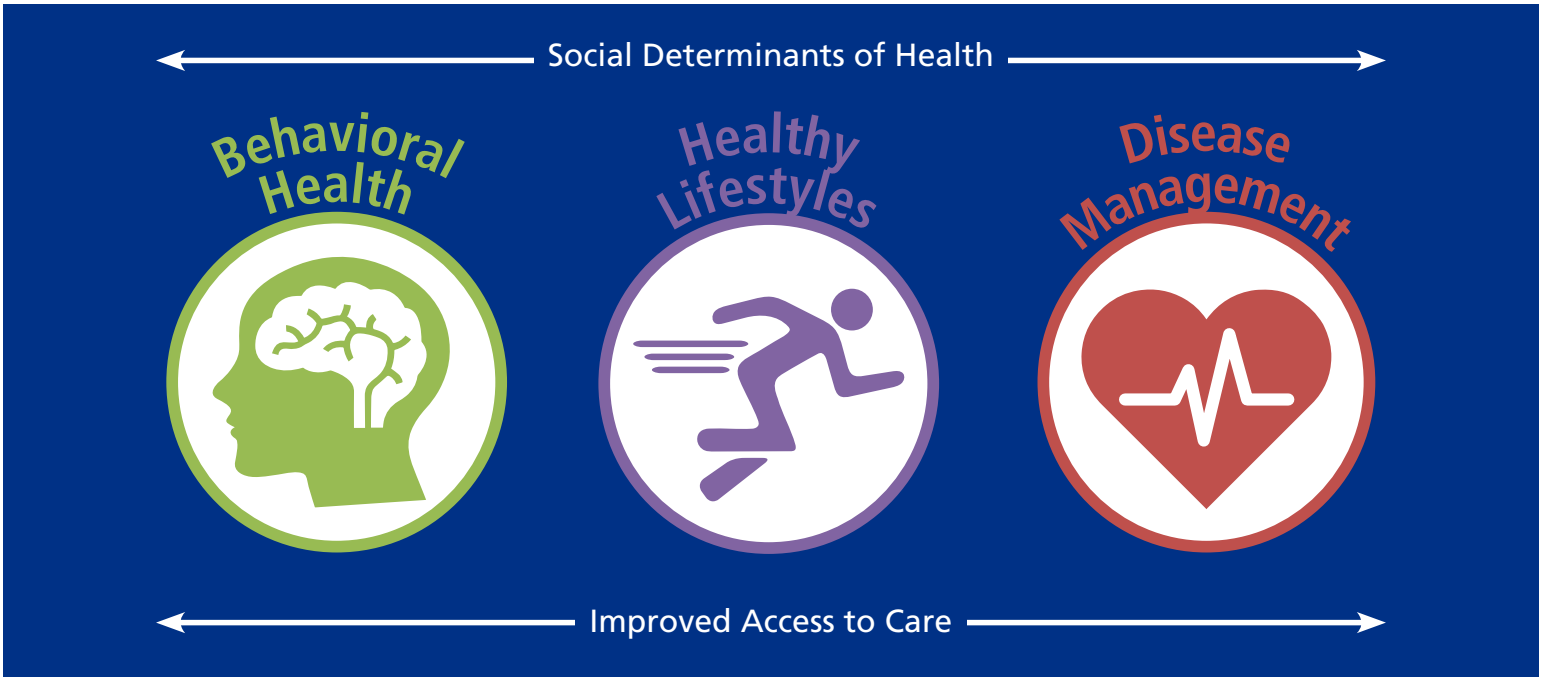
A FIVE-COUNTY

COMMUNITY HEALTH NEEDS ASSESSMENT

IMPLEMENTATION PLAN

Berks | Cumberland | Dauphin | Lancaster | Lebanon



Penn State Health Milton S. Hershey Medical Center

Penn State Health St. Joseph Medical Center

Pennsylvania Psychiatric Institute

PennState Health

2019-2022

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Our Commitment to Community Health

For its 2018 Community Health Needs Assessment (CHNA), Penn State Health formed a collective workgroup that included Penn State Health Milton S. Hershey Medical Center (PSHMC), Penn State Health St. Joseph Medical Center (PSHSJ), Pennsylvania Psychiatric Institute (PPI) and key community stakeholders to identify and address the needs of residents living in Berks, Cumberland, Dauphin, Lancaster and Lebanon counties.

This was the third CHNA conducted by entities of Penn State Health. Previous assessments in 2012 and 2015 involved a different consortium of health care institutions and study area. For the 2018 CHNA, Penn State Health opted to conduct a systemwide assessment, focusing on the collective areas served by its hospitals and affiliated health providers.

The comprehensive CHNA was conducted from January to August 2018, with Baker Tilly as our consulting partner. The study included an in-depth review of primary and secondary data for the five counties comprising Penn State Health's primary geographic service area. More than 1,500 community members participated in the CHNA process by completing Key Informant and Community Member surveys, attending forums and participating in focus groups.

Experts in community health from each health care institution, as well as key community stakeholders, participated in the 2018 CHNA workgroup to guide the process and review findings. The study culminated with the identification and prioritization of the most pressing health issues that impact residents within our five-county service area. Information collected through the CHNA is used to inform our community benefit investments, guide our health improvement initiatives and advance our population health management strategies.

Through dedication and hard work, as well as careful strategic planning, Penn State Health will successfully improve health outcomes in the community and create lasting, positive change. As a regional health system, we are committed to addressing the needs of the community and to promoting sustainable and collective action. As we continue our efforts, we invite our partners to collaborate with us to strengthen our community together. We encourage you to visit our websites to learn more about our CHNA and community health activities:

- Penn State Health Milton S. Hershey Medical Center: hmc.pennstatehealth.org/community/community-outreach
- Penn State Health St. Joseph Medical Center: thefutureofhealthcare.org
- Pennsylvania Psychiatric Institute: ppimhs.org/about-us/community-programs

Penn State Health

Penn State Health was formed in 2015 and is a multi-hospital system serving the population of central Pennsylvania. The system includes the Penn State Health Milton S. Hershey Medical Center, Penn State Children's Hospital, Penn State Cancer Institute, Penn State Health St. Joseph Medical Center, Penn State Health Medical Group and joint ventures consisting of the Penn State Health Rehabilitation Hospital and the Pennsylvania Psychiatric Institute. It employs more than 14,000 people and supports ambulatory and hospital-based services throughout central and central eastern Pennsylvania.

Penn State Health continues to expand its services to meet the needs of central Pennsylvania residents, with a number of primary care and specialty practices recently joining the system. In June 2018, Penn State Health announced the construction of the Penn State Health Hampden Medical Center in Cumberland County, featuring 108 private inpatient beds, an emergency department, physician offices, various specialty inpatient services and imaging and lab services. Construction of the hospital is slated to begin in 2019.

Collectively as Penn State Health, we are committed to enhancing the quality of life through improved health, the professional preparation of those who will serve the health needs of others and the discovery of knowledge that will benefit all.

Penn State Health Milton S. Hershey Medical Center

PSHMC was founded in 1963 through a gift from The Milton S. Hershey Foundation. With this grant and $21.3 million from the U.S. Public Health Service, a medical school, teaching hospital and research center was built, with the groundbreaking in 1966. Penn State College of Medicine opened its doors to its first class of students in 1967. PSHMC accepted its first patients in 1970. Today, PSHMC is one of the leading teaching and research hospitals in the country.

While most academic health centers subscribe to three common missions—education, research and patient care—PSHMC has gone a step further in the adoption of a fourth mission: community health. Just as it is impossible to separate cutting-edge science and medical education from practice, it is equally impossible to separate the principles that guide these three missions from the compassion that drives community health improvement.

