A Five-County Regional Community Health Needs Assessment Implementation Strategy

2016 - 2019

CUMBERLAND, DAUPHIN, LEBANON, PERRY AND YORK COUNTIES

Penn State Health Milton S. Hershey Medical Center | PinnacleHealth System
Pennsylvania Psychiatric Institute

PennState Health
Milton S. Hershey Medical Center

PINNACLEHEALTH

PENNSYLVANIA PSYCHIATRIC INSTITUTE
1855
A Collaboration of Penn State Hershey & PinnacleHealth



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Community Health Needs Assessment (CHNA)

In 2015, Pennsylvania Psychiatric Institute, Penn State Health Milton S. Hershey Medical Center, PinnacleHealth System, Carlisle Regional Medical Center, Hamilton Health Center and Holy Spirit—A Geisinger Affiliate—collectively deemed The Collaborative—completed a Community Health Needs Assessment (CHNA) of a five-county Pennsylvania region that included Cumberland, Dauphin, Lebanon, Perry and northern York counties (Appendices A and B). The Collaborative worked with regional stakeholders to discover and understand residents' range of health needs (Appendix C).

CHNA contributors included public and private organizations, such as health and human service entities, government agencies, faith-based organizations and academic institutions. Stakeholders represented populations living in urban, rural, and suburban communities. Primary and secondary data including surveys, interviews, open discussion forums and county statistics, were used to evaluate the needs of these populations. An index score was created to reflect health disparity levels in comparison to other communities in the region. Tripp Umbach, a nationally recognized consulting firm, collected and analyzed the data.

THE COLLABORATIVE

To serve the needs of the five-county region of Pennsylvania, the Pennsylvania Psychiatric Institute, Penn State Health Milton S. Hershey Medical Center and PinnacleHealth System joined together to develop one implementation strategy to outline sustainable approaches to addressing the needs identified by the community in the CHNA.

Penn State Health Milton S. Hershey Medical Center, Pennsylvania Psychiatric Institute and PinnacleHealth System worked to address the patient access gap in primary, specialty and dental care services. Secondly, the team aimed to strengthen behavioral health awareness education and outreach, and increase access to mental health and substance abuse services. Lastly, the team worked diligently to improve the lifestyle choices—through education and better access to healthy, affordable and feasible nutrition and fitness options—of residents living in the health institutions' service area.

The Pennsylvania Psychiatric Institute (PPI)

PPI is committed to providing a wide range of high quality behavioral health services. PPI is dedicated to providing clinical excellence, diverse education, research and community collaboration in a manner that evolves to meet the changing behavioral health care needs of the region.

Penn State Health Milton S. Hershey Medical Center (HMC)

HMC, Penn State College of Medicine (PSCOM), and Penn State Children's Hospital (PSCH) are committed to enhancing the quality of life for all through improved health, the professional preparation of those who will serve the health needs of others, and the discovery of knowledge. As an academic medical center, HMC's mission areas include education, patient care, community outreach and research. Community members can visit studyfinder.psu.edu to explore research opportunities and request additional information.

PinnacleHealth System

PinnacleHealth is a not-for-profit healthcare system dedicated to providing and improving the health and quality of life for the people of central Pennsylvania since 1873. A proven leader in medical innovation, PinnacleHealth offers a wide range of services from primary care to complex surgeries. The healthcare network includes four campuses (Community, Harrisburg, West Shore and Polyclinic) as well as medical services such as family practice, imaging, outpatient surgery and oncology at multiple locations throughout the region. As a community hospital, PinnacleHealth maintains a focus on the needs of the local communities and strategies that address the unique healthcare needs of the diverse populations being served.

2016 - 2019
Community Health Regional Priorities

The findings of the Community Health Needs Assessment identified three overarching priorities:

1. Access to Health Services	2. Behavioral Health Services	3. Healthy Lifestyles
✔ Primary Care	✔ Mental Health	✔ Lack of Physical Activity
✔ Specialty Care	✔ Substance Abuse	✔ Obesity and Inadequate Nutrition
✔ Dental Care		✔ Smoking Cessation and Prevention

As the Collaborative determined strategies for addressing the needs of the community, it was understood that without partnerships with regional, state and local organizations, outcomes would not be achieved. Each organization participates in coalitions such as the Hospital and Healthsystem Association of Pennsylvania (HAP), SouthCentral Pennsylvania CHNA Collaborative, the Dauphin County Health Improvement Partnership (DCHIP), the Capital Area Coalition on Homelessness, and The Pennsylvania Office of Rural Health. By working with community-based organizations that focus on health improvement, the institutions can accomplish a larger, more sustainable impact. PPI, HMC and PinnacleHealth are committed to partnering with traditional and non-traditional partners to address issues regarding health and quality of life.

The collaborative recognizes that transportation, cultural competency and attention to diversity are crucial when addressing the three priorities. The focus on culturally responsive care and diversity is based on the recognition that our community is increasingly becoming more diverse, with populations traditionally defined as racial/ethnic minorities collectively becoming the majority population. By communicating effectively with diverse individuals, the Collaborative can contribute to reducing health disparities for under-represented populations.

ACCESS TO HEALTH SERVICES

According to the Agency for Healthcare Research and Quality (2011), healthcare access is considered the timely use of personal health services to achieve the best health outcomes. Barriers that prevent access to health services include insurance, affordability and poor provider availability. The five-county region reported some of the lowest county health rankings in Pennsylvania, including health outcomes, morbidity, clinical care and mortality. County records (2015) showed close to a 12 percent rate of uninsured residents across all five counties, compared to 11 percent for all of Pennsylvania from 2013 county records. Hand-distributed surveys for the CHNA found that 20 percent of respondents did not have health insurance. Lebanon, Perry and York counties are reported as having the fewest primary care physicians per capita, compared to all of Pennsylvania. The CHNA also reported the need for more specialty and dental care providers to offer services and treatments within the regional communities.

BEHAVIORAL HEALTH SERVICES

Each year, approximately 61.5 million Americans (one in four adults) live with at least one mental illness (CDC, 2015). Sixty percent of these individuals receive no mental health services or treatment (NAMI, 2015). In 2013, more than 118,000 Pennsylvania residents visited a healthcare provider for treatment of mental illness (PHC4, 2013). Approximately 18 percent of respondents to the CHNA study area are affected by a mental illness (SAMHSA, 2012). Lack of behavioral healthcare providers in Perry and York counties (47 percent fewer and 87 percent fewer than the national average, respectively) contribute to poor mental health care in the region. The CHNA identified that substance abuse across the region has either remained the same or increased since 2002 (SAMHSA, 2010, 2011, 2012). The CHNA found that undiagnosed and untreated behavioral health problems can lead to physical, emotional and spiritual distress.

HEALTHY LIFESTYLES

According to the Center for Disease Control (CDC), engaging in regular physical activity and creating a routine of exercising from adolescence into adulthood is important to overall health (2015).
The five-county region reported, through the CHNA surveys, that more than 75 percent of residents partake in regular physical activity. Those who are overweight and obese, often as a result of physical inactivity and poor diet, can face an increase in their risk of Type 2 diabetes, high blood pressure, high cholesterol, asthma, and arthritis (CDC, 2015). The number of regional residents that smoke tobacco is more than double national figures (40 percent and 18 percent, respectively). Although the physical activity outlook is promising, inadequate nutrition and obesity and smoking cessation and prevention are a significant challenge to improved healthy living in the region.

PRIORITY:
ACCESS TO HEALTH SERVICES

The CHNA results pointed to a growing issue in many communities in the five-county region of Pennsylvania: a lack of access to quality healthcare, specifically primary, specialty, and dental care. The factors of healthcare access comprise health insurance coverage, affordability, health literacy, cultural competency, coordination of comprehensive care and the availability of physicians.

PRIMARY CARE

Lack of health insurance coverage and affordability can act as barriers to health services. Low-income and economically challenged populations are greatly affected by the lack of health care coverage. Prior to the implementation of the Patient Protection and Affordable Care Act (PPACA) coverage expansion in 2013, more than 1.2 million people were uninsured (11 percent of Pennsylvania residents). Among the 89 percent of Pennsylvanians with insurance in 2013, 62 percent were covered under an employer's plan. One in five Pennsylvanians were enrolled in Medicaid or the Children's Health Insurance Program (CHIP) while seven percent were individually insured. Fifty-one percent of CHNA survey respondents reported affordability as their primary reason for not having coverage.

GOAL:
Strengthen access to provider-based services and supportive services and increase utilization of healthcare services by community members.

OBJECTIVE:
By 2019, increase access to primary care services for residents of the five-county region.

ACCESS TO HEALTH SERVICES

Provide insurance enrollment specialists and financial advisors to educate and enroll uninsured patients in appropriate insurance plans:

Expand Certified Application Counselors (CAC) in each emergency room to identify uninsured patients as they register: The CAC will review options for insurance enrollment and follow the enrollment process to completion following the visit to the emergency room. CACs work with financial aid counselors to determine best options for enrollment and reasonable financial accountability. CACs will be present at community outreach events identifying populations that struggle, to help them understand their financial options for health care coverage.

Reach out to patients who are uninsured or underinsured and provide information and counseling on Medicaid, the Marketplace, and Financial Assistance Program in hopes of providing financial options to cover clinical care costs: Financial counselors will be placed in the HMC Emergency Department and Penn State Cancer Institute, two places where patients most often need assistance. In addition, financial counselors will assist community members with the federal and state health insurance open enrollment period and partner with local non-profit organizations to assist low-income community members with premium assistance for the state and federal marketplace and COBRA benefits. HMC representatives will attend community outreach events that specifically engage populations of people who are less educated on how to obtain and finance health insurance.

Promote awareness of and enrollment in the Children's Health Insurance Program (CHIP): This strategy allows HMC to reach parents and guardians of pediatric populations and to provide information on enrollment into CHIP. In addition to working with patient families within Penn State Health Children's Hospital, HMC will work with external health colleagues to share information with families at other community locales.

Increase the number of patients who use the HMC Prescription Assistance Program: Prescription assistance is provided to any HMC patient in need. Assistance includes application support for any pharmaceutical-run patient assistance programs, one-on-one counseling about affordable medication options, and help with grant funding opportunities (usually disease-specific) to offset medication costs. Staff members will also assist qualified individuals over 65 in completing their Pharmaceutical Assistance Contract for the Elderly (PACE/PACENET) applications.

Increase Nurse-Family Partnership Program: PinnacleHealth offers a voluntary prevention program that provides nurse home visitation services to low-income, first-time mothers. From pregnancy until the child turns two years old Nurse-Family Partnership Home Visitors form a much-needed trusting relationship with the first-time moms, instilling confidence and empowering them to achieve a better life for their children and themselves. This nationally renowned, evidence-based, community health curriculum transforms the lives of vulnerable families. In 2015 the Nurse-Family Partnership Program served 274 clients and intends to increase the number of clients served in the future.

ACCESS TO HEALTH SERVICES

Optimize the patient-centered medical home, whereby continuous quality patient care is comprehensive, team-based and accessible:

PinnacleHealth's Navigation Program: PinnacleHealth's Navigation teams provide care management and coordination to high-risk patient populations, including low-income, senior high rises, community-based shelters and community clinics.

Collaborate with social workers, nurse care managers, and community-based social service organizations to assist with social program eligibility and to overcome barriers to insurance access: HMC social workers conduct social assessments and identify patient needs, including medical and financial concerns and any home restrictions that create a barrier to care. HMC and patient resources are identified and social workers develop a customized strategy for patients to follow-up by phone. Nurse care managers perform similar tasks, but focus on the clinical aspects of care.

Provide home visits to high-risk populations: A Certified Registered Nurse Practitioner (CRNP) and medical assistant-led program will organize home visit and call assessment teams for those who cannot commute to a practice site for care, including those who have been recently discharged with acute needs.

Increase Primary Care Physicians (PCPs) and Advance Practice Clinicians (APCs) in the workforce: Having founded the first Department of Family and Community Medicine in the United States, PSCOM has a well-established history of focusing on primary care. The 3+3 family medicine accelerated program began in 2015 and identifies medical students who are interested in primary care and want to stay in central Pennsylvania for residency. This program provides financial support and enables students to complete their last year of medical school in conjunction with their first year of residency. Additionally, in 2014, PSCOM opened a Physician Assistant Program and will graduate their first class of 30 students in 2016. Penn State College of Nursing also provides grant funding, through the Advanced Nursing Education Expansion and Advanced Nursing Education Traineeship, to students who are pursuing advanced degrees and are interested in caring for rural and underserved populations.

ACCESS TO HEALTH SERVICES

Provide care to uninsured, underinsured, and diverse populations:

PinnacleHealth Service Area: Through the Community Health Navigation Network, to improve service, access and coordination of care for vulnerable populations, PinnacleHealth created a multidisciplinary care team to coordinate healthcare services for senior residents in the Harrisburg area. The innovative program offered more than just efficient, well-served healthcare; it also created a connection and relationship between clients and clinicians.

LionCare/Bethesda Mission: HMC and PSCOM provide care to patients through a free, student-run clinic operating at Bethesda Mission in Harrisburg. Services include medication, follow-up care and procedures. General and women's clinics are offered biweekly, while cardiology, neurology, psychology, orthopedics and dermatology clinics are offered monthly. A smoking cessation program is also provided to male patients free of charge. In the future, LionCare intends to open sports medicine, pediatric, and additional ophthalmology clinics. This strategy aims to provide patient navigation services, nutrition education through the Manna Food Pantry and diabetes screenings.

Hope Within Ministries: Hope Within Ministries delivers free primary health and mental services to people who are medically uninsured and have significant financial need in Lancaster and Dauphin counties. To qualify, patients must have an income 200 percent below the federal poverty level. HMC provides funding for patient laboratory and radiology needs. Select HMC faculty serve on the organization's Board of Directors.

Community Check-up Center: The Community Check-up Center is located in south Harrisburg and is a community based non-profit organization working to improve the health and wellness of low-income women and children through high quality compassionate care. HMC provides a part-time pediatrician and residents to accommodate the growing number of patients with complex health needs.

Nepalese and Bhutanese Populations: As an increased number of Nepalese and Bhutanese persons are utilizing HMC for care, steps will be taken to learn about their history and needs in order to create a culturally-competent clinic which will focus on patient-centered care and increased access.

ACCESS TO HEALTH SERVICES

Provide diversity/inclusion education for faculty, medical staff, students, and community members:

PinnacleHealth is developing a series of educational events that focus on the traditions, cultures and healthcare needs of the unique populations in the service area: Content experts and speakers will be on site to share examples and preferences with the PinnacleHealth staff to include the healthcare and medical needs of men, women and children from various cultural groups. The goal of this series is to create cultural sensitivity and awareness among staff that will result in improved quality of care for all patients, regardless of ethnic and social differences.

HMC and PSCOM provide opportunities to enhance cultural competency, increase staff and student diversity, create an inclusive work environment, improve patient-centered care and educate the community: HMC and PSCOM is launching the Inspiring Excellence Through Inclusion Academy to enhance care for diverse patients, increase awareness of diversity and inclusion issues, to improve the organization's culture of respect, and to provide educational sessions on diversity to our community. The Academy includes workshops for the senior leadership, programs for managers and supervisors, workshops for the workplace, students, and community, including information on culturally-responsive care for diverse groups.

