COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION PLAN

Lehigh Valley Health Network

TABLE OF CONTENTS

INTRODUCTION 3

SOCIO-ECOLOGICAL MODEL OF HEALTH

RECAP OF CHNA FINDINGS 5

DETERMINING KEY FOCUS AREAS FOR THE IMPLEMENTATION PLAN 6

HOW WE WILL MEASURE THE IMPACT OF OUR WORK 7

READING THE IMPLEMENTATION PLAN 9

COMMUNITY ENGAGEMENT 10

AT-RISK POPULATIONS 11

ACCESS TO CARE AND HEALTH EQUITY 13

PREVENTION AND WELLNESS 14

WORKING ALONGSIDE – AND FOR – OUR COMMUNITY 17

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INTRODUCTION

At Lehigh Valley Health Network (LVHN), it is our mission to heal, comfort and care for the people of our community. Understanding our region's health care needs is an important step in furthering our mission. Since the last Community Health Needs Assessment (CHNA) cycle (2013–2015), the number of communities served by LVHN has grown. This year's CHNA reports were prepared for the Lehigh Valley region (on behalf of Lehigh Valley Hospital (LVH)–Cedar Crest/LVH–17th Street and LVH–Muhlenberg) and for Luzerne County (on behalf of LVH–Hazleton). They were published on our website in June 2016. In September 2016, Schuylkill Health System joined Lehigh Valley Health Network and will be included in the implementation phase of the CHNA as LVH–Schuylkill.

The CHNA reports: Lehigh Valley region, Hazleton area, Schuylkill County region

As a brief review, the Lehigh Valley regional Community Health Needs Assessment was performed by the Health Care Council of the Lehigh Valley, a collaborative that included LVHN, Good Shepherd Rehabilitation Network, KidsPeace, Sacred Heart Healthcare System, St. Luke's University Health Network, Allentown Health Bureau, Bethlehem Health Bureau and Neighborhood Health Centers of the Lehigh Valley. The Health Care Council's work was supported by funding from the Dorothy Rider Pool Health Care Trust and was facilitated by 35th Street Consulting. This same consulting firm assisted with the data acquisition and CHNA report for the Hazleton region. Schuylkill Health System performed its own Community Health Needs Assessment prior to merging with LVHN. Each of the CHNA reports examined factors that impact the health and wellness of the people living within their respective communities.

We are pleased to present LVHN's Community Health Needs Implementation Plans in response to concerns identified in the CHNA reports. Each licensed facility within LVHN – LVH–Cedar Crest/LVH–17th Street, LVH–Muhlenberg, LVH–Hazleton and the two new campuses at LVH–Schuylkill (LVH–South Jackson and LVH–East Norwegian) – has prepared an implementation plan. Our implementation plans include activities designed to address needs within our communities, while also promoting health. Note that the implementation plans are presented in two separate documents – one for the LVH–Schuylkill campuses and one for the other LVHN communities. Schuylkill Health System conducted its Community Health Needs Assessment prior to joining LVHN. While we worked together to craft its implementation plan, the team at LVH–Schuylkill and the residents of Schuylkill County have a much deeper understanding of what needs to be done there. We felt it was important to present Schuylkill's CHNA report and implementation plan as a separate "matched set."