Penn State Health St. Joseph Medical Center

St. Joseph Hospital opened its door to all people regardless of race, color or creed in 1873. Since the beginning, reverence, integrity, compassion and excellence have been the core values guiding its work.

In 2015, Penn State Health acquired St. Joseph Regional Health Network from Catholic Health Initiatives. The nonprofit network consists of Penn State Health St. Joseph Medical Center, St. Joseph Downtown Reading Campus, satellite locations throughout Berks County, St. Joseph Medical Group and St. Joseph Provider Hospital Organization. The St. Joseph network provides a full range of outpatient and inpatient diagnostic, therapeutic, medical and surgical services.

Pennsylvania Psychiatric Institute

PPI was formed in 2008 as a partnership between PSHMC and PinnacleHealth (now UPMC Pinnacle) and is dedicated to promoting recovery from behavioral health illnesses by providing high-quality care to people across central Pennsylvania. Its programs and services are designed to meet the needs of individuals, to support the critical work of providers, to advance best practices through the use of evidence-based models of care and to deliver excellent service to consumers. PPI partners with PSHMC's Department of Psychiatry for psychiatrists and substance use disorder (SUD) physicians and serves as the primary training site for the department's medical students, residents and fellows in psychiatry.

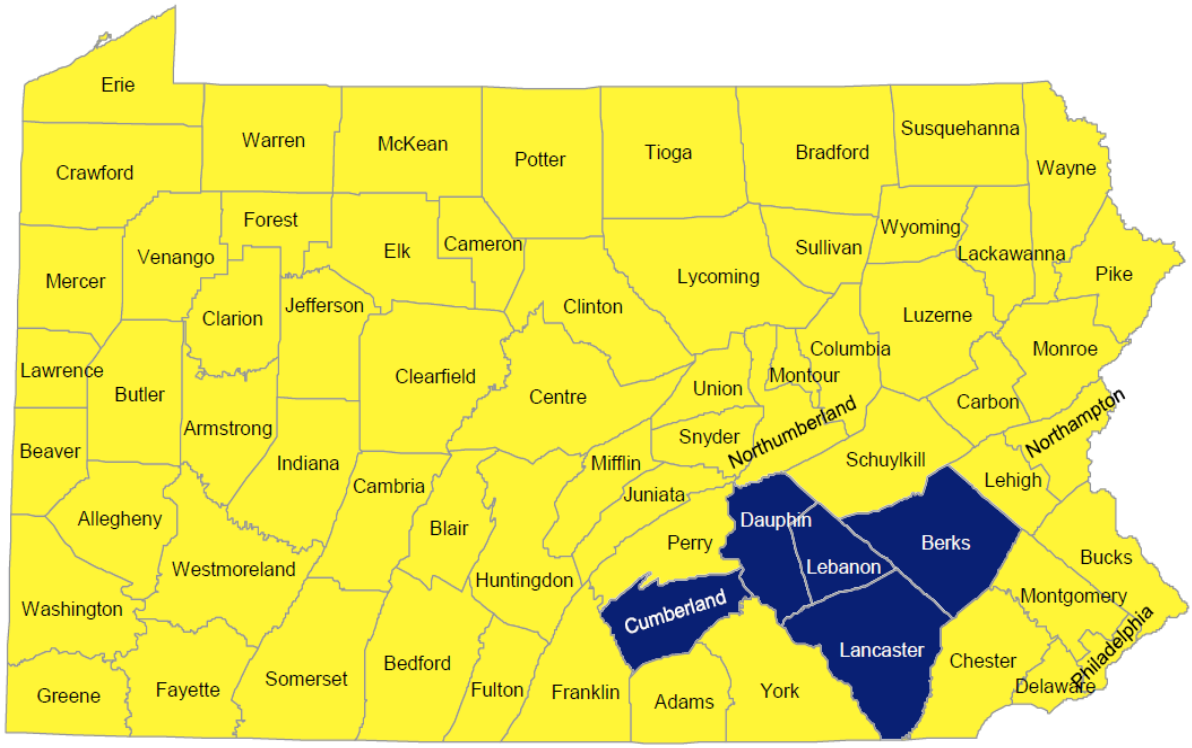
Our Consulting Partner

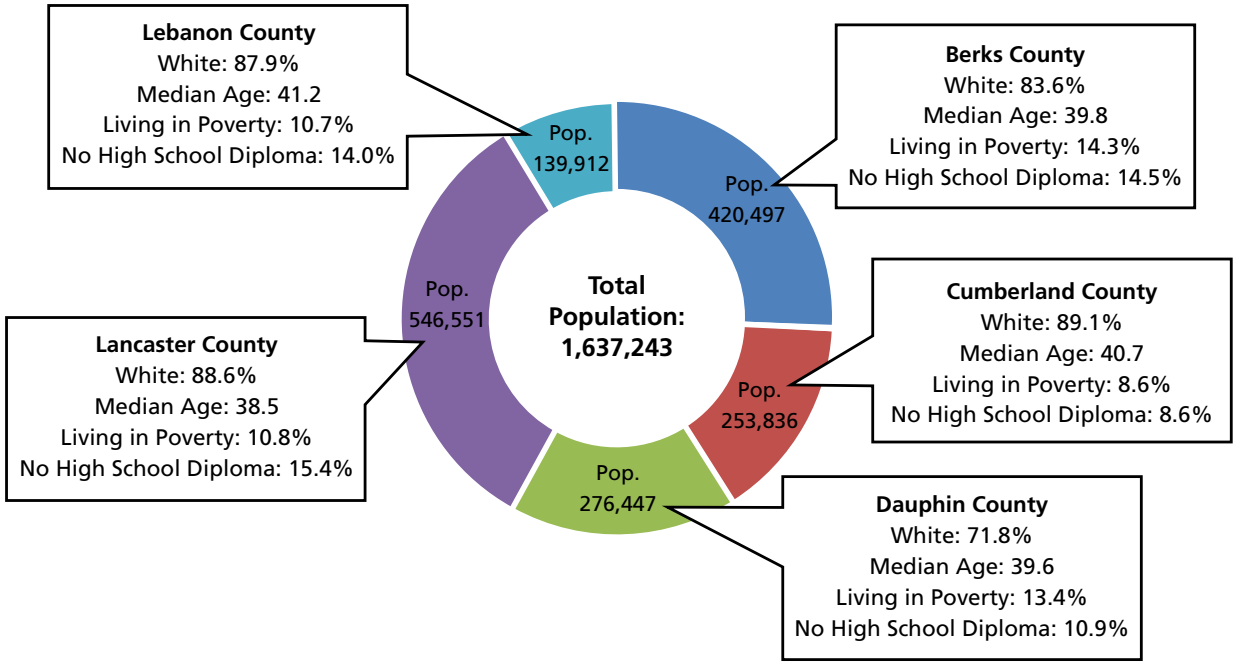
Baker Tilly assisted in all phases of the CHNA, including project management, quantitative and qualitative data collection, small- and large-group facilitation and report writing. The firm's team is recognized as a national leader in completing CHNAs and has worked with more than 100 hospitals and thousands of community partners across the nation to assess health needs and develop actionable plans for community health improvement.

Community Definition

The service area defined for purposes of the CHNA encompasses 222 zip codes in five Pennsylvania counties: Berks, Cumberland, Dauphin, Lancaster and Lebanon. These five counties represent the community where health care resources are available and provided by the partnering Penn State Health organizations. The counties are also home to the majority of Penn State Health's patient population. A total of 1.6 million people live in this 3,200-square-mile service area. The map below shows the location of the five-county service area within Pennsylvania, and the diagram further defines the population.