HMC and PSCOM is advancing its diversity imperative that includes eight areas of focus: 1) Communicating commitment to diversity, including developing a vision for diversity and inclusion; 2) Being "best in class" in creating a respectful and inclusive work and educational environment; 3) Increasing racial diversity of students as well as increasing diversity of students with disabilities and with military service; 4) Increasing the racial and gender diversity of faculty and staff; 5) Increasing the cultural competency of faculty and staff; 6) Improving the engagement of students, faculty and staff and the local community in the organization's commitment to diversity and inclusion; 7) Addressing disparities, including health disparities; and 8) Increasing use of diverse suppliers (businesses owned by racial minorities, women, LGBT, and veterans).

Implement the Teach Back Method: PinnacleHealth aims to provide staff training on the Teach back method, or communication confirmation method, to improve patient understanding of discharge instructions and improve overall health literacy.

Reduce flu transmissions with administration of influenza vaccine to employees, high-risk families, and community members: Influenza is a serious disease that can lead to hospitalization and even death. An annual flu shot is the best way to reduce flu in the community. HMC will collaborate with the Pennsylvania Department of Health and increase the number of HMC employees receiving a vaccine to 90 percent. The strategy for community members is to pinpoint a new location in the region to host drive-thru flu shots. High-risk families will be assisted by Penn State Health Children's Hospital nursing staff.

Reduce incidence and severity of avoidable pediatric injuries at home, at play, and in cars: To reduce the number and degree of pediatric injuries in the community, the Pediatric Trauma and Injury Prevention Program strives to increase awareness and provide families access to necessary education tools, resources and devices to lower the risk of injury.

Implement a Medical-Legal Partnership (MLP) at HMC with Penn State University-Dickinson Law's clinical program: By utilizing legal advocacy, Penn State Hershey Medical Group (PSHMG) provides support to ensure that patients have more income, better food, safer and more stable housing, and safer neighborhoods. MLP is a platform for legal and health professionals to jointly detect, address, and prevent health-harming social conditions for people and communities. The MLP Clinic is committed to improving the health and well-being of vulnerable populations through joint medical-legal advocacy; the professional preparation of those who will serve the legal and health needs of others, and the discovery of knowledge that will benefit all.

SPECIALTY CARE

Health disparities, social determinants (home life, education levels, income, and employment), and shortages of physicians adversely impact accessibility to specialty care services. By 2020, the Association of American Medical College's Center for Workforce Studies estimates that the United States will face a shortage of 46,100 surgeons and medical specialists. With the current obesity epidemic, increased lifespans, and an American population which is becoming slightly more physically active, the demand for orthopedic surgeons has grown. By 2025, the country's need for oncologists will nearly double. Information collected from the CHNA highlighted the need for more specialists in the five-county Pennsylvania region. Health provider survey data reported that health providers would like to see timely access to specialty care (11 percent) addressed as an area of improvement in the healthcare system.

GOAL:
Strengthen access to specialty provider-based services and supportive services and increase utilization of healthcare services by community members.

OBJECTIVE:
By 2019, increase access to specialty care services for residents within the five-county region.

ACCESS TO HEALTH SERVICES

Increase heart and stroke health education and screenings through community outreach activities:

The PinnacleHealth Cardiovascular and Thoracic Surgery team works in conjunction with health educators to ensure that the community has access to services and can overcome barriers to improved health after cardiac-related procedures: PinnacleHealth's cardiac educators attend community events and employer fairs to increase access to screenings and early detection. When necessary, PinnacleHealth refers community members to the PinnacleHealth Cardiovascular Institute. From diagnostics and bedside care, to procedures and rehabilitation, the goal is patient-centered care and a focus on improving and saving lives.

Penn State Heart and Vascular Institute (HVI) plans to reduce risk of cardiovascular disease mortality and morbidity by enhancing public awareness of heart and vascular health: Knowing the risk factors for heart attack and stroke is the first step towards reducing risk. HVI will participate in annual community events, enhancing the heart and vascular education outreach approach through the development of an "Outreach Education Package" providing screening and education for older adults and children in both English and Spanish. Lipid, glucose, blood pressure, and body mass index (BMI) screenings will also be provided. An "Omnibus Cardiovascular risk score", used by the American Heart Association, will be calculated and shared with the person screened, and recommendations to share the risk score and test results with the person's health care provider. Follow-up blood pressure and weight measurements will be offered at the site.

Penn State Children's Hospital (PSCH) will focus on patient care, education, and community service, by sharing and directing resources to areas (e.g., expansion into fetal diagnosis, adult congenital heart disease, and weight management): This strategy is to maintain and improve quality of care, support research, train physicians, streamline extensive outreach network of clinics (21 sites) and redeploy resources to sites which require additional support. PSCH plans to develop a referral base for fetal echocardiograms and Adult Congenital Heart Disease (ACHD), and will obtain funding for equipment/sonographers to support a fetal heart program, kid's camp, AHA Youth Health and advanced imaging research. This strategy also includes a multidisciplinary team of physicians, advanced practice clinicians, dieticians, and psychologists to help manage and counsel children who are overweight, obese or morbidly obese. HMC will expand referral bases in other regions, strengthen fellowship training, partner with Maternal Fetal Medicine, Family and Community Medicine and Adult Cardiology, and develop a pediatric cardiology research center.

HMC Stroke Program, in collaboration with the Community Health Team, will focus on education initiatives for school-aged children and at-risk adults: The plan includes multiple large scale events, the development and deployment of education tools, a phone application and a new stroke outpatient/outreach coordinator position. The goal is to increase the number of community members educated about cardiovascular risk factors, the signs and symptoms of stroke, and when to call 911.

ACCESS TO HEALTH SERVICES

Improve adult diabetic care

PinnacleHealth conducts group diabetic education sessions to help patients learn about diabetes and how to manage the disease: Diabetes education includes information on diabetes management, physical activity, medication usage, complication prevention and coping with the chronic disease. The nutrition portion of the education focuses on food choices and improving blood sugar control. Diabetes education aims to reduce heart disease risk factors and improve weight management. Health professionals provide diabetes during pregnancy education through individualized instruction and intensive diabetes self-management instruction on insulin therapy.

HMC will identify high-risk hospitalized adult patients (with a diagnosis of Type 2 diabetes) and provide ongoing follow-up and education post-discharge: The strategy includes utilizing secure text messaging, offering group diabetic education visits, developing diabetic support groups and improving glycemic control to reduce long-term complications and future hospitalizations.

ACCESS TO HEALTH SERVICES

Improve cancer care prevention:

PinnacleHealth focuses on prevention and treatment for various cancers, with centers located on the east and west shores of Harrisburg: Treatment and support services are offered in one of our two state-of-the-art facilities: the Ortenzio Cancer Center at PinnacleHealth, located on PinnacleHealth's West Shore Campus in Hampden Township; and the PinnacleHealth Cancer Center, located on our Community Campus in suburban Harrisburg. Physicians treat a wide range of cancer types and provide specialized program to include: Women's Cancer Programs, Prostate Cancer Program, Breast Cancer Program and Lung Cancer Program. PinnacleHealth partners with community cancer support groups such as Catalyst to reduce health disparities and improve the health of our communities. The initiatives expand existing community-based education and programs on cancer, enhance skills and inform populations on resources that improve cancer survivorship for patients, caregivers and families in the service area.

Rural Northern Appalachia Cancer Network (NACN) and Harrisburg Community Cancer Network (HCCN): Penn State Cancer Institute has established community-based networks in rural and urban Pennsylvania to decrease the risk of cancer and morbidity from cancer among residents of these communities.

Northern Appalachia Cancer Network (NACN): Established in 1992, the NACN is a community-academic partnership dedicated to reducing cancer incidence, morbidity, and mortality among rural communities of Pennsylvania. The NACN develops tests and disseminates evidence-based strategies that increase physical activity, improve nutrition, reduce obesity, increase cancer screening and enhance cancer survivorship. The NACN is piloting toolkits in faith-based settings in rural central Pennsylvania.

Harrisburg Community Cancer Network (HCCN): Established in 2010, the HCCN is a cadre of community health workers (CHWs) who provide peer education and support that reduces the cancer burden among minority residents in central Pennsylvania, with special emphasis on African Americans in Harrisburg. The CHWs provide patient navigation services, coordinate community education programs and summits, and run support groups. In conjunction with Penn State Health, the HCCN is developing and testing a peer education and navigation program to increase the uptake of colorectal cancer screening in Harrisburg.

The plan includes utilizing community-based networks for development and delivery of evidence-based interventions in communities and clinics located in rural and urban Pennsylvania. This approach allows community members and organizations, as well as clinical and academic partners, to work collaboratively with Penn State Cancer Institute to reduce cancer health disparities and improve the health of our local communities.

Skin cancer due to sun exposure: Penn State Dermatology's strategy to reduce skin cancer is to focus on expanding expertise in skin cancer detection, hosting annual skin cancer screenings at multiple locations, improving access in acute care clinics, recruiting additional faculty and increasing the number of resident physicians, expanding team-based care, training other health professionals to detect skin cancer (Family and Community Medicine/Nursing), attending public health events and advocating the use of sun protective shirts, hats, umbrellas and facilitating the construction of shade structures (gazebos at Fireman's Park-Palmyra and the Eshenour Trail-Hershey). Education events involving Hershey Gardens UV protection umbrellas and outreach with local lifeguards and grounds crews, along with special communication at HMC, Hershey Country Club and Milton Hershey School.

ACCESS TO HEALTH SERVICES

Because breast cancer is the second leading cause of cancer deaths among women, free mammograms will be offered to qualifying women 40 years of age and older:

PinnacleHealth will expand their Mammogram Voucher Program (MVP) to underserved and/or under insured women: Free mammograms are provided to women that do not have insurance to receive diagnostic care and prevention of breast cancer. MVP has provided potentially life-saving screenings for more than 3,000 uninsured and underinsured women since its inception.

HMC participates in the Pennsylvania Department of Health's The Healthy Woman Program: As a partner, free mammograms are offered at HMC to uninsured and underserved Pennsylvania residents. The goals of the program are increased education and early detection.

Improve HIV/AIDS care

Continue to provide the Resources, Education, and Comprehensive Care (REACCH) program to HIV/AIDS Clients: REACCH provides free and confidential HIV testing, as well as primary medical care, HIV treatment and treatment adherence for men, women and adolescents. The strategy supports a clinical care team composed of infectious disease doctors, a nurse practitioner and registered nurses who provide a holistic, individualized plan of care for each patient, which includes both medical and psychosocial support and helps people stay on their medications and remain healthy. Psychological and social support services to HIV/AIDS clients include case management, support services for patients and their families, nutritional counseling, social services, financial counseling, help in accessing community resources and outreach to those who have fallen out of care.

Alder Health Services director for medical services and selected board members are HMC faculty: The mission of Alder Health Services is to improve the health and well-being of individuals living with HIV/AIDs, as well as members of the LGBT community, by providing a culturally competent and affirming environment that empowers their clients.

ACCESS TO HEALTH SERVICES

Enhance TeleHealth in the region:

Primary Care TeleHealth: PinnacleHealth seeks to increase the utilization of TeleHealth in family practices and throughout the service community. PinnacleHealth's strategy includes continuing to collaborate and maintain relationships with community-based agencies and PinnacleHealth sites that provide specialty care services to promote integrated and holistic care to patients.

ALS Telemedicine: The ALS telemedicine program enables patients with ALS and their caregivers to attend multidisciplinary ALS clinic visits in their home by using secure web-based video conferencing software. Patients are identified by a physician or nurse. Examples of eligible patients include those who are prevented from traveling to a clinic due to disease progression and/or those who live a significant distance from the clinic.

Dermatology TeleHealth Initiative: HMC developed a TeleHealth platform to improve access to dermatology. Dermatology will implement the TeleDermatology platform with two partners (Physician Alliance Ltd. and J.C. Blair), and expand geographic reach beyond the five-county region of Pennsylvania.

LionNet (Stroke): LionNet has impacted nearly 5,000 lives since 2012. HMC's neurologist stroke program has enabled many of these patients to stay in their communities and still receive specialty care. The goal is to expand the reach of LionNet across the continuum and continue to grow the network of 16 community hospitals to any hospital that requests TeleStroke services. Ongoing education, advances to the TeleHealth equipment, continued research relating to TeleStroke and advances in stroke care will aid in sustaining the network. Combining resources with the virtual intensive care unit model will help to provide comprehensive care for stroke patients in community hospitals.

DENTAL CARE

Although many residents of the five-county Pennsylvania region obtain primary and preventive dental care on a regular basis, some individuals experience significant challenges receiving this care. The CHNA found that economic and financial barriers, lack of dental provider coverage and lack of awareness of the importance of good oral hygiene and its effect on the rest of the body are obstacles for residents to receive dental care services. Limits to accessing dental care also include health illiteracy, cultural competence and coordination of comprehensive care.

GOAL:
Strengthen access to dental provider-based services, supportive services, and utilization of dental services by community members.

OBJECTIVE:
By 2019, increase access to dental care for uninsured and underinsured residents in the five-county region.

ACCESS TO HEALTH SERVICES

Increase utilization of the SMILES program to minimize dental care as a barrier to overall health status improvement and coordinate care of urgent dental needs with the Emergency Department:

Utilize volunteer dentists in the SMILES network: A network of more than fifty volunteer dentists spans the east and west shores of Harrisburg. Once it is determined that a patient has an urgent dental need, he/she can be referred to the dental access coordinator who will work with the patient and dentist to set up an appointment to alleviate the urgent need. In 2015, PinnacleHealth received more than 250 referrals from community partners and PinnacleHealth emergency rooms.

Explore how patients from HMC's Emergency Department can be referred to the SMILES network and the feasibility of providing a SMILES program in the service area: An expansion of the SMILES program to regional service areas will bridge the gap, provide greater access to dental care and reinforce prevention of dental health issues.

PinnacleHealth partners with community clinics to provide ongoing preventive dental care or non-urgent dental care: Hamilton Health Center is a local Federally Qualified Health Center (FQHC) that is equipped with a state-of-the-art dental clinic. This clinic is designed to provide ongoing preventive care to patients without dental insurance, and is poised to be the dental home for these patients. Harrisburg Area Community College's dental hygiene program provides dental cleanings and a local, church-based, free clinic provides dental services.

HMC and Penn State Hershey Medical Group (PSHMG) are developing a feasibility study for establishing a dental service in the greater Hershey community: The scope of services being considered includes routine and urgent dental care as well as increased access to oral surgery services. The working models being considered focus on establishing a new dental practice site staffed with full-time dentists and hygienists. Part of this feasibility study includes evaluating the impact of potentially instituting new dentist and/or dental hygienist residency and/or training programs. This program would ideally participate in all dental insurance programs (federal, state, and commercial) and be accessible to all community residents. Another important aspect of this plan will address coordination of care across routine dental, oral surgical, and specialized dental services.

PRIORITY:
BEHAVIORAL HEALTH SERVICES

Behavioral health is a major concern across the nation and is a top health priority in the five-county study area. Behavioral healthe issues affect not only the mental well-being of an individual, but they also affect spiritual, emotional and physical health. Unmanaged mental illnesses increase the likelihood of adverse health outcomes, chronic disease and substance abuse partly due to a decrease in accessing medical care. Behavioral health patients often struggle with lengthy waiting periods, long distance travel, and the inability to secure medical appointments. The primary focus of this strategy is to address mental health and substance abuse needs.

