Economic & Workforce Impact of the Northeast Pennsylvania Clinical Education Consortium

2025 October

Recommendations for Regional and National Expansion

Submitted by Tripp Umbach

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Executive Summary

The Northeast Pennsylvania Clinical Education Consortium (NEPA-CEC) was formally established in 2023 as a pilot program, led by Lackawanna College, to align the medical education resources of three osteopathic medical schools with the clinical training capacity of hospitals and clinics in Northeastern Pennsylvania. Conceived as a cost-effective alternative to developing a new medical school in Scranton, the consortium was developed on the principle of leveraging existing academic institutions, hospitals, federally qualified health centers (FQHCs), and community providers to expand access to clinical education and graduate medical education (GME). By doing so, the NEPA-CEC seeks to grow its own physician workforce through leveraging existing resources, strengthening local healthcare delivery, and generating long-term economic and community benefits.

Stakeholders across osteopathic schools, local health systems, FQHCs, and community leaders broadly support this regional, multi-institutional training hub in Scranton, which aligns undergraduate medical education with graduate medical education and entry to practice, thereby growing and retaining the physician workforce, especially in primary care. The optimal features of this model, according to stakeholders interviewed by Tripp Umbach, involve Lackawanna College serving as a neutral convening body and coordinator of multiple schools and clinical partners, as well as strong initial buy-in from three existing osteopathic medical schools[1] and numerous hospitals and clinics.[2]

Opportunities

Tripp Umbach's independent review of recent Community Health Needs Assessments (CHNAs) across hospitals in Northeast Pennsylvania identified three overarching priorities that consistently define the region's health challenges: access to care, mental and behavioral health, and chronic disease prevention and management. These needs are interrelated and deeply influenced by underlying social determinants of health, including affordability, transportation, workforce shortages, and the geographic realities of serving both urban and rural populations.

Access to care remains the most persistent barrier, shaped by limited provider availability that delays treatment and contributes to avoidable emergency department use. Mental and behavioral health needs continue to escalate across all age groups, with growing concern over substance use, suicide risk, and youth mental well-being. Chronic diseases such as heart disease, diabetes, and respiratory illness remain prevalent, reflecting lifestyle, environmental, and socioeconomic factors that limit opportunities for prevention and wellness.

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[1] Philadelphia College of Osteopathic Medicine (PCOM), Touro College of Osteopathic Medicine (Touro COM, New York), and University of New England College of Osteopathic Medicine (UNECOM).

[2] Commonwealth Health (which includes hospitals in Scranton and Wilkes-Barre, and Wilkes-Barre General Hospital), The Wright Center (a teaching health center/FQHC look-alike, offering primary care rotations and OMM training), Scranton Primary Health Care Center (an FQHC providing family medicine, internal medicine, pediatrics, and psychiatry rotations), and Allied Services Healthcare (includes rehabilitation hospitals, outpatient clinics) as an elective training site.

Collectively, these findings underscore the need for a coordinated regional strategy that strengthens the healthcare workforce, expands behavioral health and substance use services, and invests in community-based solutions that address the root causes of poor health outcomes. The NEPA-CEC is well-positioned to play a pivotal role in this effort by expanding physician training and retention, aligning local educational resources with long-term strategies to improve access, equity, and overall community health in Northeast Pennsylvania.

Challenges

Challenges to overcome in ensuring the sustainability of the NEPA-CEC include expanding rotation capacity through preceptor development, offering incentives to increase the clinical teaching supply, and securing housing for medical students. Risks to long-term success include scheduling alignment with multiple independent medical schools, uncertainty about the sustainability of hospital partners, and a level of interest in teaching osteopathic medical students at an extensive health system in the region that owns its own medical school. Additionally, there is competition for training sites with other medical schools that have not joined the consortium, as well as with clinical sites that work with multiple programs both within and outside the consortium. Stakeholders affirm that these challenges can be mitigated through a formal advisory board, shared scheduling, and a transparent, collaborative framework.

For the NEPA-CEC to succeed, key structural elements must be advanced in the near term. Governance clarity is crucial, with stakeholders emphasizing the need for an executive director and an advisory board that can coordinate across institutions, health systems, and community partners. Equally pressing is the expansion of clinical rotation slots and housing capacity to ensure students can be placed in community-based training environments throughout the region. In the long run, sustained support for preceptors and alignment with established graduate medical education champions such as the Wright Center will be vital for anchoring new physicians in the region after training, directly addressing the state and national challenge of physician retention.

To achieve the goal of growing the physician workforce in Northeast Pennsylvania, it is necessary to build on the initiative to attract medical students to the region for clinical training while simultaneously expanding GME sponsorship or co-sponsorship capabilities to convert the medical student supply into permanent retention. The Wright Center, a strong, nationally recognized sponsoring organization with deep roots in the region, is positioned to lead GME expansion efforts, thereby increasing the number of students who participate in the medical school consortium who remain in the area for residency training and practice.

Cost-Effectiveness of the NEPA-CEC Model

The NEPA-CEC model offers a highly cost-effective alternative to establishing a new standalone medical school. By leveraging existing accredited osteopathic programs and local clinical training capacity, the NEPA-CEC expands physician education without the substantial capital investment typically required for new medical schools. Traditional medical schools require approximately $200 million in start-up funding and have an annual operating cost of about $90,000 per student. In contrast, the NEPA-CEC operates at roughly one-sixth of that cost, with no new construction or accreditation start-up expenses.

The NEPA-CEC model channels resources directly into clinical training, preceptor development, and community partnerships, areas that yield immediate benefits for the workforce and the economy. In contrast, a new medical school may generate a higher regional impact per student, but its enormous overhead results in a return on investment nearly 12 times lower than that of the NEPA-CEC when measured over 10 years. In short, the NEPA-CEC delivers the outcomes of a new medical school, economic growth, workforce expansion, and improved community health for a fraction of the cost, making it a valuable and replicable national model for physician workforce development.

Economic Impact

Even in its pilot phase, the NEPA-CEC is expected to generate $2.7 million in total regional economic activity in FY25 through student and residency spending, preceptor support, and partnerships with regional hospitals and health systems. Each medical student contributes approximately $75,000 in total direct, indirect, and induced economic benefits to the regional economy annually, while every new resident adds $450,000 to the economy each year. These recurring dollars strengthen small businesses, housing markets, and healthcare providers, creating a sustainable base of regional growth.

The long-term payoff through workforce expansion is even greater. Each locally trained physician who remains in the region to practice is projected to make cumulative economic contributions of $2.2 million annually, resulting in a total economic impact of more than $200 million from new physicians by 2030. Beyond financial implications, these physicians expand access to care, stabilize hospitals, and enhance community health, particularly in primary care and behavioral health, where shortages are most pronounced.

In social terms, the NEPA-CEC strengthens Scranton's identity as a regional hub for health, education, and innovation. By investing in people rather than buildings, a homegrown healthcare workforce is built, outmigration for care is reduced, and a more equitable, resilient, and knowledge-based local economy is fostered.

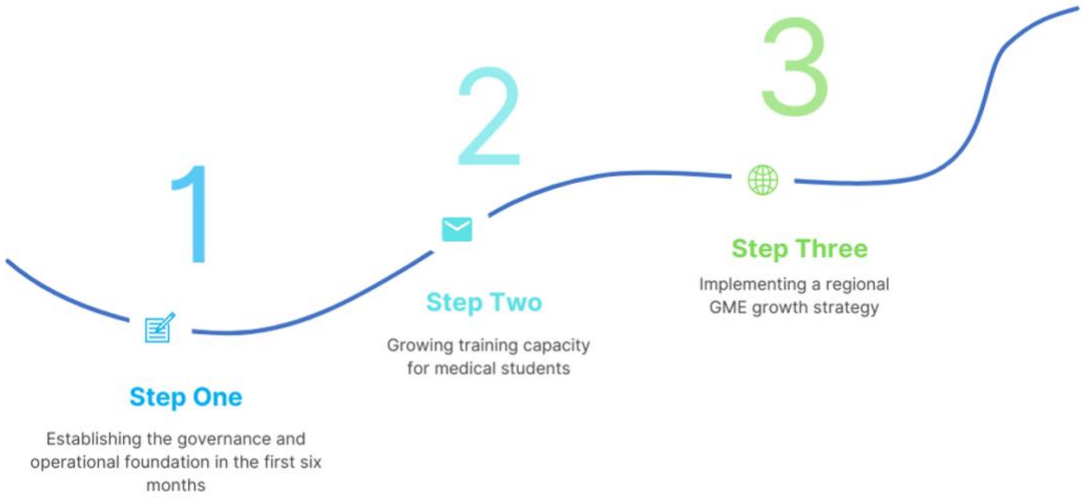
National Model

Beyond the Scranton region, this model demonstrates enormous potential as a nationally replicable framework for the American Association of Colleges of Osteopathic Medicine (AACOM) and its member institutions. By bringing together multiple medical schools under a shared governance and resource strategy, the consortium approach accelerates physician pipeline development more efficiently than

siloed efforts. In this way, the Scranton pilot is not only a regional solution but also a pioneering example of how collaboration can reshape the national physician workforce landscape.

Recommendations

Tripp Umbach recommends that the NEPA-CEC move forward with a structured and phased implementation plan designed to stabilize and expand the region's physician training pipeline. The foundation of this plan is a formal governance structure, anchored by an independent board and several working committees and led by a clinically trained executive director to ensure balanced oversight and day-to-day management. Central to the model is a standard scheduling system that equitably allocates clinical placements across institutions, supported by preceptor recruitment and development programs that combine professional recognition, CME opportunities, and financial or loan-repayment incentives.



The roadmap envisions three phases:

1. Establishing the governance and operational foundation in the first six months,
2. Growing training capacity for medical students, and
3. Implementing a regional GME growth strategy.

These steps will set the stage for the NEPA-CEC to transform Scranton into a hub for physician education, retention, and community health improvement. The Scranton consortium model represents a compelling and innovative solution to addressing physician workforce shortages in a way that is both cost-effective and scalable.

Introduction

In the summer of 2025, the AACOM and the NEPA-CEC retained Tripp Umbach, a nationally recognized consulting firm in academic medicine with deep ties to Northeast Pennsylvania, to develop a comprehensive independent report with recommendations whether the pilot could be expanded into a sustainable regional and national model. This report also evaluates the program's economic and social impact, outlines an actionable plan for scaling, and assesses its potential for replication in other regions with multiple osteopathic schools. With its unique collaborative structure and regional focus, the NEPA-CEC serves as a demonstration site for AACOM members, offering a blueprint for how communities can create scalable, cost-effective approaches to physician workforce development.

Regional Healthcare Environment in Northeastern Pennsylvania

Scranton, situated in Lackawanna County, is the most populous city in Northeastern Pennsylvania, with approximately 80,000 residents anchoring a metropolitan area of nearly 600,000. The region is experiencing modest demographic change, including almost a 10% increase in minority populations over the past decade, which reflects broader state and national diversity trends. At the same time, the region continues to face structural socio-economic challenges, with more than one in every five Scranton residents living below the poverty line.[3] These economic constraints contribute to persistent health disparities, including high rates of chronic illness, behavioral health needs, and barriers to consistent access to care.

In the Scranton–Wilkes-Barre–Hazleton metropolitan area, healthcare and education together represent the largest share of the regional economy. Health Care and social assistance employ 45,669 people, or 17.1% of the total workforce, while educational services account for another 24,987 jobs, or 9.37%. Combined, these two sectors represent 26.5% of all employment in the region.[4] These data underscore both the centrality of healthcare and education to the local economy and their importance as workforce development priorities for the future physician pipeline and related health professions.

While 93% of residents have health insurance coverage, the uninsured rate is rising, signaling growing pressure on safety-net providers. Future impacts from the 2025 congressional budget, resulting in lower Medicaid funding, place even greater pressure on maintaining a sufficient and well-distributed physician workforce trained to deliver accessible care in community-based settings.

Graduate Medical Education is already established in Scranton, presenting opportunities for expansion. The Wright Center for Graduate Medical Education, a nationally recognized HRSA-funded Teaching Health Center, anchors much of the region's residency training. Its Accreditation Council for Graduate Medical Education (ACGME)-accredited residencies, particularly in internal medicine, family medicine, and pediatrics, immerse trainees in FQHCs and community hospitals, producing graduates who are more

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[3] The median household income of $28,800 and per capita income of $16,200 fall well below the Pennsylvania and U.S. averages.

[4] Data USA, Scranton–Wilkes-Barre–Hazleton, PA Metro Profile (2024)

likely to remain in underserved areas. Geisinger Health System also represents a dominant regional healthcare and medical education force, with 10 hospitals and an expansive care network across Pennsylvania. Importantly, the Geisinger Commonwealth School of Medicine, formerly the independent Commonwealth Medical College, is headquartered in Scranton, underscoring the city's significance as a hub for medical education. However, the transition of this community-founded medical school into full Geisinger ownership highlights a critical challenge in aligning physician training pipelines with the broader community's needs rather than the strategic interests of a single health system. (See Appendix B for a more complete inventory of hospitals and training programs in the region.)

Mission of the Scranton Clinical Education Consortium

It is in this regional healthcare context that NEPA-CEC becomes vital. By convening three osteopathic medical schools, hospitals, FQHCs, and community partners under a shared governance model, the consortium leverages regional assets to expand undergraduate medical education (UME) and align it directly with GME and workforce development. The NEPA-CEC provides a neutral, collaborative mechanism to address long-standing capacity constraints in clinical rotations, to recruit and support community-based preceptors, and to strategically sponsor new residency programs in shortage specialties such as primary care, psychiatry, and general surgery. Most importantly, it ensures that a single institution does not dominate physician workforce planning but instead reflects the needs of the entire community.

Given Scranton's central role in the regional economy, its sizable health workforce sector, and its pressing socio-economic and health challenges, the NEPA-CEC represents a critical solution. It strengthens the local healthcare delivery system, expands opportunities for medical training, and increases the likelihood that medical graduates will remain to practice in the region. Over time, this coordinated approach to UME-GME alignment has the potential to stabilize hospital partners, improve access to care for vulnerable populations, and drive billions in long-term economic impact, making Scranton an ideal demonstration site for scalable physician workforce development.

Project Objectives and Methods

Tripp Umbach evaluated the program's pilot phase and offers recommendations to enhance, expand, and sustain the model over the next five years. It also explored the broader healthcare benefits of the NEPA-CEC, including expanded access to primary care and the integration of community-based and FQHC training sites. Additionally, the analysis quantifies the consortium's current and projected economic and workforce impacts, comparing its cost-effectiveness to that of establishing a new medical school. Finally, the study evaluates how the NEPA-CEC framework can serve as a scalable national model for regions with multiple osteopathic medical schools.

Tripp Umbach employed a mixed-methods approach that combined direct stakeholder engagement with secondary research. Tripp Umbach conducted structured interviews with key leaders representing medical schools, health systems, graduate medical education programs, FQHCs, and private colleges. These conversations captured firsthand perspectives on regional needs, opportunities, and barriers in growing and retaining the physician workforce in Northeast Pennsylvania. Tripp Umbach analyzed these interviews, synthesizing qualitative insights into a structured SWOT framework that highlighted

organizational strengths, existing gaps, and actionable strategic opportunities for expanding and sustaining the pilot program to grow the physician workforce. (See Appendix A for a list of stakeholders interviewed by Tripp Umbach.)

In parallel, Tripp Umbach conducted a comprehensive secondary data collection process to establish a robust inventory of regional assets. The firm also conducted an independent review of CHNAs completed by non-profit hospitals in Northeastern Pennsylvania to develop a high-level summary of community health priorities. The community health needs assessment window offers a crucial perspective for evaluating physician supply-demand balances and identifying areas of unmet need. A detailed training site capacity mapping reviewed existing clinical rotation slots, preceptor availability, geographic distribution, and the role of FQHC integration. Tripp Umbach also conducted an economic impact analysis to demonstrate the current and future economic benefits of the NEPA-CEC program, particularly the current spending in the region from medical students and future workforce development and retention, as well as the cost-effectiveness of this model compared to developing a new medical school. Finally, the report was also designed with national applicability in mind, offering a roadmap for replicating the NEPA-CEC model in other communities near one or more colleges of osteopathic medicine.