2018 CHNA Five-County Service Area




Lebanon County
White: 87.9%
Median Age: 41.2
Living in Poverty: 10.7%
No High School Diploma: 14.0%
Pop. 139,912
Berks County
White: 83.6%
Median Age: 39.8
Living in Poverty: 14.3%
No High School Diploma: 14.5%
Pop. 420,497
Total Population: 1,637,243
Cumberland County
White: 89.1%
Median Age: 40.7
Living in Poverty: 8.6%
No High School Diploma: 8.6%
Pop. 253,836
Lancaster County
White: 88.6%
Median Age: 38.5
Living in Poverty: 10.8%
No High School Diploma: 15.4%
Pop. 546,551
Pop. 276,447
Dauphin County
White: 71.8%
Median Age: 39.6
Living in Poverty: 13.4%
No High School Diploma: 10.9%

Prioritized Community Health Needs

Through multiple methods of community engagement, facilitated dialogue with community health experts and a series of criteria-based voting exercises, the most significant issues to focus systemwide health improvement efforts over the three-year cycle from 2019 to 2022 are Behavioral Health, Healthy Lifestyles and Disease Management. Addressing access to care and social determinants of health were seen as cross-cutting strategies needed to improve outcomes across all priority areas.

Implementation Plan

The following plan identifies the actions PSHMC, PSHSJ and PPI each will take to address the prioritized health needs of our community over a three-year period. The information is organized by priority and subcategories and includes:

- Description of the health concerns identified through the CHNA process
- Initiatives the hospitals intend to implement
- Anticipated health impact of these strategies based on achieving set goals, objectives and indicators
- Projected resources
- Potential community partners related to the plan

Strategies included are evidence-based, or those that will be evaluated, to ensure the most effective use of community and hospital resources. All outcomes and any necessary adjustments to this plan will be shared in annual reports that will be made public on our websites. All prioritized health needs identified will be addressed in this plan.

Priority #1: Behavioral Health

Mental Health and Substance Use Disorder

> *"Mental health first aid should be taught in the schools and community more."*
> *Key Informant Survey comment*

Mental health and SUD were identified as top health concerns for the region by Key Informant Survey respondents and Partner Forum participants. Among Community Member Survey respondents, 54 percent reported having poor mental health on at least one day in the past month. Approximately 28 percent of respondents received services or treatment for a mental health issue in the past 12 months. An additional 14 percent of respondents indicated that they needed, but did not receive, services. Young people who consistently feel depressed or sad may be at risk for self-harm and risky behaviors. According to 2017 Pennsylvania Youth Survey data, 15 to 17 percent of students reported being bullied through texting or social media, and more than one-third of all students reported feeling sad or depressed on most days. Nearly one-fifth of all students said they considered suicide within the year prior to the survey. Suicide due to overdose is an indicator of poor mental health. The rate of drug-related overdose deaths increased for all counties except Lebanon, 14 percent of all Community Member Survey respondents have taken a prescription drug that was not prescribed to them and 20 percent have taken an illegal drug. All service area counties saw an increase in the percentage of adults who report excessive drinking. While alcohol use in 2017 decreased among students in all counties, approximately 14 percent of students (or 1 in 7) reported vaping in the past 30 days, and approximately 26 percent of students responded that it would be "sort of easy" or "very easy" to access prescription drugs.

> *"It seems there is inadequate support, intervention, treatment for mental health and substance abuse."*
> *Community Member Survey comment*

Goals

- Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.
- Reduce SUD to protect the health, safety and quality of life for all.

Objectives

- Decrease the number of mentally unhealthy days reported in the last 30 days.
- Reduce the number of drug poisoning deaths per 100,000 population.
- Reduce the percentage of adults reporting binge or heavy drinking.

> *"Behavioral health is on the rise, and there are not enough providers in the area to help those who need help. Substance use issues lead to mental health concerns, and the opioid epidemic is causing a rise in community issues and concerns."*
> *Key Informant Survey comment*

Program Descriptions and Plans

Mental Health Community Screenings, Programs, Training and Education

Screenings, programs and training are key to Penn State Health and its partnering organizations to improve behavioral health for our region. The focus of this plan is to coordinate mental health screenings for high school students in high-need communities, provide mental health awareness training and programs for the community and initiate an academic fellowship program for advanced learners in psychiatry.

Responsible Party	Program Goal	Short-Term Indicator (Year 1)	Medium-Term Indicator (Year 2)	Long-Term Indicator (Year 3)
PSHMC PSHSJ PPI	Increase mental health screenings, programs, training and education provided to the community. Develop a fellowship program that aims to achieve excellence through the integration of education, research, patient care and service to the community.	1. Engage two high schools within the catchment area with an interest in addressing mental health (Derry Township and Steelton-Highspire), and obtain baseline rates of mental health referrals via the Student Assistance Program (SAP) based on the prior year's SAP reports to the state.	1. Improve the identification of mental illness following a depression screening program as demonstrated by a 5 percent increase in the rate of mental health referrals via SAP, based on school aggregate, de-identified SAP data.	1. Demonstrate a change in the community culture (Derry Township and Steelton-Highspire school districts) utilizing a PA Department of Education survey.
		2. Partner with community organizations and offer four mental health programs to the community and reach 3000 people.	2. Partner with community organizations and offer five mental health programs to the community.	2. Partner with community organizations and evaluate mental health programs to determine effectiveness.
		3. Partner with community organizations and offer: • 10 child abuse recognition trainings, reaching 1,000 people. • 10 mental health trainings to the community (one or more will be offered in Berks County), reaching 300 people.	3. Continue to partner and offer: • 10 child abuse trainings, reaching 1,000 people. • 10 mental health trainings to the community (one or more will be offered in Berks County), reaching 300 people. The mental health trainings will evaluate effectiveness via a participant survey.	3. Continue to partner and offer: • 10 child abuse trainings, reaching 1,000 people. • 10 mental health trainings to the community (at least two will be offered in Berks County), reaching 350 people. Recommendations from the participant survey will be reviewed and suggestions implemented to improve the training.
		4. Develop a recruitment plan and determine incentives, with the goal to initiate a one-year Public and Community Psychiatry Fellowship Program for two fellows per year.	4. Evaluate the initial year of recruitment and the ability to begin the Public and Community Psychiatry Fellowship Program.	4. Determine the next steps for a successful Public and Community Psychiatry Fellowship Program.
		5. PSHSJ will reconvene and restructure the Reading Youth Violence Prevention Project (RYVP) Steering Committee.	5. PSHSJ will determine next steps for the RYVP network and plan.	5. PSHSJ will assess and report on the impact and sustainability status of RYVP.

Substance Use Disorder Education, Prevention and Access to Treatment

Penn State Health and its partnering organizations will focus on education, prevention and access to treatment for the priority of behavioral health. We will host and fund educational programs, prevention strategies and treatment initiatives to reduce SUD and its negative impact on the individual, family and community.

Responsible Party	Program Goal	Short-Term Indicator (Year 1)
PSHMC PSHSJ PPI	Support and coordinate improved education and prevention efforts for medical professionals, students and community members. Enhance community partnerships for SUD. Initiate an American Board of Addiction Medicine Fellowship Program	1. Penn State Addiction Center for Translation (PS ACT) will: • Establish a website and list the titles of the talks in the monthly Topics in Addiction seminar series. • Identify five scientists and clinicians involved in the study and treatment of SUD who will talk to elementary, middle and high school students. • Plan a mini med school on addiction for 2021.
		2. The Addiction Medicine Fellowship will be approved and the first two fellows will participate in the two-year program.
		3. PSHMC will provide three drug (including smoking, tobacco and vaping) and alcohol programs, reaching 300 people, to provide education and give support to community members.
		4. Opioid Task Force and Stewardship Program (OTFSP) will develop opioid prescription and tapering guidelines.
		5. Project ECHO (Extension for Community Health Outcomes) will be expanded to train providers on SUD and Medication-Assisted Treatment (MAT).
		6. Design and promote a comprehensive Drug Safety Program for storage of medications and safe disposal at home, drop boxes on the PSHMC campus and two Drug Take-Back Days.
		7. PSHSJ will increase representation on the Berks County Opioid Task Force and assist with the development of the Council on Chemical Abuse (COCA) Prevention Needs Assessment for Berks County.

