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2018-2019 IMPLEMENTATION  
PLAN UPDATE REPORT

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ST. LUKE'S DEPARTMENT OF COMMUNITY HEALTH AND  
PREVENTIVE MEDICINE

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# Introduction: Community Health and Preventive Medicine Overall

The 2018-2019 Community Health Needs Assessment (CHNA) Implementation Plan Update is the last submission under the 2016-2019 CHNA. This report serves as an implementation plan update for the work undertaken by the Department of Community Health and Preventive Medicine (CHPM) at St. Luke's University Health Network (SLUHN) in conjunction with a variety of network and community partners.

As we get ready to transition into the new 2019-2022 CHNA cycle, we have funneled all implementation projects into three initiatives: Health For All, Fit for Life and Healthy Kids, Bright Futures. These initiatives address CHNA goals related to Improving Access to Care and Reducing Health Disparities, Preventing Chronic Disease and promoting Healthy Lifestyles, Improving Mental and Behavioral Health, Improving Child and Adolescent Health and Improving Elder Health. *To learn more about the programs and outcomes achieved, please refer to the table of contents within this publication.*

## 1.1 Community Health and Preventive Medicine Mission

CHPM is committed to affirming that the needs of our communities and vulnerable populations are heard, the department effectively engaged 269 differ-

ent providers, residents, medical students, undergraduates and volunteers to ensure the mission of the department is seen to fruition.

## **1.2 Learn More**

If you would like to learn more, please visit our website at: <https://www.slhn.org/communityhealth>.

# 2

SECTION

## **Fit For Life: Preventing Chronic Disease and Promoting Healthy Lifestyles - Improving Mental and Behavioral Health**

The Fit For Life initiative addresses CHNA goals related to Improving Access to Care and Reducing Health Disparities, Preventing Chronic Disease, Improving Mental and Behavioral Health, Improving Child and Adolescent Health and Improving Elder Health.

Reducing obesity through diet and exercise is the cornerstone of this health priority. Research shows that people with lower BMI's are at lower risk for a variety of chronic diseases. This is especially pertinent when addressing the growing diabetes epidemic. Obesity is determined by BMI, which is an indirect measure of an individual's body fat. Based on standardized BMI calculations, 71% of the 2016 CHNA survey respondents fell into the "overweight or obese" category. As BMI of respondents increases, so does the prevalence of chronic disease. 40.2% of respondents with a healthy BMI reported having chronic diseases, while 75.5% of morbidly obese respondents reported having a chronic disease. An inversely proportional relationship is observed when consumption of fruits and vegetables is compared to the presence of chronic disease. As the consumption of fruits and vegetables increases, the presence of chronic diseases decreases. 65.4% of respondents who reported having zero servings of fruits and vegetables had a chronic disease, whereas

only 40% of those reporting more than 7 servings of fruits and vegetables had a chronic disease.

## **2.1 Prevention and Wellness**

### **Nutrition Initiatives**

St. Luke's is working with the community to teach and develop the skills to make healthy behavior changes that will lead to improved diet and nutritional well-being. Through hands-on educational approaches, community participants learn to grow and prepare nutrient-dense foods, make nutritionally sound food choices and learn how to shop for nutritious foods on a budget. As part of the Adopt a School Model, St. Luke's has partnered with the Kellyn Foundation, to provide resources for classroom visits, school garden preparation and maintenance, and produce distribution to community members.

- Allentown School District – Union Terrace, McKinley, Cleveland
- Bethlehem Area School District – Fountain Hill, Donegan, Marvine, William Penn
- Bangor Area School District – Washington, Five Points, DeFranco
- Panther Valley School District – Panther Valley Elementary and Panther Valley Intermediate
- Phillipsburg Area School District – Phillipsburg Elementary

This year the Kellyn/St. Luke's partnership visited 129 unique classrooms for a total of 297 visits in which 3,225 students were reached.