MENTAL HEALTH

The majority of adults with mental illness received no mental health treatment in the last year, indicating a nationwide issue with individuals being able to receive proper mental health services and treatment. There is a lack of mental health providers available to United States citizens. Close to 91 million adults live in areas where there is a shortage of mental health professionals. The primary data received from residents, health professionals and community leaders across the study area showed the need for attention to mental health services. Treatment of mental health is often reactive in the form of crisis intervention through hospital emergency rooms rather than proactive practices. Additional barriers to mental health services include out-of-pocket costs/insurance coverage, negative social stigmas and lack of health education. Many residents who have mental health issues tend to also have multiple behavioral diagnoses, making it even more essential for those in need to access and receive continuous treatment.

GOAL:
Residents will have access to the best practices in screenings, assessment, treatment and support programs for mental health and child protection.

OBJECTIVE:
By 2019, improve the mental health of all adults and children living in the five-county region.

BEHAVIORAL HEALTH SERVICES

PPI

Create a direct admit program: A direct admit program provides individuals experiencing a mental health crisis in a physician office, therapy office or outpatient facility direct access to a psychiatric facility and increased access to inpatient, partial hospitalization and outpatient services. The plan includes developing assessment and placement tools to determine level of care required, utilizing screening, assessment, and placement methods to determine emergent care needs in emergency departments (e.g., psychiatric care, determining level of care).

Implement an integrated care model for behavioral health services:

Integrate PinnacleHealth Psychological Associates (PHPA) services into the PinnacleHealth Medical Group (PHMG) practices: Having the mental health professional on site will enhance continuity in services and integration of mental and physical health. The approach allows the professional to engage the patient while they are on site.

The HMC Department of Psychiatry is partnering with the PSHMG and several other HMC departments to introduce a coordinated and integrated model of care for behavioral health services into PSHMG-operated, outpatient practice sites: Behavioral Health providers (psychologists, therapists, clinical psychiatric specialists) are placed into medical outpatient practice sites to perform mental health evaluations, provide short-term treatment and counseling, and consult with practice site clinical staff to serve patients that are identified with a demonstrated need for behavioral health treatment and interventions.

There are currently 15 practice sites that have been licensed or are in the process of being licensed that function as satellite locations under the auspices of the outpatient psychiatry clinic. Providers at these sites are required to meet the standards of the Pennsylvania Department of Health. Sustaining these services will require ongoing funding of the positions, availability of appropriate space in each clinic to perform behavioral health services, and an improved process to identify patients in need of behavioral health services.

PPI

Psychological evaluation at medical offices: Primary care settings have become a gateway for many individuals with behavioral health and primary care needs. While patients typically present with a physical health complaint, data suggests that underlying mental health or substance abuse issues are often the cause of these visits. PPI will establish satellite offices and provide psychiatric evaluation for patients in need of behavioral health services at specialist medical offices.

PPI will perform evaluations via TelePsychiatry at HMC Emergency Department and PinnacleHealth West Shore Emergency Department: Psychiatric patients seeking emergency mental health evaluations are on the increase more than any other patient group. However, services to meet these needs are dwindling. In the absence of a readily available psychiatrist, TelePsychiatry can be an effective tool for patient evaluation and facilitating access to care in an emergency setting. The use of TelePsychiatry as a strategy to evaluate patients with behavioral health illnesses in an emergency room could potentially expedite dispositions when an on-site psychiatrist is not available.

BEHAVIORAL HEALTH SERVICES

Provide optimal care for specific mental health diagnoses

Anxiety is characterized by excessive and/or persistent worry that impacts the ability to complete daily functions, including school and/or home activities: In children, worry can present as inattention, irritability, physical complaints and/or a need for constant reassurance. To improve the screening and treatment of children experiencing anxiety, our strategy includes dissemination of evidence-based tools and treatments at local schools, regional provider sites and general pediatric clinics.

Attention Deficit Hyperactivity Disorder (ADHD) typically presents as persistent and/or intense difficulty with paying attention, sitting still, controlling behavior and failing to think before acting: Many children can experience some of these behaviors at times. In order to be diagnosed as having ADHD, a child must have consistent difficulty functioning at home or in school. Children with ADHD can also experience significant hardships getting along with peers, siblings and adults, following rules at home or school and performing well academically. It is important to assess all of these areas when evaluating for ADHD. ADHD is not just a disorder of childhood, as many patients will continue to have symptoms into adolescence and adulthood. Therefore, it is important to periodically evaluate how children with ADHD are progressing as they age.

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder, present from early childhood, characterized by difficulty in social communication and the presence of restricted and repetitive behavior: The Department of Psychiatry provides a broad array of assessment and treatment services for individuals with ASD throughout the lifespan, with a focus on adolescents transitioning to adulthood. HMC plans to improve resources and education for transition-aged individuals with ASD. Social media and newsfeeds will be used and success will be measured by website analytics (e.g., numbers of "likes" and "shares"). The strategy includes the facilitation of adolescent and young adult social skills groups at HMC and disseminating these models to the Pittsburgh area and later other parts of Pennsylvania.

BEHAVIORAL HEALTH SERVICES

Enhance behavioral services for children in need:

In 2011, HMC committed its expertise and research power to the development of the Center for the Protection of Children (CPC): Penn State Children's Hospital is the region's provider of pediatric specialty services. The Center for the Protection of Children provides 24/7 response to victims of abuse or neglect in the institution and in the region served by Penn State Health. At the Stine Family Foundation Transforming the Lives of Children (TLC) Clinic, mental health services are provided to children and families who have experienced abuse or neglect. A medical home clinic for children in out-of-home placement is also part of the TLC clinic.

Collaboration with PinnacleHealth's Children's Resource Center (an accredited Children's Advocacy Center) expands the specialized medical services for abused and neglected children into the community and seven surrounding counties.

PPI Inpatient Children's Behavioral Health Unit: The demand for child and adolescent services at PPI has increased dramatically since its opening eight years ago. Because of limited clinical space, 120 children and their families needing our care and support were unable to be helped in 2015. A new unit is being designed to meet this need. The new children's unit will include the addition of nine, private rooms for children ages 4-12, a play-therapy room and a sensory room.

Develop education to improve early detection for suicide: Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities. While its causes are complex and determined by multiple factors, the goal of suicide prevention is simple: Eliminate factors that increase risk and increase factors that promote resilience. Prevention addresses all levels of influence: individual, relationship, community and societal. As the CDC states, effective prevention strategies are needed to promote awareness of suicide and encourage a commitment to social change.

PPI will increase awareness of psychological distress symptoms and risk factors for suicide. PPI will provide access to free suicide prevention and health literacy education with the following groups: community groups, faith-based organizations, and beauty/barber shops. The strategy includes initially targeting counties with high rates of suicide and exploring areas with current successes to replicate in high risk regions. PPI will host suicide prevention presentations at area agencies on aging, senior centers and veteran service centers. The strategy is to support the Pennsylvania Department of Education and schools in implementation of Act 71 and to identify existing Mental Health First Aid (MHFA) trainers or other awareness raising trainings. PPI will use social media as a vehicle to educate suicide prevention.

PinnacleHealth will partner with Hamilton Health Center to provide behavioral health services: As a partner in the collaboration and a major provider of services in the Harrisburg community, Hamilton Health Center will continue to be a satellite site for Behavioral Health Services staffed with a PinnacleHealth psychiatrist, psychologist and LCSW personnel.

BEHAVIORAL HEALTH SERVICES

Promote consumer and system health literacy on mental health concerns:

PinnacleHealth is committed to understanding how consumers engage in their health, and reducing barriers to health for our community members: Health literacy plays an important role with total well-being. In 2011, efforts on educating inpatient clinicians on health literacy, and health literate communication techniques began. In 2015, health literacy education and training techniques were expanded to all areas of the health system and throughout community-based organizations. A health literacy screening tool is being implemented in the Emergency Department. Through use of this tool, clinicians will screen for patients at high risk for communication errors or adherence issues. The patient can be connected to resources based on need, prior to being readmitted or surfacing as a high-utilizer of the health system. Assessing and taking action on health literacy provides appropriate care when and how patients need it most and helps reduce disparities.

PPI

PPI will provide health education on the understanding of mental health concerns and where resources may be found as needed for community outreach activities.

SUBSTANCE ABUSE

More than 24 million individuals, ages 12 years and older, were current, illicit drug users during the time of the Substance Abuse and Mental Health Services Administration 2013 National Survey of Drug Use and Health. More than half of Americans ages 12 years and older, were current alcohol users in 2013 (nearly 137 million individuals). Of the 22.7 million individuals ages 12 and older, who needed treatment for an illicit drug or alcohol problem, only 2.5 million received treatment in a specialty facility.

GOAL:
Residents will gain better access to the best practices in screening, assessment, treatment, and support programs for substance abuse disorders.

OBJECTIVE:
By 2019, decrease adolescent and adult deaths caused by substance abuse within the five-county Pennsylvania region.

BEHAVIORAL HEALTH SERVICES

Implement an Opioid Task Force and Stewardship Program (OTF&SP): In 2012, the Joint Commission issued a Sentinel Event Alert about the many dangerous side effects of increasing opioid misuse, abuse and dependence. In response to this trend, HMC's departments of Anesthesiology, Nursing, and Pharmacy introduced an Inpatient Opioid Task Force and Stewardship Program (IOTF&SP) in 2016. A team consisting of a pain management physician, a Certified Registered Nurse Practitioner, and a pharmacist provide inpatient consultations to individuals who have chronic pain or complex pain conditions. The team's goals include decreasing the dispensation of unnecessary opioid prescriptions, educating providers on alternatives to opioid treatment and disseminating information on safe prescribing practices to reduce the risk of sentinel events.

PPI

PPI will initiate an Opiate Treatment Center by 2017: The Opiate Treatment Program offered at the center will support the safe and effective delivery of medication-assisted treatment. Services will be individualized, according to the needs of each patient.

BEHAVIORAL HEALTH SERVICES

Educate the community on how to prevent prescription drug and opioid misuse, abuse, and overdose

Drugs 101: What Parents and Kids Need to Know is a drug and alcohol awareness program for parents and children ages 10 years and older: The program is unique because it engages parents and children at the same event. The adult portion seeks to educate parents about the various forms of drugs and the kind of peer pressure that children/adolescents may face. A mock bedroom of a teenage drug user serves as the backdrop to the two-hour presentation. The student portion provides first-hand information to teens, to help guide healthy decision-making, in a fun and relaxed format. Community representatives from the Dauphin County Coroner's Office, Harrisburg City Police Department, Dauphin County Probation Office, local drug treatment programs, Penn State Children's Hospital's Trauma and Injury Prevention and other mental health providers offer a glimpse into the life of a person experiencing addiction. A Belgian Malinois dog named Zeke, a retired Harrisburg City K-9 "officer" who was shot during a pursuit, also joins the event.

PinnacleHealth, HMC, and PPI will provide high schools, colleges and higher education institutions with easily understood advertising materials about the negative effects of drug and alcohol to enhance community awareness. The Pennsylvania Client Placement Criteria (PCPC) screening tool will be promoted to determine the most appropriate care for community members with drug and alcohol problems.

Reduce access to prescription drugs, and the possibility of misuse and abuse, by participating in National Drug Take Back Day and promoting drug take back collection sites:

HMC participates in National Drug Take Back Day by organizing a drive-thru take-back site on the hospital campus. The plan aims to provide a safe, convenient and responsible means of disposing prescription drugs with no questions asked, while educating the public on the potential abuse of medications. Medication cards and pill boxes are provided to participants and a baseline of medications returned (in pounds) is being obtained.

Participate in collaborative efforts to improve policy and address drug addiction and abuse:

The Attorney General of Pennsylvania assembled a team to share information regarding hospital admissions, emergency department visits and treatment services related to current drug trends. Collecting and collating this information will enable policy makers to make informed decisions about the allocation of funds and effective strategies to support law enforcement, health care professionals and treatment professionals. HMC and PinnacleHealth are members of this collaborative team.

Offer AL-Anon support for those in need:

AL-Anon is a fellowship program for relatives and friends of alcoholics who share their experience to solve their common problems. The monthly meeting meets on the HMC campus and is open to employees and community members. The philosophy is that alcoholism is a family illness and that changed attitudes can aid recovery. The purpose is to support and inspire hope for families of alcoholics.

PRIORITY 3:
HEALTHY LIFESTYLES

The CHNA revealed a lack of healthy lifestyles in the five-county Pennsylvania region. Obesity, being overweight, poor nutrition, physical inactivity and smoking are associated with profound, adverse health conditions—evidence links these behaviors and conditions to shortened lifespans. The Implementation Strategy addresses this need by increasing opportunities for physical activity, promoting healthy eating, offering health screenings and facilitating smoking cessation and prevention programs.

PHYSICAL ACTIVITY

The CHNA cites the U.S. Office of Disease Prevention and Health Promotion's Physical Activity Guidelines' statistics, in which more than 26 percent of Pennsylvania adults do not engage in any leisure-time physical activity. County Health Rankings reported that Perry (27 percent) and Dauphin (25 percent) counties had the highest percentage of adults aged 20 and older who reported no leisure-time physical activity when compared to Lebanon (23 percent), York (22 percent), Cumberland (19 percent) counties and the state of Pennsylvania (24 percent). Lower socioeconomic statuses are linked to a lack of physical education. Health information and education in schools, community organizations and media outlets must reinforce the overall health benefits of daily physical activity and exercise.

GOAL:
Increase opportunities for and engagement in physical activity.

OBJECTIVE:
By 2019, decrease the average percentage of adults in the Pennsylvania five-county region who report no leisure-time physical activity.

HEALTHY LIFESTYLES

Assess existing venues for physical activity:

Conduct a Walk-Friendly Community Assessment: The Walk–Friendly Communities Strategy to improve walkability includes: 1) recognizing walkable communities and 2) providing a framework to improve walkability. HMC and Partners for Healthy Communities of Central PA plan to conduct a walkability assessment of Derry Township in Dauphin County, submit the assessment and promote the results. For more information, please visit: www.walkfriendly.org/assessment.

Initiate new physical activity programs:

Get Fit Together: The Harrisburg East Shore YMCA is committed to helping low-income families in the five-county region improve their health. Get Fit Together will be a free exercise program to increase strength, endurance and flexibility. Each family participating in the program will meet with a certified personal trainer two times per week. The objective is to make being active a fun and interactive experience for families, encouraging a lifetime of fitness. In addition, each family will meet with a registered dietitian to learn healthy eating habits and how to read Nutrition Facts labels. Participants will learn the importance of eating a healthy diet and understand the long-term health benefits associated with proper nutrition. Get Fit Together will measure outcomes by conducting evaluations before, during and after the program.

HMC Bike Share Program: Bike share programs are an excellent opportunity to increase active transportation. HMC will investigate the possibility of establishing a program to make bicycles available to staff and students on campus, with future plans to expand to the larger community.

HEALTHY LIFESTYLES

Expand existing physical activity programs:

Walking and 5K Events: Increasing physical activity opportunities, PinnacleHealth and regional partners will promote and volunteer at 10 large walking events annually. There is a focus on the number of people participating and the number of events per year.

Eat Smart Play Smart (ESPS): PinnacleHealth continues to develop programs focused on improving health for the children in our service area. ESPS focuses on families with children to improve education and awareness of healthy choices. This program is offered three to four times per year and will incorporate smoking prevention into the curriculum in the future.