Medium-Term Indicator (Year 2)	Long-Term Indicator (Year 3)
1. PS ACT will: • Establish a link on the website to allow schools to select a visiting speaker, and expand the list of visiting speakers to include 10 members of PS ACT. • Join with the Consortium to Combat Substance Abuse (CCSA) to bring in higher profile speakers one time per semester. • Allow community members to access the session via webinar. • Publicize the featured speaker on RSVPa, WITF's Local Events Calendar. • Participate in a mini med school on the topic of SUD and addiction.	1. PS ACT will: • Provide evidence-based educational material at the talks, including information provided by the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism and PA Drug and Alcohol Programs. • In collaboration with the CCSA, continue to bring in two higher profile speakers to present in the Topics in Addiction seminar series. • Provide community access via webinar. • Advertise via RSVPa, WITF's Local Events Calendar. • Request that the speakers who participated in the mini med school on SUD present on similar topics in a seminar series to be held at the Hershey Public Library.
2. Two additional fellows will begin in the Addiction Medicine Fellowship.	2. Another two fellows will begin in the Addiction Medicine Fellowship. Evaluate the outcomes of the completion of the first two graduates of the program.
3. PSHMC will provide three drug (including smoking, tobacco and vaping) and alcohol programs, reaching 300 people, to provide education and give support to community members.	3. PSHMC will provide three drug (including smoking, tobacco and vaping) and alcohol programs, reaching 300 people, to provide education and give support to community members. Evaluation of the three years of programming will be completed to determine plans for the future and funding.
4. OTFSP will finalize opioid prescription and tapering guidelines.	4. OTFSP will explore how to disperse and educate opioid prescription and tapering guidelines to local providers.
5. Project ECHO expands into the community to train providers on SUD and MAT.	5. Project ECHO will continue to expand into the community to train providers on SUD and MAT.
6. Develop metrics to measure impact, such as numbers of lock boxes and safe disposal bags distributed, drop boxes placed and locations for Drug Take-Back Days.	6. Explore ways to expand the Drug Safety Program.
7. PSHSJ will maintain representation on the Berks County Opioid Task Force and assist with the development of the COCA Prevention Needs Assessment Community Conversations process and Implementation Plan for Berks County.	7. PSHSJ will sustain representation on the Berks County Opioid Task Force and continue engagement with the COCA Prevention Implementation Plan for Berks County.

Priority #2: Healthy Lifestyles

Nutrition

Statewide, 30 percent of adults and 17 to 19 percent of youth are obese, but Berks, Dauphin and Lebanon counties have rates higher than the state. Obesity was ranked as a top health concern among community stakeholders. Vulnerable populations are often disproportionately affected by factors that contribute to poor health habits, including food accessibility and food insecurity (defined as being without a consistent source of sufficient and affordable nutritious food). The percentage of residents in the five-county region that have low access to food (22.8 percent) is greater than both the state (21.1 percent) and nation (22.4 percent), with residents in Berks and Dauphin counties most likely to report food insecurity. Only one-third of respondents to the Community Member Survey met federal guidelines for adequate fruit and vegetable consumption. Key concerns cited on the survey include lack of nutrition education and confusing messages about what foods are healthy, high cost of fruits and vegetables, stigma around food insecurity and transportation to grocery stores.

"The client population we serve struggles with hunger and food insecurity. Their income generally falls at 150 percent or less of the poverty level; more than 60 percent are single female heads of households, and 18 percent are individuals over the age of 60. They are disproportionately represented with heart disease, high blood pressure, diabetes and a host of other health issues that are not helped by poor nutritional habits."

Key Informant Survey comment

Goal

- Address issues related to obesity and food insecurity by promoting access to and consumption of healthful diets, and implementing standardized nutrition education programs.

Objectives

- Reduce obesity rates in Berks, Dauphin and Lebanon counties.
- Reduce percentage of residents that have low access to food in Berks, Dauphin and Lebanon counties.

Program Descriptions and Plans

Nutrition and Food Access Programs

PSHMC offers a Food Box Initiative, Community Garden and the Farmers Market in Hershey, including Wellness on Wheels outreach initiatives to food pantries and food deserts. The PSHSJ Bern Campus hosts a weekly Farmers Market. The PSHSJ Downtown Reading Campus offers the Farm Stand, Healthy Food Pantry and Veggie Rx initiatives. These programs are designed to increase access to healthy options and address food insecurities.

Responsible Party	Program Goal	Short-Term Indicator (Year 1)	Medium-Term Indicator (Year 2)	Long-Term Indicator (Year 3)
PSHMC PSHSJ	Increase access to and consumption of healthful diets.	1. Engage at least 4,000 participants across all nutrition and food access programs (Food Box Initiative, Community Garden, Farmers Markets, Wellness on Wheels, Farm Stand, Veggie Rx and Downtown Healthy Food Pantry).	1. Engage at least 4,000 participants across all nutrition and food access programs (Food Box Initiative, Community Garden, Farmers Markets, Wellness on Wheels, Farm Stand, Veggie Rx and Downtown Healthy Food Pantry).	1. Engage at least 4,000 participants across all nutrition and food access programs (Food Box Initiative, Community Garden, Farmers Markets, Wellness on Wheels, Farm Stand, Veggie Rx and Downtown Healthy Food Pantry).
		2. Distribute 1,000 pounds of produce from the Community Garden.	2. Distribute 1,000 pounds of produce from the Community Garden.	2. Distribute 1,000 pounds of produce from the Community Garden.
		3. Enroll 100 participants in the Veggie Rx Program and achieve 75 percent voucher redemption rate.	3. Enroll 200 participants in the Veggie Rx Program and achieve 75 percent voucher redemption rate.	3. Enroll 250 participants in the Veggie Rx Program and achieve 80 percent voucher redemption rate.

Standardized Nutrition Education Program

A need for standardized, understandable and culturally appropriate messaging was realized through the CHNA process. These materials will be developed as part of the Centers for Disease Control and Prevention (CDC)-funded Racial and Ethnic Approaches to Community Health (REACH) Project for Berks and Lebanon counties, in partnership with community experts, and utilized throughout Penn State Health nutrition and food access programs. Educational messaging will encourage people to learn basic cooking skills and prepare simple, quick and affordable meals at home. Additional topics will include what a healthy plate looks like, important nutrients, reading a nutritional facts label, recommended serving sizes, staying hydrated and stretching a food budget.

Responsible Party	Program Goal	Short-Term Indicator (Year 1)	Medium-Term Indicator (Year 2)	Long-Term Indicator (Year 3)
PSHMC PSHSJ	Develop evidence-based nutrition education curriculum and align it with nutrition and food access programs at Penn State Health.	1. Penn State Pro Wellness will determine nutrition education curriculum by August 2019.	1. Train staff within at least three nutrition and food access programs in Berks, Dauphin and Lebanon counties, with new curriculum.	1. Implement new curriculum in all Penn State Health nutrition and food access programs.
		2. Implement monthly nutrition and food access task force meetings to align programs.	2. Implement a pre- and post-survey to review and evaluate curriculum after nutrition programs have been implemented.	2. Educate at least 4,000 participants across all nutrition and food access programs, with the goal of survey results demonstrating that participants have an increased understanding of proper nutrition and healthy foods.