COMMUNITY ENGAGEMENT

AT-RISK POPULATIONS

ACCESS TO CARE AND HEALTH EQUITY

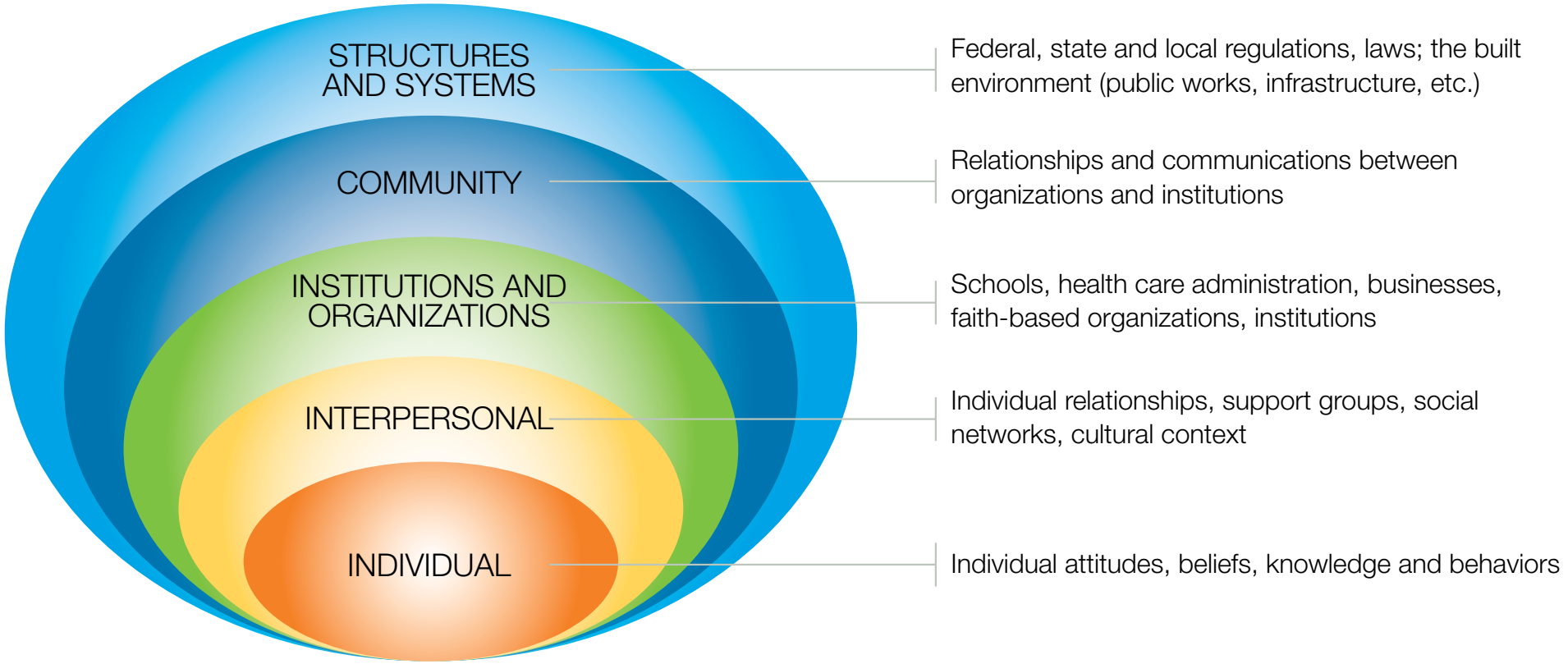
PREVENTION AND WELLNESS

SOCIO-ECOLOGICAL MODEL OF HEALTH

This diagram shows that health within a community depends on "everyone." The life and health of an individual is influenced by conditions within the community – by the quality of relationships with others, experiences in schools and neighborhoods, capacity of community organizations to support persons and families, local government, etc. The Centers for Disease Control's (CDC) Socio-Ecological Model of Health captures this "interdependence."

Caring for an entire community – whether that is a county, town, neighborhood or group of underserved individuals – takes a team of dedicated people. Some portions of the implementation plan will be focused on activities within our health network. We will be working in specific areas to improve the quality of clinical care and experiences of our patients. To address other needs identified in the CHNA, the team extends beyond the health care professionals at LVHN. Within the communities we serve we will work collaboratively with community organizations, faith-based organizations, social service agencies, local health departments and civic leaders to help grow healthier communities, one relationship at a time.

Creating healthier communities is our common focus. By working on the implementation plan together, we can take meaningful steps to improve health, grow resilience and raise awareness of the many factors that influence our health.



RECAP OF CHNA FINDINGS

When the Community Health Needs Assessment was developed, it identified several health and social issues that required community-wide attention.

PRIORITY AREAS IN LEHIGH VALLEY REGION:

- Mental health support
- Homelessness and substandard housing conditions
- Low rates of social association
- High rates of sexually transmitted infections (STIs)

PRIORITY AREAS IN HAZLETON REGION:

- Cancer mortality rates
- Cardiac mortality rates
- Diabetes care
- Improved access to care
- Low rates of social association

COMMON PRIORITY AREAS IN BOTH REGIONS:

- Social isolation
- Health equity, language and culture
- Education
- Violence

DETERMINING KEY FOCUS AREAS FOR THE IMPLEMENTATION PLAN

Community health specialists at LVHN reviewed priority areas identified for the Lehigh Valley and Greater Hazleton areas. Identified needs were shared. and discussed with LVHN clinical leaders, community and public health representatives, and other health care organizations. Four criteria were used to identify key focus areas for the implementation plan:

MAGNITUDE

How big or widespread is the issue?

IMPACT

Is the problem a "driver" of other health outcomes?

CAPACITY

What does LVHN already have in place that can support improvement or measurement?

ALIGNMENT

Which items are consistent with LVHN's clinical, community and population health goals?

LVHN identified the following as our four overarching Key Focus Areas:

COMMUNITY ENGAGEMENT

We defined Community Engagement as "Developing community partnerships to identify priorities and support complex issues that impact health." LVHN will focus on exploring and building community partnerships with an aim to address social and health needs of community populations such as homeless individuals and families with young children.