Community Health Needs in Northeast Pennsylvania

Tripp Umbach completed an independent evaluation of hospital CHNAs completed in Northeast Pennsylvania over the past five years and found three highest priorities: 1) Access to care, 2) Mental and behavioral health, and 3) Chronic disease prevention and management. Multiple health systems, including Geisinger's Northeast region and Allied Services/John Heinz, explicitly confirm these three community health priorities and tie them to upstream social drivers of health, such as affordability, transportation, rurality, language, and health literacy.[5]

In practical terms, access to health is primarily constrained by the size and distribution of the physician workforce, which the NEPA-CEC aims to address. Wayne Memorial's 2025 CHNA reveals significantly fewer providers per capita than the state, with mental health patient-to-provider ratios of 880:1 in Wayne County and 1,080:1 in Pike County, compared to about 350:1 statewide. Additionally, there are fewer primary care clinicians and dentists, and public transportation is limited. Again, these issues that the NEPA-CEC is addressing contribute to delayed care and increased emergency department use, especially among older and rural residents.[6]

The region's poor behavioral-health status is also substantial. Geisinger's Northeast report documents suicide mortality in Wayne County at 26.6 per 100,000, nearly double the U.S. rate, and notes accidental overdose death rates above 40 per 100,000 in Wyoming, Luzerne, and Lackawanna counties. Geisinger's CHNA for its Northeast region also highlights that about one-fifth to one-quarter of adults report depression and that, outside of Lackawanna, mental health provider availability lags far behind state and national levels. Youth mental health has emerged as a pressing concern as St. Luke's Monroe Campus reports that 41.3% of Monroe County students felt sad or depressed most days in the past year, underscoring the need for school-based prevention and timely care.[7]

Related to chronic disease, Allied Services' assessment finds the region experiencing poorer outcomes and higher mortality from diabetes, heart disease, and chronic lower respiratory disease than statewide averages. County health profiles reinforce the risk profile within the community. Nearly one-third of adults (32.7%) in Luzerne County are obese, and almost one-fourth (23.3%) of Monroe County adults report no leisure-time physical activity.[8] Rural counties, such as Susquehanna, Wayne, and Wyoming, also report limited access to safe places for physical activity, which contributes to an increased risk of chronic disease. Together, these findings suggest an integrated regional agenda that focuses on strengthening the care workforce and navigation; expanding behavioral health and substance use services, particularly for youth; and addressing chronic disease drivers through solutions that improve transportation, affordability, language access, and the built environment.[9]

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[5] Geisinger, Allied Services, and Evangelical Community Hospital Community Health Needs Assessment
[6] Wayne Memorial Hospital & Wayne Memorial Community Health Centers Community Health Needs Assessment
[7] St. Luke's University Health Network Community Health Needs Assessment
[8] Allied Service Integrated Health System Community Health Needs Assessment
[9] Lehigh Valley Health Network Community Health Needs Assessment

Stakeholder Interview Results

Below is a summary of interviews with key leaders representing medical schools, health systems, graduate medical education programs, federally qualified health centers, and private colleges. Tripp Umbach analyzed these interviews, synthesizing them within a structured framework, such as the strengths, weaknesses, opportunities, and threats (SWOT) analysis, which highlighted organizational strengths, existing gaps, and actionable strategic opportunities for expanding and sustaining the pilot program to grow the physician workforce.

SWOT Analysis

Strengths

- Cost-Effective Model: Leverages three established osteopathic schools instead of building a new medical school, reducing overhead and accelerating impact. It also provides expanded rotation capacity for the existing COMs.
- Regional Collaboration: Broad willingness among PCOM, Touro, UNECOM, and others to participate in a shared hub with Lackawanna College as a neutral convener.
- Wright Center: One of the largest community-based GME platforms in the United States, offering multi-specialty residencies and credibility for expansion.
- Community Buy-In: Stakeholders emphasize local pride and the desire to home-grow physicians, with alignment around stabilizing Scranton's hospitals.
- National Model Potential: Interviewees view Scranton as a replicable framework for regions lacking the financial resources to develop their own medical schools.
- Positive student experience, demonstrated by word-of-mouth in student-to-student in the first and second cohorts from Touro and PCOM.

Weaknesses

- Fragmented Scheduling: The use of different academic calendars across partner schools creates conflicts and inefficiencies in student placement.
- Rotation Bottlenecks: Shortages in psychiatry, emergency medicine, and other specialties limit the immediate expansion of available seats.
- Housing Limitations: Student housing and logistics remain underdeveloped, echoing prior failures in other regions.
- Governance Gaps: The lack of a formalized advisory board or apparent decision-making authority creates a risk of misalignment or turf battles.
- Hospital Stability: Ongoing financial distress and ownership changes in local hospitals introduce uncertainty for long-term planning and operational stability.

Opportunities

- Workforce Retention: Aligning UME with GME and entry into practice creates a robust pipeline, with 65% retention potential translating into maximum economic impact on the region.
- Preceptor Development and Incentives: Coordinated faculty development, CME credits, and loan repayment advocacy could dramatically expand teaching capacity.
- Economic Impact: Each physician contributes approximately $2.2 million annually to the regional economy. By 2030, the NEPA-CEC's workforce development activities could support more than $200 million in annual economic activity.
- Community Health Access: Embedding students in FQHCs and underserved settings fosters a workforce that is attuned to equity and access.
- National Model: Success in Scranton positions AACOM to export the model nationally, reinforcing osteopathic leadership in community-based medical education.

Threats

- Institutional Turf Dynamics: Competing priorities between medical schools and health systems could fracture the hub without neutral governance.
- Market Consolidation: Dominant health system behavior in the region could sideline consortium efforts or reduce training site availability.
- Political Volatility: State/federal support for residency funding and loan repayment may fluctuate and is crucial to this program's long-term success and impact.
- Preceptor Fatigue: Without strong incentives, local physicians may decline to precept as patient volumes grow, and reimbursement is lowered through Medicaid cuts.
- Overpromising: Risk of overstating early impact without strong governance, echoing prior lessons learned and other start-ups.
- Accreditation: It is unclear how the COCA will react to a model where multiple COMs are accessing clinical training in the same region at shared clinical sites.

Key Findings

1) Strong governance with a neutral convener is key to long-term success

The long-term success of the consortium model depends on establishing a transparent and credible governance framework that strikes a balance between coordination and institutional autonomy. Stakeholders emphasized the need for a more robust organizational structure to emerge from the pilot managed by Lackawanna College. This should include a formal organizational chart and several working committees to align undergraduate and graduate medical education partners, ensuring stability as the program scales rapidly. Effective governance must span the full UME-to-GME continuum, supported by infrastructure capable of sustaining both academic and clinical operations.

A central tenet is the creation of a shared clinical learning environment that fosters collaboration and mutual benefit among participating institutions, while reducing insular behaviors that can undermine collective progress. To achieve this, the consortium should adopt a transparent governance model, anchored by an advisory board and working committees, with clearly defined decision-making rights covering curriculum alignment, site allocation, quality assurance, and funding flows. In this structure, Lackawanna College emerges as a logical middle-office entity to manage contracts, housing, and logistics, providing practical administrative support that complements the academic and clinical missions. This governance framework ensures that leadership is both credible and impartial, empowering a point person to coordinate across institutions without compromising their autonomy, while creating a scalable and sustainable platform for physician workforce development.

Stakeholders highlighted the importance of having a nimble, locally embedded higher education institution to manage the practical aspects of student life and program administration. Lackawanna College was repeatedly cited as an ideal partner to serve as the operational backbone of the consortium. Already positioned as a coordinator for contracts, licensure, housing, and logistical support, Lackawanna should more formalize its role in delivering shared services across multiple medical school partners.

The vision includes developing a dedicated clinical campus to host third- and fourth-year medical students from different institutions, creating a hub that enhances Scranton's appeal as a clinical training destination. Through memoranda of understanding (MOUs), Lackawanna could take on responsibility for student onboarding, housing, meal plans, orientation, and site contracting, ensuring consistency and reducing friction across institutions. By anchoring these operational functions, the college would free the consortium's academic and clinical partners to focus on their core missions of education and patient care.

2) Focus on rotation capacity, scheduling, and housing

Community interviews revealed that the most pressing obstacles to near-term growth are centered on access to clinical rotations, misaligned academic calendars, and student housing shortages. Stakeholders consistently noted that psychiatry and emergency department rotations are the most difficult to secure, mainly because of the way contracts are structured with existing health systems. Without targeted site

development in these specialties, the consortium risks hitting capacity ceilings quickly. Compounding this challenge, differences in academic calendars across participating medical schools create scheduling inefficiencies and mismatches, highlighting the urgent need for a common regional scheduling exchange or protocol to coordinate placements more effectively. Beyond clinical logistics, student housing emerged as an equally critical issue. Interviewees pointed to other sites, which were limited or inadequate housing significantly constrained growth, underscoring the importance of developing an expandable housing plan early in the implementation process. Taken together, these barriers emphasize the need for a specialized working steering committee to develop and implement a plan for expanding specialty-specific rotation sites, standardizing scheduling practices, and enhancing housing capacity. These actions will enable the consortium to unlock additional training seats and realize the immediate potential of the model.

3) Increase Preceptor Supply as the Driver of Capacity

Interviews underscored that the ability to expand medical education in the region ultimately depends on the availability of preceptors, making their recruitment and retention a central priority. Stakeholders emphasized that precepting must be framed as both professionally rewarding and institutionally supported, with structures and incentives in place to promote teaching excellence and recognition. A Faculty Development Committee was proposed as a vehicle to build community among preceptors, share best practices, and elevate the value of teaching in clinical environments. At the same time, interviewees pointed to the need for tangible incentives to encourage more physicians to serve as preceptors, citing state-level programs that have successfully offered tax credits or loan repayment benefits as models worth pursuing. FQHCs provided particularly valuable insights, highlighting how strong educational cultures, exposure to diverse patient populations, and mission-driven service can enrich training, while also noting the limits of current incentive programs in sustaining preceptor participation.

To meet this challenge, the steering committee should establish a comprehensive regional preceptor program that combines professional development opportunities, such as CME credits, micro-credentials, teaching awards, and tuition benefits, with streamlined onboarding processes that reduce administrative burdens. In parallel, coordinated advocacy for enhanced state and federal incentives, including loan repayment and tax credits, will be crucial to creating a durable pipeline of committed preceptors and ensuring that clinical capacity grows in tandem with student demand.

4) Building a sustainable UME/GME medical education continuum to drive retention

Interviewees were unanimous in their belief that physician retention is strongly linked to the availability of graduate medical education opportunities in the region. Stakeholders emphasized that medical students are far more likely to remain in the community if there is a seamless pipeline from undergraduate UME into residency and fellowship training locally. The Wright Center was repeatedly cited as a significant asset in this regard, with its broad portfolio of multi-specialty residency programs serving as a regional anchor for GME expansion. Participants also expressed strong support for the consortium to play an active role in sponsoring or co-sponsoring new residency programs, particularly in primary care and specialties with shortages that align with community needs. By strengthening the

NEPA-CEC's coordination efforts, Scranton can position itself not only as a training hub but also as a retention engine. This will ensure that the time, effort, and resources invested in learners translate into long-term commitments to practice in the region. A structured pathway that connects UME to GME and ultimately to local practice is essential for addressing persistent workforce shortages.

5) Hospital system stability poses a threat to success

Another key finding from community interviews is that the stability of regional hospitals is a critical factor in sustaining and scaling physician training. Stakeholders raised concerns about the financial health of local hospitals, citing potential closures and ownership transitions as significant risks to the continuity of medical education. Many participants noted that residency programs can serve as a stabilizing force, both by attracting state support and by anchoring service lines to patient care needs. For this reason, several have recommended that the final consortium plan explicitly integrate hospital stabilization strategies, including fostering teaching hospital designations, aligning service lines with residency program development, and forging governance compacts with potential new owners. Without stable hospital partners, training pipelines cannot be maintained. Still, with them, the consortium can leverage residency presence to strengthen both the healthcare and economic infrastructure of the region.

6) Nursing and allied health program Integration will drive even greater benefits

Community interviews highlighted that the consortium must extend beyond physician training to address broader community health, diversity, and workforce transformation goals. A multi-disciplinary hub that integrates allied health education and prioritizes diversity was viewed as essential for both meeting healthcare needs and aligning with the region's economic development trajectory toward knowledge-intensive jobs. FQHCs play a crucial role in this vision, providing students with exposure to primary care settings, team-based care models, and diverse patient populations. By embedding interprofessional education and community-based training into the model, the consortium can foster collaborative practice skills and reinforce its commitment to addressing health equity. This approach not only strengthens the pipeline of physicians but also builds a broader ecosystem of healthcare professionals, including nurses, pharmacists, physician assistants, and allied health workers, who collectively contribute to enhancing community well-being.

7) The regional hub model is more cost-effective than developing a new medical school

A consortium-based physician workforce development model that leverages existing osteopathic medical schools and regional clinical capacity offers a highly cost-effective alternative to starting a new medical school. Rather than requiring an estimated $200 million in start-up funds to launch a new institution, the regional training approach, in collaboration with medical school partners, leverages existing infrastructure, including accredited D.O. schools and affiliated health systems, to expand training capacity and achieve comparable workforce outcomes. By coordinating across multiple schools, the model enhances efficiency, reduces duplication, and creates flexibility for clinical rotations, while also

addressing bottlenecks that often arise when a single system bears the full responsibility for training. The contrast between developing a full-scale osteopathic medical school and supporting a regional clinical education consortium highlights the dramatic difference in per-student costs and scale of investment.

Establishing a new D.O. school requires more than $200 million in startup capital over a six-year period (including facilities and escrow), with an eventual annual operating budget of $65 million to support a student body of 720. M.D. granting schools typically cost more in start-up and require significant ongoing support. Over the course of 10 years, this equates to $300,000 per student in startup costs alone, before accounting for annual operating expenses. By comparison, NEPA-CEC operates with total costs of just $374,200, or roughly $15,000 per third-year student, resulting in six times lower operating costs when compared with $90,000 per-student operating costs incurred by a D.O. school and nearly 30 times lower when compared to the per-student startup costs of establishing a new medical school.

8) This program is poised to be a national model

Stakeholders view this as a replicable national model, particularly valuable in regions without a local D.O. school, as it allows for scalable workforce expansion without the prohibitive capital costs associated with a new build. Positioned as a demonstration site, NEPA-CEC illustrates how AACOM's leadership in promoting a consortium framework generates significant returns on investment, achieving similar physician workforce impacts at a fraction of the traditional cost. With the right governance structures, scheduling protocols, and GME linkages, the hub-and-network framework can be adapted for use in other regions, particularly those without local medical schools but with sufficient clinical capacity. Several interviewees, however, cautioned that barriers such as academic calendar misalignment and system-level politics must be proactively addressed to ensure replicability. To maximize its national relevance, the consortium should produce a detailed replication playbook, including governance templates, sample MOUs, scheduling protocols, and a preceptor program toolkit. By documenting the model and codifying its lessons learned, Scranton can demonstrate how a regional, multi-school approach delivers cost-effective workforce expansion and provides a scalable solution to address physician shortages nationwide.

Economic & Social Impact

The NEPA-CEC represents an innovative and cost-effective approach to medical education that delivers powerful economic and social returns for Northeast Pennsylvania. Rather than investing hundreds of millions of dollars in a new medical school, the NEPA-CEC leverages existing osteopathic medical schools located within driving distance to expand clinical training, grow GME, and retain physicians in the region long term. This collaborative model directs resources where they matter most, including preceptors, training sites, student housing, and community hospitals, yielding both immediate economic benefits and lasting workforce advantages.