Band Together: Band Together is an exercise program for seniors that includes strength and balance exercises. HMC currently has 15 sites in local churches and community centers with more than 250 participants each week. In 2015, HMC was awarded $14 million to evaluate whether or not the program is effective at reducing injuries from falls. The strategy includes opening 50 new Band Together sites in Pittsburgh, central Pennsylvania, and Philadelphia and to enroll more than 2,000 seniors in the program.

Walking opportunities: Walking is an effective, low-cost form of exercise that also promotes socialization. The strategy aims to promote walking/biking days, promote walking trails and maps, promote participation in annual walking events and increase participation in "Walk, Central PA, Walk," is a grassroots walking club that offers multiple opportunities to walk throughout the week. A schedule of walks can be found online at facebook.com/walk.centralpa.walk or meetup.com/Walk-Central-PA-walk-Walking-Group-Meetup. Walks vary from "strolls" to "fitness walks" with a pace of 20 minutes/mile or less. The club plans to track their walks and mileage throughout the five-county region.

INADEQUATE NUTRITION AND OBESITY

The CHNA reports inadequate nutrition and obesity as an issue for residents in the five-county region. County health rankings report that Lebanon (32 percent), Perry (31 percent) and York (33 percent) counties have seen an increase in the number of people who are overweight and/or obese over the past several years; these rates were higher than the average for the state of Pennsylvania (29 percent). Totals in Cumberland and Dauphin counties stayed the same (26 percent and 32 percent). Dauphin County had the highest overweight student rate (33 percent), while Lebanon County had the highest obesity rate (17 percent) for students in kindergarten through sixth grade; both are higher than the State's rate. In grades 7–12, Dauphin County had the highest rate of overweight students (37 percent), and Perry County had the highest rate of obese students (23 percent), both higher than Pennsylvania's rate. Low socioeconomic statuses, poor education and lack of access to healthy, fresh foods are the top reasons for inadequate nutrition and spiked obesity rates in the region.

GOAL:
Increase opportunities for people to learn about and make healthy food choices.

OBJECTIVE 1:
By 2019, reduce adult and childhood obesity rates in the five-county region.

OBJECTIVE 2:
By 2019, decrease percentage of area residents that report inadequate fruit and vegetable consumption.

HEALTHY LIFESTYLES

Increase access to healthy food choices and nutrition education:

Power Pack Program: The program is designed to provide nutrition to students over the weekend when they are away from the school setting. Currently, PinnacleHealth supports programs in the Harrisburg, Central Dauphin and Newport School Districts. The ultimate goal is to address the root cause of hunger and disseminate educational and employment opportunities to families eligible for the Power Pack program to assist them in achieving a higher socioeconomic status.

COCOA PACKS INC: HMC provides nutrition education resources and financial support to the Derry Township School District for the COCOA PACKS INC program, an essential assistance program for students who face food shortages at home.

Food as Medicine Program / Farmers Market in Hershey: To promote healthy eating and community health, HMC and PSCOM support the Farmers Market in Hershey and Summer Concert Series from May through October. As an extension of this market, the Food as Medicine Program offers several educational and outreach initiatives including health screenings, a children's educational summer program, Wellness on Wheels, Senior Farmers' Market Nutrition Program (SFMNP) and Prevention Produce. Prevention Produce is a program that pairs patients and/or community residents with student "nutrition navigators" at the Farmers Market in Hershey and summer concert series, as well as the Broad Street Market in Harrisburg.

Hershey Community Garden: Located on HMC's campus and operated by Hershey Impact (Hershey Entertainment & Resorts, The Hershey Company, Hershey Trust, Penn State Health Milton S. Hershey Medical Center, Milton Hershey School, M.S. Hershey Foundation), Hershey Community Garden contains 124 free community plots under the direction of a garden manager. In addition to increasing access to fresh fruits and vegetables, the garden also provides opportunities for increased physical activity and socialization. Each year, a portion of fresh produce is donated to organizations who serve underprivileged populations in our region.

Food Pantry Outreach and Education / Children's Summer Program: Central PA Food Bank distributes more than 40 million pounds of food and groceries each year to clients in Pennsylvania counties. HMC has partnered with Penn State Extension and PPI to develop monthly health education sessions for food pantry clients. In addition, HMC faculty and staff, PSCOM students and Penn State College of Nursing students have collaborated with Mary's Helpers food pantry at Prince of Peace Parish and Penn State Extension to bring health education to children, as part of a summer lunch program. The program provides free meals to children from low-income families, so they may receive the same high-quality nutrition in school cafeterias throughout the academic year. Consistency in diet helps children return to school nourished and ready to learn. The plan is to strengthen these partnerships and provide health education (nutrition and physical activity) to new clients in need.

HEALTHY LIFESTYLES

Expand community nutrition education and obesity prevention programs:

School-based assessments and evidence-based interventions: Every year, nurses and health partners from HMC and PinnacleHealth team up with local school nurses to expedite required school-based assessments (height, weight, vision, hearing, and scoliosis) and to assist with the data entry for Pennsylvania Department of Health reporting. The goal is to give school nurses the opportunity to spend more time with children who require one-on-one health interventions. The strategy includes continuing participation in school-based assessments and sharing evidence-based interventions, including local summer nutrition programs.

HealthSLAM: PSCOM students have designed a health education curriculum to teach nutrition concepts to fourth and fifth grade students, a critical age for the formation of healthy eating habits. A web-based presentation is the foundation for the teaching rubric and classroom exercises.

SMOKING CESSATION

The National Survey on Drug Use and Health, conducted by Substance Abuse and Mental Health Services Administration (study years 2010, 2011, 2012), reported that Cumberland and Perry counties have the highest rates of cigarette use and tobacco use within the region at 27 percent and 34 percent, respectively. These rates are also higher than the Pennsylvania rate of nearly 25 percent. However, all of the counties in the study area had decreased rates of cigarette use since previous studies. Dauphin, Lebanon, and York counties decreased from 26 percent to 22 percent, while Cumberland and Perry counties decreased fhalf a percentage point to 27 percent. The decreased use is an encouraging sign that more community members understand the long-term, detrimental effects of smoking on one's health; however, there is still a need for community outreach focused on smoking risks, prevention, and cessation.

GOAL:
Increase access to evidence-based smoking cessation and prevention programs.

OBJECTIVE 1:
By 2019, reduce the percentage of adult smokers in the five-county Pennsylvania region.

OBJECTIVE 2:
Decrease the use of any tobacco product by middle and high school students.

HEALTHY LIFESTYLES

Provide tobacco cessation programs:

Conduct PinnacleHealth tobacco cessation lunch and learn: Expand Class Series to community-based locations and worksites, increase 1:1 face-to-face sessions, increase participation in support groups, and engage practices in educational programs.

Implement Text to Quit and Better Breathers clubs: These programs are offered at both PinnacleHealth campuses and will expand to community locations. They offer the opportunity to learn ways to better cope with COPD while getting the support of others who share in your struggles.

HMC weekly support group for community members and employees: Counseling sessions are held in the University Conference Center. The goal of this program is to provide tobacco cessation information, guidance, and support to current and past tobacco users. Participants share their tobacco cessation tips, personal successes and struggles. Employee sessions are also offered biweekly.

Provide tobacco prevention programs:

Utilize "Healthy Lungs" and "Tar in a Jar" stations: PinnacleHealth Tobacco Cessation specialist will continue to conduct school visits, add a smoking prevention component to Eat Smart Play Smart, and participate in community-based events targeting key audiences.

Carbon Monoxide (CO) Testing, Pulmonary Function Testing (PFT) and prevention/cessation resources provided at community events: The piCO CO monitor is a breath-test CO monitor. It is an effective teaching tool and utilizes a traffic light system to illustrate normal, above-normal, and high levels of CO in individuals. PFT testing is an additional effective measurement to analyze how well your lungs work. The strategy includes conducting CO and PFT tests at community health events and educating young people about e-cigarettes, vaping, and the risk of long-term addiction.

Conduct inpatient initiatives:

PinnacleHealth's inpatient COPD initiative: Continue to use The Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines (goldcopd.org). The goals of effective COPD management are to prevent disease progress, relieve symptoms, improve exercise tolerance, prevent and treat complications, treat exacerbations and reduce mortality.

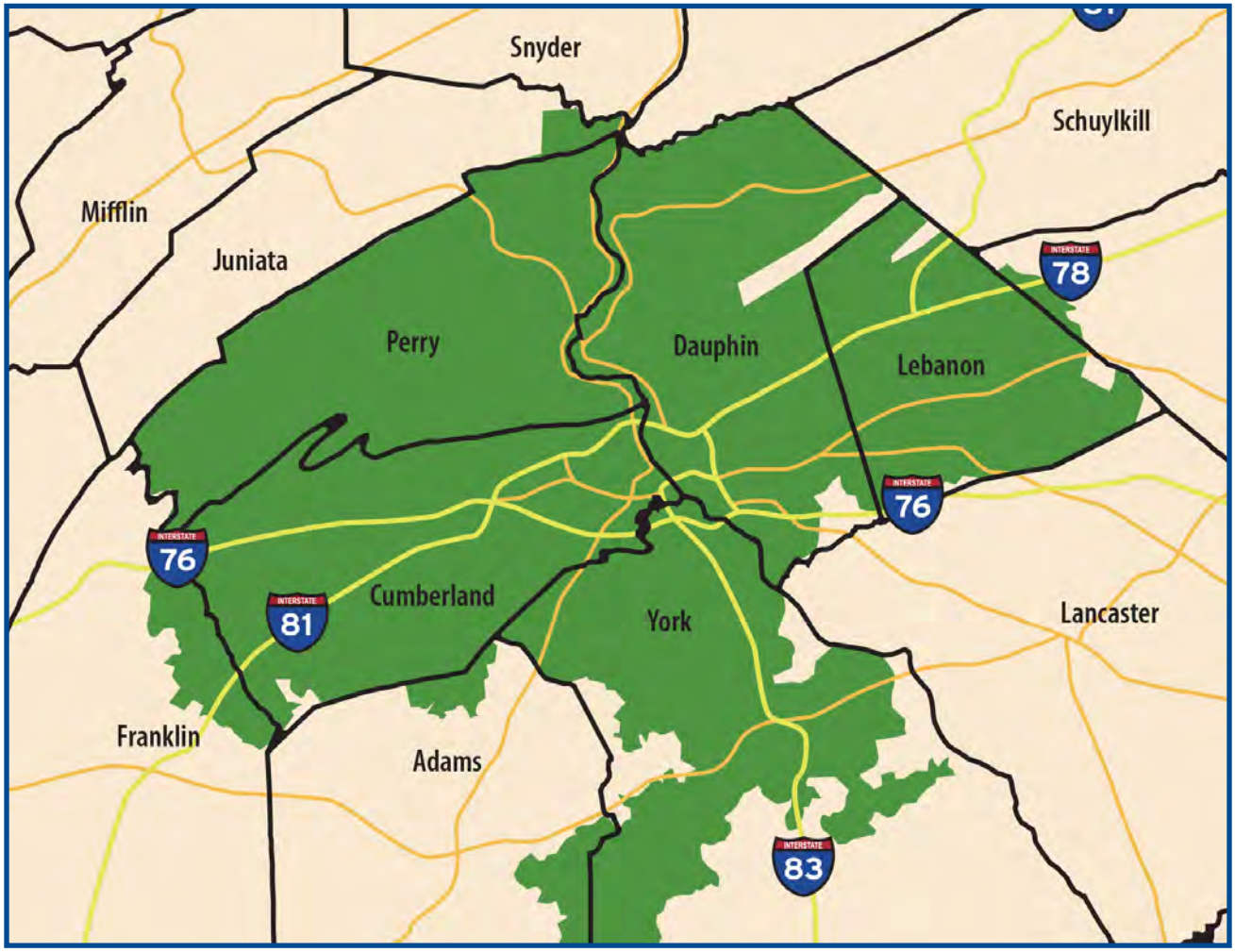
The HMC tobacco intervention program (TIP): TIP informs those admitted to the Emergency Department about the tobacco support group meetings and facilitates a Q&A session around basic cessation topics.

Chronic Obstructive Pulmonary Disease (COPD) inpatient initiatives: HMC educators trained by the American Association of Respiratory Care meet with inpatient COPD patients to discuss proper medication administration and energy conservation techniques. A respiratory therapist (RT) assesses patients' combination and dosage of breathing medications as well as their risk of readmission based on the GOLD guidelines. The RT also makes follow-up phone calls to answer questions and help address any barriers to proper self-care.

APPENDIX A: CHNA Study Area

ZIP	CITY	COUNTY
17007	Boiling Springs	Cumberland
17011	Camp Hill	Cumberland
17013	Carlisle	Cumberland
17015	Carlisle	Cumberland
17025	Enola	Cumberland
17043	Lemoyne	Cumberland
17050	Mechanicsburg	Cumberland
17055	Mechanicsburg	Cumberland
17065	Mount Holly Springs	Cumberland
17070	New Cumberland	Cumberland
17240	Newberg	Cumberland
17241	Newville	Cumberland
17257	Shippensburg	Cumberland
17266	Walnut Bottom	Cumberland
17324	Gardens	Cumberland
17005	Berrysburg	Dauphin
17018	Dauphin	Dauphin
17023	Elizabethville	Dauphin
17030	Gratz	Dauphin
17032	Halifax	Dauphin
17033	Hershey	Dauphin
17034	Highspire	Dauphin
17036	Hummelstown	Dauphin
17048	Lykens	Dauphin
17057	Middletown	Dauphin
17061	Millersburg	Dauphin
17080	Pillow	Dauphin
17097	Wiconisco	Dauphin
17098	Williamstown	Dauphin
17102	Harrisburg	Dauphin
17103	Harrisburg	Dauphin
17104	Harrisburg	Dauphin
17109	Harrisburg	Dauphin
17110	Harrisburg	Dauphin
17111	Harrisburg	Dauphin
17112	Harrisburg	Dauphin
17113	Steelton	Dauphin
17003	Annville	Lebanon
17026	Fredericksburg	Lebanon
17028	Grantville	Lebanon
17038	Jonestown	Lebanon
17042	Lebanon	Lebanon
17046	Lebanon	Lebanon
17067	Myerstown	Lebanon
17073	Newmanstown	Lebanon
17078	Palmyra	Lebanon
17006	Blain	Perry
17020	Duncannon	Perry
17024	Elliottsburg	Perry
17037	Ickesburg	Perry
17040	Landisburg	Perry
17045	Liverpool	Perry
17047	Loysville	Perry
17053	Marysville	Perry
17062	Millerstown	Perry
17068	New Bloomfield	Perry
17071	New Germantown	Perry
17074	Newport	Perry
17090	Shermans Dale	Perry
17019	Dillsburg	York
17315	Dover	York
17319	Etters	York
17331	Hanover	York
17339	Lewisberry	York
17345	Manchester	York
17356	Red Lion	York
17362	Spring Grove	York
17365	Wellsville	York
17370	York Haven	York
17401	York	York
17402	York	York
17403	York	York
17404	York	York
17406	York	York
17408	York	York

APPENDIX B:
Map of CHNA Study Area



APPENDIX C:
CHNA Study Area Regional Stakeholders

- Alder Health Services
- Capital Area Head Start
- Capital Area Intermediate Unit
- Carlisle Area School District
- Catholic Charities of Diocese of Harrisburg
- Central Pennsylvania Food Bank
- Community Check Up Center
- CONTACT Helpline
- County Commissioners Association of Pennsylvania
- Cumberland – Perry Drug and Alcohol Commission
- Cumberland – Perry Mental Health, Intellectual & Developmental Disabilities (MH.IDD)
- Cumberland County Aging and Community Services
- Cumberland County Crisis Intervention at Holy Spirit—A Geisinger Affiliate
- Dauphin County Area Agency on Aging
- Dauphin County Case Management Unit
- Dauphin County Drug & Alcohol Services
- Dauphin County Library System
- Dauphin County Mental Health, Intellectual & Developmental Disabilities
- Domestic Violence Services of Cumberland and Perry Counties
- Gaudenzia, Inc.
- Harrisburg Area Community College (HACC)
- Harrisburg Area Dental Society
- Harrisburg Center for Peace & Justice
- Harrisburg Housing Authority
- Health Ministries of Christ Lutheran Church
- Hope Within Ministries
- Latino Hispanic American Community Center of the Greater Harrisburg Region
- Lebanon School District
- Lebanon VA Medical Center
- Mazzitti & Sullivan Counseling Services, Inc.
- Mechanicsburg School District
- Mental Health Association of the Capital Region
- National Alliance for the Mentally Ill (NAMI) of Dauphin County
- Northern Dauphin Human Services Center
- Partnership for Better Health
- Pastoral Care at Holy Spirit—A Geisinger Affiliate
- Pennsylvania Department of Health – The District Office of five-county region
- Pennsylvania Immigrant and Refugee Women's Network
- Pennsylvania State Representative
- Perry County Commissioner
- Philhaven Hospital
- Pressley Ridge
- Sadler Health Center
- The Foundation for Enhancing Communities
- The Hershey Company
- Tri County Community Action
- United Way of the Capital Region
- Wesley Union African Methodist Episcopal Zion Church
- YMCA Camp Curtin

APPENDIX D: ACCESS TO HEALTH SERVICES

PRIMARY CARE

Goal: Strengthen access to provider-based services and supportive services and increase utilization of healthcare services by community members.