AT-RISK POPULATIONS

We defined At-Risk Populations as "Providing clinical services that meet a significant community need for an at-risk population, but are not financially viable on their own." Some examples of At-Risk populations include those with behavioral health or psycho-social needs, as well as children, adolescents and veterans. Our implementation plan addresses working with community agencies and services to engage people who are at risk for undertreated chronic conditions and help them receive the treatment and medication(s) they need. The plan also will focus on helping to identify and reduce sexually transmitted diseases.

ACCESS TO CARE AND HEALTH EQUITY

We defined Access to Care and Health Equity as "Being attentive to the needs for access to medical care in the communities we serve and to each person's language and culture." LVHN will address this need in several ways: by recruiting additional staff to see patients with specific chronic conditions (cardiac disease and diabetes in particular), offering new services in underserved counties and improving and improving access to the latest treatments in cancer care, among other initiatives.

PREVENTION AND WELLNESS

We defined Prevention and Wellness as "Increasing the number of people who are healthy and well by empowering people to take an active role in their health and addressing issues that contribute to preventable disease." Such initiatives include promoting mammograms, flu shots, timely pregnancy care and obesity screening, and building awareness about the emerging opioid drug use and abuse issues facing our communities.

How the CHNA Implementation Plans are organized

The implementation plans are presented in a table format and are organized by the four Key Focus Areas described above: Community Engagement, At-Risk Populations, Access to Care, Health Equity, and Prevention and Wellness. Within each Key Focus Area, objectives and tactics are described. These address "priority areas" named in the CHNA reports (housing and homelessness, for example). Each LVHN campus has its own column, and specific tactics are marked with a ■. Some activities will be adopted across multiple campuses. Community collaborators for a particular item also are listed.

While LVHN is committed to your health and wellness, we also know that every member of our community plays a role in helping to shape a better tomorrow. We hope the information in these implementation plans and the 2015–2016 CHNA report encourages you to join our quest to make the Lehigh Valley, Hazleton and Schuylkill regions better, healthier places to live. Should you wish to join us in our mission, send an email to: **community_health@LVHN.org**.

HOW WE WILL MEASURE THE IMPACT OF OUR WORK

ALWAYS WORKING TO IMPROVE

At Lehigh Valley Health Network (LVHN) we believe that measuring our progress and our areas for improvement helps show our ongoing commitment to the health of the community. Measuring improvement in a community can take several years. It is an ongoing process. Within the three-year timeframe of this Community Health Needs Assessment (CHNA) cycle, there are still ways to measure progress. At times, we will use shorter "cycles of improvement" designed to show progress one step at a time. We will take what we learn each year and build on that to improve the care we provide, experiences of our patients and health of the communities we serve. Our goal is to have a positive impact on health and things that influence it.

WORKING TOGETHER ON THE SOCIAL INFLUENCES ON HEALTH

There are also complex factors within a community – called "social determinants" – that influence health. Social determinants include education, employment, lifestyle, housing, food, violence, alcohol and substance use, and other factors. They can help support health or can get in the way of staying healthy. At LVHN, we believe there can be a greater impact on health by partnering with others in the community to address a health issue rather than managing it alone. Making progress with chronic health conditions like asthma and diabetes may require cooperation among clinicians, educators, grocery store owners, consumers and community advocates.

THE BASICS OF MEASUREMENT

In health care, we use measurement science to tell us more about how we are doing. Here are a few basic concepts that guide our decisions around selecting metrics and measures:

- Sometimes improvement is measured by a number, such as a patient's blood pressure or the weight of a child. These are called "quantitative" methods. In other situations, we may measure how people feel about themselves or the things around them – perceptions about eating habits, health or nutrition, for example. These are called "qualitative" measures. Both types of measures are important. They provide different kinds of information and help us look at an issue from different angles.
- If we are measuring the development of a new program or service, we may describe key steps along the way, similar to mileposts on a road. We look at whether these steps are happening as expected and what helps or gets in the way. These are called "process" measures.
- Sometimes we measure the number of people touched by an activity. This is called an "output" measure. An example might be a community-based home visiting program. Here we might focus on the number of people seen during a particular week or number of concerns addressed during a visit.
- If we are measuring an "outcome," we are looking at specific changes in a person's health, behavior, knowledge or ability to do something. Rates of death from cancer or graduation rates from high school are examples. Outcomes are the strongest measures of progress. They are also the most difficult to measure over a short period of time. Some outcome improvements, such as reduced death rates from heart disease, can take several years to show.