The Kellyn Foundation's Mobile Market continues to provide produce for sale across locations in Northampton County, all of which are in areas with little or no access to fresh produce. St. Luke's has sponsored Mobile Market Vouchers to participants in multiple programs and clinical settings endorsing a "Food is Medicine" model.

The United States Department of Agriculture (USDA) instituted a national Summer Food Service Program (SFSP) to address the gap in food security and

access to healthy meals when school is not in session. In June 2019, St. Luke's Quakertown and Sacred Heart served as sponsors for the summer feeding program. The program provided a healthy lunch daily; produce to take home weekly; a bag of food for the weekend every Friday; and healthy living activities and education sessions which included dental hygiene, nutrition, health and wellness and healthy cooking programs.

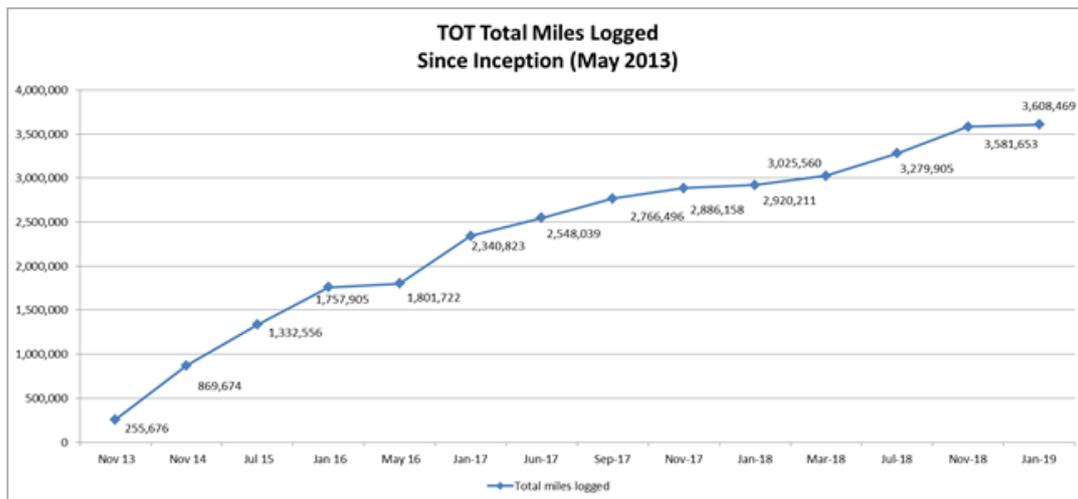
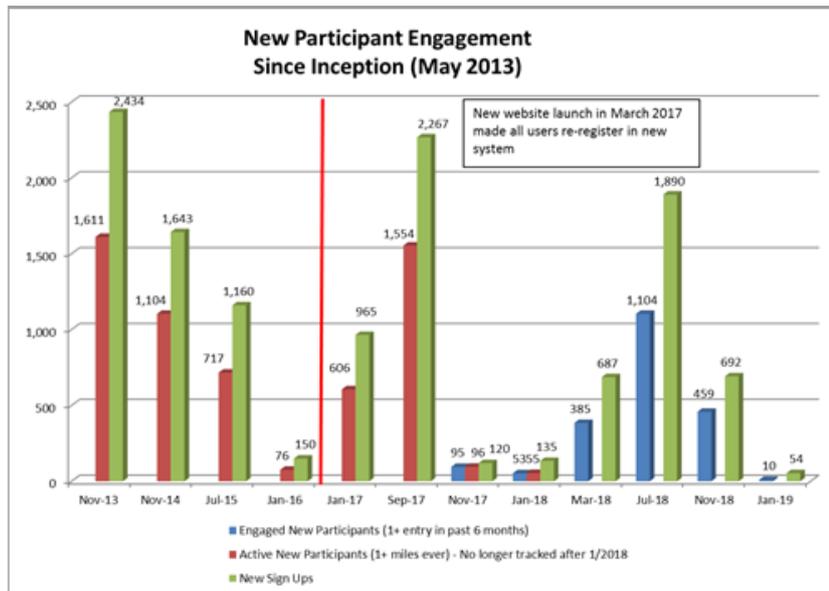
Additionally, healthy living information sessions were held at schools throughout the network during the school year.

