frequently attribute persistent, observed differences in health care access, conditions and health behaviors that disproportionately impact a particular demographic group to health variances. Often, the observed differences can include not only demographic attributes but also psychosocial stressors, such as discrimination and trauma.<sup>8</sup> Social determinants thinking suggests that health is determined by access to social and economic opportunities that arise from the places where we learn, live and work. According to the Centers for Disease Control (CDC), “The conditions in which we live explain in part why some Americans are healthier than others, and why Americans more generally are not as healthy as they could be.”

Table 5 displays the relationships between each survey indicator and demographic information such as poverty status, race and ethnicity, gender, age and county, as well as psychosocial determinants such as depression, trauma experiences and discrimination. The color coding identifies whether there is a significant relationship between each indicator and each subgroup and how strong those differences are; the darkest coloring indicates the strongest associations.

Age is significantly associated with differential outcomes related to many indicators. Older residents are more likely to have better access to health care and have better rates on most prevention-related indicators, although they are also more likely to have specific health conditions. Younger residents are more likely to drink, use illegal drugs and smoke (cigarettes and e-cigarettes). Race/ethnicity is also significantly associated with differential outcomes related to access, conditions and prevention behaviors. Poverty is significantly associated with differential outcomes related to access, behaviors, conditions and prevention. There are few notable differences by gender.

This table also shows the overwhelming variances that relate to psychosocial indicators related to depression, trauma experiences and discrimination. These experiences produce some of the strongest disparities across most types of indicators. In most cases, these psychosocial attributes result in greater disparities for more indicators than any of the demographic characteristics, although it is essential to note that some groups are more likely to report these experiences.

Responding to identified variances necessitates a deep dive into the specific populations disproportionately impacted by various indicators.



The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.”

Table 5.

Indicator	Age	County	Depression	Gender	Parents	Poverty	Race/ Ethnicity	Trauma Experience	Unfair Treatment
Adult e-cigarette vaping (% current vapers)									
Adult smoking (% current smokers)									
At least one day mental health was not good in past month									
At least one day physical health was not good in past month									
Ate fast food three or more days in past week									
Binge drinking behavior									
BMI: Overweight and Obese									
Did not exercise 30 minutes on five days in past week									
Did not participate in physical activities or exercise in past month									
Did not receive health care because of a lack of transportation									
Did not receive health care in past year because of cost									
Does not believe vaccines are generally safe and effective									
Does not get needed social and emotional support									
Does not have a personal physician									
Economic hardships (one or more)									
Ever experienced trauma									
Experienced a reduction in pay									
Experienced any symptoms of not getting enough sleep									
Experienced any unfair treatment b/c of race, ethnicity or cultural background									
Fell behind paying rent or mortgage									
Has a high-deductible health plan									
Has not seen a dentist in past year									
Needs help reading health materials at least occasionally									
No health insurance any time during past year (ages 18 -64)									
No routine check-up with doctor in past 12 months									
No strength training in past month									
One or more days with depressive symptoms in past two weeks									
PHQ-8 current depression indicator-currently depressed									
Poor or fair health									
Skipped or reduced meals									
Stressed about money worries									
Stressed about recent loss of a loved one									
Used illegal drugs in past year									
Used marijuana one or more days in past month									
Uninsured (% of pop. under age 65 without health insurance)									

## Legend

- No significant difference
- Significantly different, weak association
- Significantly different, moderate association
- Significantly different, strong association

## Definitions

**Poverty:** a. Above poverty/low income level (n=1,369) b. Below poverty/low income level (n=251) (determined by household size and poverty guidelines based on the Census)

**Race/Ethnicity:** a. Non-Hispanic White (n=1,485) b. Hispanic (n=80) c. Black (n=54) d. Other (n=27)

**Gender:** a. Male (n=792) b. Female (n=854)

**Age:** a. Under 35 (n=401) b. 35-54 (n=514) c. Over 55 (n=731)

**Depression:** a. PHQ8 Current depression indicator - currently depressed (n=161); b. No current depression (n=1,436)

**Trauma experience:** a. Ever experienced trauma (n=760) b. Never experienced trauma (n=886)

**Unfair treatment:** a. One or more experiences of unfair treatment (n=188); b. No unfair treatment (n=1,458)

**Parents:** a. One or more children under 18 currently living in the home (n=506); b. No children living in the home (1,130)

Source: WellSpan 2025 CHNA Survey



**Mental Health**

Nearly half of the community reports having experienced emotional trauma, and 10% were identified as currently depressed.