For each activity identified in our CHNA Implementation Plan, we have chosen a "metric" – a way to measure the progress and impact of that activity. Periodically, we will collect data from our systems to support measuring what matters. There are always some challenges with this. For instance, Lehigh Valley Health Network has recently expanded into new communities that use separate electronic medical record (EMR) systems. This makes for extra work when looking at data and progress. However, there is good news as we look toward the future.

EXPANSION OF A COMMON ELECTRONIC MEDICAL RECORD

LVHN has embarked on a multi-year project to transition to a new system-wide integrated electronic medical record system. Doing this will help us bring together data and reports that support CHNA priorities within our communities. Having a common way to collect key data using an integrated EMR will help us monitor trends, measure outcomes and design "cycles of improvement" to address areas of need.

READING THE IMPLEMENTATION PLAN

When reviewing the chart, each LVHN campus is listed in the columns with a ■ placed to show where a particular tactic will be implemented and which campus(es) and/or community collaborator(s) will help implement the initiative(s).

While LVHN is committed to your health and wellness, we also know that every member of our community plays a role in helping to shape a better tomorrow. We hope the information in this implementation plan and 2015–2016 CHNA report encourages you to join our quest to make the Lehigh Valley and Hazleton regions better, healthier places to live.

COMMUNITY ENGAGEMENT

DEVELOP COMMUNITY PARTNERSHIPS TO IDENTIFY PRIORITIES AND SUPPORT COMPLEX ISSUES THAT IMPACT HEALTH

PRIORITY AREA	OBJECTIVE	TACTIC	CORP.	LVH–CC LVH–17	LVH–MUH	LVH–H	COMMUNITY COLLABORATORS
COMMUNITY COLLABORATION	Explore and develop collaborative relationships that recognize diverse stakeholder perspectives and that promote shared understanding, mutual goals and shared responsibility for better health and care within our communities.	**1.1** Connect with local Federally Qualified Health Center (NHCLV), community and faith-based organizations to support the diverse health needs of our communities – maintain stakeholder listing and areas of common interest; dates we met.	■	■	■	■	Neighborhood Centers of the Lehigh Valley (NHCLV) for LV region, Hazleton Integration Project (HIP) for Hazleton area; community and faith-based organizations
		1.2 Partner with United Way 211 to create and maintain a database (UW211 East) of community resources, accessible to LVHN case managers, clinicians, patients, caregivers and community organizations.		■	■	■	United Way
		1.3 Educate and support patients, caregivers and community members around advance care planning (ACP). Host community-based conversations to educate about advance care principles, shared decision-making. Encourage completion of ACP documents.	■	■	■		Allspire Health Partners,faith-based organizations, Alzheimer's Association
SOCIAL ASSOCIATIONS	Build social connection through a community-based time-banking program that emphasizes reciprocity.	**2.1** Promote LVHN Community Exchange (CE) time-banking program to increase social connections.	■	■	■	■	NHCLV (FQHC), Community organizations interested in program
HOMELESSNESS/ HOUSING	Work with community stakeholders and civic leaders to address the health and social needs of homelessness, lack of affordable rental housing and substandard housing conditions.	**3.1** LVHN's Street Medicine Program provides medical care within defined shelter-based clinics and on "street rounds" to the unsheltered.		■	■		Allentown Rescue Mission, Safe Harbor, New Bethany Ministries, St. Paul's Lutheran Church, Allentown Rescue Mission, Lehigh County Conference of Churches, Ecumenical Soup Kitchen, Hope for Veterans
		3.2 Street Medicine collaborates with LVHN case management, community collaborators to provide case management services, improve access to insurance, and introduce patients to a medical home when ready.		■	■		LVHN Population Health, New Bethany Ministries, Lehigh County Conference of Churches, Marywood University, Kutztown University
		3.3 Host and/or participate in a multi-sector discussion on housing and health with area stakeholders.		■	■		LVHN, DeSales University, Dorothy Rider Pool Health Care Trust