### **Physical Activity Initiatives**

People who are physically active generally live longer and have a lower risk for heart disease, stroke, type 2 diabetes, depression, some cancers, and obesity. St. Luke's works with partners to create safe places for physical activity throughout schools and communities. Patients are encouraged to become more physically active through programs such as *Get Your Tail on the Trail (TOT)* and *Walk with a Doc (WWAD)*.

The WWAD program has been active with walks occurring in each region served by St. Luke's University Health Network. This year there were over 900 documented walks taken within this network program.

The TOT program continued to expand with a total 6,922 enrolled users and the addition of a Northeast Pennsylvania (NEPA) Chapter. This year, a milestone of 4 million miles logged was achieved.



## Community Centered Health Home

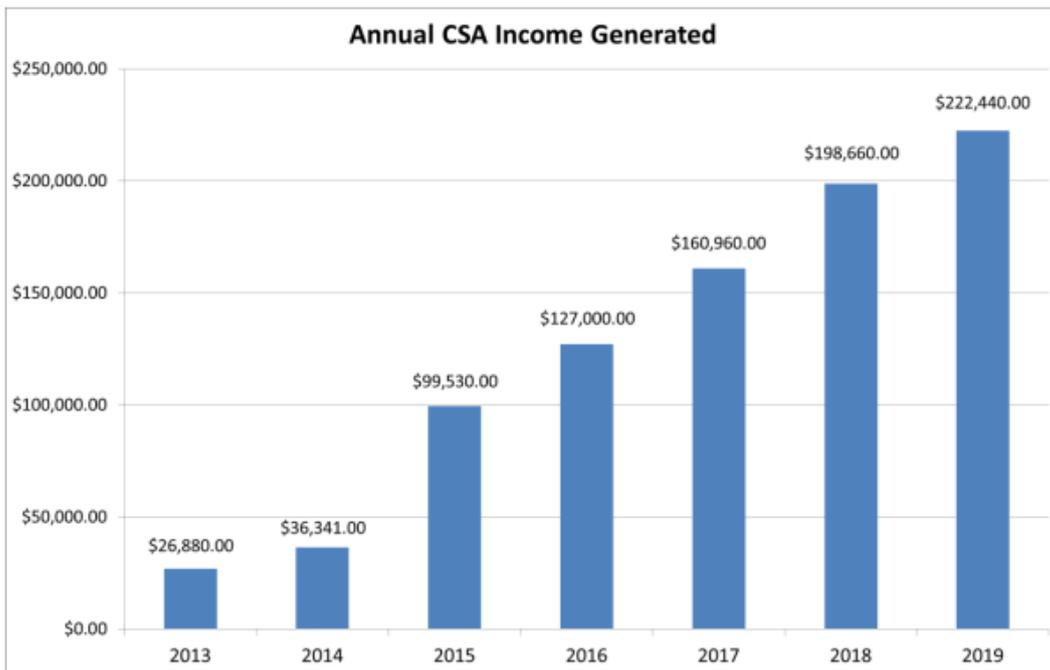
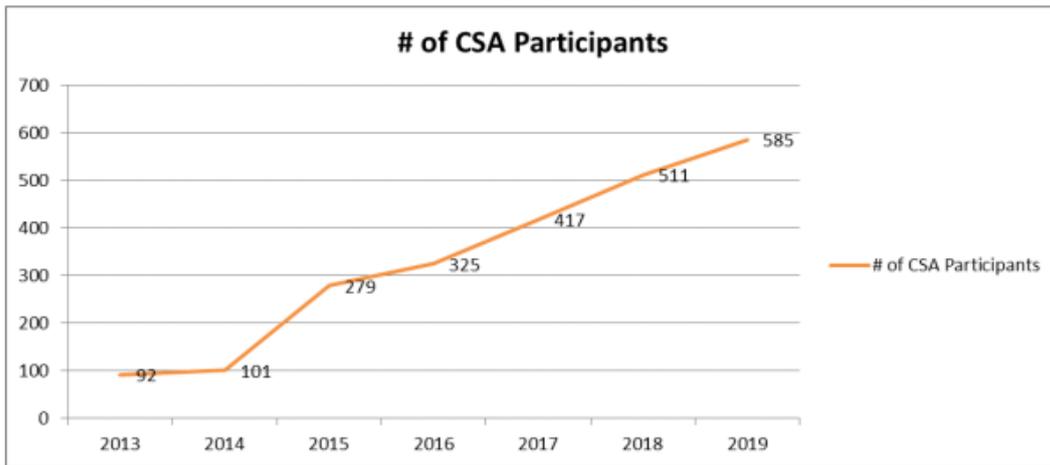
Beginning in 2018, St. Luke's opened a Wellness Center at the HOPE Easton Clinic with the mission to promote education, health services and access to resources in support of healthy living initiatives. In addition, this year community members were invited and programming was extended to our Bethlehem HOPE clinic and Diabetes Program. Programs were focused on wellness and chronic disease management and included physical activity, strength training, yoga, meditation and mindfulness, support groups, nutrition, and social activities. This year there were over 100 unique participants and over 1400 encounters for programming.