Local Spending and Training Infrastructure

The NEPA-CEC demonstrates how a multi-stakeholder consortium can deliver outsized economic and workforce returns without the expense of constructing a new medical school. Tripp Umbach reviewed data supplied by the NEPA-CEC and developed current and future economic impact analysis of the program. Tripp Umbach found that even in its pilot phase with 9 students, the Scranton medical education hub generates substantial local spending and economic expansion. Analysis indicates that the total economic impact of the pilot program in 2025, including student spending while in the region, amounts to $2.7 million. According to data supplied by NEPA-CEC, the program's total budget in 2025-26 equals $374,200.[10]

The NEPA-CEC shows how a regional consortium can deliver medical education at a fraction of the cost of building a new school. Each year, the program pays approximately $288,000 to preceptors who oversee 360 third-year student blocks, at a rate of $800 per block. It also supports a medical director with a $55,000 stipend and a clinical coordinator with a $25,000 stipend to manage day-to-day operations. Additional costs include about $1,200 for student orientation and $5,000 to cover social events that foster networking and professional development. Altogether, these modest expenses total $374,200 annually, averaging just $15,000 per third-year student. As the program grows, in terms of the number of students, costs will also increase; however, economic impact will also grow from the additional students.

Looking ahead, the program is positioned for growth. In 2025–26, it will support 36 third-year students across 42 preceptors, eight training sites, and three medical school partners. By FY30, the program anticipates scaling to 96 third-year students and 32 fourth-year students, supported by 100 preceptors and 20 clinical training sites, while maintaining its network of three medical school partners. This trajectory illustrates how relatively small, targeted investments can expand clinical training capacity without the massive upfront and ongoing costs associated with developing a new medical school.

With an economic impact of $75,000 per student trained in the region at a cost of approximately $15,000 per student to provide training support, the return on investment to the regional economy, even in the pilot stage, is $5.00 for every $1 invested. With approximately 130 students projected by 2030, the

[10] Based on Tripp Umbach's economic impact modeling reflecting programming and student spending in Northeast Pennsylvania.

direct economic impact on the regional economy is expected to exceed $9.8 million annually in the Scranton economy, with an even greater ROI as today's students are likely to remain in the region for residency and eventually to practice.

GME expansion further amplifies this impact. Based on previous studies, Tripp Umbach estimates that the total regional economic impact per resident is approximately $450,000.[11] Direct and indirect economic activity, includes program spending, resident salaries, housing, local purchases, and practice support.[12] Every new cohort of 10 residents thus adds $4.5 million annually to the regional economy. Together, student and residency spending form a sustainable base of recurring local revenue that strengthens small businesses, supports housing markets, and stabilizes hospital operations.

Notably, the total return on investment to the regional economy is achieved by channeling resources directly into students, residents, and community health systems rather than bricks and mortar, making it both cost-effective and highly scalable. When adding the economic impact of new residency training programs developed by the NEPA-CEC in partnership with the Wright Center, the total combined economic impact of both medical student and residency training is expected to reach $27.75 million in FY30. With program costs expected to total approximately $1.3 million, the total return on investment in NEPA-CEC by FY30 is likely to exceed $20 in total impact for every $1 invested in running the program (see Table 1).

Table 1: Economic Impacts of NEPA-CEC Operations (FY25–FY30)

Economic Driver	Current Students (2025-2026)	Regional Economic (FY25)	Projection (2030-2031)	Regional Economic (FY30)
NEPA-CEC Program and Medical Student Spending in the Region	36	$2.7 million	130	$9.8 million
GME Residency Programs and Residency Spending in the Region			40 residents	$18.0 million
Total Annual Economic Impact				$27.75 million
Program Direct Cost		$374,200		$1,351,300
Return on Investment		$1: $5.00		$1: $20.54

[12] A recent independent study in Arkansas provides a similar total economic impact estimate of $482,000. Economic Contributions of Medical Residencies to Arkansas 2025

Cost-Effectiveness of the NEPA-CEC Compared with Developing a New Medical School

The NEPA-CEC leverages existing accredited D.O. schools and local clinical capacity to expand physician training at a fraction of the cost of launching a new medical school. Compared to a traditional D.O. school, which requires approximately $200 million in start-up capital and annual operating expenses of roughly $90,000 per student, NEPA-CEC's operating budget is six times lower on a per-student basis, while also eliminating the need to raise $200 million to support facilities, escrow, and start-up expenses.[13]

Therefore, for a fraction of the cost of constructing a new medical school, the NEPA-CEC demonstrates a replicable and scalable model for clinical medical education that delivers immediate economic returns and long-term workforce resilience. By coordinating with existing osteopathic institutions, aligning community health systems, and focusing on retention, by FY30 the NEPA-CEC will support more than $20 million annually in regional economic impact and contribute to a $200 million annual physician-driven economy. While new medical schools have a much higher impact on a per student basis ($75,000 per student for the NEPA-CEC vs. $250,000 per student for a new medical school), because of much lower costs, the financial return on investment for educating 130 medical students through the NEPA-CEC is nearly 12 times higher than for a new school (see Table 2).

Table 2: Economic and Cost-Effectiveness Comparison between NEPA-CEC and New D.O. School

Dimension	NEPA-CEC (FY31)	New D.O. School (after 10 years)
Upfront Capital (multi-year)	Minimal (leverages existing schools/sites)	$200 million
Annual Operating Budget for 130 Students	$1.3 million	$11.7 million
Cost per Student (10-year view)	$10,000 in operations + $0 Capital = $10,000	$90,000 in operations + $300,000 in capital = $390,000
Total Economic Impact per Student	$9.75 million / 130 students = $75,000	$32.4 million / 130 students = $250,000
Return on Investment to the Regional Economy for Every $1 in Program Costs per Student	$1: $7.50	$1: $0.64

Economic Impact of Future Physician Retention

The most transformative impact of the NEPA-CEC lies in its ability to expand and retain the regional physician workforce. Each physician who remains to practice in the Scranton region generates approximately $2.2 million in annual economic activity through practice revenues, staff employment, local spending, and tax contributions.[14] Assuming 50% retention of students and 65% retention of

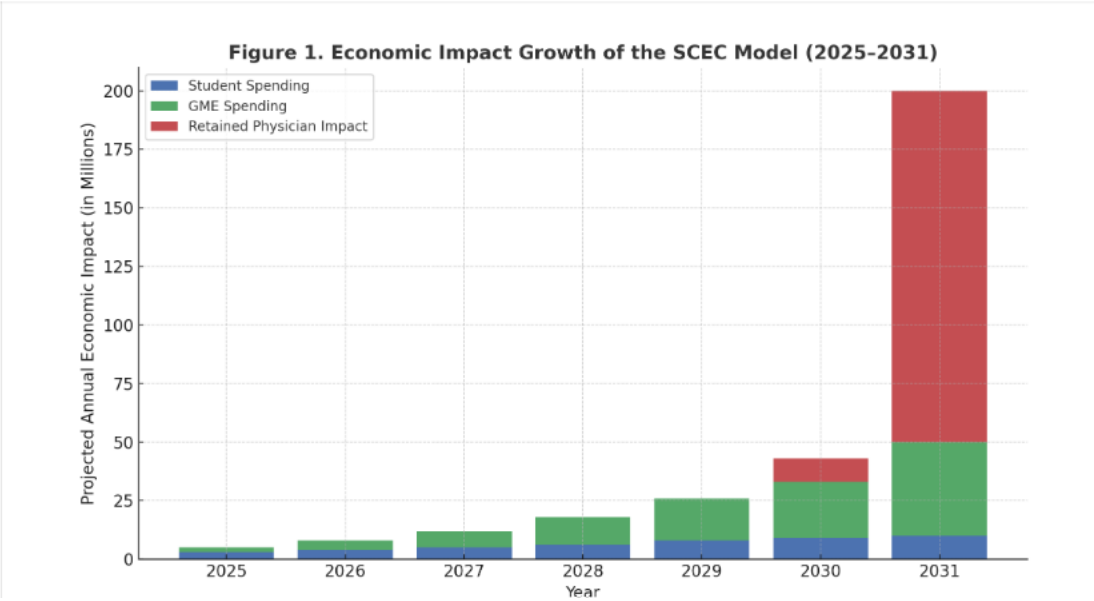
[13] Tripp Umbach has completed business plans for 20 newly developed colleges of osteopathic medicine over the past 20 years and based these estimates on new medical school proforma from the past two years.
[14] American Medical Association

residents, the NEPA-CEC's physician pipeline could add more than 65 new long-term physicians to the regional workforce by 2030, translating to more than $143 million annually in recurring economic output (see Table 3).

Table 3: Long-Term Economic and Workforce Impacts (2030)

Impact Category	Estimated Retained Physicians	Per-Physician Economic Output	Total Annual Regional Impact (FY2030)
Practicing Physicians Retained from Students (50%)	65	$2.2 million	$143 million
GME Expansion and Retained Residents (65%)	26	$2.2 million	$57 million
Total Physician Workforce Impact	91	—	$200 million

Figure 1: Economic Impact Growth of the NEPA-CEC Model (2025–2031)



Social and Community Impacts

The NEPA-CEC model extends well beyond economic metrics. By nurturing homegrown talent, it fosters stronger community ties, reduces outmigration for care, and improves patient continuity. Stable, long-term physician relationships contribute to lower healthcare costs, improved preventive care outcomes, and a healthier, more resilient population. Rotations through FQHCs also enhance health equity by connecting students and residents to underserved populations, reinforcing a mission-driven commitment to community care.

Additionally, the NEPA-CEC strengthens Scranton's identity as a regional hub for health and education, catalyzing the shift from a manufacturing-based economy to a knowledge-driven ecosystem. Community preceptors and teaching physicians benefit from professional development opportunities, CME credits, and a sense of shared purpose. Hospitals establish sustainable clinical staffing pipelines, and students benefit from an immersive, supportive training environment that connects them to the community from the outset of their careers.

The result is not only economic growth, but also social transformation; a healthier, better-served population; and a more vibrant, knowledge-based regional economy anchored in education, healthcare, and community well-being.

Recommendations

1. Consortium Governance

A strong and transparent governance structure is essential to the long-term success of the NEPA-CEC. Establishing a formal board that includes representatives from participating medical schools, the Wright Center, local hospitals, FQHCs, Lackawanna College, and community representatives will ensure balanced decision-making and shared accountability. To effectively manage the complexity of a multi-institution partnership, the consortium should also implement standing committees focused on key operational areas: Clinical Placements & Scheduling, Faculty Development, GME & Workforce, Student Experience, and Quality & Evaluation. Each committee would provide specialized oversight and drive measurable progress in its domain. The appointment of an Executive Director, ideally a clinically credible leader, should complement oversight and should be empowered to manage day-to-day operations, resolve cross-institutional challenges, and serve as the central point of accountability for the initiative.

2. Common Scheduling and Capacity Management

One of the most critical elements of consortium success will be the development of a standard scheduling system that ensures equitable access to training sites. A shared rotation marketplace, built around a standardized block structure and transparent seat inventories, will allow schools to plan clinical placements more efficiently and minimize conflicts while also recognizing student preferences. Priority rules must be established to respect each school's curricular requirements while maintaining fairness across institutions. This approach not only maximizes the utilization of available training capacity but also reduces administrative friction, enabling participating schools and clinical partners to focus on delivering high-quality educational experiences.

3. Preceptor and Site Enablement

The sustainability of the hub depends on expanding and supporting the network of community preceptors. To achieve this, the consortium should establish a Faculty Development Committee that provides continuing medical education (CME), offers micro-credentials, and offers peer learning opportunities designed to enhance teaching capacity and recognition. Additionally, an incentive framework, or "incentive stack," should be implemented to recruit and retain preceptors. This could include stipends for teaching contributions, public recognition programs, advocacy for state or federal loan repayment benefits, and billing support where applicable. From Tripp Umbach's evaluation, it appears that benefits offered by each of the participating COMs are provided to faculty; thereby, providing more preceptor support through stacked benefits. By providing both professional development and tangible rewards, the consortium will ensure preceptor engagement remains strong, which is essential for scaling the hub.

4. GME Alignment and Sponsorship

GME expansion is crucial to retaining physicians in the region, and the NEPA-CEC is positioned to facilitate this growth. The recommendation is to establish a consortium-enabled sponsoring or co-sponsoring entity, in partnership with the Wright Center and local hospitals, that can strategically target

residency development in primary care and other high-need specialties such as psychiatry, pediatrics, and general

surgery. This model enables the hub to coordinate resources, streamline accreditation processes, and leverage existing clinical infrastructure, ensuring that residency growth aligns directly with regional workforce needs. By prioritizing GME expansion, the consortium will create a durable pipeline from medical education through residency to practice. Since many programs have their CMS funding capped, it will be important for the NEPA-CEC to advocate for federal and state funding to bridge funding gaps for residency program start-up and ongoing development.

5. Establish a Longitudinal Physician Retention Tracking System

Tripp Umbach recommends that the NEPA-CEC develop and maintain a comprehensive, long-term tracking system to measure the success of its programs in retaining physicians within the region following their education and training. Specifically, the NEPA-CEC should systematically collect and analyze data on medical students who participate in the pilot and subsequent phases of the programs, tracking where these individuals complete their graduate medical education in the region and whether they ultimately establish clinical practice within the regional service area.

This ongoing monitoring should span a 10-year horizon to capture the complete training and career trajectory, from medical school enrollment through residency, and for a minimum of five years into practice. Tripp Umbach suggests, based on national best practices, that the NEPA-CEC should utilize a five-year in-practice milestone as a meaningful retention measure, as physicians who remain in the region for at least five years are significantly more likely to stay in the long term.[15]

In studying a national cohort of rural physicians, researchers found that retention expectations closely tracked actual behavior, with four out of five physicians who predicted remaining at least five years actually doing so, and those expecting to leave sooner generally did so before the five-year mark.[16] Finally, federal and state workforce evaluations emphasize retention beyond initial two-year service obligations as the key indicator of lasting workforce impact, using five years as a policy-relevant threshold.[17]

Improving the overall student experience is also critical for retention and long-term workforce outcomes. The NEPA-CEC should establish a student experience committee to unify the onboarding process, standardize orientation, provide coordinated housing and meal plans, and offer a consistent introduction to the region's health systems and communities. Embedding students in community life through rotations in FQHCs, public health programs, and local civic initiatives will help cultivate ties that encourage them to remain in the region after training. Furthermore, developing early-career

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[15] Kandrack R, Martsolf GR, Reid RO, Friedberg MW. Primary Care Physician Migration Patterns and Their Implications for Workforce Distribution. J Gen Intern Med. 2019 Jul;34(7):1108-1109. doi: 10.1007/s11606-019-04872-4. PMID: 30847832; PMCID: MC6614238.https://pmc.ncbi.nlm.nih.gov/articles/PMC6614238/?utm

[16] Pathman DE, Konrad TR, Agnew CR. "Predictive accuracy of rural physicians' stated retention plans." Journal of Rural Health. 2003;19(3):236–244.

[17] Evaluating Retention in BCRS Programs Final Report

matchmaking programs with regional employers will provide medical students and residents with clear pathways into local practice opportunities.

6. Clinical Partner Engagement

Hospitals in the region face financial and operational uncertainties that directly impact the sustainability of their training programs. The consortium should formalize commitments to teaching hospitals, align service lines with residency development, and incorporate shared quality and performance targets. Importantly, this initiative would include mechanisms for state and community support during periods of transition, ensuring that hospitals remain viable training environments. By linking the stability of hospitals to the growth of residency programs, the consortium can simultaneously strengthen both healthcare delivery and the physician training pipeline.

Recommended Next Steps

Step 1: Governance

During the next year, the highest priority is to establish governance, leadership, and operational systems that will drive the consortium's success. The NEPA-CEC should begin by forming a governing board and appointing a clinically credible Executive Director who has apparent authority and accountability for results. This leadership team will set the tone for collaboration and ensure that all partners work toward shared goals. Once leadership is in place, the consortium should execute a unified set of Memoranda of Understanding (MOUs) that define governance structure, scheduling procedures, data-sharing protocols, and quality standards across all participating institutions.

Step 2: The Wright Center Partnership

The consortium should simultaneously develop a formal partnership with the Wright Center to advance a unified UME/GME medical education pipeline as well as initiate a strategic plan for GME expansion, focusing on high-need specialties such as primary care, psychiatry, pediatrics, and general surgery.

Step 3: Program Capacity Committee

The NEPA-CEC should launch a program capacity committee to manage and publish a standardized rotation calendar. This system will make clinical training slots transparent and ensure optimal use of available teaching capacity. To support the teaching network, the consortium should also establish a faculty development program that offers continuing medical education (CME) and micro-credential opportunities for community-based faculty.