# Prioritization of Needs Primed for Action

After compiling data and reviewing findings with top experts, community stakeholders, WellSpan leaders and the WellSpan Boards of Directors, WellSpan will look for key themes and priorities for inclusion in the Community Health Improvement Plan.

The CHNA data will 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

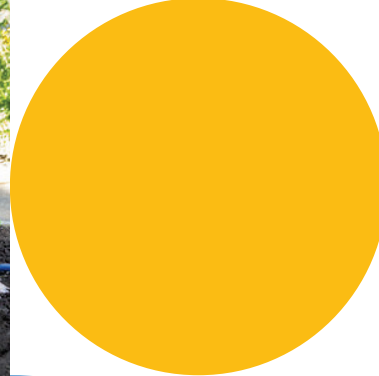
- The community resources available to implement change
- The alignment of these problems with local health systems' goals, missions and resources

WellSpan partners with patients, neighbors, community organizations and policy makers to tackle community health priorities. Complex issues identified in the needs assessment cannot be solved by WellSpan alone and require the coordination of efforts at many levels. Through community-engaged partnerships, we will develop coordinated strategies to produce and reinforce change for our community.

# Conclusion

Our community faces many health issues, which you have learned about in this report. The vastness of these health needs, and the ever-changing landscape of our communities, necessitates an ongoing commitment to learning, understanding and prioritizing needs for community action. The next chapter of this work becomes the orchestration and coordination of community and organizational action to address identified needs, starting with topics that affect large populations in the community. The engagement of many partners will be critical to address the wide-ranging needs in our community.

WellSpan looks forward to sharing the learnings from this assessment and working as one with our community partners to drive actionable improvements.



## Acknowledgments

We are proud to share this 2025 WellSpan CHNA. We are confident that this report demonstrates a data-driven depiction of the health needs facing our neighbors, friends, families and community. This project would not be possible without the tremendous talents of many who have contributed.

The Center for Opinion Research at Franklin & Marshall College in Lancaster, Penna., is WellSpan's partner in this work — leading data collection, analysis and reporting. WellSpan wishes to express its gratitude to the Center for Opinion Research's Director, Berwood Yost, and Project and Data Specialist, Scottie Thompson Buckland, for their tireless efforts to complete the assessment.

Additionally, health coalitions across the region, including Healthy Adams County, Healthy Franklin County, Healthy York Coalition and the Community Health Council of Lebanon County have been instrumental in the completion of this CHNA. Coalition leaders have been actively engaged throughout the process and have provided

expertise and guidance, while ensuring their leadership and community partners are heard and engaged.

Our CHNA is utilized at WellSpan as a strategic document that drives action. WellSpan leaders, Boards, physicians, advanced practice providers (APPs) and subject matter experts are pertinent to the success of our CHNA. Despite the enormity of leading a growing, integrated health system, our leaders, Boards, physicians, APPs and subject matter experts consistently prioritized this work and remained focused on the tremendous commitment WellSpan has to the community and its health.

Lastly, WellSpan wishes to thank our community. Without participation from our community in the survey, this assessment would not be possible. Our community partners remain invaluable messengers and have demonstrated the value of collaboration time and time again.

Thank you all for your support and engagement.

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Colyer, Cory, Cory Anderson, Joseph Donnermeyer, Rachel Stein and Samson Wasao. 2017. “Reviving the Demographic Study of the Amish.” *Journal of Amish and Plain Anabaptist Studies* 5(1):96-119.

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The correlations at the state level show that life expectancy increases with higher median household income ( $r = .56$ ), educational attainment ( $r = .51$ ) and non-Hispanic White population shares ( $r = .48$ ).

Visit <https://www.neighborhoodatlas.medicine.wisc.edu/> for more information about the Area Deprivation Index.

See “Discrimination: A Social Determinant of Health Inequities”, Health Affairs Blog, February 25, 2020.

• DOI: 10.1377/hblog20200220.518458

# Appendices

## Appendix 1:

# WellSpan 2025 CHNA Survey

### Notes

The order of questions varied by respondent, as did the order of response options.

Sections highlighted in light blue were randomized — each respondent received 50% of the sections (sections are divided by text box outlines) to reduce the overall length of the survey.