## **Employee Health Initiatives**

In order to assess and address the health needs of SLUHN employees and spouses, SLUHN has an established employee wellness initiative called *Caring Starts with You (CSWY)* that serves employees and their spouses.

Research shows that regularly eating a well-balanced diet and maintaining a healthy weight can help reduce risk for many health conditions, including high blood pressure, high cholesterol, high triglycerides, diabetes and certain cancers. According to the CDC, 76% of the US population did not meet fruit intake recommendations, and 87% did not meet vegetable intake recommendations. The CDC also states that “substantial new efforts are needed to build consumer demand for fruits and vegetables through competitive pricing, placement, and promotion in child care, schools, grocery stores, communities, and worksites.”

Increasing employee access to locally-grown produce through the expansion of the Community Supported Agriculture (CSA) program was a continued area of focus for SLUHN CSWY in 2018/2019. The program was offered network-wide for the fifth year, and currently serves 18 locations, including new distribution sites at our new campuses, St. Luke’s Sacred Heart, St. Luke’s Gnaden Huetten, and St. Luke’s Palmerton. The ability to provide weekly shares of produce is possible through sustained partnerships with local farmers throughout the Network’s region. At St. Luke’s Center, we also offer community shares to employees of other companies in the building. The program has grown from one farmer delivering weekly to three locations (during and prior to 2014) to 10 farmers delivering weekly to 18 locations throughout the network. CSA membership growth has increased year over year since 2013. This year, locally grown produce was provided to 585 people at 18 network locations in Pennsylvania and NJ. Over \$222,000 was generated and returned into the pockets of 10 local farmers. We used interns, residents and volunteers at distribution sites to aid with staffing. In 2018, 589 shares were donated to local soup kitchens and food pantries.



### Care Transformation: Diabetes Prevention and Management Initiatives

Diabetes Education Programs continue to grow throughout the network. The St. Luke’s Miners Diabetes Education Center expanded the Diabetes Accreditation Program (DEAP) to Southside Bethlehem in 2018. In FY18, there were 65 participants with 39 completing the program and this year there were 85 participants with 55 patients completing the program. Aggregate data showed participant improvements in all program metrics: BMI, A1C, Blood pressure, weight, total cholesterol, HDL, LDL and triglycerides. Additional sites have been set up in Allentown, Bethlehem and Easton to promote easy access for the clinic population in future years.

## **2.2 Research & Partnerships**

Our partnership with the Kellyn Foundation exposed medical students, residents, undergraduate and graduate students to the importance of consuming healthy, nutritious food and a plant-based diet for warding off chronic disease.