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HEALTH ADVOCACY/ CONNECTION THROUGH PARTNERSHIPS	Implement programs designed to alleviate social needs that affect patients' health and well-being.	**4.1** Health Advocacy program: provide support, navigation and problem-solving assistance for patients with social needs, using specially trained university students interested in the health professions or social sciences.		■	■		Penn State Lehigh Valley, Cedar Crest College
		4.2 Pilot a civil legal assistance program in collaboration with North Penn Legal Services for patients with legal issues that affect their health and well-being.		■	■		North Penn Legal Services
FOOD ACCESS / HEALTHY NUTRITION	Improve access to healthy foods and nutrition education for children and families living in lower-income urban communities of Allentown, Bethlehem and Easton.	**5.1** Healthy Corner Store Initiative (HCSI): Several local corner stores in low income communities have been identified and encouraged to add > 4 healthy food items to their store inventory after baseline assessment. Store owners receive training by staff on how to display and sell healthy food items. Follow-up assessments determine adherence to recommendations.		■	■		Tobacco-Free Northeast Pennsylvania, American Lung Association, Sodexo, Bethlehem Health Bureau, Allentown Health Bureau, Second Harvest Food Bank, PA Department of Health, The Food Trust
		5.2 Participation in the regional Food Policy Council which seeks to improve food security in the Lehigh Valley and to support growth in the local food economy.		■	■		United Way, Community Action Committee of the LV
		5.3 Food collection drives: Nonperishable food is collected at LVHN's drive-through flu vaccine events and by employees throughout the year to assist local food cupboards.		■	■		M.A.R.T.I.N. Flu Foundation, LVHN employees
SUPPORTING YOUNG FAMILIES AND EARLY CHILDHOOD EDUCATION	Allentown Children's Health Improvement Project (ACHIP)	**6.1** Outreach to young mothers, children and families in the Allentown Promise Neighborhood, using community health workers and a nurse navigator to provide education, support, connection to health care and social services – goals include supporting families, early childhood education, improving health and health care utilization.		■			Allentown Promise Neighborhood, Dorothy Rider Pool Trust, (Nurse Family Partnership of St. Luke's Hospital Network, Community Services for Children, Lehigh Valley Children's Centers)
	Improve communication within families and help reduce potential for family violence through parenting classes.	**6.2** Implement parenting classes within ACHIP and in collaboration with other local agencies; pilot strategies to increase engagement.		■	■	■	American Psychological Association, Catholic Charities of Allentown, Catholic Social Services in Hazleton
	Provide a nurturing, high-quality educational environment to children who have been exposed to or who are at risk for trauma or violence.	**6.3** Early Head Start – SafeStart Program provides quality early childhood education to young children of families involved with PA's Office of Children and Youth. Goals include; addressing health problems, developmental delays and emotional trauma.		■			LVHN Children's Clinic, LV Children's Hospital, Community Services for Children, Office of Children & Youth in Lehigh and Northampton counties

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AT-RISK POPULATIONS

PROVIDE CLINICAL SERVICES THAT MEET A SIGNIFICANT COMMUNITY NEED FOR AN AT-RISK POPULATION, BUT ARE NOT FINANCIALLY VIABLE

PRIORITY AREA	OBJECTIVE	TACTIC	CORP.	LVH–CC LVH–17	LVH–MUH	LVH–H	COMMUNITY COLLABORATORS
BEHAVIORAL HEALTH	Increase the number of primary care patients who are screened for depression and, when appropriate, referred to effective resources.	**1.1** Depression screening: Within practices using Epic electronic health record, implement anxiety/depression screening using PHQ-2/9 (a standardized tool); provide feedback to clinicians regarding their screening rates.		■	■		
		1.2 Assess and improve treatment and referral workflows for patients who screen positive for depression with PHQ-9 within selected primary care practices; PHQ score >9 in adults, >5 in children and adolescents <18 years old.		■	■		
	Educate patients and community stakeholders about depression; reduce stigma associated with mental health conditions.	**2.1** Public Health informational campaign to promote importance of early identification of depression and connecting to treatment for behavioral health issues; employee assistance programs. "Tell your story campaign."	■	■	■	■	National Alliance on Mental Illness, local Suicide Prevention Resource Center, local counties, local media
	Develop innovative delivery models and partner with community stakeholders to develop capacity to address whole health needs impacting behavioral health patient.	**3.1** Behavioral health integration pilot: co-located medical and behavioral health care SAMSHA grant site. Implementation of a reverse co-location model of care for seriously mentally ill patients to include nurse care coordination and participation in wellness events.			■		Substance abuse treatment providers
	Provide a continuum of high-quality mental health care to adults and adolescents in need.	**4.1** Inpatient behavioral health unit team provides safe acute psychiatric care for community focused on safety and stabilization.		■	■		Community EMS providers, regional Psychiatric Emergency Services providers
		4.2 Partial/Residential programs (Adult and Adolescent Transitions, Alternatives and Transitional Living Center) provide intensive treatment, education and support, improving community function and avoiding unnecessary hospitalizations.		■	■		LVHN and community-based care management agencies
		4.3 Outpatient psychiatric care: Multiple programs provide evaluation, diagnosis and treatment for members of our community.		■	■		