Step 4: Student Experience Committee

To strengthen the learner experience, a student experience committee should be formed to develop a unified onboarding and orientation process for all students. This should include standardized housing, community immersion experiences, and a regional matchmaking system that connects graduates with local employers early in their careers. Because student housing is a significant barrier, the committee should conduct a regional housing audit to identify master lease options and develop a consistent housing policy in collaboration with local partners.

Step 5: Preceptor Incentive Committee

The NEPA-CEC should establish a committee of engaged preceptors to develop and implement a comprehensive preceptor incentive package. This package should include stipends, recognition programs, billing support, and advocacy for state-level incentives, such as tax credits or loan repayment.

- **Step 6: Scorecard and Toolkit**

  The NEPA-CEC should publish an annual public scorecard that reports measurable outcomes, including growth in clinical capacity, expansion of residency programs, physician retention rates, and economic impact. This transparency will build trust, attract additional partners, and position the Scranton region as a national model for regional medical education collaboration. The consortium should also develop a replication toolkit to assist other areas in adapting and applying the NEPA-CEC model.

- **Step 7: Strategic Plan Development**

  A UME-GME strategic growth plan is recommended, focused on expanding clinical capacity for COM students, creating incentives for participation, and setting the groundwork for new GME programs. The strategic plan should set goals for increasing the number of rotations in high-demand fields such as psychiatry and emergency medicine, while also developing new partnerships with rural hospitals and federally qualified health centers. A key objective of the strategic plan is to create a GME sponsorship model in collaboration with The Wright Center and regional hospitals. The goal should be to develop and submit program applications for new residency programs, especially in primary care and other specialties experiencing shortages.

Conclusion

The Scranton Clinical Education Consortium represents a forward-looking, cost-effective solution to both immediate and long-term needs of the physician workforce. By establishing a neutral governance structure with broad representation, including medical schools, hospitals, FQHCs, the Wright Center, and community leaders, the consortium ensures transparent, collaborative, and strategically aligned decision-making. The standing committees recommended above, and a clinically credible executive director, will further strengthen operations, reduce friction, and build sustainable capacity. Shared scheduling infrastructure and preceptor incentives will maximize limited training resources while sustaining faculty engagement.

Through coordinated sponsorship of new residency programs in high-need specialties, NEPA-CEC will expand graduate medical education, anchor a robust physician pipeline, and directly address community health needs. While risks such as scheduling conflicts, hospital volatility, and preceptor fatigue remain, the consortium has made the model both resilient and scalable.

Ultimately, NEPA-CEC embodies the osteopathic mission of community-based, primary care-focused training while delivering substantial economic returns and creating a replicable framework for AACOM regions nationwide. For Northeast Pennsylvania, it provides not only a physician workforce solution but also a transformational path toward healthcare stability, economic growth, and community vitality. The financial and social impacts outlined in this report underscore the need for sustained commitment and community investment.

Ultimately, the NEPA-CEC demonstrates that regional collaboration provides a scalable and cost-effective approach to expanding medical education and strengthening the physician workforce. By leveraging existing D.O. schools, hospitals, FQHCs, and community providers, the consortium avoids the significant capital requirements of building a new medical school while still delivering comparable workforce outcomes. In the near term, NEPA-CEC generates measurable economic impact through student and resident spending. In the long term, it enhances physician retention and contributes to hospital stability and community vitality. Most importantly, the model addresses preceptor development, equitable access to training in underserved settings, and alignment of UME and GME, with a structure that is replicable in other regions across the country. With its combination of efficiency, high return on investment, and national scalability, the consortium represents a promising solution for communities seeking to expand healthcare capacity and ensure a steady pipeline of physicians for the future.

APPENDIX

Appendix A: Key Stakeholders Interviewed

Table 4 depicts community stakeholders who were interviewed to provide insights, perspectives, and local knowledge that informed the assessment.

Table 4: Key Community Stakeholders Interviewed

Name	Title
Peter Bidey, D.O.	Dean, Philadelphia College of Osteopathic Medicine (PCOM)
Patrick Conaboy, M.D.	Chief Medical Officer, Community Health Systems
William Conaboy, J.D.	President and CEO, Allied Services Integrated Health System
Linda Thomas-Hemak, M.D.	President and CEO, The Wright Center for Community Health and The Wright Center for Graduate Medical Education
Joseph Hollander	CEO, Scranton Primary Health Care Center Inc.
V. Scott Koerwer, Ed.D., Ph.D.	Executive Director, Iacocca Institute, Lehigh University
Frank Kolucki, M.D.	Regional Medical Director, Northeast Pennsylvania Clinical Education Consortium (NEPA CEC)
John Lowery, D.O.	Assistant Dean, Clinical Education at University of New England College of Osteopathic Medicine (UNECOM)
Jill Murray, Ph.D.	President, Lackawanna College
Teri Ooms, M.B.A.	President, The Institute
Sharon Obadia, D.O.	Dean, A.T. Still University School of Osteopathic Medicine (AT Still SOM)
Ken Steier, D.O.	Executive Dean and Chief Academic Officer at Touro College of Osteopathic Medicine, New York (TouroCOM)
Richard Terry, D.O.	Associate Dean of Academic Affairs, Lake Erie College of Osteopathic Medicine (LECOM), Elmira, New York

Appendix B: Environmental Scan

Regional Environmental Scan

The focus areas for the feasibility study encompassed the following Pennsylvania counties: Carbon, Lackawanna, Luzerne, Monroe, Pike, Susquehanna, Wayne, and Wyoming counties.

Pennsylvania Population Data

Pennsylvania, the nation's 32nd-largest state by area, covers 44,742.1 square miles of land and 1,311.8 square miles of water area.[18] Pennsylvania has 67 counties, 48 of which are considered rural and 19 are urban. "Rural" is characterized by a total population under 2,500 residents or fewer than 284 persons per square mile.[19] The three most populous PUMAs (Public Use Microdata Areas) are Pittsburgh City, Butler County, and Philadelphia City.[20] The largest universities in Pennsylvania based on student population are Pennsylvania State University, the University of Pittsburgh, and Temple University.[21]

Pennsylvania had a 2024 population of 13,078,751 people, a 0.47% increase from the 2023 population of 13,017,721.[22] Based on the 2023 data from the U.S. Census Bureau, an estimated 75.8% of the state's population is White, 10.7% is African American/Black, 3.7% is Asian, 0.2% is Native American or Alaska Native, 0.00% is Native Hawaiian or Other Pacific Islander, 3.4% is Some Other Race, and 6.1% are Multiple Race.[23]

According to the Economic Research Service, the average per capita income of Pennsylvania residents in 2023 totaled $68,945.[24] Urban residents earned $71,504, while rural residents earned $52,614.

The ERS reports that the 2023 poverty rate statewide in Pennsylvania is 11.9%. The 2023 unemployment rate in Pennsylvania is 3.4%, compared to 4.1% in 2022. A total of 8.1% of the population has not completed high school, while 33.2% of the population obtained a high school diploma or equivalent (USDA-ERS, 2023).[25]

Demographics

- According to Data USA, of Pennsylvania's 2023 population estimate of 13 million, 96.7% are citizens. This rate is higher than the national average of 93.4%.[26]

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[18] U.S. Census Bureau
[19] Center for Rural Pennsylvania
[20] Data USA
[21] Univstats. "Largest Student Population in Pennsylvania." 2023
[22] U.S. Census Bureau via FRED
[23] U.S. Census Bureau
[24] USDA Economic Research Service
[25] USDA Economic Research Service
[26] Data USA

Race[27]

- In 2023, Pennsylvania had 7.16 times more White (non-Hispanic) residents (9.59 million) than any other racial or ethnic group. There were 1.34 million Black or African American (Non-Hispanic) and 477,000 Asian (Non-Hispanic) residents, the second and third-most common ethnic groups.
- According to the 2023 U.S. Census Bureau, the Hispanic population in Pennsylvania is estimated at 8.38% (1.09 million). Data from 2025 indicate the Hispanic population continues to grow at a faster pace PA than any other racial group.[28]
- As of 2023, 7.25% of Pennsylvania residents (942,000 people) were born outside of the United States, compared to a national average of 13.8%. In 2022, the percentage of foreign-born citizens in Pennsylvania was 7.12% (924,000), indicating an increase in the rate.
- The most common non-English language is Spanish (664,669 households), followed by Chinese (96,237 households), and Yiddish or other Dutch and Germanic languages (73,602 households).

Table 5: Race[29]

2023	White	Black	Asian	Native American or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Carbon County	90.0%	2.3%	0.5%	0.6%	0.0%	1.4%	5.2%
Lackawanna County	83.4%	3.1%	3.0%	0.1%	0.0%	3.1%	7.3%
Luzerne County	78.3%	5.2%	1.1%	0.1%	0.2%	7.3%	7.8%
Monroe County	66.5%	14.0%	0.2%	2.6%	0.0%	6.4%	10.3%
Pike County	80.4%	6.6%	1.5%	0.1%	0.0%	3.7%	7.7%
Susquehanna County	95.7%	0.2%	0.5%	0.0%	0.0%.	0.4%	3.2%
Wayne County	90.1%	3.2%	0.7%	0.3%	0.1%	0.9%	4.8%
Wyoming County	94.5%	0.8%	0.2%	0.1%	0.0%	0.6%	3.7%
Pennsylvania	75.8%	10.7%	3.7%	0.2%	0.0%	3.4%	6.1%

[27] Ibid.
[28] Pennsylvania State Data Center. June 2025. pdf
[29] U.S. Census Bureau. ACS 5-Year Estimate. 2023

2023	White	Black	Asian	Native American or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
United States	63.4%	12.4%	5.8%	0.9%	0.2%	6.6%	10.7%

Age

In 2023, the median age of all people in Pennsylvania was 40.9. Pike County has the most aging population within the study area, with a median age of 49.4, higher than the state (40.9) and national (38.7) medians. Lackawanna County had the youngest population, with a median age of 41.9.

Table 6: Median Age-Pennsylvania[30]

County	Median Age
Carbon County	46.3
Lackawanna County	41.9
Luzerne County	42.1
Monroe County	43.9
Pike County	49.4
Susquehanna County	48.6
Wayne County	48.9
Wyoming County	45.2
Pennsylvania	40.9
United States	38.7

Population

Pennsylvania has experienced an overall population increase of 1.5% since 2020. The highest rate of growth was observed in Pike County, at 7.2%. Although the state experienced slight population growth

[30] U.S. Census Bureau. ACS 5-Year Estimate. 2023

during this period, Monroe, Susquehanna, Wayne, and Wyoming counties saw declines in population.[31] From 2020 to 2023, Pennsylvania had more residents under the age of 18 than those 65 and older.

Table 7: Demographics of Pennsylvania[32]

2023	Pop., 2023 estimate	Pop., 2020 estimate	Pop., % change	Persons < 5 years, 2023	Persons <18 years, 2023	Persons 65+, 2023
Carbon County	65,191	63,964	1.9%	3,033	12,454	14,403
Lackawanna County	215,834	210,162	2.7%	10,990	44,299	43,716
Luzerne County	325,978	317,547	2.7%	17,194	66,051	65,007
Monroe County	167,784	168,824	-0.62%	7,806	32,451	44,818
Pike County	59,691	55,660	7.2%	2,206	10,325	14,155
Susquehanna County	38,349	40,604	-0.06%	1,822	7,212	9,482
Wayne County	51,189	52,268	-0.02%	2,081	8,515	12,806
Wyoming County	26,075	27,078	-0.04%	1,208	5,308	5,846
Pennsylvania	12,986,518	12,794,885	1.5%	685,379	2,673,811	2,476,241

Income and Poverty

In 2023, households in Pennsylvania reported a median annual income of $76,081, which is lower than the median annual income of $78,538 nationwide. The median income totaled $71,798 in 2022.

Table 8: Income[33]

[31] US Census Bureau. ACS 5-Year Estimate. 2023
[32] US Census Bureau. ACS 5-Year Estimate. 2023
[33] U.S. Census Bureau. ACS 5-Year Estimate. 2023

2023	Total Households	Average Household Income	Median Household Income
Carbon County	27,093	$85,885	$67,877
Lackawanna County	88,266	$87,019	$64,691
Luzerne County	133,434	$82,477	$62,321
Monroe County	60,562	$100,240	$82,374
Pike County	24,009	$101,573	$79,318
Susquehanna County	15,639	$92,206	$66,930
Wayne County	20,314	$81,581	$62,182
Wyoming County	10,892	$94,177	$70,268
Pennsylvania	5,235,339	$104,925	$76,081
United States	127,482,865	$110,491	$78,538

In 2023, 11.8% of the population in Pennsylvania, for whom poverty status is determined (approximately 1,148,981 of the 12,575,248 people), lived below the poverty line, which is lower than the national average of 12.4%. The largest impoverished demographic is those aged under 18, at 16.0%, followed by those aged 18 to 34, at 13.9%. A higher percentage of females were found to be living below the poverty line compared to males, at 24.9% and 20.7%, respectively.[34]

Table 9: Population in Poverty, Pennsylvania[35]

2023	Total Population	Population in Poverty	Population in Poverty (Percentage)
Carbon County	63,884	7,697	12.0%
Lackawanna County	208,111	29,224	14.0%
Luzerne County	314,647	48,562	15.4%

[34] U.S. Census Bureau, ACS 5-Year Estimate. 2023
[35] U.S. Census Bureau, ACS 5-Year Estimate. 2023

2023	Total Population	Population in Poverty	Population in Poverty (Percentage)
Monroe County	164,816	18,566	11.3%
Pike County	59,153	5,482	9.3%
Susquehanna County	37,913	4,146	10.9%
Wayne County	47,922	5,845	12.2%
Wyoming County	25,264	2,871	11.4%
Pennsylvania	12,575,248	1,148,981	11.8%
United States	324,567,147	40,390,045	12.4%

In 2023, the Some Other Race population in Pennsylvania had the highest proportion of those living in households with income below the federal poverty level at 27.1%, followed by Native American or Alaska Native at 26.1% and Black or African American (24.2%).[36]

Table 10: Race and Poverty

2023	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Carbon County	11.3%	25.5%	2.7%	6.6%	No Data	22.5%	18.5%
Lackawanna County	12.2%	30.3%	18.7%	7.2%	100.0%	31.4%	24.3%
Luzerne County	11.9%	35.5%	27.7%	5.3%	4.0%	28.2%	27.9%
Monroe County	10.1%	13.7%	0.0%	12.4%	0.0%	16.2%	12.2%
Pike County	8.9%	15.3%	20.0%	0.7%	0.0%	9.9%	8.8%
Susquehanna County	10.7%	10.6%	0.0%	8.9%	No Data	20.7%	16.1%
Wayne County	12.1%	20.1%	55.6%	9.5%	0.0%	14.1%	10.6%
Wyoming County	11.2%	13.0%	23.1%	3.1%	No Data	9.0%	16.1%

[36] U.S. Census Bureau, ACS 5-Year Estimate. 2023

2023	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Pennsylvania	8.9%	24.2%	26.1%	12.2%	18.8%	27.1%	17.1%
United States	9.9%	21.3%	21.8%	9.9%	17.2%	18.2%	14.7%

Employment

The most current data show that in July 2025, there were 6,274,000 employed people in Pennsylvania.[37] This represents a decrease from 6,335,000 people in July 2024. [38]

Table 11: Employment, Pennsylvania[39]

December 2024	Labor Force (thousands)	Number Employed	Number Unemployed	Unemployment
Carbon County	32,300	30,900	1,400	4.3%
Lackawanna County	105,100	100,400	4,700	4.4%
Luzerne County	160,800	152,700	8,100	5.0%
Monroe County	82,600	78,900	3,700	4.5%
Pike County	28,800	27,500	1,300	4.5%
Susquehanna County	17,200	16,500	700	4.1%
Wayne County	21,400	20,500	900	4.3%
Wyoming County	12,400	11,800	500	4.2%
Pennsylvania	6,537,000	6,274,000	263,000	4.0%
United States	170,342,000	163,100,000	7,236,000	4.2%

[37] Commonwealth of Pennsylvania. County Profiles. August 2025
[38] Commonwealth of Pennsylvania. Department of Labor and Industry. August 2025
[39] Commonwealth of Pennsylvania. County Profiles. August 2025

According to the Commonwealth of Pennsylvania, Department of Labor and Industry, Pennsylvania had an unemployment rate of 4.0% in July 2025, as shown in Table 8. This rate is the same as the rate for June 2025. This is lower than the national average of 4.1% during the same period. The Education and Health industry had the highest number of employees at 1,408,200 people, followed by the Trade, Transportation, and Utilities industry (1,143,400) and the Professional and Business Services industry (840,700).