Oral Health

Key Informants responded that dental problems are one of the top 10 health conditions affecting our community. Across the service area, 58 percent of Community Member Survey respondents visited a dentist or dental clinic in the past year. Nearly 60 percent of patients surveyed during a two-day dental clinic in Berks County said they had never had their teeth cleaned or that it had been longer than two years since their last cleaning. The rate of dental providers has continued to increase from 2010 to 2015, but the rates remain lower than the state and national rates in Berks, Lancaster and Lebanon counties, with Lebanon County having the lowest rate of dentists. The barriers to dental care are dental provider shortages, limited dental providers that accept entitlement programs such as Medicare and Medicaid, the high cost of dental services and the need for dental information regarding prevention, disease treatment and oral hygiene education.

> *"I had to take two loans out for dental care. Need more work done/can't afford it."*
>
> *Community Member Survey comment*

Goal

- Increase access to oral health preventive services and dental care to improve overall health.

Objective

- Increase the proportion of children, adolescents and adults who used the oral health care system in the past year.

Program Descriptions and Plans

Community Oral Health Resource Bank and Professional Education

PSHMC will develop and maintain an oral health resource bank of information sources to improve community access to dental care and develop an early childhood/adolescent oral health professional education program. PSHSJ will continue as a key participant in the Berks County Oral Health Task Force Brush-Up on Oral Health! Campaign. PSHSJ will integrate early childhood oral health care into maternal child health and well child care utilizing a Community Health Worker (CHW) approach and group models of care, including the Centering Pregnancy and Centering Parenting programs.

Responsible Party	Program Goal	Short-Term Indicator (Year 1)	Medium-Term Indicator (Year 2)	Long-Term Indicator (Year 3)
PSHMC PSHSJ	Improve dental access through the shared knowledge of available resources and increase professional awareness of the importance of oral health interventions in early childhood and adolescence.	1. Compile oral health information by researching various community resources and communicating with community partners; share with CONTACT Helpline 211 and work with them to update resources.	1. Promote CONTACT Helpline 211 as the oral health resource bank via various communication formats with community partners.	1. Promote CONTACT Helpline 211 as the oral health resource bank via various communication formats with community partners.
		2. Identify a minimum of two educational parameters for early childhood/adolescent oral health.	2. Develop an early childhood/adolescent oral health professional education program using the parameters identified.	2. Provide early childhood/adolescent oral health education presentations at two professional events.
		3. Offer or partner on at least two training opportunities for women's health and pediatric providers.	3. Offer or partner on at least two training opportunities for women's health and pediatric providers.	3. Offer or partner on at least two training opportunities for women's health and pediatric providers.
		4. Update the CHW core curriculum to include early childhood oral health care enhancements.	4. Update the Centering Pregnancy core curriculum to include early childhood oral health care enhancements.	4. Update the Centering Parenting core curriculum to include early childhood oral health care enhancements.

Penn State Health Dental Clinic and Residency Programs

PSHMC has approved the creation of a dental service to include a general practice residency program and practice site. The motivating factors behind the program are: 1) an institution wide consensus for the need to significantly improve the scope and expertise of the existing dental care services being provided to our inpatient and Emergency Department patient populations, and 2) the commitment made by the organization in its 2016 Community Health Needs Assessment of south central Pennsylvania regarding access to ambulatory dental care in our local underserved communities. The existing PSHSJ Dental Clinic and Residency Program will provide free oral cancer screenings and other oral health outreach in community settings, with an emphasis on urban and Latino health events, and revitalize the Children's Dental Clinic, Sealant Saturday and/or other free clinic programs to increase access for the uninsured.

Responsible Party	Program Goal	Short-Term Indicator (Year 1)	Medium-Term Indicator (Year 2)	Long-Term Indicator (Year 3)
PSHMC PSHSJ	Provide integrated care to manage the dental needs of our patients and members of the community in high risk health groups.	1. PSHMC will: • Open an on-campus dental operatory. • Recruit an on-campus dental operatory program director, to be on board by the first quarter of fiscal year 2019.	1. PSHMC will: • Begin renovations for an off-campus, 5,000-square-foot dental clinic, consisting of nine operatories and one procedure room and located on a bus li ne. • Establish a one-year general dental residency program.	1. PSHMC will: • Complete construction for the off-campus clinic, and recruit dental staff and additional faculty. • Begin the residency program with three full-time residents.
		2. PSHSJ will provide at least three targeted oral health outreach events, including one Children's Dental Clinic, Sealant Saturday and/or other free clinic programs to increase access for the uninsured quarterly.	2. PSHSJ will provide at least three targeted oral health outreach events, including one Children's Dental Clinic, Sealant Saturday and/or other free clinic programs to increase access for the uninsured quarterly.	2. PSHSJ will provide at least three targeted oral health outreach events, including one Children's Dental Clinic, Sealant Saturday and/or other free clinic programs to increase access for the uninsured quarterly.

Physical Activity

Current behaviors are determinants of future health, and not participating in leisure-time physical activity may contribute to health issues, such as obesity and poor cardiovascular health. The Office of Disease Prevention and Health Promotion recommends that adults participate in at least 150 minutes of moderate-intensity aerobic physical activity each week. Fewer than 30 percent of Community Member Survey respondents met physical activity guidelines, and 21 percent of respondents did not participate in at least 30 minutes of physical activity on any day in the past month. Physical activity is impacted by a variety of social factors, including access to recreation facilities, income, transportation and health literacy, as well as personal choice. Access to recreation and fitness facilities encourages physical activity and other healthy behaviors. From 2010 to 2015, there was an overall downward trend in the rate of recreation and fitness facilities in the five-county area. Affordable fitness facilities, groups, safe parks and a feeling of community are needed.

Goal

- Improve health, fitness and quality of life through daily physical activity.

Objective

- Reduce the percentage of adults who do not engage in leisure-time physical activity.

"Initiate a comprehensive, long-term initiative to promote community-wide physical activity."
Community Member Survey comment

Program Descriptions and Plans

Active Transportation

Continue to make the PSHMC campus and surrounding community safer and connected for walking and biking opportunities. Partner to conduct a Walk-Friendly Community (WFC) Assessment of Derry Township to: 1) provide a framework to improve walkability, and 2) be recognized and promote our walkable community to engage more walkers. For more information, please visit assessment.walkfriendly.org. Bike-share programs are an excellent opportunity to increase active transportation. PSHMC will continue to make bicycles available to staff and students on campus and expand to the larger community.

Responsible Party	Program Goal	Short-Term Indicator (Year 1)	Medium-Term Indicator (Year 2)	Long-Term Indicator (Year 3)
PSHMC	Increase walkability in the PSHMC community, evident by an annual increase in Derry Township walk counts and bike-sharing opportunities, reflected in an increased number of riders and total miles ridden per annual riding season (April through November).	1. Review second WFC assessment report card, develop a plan and promote results.	1. Improve two areas recommended from WFC assessment report card and promote through two media outlets.	1. Achieve next WFC level of recognition.
		2. Maintain and promote campus-wide bike-share program and add one community bike rack location, including five bikes.	2. Add one additional community bike-share rack location, including five bikes.	2. Add one additional community bike-share rack location, including five bikes, totaling three new locations by the end of this plan.