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PRIORITY AREA	OBJECTIVE	TACTIC	CORP.	LVH–CC LVH–17	LVH–MUH	LVH–H	COMMUNITY COLLABORATORS
OUTPATIENT CARE MANAGEMENT SUPPORT	Use Community Health Workers (CHWs) who are trusted members of the community to engage patients in their health.	**5.1** Community Asthma Education Program (CAEP) for children – engages Community Health Workers to conduct individual and group education sessions and in-home assessments for asthma trigger remediation.		■	■		Allentown School District
		5.2 Geriatric Workforce Improvement Program (GWEP) – engages Community Health Workers (CHWs) to partner with nurses in conducting home visits to geriatric patients (and their caregivers) with chronic illnesses or memory-related disorders, including Alzheimer's disease. CHWs assess patients' social needs and provide connections to community resources.		■	■		Area Agencies on Aging, Alzheimer's Association, Allentown Health Bureau, Lehigh County Office of Aging and Adult Services
		5.3 See Allentown Children's Health Improvement Project in Community Engagement section (6.1).		■	■		
	Teams from the Population Health Department (see 6.1) will address a variety of medical, social and behavioral health needs for patients with complex conditions and higher than average risk for hospitalizations. Population Health team members help close clinical gaps and support safe, effective and efficient patient-centered medical care.	**6.1** Population Health Department (Community Care Teams – nurse case manager, social worker, behavioral health specialist, +/- pharmacist, Transitions of Care Call Center and Centralized payer resources) will engage and manage patients in their health and address barriers to care.		■	■		
		6.2 Social workers placed in practices served by Population Health Department will assist patients in obtaining medications they cannot afford.		■	■		
		6.3 Social workers placed in practices served by Population Health Department assist eligible patients in applying for Social Security Disability income using the SOAR process.		■	■		
ELEVATED RATES OF STIs	Reduce transmission of sexually transmitted infections (STIs) through screening, early detection, treatment, education and referral to specialty medical services as needed.	**7.1** Improve capacity by offering additional STI clinic services at 17th St. campus (including evening hours) to address community need and to supplement services offered by Allentown Health Bureau (AHB).		■			LVHN AAO at 17th Street, Allentown Health Bureau (AHB), Allentown School District
CHILDREN AT RISK FOR VIOLENCE OR NEGLECT	Provide specialized health care and linkage to social support resources for vulnerable infants and children at risk for violence and/or neglect.	**8.1** LV Children's Hospital Child Advocacy Center addresses needs of children who are at risk for or are victims of violence and/or neglect. Child protection team resources are available within emergency department, inpatient units and in an outpatient setting for agency and community referrals. Follow-up services, community outreach and professional educational programs are also available.		■	■		Lehigh County Office of Children & Youth Services, Lehigh County District Attorney, Allentown Police, Crime Victims Council of the Lehigh Valley

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ACCESS TO CARE AND HEALTH EQUITY

BE ATTENTIVE TO THE NEEDS FOR ACCESS TO MEDICAL CARE IN THE COMMUNITIES WE SERVE AND TO PERSON'S LANGUAGE AND CULTURE

PRIORITY AREA	OBJECTIVE	TACTIC	CORP.	LVH–CC LVH–17	LVH–MUH	LVH–H	COMMUNITY COLLABORATORS
ACCESS TO PRIMARY CARE	Develop and maintain strong safety net of services that improve access to care among vulnerable populations.	**1.1** Maintain and broadly communicate Lehigh Valley Health Network's financial assistance policy, providing free or discounted care for qualifying patients.	■	■	■	■	
	Increase access to primary care services through expansion of access services and recruitment of clinicians.	**2.1** Expansion of primary care services for vulnerable populations.			■	■	
		2.2 Recruitment of primary care clinicians to support timely access to care.			■	■	
		2.3 Improvement in timely access to primary care clinician services.		■	■	■	
ACCESS TO COMPLEX DISEASE CARE	Improve access to complex disease care in surrounding counties.	**3.1** Palmer Township and Easton Health Centers (opening summer 2017) will provide improved face-to-face and telemedicine access to complex disease care.			■		
	Improve health outcomes for cardiac disease (one of the leading causes of death) by improving timely access to treatment, care and disease self-care education.	**4.1** Improve outpatient access for new patients seeing a cardiologist.				■	
		4.2 Improve access to diabetes care and education by adding additional diabetes care clinician, nurse educator and nutritionist to care team.				■	
		4.3 Improve outpatient access for new patients with peripheral vascular disease.				■	
	Increase awareness to improve risk factor identification for heart disease.	**5.1** Provide community-based education by hosting community events such as health fairs, CPR classes and health screenings to assess CV risk factors.				■	
	Improve health outcomes for patients with cancer (one of the leading causes of death) by improving timely access to care and clinical trials.	**6.1** Improve outpatient access for new patients seeing a cancer care specialist.				■	
		6.2 Improve access to clinical trials for patients with cancer who live in Luzerne County.				■	
ATTENTIVENESS TO CULTURE AND LANGUAGE	Provide care and communication that is sensitive to culture and language through workforce education, training and use of interpreter services.	**7.1** Provide LVHN colleagues with cultural, linguistic training via variety of delivery mechanisms.	■	■	■	■	
		7.2 Patient's preferred language for health care discussions is recorded at time of registration.		■	■	■	
		7.3 Assess availability of language assistance resources in all care delivery sites to meet needs of patients with limited English proficiency.		■	■	■	Bridging the Gap Program