Table 12: Pennsylvania Economy[40]

	June 2025	July 2025
Labor Force Data (number of people in thousands; seasonally adjusted)	**Pennsylvania**	
Civilian Labor Force	6,540	6,537
Employment	6,280	6,274
Unemployment	260	263
Unemployment Rate %	4.0	4.0
Nonfarm Wage and Salary Employment		
Total Nonfarm	6,230.1	6,229.8
Mining and Logging	21.7	21.5
Construction	260.1	260.2
Manufacturing	561.5	561.8
Trade, Transportation, and Utilities	1,143.4	1,143.1
Information	89.9	90.1
Financial Activities	343.5	346.5
Professional & Business Services	840.7	842.2
Education & Health Services	1,408.2	1,414.1
Leisure & Hospitality	587.1	584.2

[40] Commonwealth of Pennsylvania. Department of Labor and Industry. August 2025

	June	July
	2025	2025
Labor Force Data (number of people in thousands; seasonally adjusted)	**Pennsylvania**	
Other Services	270.7	270.0
Government	703.3	703.5

Education

In 2023, universities in Pennsylvania awarded 190,032 degrees. Table 9 reveals that the student population of Pennsylvania consisted of more women than men, with 279,244 male students and 374,395 female students.

Table 13: Number of Degrees and Student Population by Gender[41]

Student Population			
2023	**Degrees**	**Male**	**Female**
Carbon County	No Data	No Data	No Data
Lackawanna County	3,914	5,434	7,311
Luzerne County	3,495	5,322	9,361
Monroe County	1,426	2,341	3,478
Pike County	No Data	No Data	No Data
Susquehanna County	40	21	38
Wayne County	No Data	No Data	No Data
Wyoming County	257	492	559
Pennsylvania	190,032	279,244	374,395
United States	5,397,666	8,339,195	11,363,835

[41] Data USA. 2023

Most students graduating from universities in Pennsylvania are White (115,579 or 66.4%), followed by Black or African American (16,862 or 9.69%), Hispanic or Latino (13,898 or 7.99%), and Asian (13,046 or 7.5%).

The largest universities in Pennsylvania, by number of degrees awarded, are Penn State University-Main Campus (14,268, 7.51%), the University of Pennsylvania (11,126, 5.85%), and the University of Pittsburgh-Pittsburgh Campus (9,555, 5.03%). [42]

Table 14: University Degrees Awarded, Pennsylvania[43]

2023	The Largest Universities by Number of Degrees Awarded
Carbon County	No Data
Lackawanna County	University of Scranton (1,508 and 38.5%), Marywood University (833 and 21.3%), and Lackawanna College (578 and 14.8%).
Luzerne County	Wilkes University (1,355 and 38.8%), Misericordia University (657 and 18.8%), and King's College (611 and 17.5%).
Monroe County	East Stroudsburg University of Pennsylvania (1,290 and 90.5%), CDE Career Institute (84 and 5.89%), and The Beauty Institute (52 and 3.65%).
Pike County	No Data
Susquehanna County	Susquehanna County Career and Technology Center (40 and 100%)
Wayne County	No Data
Wyoming County	Keystone College (257 and 100%).
Pennsylvania	Pennsylvania State University-Main Campus (14,268 and 7.51%), University of Pennsylvania (11,126 and 5.85%), and University of Pittsburgh-Pittsburgh Campus (9,555 and 5.03%).
United States	Western Governors University (48,180 and 0.856%), Southern New Hampshire (35,593 and 0.659%), Ivy Tech Community College (31,550 and 0.585%).

[42] In the proceeding pages, the raw number and percentages of the respective data points indicate the fraction of the counties and state.
[43] Data USA. 2023

The most popular degree majors awarded in Pennsylvania are Registered Nursing (9,211, 4.85%), General Business Administration and Management (8,898, 4.68%), and General Psychology (4,864, 2.56%).

In 2023, White students were the most common racial or ethnic group to be awarded degrees at institutions. These 115,579 degrees mean that there were 6.85 times more degrees awarded to White students than the next closest race/ethnicity group, Black or African American, with 16,862 degrees awarded.

Table 15: Popular Majors, Pennsylvania[44]

	Popular majors
Carbon County	No Data
Lackawanna County	General Business Administration & Management (333 and 8.51%), Accounting (333 and 8.51%) and Registered Nursing (134 and 3.42%).
Luzerne County	Registered Nursing (575 and 16.5%), General Business Administration & Management (250 and 7.15%), and Liberal Arts and Sciences (138 and 3.95%)
Monroe County	General Business Administration & Management (98 and 6.87%), General Psychology (75 and 5.26%), and Kinesiology and Exercise Science (72 and 5.05%).
Pike County	No Data
Susquehanna County	General Cosmetology (23 and 57.5%), Licensed Practical and Vocational Nurse Training (11 and 27.5%), and Massage Therapy (5 and 12.5%).
Wayne County	No Data
Wyoming County	General Business Administration & Management (42 and 16.3%), Applied Psychology (24 and 9.34%), and Sport & Fitness Management (18 and 7%).
Pennsylvania	Registered Nursing (9,211 and 4.85%), General Business Administration & Management (8,898 and 4.6%), and General Psychology (4,864 and 2.56%).
United States	General Business Administration & Management (336,268 and 6.23%), Liberal Arts and Sciences (334,324 and 6.19%), and Registered Nursing (253,629 and 4.7%).

[44] Data USA. 2023

Table 16: High School Enrollment Rate, Pennsylvania, October 2024-2025[45]

Location	Number
Carbon County	2,637
Lackawanna County	9,636
Luzerne County	16,550
Monroe County	9,186
Pike County	2,374
Susquehanna County	2,117
Wayne County	1,288
Wyoming County	943
Pennsylvania	586,000

The tables below indicate counties in Pennsylvania and their rates of educational attainment. Table 13 shows the population aged 18-24 who do not have a high school diploma. Carbon County had the highest rate, at 17.1%, followed by Wayne County at 16.9%, and Susquehanna County at 15.4%. Wyoming County had the lowest rate at 6.5%.

Table 14 reveals the counties in Pennsylvania with populations that have earned a degree higher than a high school diploma, as well as those with bachelor's degrees. Pike County had the highest rate of the population with a high school diploma at 93.2%. The county with the highest rate of individuals aged 25 and older holding a bachelor's degree is Luzerne, at 34.3%. Luzerne County also had a high rate of those with a high school diploma at 90.7%. All counties in the focus areas have a rate that is lower than the state and the nation among the 25 and older population with a bachelor's degree.

Table 17: 18- to 24-Year-Olds Without a High School Diploma, Pennsylvania, 2023[46]

	Percent	Urban/Rural
Carbon County	17.1%	Rural
Lackawanna County	10.5%	Urban

[45] Commonwealth of Pennsylvania. Enrollment.2024-2025.

[46] U.S. Census Bureau. ACS 5-Year Estimate. 2023.

	Percent	Urban/Rural
Luzerne County	14.2%	Urban
Monroe County	13.3%	Rural
Pike County	13.6%	Rural
Susquehanna County	15.4%	Rural
Wayne County	16.9%	Rural
Wyoming County	6.5%	Rural
Pennsylvania	11.5%	N/A
United States	11.6%	N/A

Table 18: Education in Pennsylvania, 2023[47]

2023	High School Graduate or Higher, Age 25+	Bachelor's Degree or Higher, Age 25+
Carbon County	90.3%	18.3%
Lackawanna County	91.6%	25.0%
Luzerne County	90.7%	34.3%
Monroe County	90.3%	27.9%
Pike County	93.2%	28.9%
Susquehanna County	91.5%	19.8%
Wayne County	91.4%	21.6%
Wyoming County	92.4%	21.5%
Pennsylvania	91.9%	34.5%
United States	89.4%	35.0%

[47] U.S. Census Bureau. ACS 5-Year Estimate. 2023

Health

Per capita personal healthcare spending in Pennsylvania totaled $9,609 in 2023. This is a slight increase (approximately 4.1%) from the 2022 spending of $9,234.[48] The United States' per capita healthcare spending reached $14,570, an increase of 7.5% from 2022.[49]

In 2024, primary care physicians in Pennsylvania saw an average of 1,261 patients. This represents an increase of 4.03% from the previous year (1,216 patients).[50] All counties in the focus areas, except for Wyoming, experienced a loss in primary care physicians in 2024.

Table 19: Primary Care Physicians[51]

2024 Reported Year	Primary Care Physicians 2023	Primary Care Physicians 2024	% Change Primary Care Physicians
Carbon County	24	22	-9.0%
Lackawanna County	205	178	-15.1%
Luzerne County	249	247	-0.81%
Monroe County	72	68	-5.9%
Pike County	18	15	-20.0%
Susquehanna County	15	14	-7.1%
Wayne County	22	19	-15.8%
Wyoming County	13	15	13.3%
Pennsylvania	10,514	10,252	-2.6%

Mental health providers in Pennsylvania saw an average of 371 patients in 2024. This represents a 6.55% decrease (397 patients) from the previous year.[52] All counties in the focus areas, except for Susquehanna and Wyoming, experienced positive growth in the number of mental health providers.

Table 16: Mental Health Providers[53]

[48] U.S. Bureau of Economic Analysis via FRED
[49] CMS.gov. Center for Medicare & Medicaid Services
[50] Data USA
[51] County Health Rankings and Roadmaps. 2024
[52] Data USA
[53] County Health Rankings & Roadmaps. 2024

2024 Reported Year	Mental Health Providers 2023	Mental Health Providers 2024	% Change Mental Health
Carbon County	45	51	11.7%
Lackawanna County	562	603	6.8%
Luzerne County	397	434	8.5%
Monroe County	243	254	4.3%
Pike County	55	56	1.8%
Susquehanna County	32	31	-3.2%
Wayne County	55	58	5.2%
Wyoming County	20	19	-5.3%
Pennsylvania	32,643	34,970	6.7%

Health Risks

The table below shows the percentage of adults who have diabetes and obesity within the study area.

Table 20: Adults with Chronic Conditions[54]

2024	% Adults with Diabetes	% Adults with Obesity
Carbon County	9.0%	36.2%
Lackawanna County	9.3%	32.8%
Luzerne County	10.0%	37.0%
Monroe County	9.8%	33.3%
Pike County	8.9%	38.8%
Susquehanna County	8.9%	41.1%
Wayne County	9.2%	34.1%
Wyoming County	8.5%	37.1%
Pennsylvania	9.4%	33.3%

[54] Data USA. 2024

Health Overview [55]

- Overall, 7% of Pennsylvania's population under age 65 did not have health insurance in 2024.
- In 2024, the population-to-primary care physician ratio in Pennsylvania reached 1,260:1.
- In 2024, the number of hospital discharges for ambulatory-care-sensitive conditions per 100,000 Medicare enrollees was 3,014.

Challenges in Pennsylvania[56]

- High Black/white residential segregation
- High level of air pollution
- Low per capita public health funding

Strengths in Pennsylvania[57]

- Low occupational fatality rate
- Low uninsured rate
- Low average number of health-based drinking water violations

Highlights in Pennsylvania[58]

- Drug deaths increased 160% from 15.3 to 39.8 deaths per 100,000 population from 2010 to 2022.
- Crowded housing increased 38% from 1.3% to 1.8% of occupied housing units from 2014 to 2022.
- Air pollution decreased 25% from 12.0 to 9.0 micrograms of fine particulate per cubic meter from 2009-2011 to 2021-2023.
- Severe housing problems decreased 10% from 15.4% to 13.8% from 2009-2013 to 2017-2021.

County Health Rankings[59]

Health is influenced by every aspect of how and where we live. Access to secure and affordable housing, safe neighborhoods, good-paying jobs, and quality early childhood education are important factors that can put people on a path to a healthier life. But access to these opportunities often looks different based on where you live, your race, or the circumstances into which you were born. Data show persistent barriers to opportunity for people with lower incomes and communities of color across the

[55] County Health Rankings & Roadmaps
[56] America's Health Rankings
[57] Ibid
[58] Ibid
[59] County Health Rankings & Roadmaps.2023

United States. Differences in health factors emerge from unfair policies and practices at many levels over many decades.

Medical education programs anchored in communities have great potential to address the present and future needs of physicians who care for the region. Maintaining strong ties to the community improves clinical outcomes. Strong community partnerships through medical education will become increasingly critical as hospitals become responsible for health outcomes.

The table below shows the 2023 ranking of each county according to specific factors. The number is based on 67 counties in Pennsylvania. The higher the number, the unhealthier the county for each category.

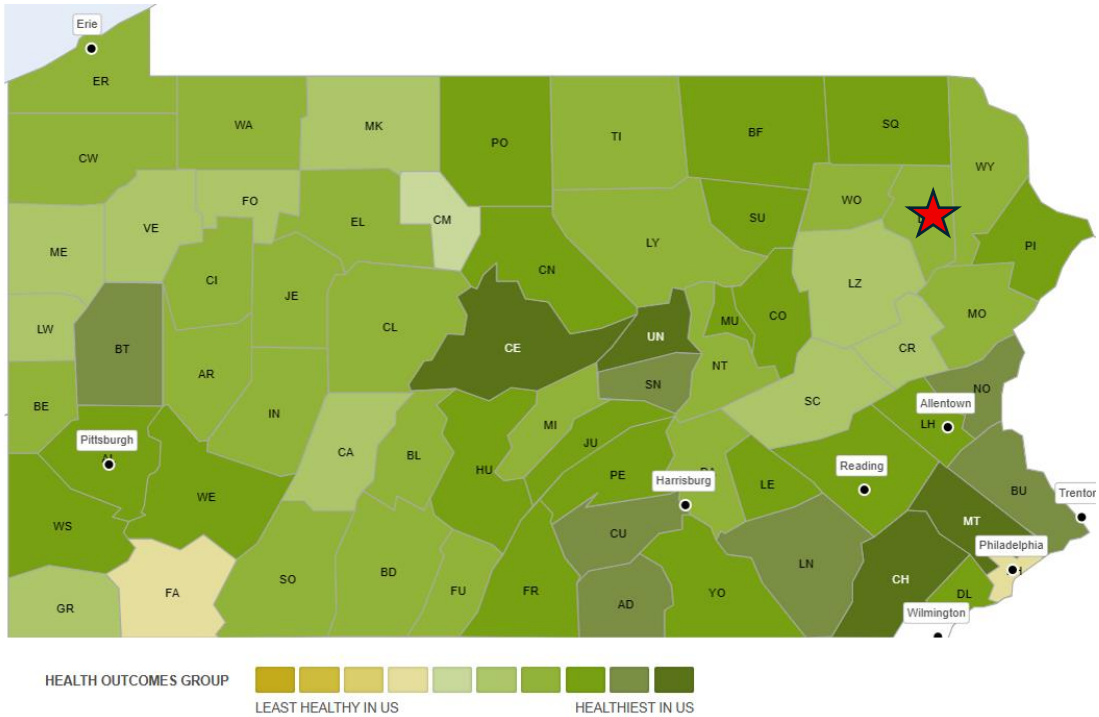
Table 21: County Health Rankings Within the Study Area of Pennsylvania, 2023[60]

	Health Outcomes	Length of Life	Quality of Life	Health Factors	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Carbon County	60	61	49	56	26	56	62	61
Lackawanna County	56	54	52	24	12	26	46	22
Luzerne County	61	62	59	59	44	30	64	33
Monroe County	43	32	48	40	13	63	56	63
Pike County	24	34	21	27	17	40	34	64
Susquehanna County	25	21	34	33	48	52	32	2
Wayne County	32	28	27	39	24	48	52	39
Wyoming County	45	59	14	28	28	25	35	30

Health Outcomes reveal how long people live on average within a community and how much physical and mental health people experience in a community while they are alive. Counties with darker shaded areas of the map indicate healthier counties. Within the focus areas, Pike and Susquehanna counties are healthier than the others in the study.