Social Walking Programs

Walking is an effective, low-cost form of exercise and, when done with others or in a group, promotes socialization and a sense of community. PSHMC will continue to promote the Walk Central PA Walk, as well as implement Walk with a Leader programs in underserved communities. The Walk Central PA Walk is a grassroots walking club that offers multiple opportunities to walk throughout the week. The PSHSJ Family Medicine Residency Program, based at the Downtown Reading Campus, will initiate a "Walk with a Doc" or similar program in conjunction with the CDC-funded REACH Project for Berks and Lebanon counties. Walk with a Leader, Doc and Cop programs bring communities together in a safe environment not only to walk, but also to experience health education.

Responsible Party	Program Goal	Short-Term Indicator (Year 1)	Medium-Term Indicator (Year 2)	Long-Term Indicator (Year 3)
PSHMC PSHSJ	Provide and encourage safe, social, community-based opportunities for people of all ages to walk.	1. Increase the scope (expand to a minimum of two underserved communities) and visibility (use two media outlets) of Walk Central PA, Walk and Walk with a Leader programs.	1. Initiate one additional Walk with a Leader series in coordination with a local school district or community group.	1. Initiate one additional Walk with a Leader series in coordination with a local school district or community group.
		2. Engage at least 100 participants annually through weekly walks, special community events and the Walk with a Leader program.	2. Engage at least 150 participants annually through weekly walks, special community events and the Walk with a Leader program.	2. Engage at least 200 participants annually through weekly walks, special community events and the Walk with a Leader program.

Priority #3: Disease Management

Cancer, Cardiovascular Disease and Diabetes

Chronic disease rates are increasing across the nation and are the leading causes of death and disability. Chronic diseases are often preventable through reduced health risk behaviors, such as smoking and alcohol use, increased physical activity and good nutrition and early detection of risk factors and disease. Key Informant Survey respondents identified chronic diseases, including diabetes, cancer and cardiovascular disease, among the top eight health conditions affecting service area residents. High blood pressure and high cholesterol are leading contributors to chronic conditions, particularly diabetes and cardiovascular disease (heart disease and stroke). Across the five-county region, more than 50 percent of Medicare beneficiaries have been diagnosed with high blood pressure and/or high cholesterol. Approximately 9 percent of adults age 20 and older have been diagnosed with diabetes. One-third or more of Community Member Survey respondents reported having high blood pressure and/or high cholesterol. Approximately 23 percent of respondents also reported having diabetes, and 18 percent reported having heart problems. All service area counties have a higher incidence of at least one common cancer type when compared to the state. Key concerns respondents shared that prevent them from managing disease include lack of transportation, care coordination and transition between providers, patient compliance and self-management impacted by language barriers, cultural habits, family support and cost.

Goal

- Improve chronic disease management and treatment outcomes by providing screenings, educational sessions and care navigation to identified high-need communities.

Objectives

- Increase the percentage of female Medicare beneficiaries receiving mammograms.
- Increase the percentage of adults age 50 and older who have had colon cancer screenings.
- Reduce hospital readmission of chronic disease populations.

"The issues of poverty, including transience, lack of adequate and stable housing options, language barriers, access to affordable healthy food and transportation issues, compound to make all three of these issues important to and significant in our community. We need to do more to deal with preventable and manageable diseases, reduce hospitalization and re-admission for preventable illnesses."

Key Informant Survey comment

Program Descriptions and Plans

Community Screening, Education and Support Programs

Penn State Health is proud to host and fund several free community screening and educational programs, support groups, summer camps, professional education programs and mission trips across all hospital and college disciplines. PSHMC's focus in this plan is to coordinate cancer, cardiovascular disease (heart and stroke) and diabetes preventive screenings and educational messages for children and adults in high-need communities. PSHSJ and Penn State Cancer Institute will provide breast, colorectal and cervical cancer screening, education, diagnostics, treatment and support access for un- and underinsured minorities and other underserved women by using a CHW/promotora approach to outreach and care coordination. A PSHSJ diabetes nurse navigator and CHW will hold group educational sessions on diabetes management in both English and Spanish at the Downtown Reading Campus and at community locations. Provide patients with chronic diseases, such as chronic obstructive pulmonary disease (COPD), diabetes, heart failure and stroke, and their caregivers, with educational and emotional support in a safe environment through monthly activities, shared experiences and informational talks from health care professionals.

Responsible Party	Program Goal	Short-Term Indicator (Year 1)	Medium-Term Indicator (Year 2)	Long-Term Indicator (Year 3)
PSHMC PSHSJ	To increase opportunities for coordinated screenings, educational programs and support groups in high-need communities, empowering participants with important health and disease management information and reducing barriers to care.	1. Develop a shared calendar of events and combined literature that ties a common message between disease programs. • Offer four events in high-need communities to provide joint screenings and health messaging by the pediatric, heart disease, stroke, diabetes, cancer and patient access services teams.	1. Offer four annual events in high-need communities to provide joint screenings and health messaging. • Establish a marketing plan for events.	1. Offer four annual events in high-need communities to provide joint screenings and health messaging. • Increase numbers reached by events and promotions.
		2. Offer atherosclerotic cardiovascular disease screenings and other health messaging in one additional food pantry/ high-need center.	2. Develop and implement a system to track participants referred for follow-up regarding access to care needs.	2. Evaluate the tracking system to demonstrate that participants referred for follow-up have improved access to care.
		3. Serve at least 100 breast and colorectal cancer screening participants.	3. Serve at least 125 breast and colorectal cancer screening participants.	3. Serve at least 150 breast, colorectal and cervical cancer screening participants.
		4. Investigate a community outreach component of a diabetes management program.	4. Implement a community outreach component of a diabetes management program in two underserved community locations.	4. Evaluate a community outreach component of a diabetes management program and demonstrate increased knowledge in program participants.
		5. Host monthly chronic conditions support groups.	5. Host monthly chronic conditions support groups, monitor participation and survey participants to determine if their needs are being met.	5. Host monthly chronic conditions support groups; continue to assess and adjust to ensure groups are effective.

Enhanced Community Care Navigation

Navigating care and social needs has become an important Penn State Health goal along the continuum of care for various chronic diseases. Expanding navigation support services, such as CHW partnerships, patient navigation and Community Paramedicine, will be a key focus of this Implementation Plan. PSHMC partners with Penn State College of Medicine to embed first-year medical students as patient navigators in the Science of Health Systems Curriculum. In the 2018–2019 academic year, 140 students served 24 clinical sites. Student patient navigators assist by completing home visits, providing emotional and supportive care and identifying patient-specific social needs and other barriers to high-quality health care. Community Paramedicine is a nonemergent, community-based, free-to-participant initiative to utilize paramedics to enhance access to health education, primary care and health system navigation for medically underserved populations, which helps to reduce emergency transports and hospital admissions. CHWs are trusted individuals who are proven to contribute to improved health outcomes in the community. They promote health within the community in which they reside and/or share ethnicity, language, socioeconomic status and life experiences. The CHW Training Institute at the PSHSJ Downtown Reading Campus offers a 100-hour training program designed to provide the core competencies needed for work in community-based and clinical settings. Penn State Cancer Institute's Cancer Navigation and Survivorship Network (CaNSuN) provides training, resources and other support for those who offer navigation for cancer prevention, early detection, treatment and survivorship in Pennsylvania.