Objective: By 2019, increase access to primary care services for residents in the five-county region.

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Insurance enrollment certified application counselors (CAC)	PHS	1. Establish processing for identifying eligible and engaged uninsured patients to pursue options for insurance enrollment.	1. Increase the number of eligible clients that complete application for insurance by 30% per year.	1. Increase the number of eligible clients that complete application for insurance by 30% per year.
Insurance enrollment/ financial assistant program	PSHMC	1. Analyze needs by zip code to identify the four practice sites best situated to reach patients who are uninsured or underinsured and place financial advisors at those sites. 2. Place Financial Counselors in the Emergency Department by July, 2016. Financial Counselor will provide services to self-pay and underinsured ED patients and at the bedside for the Inpatient population as requested by the patient. 3. Participate in 4 community outreach events that serve the uninsured and underinsured populations. 4. Have 3 members of the Financial Counseling team become certified prior to the Fall 2016 marketplace open enrollment period. Assist 30 patients with the enrollment process (10 per CAC.)	1. Place one Financial Counselor in five different practice sites every week, 50 weeks per year, creating 250 days of practice site financial counseling services per year. 2. Place Financial Counselor in the Cancer Institute by July 2017 to meet every new patient who is self-insured or Medicare insured by July 2017. 3. Participate in 5 community outreach events. 4. Expand CAC certification to 6 team members and assist 72 patients with the enrollment process (12 per CAC).	1. Calculate patient financial counseling opportunities performed in the previous year and identify the two practice sites with highest volumes of services rendered. Increase Financial Counselor presence at two highest volume sites to two days per week to increase benefit of presence. This will create an additional 100 days of practice site financial counseling services per year for a total of 350 days per year. 2. Provide cost estimation to all Radiology patients receiving MRI studies by July 2018 and provide financial counseling assistance with patient liability. 3. Participate in 6 community outreach events in FY 2019. 4. Expand CAC certification to 9 team members and assist 135 patients with the enrollment process (15 per CAC).

APPENDIX D: ACCESS TO HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Promote awareness of and enrollment in the CHIP insurance program for children.	PSHMC	1. Place Financial Counselors in General Pediatrics practice site. Place one Financial Counselor in General Pediatrics (on campus) one day per week. 2. Place Financial Counselors within the hospital setting. Financial Counselor in the hospital setting will review worklist for inpatient pediatric patients to identify CHIP opportunity. With consent of head nurse, will meet with parents to provide education on CHIP and assist in the enrollment process. 3. Provide Financial Counselors at community outreach events that serve the uninsured and underinsured populations. Participate in 4 community outreach events in FY 2017.	1. Expand practice site Financial Counselor presence to two days per week. 2. Financial Counselor will work proactively with Emergency Department Registration Associate to identify uninsured ED to inpatient pediatric patient. With consent of head nurse, will meet with parents to provide education on CHIP and assist in the enrollment process. 3. Participate in 5 community outreach events in FY 2018.	1. Assess success of efforts to date and identify strategy to increase CHIP education and enrollment opportunities by 5%. 2. Provide cost estimation to all Radiology patients receiving MRI studies by July 2018 and provide financial counseling assistance with patient liability. 3. Participate in 6 community outreach events in FY 2019.
Prescription Assistance Program	PSHMC	1. Continue to provide prescription assistance and counseling to any PSHMC patient who is uninsured or underinsured by exploring all programs available. The target for new and renewal applications is 900 annually.	1. Continue as year one and explore potentially the support of PSHMC Specialty Pharmacy through assessing copay funding for the underinsured.	1. Continue as years one and two.
Nurse-Family Partnership Program	PHS	1. Continue to provide nurse home visitation services through the Nurse Family Partnership Program 2. Enroll 110 clients bi-annually with a 2 year enrollment period for all patients. 3. Support other nurse home visiting services reducing health disparity among first-time, low-income mothers.	1. Continue to provide nurse home visitation services through the Nurse Family Partnership Program 2. Enroll 110 clients bi-annually with a 2 year enrollment period for all patients 3. Support other nurse home visiting services reducing health disparity among first-time, low-income mothers.	1. Continue to provide nurse home visitation services through the Nurse Family Partnership Program 2. Enroll 110 clients bi-annually with a 2 year enrollment period for all patients 3. Support other nurse home visiting services reducing health disparity among first-time, low-income mothers.

APPENDIX D: ACCESS TO HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
PHS Navigation Program	PHS	1. Reduce readmissions as a percent of total admissions for those being case managed by Community Health Outreach by 17% of baseline.	1. Reduce readmissions as a percent of total admissions for those being case managed by Community Health Outreach by 16.5% of baseline.	1. Reduce readmissions as a percent of total admissions for those being case managed by Community Health Outreach by 16% of baseline.
Collaboration of inpatient social workers, nurse care managers, and community-based social service organizations to improve access	PSHMC	1. Create 1.5 liaisons with inpatient social workers and outside agencies to provide better care to patients	1. Develop a partnership with a master of social work (MSW) program in the geographic area to have MSW students intern with PSHMG social worker. 2. Employ 2 additional social workers for PSHMG.	1. Sustain the program.
Home visits to high risk populations	PSHMC	1. Develop process and identification of high risk patients 2. Increase visits by 30 patients. 3. Track outcomes for improvement.	1. Expand to all of family and community and general internal medicine practice sites to reach 100 patients annually.	1. Continue home visits at all of family and community and general internal medicine practice sites to reach 200 patients annually.
PHS Service Area	PHS	1. Continue providing resources to PHS employees and community members through the Cultural Diversity and Inclusion Committee and serving all patients regardless of race, ethnicity, ability to pay, religion, sexual orientation, or gender. 2. Provide uncompensated care as a nonprofit, community based hospital. 3. Continue to meet the needs of diverse patient populations.	1. Continue providing resources to PHS employees and community members through the Cultural Diversity and Inclusion Committee and serving all patients regardless of race, ethnicity, ability to pay, religion, sexual orientation, or gender. 2. Provide uncompensated care as a nonprofit, community based hospital. 3. Continue to meet the needs of diverse patient populations.	1. Continue providing resources to PHS employees and community members through the Cultural Diversity and Inclusion Committee and serving all patients regardless of race, ethnicity, ability to pay, religion, sexual orientation, or gender. 2. Provide uncompensated care as a nonprofit, community based hospital. 3. Continue to meet the needs of diverse patient populations.

APPENDIX D: ACCESS TO HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
LionCare at Bethesda Mission	PSHMC	1. Open a sports medicine clinic 1 time per month 2. Open 3 ophthalmology clinics per month 3. Expand preventative care to one new initiative (such as patient education, smoking cessation, patient navigation, nutrition education through the Manna Food Pantry, or diabetes screening).	1. Explore a new location within Harrisburg or the surrounding area to open a second clinic for under-served populations.	1. Open a pediatrics clinic 1 time per month at LionCare/ at Bethesda Mission. 2. Continue to explore new location options and if possible open a new location.
Hope Within Ministries:	PSHMC	1. Continue to support the ministry with 2 Board Members. 2. Provide $35,000 dollars for laboratory and radiology services.	1. Sustain involvement and resources.	1. Sustain involvement and resources.
Community Check-up Center	PSHMC	1. Continue to provide a pediatrician 2 days/week. 2. Continue to utilize clinical site for pediatric residents and their underserved rotation	1. Continue to provide a pediatrician 2 days/week. 2. Continue to utilize clinical site for pediatric residents and their underserved rotation.	1. Continue to provide a pediatrician 2 days/week. 2. Continue to utilize clinical site for pediatric residents and their underserved rotation.
Nepalese and Bhutanese Population	PSHMC	1. Implement and present a refugee resettlement services presentation for family practice residents to improve knowledge and understanding. 2. Pilot a clinic every other week starting July, 2016 for 4 hours with 2 interpreters on site, and 20 allotted time slots. 3. Evaluate pilot by reviewing utilization of time slots.	1. Expand the clinic hours every other week to 8 hours.	1. Explore the possibility of a community walk-in clinic.
Educational events for unique populations	PHS	1. Provide 3 educational sessions to staff addressing cultural differences and healthcare needs.	1. Provide 3 educational sessions to staff addressing cultural differences and healthcare needs.	1. Provide 3 educational sessions to staff addressing cultural differences and healthcare needs.

APPENDIX D: ACCESS TO HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Increase cultural excellence of faculty, staff and students and increase awareness of diversity and inclusion within the local and surrounding communities.	PSHMC	1. Establish individuals to be trained for Safe Zone training in support of more inclusive environment for LGBT employees and patients. 2. 90% of campus events have option for individuals to request accommodation because of a disability to participate in programs offered by Penn State Health and College of Medicine. 3. Two workshops for senior leaders on unconscious bias and micro-aggressions/workplace bullying are held with 75% participation.	1. One representative from 20% of departments have completed Safe Zone training. 2. Two workshops for senior leaders on "isms" have been held with 75% participation. 3. 100% of workforce with patient contact and 40% of non-patient contact workforce attend 3 or more sessions of Inclusion Academy	1. One representative from 40% of departments have completed Safe Zone training. 2. Two sessions held for senior leaders on effectively managing inclusion with 75% participation. 3. 100% of workforce with patient contact and 40% of non-patient contact workforce attend 3 or more sessions of Inclusion Academy 4. Four diversity awareness events are held for local community members with 20% participation
Teach Back method	PHS	1. Provide training for all staff on utilizing the Teach Back method to improve patient understanding of discharge instructions and improve overall health literacy.	1. Provide ongoing training for staff on appropriate use of the Teach Back Method.	1. Provide ongoing training for staff on appropriate use of the Teach Back Method.

APPENDIX D: ACCESS TO HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Influenza Administration- hospital employees, community, and Children's Hospital high risk families	PSHMC	**Employees:** 1. Collaborate with PA DOH to determine a strategy to increase employees who receive the influenza vaccine. Increase employees receiving vaccine to 90%. 2. Increase employee education through hospital orientation for new employees, weekly emails during flu season, monthly I News articles, and information posted on Lion's Eye . **Community:** 1. Determine 1 new location in community and initiate Drive Thru Flu Shots. 2. Expand to 5 shelters or food pantries. 3. Develop simple message to high risk populations on importance of flu vaccine and advertise at least two weeks prior to scheduled date. 4. Administer a survey, yearly, to determine scope of reach. Children's Hospital: 1. Initiate Penn State Health Children's Hospital Family Flu Clinic as soon as vaccinations are available 2. Purchase cart dedicated to mobilization of PSHCH Family Flu Clinic. 3. Partner with HMC Employee Health Department to increase number of PSHCH employees vaccinated and to host Drive Thru Family Flu Clinic. 4. Expand Family Flu Clinic mobile cart to service on-site pediatric clinics.	**Employees:** 1. Maintain 90% of employees receiving annual vaccine. **Community:** 1. Evaluate year 1 and determine next steps to expand to underserved populations. Children's Hospital: 1. Explore a partnership with Rite Aid in hosting Penn State Health Family Flu Clinics at least 1 location of greatest need as determined by the organization and Community Health Needs Assessment. 2. Partner with at least 1 pediatric and family oriented community event on to offer flu vaccinations at or during their events.	**Employees:** 1. Maintain 90% of employees receiving annual vaccine. **Community:** 1. Continue flu shot initiatives in the community. **Children's Hospital:** 1. Explore a partnership with Rite Aid, PHS and PA Department of Health in hosting Penn State Health Family Flu Clinics at least locations 2 locations of greatest as determined by the organizations and Community Health Needs Assessment. 2. Expand Family Flu Clinic to include elderly population by offering Family Flu Clinics at one neighboring geriatric homes and centers—inviting all members of the family to a family health day geared toward supporting health across the life span with emphasis on geriatric health (supporting bond between young and old).

APPENDIX D: ACCESS TO HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Pediatric injuries at home, at play, and in the car	PSHMC	1. Child Passenger Safety – Provide education on proper usage of car seats to 500 families. Identify 100 at risk families to provide education and car seats to reduce the risk of injury while in a motor vehicle. 2. Safe Sleep – Implement hospital-wide policy to provide education and best safe sleep practices to all in-patient families with a child less than 1 year of age. 3. Safe Kids Coalition – Increase coalition member agencies and participation in the coalition to 25 to better reach families in educating and providing resources for pediatric injury prevention.	1. Child Passenger Safety – Be the lead resource in Child Passenger Safety by creating educational materials and a process for surrounding health care institutions to contact the Children's Hospital's Injury Prevention program in order to increase awareness of child passenger safety best practices and access resources for child passenger safety including children with special health care needs. 2. Safe Sleep – Be the lead resource in Safe Sleep Education by creating one educational brochure for distribution and a process for surrounding social service agencies to contact the Children's Hospital's Injury Prevention program in order to increase awareness of safe sleep best practices. 3. Safe Kids Coalition – Implement a Home Safety program for 8 home visitor agencies to provide needed safety devices and education to at-risk families.	1. Child Passenger Safety – 30 Area health care institutions and social service agencies will provide education and awareness to expectant families and families with children to encourage participation with a Child Passenger Safety Technician to assist with education on proper use of car seats. 2. Safe Sleep – 20 Area health care institutions and social service agencies that provide care to expectant families and children under 1 year of age will provide educational resources with consistent messaging to families regarding best safe sleep practices. 3. Safe Kids Coalition – Implement a Pedestrian Safety program to reach 800 families to provide education to children and families in order to reduce to risk of injury
Implement a medical-legal partnership at HMC with Penn State Dickinson Law's clinical program:	PSHMC	1. Initiate pilot at one practice site. 2. Screen 40 patients with social problems affecting health. 3. Collect baseline patient satisfaction data.	1. Evaluate effectiveness of pilot. 2. Increase the number of referrals over previous short-term goal.	1. Sustain program. 2. Explore expansion to other practice sites.