[60] Country Health Rankings and Roadmaps. 2023.

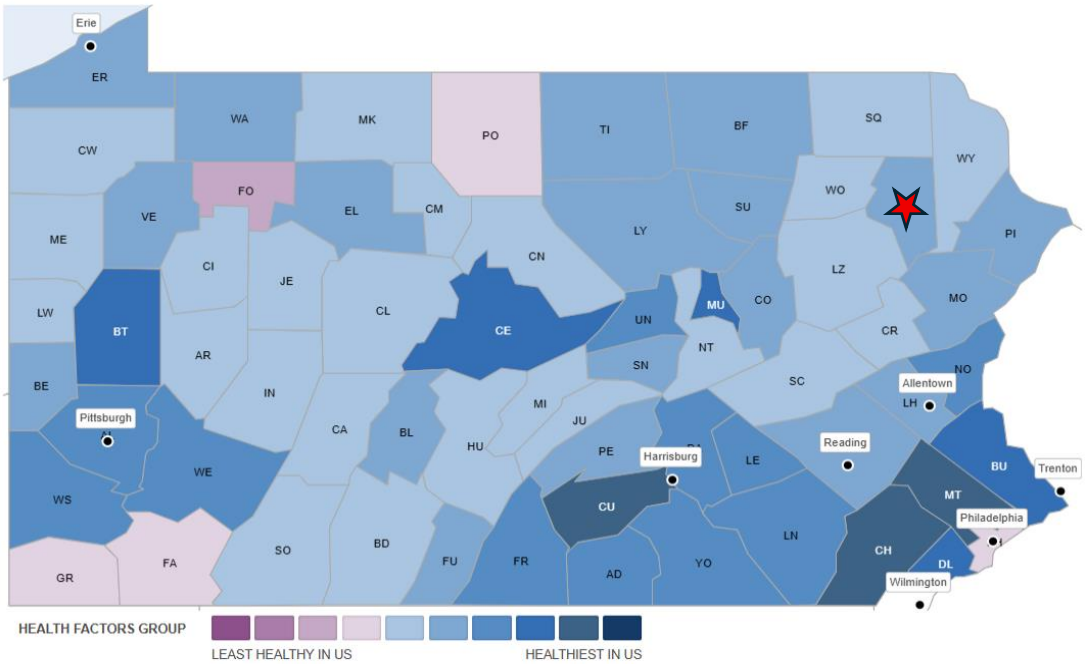
Map 1: Health Outcomes – Pennsylvania, 2024[61]



Health Factors represent those things that can improve the lives of people and help them live longer and healthier. They are indicators of the future health of our communities. Counites with darker shades indicate a healthy county. The counties in the focus area of Northeastern Pennsylvania are shaded in the middle range of the scale, with Monroe, Pike, and Lackawanna counties having more healthy results.

[61] County Health Rankings & Roadmaps.2024.

Map 2: Health Factors – Pennsylvania, 2024[62]



A state demonstrates a high need for primary-care physicians as measured by the number of counties in the state that are full or partial HPSAs for primary-care physicians. Table 19 shows that Pennsylvania has 131 primary-care HPSA designations, resulting in the need for an additional 73 practitioners to remove the HPSA designation label as of December 2024.

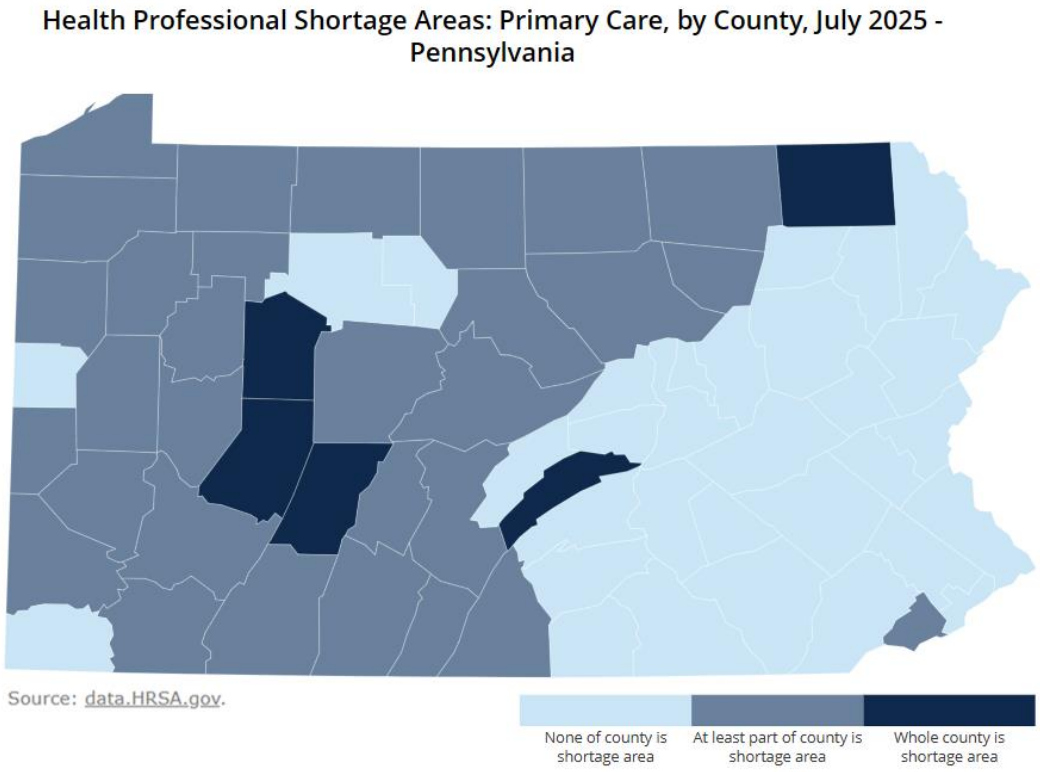
Table 22: Designated Health Professional Shortage Areas, 2024[63]

Pennsylvania	Number of Designations	Population of Designated HPSAs	Percent of Need Met	Practitioners Needed to Remove HPSA Designation
Primary Care	131	383,121	56.44%	73
Dental Care	149	1,684,495	35.56%	294
Mental Care	120	857,739	31.09%	65

[62] County Health Rankings & Roadmaps.2024
[63] Designated Health Professional Shortage Areas-2024

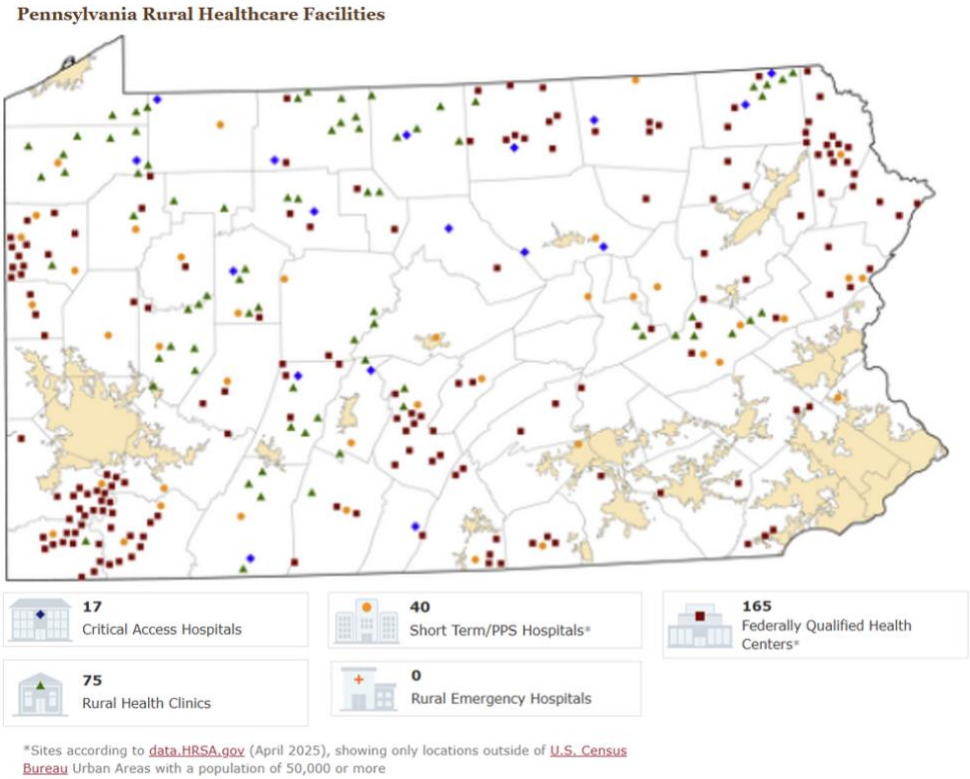
Map 3 identifies the primary-care shortage areas throughout Pennsylvania. A darker HPSA shade indicates a more severe shortage of primary care physicians. Most of the HPSA areas are located throughout central and western Pennsylvania. Within the focus counties, Susquehanna County is the only one identified as an HPSA.

Map 3: Health Professional Shortage Areas in Pennsylvania



Map 4: Pennsylvania Rural Healthcare Facilities-2024 [64]

The map below shows the distribution of rural healthcare facilities in Pennsylvania.



Clinical Landscape in Pennsylvania

The table below reports Federally Qualified Health Centers (FQHCs) and Look-Alike clinics located in the targeted regions of Pennsylvania, offering accessible, community-based primary and preventive care to underserved populations.

Table 23: Federally Qualified Health Centers and Look-Alikes in Focus Areas of Pennsylvania[65]

Site Name	Address	City	ZIP Code	County
Andrew C. Mazza Memorial Health Center	127 Route 106	Greenfield Township	18407-3526	Lackawanna
Alder Street	425 Alder St	Scranton	18505-4116	Lackawanna
Lackawanna College	406 N Washington Ave	Scranton	18503-1306	Lackawanna

[64] Rural Health Information Hub. 2024
[65] HRSA Data Warehouse. HPSA Find Tool.

Site Name	Address	City	ZIP Code	County
Scranton Primary Health Center Inc.	959 Wyoming Ave	Scranton	18509-3095	Lackawanna
Scranton Primary Health Care Center Inc. Administrative Offices	921 Wyoming Ave	Scranton	18509-3023	Lackawanna
Carbondale Family Health Center	150 Brooklyn St	Carbondale	18407-2274	Lackawanna
Caring Community Health Center - Mount Pleasant	531 Mt Pleasant Dr	Scranton	18503-1987	Lackawanna
The Wright Center for Community Health Clarks Summit Practice	1145 Northern Blvd	South Abington Township	18411-2221	Lackawanna
The Wright Center for Community Health Dickson City Practice	312 Boulevard Ave	Scranton	18519-1731	Lackawanna
The Wright Center for Community Health Driving Better Health	5 S Washington Ave	Jermyn	18433-1121	Lackawanna
The Wright Center for Community Health Friendship House Practice	200 Wyoming Ave	Scranton	18503-1412	Lackawanna
The Wright Center for Community Health Mid Valley Practice	5 S Washington Ave	Jermyn	18433-1121	Lackawanna
The Wright Center for Community Health North Pocono Practice	260 Daleville Hwy, Ste 103	Covington Township	18444-7951	Lackawanna
The Wright Center for Community Health North Scranton Practice	1721 N Main Ave	Scranton	18508-1995	Lackawanna
The Wright Center for Community Health Northeast Scranton Intermediate School	721 Adams Ave	Scranton	18510-1603	Lackawanna
The Wright Center for Community Health School Based Practice	1401 Fellows St	Scranton	18504-2222	Lackawanna

Site Name	Address	City	ZIP Code	County
The Wright Center for Community Health Scranton Counseling Practice	329 Cherry St	Scranton	18505-1505	Lackawanna
The Wright Center for Community Health Scranton Practice	501 S Washington Ave	Scranton	18505-3814	Lackawanna
The Wright Center for Community Health South Scranton Intermediate School	355 Maple St	Scranton	18505-1215	Lackawanna
Black Creek Health Center	Pineapple St	Sugarloaf	18249	Luzerne
Freeland Health Center	404 Ridge St	Freeland	18224-1802	Luzerne
Hazelton Pediatrics	1730 E Broad St	Hazleton	18201-5657	Luzerne
McKinney Clinic	39 E Jackson St	Wilkes-Barre	18701	Luzerne
McKinney Clinic	90 Union St	Wilkes-Barre	18705	Luzerne
Rural Health Corporation of Northeastern Pennsylvania	276 E End Ctr	Wilkes-Barre	18702-6970	Luzerne
Shickshinny Health Center	26 N Main St	Shickshinny	18655-1302	Luzerne
Valley Medical	75 S Wyoming Ave	Kingston	18704-3103	Luzerne
Caring Community Health Center - Hazleton	426 Airport Rd	Hazleton	18202-3361	Luzerne
Caring Community Health Center - Kistler Clinic	175 S Wilkes Barre Blvd	Wilkes-Barre	18702-5040	Luzerne
Barnes Building	324 S Franklin St	Wilkes-Barre	18702-3809	Luzerne
Conyngham Primary Health Care Center and Building A	335 S Franklin St	Wilkes-Barre	18702-3808	Luzerne
HR Building	334 S Franklin St	Wilkes-Barre	18702-3809	Luzerne
SUD Building	21 Academy St	Wilkes-Barre	18702-3801	Luzerne
The Wright Center for Community Health Wilkes-Barre Practice	169 N Pennsylvania Ave	Wilkes-Barre	18701-3603	Luzerne

Site Name	Address	City	ZIP Code	County
VHP Pediatrics - Plaza Ct.	500 Plaza Ct	East Stroudsburg	18301-8262	Monroe
VHP Pediatrics - Stroud West	205 Applegate Rd	Stroudsburg	18360-6502	Monroe
VHP Pediatrics - Tobyhanna	100 Community Dr, Ste 202	Tobyhanna	18466-8987	Monroe
VHP Pediatrics - West End	120 Burrus Blvd	Brodheadsville	18322-7812	Monroe
Pike County Dental Center	750 Route 739	Hawley	18428-6058	Pike
Pike Family Health Center	750 Route 739	Hawley	18428-6058	Pike
Pinnacle Family Health Center	132 Manly Rd	Tafton	18464-7829	Pike
Women's Health of Pike County	1592 Route 739, Ste 2	Dingmans Ferry	18328-3513	Pike
LaPorte Health Center	217 King St	Laporte	18626	Sullivan
Matthew W. Stahl Memorial Health Center	498 S Main St STE D	Montrose	18801-1317	Susquehanna
NEPA Community Health Care Elk Lake School District	2380 Elk Lake School Rd	Springville	18844-7710	Susquehanna
NEPA Community Health Care-Hallstead	25066 State Route 11	Hallstead	18822-8816	Susquehanna
Forest City Family Health Center	100 Dundaff St	Forest City	18421-1317	Susquehanna
Hamlin Family Health Center	543 Easton Tpke	Lake Ariel	18436-4718	Wayne
Highland Physicians Family Health Center	1839 Fair Ave	Honesdale	18431-2121	Wayne
Honesdale Behavioral Health	600 Maple Ave, Ste 15	Honesdale	18431-1460	Wayne
Honesdale Health Center Family	600 Maple Ave STE 2	Honesdale	18431-1436	Wayne
Honesdale Pediatric Center	1837 Fair Ave	Honesdale	18431-2121	Wayne
Honesdale Podiatry	600 Maple Ave, Suite 4	Honesdale	18431-1436	Wayne

Site Name	Address	City	ZIP Code	County
Lake Ariel Family Health Center	358 Hamlin Hwy	Lake Ariel	18436-9382	Wayne
Lake Region Walk-in	273 Grandview Ave	Honesdale	18431-1163	Wayne
Northern Wayne Family Health Center	412 Como Rd	Lake Como	18437-1020	Wayne
Sterling Pediatric Center	62 Industrial Park Rd	Lake Ariel	18436-5606	Wayne
Together for Health Dental Center	600 Maple Ave STE 7	Honesdale	18431-1460	Wayne
Waymart Family Health Center	29 Woodlands Dr	Waymart	18472-9366	Wayne
Waymart Pediatric Center	27B Woodlands Dr	Waymart	18472-9366	Wayne
Wayne Memorial Community Health Centers Administration	600 Maple Ave STE 6	Honesdale	18431-1436	Wayne
Women's Health Center	626 Park St	Honesdale	18431-1446	Wayne
The Wright Center for Community Health Hawley Practice	103 Spruce St	Hawley	18428-1149	Wayne
The Wright Center for Community Health Wayne Practice	1855 Fair Ave	Honesdale	18431-2121	Wayne
Exeter Township Medical Center	2795 Sullivans Trial	Falls	18615-7949	Wyoming
Monroe-Noxen Rural Health Center	2888 State Route 29 S	Noxen	18636	Wyoming
The Wright Center for Community Health Tunkhannock Practice	5950 Sr 6	Tunkhannock	18657-7905	Wyoming

Source: Health Resources & Services Administration

Table 24: ACGME and AOA Family Medicine Residency Programs in Pennsylvania[66]

[66] Accreditation Council for Graduate Medical Education (ACGME)

The table below reports Pennsylvania has family medicine residency programs accredited by the Accreditation Council for Graduate Medical Education, expanding training opportunities for both allopathic and osteopathic medical graduates.