### Demographics

1. What COUNTY do you live in?
2. What is your ZIP Code where you live?
3. How do you describe yourself?
  - Male
  - Female
  - Transgender
  - Do not identify as female, male, or transgender
4. (If transgender) Do you consider yourself to be:
  - Male
  - Female
  - Do not identify as female, male
5. Do you consider yourself to be:
  - Straight
  - Lesbian or gay
  - Bisexual
  - Other
  - Don't Know
  - Refused
6. What was your age on your last birthday?
7. Are you Hispanic or Latino, or NOT?
8. What is your race or ethnicity (select all that apply)?
  - White
  - Hispanic or Latino
  - Black or African American
  - Asian
  - American Indian or Alaska Native
  - Middle Eastern or North African
  - Native Hawaiian or Pacific Islander
9. We are interested in knowing whether you have experienced any unfair treatment because of your race, ethnicity, or cultural background. Within the past 12 months, that is since [one year ago date], have you felt treated unfairly when you were...
  - At work like a restaurant or store
  - At school
  - Getting medical care
  - On the street or in a public setting,
  - By police or in the courts
  - Using social media
10. Do you have a criminal record?
  - Do you have a felony on your record?
11. What is your CURRENT marital status?
12. How many children LESS than 18 years of age live in your household?
13. [PARENTS ONLY]
  - What is the biggest problem or issue that you and your children have dealt with in the last year?
  - How often do you feel you could use some guidance in dealing with the issues and problems your children are facing: frequently, often, sometimes or never?
  - Have any of your children had a problem with drugs or alcohol in the past 12 months?
14. Including yourself, how many adults 18 years of age or older currently live in your household?
15. Some people play the role of caregiver as part of their daily lives, which means they are responsible for meeting the physical and psychological needs of others. Do you act as an unpaid caregiver for another ADULT, such as a spouse, sibling, aunt, uncle, parent, or grandparent?
  - Yes
  - No
16. Do you care for someone regularly, on a daily basis?
  - Yes
  - No
17. What is the highest grade or year of school you completed?
18. Are you currently...
  - Employed for wages
  - Self-employed
  - Out of work for MORE than one year
  - Out of work for LESS than one year
  - A Homemaker
  - A Student
  - Retired
  - Unable to work
19. What is your annual household income from all sources?
20. About how much do you weigh without shoes?
21. About how tall are you without shoes?

### Health Status

22. Would you say that in general your health is excellent, very good, good, fair or poor?

## Health Days – Health Related Quality of Life

23. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health NOT good?
24. Do you suffer from any type of chronic pain, that is, pain that occurs constantly or flares up frequently?
  - Are you currently taking any opioid or narcotic prescription medications for your pain?
25. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?
26. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?
27. During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?
28. When you took part in this physical activity for how many MINUTES did you usually keep at it?

29. During the PAST MONTH, how many TIMES PER WEEK did you take part in these physical activities?
30. During the PAST MONTH, how many times PER WEEK did you do physical activities to STRENGTHEN your muscles?

## Health Care Access

31. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?
  - Why don't you have health insurance?
32. Which is it, health insurance from employer, private health insurance, a prepaid plan such as an HMO, a state or federal health exchange, Medicaid, Medicare, or something else?
33. Do you have a high deductible health plan?
  - If yes, have you delayed preventative screenings such as mammography or colonoscopy due to cost?
34. Do you have one person you think of as your personal doctor or health care provider?
35. About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.
  - Within past year (anytime less than 12 months ago)
  - Within past 2 years (1 year ago but less than 2 years ago)
  - Within past 5 years (2 years ago but less than 5 years ago)
  - 5 or more years ago
  - Never
36. Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?
37. Has a lack of transportation kept you from getting to a doctor's office or to any other health care appointment during the PAST YEAR?
38. How often do you have someone help you read materials you receive from your doctor or hospital?
  - Always,
  - Often,
  - Sometimes,
  - Occasionally, or
  - Never?
  - PR says has NEVER visited provider
  - Do Not Know
  - Refused
39. How confident do you feel when leaving the doctor's office that you understand what the doctor has told you?

- Extremely confident,
  - Quite a bit,
  - Somewhat,
  - A little bit, or
  - Not at all confident?
  - Do Not Know
  - Refused
40. How long has it been since you last visited a dentist or a dental clinic for any reason?
  41. What is the MAIN reason you have NOT visited the dentist in the last year? (Select all that apply)

## Immunization

42. Generally speaking, do you believe that vaccines used to prevent illness are safe and effective: definitely yes, probably yes, probably no, definitely no?