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PREVENTION AND WELLNESS

INCREASE NUMBER OF PEOPLE WHO ARE HEALTHY AND WELL BY EMPOWERING PEOPLE TO TAKE AN ACTIVE ROLE IN THEIR HEALTH AND ADDRESSING ISSUES THAT CONTRIBUTE TO PREVENTABLE DISEASE

PRIORITY AREA	OBJECTIVE	TACTIC	CORP.	LVH–CC LVH–17	LVH–MUH	LVH–H	COMMUNITY COLLABORATORS
OBESITY AND NUTRITION	Implement network-wide approach to identification, prevention and management of patients at-risk for or classified as overweight or obese (BMI ≥25).	**1.1** Capture (BMI) data for LVHN patients through Epic (LVHN's electronic health record); analyze aggregated data to identify opportunities for practice-based or programmatic interventions.		■	■		
		1.2 Identify and refer patients identified as "high risk" (by virtue of lifestyle issues or co-morbid conditions) to LVHN and community resources to assist with patient engagement, education, motivation and support for management of their condition.		■	■		
		1.3 Community Canvas: a school- and community-based educational program that includes in-school instruction and evening programs for families of elementary students, and emphasizes wellness through healthy habits and good nutrition. In 2016–17 schools in Easton and Whitehall are included in the program.		■	■		Lehigh Valley ArtSpark, Kellyn Foundation, Easton Area School District, Whitehall-Coplay School District
		1.4 Surgical Weight Management Information Sessions: Information events held monthly, facilitated by the Weight Management Center's registered nurse patient navigator. Participants are provided with options available at the Center for medically supported, nonsurgical weight management. Attendees learn how the team of physicians, RN patient navigator, registered dietitians and behavioral health specialists can tailor an individualized, safe and effective program of diet, nutrition, exercise and lifestyle changes.		■	■	■	
	Increase rates of physical activity among residents of community.	**2.1** Healthy Latinas Pilot program: Healthy Latinas is a community-based, multi-component intervention targeting overweight and obese Hispanic adolescent females and their mothers or caregivers. Aim of this program is to promote healthy habits, physical activity and body image as well as decrease unhealthy weight gain. Healthy Latinas is a pilot program based on a successful model, Healthy Chicas, implemented in Miami, Fla.		■			
		2.2 Rededication of the "Health & Wellness Center," which offers fitness, rehab and other health promotion services.			■		
PREVENTABLE INFECTIOUS DISEASE	Protect residents and patients from influenza, a major cause of morbidity and mortality among patients at risk.	**3.1** Free mass influenza immunization "drive-through" program held at two major venues in the Lehigh Valley region.	■	■	■		
		3.2 Free influenza vaccine clinics within regional soup kitchens and homeless shelters to reach vulnerable patients at risk for influenza.		■	■		New Bethany Ministries, Ecumenical Soup Kitchen, Safe Harbor shelter

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INCREASE NUMBER OF PEOPLE WHO ARE HEALTHY AND WELL BY EMPOWERING PEOPLE TO TAKE AN ACTIVE ROLE IN THEIR HEALTH AND ADDRESSING ISSUES THAT- CONTRIBUTE TO PREVENTABLE DISEASE

PRIORITY AREA	OBJECTIVE	TACTIC	CORP.	LVH–CC LVH–17	LVH–MUH	LVH–H	COMMUNITY COLLABORATORS
SCHOOL-BASED HEALTH INITIATIVES	Support health and learning in school-based and community settings through skills training and collaboration with schools' curricular activities.	**4.1** Dental Sealant Program; provides second and third-grade children from lower-income communities in both Allentown and Easton school districts access to dental sealants, an evidence-based form of preventive oral health care. Children also receive a toothbrush and instruction in how to use.		■	■		Local (Allentown and Easton) school districts
		4.2 Building 21 of Allentown School District Health Care Career Discovery program exposes students to a wide variety of health care careers and positive adult role models in authentic, real-world settings. Year 1 pilot complete with goal of creating an evidence-based, four-year model. Year 2 pilot with program expansion to two other high schools in Allentown School District.		■	■		Allentown School District
		4.3 Provision of school-based health services to elementary, middle and high school students, addressing deficient physicals and vaccines.		■	■		Allentown School District
		4.4 ELECT Pregnant and Parenting Program for at-risk population: Community health staff teaches health-related topics at William Allen HS each month.		■			Allentown School District
DEVELOP HEALTH PROMOTION WORKFORCE	Develop Community Health Worker (CHW) Workforce and engage them as team members to promote disease self-management and prevention, alleviate social and material needs burden, and improve health of those they serve.	**5.1** Ensure all CHWs working within LVHN receive training in CHW competencies.		■	■		East Central Area Health Education Center, Northampton Community College
		5.2 Deploy CHWs in programs and practices that serve individuals and families with social and economic needs.		■	■		