Facility Name	City	Number of Program(s)	County
Tower Health	West Reading	34	Berks
Indiana Regional Medical Center	Indiana	1	Indiana
University of Pennsylvania Health System	Philadelphia	95	Philadelphia
Lancaster General Hospital	Lancaster	3	Lancaster
Corry	Corry	1	Erie
Children's Hospital of Philadelphia	Philadelphia	40	Philadelphia
Butler Memorial Hospital	Butler	1	Butler
St Luke's University Hospital	Bethlehem	28	Northampton
Conemaugh Memorial Medical Center	Johnstown	5	Cambria
Geisinger Health System	Danville	62	Montour
Delaware Valley Community Health Inc.	Philadelphia	1	Philadelphia
Robert Packer Hospital	Sayre	11	Bradford
St. Clair Health Graduate Medical Education	Pittsburgh	2	Allegheny
UPMC Washington Hospital	Washington	1	Washington
Wayne Memorial Community Health Centers	Honesdale	1	Wayne
Temple University Hospital	Philadelphia	46	Philadelphia
Abington Memorial Hospital	Abington	5	Montgomery
Penn State Milton S. Hershey Medical Center	Hershey	74	Dauphin

Facility Name	City	Number of Program(s)	County
Allegheny County Medical Examiner's Office	Pittsburgh	1	Allegheny
Latrobe Area Hospital	Latrobe	1	Westmoreland
Wright Center for Graduate Medical Education	Scranton	8	Lackawanna
Lehigh Valley Health Network	Allentown	38	Lehigh
Heritage Valley Health System	Beaver	1	Beaver
UPMC Medical Education	Pittsburgh	162	Allegheny
Mercy Catholic Medical Center	Darby	4	Delaware
Meadville Medical Center	Meadville	1	Crawford
Dermatologic Surgicenter (Philadelphia)	Drexel Hill	1	Delaware
Zitelli and Brodland Clinic	Pittsburgh	1	Allegheny
Allegheny Health Network Medical Education Consortium	Pittsburgh	47	Allegheny
Philadelphia College of Osteopathic Medicine	Philadelphia	10	Philadelphia
Nazareth Hospital	Philadelphia	5	Philadelphia
Sidney Kimmel Medical College at Thomas Jefferson University	Philadelphia	102	Philadelphia
St. Mary Medical Center	Langhorne	3	Bucks
Doylestown Hospital	Doylestown	2	Bucks
Main Line Health System	Wynnewood	12	Montgomery
Jefferson Health Northeast	Philadelphia	8	Philadelphia
Penn Highlands DuBois	Dubois	3	Clearfield
St Luke's Hospital - Anderson Campus	Easton	19	Northampton

Facility Name	City	Number of Program(s)	County
Clarion Hospital	Clarion	1	Clarion
Lake Erie College of Osteopathic Medicine	Erie	5	Erie
Cornerstone Care Teaching Health Center	Mount Morris	1	Greene
WellSpan Health	York	14	York
Jefferson Health Medical Education	Philadelphia	35	Philadelphia

Source: ACGME.org.

Table 25: Nursing Homes in Focus Areas of Pennsylvania[67]

Facility	Address	Beds	Medicare	Medicaid	County
Forest Hills Rehabilitation and Healthcare Center	1000 Evergreen Avenue, Weatherly	200	X	X	Carbon
Mahoning Valley Nursing and Re Lehighton	397 Hemlock Drive, Lehighton	142	X	X	Carbon
The Summit at Blue Mountain Nursing and Rehab Center	211 North 12th Street, Lehighton	91	X	X	Carbon
Abington Manor	100 Edella Road, South Abington Towns	119	X	X	Lackawanna
Allied Services Skilled Nursing Center	303 Smallacombe Drive, Scranton	327	X	X	Lackawanna
Allied Services Transitional Rehab Unit	475 Morgan Highway, Scranton	51	X		Lackawanna

[67] Pennsylvania Nursing Home Ratings by County

Facility	Address	Beds	Medicare	Medicaid	County
Aventura at Creekside	45 North Scott Street, Carbondale	81	X	X	Lackawanna
Aventura at Terrace View	260 Terrace Drive, Peckville	272	X	X	Lackawanna
Carbondale Nursing and Rehabilitation Center	10 Hart Place, Carbondale	115	X	X	Lackawanna
Dunmore Health Care Center	1000 Mill Street, Dunmore	92	X	X	Lackawanna
Elan Skilled Nursing and Rehab, a Jewish Senior Living	1101 Vine Street, Scranton	145	X	X	Lackawanna
Embassy of Scranton	824 Adams Avenue, Scranton	139	X	X	Lackawanna
Gino J. Merli Veterans' Center	401 Penn Avenue, Scranton	196	X	X	Lackawanna
Green Ridge Care Center	2741 Boulevard Avenue, Scranton	95	X	X	Lackawanna
Linwood Nursing and Rehabilitation Center	100 Florida Avenue, Scranton	102	X	X	Lackawanna
Marywood Heights	2500 Adams Avenue, Scranton	72	X	X	Lackawanna
Mid-Valley Health Care Center	81 Sturges Road, Peckville	38	X	X	Lackawanna
Mountain View Care and Rehabilitation Center	2309 Stafford Avenue, Scranton	180	X	X	Lackawanna
Oak Ridge Rehabilitation and Healthcare Center in Taylor	500 West Hospital Street, Taylor	142	X	X	Lackawanna

Facility	Address	Beds	Medicare	Medicaid	County
St. Mary's Villa Nursing Home	516 St. Mary's Villa Road, Moscow	112	X	X	Lackawanna
Scranton Health Care Center	2933 McCarthy Street, Scranton	44	X	X	Lackawanna
Allied Services Center City Skilled Nursing	80 E. Northampton Street, Wilkes-Barre	92	X	X	Luzerne
Allied Services Meade Street Skilled Nursing	200 S. Meade Street, Wilkes-Barre	133	X	X	Luzerne
Birchwood Rehabilitation and Healthcare Center	395 Middle Road, Nanticoke	121	X	X	Luzerne
Edenbrook at Hampton	1548 Sans Souci Parkway, Wilkes-Barre	104	X	X	Luzerne
Edenbrook on Second Avenue	200 Second Avenue, Kingston	160	X	X	Luzerne
Embassy of East Mountain	101 East Mountain Drive, Wilkes-Barre	120	X	X	Luzerne
Embassy of Wyoming Valley	50 N. Pennsylvania Avenue, Wilkes-Barre	120	X	X	Luzerne
Heinz Transitional Rehabilitation Unit	150 Mundy Street, Wilkes-Barre	44	X	X	Luzerne
Highland Manor Rehabilitation and Nursing Center	750 Schooley Avenue, Exeter	120	X	X	Luzerne
Kadima Rehabilitation and Nursing at Lakeside	245 Old Lake Road, Dallas	31	X	X	Luzerne
Kadima Rehabilitation and Nursing at Luzerne	463 North Hunter Hwy, Drums	37	X	X	Luzerne

Facility	Address	Beds	Medicare	Medicaid	County
Lakewood Rehabilitation and Healthcare Center	147 Old Newport Street, Nanticoke	110	X	X	Luzerne
Manor at St Luke Village	1711 East Broad Street, Hazelton	104	X	X	Luzerne
Maple Ridge Rehabilitation and Healthcare Center	615 Wyoming Avenue, Kingston	92	X	X	Luzerne
Meadows Nursing and Rehabilitation Center	4 East Center Street, Dallas	130	X	X	Luzerne
Mountain City Nursing and Rehabilitation Center	403 Hazle Township Boulevard, Hazelton	297	X	X	Luzerne
Mountain Top Rehabilitation and Healthcare Center	185 South Mountain Boulevard, Mountain Top	106	X	X	Luzerne
The Pavilion at St Luke Village	1000 Stacie Drive, Hazelton	120	X	X	Luzerne
River View Nursing and Rehabilitation Center in Wilkes Barre	1555 East End Boulevard Plains Township	180	X	X	Luzerne
Riverstreet Manor	440 North River Street, Wilkes-Barre	122	X	X	Luzerne
Third Avenue Health and Rehab Center	702 Third Avenue, Kingston	65	X	X	Luzerne
Wesley Village	209 Roberts Road, Pittston, PA 18640	160	X	X	Luzerne
Brookmont Healthcare and Rehabilitation Center Effort	510 Brookmont Drive, Effort	119	X	X	Monroe

Facility	Address	Beds	Medicare	Medicaid	County
Sapphire Care and Rehab Center	221 East Brown Street, East Stroudsburg	127	X	X	Monroe
Stroudsburg Post Acute Nursing and Rehabilitation	4227 Manor Drive, Stroudsburg	174	X	X	Monroe
Whitestone Care Center	370 White Stone Corner Road, Stroudsburg	90	X	X	Monroe
Delaware Valley Skilled Nursing and Rehabilitation Center	111 Rivers Edge Drive, Matamoras	70	X	X	Pike
Milford Healthcare and Rehabilitation Center	264 Route 6 and 209, Milford	80	X	X	Pike
Barnes-Kasson County Hospital	2872 Turnpike Street, Susquehanna	58	X	X	Susquehanna
Forest City Nursing and Rehab Center	915 Delaware Street, Forest City	132	X	X	Susquehanna
Meadow View Rehabilitation and Healthcare Center	225 Park Street, Montrose	63	X	X	Susquehanna
Ellen Memorial Health Care Center	23 Ellen Memorial Lane, Honesdale	128	X	X	Wayne
Julia Ribaudo Extended Care Center	1404 Golf Park Drive, Lake Ariel	119	X	X	Wayne
Wayne Woodlands Manor	37 Woodlands Drive, Waymart	117	X	X	Wayne
Embassy of Tunkhannock	30 Virginia Drive, Tunkhannock	124	X	X	Wyoming

American Association of Colleges of Osteopathic Medicine (AACOM) – Student Profile[68]

The 2024 AACOMAS Profile: Applicants and Matriculants

American Association of Colleges of Osteopathic Medicine Applicant and Matriculant Characteristics

- A total of 28,998 applicants and 7,677 matriculants are represented. These applicants submitted 259,000 individual school applications, and the matriculants submitted 79,800.
- The mean number of individual school applications per applicant was 9.0 and per matriculant was 10.4.
- Women represented 58.7% of the applicant pool and 56.4% of the matriculant pool.
- The mean age was 24.6 for applicants and 24.8 for matriculants in 2024.
- For the single race/ethnicity category, the percentage of underrepresented minorities is 16.2% for applicants and 13.8% for matriculants.

GPA

Applicant's undergraduate GPAs are as follows:

- Non-Science: 3.68
- Science: 3.44
- Total: 3.56

Matriculants' undergraduate GPAs are as follows:

- Non-Science: 3.71
- Science: 3.49
- Total: 3.59

Women had a higher total undergraduate mean GPA than men, 3.57 compared to 3.52 for applicants and 3.61 to 3.56 for matriculants.

Nonresident alien applicants' and matriculants' total undergraduate mean GPAs were 3.63 and 3.65, respectively, the highest compared to all other single-category races/ethnicities.

MCAT Scores[69]

Applicants' mean scores for the MCAT:

- Psychological, social, and biological foundations of behavior: 126.64
- Biological and biochemical foundations of living systems: 125.61

[68] AACOM.org. 2023 Entering Class AACOMAS Profile: Applicant and Matriculant Report. 2024.
[69] AACOM.org. Applicant and Matriculant Average MCAT 2016-2024

- Chemical and physical foundations of biological systems: 125.28
- Critical analysis and reasoning skills: 124.90
- Total for all sections: 502.43

Matriculants' mean scores for the MCAT:

- Psychological, social, and biological foundations of behavior: 126.80
- Biological and biochemical foundations of living systems: 126.10
- Chemical and physical foundations of biological systems: 124.80
- Critical analysis and reasoning skills: 124.99
- Total for all sections: 502.7

Health Resources and Services Administration (HRSA) Indicators:[70]

- A total of 6,312 (21.8%) applicants graduated from a high school where many students are eligible for free or reduced lunch. Two other HRSA indicators—living in a Health Professional Shortage Area (HPSA) and being economically disadvantaged—are reported by 4,562 applicants (20.6%) and 4,034 (18.2%) applicants, respectively.
- A total of 2,048 (26.7%) matriculants graduated from a high school where many are eligible for free or reduced lunch. 1,835 or 19.1% are reported as living in an HPSA, and 1,462 (15.2%) identify as being economically disadvantaged.
- Applicants living in a large town totaled 5,993 (27.1%). Nearly 4.3% of applicants or 944 were from an isolated rural area.
- Matriculants living in a large town totaled 2,655 (27.6%), 4.2% of matriculants or 401 were from an isolated rural area.

[70] AACOM.org. 2023 Entering Class AACOMAS Profile: Applicant and Matriculant Report. 2024

Appendix C: Graduate Medical Education Inventory

Graduate Medical Education programs play a critical role in training the next generation of physicians and strengthening the local healthcare workforce. Across Lackawanna, Luzerne, Pike, and Wayne Counties, multiple hospitals currently host residency programs accredited by the ACGME. Collectively, these hospitals provide structured residency training across multiple specialties, positioning the region as a significant hub for GME and physician workforce development.

Table 26: Graduate Medical Education Inventory

Name of Facility	# of Beds	Do they have residency programs?	# of ACGME-accredited programs	GME Programs
Lackawanna County				
Geisinger Community Medical Center	262	Y	53	GME Program(s)
Moses Taylor Hospital	102	Y	5	GME Program(s)
Regional Hospital of Scranton	234	Y	4	GME Program(s)
Luzerne County				
Geisinger South Wilkes-Barre	48	Y	3	GME Program(s)
Geisinger Wyoming Valley Medical Center	318	Y	30	GME Program(s)
Wilkes-Barre General Hospital	396	Y	2	GME Program(s)
Veterans Affairs Medical Center (Wilkes-Barre)	100	Y	7	GME Program(s)
Pike County				
Pike Family Health Center	N/A	Y	1	GME Program(s)
Wayne County				
Wayne Memorial Hospital	98	Y	1	GME Program(s)

Appendix D: Resource Inventory

The table below from the American Hospital Association provides an overview of hospital profiles in the state displaying key characteristics such as bed capacity, total discharges, patient days and gross patient revenue. Acute care hospitals in Pennsylvania, total more than 33,633 beds. These sites are available for opportunities for students to obtain clerkships and residency training. Clinical partnership opportunities exist at FQHCs, physician offices, community centers, nursing homes and clinics.