## Tobacco Use

43. Have you smoked at least 100 cigarettes in your entire life?
  - Do you now smoke cigarettes every day, some days, or not at all?
  - During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

44. Electronic cigarettes (e-cigarettes) and other electronic “vaping” products include electronic hookahs (e-hookahs), vape pens, e-cigars, and others. Have you ever used an e-cigarette or other electronic “vaping” product containing nicotine, even just one time, in your entire life?
- Do you now use e-cigarettes or other electronic “vaping” products every day, some days, rarely, or not at all?

### Alcohol Consumption

45. During the past 30 days, have you had at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?
- During the past 30 days, how many DAYS per WEEK OR per MONTH did you have at least one drink of any alcoholic beverage?
  - During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?
  - Considering all types of alcoholic beverages, how many times during the past 30 days did you have FIVE (men) / FOUR (women) or more drinks on an occasion?

### Substance Abuse

46. In the past year, have you used an illegal drug or a prescription medication for non-medical reasons?

### Marijuana Series - SAMHSA

47. The next questions are about marijuana and hashish. Marijuana is also called pot or grass. Marijuana can be smoked, either in cigarettes, joints, pipes, or vapes, and can be cooked into food or candy and eaten as “edibles”. Hashish is also called “hash” or “hash oil.” Have you ever, even once, used marijuana or hashish?
- Think specifically about the past 30 days, from [date] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish? [Asked if yes to prior question]
  - Do you have a medical marijuana card issued by the state of Pennsylvania?
48. During the past 12 months, have you received treatment or counseling for your use of alcohol or any drug, not including cigarettes?

### Anxiety and Depression

49. Over the last 2 weeks, how many days have you...
- had little interest or pleasure in doing things?
  - felt down, depressed or hopeless?
  - had trouble falling asleep or staying asleep or sleeping too much?
  - felt tired or had little energy?
  - had a poor appetite or eaten too much?
  - felt bad about yourself or that you were a failure or had let yourself or your family down?
  - had trouble concentrating on things, such as reading the newspaper or watching the TV?
  - moved or spoken so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?
50. Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example, a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, or having a loved one die through homicide or suicide. Have you ever experienced this kind of event?
- Yes
  - No

51. In the past 12 months, have you wanted but not sought help for mental health because:
- You could not afford it
  - You did not have insurance
  - You did not have transportation
  - You were turned away by a medical provider
  - You are not comfortable asking others for this kind of help
52. If you sometimes experience stress, anxiety, feeling alone, or sadness and think you need help to cope, what do you do?

### Social Context

53. The following questions are about several factors that can affect a person's health. Did any of the following hardships happen to you in the last 12 months...
- Did you lack or lose health insurance coverage?
  - Did you experience a reduction in pay for any reason?
  - Were you unemployed and looking for work for as long as a month?
  - Did you skip or reduce your meals?
  - Were you worried that your food would run out before you got money to buy more?
  - If yes to either d. Did you skip or reduce your meals OR Were you worried that your food would run out before you got money to buy more, then ask:

- Has your household used a food bank, food pantry, or other food distribution service within the past year?
- Do you or does anyone in your household receive food stamps, SNAP, or EBT?
- Were you unable to get any needed prescription medications because you couldn't afford it?
- Did you fall behind in paying your rent or mortgage?
- Were you unable to purchase needed FOOD because you couldn't afford it?
- Were you unable to get needed MEDICAL CARE because you couldn't afford it?
- Were you unable to purchase needed GAS because you couldn't afford it?
- Were you let go or permanently laid off from your job?
- Did you have any UTILITIES, such as water, heat, or electricity, shut off because you couldn't afford the bill?
- For financial reasons, did you have to temporarily live with others or in a shelter or on the street?
- Were you evicted from your apartment or house?

54. To what degree do you feel grief, loss and burnout has impacted you: not at all, a fair amount, somewhat, a moderate amount, or a great deal?

The following sections will be randomized so that each respondent will receive 50% of the sections, as defined by the colored boxes.