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PREVENTION AND WELLNESS

INCREASE NUMBER OF PEOPLE WHO ARE HEALTHY AND WELL BY EMPOWERING PEOPLE TO TAKE AN ACTIVE ROLE IN THEIR HEALTH AND ADDRESSING ISSUES THAT CONTRIBUTE TO PREVENTABLE DISEASE

PRIORITY AREA	OBJECTIVE	TACTIC	CORP.	LVH–CC LVH–17	LVH–MUH	LVH–H	COMMUNITY COLLABORATORS
USE AND MISUSE OF OPIOIDS	Safe prescribing of opioids.	**6.1** Guideline development for acute and chronic pain management, patient screening for safe prescribing of opioid analgesics; physician outreach and education.		■	■	■	Pennsylvania Medical Society Opioid Task Force
	Help improve linkage to treatment from LVHN clinical care sites for patients experiencing addiction.	**7.1** Improve communication process for referrals for assessment by county Drug & Alcohol (D & A) providers. Pilot liaison in ED for "warm hand-offs" to D & A from LVHN clinicians.		■		■	
		7.2 Make D & A resource listings available to clinical settings, case managers, social workers.		■	■	■	
	Targeted community education to decrease adolescent behavioral risk and increase family coping.	**8.1** Host and sponsor community-based opioid-abuse prevention presentations targeted to schools, parents; include outreach to families experiencing addiction.		■	■	■	Allentown and Bethlehem Health Bureaus, Center for Humanistic Change, community-based organizations Hazleton Improvement Project (HIP), Luzerne–Wyoming County Drug and Alcohol Program, Pennsylvania Medical Society Opioid Task Force, Pathway to Recovery and community-based organizations
	Improve cancer screening awareness and patient engagement within vulnerable communities.	**9.1** Provide educational outreach to vulnerable populations in urban areas about colon cancer screening and assist with access to screening options.		■	■		
		9.2 Engage community members, patients, payers, employers and health care systems through a learning community model designed to develop common agenda for reducing colorectal (CRC) and lung cancer (LCa) screening disparities among minority populations.		■	■		
		9.3 Develop and offer lung screening program to detect early lung cancer.				■	
TIMELY PREGNANCY CARE	Educate pregnant women and their partners about the importance of early pregnancy care for healthy babies.	**10.1** Public health messaging campaign to encourage early pregnancy care.		■	■		
	Increase access to maternity services.	**10.2** Development of new pavilion on LVH–M campus that will improve access to Family Birth and Newborn Care services.			■		

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WORKING ALONGSIDE – AND FOR – OUR COMMUNITY

Lehigh Valley Health Network's (LVHN's) Community Health Needs Assessment Implementation Plan will require the next two years – and more – to achieve the Triple Aim of "Better Care, Better Health and Better Cost." In fact, this plan is truly a starting point that allows us to "Plan, Do, Measure and Improve" in continuous cycles of collaborative effort. We are walking together in what is a long-term journey to understand, discuss and address issues faced by members of our communities. We will work together to create healthier communities – one relationship at a time.

Our implementation plan covers many areas of public health and social need. It does not, however, cover two areas identified by the Community Health Needs Assessment: Transportation and Air Quality. We realize these two problems are complex issues that will need further study to define and address. At present, they are beyond the scope of what LVHN can address alone. We will need additional help from community and government agencies in these areas.

The plan does cover a large number of health and social priorities that will be addressed by LVHN and our partners in our communities. So many of our community collaborators have deep roots and a strong commitment to the common good. The CHNA implementation plan provides an opportunity for every person and every organization to make a positive contribution. By combining our strengths and insights, we can improve health and well-being, and support those struggling under the burdens of life.

We invite others to join our efforts to make the Lehigh Valley and the Greater Hazleton areas healthier for present and future generations. Talk with organizations listed in the implementation plan. Share your thoughts about how you might be able to help us achieve health goals that will benefit the community as a whole.

BETTER CARE

BETTER HEALTH

BETTER COST

Lehigh Valley Health Network

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