Table 27: Resource Inventory

Hospital Name	City	Staffed beds	Total Discharges	Patient Days	Gross Patient Revenue
Advanced Surgical Hospital	Washington	14	455	816	$87,890
AHN Brentwood Neighborhood Hospital	Brentwood	0	0	0	$0
AHN Grove City	Grove City	67	878	2,468	$331,256
AHN Harmar Neighborhood Hospital	Pittsburgh	0	0	0	$0
AHN Hempfield Neighborhood Hospital	Greensburg	40	394	1,037	$286,489
AHN McCandless Neighborhood Hospital	Pittsburgh	0	0	0	$0
AHN Saint Vincent Hospital	Erie	347	11,491	61,148	$2,746,538
Allegheny General Hospital	Pittsburgh	508	21,143	133,843	$4,054,082
Allegheny Valley Hospital	Natrona Heights	166	2,733	9,674	$512,146
Armstrong County Memorial Hospital	Kittanning	83	2,691	12,716	$463,318
Bradford Regional Medical Center	Bradford	202	2,904	14,778	$142,994
Bryn Mawr Hospital	Bryn Mawr	284	14,345	58,869	$1,930,687
Butler Memorial Hospital	Butler	294	9,650	47,527	$1,157,690
Canonsburg Hospital	Canonsburg	104	1,214	4,744	$324,055
Chan Soon-Shiong Medical Center at Windber	Windber	47	1,028	3,035	$145,883
Chester County Hospital	West Chester	309	20,705	77,000	$2,590,518

Hospital Name	City	Staffed beds	Total Discharges	Patient Days	Gross Patient Revenue
Children's Hospital of Philadelphia - Middleman Family Pavilion	King of Prussia	0	0	0	$0
ChristianaCare West Grove Campus	West Grove	52	1,586	5,640	$156,629
Clarion Hospital	Clarion	67	782	3,132	$148,386
Conemaugh Memorial Medical Center	Johnstown	329	12,970	69,216	$1,417,383
Conemaugh Memorial Medical Center - Lee Campus	Johnstown	214	6,951	29,459	$200,471
Conemaugh Nason Medical Center	Roaring Spring	45	1,992	5,911	$202,863
Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center	Philadelphia	0	0	0	$0
Eagleville Hospital	Eagleville	83	862	10,010	$71,025
Edgewood Surgical Hospital	Transfer	10	141	197	$84,639
Erie VA Medical Center	Erie	0	0	0	$0
Excela Health Frick Hospital	Mount Pleasant	33	2,237	9,299	$227,791
Excela Latrobe Hospital	Latrobe	115	6,620	27,360	$484,588
Forbes Hospital	Monroeville	290	12,200	62,264	$1,618,824
Fox Chase Cancer Center	Philadelphia	100	3,422	22,024	$1,783,829
Geisinger Bloomsburg Hospital	Bloomsburg	62	3,356	7,391	$575,562
Geisinger Community Medical Center	Scranton	262	16,004	78,164	$4,283,392
Geisinger Janet Weis Children's Hospital	Danville	0	0	0	$0
Geisinger Lewistown Hospital	Lewistown	133	6,804	25,088	$1,136,472
Geisinger Medical Center	Danville	574	31,619	157,628	$11,850,453

Hospital Name	City	Staffed beds	Total Discharges	Patient Days	Gross Patient Revenue
Geisinger Medical Center Muncy	Muncy	20	1,358	3,773	$267,253
Geisinger Shamokin Area Community Hospital	Coal Township	70	2,126	8,224	$74,799
Geisinger South Wilkes-Barre	Wilkes-Barre	0	0	0	$0
Geisinger St. Luke's Hospital	Orwigsburg	60	4,325	17,236	$575,515
Geisinger Wyoming Valley Medical Center	Wilkes-Barre	318	20,592	89,432	$7,093,090
Guthrie Robert Packer Hospital	Sayre	332	14,353	66,068	$2,084,646
Guthrie Robert Packer Hospital, Towanda Campus	Towanda	99	267	1,095	$87,749
H. John Heinz III Department of Veterans Affairs Medical Center	Pittsburgh	0	0	0	$0
Heritage Valley Beaver	Beaver	176	7,883	31,946	$675,531
Heritage Valley Sewickley	Sewickley	265	4,478	17,548	$451,022
Holy Redeemer Hospital	Meadowbrook	258	9,230	47,541	$889,331
Hospital of the University of Pennsylvania	Philadelphia	1,069	43,429	302,835	$21,604,591
Indiana Regional Medical Center	Indiana	166	4,636	20,955	$705,527
James E. Van Zandt VA Medical Center - Altoona, PA	Altoona	0	0	0	$0
Jefferson Abington Hospital	Abington	634	35,432	170,989	$2,749,450
Jefferson Bucks Hospital	Langhorne	0	0	0	$0
Jefferson Einstein Montgomery Hospital	East Norriton	175	10,352	54,198	$1,231,087
Jefferson Einstein Philadelphia Hospital	Philadelphia	619	19,568	100,052	$2,923,818

Hospital Name	City	Staffed beds	Total Discharges	Patient Days	Gross Patient Revenue
Jefferson Frankford Hospital	Philadelphia	0	0	0	$0
Jefferson Hospital	Jefferson Hills	333	11,004	50,595	$1,827,801
Jefferson Lansdale Hospital	Lansdale	140	5,452	25,489	$414,441
Jefferson Methodist Hospital	Philadelphia	0	0	0	$0
Jefferson Moss-Magee Rehabilitation Hospital - Elkins Park	Elkins Park	154	2,392	12,390	$194,402
Jefferson Torresdale Hospital	Philadelphia	457	22,947	120,866	$2,373,010
Kensington Hospital	Philadelphia	14	27	536	$11,029
Lancaster General Hospital	Lancaster	620	27,675	150,309	$4,291,126
Lankenau Medical Center	Wynnewood	370	20,019	105,248	$3,478,546
Lebanon VA Medical Center	Lebanon	0	0	0	$0
LECOM Medical Center and Behavioral Health Pavilion	Erie	161	2,552	19,726	$176,361
Lehigh Valley Health Network	Allentown	20	447	835	$299,502
Lehigh Valley Health Network - Highland Avenue	Bethlehem	20	214	471	$99,547
Lehigh Valley Hospital - Carbon	Lehighton	0	0	0	$0
Lehigh Valley Hospital - Cedar Crest	Allentown	1,330	58,745	309,745	$15,752,841
Lehigh Valley Hospital - Dickson City	Dickson City	40	2,349	8,742	$662,450
Lehigh Valley Hospital - Hecktown Oaks	Easton	0	0	0	$0
Lehigh Valley Hospital - Macungie	Macungie	0	0	0	$0

Hospital Name	City	Staffed beds	Total Discharges	Patient Days	Gross Patient Revenue
Lehigh Valley Hospital - Muhlenberg	Bethlehem	238	9,294	54,968	$1,769,137
Lehigh Valley Hospital - Pocono	East Stroudsburg	249	7,353	34,857	$1,784,064
Lehigh Valley Hospital - Schuylkill E. Norwegian Street	Pottsville	129	5,284	22,626	$299,548
Lehigh Valley Hospital- Hazleton	Hazleton	150	4,944	20,138	$1,109,312
Lehigh Valley Hospital- Schuylkill S. Jackson Street	Pottsville	186	4,585	21,440	$723,564
Lehigh Valley Reilly Children's Hospital	Allentown	0	0	0	$0
Lower Bucks Hospital	Bristol	150	2,907	9,067	$343,060
Meadville Medical Center	Meadville	232	5,567	25,486	$918,786
Mercy Fitzgerald Hospital	Darby	183	6,692	29,363	$884,486
Milton S. Hershey Medical Center	Hershey	629	28,494	176,879	$7,161,818
Moses Taylor Hospital	Scranton	102	3,612	14,809	$822,996
Mount Nittany Medical Center	State College	260	10,890	49,231	$1,394,060
Nazareth Hospital	Philadelphia	180	7,159	30,254	$640,564
OSS Health Orthopaedic Hospital	York	30	858	1,818	$536,729
Paoli Hospital	Paoli	261	15,824	72,249	$2,033,066
Penn Highlands Clearfield	Clearfield	50	1,025	3,468	$139,365
Penn Highlands Connellsville	Connellsville	61	1,204	7,273	$124,530
Penn Highlands DuBois	DuBois	286	10,409	49,793	$1,299,562
Penn Highlands Huntingdon	Huntingdon	89	1,987	9,604	$184,151
Penn Highlands Mon Valley	Monongahela	190	4,590	24,179	$407,083

Hospital Name	City	Staffed beds	Total Discharges	Patient Days	Gross Patient Revenue
Penn Highlands State College Hospital	State College	0	0	0	$0
Penn Medicine Doylestown Hospital	Doylestown	233	14,216	60,322	$1,557,750
Penn Presbyterian Medical Center	Philadelphia	347	16,632	106,314	$6,507,509
Penn State Health Hampden Medical Center	Enola	82	5,265	18,618	$575,831
Penn State Health Holy Spirit Medical Center	Camp Hill	253	9,143	47,037	$1,498,823
Penn State Health Lancaster Medical Center	Lancaster	100	5,356	22,453	$702,967
Penn State Health St. Joseph Medical Center	Reading	165	8,218	32,329	$1,410,865
Pennsylvania Hospital	Philadelphia	462	22,770	90,647	$4,727,315
Phoenixville Hospital	Phoenixville	144	7,677	30,657	$1,036,342
Physicians Care Surgical Hospital	Royersford	12	264	558	$166,766
Pittsburgh VA Medical Center-University Drive	Pittsburgh	0	0	0	$0
Pottstown Hospital	Pottstown	213	6,913	28,451	$993,733
Punxsutawney Area Hospital	Punxsutawney	44	980	3,714	$166,718
Reading Hospital	West Reading	691	34,024	169,645	$4,661,785
Regional Hospital of Scranton	Scranton	234	8,306	45,739	$1,481,273
Riddle Hospital	Media	230	10,846	49,355	$1,513,134
Rothman Orthopaedic Specialty Hospital	Bensalem	24	846	1,008	$273,331
Roxborough Memorial Hospital	Philadelphia	131	2,795	11,564	$326,157
Saint Clair Hospital	Pittsburgh	320	13,053	56,933	$1,607,295
Saint Luke's Allentown Campus	Allentown	112	4,344	20,116	$61,384

Hospital Name	City	Staffed beds	Total Discharges	Patient Days	Gross Patient Revenue
Saint Luke's Hospital - Miners Campus	Coaldale	97	2,555	9,673	$636,368
Saint Luke's Sacred Heart Campus	Allentown	167	1,492	21,025	$686,332
Saint Lukes Hospital - Monroe Campus	Stroudsburg	134	7,600	29,627	$2,030,260
Saint Mary Medical Center	Langhorne	348	15,970	72,529	$1,536,556
Sharon Regional Health System	Sharon	141	4,577	22,600	$491,416
St. Luke's Easton Campus	Easton	29	1,691	5,577	$513,070
St. Luke's Grand View Campus	Sellersville	194	8,935	38,379	$832,851
St. Luke's Hospital - Anderson Campus	Easton	183	18,057	59,084	$3,239,284
St. Luke's Hospital - Carbon Campus	Lehighton	52	3,563	13,865	$751,890
St. Luke's University Hospital - Bethlehem Campus	Bethlehem	813	30,743	161,858	$9,597,129
St. Luke's Upper Bucks Campus	Quakertown	110	7,196	29,472	$1,572,821
Suburban Behavioral Health Campus of Roxborough Memorial Hospital	East Norriton	126	2,057	7,941	$238,480
Surgical Institute of Reading	Wyomissing	15	364	685	$225,090
Temple Health-Chestnut Hill Hospital	Philadelphia	148	6,143	30,701	$1,855,690
Temple University Hospital - Episcopal Campus	Philadelphia	0	0	0	$0
Temple University Hospital - Jeanes Campus	Philadelphia	146	7,366	32,567	$1,844,585

Hospital Name	City	Staffed beds	Total Discharges	Patient Days	Gross Patient Revenue
Temple University Hospital - Main Campus	Philadelphia	879	33,371	205,572	$15,967,399
Thomas Jefferson University Hospital	Philadelphia	882	37,771	232,635	$7,356,415
UPMC Altoona	Altoona	315	15,016	80,746	$2,426,068
UPMC Bedford	Everett	36	1,207	3,570	$207,102
UPMC Carlisle	Carlisle	80	5,217	18,809	$621,170
UPMC Community Osteopathic	Harrisburg	114	4,300	22,694	$89,604
UPMC East	Monroeville	155	7,474	42,010	$1,629,160
UPMC Greene	Waynesburg	18	286	717	$42,990
UPMC Hamot	Erie	412	18,512	102,833	$4,371,758
UPMC Hanover	Hanover	80	5,306	21,631	$740,018
UPMC Harrisburg	Harrisburg	530	32,826	167,180	$4,992,293
UPMC Horizon - Greenville	Greenville	99	3,599	13,447	$1,128,753
UPMC Horizon - Shenango Valley	Farrell	0	0	0	$0
UPMC Jameson	New Castle	146	5,176	25,114	$548,552
UPMC Kane	Kane	18	236	991	$73,791
UPMC Lititz	Lititz	36	3,697	11,494	$406,006
UPMC Magee-Womens Hospital	Pittsburgh	361	18,076	90,007	$6,377,896
UPMC McKeesport	McKeesport	164	3,948	27,469	$812,048
UPMC Memorial	York	74	5,550	23,401	$800,199
UPMC Mercy	Pittsburgh	398	11,435	71,703	$2,456,597
UPMC Montefiore	Pittsburgh	0	0	0	$0
UPMC Northwest	Seneca	164	4,557	22,950	$683,391
UPMC Passavant - Cranberry	Cranberry Township	0	0	0	$0
UPMC Passavant - McCandless	Pittsburgh	390	13,407	73,089	$3,237,225
UPMC Presbyterian	Pittsburgh	1,395	39,327	301,649	$18,767,002
UPMC Saint Margaret	Pittsburgh	207	6,860	33,870	$1,869,017
UPMC Shadyside	Pittsburgh	433	22,192	121,785	$1,375,973
UPMC Somerset	Somerset	56	2,356	12,380	$338,850

Hospital Name	City	Staffed beds	Total Discharges	Patient Days	Gross Patient Revenue
UPMC Washington	Washington	244	7,275	30,537	$602,706
UPMC West Shore	Mechanicsburg	0	0	0	$0
UPMC Williamsport	Williamsport	257	10,484	57,023	$2,359,424
VA Butler Healthcare	Butler	0	0	0	$0
Valley Forge Medical Center and Hospital	Norristown	70	2,229	23,955	$201,861
Warren General Hospital	Warren	85	2,389	9,738	$262,485
Wayne Memorial Hospital	Honesdale	72	3,376	11,434	$452,511
WellSpan Chambersburg Hospital	Chambersburg	274	12,086	52,973	$1,425,136
WellSpan Ephrata Community Hospital	Ephrata	141	5,667	24,440	$1,120,040
WellSpan Evangelical Community Hospital	Lewisburg	131	5,021	19,107	$1,102,322
Wellspan Gettysburg Hospital	Gettysburg	76	4,930	20,104	$931,476
WellSpan Good Samaritan Hospital	Lebanon	163	7,223	36,050	$1,078,373
Wellspan Surgery and Rehabilitation Hospital	York	73	174	389	$267,124
Wellspan Waynesboro Hospital	Waynesboro	57	1,959	7,592	$289,923
WellSpan York Hospital	York	593	26,992	156,720	$4,397,838
West Penn Hospital	Pittsburgh	288	10,913	70,412	$3,199,853
Westmoreland Hospital	Greensburg	309	14,044	67,497	$910,514
Wexford Hospital	Wexford	144	7,295	15,898	$824,267
Wilkes-Barre General Hospital	Wilkes-Barre	156	7,022	33,979	$1,856,475
Wilkes-Barre VA Medical Center	Wilkes-Barre	0	0	0	$0
Wills Eye Hospital	Philadelphia	4	275	757	$155,797
WVU Medicine Uniontown Hospital	Uniontown	145	6,860	29,883	$489,751
TOTAL		**33,633**	**1,389,580**	**7,062,061**	**$287,154,160**

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420 Nichols Rd; 2nd Flolor
Kansas City, MO 64112

888-910-5176

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