Responsible Party	Program Goal	Short-Term Indicator (Year 1)	Medium-Term Indicator (Year 2)	Long-Term Indicator (Year 3)
PSHMC PSHSJ	Offer community navigation support and build CHW capacity in key areas, resulting in increased education; improved health care access, utilization and coordination; and chronic disease management.	1. By providing in-home education and evaluation for high-risk heart failure patients, Community Paramedicine will reduce 30-day all-cause readmissions for this group.	1. Expand Community Paramedicine in-home education and evaluation services to one additional chronic disease population.	1. Expand Community Paramedicine in-home education and evaluation services to one additional chronic disease population.
		2. Medical Student Patient Navigation will serve 20 sites and 600 patients located within south-central Pennsylvania.	2. Expand community outreach and programs within established patient navigation sites.	2. Expand collaboration between patient navigation hub sites and community.
		3. Partner with CHW programs in one high-need community.	3. Partner with CHW programs in one high-need community.	3. Partner with CHW programs in one high-need community.
		4. Offer at least two CHW training sessions and train at least 25 new CHWs.	4. Offer at least two CHW training sessions and train at least 25 new CHWs.	4. Offer at least two CHW training sessions and train at least 25 new CHWs.
		5. CaNSuN will provide training, resources and support to 25 navigators/CHWs.	5. CaNSuN will provide training, resources and support to 25 new navigators/CHWs.	5. CaNSuN will provide training, resources and support to 25 new navigators/CHWs.

Cross-Cutting Strategies

Addressing access to care and social determinants of health were seen as cross-cutting strategies needed to improve outcomes across all priority areas. Ability to access care is impacted by multiple health and socio-economic factors. Measures such as health insurance coverage, affordability, availability of providers, transportation options, health literacy, language and cultural barriers and stigma are just a few of the barriers residents may face in trying to receive care when they need it.

Specific examples of how Penn State Health will address cross-cutting strategies include initiating several programs to increase access to mental health and SUD screenings and education in the schools and community, as well as training additional community providers via Project ECHO and initiating two fellowship programs. Healthy food access programs will be continued and expanded to address this critical social need. An oral health resource bank, clinic, residency programs and community prevention screenings will be held to increase access to free and reduced-cost oral health care. CHW programs, patient navigation and Community Paramedicine will be continued and expanded to help vulnerable populations better navigate the health care system and available community services.

Projected Resources

Penn State Health is committed to addressing the health need priorities of our community. As described, we will coordinate with our internal and external community partners to ensure we are making the most effective use of our resources to have the greatest impact on health.

PSHMC has developed a culture of community health evident by our annual increase in community health improvement numbers tracked over the past three years of the current Implementation Plan. In fiscal year 2018 alone, 90,713 employee hours and 77,056 volunteer hours contributed $3,343,841 to serve 409,140 community members. Of the FY 2018 community health total dollar amount, $819,444 was accounted for by programs serving CHNA priorities, of which 90 percent of the set indicators were met; and $521,691 was dedicated to sponsorships of community-based health organizations, with precedence given to those addressing prioritized community health needs. The same level of commitment will be provided over the next three years of this Implementation Plan.

As a faith-based, community hospital whose roots are in caring for the underserved in the city of Reading, Pennsylvania, PSHSJ has maintained its Catholic identity and is committed to providing health improvement services, education, contributions and building activities to serve our market and, specifically, the city population, through programs and services at our St. Joseph Downtown Reading Campus. Total charity care for FY 2018 totaled $3.3 million. In addition, PSHSJ has recorded 6,400 hours of staff time, connecting with nearly 508,000 persons in the community. Cost of these services are recorded at $318,517. Moving forward, PSHSJ is committed to continuing community programs that are focused on initiatives directed at behavioral health, healthy lifestyle and disease management.

PPI is committed to understanding how and why behavioral health illnesses develop and can best be treated. During FY 2018, PPI served a total of 27,865 patients: 3,097 children (ages 4 to 12), 5,887 adolescents (ages 13 to 18), 16,063 adults (ages 19 to 64) and 2,818 mature adults (ages 65 and older). Our patients came from more than 39 counties in Pennsylvania. More than $164,969 in charitable care was provided to patients who did not have insurance or were unable to pay. The costs of these services totaled $109,869. Staff at PPI are a professional resource for community organizations and are frequently asked to provide trainings and seminars. During FY 2018, PPI staff provided 133 hours of training to help more than 900 community professionals and volunteers recognize the symptoms of mental health issues, and provide appropriate first aid support and referrals for care. Over the next three years, PPI will continue its commitment to serving the community through continued and improved access to services, voluntary programs and ongoing education.

Penn State Health offers annual start-up grants and has provided $200,000 to fund 54 projects over the past four years. This successful endeavor engages employee teams to partner with community organizations to initiate a program addressing at least one of the health need priorities identified in the CHNA. These grants are intended to help initiate a sustainable project that will have a positive health impact on our community. Not only do these grants provide local health programming, but they also: 1) engage a variety of employee talent in community outreach, 2) help develop an organizational culture of community health improvement, and 3) provide our employees and students with the opportunity to learn from community partners and better understand the social influences on health that our patients experience outside our hospital walls. The following table outlines the most recently awarded grants.

Community Relations Start Up Grants 2019

Project Title	Contact(s)	CHNA Priority	Description
Increasing Patient Adherence and Access to Care at a Student Run Free Clinic through Uber Health	Megan Mendez Miller	Primary Care	Assess the impact of UberHealth in improving barriers to care. Improve patient adherence to medications and follow-up care.
Beacon Clinic Diabetic Education Program	Leesha Helm	Specialty Care	Provide support for diabetic patients cared for by Beacon Clinic with respect to education, nutrition and physical activity.
Community AEDs	Franklin Banfer	Specialty Care	Purchase three AEDs to award to community locations selected via application review process. Provide training to AED awardees.
Community-based Diabetes Education in Nepali Speaking Bhutanese (NSB) Population in Harrisburg, PA	Aditi Sharma	Specialty Care	Provide community-based diabetes education to Nepali-Speaking Bhutanese population in Harrisburg, comprising of meal-planning, cooking demonstrations, exercise, self-monitoring and Nepali-translated Diabetes education materials.
Community Provider Training Improves Care and Safety of Laryngectomy and Tracheostomy Patients	Erin Sarsfield	Specialty Care	Deliver education and skills training to external providers with the goal of improving care for laryngectomy and tracheostomy patients in our surrounding communities.
Dangers of Distracted Driving	Kimberly Patil	Specialty Care	Obtain educational tools to engage participants in learning the dangers of distracted driving. Use these tools at local health fairs and for the teen driver program utilized by the court when teens have driving violations.
Lower Dauphin Communities that Care (LDCTC) Be Kind Initiative	Gail Snyder	Mental Health	Challenge kids of all ages and adults in the Lower Dauphin community to perform intentional acts of kindness in all schools and the community at large.
The Penn State Summer Treatment Program: Dissemination of evidence-based treatment of ADHD	Daniel Waschbusch	Mental Health	Train school and community behavioral health staff working in schools on evidence-based behavioral treatments for ADHD and related behavioral problems with the ultimate goal of optimizing the functioning of these children at home and school.
Community Scholarships for Mindfulness Based Stress Reduction at Penn State Health	Tim Riley	Mental Health	Create and evaluate a Mindfulness Based Stress Reduction program. Make the program available to community members with limited financial resources.
Community Engagement for Enhancement of the Therapeutic Environment	Elisabeth Kunkel	Mental Health	Enhance awareness of mental health issues among students in the Lower Dauphin School District by creating training programs for staff/teachers. Engage students to create art in a collaborative environment for the benefit of patients of the adolescent inpatient unit at PPI.
Interfaith Community Advocacy Project	Julianna Naccarato	Healthy Lifestyles	Aid children who are temporary residents of the Interfaith Shelter to gain basic health knowledge within the domains of hand hygiene, dental hygiene, physical activity and nutritional wellness.
Downtown Daily Bread and Penn State Health Partner for a Healthy Food Initiative	David Frankenfield	Inadequate Nutrition & Obesity	Work with the Downtown Daily Bread kitchen manager to create a comprehensive portfolio of menus that include fresh fruits and vegetables along with other natural, healthy ingredients.
#HealthEtown – helping our community develop healthy habits that lead to a healthy lifestyle	Sharon Watson	Inadequate Nutrition & Obesity	Educate Elizabethtown community members on health and wellness through exposure to yoga, mindfulness and other exercises to provide tips for daily living.
Jump Start Nutrition	Jennifer Bouligny & Jo Ann Seifrit	Inadequate Nutrition & Obesity	Educate children on overall healthy nutrition and lifestyle choices that will carry over into adulthood utilizing food models and individualized goal-tracking calendars.