APPENDIX D: ACCESS TO HEALTH SERVICES

SPECIALTY CARE

Goal: Strengthen access to specialty provider-based services and supportive services and increase utilization of healthcare services by community members.

Objective: By 2019, increase access to specialty care services for residents of the five-county region.

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
PHS cardiovascular and thoracic surgery education	PHS	1. Provide preventative resources for patients within the specialty care setting to include cardiac and stroke risk assessment, heart failure clinic, and cardiac risk assessment screenings and referrals.	1. Provide preventative resources for patients within the specialty care setting to include cardiac and stroke risk assessment, heart failure clinic, and cardiac risk assessment screenings and referrals.	1. Provide preventative resources for patients within the specialty care setting to include cardiac and stroke risk assessment, heart failure clinic, and cardiac risk assessment screenings and referrals.
Heart and vascular health for adults	PSHMC	"1. Complete 25 risk assessments at 1 site and provide education/ potential actions to all clients screened. Determine a follow-up mechanism for clients identified as high risk.	"1. Complete 50 risk assessments at 3 sites and provide education/potential actions to all clients screened. Initiate a follow-up plan for clients determined high risk.	"1. Complete 100 risk assessments at 5 sites and provide education/potential actions to all clients screened. Evaluate effectiveness of follow-up of clients of high risk.
Heart health for children	PSHMC	1. Streamline extensive outreach network of clinics (21 sites), and redeploy resources to sites which require additional support 2. Develop a referral base for fetal echos, ACHD 3. Obtain funding for equipment/sonographers to support fetal program, kids camp, AHA Youth Health 4. Obtain funding for advanced imaging research (3D printing)	1. Rebuild referral bases Lancaster, Reading, York, Scranton, State College, Allentown/Bethlehem, Geisinger 2. Strengthen fellowship training program (quality of recruits/trainee's, research productivity)—possible addition of 4th year subspecialty training 3. Partner with MFM, Family Medicine and adult cardiology colleagues to develop perinatal program, ACHD, weight management	1. Develop Pediatric Cardiology Research Center
Stroke health for adults and children	PSHMC	1. Participate in minimum 4 large health assessments (>300 participants) per year – mix of children and adult events. 2. Explore strategies for reaching underserved, high risk populations with stroke assessments in the community.	1. Establish method for tracking and measuring participation - utilizing hash tag tracking, brief post education phone call surveys, free app for phones. 2. Continue participation in minimum 4 large health assessments with additional appropriate opportunities evaluated.	1. Expand focus to larger and at-risk communities. 2. Develop Spanish-language versions of FAST card, stroke risk scorecard, and family tree risk assessment. 3. Establish stroke outpatient/ outreach coordinator position.

APPENDIX D: ACCESS TO HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Diabetic adult care	PHS	1. Decrease the prevalence of Type 2 Diabetes in adults. 2. Increase awareness of high-sugar, high-carbohydrate foods within healthy living and healthy grocer programs. 3. Decrease the percent of adult patients in family practice with A1C > 8.	1. Decrease the percent of adult patients in the clinic settings with an A1C > 8.	1. Decrease the percent of patients in the community as measure by the inpatient setting with an A1C > 8.
Diabetic adult care	PSHMC	1. Utilize Sanuseo Text messaging program pilot to identify and follow high risk patients post discharge. 2. Develop resident led group diabetic education visits held at Fishburn Road and develop diabetic support groups including but not limited to insulin pump and continuous glucose monitor support group meetings held at least bi-annually.	1. Continue to develop plan for more inpatient diabetic Education 2. Support the hire of an inpatient diabetic educator.	1. Improve glycemic control with a goal hemoglobin A1C of less than 8% to reduce long term complications and future hospitalizations with patients who have diabetes.
PHS Cancer Institute	PHS	1. Increase awareness and early detection of cancer through access to oncology education and support services; Provide Oncology Programs to all patients, regardless of ability to pay; Provide cardiac lung cancer screenings; Increase awareness of skin health information; provide colon health information.	1. Increase awareness and early detection of cancer through access to oncology education and support services; Provide oncology programs to all patients, regardless of ability to pay; Provide cardiac lung cancer screenings; Increase awareness of skin health information; Provide colon health information.	1. Increase awareness and early detection of cancer through access to oncology education and support services; Provide oncology programs to all patients, regardless of ability to pay; Provide cardiac lung cancer screenings; Increase awareness of skin health information; Provide colon health information.

APPENDIX D: ACCESS TO HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Northern Appalachia Cancer Network (NACN)/Harrisburg Community Cancer Network (HCCN)	PSHMC	1. Continue to complement cancer studies that evaluate the biologic development and treatment of cancer with studies of people, their behaviors, their environments, and their risk of developing cancer. 2. Utilize community-based networks to develop, test, and disseminate evidence-based interventions in rural and urban communities and clinics. 3. Collaborate with 25 partners to identify cancer health disparities and improve the cancer health of our communities. 4. Participate with the NACN to complete 3 research studies that test the impact of twelve-month physical activity and cancer education intervention in rural faith-based settings. 5. Test initiatives to increase colorectal cancer screening among minorities in central Pennsylvania.	1. Expand existing community-based education and dissemination initiatives to 8 new community organizations. 2. Test the dissemination of the NACN cancer control toolkit to 5 churches in Perry and northern Dauphin counties. 3. In collaboration with Penn State Health, develop and test a peer-led intervention to increase the uptake of colorectal cancer screening among 100 residents of Harrisburg.	1. Provide evidence-based education, skills, and resources to improve quality of life for 25 cancer survivors in Harrisburg and their caregivers.
Skin cancer due to sun exposure	PSHMC	1. Reach 50 employees who spend most of their workday in direct sun (Lifeguards at a local pool, grounds crew at Capitol). 2. Educate 75 people per year on sun safety. 3. Continue to provide umbrellas to Hershey Gardens for visitors to utilize. 4. Continue to provide a sunscreen station for Hershey Community Garden. 5. Hold free skin assessment clinic annually and reach 200 people.	1. Continue to reach 50 employees who spend most of their workday in the sun. 2. Educate 100 people per year on sun safety. 3. Continue to provide umbrellas to Hershey Gardens for visitors for visitors to utilize. 4. Continue to provide a sunscreen station for Hershey Community Garden. 5. Hold free skin assessment clinic annually and reach 200 people.	1. Continue to reach 50 employees who spend most of their workday in the sun. 2. Continue to educate 100 people per year on sun safety. 3. Continue to provide umbrellas to Hershey Gardens for visitors to utilize 4. Continue to provide a sunscreen station for Hershey Community Garden. 5. Hold free skin assessment clinic annually and reach 200 people.

APPENDIX D: ACCESS TO HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Mammogram Voucher Program (MVP)	PHS	1. Increase awareness and early detection of cancer through access to oncology education and support services.	1. Continue to promote and provide the free mammogram program to women in need throughout the community. 2. Provide oncology programs. 3. Provide cardiac lung cancer screenings. 4. Increase awareness of skin health information. 5. Provide colon health information.	1. Continue to promote and provide the free mammogram program to women in need throughout the community. 2. Provide oncology programs. 3. Provide cardiac lung cancer screenings. 4. Increase awareness of skin health information. 5. Provide colon health information.
Healthy Woman free mammogram program	PSHMC	1. Continue to fund the program through the Weis Endowment fund to reimburse the routine screening exams. 2. Continue partnership with the Department of Health to receive funds from the CDC and the Alliance of PA councils, Inc. The Alliance allocates screening slots to providers.	1. Sustain program.	1. Sustain program.
PHS operates Resources, Education, and Comprehensive Care for HIV (REACHH)	PHS	1. Continue to provide a holistic, individualized plan of care for each patient, which includes both medical and psychosocial support.	1. Help people stay on their medications and remain as healthy as they can.	1. Continue to help people stay on their medications and remain as healthy as they can.
Alder Health Services	PSHMC	1. Provide leadership for the medical services to Alder Health Service. 2. Provide medical expertise by providing the medical director and one staff to the board of directors.	1. Sustain collaboration.	1. Sustain collaboration.

APPENDIX D: ACCESS TO HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Primary Care Tele-Health	PHS	1. Increase utilization of Tele-Health in practices and throughout the service community 2. Continue to collaborate and maintain relationships with community based agencies and PHS sites that currently provide specialty care services to patients to promote integrated and holistic care.	1. Increase utilization of TeleHealth in practices and throughout the service community 2. Continue to collaborate and maintain relationships with community based agencies and PHS sites that currently provide specialty care services to patients to promote integrated and holistic care.	1. Increase utilization of TeleHealth in practices and throughout the service community 2. Continue to collaborate and maintain relationships with community based agencies and PHS sites that currently provide specialty care services to patients to promote integrated and holistic care.
ALS Telemedicine	PSHMC	1. Conduct telemedicine visits with 25 patients and their caregivers 2. Assess feasibility and comfort with the telemedicine program from patient, caregiver, and health care provider perspectives.	1. Share feasibility findings and best practices with Penn State Health and the ALS and Scientific communities. Disseminate findings through journal publications, presentations at professional conferences, and communications from the ALS Association Greater Philadelphia Chapter. 2. Identify potential barriers for long-term sustainability of the program.	1. Assess long-term feasibility of a telemedicine program for ALS care and PSHMC, considering the utility of the program along with IT possible IT and financial barriers. 2. Identify long-term funding solutions to ensure sustainability 3. Identify process to provide IT support to patients, caregivers, and health care providers.

APPENDIX D: ACCESS TO HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Dermatology Tele-Health Initiative	PSHMC	1. Implement TeleDermatology platform (primary care to dermatologist) with 2 partners (PAL and JC Blair). 2. Implement TeleDermatology platform (primary care to dermatologist) at Bethesda Mission 3. Perform 100 TeleDermatology visits.	1. Develop direct to consumer TeleDermatology platform 3. Increase TeleDermatology platform (primary care to dermatologist) to three partners. 3. Perform 150 TeleDermatology visits.	1. Implement direct to consumer TeleDermatology platform. 2. Increase TeleDermatology platform to 4 partners. 3. Perform 250 TeleDermatology visits.
LionNet (Stroke)	PSHMC	1. Increase number of partner hospitals in the LionNet program to 16 by the end of 2016, thus increasing the number of patients in the community that have a greater access to this level of specialty care.	1. Increase number of partners to twenty partners in two years, thus increasing the number of patients in the community that have a greater access to this level of specialty care.	1. Disseminate information to all members of the network with ongoing education, changes/advances to the TeleHealth equipment, continued research relating TeleStroke, and advances in stroke care every three months. 2. Determine process on how to combine resources with the virtual ICU model and be able to provide comprehensive care across the continuum for stroke patients in the community hospitals.

APPENDIX D: ACCESS TO HEALTH SERVICES

DENTAL CARE

Goal: Strengthen access to dental provider-based services and supportive services and increase utilization of dental services by community members.

Objective: By 2019, increase access to dental care for uninsured and underinsured residents in the five-county region.

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
SMILES network	PHS	1. Reduce the number of dental cases presenting at the PHS emergency rooms.	1. Reduce the number of dental cases presenting at the PHS emergency rooms.	1. Reduce the number of dental cases presenting at the PHS emergency rooms.
Referrals to SMILES dental program	PSHMC	"1. Initiate a pilot with the plan to complete 6 referrals.	1. Sustain program.	1. Sustain program.
Partner with community clinics	PHS	1. Refer patients to community clinics to establish dental home for ongoing preventive care.	1. Increase referrals to community clinics to establish dental home for ongoing preventive care.	1. Continue to increase referrals to community clinics to establish dental home for ongoing preventive care.
Dental Services	PSHMC	1. Complete a feasibility study.	1. Pending feasibility study results, develop models to establish a new dental practice site staffed with full-time dentists and hygienists. 2. Evaluate the impact of potentially instituting a new dentist and/or dental hygienist residency and/or training programs.	1. Participate in all dental insurance programs (federal, state, and commercial) and make services accessible to all community residents. 2. Address coordination of care across routine dental, oral surgical, and specialized dental services. 3. Continue evaluation of potentially instituting a new dentist and/or dental hygienist residency and/or training programs.

APPENDIX D: BEHAVIORAL HEALTH SERVICES

MENTAL HEALTH

Goal: Residents will have access to best practices in screenings, assessment, treatment and support programs for mental health and child protection.

Objective: By 2019, improve the mental health of adults and children living in the five-county region.

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Direct Admit Program	PPI	1. Develop assessment tools and placement tools to determine level of care required. Utilize screening assessment, and placement tools to determine emergent care needs in ED's (e.g., psychiatric care and determining level of care).	1. Mobile intake coordinators/liaisons within various local facilities	1. Decrease patients requiring placement in the ED before receiving care, creating shorter wait times for open beds.
Integrate Pinnacle-Health Psychological Associates (PHPA) services into the PinnacleHealth Medical Group (PHMG)	PHS	1. Continue to support the integration of PHPA behavioral health staff services in PHMG practices.	1. Continue to support the integration of PHPA behavioral health staff services in PHMG practices.	1. Continue to support the integration of PHPA behavioral health staff services in PHMG practices.
Behavioral Health providers in Penn State Hershey Medical Group (PSHMG)	PSHMC	1. Implement full implementation of behavioral health services at 15 behavioral sites to support an integrated model of care.	1. Increase to16 behavioral health sites to support an integrated model of care in outpatient practice site locations.	1. Increase to 17 behavioral health sites to support an integrated model of care in outpatient practice site locations.
Psychological evaluation at psychological medical offices	PPI	1.Create Satellite offices at specialist clinics to provide level of treatment	1. Develop appropriate partnerships to activate and leverage existing resources. 2. Utilize screening, assessment, and placement tools to determine behavioral health care needs in medical settings	1. Increase satellites offices by 2 per year
TelePsychiatry Program	PPI	1. Perform evaluations for inpatient stay to PPI via TelePsychiatry from PSHMC emergency room	1. Perform evaluations to identify levels of service required from PHMG or PHS Westshore emergency department correct level of stay to PPI via TelePsychiatry	1. Target additional TelePsychiatry needs in 5 county area