### Housing

1. Do you currently rent your home, own your home, is it someone else's home, or is it some other type of place?
2. In the past two years, have you been homeless, couch surfing, or stayed in a shelter?
3. On a scale of 1 to 7 where 1 means "not at all worried" and 7 means "extremely worried", how worried are you that you will not be able to pay your [rent/mortgage] next month?
4. How many years have you lived at your current residence?
5. How safe do you feel in this neighborhood?
  - Not at all safe
  - Somewhat safe
  - Somewhat unsafe
  - Very safe

### For Renters only

6. Excluding any assistance you, or someone living with you, might receive, how much is the total rent each [week/month]? [If a mobile home, ask for cost of trailer and lot combined]

7. Since living at this place, how often have you or the people you lived with been late with a rent payment?

- Always
- Often
- Sometimes
- Rarely
- Never
- Do not know

8. An eviction is when your landlord forces you to move when you don't want to. A landlord might force you to move because you didn't pay your rent, because you damaged the property, or for any number of other reasons. Sometimes a landlord gives you a paper, or tapes a paper to your door, saying you have to move. Sometimes you go to court; other times you don't. Whatever the case, an eviction happens when you move out because a landlord makes you. Were you, or a person you were staying with evicted from a place in the last two years?

- How many times were you or a person you were staying with evicted in the last two years?
- Were you, or a person you were staying with, evicted because you or they fell behind in rent?

9. Which of the following statements best describes your household's general financial situation:

- Have enough money to go beyond each payday
- Living payday to payday

- Sometimes don't have enough money for basics
  - Do not know
10. Which of the following statements best describe your general feelings about your current debt:
    - Don't have any debt
    - Manage debt without any setbacks
    - Occasional difficulties but making progress
    - Never able to make any progress
    - Do not know

### Food

11. How many days in the past WEEK did you prepare your evening meal at home?
12. How many days in the past week did you purchase or receive food from the following sources:
  - A senior center or food pantry?
  - A Wal-Mart, Target, or other big box store?
  - A convenience store or corner store?
  - A farmer's market?
  - A grocery store such as Giant, Weis, or Food Lion?
  - A fast food or chain restaurant?
  - A dollar store?

13. Has your household used a food bank, food pantry or other food distribution service within the past year?
14. Do you or does anyone in your household receive food stamps, SNAP or EBT?
15. Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree with the following statements about how well you sleep each night.
  - I often feel drowsy during the day, more than I expect is normal
  - I feel unrefreshed or tired in the morning despite sleeping at night
  - I have trouble falling asleep
  - I have trouble remaining asleep
  - I awaken frequently during the night

### Cancer Screening

16. Have you ever had a mammogram? (asked all women over 40)
17. Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had either of these exams? OR, have you done an at-home colon cancer screening, such as Cologuard? (asked everyone over 50)
18. What has prevented you from having these exams?

### Emotional Support and Life Satisfaction

19. How often do you get the social and emotional support you need?
20. People sometimes look to others for companionship, assistance or other types of support. How often is each of the following kinds of support available to you if you need it? How often is
  - Someone to love and make you feel wanted available
  - Someone available who shows you love and affection
  - Someone available to take you to the doctor if you need it
  - Someone available to confide or talk to about yourself or your problems
  - Someone available to share your private worries and fears with
  - Someone available to help with daily chores if you are sick
  - Someone available to do something enjoyable with
  - Someone available to get together with for relaxation
21. In general, how satisfied are you with your life
  - Very satisfied,
  - Satisfied,
  - Dissatisfied, or
  - Very dissatisfied?
  - Don't Know, Not sure
  - Refused

22. How much of a hassle were the following things for you – did they cause no stress, some stress, moderate stress, or severe stress for you during the past 12 months?
  - Problems with alcohol or drugs
  - Sexual, emotional, or physical abuse
  - Crime or safety in your neighborhood
  - Problems with your friends
  - Worries about food, shelter, health care and transportation
  - Having to move, either recently or in the future
  - Recent loss of a loved one
  - Work or job problems
  - Money worries like paying bills
  - Problems related to family
  - Feeling generally “overloaded”

### Open-Ended Questions

23. This survey has asked about many different health-related topics. What do you think is the most important health problem confronting your community today?
24. What, if anything, should be done to improve the health and meet the health needs of your local community?

## Appendix 2:

# Provider Survey Executive Summary

WellSpan incorporated the voice of our physicians and advanced practice providers (APPs) in the 2025 Community Health Needs Assessment (CHNA) in the form of a survey to our clinical provide The survey, co-developed with a multi-disciplinary physician workgroup, collected feedback about community health issues they are observing in clinical care. A total of 495 providers (18.3% response rate) responded to the survey conducted from 3/24/25–4/4/25. Respondents were a diverse group, varying in specialty, practice setting, county of practice, years of practice and race/ethnicity.