For More Information

We thank our community partners for their valuable contributions to the CHNA and collaboration to improve the health of all residents in the region. For additional information about the CHNA, Implementation Plan and opportunities to partner, please contact us.

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Board Approval

The 2018 CHNA final report and corresponding implementation plans were reviewed and approved by the Penn State Health Boards of Directors in April 2019. Following the Boards' approval, all were made available to the public via each hospital's website:

Penn State Health Milton S. Hershey Medical Center:
hmc.pennstatehealth.org/community/community-outreach

Penn State Health St. Joseph Medical Center:
thefutureofhealthcare.org

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

Potential Community Partners Related to This Plan

Al-Anon
Alcoholics Anonymous
Alder Health Services
American Cancer Society
American Heart Association
American Stroke Association
BAYADA Home Health Care
Beacon Clinic for Health and Hope
Berks Agricultural Resource Network
Berks Counseling Center
Berks County: Brush-Up on Oral Health! Campaign
Berks County Community Foundation
Berks County Opioid Task Force
Berks County Task Force for Oral Health
Bethesda Mission
Better Together: Lebanon County
Beulah Baptist Church, Steelton, Pa.
Bhutanese Community in Harrisburg
Blue Mountain Academy Agriculture Program
Borough of Hummelstown
Breast Center Support Services of Berks
Byrnes Health Education Center
Centering Pregnancy/Parenting Steering Committee
Central Dauphin School District
Central Penn Parent Magazine
Central Pennsylvania Coalition United To Fight Cancer–CATALYST
Central Pennsylvania Food Bank
Centro Hispano Daniel Torres, Inc.
Christ Lutheran Church, Harrisburg, Pa.
Cocoa Packs, Hershey, Pa.
Common Ground Café and Common Ground Community Center
Communities Practicing Resiliency (CPR)
Community Check-Up Center
Community Services Group (CSG)
Compeer of Lebanon County
Consortium to Combat Substance Abuse (CCSA)
CONTACT Helpline 211
Council on Chemical Abuse
Country Meadows Retirement Communities
Cumberland County Coroner's Office
Cumberland Valley School District
Dauphin County Adult and Juvenile Probation Departments
Dauphin County Coroner and Forensic Center
Dauphin County Department of Drug and Alcohol Services
Dauphin County District Attorney's Office Drug Enforcement Team
Dauphin County Heroin Opioid Prevention Education (HOPE) Collaborative
Dauphin County Human Services
Derry Township
Derry Township Police Department
Derry Township School District
Downtown Daily Bread
Drug Free Workplace PA
Eastcentral and Northeast PA Area Health Education Center
El Poder del Rosado (Annual Latino Pink Power Luncheon) Steering Committee
Elizabethtown Community Housing & Outreach Services (ECHOS)
Farmers Market in Hershey & Summer Concert Series
Frey Village Retirement Center
Gaudenzia, Inc.
Geisinger Holy Spirit Hospital
Giving Tree of Hummelstown
Grantville Food Pantry–Faith United Church of Christ
Greater Berks Food Bank
Greater Reading Chamber Alliance
Hamilton Health Center
Harrisburg Bureau of Police K-9 Officers
Hershey Community Garden
Hershey Entertainment & Resorts
Hershey Food Bank
Hershey Impact
Hershey Plaza Apartments
Hershey Public Library
Highmark Inc.
Highmark Foundation
Hispanic/Latino Community Cancer Advisory Board
Hope Within Ministries
Hummelstown Food Pantry–Zion Evangelical Lutheran Church
I Care Recovery Services
Interfaith Shelter for Homeless Families
Josiah W. and Bessie H. Kline Foundation
Jump Street
Keystone Farmworker Health Program
La Belleza de Nuestra Salud (Annual Latina Health Conference) Steering Committee

Lancaster General Health Care Connections
Lebanon Family Health Services
Lebanon Free Clinic/Lebanon Rescue Mission
Lebanon School District
Lebanon VA Medical Center
Lebanon Valley Volunteers in Medicine
Literary Council of Reading-Berks
Lower Dauphin Communities That Care
Lower Dauphin School District
M.S. Hershey Foundation
Manna Food Pantry, Penbrook United Church of Christ, Harrisburg, Pa.
Mary's Helpers, Prince of Peace Parish Food Pantry, Steelton, Pa.
Mazzitti & Sullivan Counseling Services, Inc.
Middletown Area Interfaith Food Pantry, Royalton, Pa.
Middletown Area School District
Migliore Treatment Services
Milton Hershey School
Mohler Senior Center
Mt. Zion United Methodist Church, Steelton, Pa.
Nar-Anon
Natalie Cribari Drug Awareness Fund
New Beginnings Counseling Services
Northern Appalachia Cancer Network
PA Coalition for Oral Health
PA Coordinated Medication-Assisted Treatment Program (PacMAT)
PA Family Support Alliance
PA State Police Cadets
Partners for Healthy Communities of Central PA Coalition
Paxton Ministries
Penn National Race Course
Penn State Berks
Penn State Dickinson School of Law
Penn State Extension
Penn State Harrisburg
Penn Street Market
Pennsylvania Area Health Education Center (AHEC)
Pennsylvania Counseling Services
Pennsylvania Dental Association
Pennsylvania Dental Hygienists' Association
Pennsylvania Department of Health
Pennsylvania Horsemen's Benevolent and Protective Association (HBPA) Jeanette Johnson Medical Clinic
Project ECHO (Extension for Community Health Outcomes)
Public Health 3.0 Dauphin County
Reading Fairgrounds Market
Reading School District
Recovery, Advocacy, Service, Empowerment (RASE) Project
Roxbury Treatment Center
South Central PA Opioid Awareness Coalition (SCPAOAC)
Spanish American Civic Association (SACA)
Spring Creek Rehabilitation and Nursing Center
Steelton Police Department
Steelton-Highspire School District
Support for People with Oral and Head and Neck Cancer (SPOHNC)
Susan G. Komen Philadelphia
Susquehanna Township School District
Susquenita School District
The Caring Cupboard, Palmyra, Pa.
The Cancer Navigation and Survivorship Network (CaNSuN), Penn State Cancer Institute
The First Baptist Church of Steelton
The Food Trust
The Foundation for Enhancing Communities
The Hershey Company
The Peyton Walker Foundation
The Salvation Army Harrisburg Capital City Region
The Salvation Army of Reading
The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Clinics
T. W. Ponessa & Associates Counseling Services, Inc.
Tri-County Community Action Agency
United Concordia
United Way of Berks County
United Way of the Capital Region
United Way of Lebanon County
University of Pittsburgh Technical Assistance Center (TAC)
Walk Central PA Walk
We Matter
West Perry School District
Wholesome Wave
WITF RSVPa Local Events Calendar
YMCA of Harrisburg Area
YMCA of Reading and Berks County
YWCA of Greater Harrisburg
Zagster Bike Share

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Notes


PennState Health