APPENDIX D: BEHAVIORAL HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Anxiety	PSHMC	1. Expand dissemination efforts about evidenced based treatments for Anxiety as well as treatment services available at HMC to 25+ local schools and medical and behavioral health providers. 2. Enhance screening efforts for anxiety in General Pediatrics with goal of over 75% of patients ages 8 and up will be screened annually.	1. Increase number of children and adolescents participating in individual or group based evidence-based psychotherapy services by 25%. 2. Develop specialized programming for children struggling with anxiety and weight management. 3. Expand the scope of our integrated care efforts by increasing pediatric anxiety treatment options directly available at HMC's primary and specialty medical settings.	1. Expand group therapy services for anxiety to include the PPI campus. 2. Systematically evaluate the impact of anxiety and its treatment on the medical course and outcome of children and adolescents in at least 3 different specialty medical settings across the HMC campus.
ADHD (Attention Deficit Disorder)	PSHMC	1. Increase number of families attending outpatient group therapy programs by 25%. 2. Identify a physical location for therapeutic summer camp for children.	1. Expand outpatient ADHD programming to include specialty content for adolescents and parents with ADHD 2. Expand dissemination efforts about evidenced based treatments for ADHD to 25 + local schools and community medical/mental health providers. 3. Commence first therapeutic summer camp for 30 + children with ADHD	1. Establish a therapeutic summer camp for at least 30 children with ADHD as a recurring program 2. Expand group therapy services for ADHD to include the PPI campus

APPENDIX D: BEHAVIORAL HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
ASD (Autism Spectrum Disorder)	PSHMC	1. Launch a new social media campaign (#ASDNext) and achieve 150 visits to website, 50 Facebook likes. 2. Initiate one adolescent and young adult social skills groups at Penn State Hershey, as well as begin dissemination to the Pittsburgh area. 3. Evaluate data to determine improvement in social communication. 4. Publish and share results in at least one journal, at one conference, and through one social media campaign.	1. Add 12 blogs/newsfeeds to #ASDNext and allow Individuals to make comments and participate in live chats with professionals in the field or with each other. 2. Increase social skills groups to 4 sites	1. Complete stakeholder analysis to determine additional changes needed to enhance or revise #ASDNext. 2. Increase the dissemination of social skills groups to 6 sites across Pennsylvania. 3. Continue to distribute results as appropriate.
Center for Protection of Children	PSHMC	1. Add prevention services through an evidence based training called "The Incredible Years", facilitated through TLC to expand parenting training. The first pilot of this project will begin in June 2016 in the Camp Hill primary Care 2. Accreditation of an ACGME fellowship in child abuse pediatrics. 3. Post doctoral position in evidence based mental health treatment 4. Development, and implementation of training resources for Pennsylvania's mandatory reporters. 5. An annual conference on mental health issues in child maltreatment. The first conference on attachment with renowned attachment experts will be held March 2017 at the Conference Center on the Campus of Penn State Hershey.	1. Increased integration with PHS and other rural children's advocacy centers through the use of Tele-Health applications. 2. Continued training throughout the institution and community on recognition and reporting of child abuse and neglect. 3. Expanding the research network through collaboration with Penn State Network on the Protection of Children. Hiring of an additional researcher in this regard.	1. Increased clinical and training capacities. 2. Increased research footprint for the development of new modalities to serve vulnerable children in central Pennsylvania.

APPENDIX D: BEHAVIORAL HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
PPI Inpatient Children's Behavioral Health Unit	PPI	1. Open new children's unit with the addition of nine private-rooms for children ages 4-12. 2. Increase Adolescent beds to 16. 3. Increase Child Partial by 5 new pts.	1. Grow Child Partial by 12%.	1. Increase referrals for Child Partial by 12%
Education for early detection for suicide	PPI	1. Increase awareness of psychological distress symptoms and risk factors for suicide though media by attending at least 5 community health screenings per fiscal year. 2. Provide access to free suicide prevention and health literacy education with the following groups: community groups, faith-based organizations, beauty shops and barber shops. 3. Host suicide prevention presentations at five area agencies on aging and senior centers and veteran service centers. 4. Support PDE and schools in implementation of Act 71. 5. Identify existing Mental Health First Aid (MHFA) trainers or other awareness raising trainings (e.g. suicide).	1. Evaluate areas with current successes to replicate in other high risk areas. 2. Utilize social media as a vehicle to educate on suicide prevention. 3. Engage PHS in identifying needs within their already established relationships with community agencies target 5 new referrals .	1. Increase new agencies by 5 new locations

APPENDIX D: BEHAVIORAL HEALTH SERVICES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Partner with Hamilton Health Center	PHS	1. Continue to be a satellite site for Philhaven Behavioral Health Services. 2. Provide psychiatrist, psychologist, and LSW personnel.	1. Continue to improve access to behavioral health services.	1. Continue to improve access to behavioral health services.
Consumer and system health literacy	PHS	1. Develop the basic understanding of the role health literacy plays in total well-being among healthsystem staff.	1. Implement health literacy screening tool in the EMR.	1. Continue to provide health literacy education to clinicians, communities, and patients.
Consumer and system health literacy on mental health	PPI	1. Create strategy and presentation. 2. Obtain CEU's for HR Professionals. 3. Create Community Resource Guide for the patients and the community.	1. Target HR professionals, community wide.	1. Continue with objectives from year 1 and 2.

APPENDIX D: BEHAVIORAL HEALTH

SUBSTANCE ABUSE

Goal: Residents will gain better access to best practices in screening, assessment, treatment and support programs for substance abuse disorders.

Objective: By 2019, decrease adolescent and adult deaths caused by substance abuse in the five-county region.

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Inpatient Opioid Task Force and Stewardship Program	PSHMC	1. Identify 3 departments with the highest utilization of opioids for education and safe approaches. 2. Plan for each department: education at 1 division meeting and 1 grand rounds. 3. Design 1 web-based educational session with self-assessment on proper prescribing methods for HMC medical staff. 4. Decrease inappropriate prescriptions of opioids by HMC providers by 10% year. 5. Decrease sentinel events related to opioids by 10%. 6. Introduce EMR order set that deemphasizes the role of opioids in pain control, while introducing non-opioid analgesics and adjuvant medications. 7. Introduce uniform sedation scale such as Pasero Sedation Scale for inpatients receiving opioids.	1. Identify 3 departments with the highest utilization of opioids for education and safe approaches. 2. Plan for each department: education at 1 division meeting and 1 grand rounds. 3. Design 1 web-based educational session with self-assessment on proper prescribing methods for HMC medical staff. 4. Decrease inappropriate prescriptions of opioids by HMC providers by 10% year. 5. Decrease sentinel events related to opioids by 10%. 6. Introduce EMR order set that deemphasizes the role of opioids in pain control, while introducing non-opioid analgesics and adjuvant medications. 7. Introduce uniform sedation scale such as Pasero Sedation Scale for inpatients receiving opioids.	1. Continue expansion to 7 departments. 2. Plan for each new department: education at 1 division meetings and 1 grand rounds. 3. Evaluate effectiveness of web-based education by review of self-assessment results and continue to offer HMC medical staff. 4. Decrease inappropriate prescriptions of opioids by HMC providers by 20% year 5. Decrease sentinel events related to opioids by 20%.
Opiate Treatment Center	PPI	1. Create Scope Inc. finances and donations and identify space. 2. Create policies for opioid medical model clinic.	1. Open Opioid Substance abuse office base model, September 2016 - June 2017, with a target of 2,000 new visits.	1. Increase services and appointments to clinic base model with a target 70,000 - 90,000 increase.
Drugs 101- What Parents and Kids Need to Know	PSHMC	1. Provide 3 programs to students and parents in 3 counties on Drugs 101. 2. Apply for funding for sustainability. 3. Incorporate improvements obtained from evaluations. 4. Increase participation by 10%.	1. Evaluate program and modify as needed for effectiveness. 2. Add a year 2 program for schools who participated in year 1. 3. Explore ways to reach diverse populations.	1. Continue programming. 2. Continue to explore ways to obtain funding.

APPENDIX D: BEHAVIORAL HEALTH

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Community awareness in schools	PHS, PSHMC, and PPI	1. Target high schools, colleges, and higher education with advertising materials promoting the negative effects of drug and alcohol and mental disorder.	1. Continue programming. 2. Continue to obtain funding.	1. Continue programming. 2. Continue to obtain funding.
Drug Take Back Day	PSHMC	1. Participate in the annual fall and spring National Drug Take Back dates. 2. Provide education, medication cards and pill boxes to participants. 3. Obtain a baseline of cars served, pounds of medications returned, and number of sharp containers filled with needles and syringes.	1. Evaluate results to determine continuation of event. 2. Continue to monitor cars served, pounds of drugs returned, and sharp containers filled.	1. Evaluate results to determine continuation of event. 2. Continue to monitor cars served, pounds of drugs returned, and Sharp containers filled. 3. Explore the possibility of expansion to a new site.
Attorney General's Task Force	PHS and PSHMC	1. Hold quarterly informative meetings with speakers that benefit 3 professions (ED staff, treatment providers, and law enforcement personnel) with greater than 100 in attendance. 2. Collaborate with 3 EDs for data collection on opioid related admissions.	1. Continue quarterly informative meetings with speakers that benefit 3 professions (ED staff, treatment providers, and law enforcement personnel) with greater than 100 in attendance. 2. Collaborate with 5 EDs for data collection on opioid related admissions. 3. Establish one pilot program with 1 local police department to assist in diverting individuals to treatment.	1. Continue quarterly informative meetings with speakers that benefit 3 professions (ED staff, treatment providers, and law enforcement personnel) with greater than 100 in attendance. 2. Continue to collaborate with 5 EDs for data collection on opioid related admissions. 3. Evaluate pilot program with local police department to assist in diverting individuals to treatment and explore expansion to other local police departments. 4. Develop and initiate an annual one day conference on drug related topics.
Al-Anon	PSHMC	1. Offer support with facilitator and location for weekly meetings on campus. 2. Furnish copies of "Faces of Al-Anon" on campus at 4 locations.	1. Continue to offer support with facilitator and location for weekly meetings on campus. 2. Furnish copies of "Faces of Al-Anon" on campus at 4 locations.	1. Continue to offer support with facilitator and location for weekly meetings on campus. 2. Furnish copies of "Faces of Al-Anon" on campus at 4 locations.

APPENDIX D: HEALTHY LIFESTYLES

LACK OF PHYSICAL ACTIVITY

Goal: Increase opportunities for and engagement in physical activity.

Objective: By 2019, decrease the average percent of adults in the five-county region who report no leisure-time physical activity.

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Walk Friendly Community Assessment	PSHMC	1. Conduct assessment of Derry Township	1. Submit assessment and promote results	1. Improve at least 2 aspects of walkability in Derry Township.
Get Fit Together Program	PSHMC	1. Conduct fitness and health assessments at the beginning, three-weeks and end of program on all participants. 2. All (40) participants will complete knowledge surveys at the beginning and end of the program. 3. Conduct one-year post survey of all (40) participants to determine if they sustained their achievements and stuck with goals.	1. Increase participation by 10% each year. 2. Increase number of trainers. 3. Improved health, fitness and nutrition results through pre and post measurement. 4. Increase days offered during the week. 5. Conduct one-year post survey of all participants to determine if they sustained their achievements and continued with their goals.	1. Increase participation by 10% each year. 2. Improved health, fitness and nutrition results through pre and post measurement. 3. Conduct one-year post survey of all participants to determine if they sustained their achievements and stuck with goals. 4. Survey all past participants to determine if they continued with their goals and/or would like to revisit the program.
Bike Share Program	PSHMC	1. Establish a bike share program for the HMC Campus. 2. Establish a relationship with University Park and campus wellness offerings.	1. Interface with other bike share programs in Derry Township. 2. Increase use of bicycles and ridership.	1. Sustain program.
Walking and 5k events	PHS	1. Promote and volunteer at 10 large walking events annually throughout the community.	1. Promote and volunteer at 15 large walking events annually throughout the community.	1. Increase the number of people who will participate in the total number of walking events throughout the community.
Eat Smart, Play Smart Program	PHS	1. Revise program to be culturally sensitive and adaptable to various populations.	1. Identify age appropriate curriculums and expand targeted age groups.	1. Continue to identify age appropriate curriculums and expand targeted age groups.
Band Together	PSHMC	1. Begin 50 new Band Together sites.	1. Enroll 2,000 seniors in a study to test the impact of Band Together. 2. Engage an out-of-state health plan who are interested in offering Band together to seniors who they insure.	1. If effective, apply to Medicare to fund nationwide.

APPENDIX D: HEALTHY LIFESTYLES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Walking Opportunities	PSHMC	1. Increase Walk Central PA Walk by 2 additional groups or leaders annually; engage at least 100 participants annually. 2. 10 organizations will promote Walk/Bike days annually. 3. Participate in 1 large walking event such as the Highmark Walk.	1. Increase Walk Central PA Walk by 2 additional groups or leaders annually; engage at least 100 participants annually. 2. 10 organizations will promote Walk/Bike days annually.	1. Increase number of participants in all walking programs annually.

APPENDIX D: HEALTHY LIFESTYLES

OBESITY AND INADEQUATE NUTRITION

Goal: Increase opportunities for people to learn about and make healthy food choices.

Objective 1: By 2019, reduce adult and childhood obesity rates in the five-county region.

Objective 2: By 2019, decrease percentage of area residents who report inadequate fruit and vegetable consumption.

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Power Pack Program	PHS	1. Continue to provide support to local school districts to sustain the Power Pack program. Identify partners throughout the community that provide resources to the school districts to help sustain programs.	1. Continue to provide support to local school districts to sustain the Power Pack program. Identify partners throughout the community that provide resources to the school districts to help sustain programs.	1. Continue to provide support to local school districts to sustain the Power Pack program. Identify partners throughout the community that provide resources to the school districts to help sustain programs.
Cocoa Pack Program	PSHMC	1. Provide $5,000 sponsorship annually to purchase healthy food for Cocoa Packs. 2. Provide seasonal health education and nutrition messages to include in Cocoa Packs.	1. Provide $5,000 sponsorship annually to purchase healthy food for Cocoa Packs. 2. Provide seasonal health education and nutrition messages to include in Cocoa Packs.	1. Evaluate impact. 2. Investigate opportunities to education families on other available community resources to empower them to overcome poverty.
Food as Medicine Program / Farmers Market	PSHMC	1. Reach over 2,500 adults and children annually with screenings and programs. 2. Enroll 30 individuals in the Prescription Produce and Senior Voucher programs. 3. Engage 20 students to serve as Navigators and expand to all campus student groups. 4. Continue all market outreach programs and initiate an evaluation survey to measure impact. 5. Engage 50 children in outreach effort from Farmers Market in Hershey. 6. Offer 50 vouchers for low income senior residents in Dauphin County.	1. Meet annual reach and enrollment. 2. Partner with Farmstead Market in Palmyra as another outreach location. 3. Introduce prevention produce to the family medicine faculty and residents.	1. Meet annual reach and enrollment. 2. Evaluate impact.

APPENDIX D: HEALTHY LIFESTYLES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Hershey Community Garden	PSHMC	1. Collaborate with Hershey Impact to offer 2 community educational programs at the Garden and 5 educational visits and tours at the Garden annually. 2. Continue all garden operations. 3. Donate fresh produce to four or more local food pantries. 4. Donate fresh produce to medical student Wellness on Wheels program and Gemma's Angels program.	1. Continue annually. 2. Plan for future expansion of the Community Garden.	1. Continue annually. 2. Fundraise to expand garden in three years.
Food Pantry Outreach and Education / Children's Summer Program	PSHMC	1. Offer year-round screenings at Steelton, Manna and Palmyra Food Pantries reaching 1,500 people. 2. Survey clients to determine needs. 3. Investigate effective health education offered at other Food Pantries across the country to determine best practices. 4. Determine effective role for Partners for Healthy Communities of Central PA Coalition. 5. Offer 5 week, 3 days per week summer program in Steelton reaching 20 children.	1. Expand Food Pantry educational program to include smoking cessation and prevention messages. 2. Determine effectiveness of screening and education by number of necessary referrals made and services provided. 3. Explore disseminating health education to three new food pantries.	1. Reach 2,000 people annually with food pantry programs. 2. Evaluate impact. 3. Investigate opportunities to education individuals about other available community resources to empower them to overcome poverty.
School Health Assessments	PHS	1. Conduct assessments in Harrisburg, Newport, and Greenwood School Districts.	1. Continue screenings in 3 school districts. 2. Collect data to establish baseline for each school. 3. Work with community partners to offer 1 follow-up intervention in each district.	1. Continue all assessments in Harrisburg , Newport and Greenwood School Districts.