### WellSpan Provider Survey Highlights

Noteworthy findings in provider survey responses include:

- Top 3 community health issues are Healthcare Access, Behavioral Health, and Health Behaviors/Lifestyle.
- Insurance coverage, availability, and affordability were identified by over 75% of respondents as the main issues within health care access.

- An alarming number of providers indicated that depression and anxiety were key factors affecting their patient's health.
- Social determinant of health indicators, like safe/stable housing, transportation, and food access, along with socio-economic status and loneliness/social connection, were the top attributes our providers felt impacted their patient's health and longevity.
- WellSpan continues to make strides in illuminating the pathways that connect patients to vital resources, with providers noting that continued efforts via education and care team support would further improve patient outcomes.
- Preventative care and behavioral health were repeatedly mentioned as areas of concern in helping to improve the life expectancy of patients
- The majority of respondents were unaware of the resources available to support community referrals

Common themes in open-ended responses include:

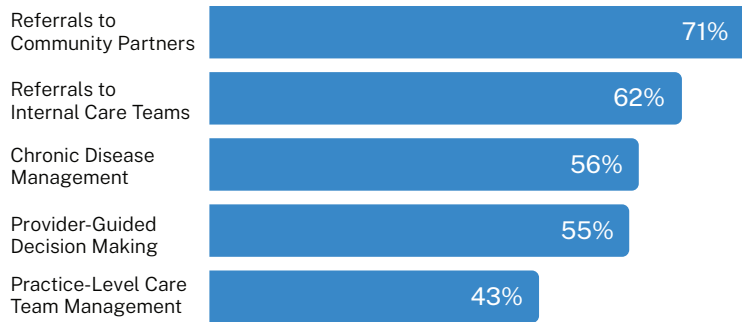
- Increased access and affordability are key to our patients
- Limited care team and community resources were the main barriers acknowledged to helping respondents take action on identified social determinant of health challenges

Potential opportunities to support providers in alignment with our community health priorities include:

- Increased and better access to care
- Improved alignment with community resources/engagement
- Evolving the referral process and integration/expansion of care management, coordination and navigation
- Leverage opportunities to support patient transportation needs
- Utilization of AI to assist patients with care needs

Overall, the survey expressed solid alignment between what our physicians/APPs perceived as top health issues, and the priorities identified through broader secondary and primary data collection for our CHNA. The top three health issues identified by our providers—Health Care Access, Behavioral Health and Health Behaviors/Lifestyle—highlight a multifaceted approach to improving patient and community well-being. These priorities underscore the need to address affordability, access, mental health challenges and preventive care, reinforcing WellSpan's commitment to exceptional health care, simplified. Compared to the 2022 survey, providers showed greater ambivalence in their responses this year, though the survey instruments were very similar. Likely the timeliness of the previous, inaugural survey in 2022, as the pandemic continued to plague our communities, influenced responses. The consistency in key themes identified in the Provider Survey responses highlights the continued relevance of the 2030 plan.

## Non-Medical Factor Considerations to Support Patient Well-Being



Care for all remains a foundational priority within WellSpan's CHNA and improvement plan frameworks. WellSpan physicians/APPs recognize that personalized care for patients is necessary — data suggests that variances in patients' health affects patients in different ways across the WellSpan footprint. Survey results indicate strong physician/APP awareness of factors that influence patients' health, with Socio-Economic Status ranked as the most influential factor affecting patient well-being (cited by 90% of providers). Other key attributes include Safe/Stable Housing, Loneliness/Social Connections, Transportation, Food Access and Age — each identified by over half of respondents. Additional factors such as

Geography, Race/Ethnicity, Gender and Sexual Orientation were noted as well. Providers also emphasized the influence of non-medical factors, often referred to as social drivers of health, including the influence of mental health conditions on patient outcomes. Recognizing the pivotal role of culturally competent care, 75% of physicians/APPs believe it directly affects patient health outcomes. However, only 29% expressed strong confidence in their ability to provide culturally competent care, highlighting an opportunity for targeted education and systemic support.

WellSpan physicians/APPs actively acknowledge their role in addressing

non-medical factors, or social drivers of health (SDoH), to support patient well-being. Key areas of involvement include referrals to community partners (71%), referrals to internal care teams (62%), chronic disease management (56%), provider-guided decision-making (55%) and practice-level care team management (43%). However, 11% of providers did not identify a role in SDoH management. Providers face substantial barriers in effectively addressing SDoH challenges. The most cited obstacles include inadequate or limited care team resources (99%) and inadequate or limited community resources (88%). Only 4% of providers reported no barriers, indicating a need for enhanced resource support and infrastructure to empower providers in fulfilling their roles.

Across our footprint, our providers know of many ways to take action on identified community health issues. While WellSpan may have a role to play in each area, we must distinguish between where we best lead and where we better support others taking charge. While WellSpan is seen as well-positioned to lead initiatives in chronic disease management, health care access/value/quality, family health, behavioral health and health behaviors/lifestyle, other issues such as community challenges, resources/support and poverty-related concerns are perceived as areas better addressed through community action and public policy. This

strategic insight highlights the importance of collaboration across sectors, ensuring that while WellSpan's strengths are leveraged effectively, partnerships are fostered to tackle broader challenges in the community.

Open-ended responses from WellSpan physicians and APPs reflect the profound challenges and emotions associated with delivering patient care in an ever-evolving, demanding health care environment. Their comments underscore the need for deeper engagement and dialogue to address gaps and identify opportunities for improvement. Despite these challenges, a unified mission emerges: to deliver the highest quality, patient-centered care to every individual they serve. In addition, providers shared numerous ideas for how WellSpan can support them in overcoming barriers, enhancing services and optimizing efforts at all levels. Their insights offer valuable guidance for shaping strategic initiatives aimed at empowering providers and advancing care delivery.

WellSpan Health is committed to becoming a national leader in providing exceptional care for all by addressing significant variations in life expectancy across its service areas. Life expectancy is used as a long-term indicator of health, shaped by three main factors: Premature Death, Longevity and Quality of Life. To support this goal, WellSpan focuses on strategies like increasing access to care, providing education, improving

affordability, expanding preventative and behavioral health services, reducing barriers and enhancing health literacy. Results from the Provider Survey indicated support for the life expectancy approach broadly and contributed feedback on how they may contribute to these efforts. Feedback from providers indicated interest in influencing life expectancy through, for example:

- Adequate prevention, screening and education for patients from clinical teams to include lifestyle factors contributing to chronic disease
- Access, affordability and quality as necessary components to enhance longevity and ensure a positive quality of life
- Affording providers the time they need to engage patients in meaningful ways
- Enhanced familiarity and connectedness with community resources to adequately close identified SDoH gaps
- Exploring personalized approaches to patient care that allow providers to build trust, support patients with individual goals and focus on a balanced approach to medical and quality of life needs

While it is difficult to directly compare the results of this survey to the 2022 survey due to the influence of COVID-19 on the previous survey, notable similarities emerged — particularly the continued call for enhanced

care coordination roles to better support teams and providers in meeting patient needs. Specific strategies identified include:

- Offering post-visit virtual connections with centralized social care navigators familiar with available resources
- Developing a comprehensive inventory of community partners and resources along with seamless referral processes
- Expanding community programs for patients with chronic or severe mental illness, especially those that include housing support
- Providing more practical, practice-based education for providers on available tools
- Leveraging AI to help individuals navigate social services effectively

Contextually, this survey plays a role in shaping strategies for the Community Health Improvement Plan and beyond. The synergy between provider and community feedback provides an opportunity to prioritize actionable solutions, leverage strategic perspective from the WellSpan 2030 plan and partner to advance the health of the community broadly.

### Appendix 3:

## 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 social drivers of health (SDoH) barriers 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 likelihood 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.

##### Social Drivers of Health Opportunities

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>

## Community Health Implementation Plan

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.

- 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.

## Consistent Community Priorities & Contributing Factors

Access to Care	Chronic Disease Prevention & Management	Mental Health & Substance Use Disorder
Ability to afford care Availability of providers Cultural competence Digital access Healthcare navigation Health insurance Medical home Transportation	Aging, rural population Comorbidities Disparities in disease, mortality Early detection, screening Health education Healthy food access Physical activity Tobacco use	Availability of providers Comorbidities Depression and stress Impact of COVID pandemic Opioid and alcohol use Social isolation Stigma Suicide attempts, death

← Focus on Non-Medical Factors Influencing Health →

- 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 social determinants of health (SDoH) 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 social variances with various community health and social 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 social drivers 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.**

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Approved by the board.