APPENDIX D: HEALTHY LIFESTYLES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
School Health Assessments	PSHMC	1. Conduct assessments in 3 School Districts 2. Implement summer nutrition program to a minority population in the Lebanon Middle School and explore follow-up with students on a regular basis during the school year. 3. Offer a menu of possible evidence-based follow-up programs to each district.	1. Continue assessments in school districts. 2. Evaluate middle school program to determine next steps.	1. Continue assessments in schools.
HealthSLAM Program	PSHMC	1. Continue program in current schools. 2. Evaluate current program model.	1. Implement format changes based on evaluation of model. 2. Train next student leadership and continue program in current schools. 3. Add 1 additional school.	1. Evaluate impact of program through pre and post tests conducted with student participants.

APPENDIX D: HEALTHY LIFESTYLES

SMOKING CESSATION AND PREVENTION

Goal: Increase access to evidence-based smoking cessation and prevention programs.

Objective 1: By 2019, reduce the percentage of adult smokers in the five-county region.

Objective 2: By 2019, decrease the use of any tobacco product by middle and high school students.

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Lunch and Learn Series Tobacco Cessation Programs	PHS	1. Offer Lunch and Learn series at all PHS campuses and expand to 3 community based sites.	1. Identify additional community based sites and continue cessation program at PHS 2. Measure quits by conclusion of 1:1 class series	1. Expand to 15 community based organizations. 2. Corporate wellness sites to provide cessation Lunch and Learn Series increasing the number of participates who quit by 5%.
Community / Employee Monday Night Support Group and Cessation Program	PSHMC	1. Track quit metrics. 2. Further develop cessation education. 3. Develop awareness campaign to promote.	1. Track quit metrics. 2. Promote to outside organizations.	1. Track quit metrics. 2. Expand to offer in other locations and family practices by identifying champions and training as tobacco treatment specialists. 3. Develop educational session to train tobacco treatment specialists.
Children's Healthy Lungs and Tar-in-a-Jar Stations	PHS	1. Utilize Children's "Healthy Lungs" and "Tar in a Jar" stations. 2. Conduct 3 School visits throughout the community 3. Add prevention component to Eat Smart Play Smart. 4. Participate in community based fairs.	1. Utilize Children's' "Healthy Lungs" and "Tar in a Jar" stations. 2. Conduct 6 School visits throughout the community 3. Add prevention component to Eat Smart Play Smart. 4. Participate in community based fairs.	1. Utilize Children's' "Healthy Lungs" and "Tar in a Jar" stations. 2. Conduct 9 School visits throughout the community 3. Add prevention component to Eat Smart Play Smart. 4. Participate in community based fairs.
Carbon Monoxide (CO) & Pulmonary Function Testing (PFT) in the Community.	PSHMC	1. Conduct CO testing and prevention education at three community screenings for high risk populations. 2. Complete a survey for each participant. 3. Provide relevant referrals to 20% of smokers that were screened at the event. 4. Pilot PFT through public health screenings	1. Conduct CO testing and prevention education at four community screenings for high risk populations. 2. Develop a PFT protocol for community health screenings for internal staff and partners use	1. Continue to conduct CO & PFT testing and education with follow-up. 2. Track numbers reached and quit metrics.

APPENDIX D: HEALTHY LIFESTYLES

Strategy /Program Name	Responsible party	Short term (< 1 year)	Medium term (1-2 years)	Long term (1-3 years)
Chronic Obstructive Pulmonary Disease (COPD) Initiative	PHS	1. Conduct COPD initiatives throughout the community. 2. Track number of cardiac risk assessment visits conducted. 3. Reduce 30 day readmission for COPD patients. 4. Relieve chronic symptoms. 5. Improve overall quality of life.	1. Conduct COPD initiatives throughout the community. 2. Track number of cardiac risk assessment visits conducted. 3. Reduce 30 day readmission for COPD patients. 4. Relieve chronic symptoms. 5. Improve overall quality of life.	1. Conduct COPD initiatives throughout the community. 2. Track number of cardiac risk assessment visits conducted. 3. Reduce 30 day readmission for COPD patients. 4. Relieve chronic symptoms. 5. Improve overall quality of life.
Tobacco Intervention Program (TIP)	PSHMC	1. Track patient encounters in the electronic medical record (EMR) via First-Net. 2. Develop a tracking system to engage Emergency Room and Inpatients into support group and cessation services. 3. Track quit metrics. 4. Develop an awareness campaign to promote program.	1. Track patient encounters in the electronic medical record (EMR) via First-Net. 2. Engage patients in support groups and cessation programs. 3. Track quit metrics.	1. Track patient encounters in the electronic medical record (EMR) via First-Net. 2. Engage patients in support groups and cessation programs. 3. Track quit metrics.
COPD Inpatient Initiatives	PSHMC	1. Train small RT staff to provide individualized COPD related patient education. 2. Develop processes to efficiently identify COPD patients. 3. Document education and post-discharge follow-up for identified patients.	1. Improve collaboration with care coordination to identify and mitigate barriers to self-care.	1. Improve effectiveness of self-care and quality of life for COPD patient population. 2. Reduce COPD readmission rate for patient population.

APPENDIX E: COMMUNITY RELATIONS START UP GRANTS

The HMC Community Relations department offers Start-Up Grants to community programs that address priorities identified in the CHNA. Applications are accepted annually from July to October and are awarded from January to December, up to $5,000 each. These grants are intended to help initiate a sustainable project that will have a positive health impact on our community. All PSHMC and PSCOM faculty, staff and students that apply must apply with a community partner. Not only do these grants provide local health programming, but they also 1) engage employee talent in community outreach, 2) help develop an organizational culture of community health improvement, and 3) provide our employees and students with the opportunity to learn from community partners and better understand the social influences on health that our patients experience outside of our hospital walls. The following table outlines the grants awarded for Fiscal Year 2016.

Project Title	Contact(s)	CHNA Priority	Description
HealthSLAM - Effectiveness of a Health Education Session in 3rd, 4th and 5th Grade Classrooms	Alexandra Petrie	Healthy Lifestyles - Nutrition	This is an educational partnership between the Pennsylvania State University College of Medicine Family Medicine Interest Group and local elementary schools. The program educates third, fourth and fifth graders about healthy food choices.
Get Fit Together	Brian Lentes	Healthy Lifestyles - Lack of Physical Activity	This is a free program that provides low-income families with exercise and nutrition tools. Specifically, each family participating in the program will meet with a certified personal trainer two times per week, as well as a registered dietitian once per week.
Improving Health Care Quality Through Language Bridging Programs	Patricia Silveyra	Access - Primary	This is an interpretation skills program that trains a group of bilingual medical students as interpreters in their native language and enables them to obtain certification as medical interpreters. A goal of this program is to allow student interpreters to take full advantage of their service time.
Prevention Produce: Prescribing Fruits, Vegetables, and Nutrition Education for Underserved Populations	Daniel George	Healthy Lifestyles - Nutrition	Food as Medicine facilitates a "fruit and vegetable prescription" voucher program for community members in need. Participants redeem their vouchers at local markets–the Broad Street Market in Harrisburg and the Farmers Market in Hershey–while medical students offer nutrition and food choice advice.
Assessing the Health and Wellness Priorities of Local Childcare Facilities	Erica Francis	Healthy Lifestyles - Nutrition	This research project is focused on promoting healthy lifestyles in early childhood education centers. Investigators will work to determine what local childcare facilities are utilizing validated assessment tools to improve and promote wellness in their centers.
Toolkits for Cancer Risk Reduction and Screening in Rural, Faith-Based Communities	Marcyann Bencivenga	Access - Specialty Healthy Lifestyles - Nutrition	This is an educational partnership between the Pennsylvania State University College of Medicine Family Medicine Interest Group and local elementary schools. The program educates third, fourth and fifth graders about healthy food choices.

APPENDIX E: COMMUNITY RELATIONS START UP GRANTS

Project Title	Contact(s)	CHNA Priority	Description
LionCare Tyrone: Establishing a Student-Run Free Clinic at the University Park Regional Campus	Clayton Cooper	Access - Primary	This program places physicians-in-training at an interdisciplinary free clinic in Tyrone, PA (within close proximity to a primary care health professional shortage area). This clinic gives students the opportunity to improve access to healthcare while also gaining vital experience.
Colorectal Cancer Community Education Program	Patricia A. Robinson	Access - Specialty	Colorectal cancer Community Education Program engages and equips 12 Harrisburg community health workers (CHWs) to increase colorectal cancer screenings among African-American residents in Dauphin County. The CHWs will also conduct community education events to raise general awareness of colorectal cancer, including the benefits of early detection and treatment.
EMS Feedback Tool Standardized Stroke Educational Video	Kelly Rotondo	Access - Specialty	This media tool intends to help standardize pre-hospital care for stroke patients. The procedures to be reviewed are: recognition of stroke by dispatchers and paramedics, remote clinical examination and imaging in ambulances, integration of CT scanners, and point-of-care laboratories in ambulances.
School to Table™	Elizabeth Hivner	Healthy Lifestyles - Nutrition	This program introduces K-6th grade students to controlled environment agriculture. Students learn about growing organic produce through an aquaponics system. Opportunities are available for students who have participated in the curriculum and are interested in small business, food safety, engineering, entrepreneurial education, nutrition, and e-commerce centered on local food production.
Interdisciplinary Service Learning: Hershey Plaza Apartments	Kelly Karpa Charlie Lin	Access - Primary	This is a service learning opportunity to address residents' growing need for health education and lifestyle counseling. These patient education sessions empower low-income healthcare consumers to participate in shared decision-making with their caregiver and help patients proactively maintain their health, helping to reduce care costs and improve quality of life.
Transformational Ministry Program - Addressing the Impact of Poverty on Family Health	Liz Massar	Access - Primary	This program provides education and long-term mentoring in physical, social, mental and spiritual health for low-income individuals through Love, INC. Classes will focus on topics such as personal and family financial management, job searching, parenting, life organization skills, cooking and nutrition, and exercise.
"My Gift of Grace" - An Educational Activity that Helps Families and Friends Talk about Death and Dying	Lauren J. Vanscoy	Access - Specialty	This pilot program engages community members in an enjoyable activity (called "My Gift of Grace") that will stimulate meaningful, impactful discussions on end-of-life issues, clarifying values and goals related to future healthcare, and recording preferences.

APPENDIX F: COMMUNITY PARTNERS

- AETNA Better Health of Pennsylvania
- Al-Anon
- Alder Health Services
- ALS Association
- American Cancer Society
- American Heart Association
- American Lung Association
- American Stroke Association
- Annville-Cleona School District
- Aspirations, LLC
- Baby Love Program
- Bethesda Mission
- Brethren Housing Association
- Broad Street Market
- Byrnes Health Education Center
- C.O.C.O.A. Packs Program
- Capital Area Coalition on Homelessness
- Capital Area Head Start
- Catholic Charities
- Central Dauphin School District
- Central Pennsylvania Food Bank
- Child and Adolescent Service System Program of Cumberland and Perry Counties
- Children's Health Insurance Program
- Children's Miracle Network
- Community Check-Up Center
- Cumberland County Coroner's Office
- Cumberland Valley School District
- Cumberland, Perry, and Dauphin Counties Crisis Intervention
- Dauphin County Area Agency on Aging
- Dauphin County Coroner's Office
- Dauphin County Drug and Alcohol Bureau
- Dauphin County Health Improvement Partnership
- Dauphin County Probation and Parole
- Derry Township
- Derry Township Police Department
- Derry Township School District
- Ellie's Heart Foundation
- Farmers Market in Hershey & Summer Concert Series
- Farmstead Market
- Food Bank of Derry Township
- Gaudenzia, Inc.
- Gemma's Angels
- Genentech
- Giving Tree of Hummelstown
- Greater Harrisburg Healthy Start
- Hanover Hospital
- Harrisburg Area Community College
- Harrisburg Area Dental Society
- Harrisburg Area YMCA
- Harrisburg City K9 Police
- Harrisburg Community Cancer Network
- Healthy Living Kitchen
- Hershey Community Garden
- Hershey Entertainment & Resorts
- Hershey Food Bank
- Hershey Impact
- Hershey Plaza Apartments
- Hope Within Ministries
- Hummelstown Food Pantry
- Institute for a Drug Free Workplace
- Jeanette Johnston Horse Benevolent Protective Association Medical Clinic
- Josiah W. and Bessie H. Kline Foundation
- Lebanon County Career and Technology Center
- Lebanon Family Health Services
- Lebanon School District
- Lower Dauphin Communities that Care
- Lower Paxton Township Police Department
- M.S. Hershey Foundation
- Manna Food Pantry at Penbrook United Church of Christ
- Mary's Helpers Food Pantry at Prince of Peace Parish
- Mazziti and Sullivan Counseling Services, Inc.
- Milton Hershey School
- Mohler Senior Center
- Morningstar Pregnancy Services
- Muscular Dystrophy Association
- Nar-Anon
- Natalie Cribari Drug Awareness Fund
- Northern Appalachia Cancer Network
- Northern Dauphin Health Initiative
- Palmyra 250th Anniversary Committee
- Palmyra Area School District
- Partners for Healthy Communities of Central PA
- Penn National Race Course
- Penn State Dickinson School of Law
- Penn State Extension
- Pennsylvania Bureau of Autism Services
- Pennsylvania Department of Health
- Pennsylvania Department of Transportation
- Pennsylvania Office of Attorney General Bureau of Narcotic Investigation and Drug Control Division
- Pennsylvania Psychiatric Institute
- Pennsylvania State Police
- Pennsylvania Traffic Injury Prevention Project
- Philhaven Hospital
- Physicians' Alliance, Ltd.
- Pressley Ridge
- Rase Project
- Rite Aid
- Roxbury Treatment Center
- Safe Kids Pennsylvania
- Salvation Army
- SanusEO
- Scotts Miracle-Gro Company
- Senior Farmers' Market Nutrition Programof Pennsylvania
- Someone To Tell It To
- South Central PA Highway Safety Program
- Steelton Police Department
- Steelton-Highspire School District
- Strawberry Square
- Susquehanna Township School District
- Susquenita School District
- Sutliff Auto Group
- Swatara Police Department
- The Caring Cupboard
- The Foundation for Enhancing Communities
- The Hershey Company
- The Hospital and Healthsystem Association of Pennsylvania
- U-Gro
- United States Drug Enforcement Agency
- United Way of the Capital Region
- Walk, Central Pa, Walk
- Weis Markets
- WellSpan Health
- Women, Infants, and Children (WIC)
- York Memorial Hospital
- YWCA of Greater Harrisburg