Additionally, we had members serving on the Lehigh Valley Food Policy Council Steering Committee as well as several work groups. We partnered with multiple agencies to promote food access, and nutrition information including Buy Fresh Buy Local (BFBL), Second Harvest Food Bank, WIC Office at Casa Guadalupe, and local health bureaus. For exercise our primary partners are Delaware & Lehigh National Heritage Corridor (D & L), Walk with a Doc, and Bike Works.

We continue to address the needs determined through our CHNA with collaborative partnerships at the local, regional, state and national levels.

### **Improving Mental and Behavioral Health**

Our goal is to improve the mental and behavioral health for residents in our region through prevention and access to appropriate, quality mental and behavioral health services while building infrastructure across our St. Luke's University Health Network (SLUHN) communities through the Department of Community Health & Preventive Medicine (CHPM). In order to address the mental and behavioral health outcomes of residents, our first step was to assess the mental health needs of the community using the CHNA and identify major challenges. Our 2019 CHNA revealed that approximately one third of our population experiences one or more poor mental health days when asked about the last 30 days. The 2017 PA Youth survey independently reported elevated rates of mental health issues among adolescents. 38% of all students felt depressed or sad most days in the past twelve months, with Monroe County having the highest rate (44%) in the network. Adolescents have also seen an increase in vaping. There has been a 900% increase in e-cigarette usage among high school students nationally from 2011 to 2015. The highest rate of electronic vapor product usage (8%) was found for the young adult 18-24 age group. In 2016, the Surgeon General declared youth

usage of vapor products to be a significant public health concern. There has been a 600% increase in synthetic opioid (fentanyl) deaths in the U.S. since 2013. Each county within the network saw rises in the rate of opioid overdose deaths, with Warren County having the most significant rate increase, from 7.0 (2007-2011) to 26.7 (2012-2016) per 100,000 residents. For binge drinking, 19% of network survey respondents reported at least one episode of binge drinking behavior and 7% reported at least 3 episodes of binge drinking behavior in the past month. Survey data indicated that the highest rate of binge drinking (18%) occurs in the 18-24 age group.

### **Prevention and Wellness**

Public health research has effectively indicated that changing the environment for communities can create effective behavior change. We have built infrastructure to support this as we continue to collaborate to include anti-bullying, mindfulness and yoga practices for staff and students into the behavioral health component of our Adopt a School Model at Bethlehem, Allentown, Bangor and Panther Valley School Districts. Districts such as Bethlehem and Allentown School are embarking on trauma informed care models with community partners such as SLUHN and the United Way.

Additionally, Employee Wellness launched SilverCloud across SLUHN. SilverCloud is an online behavioral health program for employees and their spouses, providing supported cognitive behavioral therapy content relating to anxiety, depression and stress. To date there are 2,679 SilverCloud users, and the program has demonstrated effectiveness and cost-effectiveness to the Network. The program was awarded a 1st place SLUHN Quality Award in 2019 based upon the outcome data from the 2-year pilot (2017-2019).

St. Luke's has assembled a team of highly qualified licensed athletic trainers that work within our schools setting a new standard for comprehensive training and sports medicine services. These services include 18 local high schools, 12 school districts, 5 Colleges, and over 28 youth organizations. Over 100 of the St. Luke's Athletic Trainers have been trained in Mental Health First Aid (MHFA). MHFA is an evidence based training operated under The National Council for Behavioral Health that provides the skills to identify and respond to someone who is experiencing a mental health crisis. MHFA is

endorsed by the US Department of Health and Human Services Substance Abuse and Mental Health Service Administration (SAMHSA). CHPM works closely with the Sports Medicine Department and is planning on expanding MHFA trainings through our collective efforts and programs.

### **Care Transformation**

SLUHN is committed to identifying new models of care to more effectively address mental health, including routine screening of all patients for behavioral health issues through PHQ-2/9, using Integrated Behavioral Health models, and through collaboration with other community agencies. In order to enhance the nature and scope of mental health interventions to fill gaps, improve effectiveness, reduce stigma, and identify and address problems early behavioral health services are being offered on the mobile vans. Each student seen on the Mobile Health Van is screened for behavioral health issues and services are provided by a licensed clinical social worker (LCSW), in partnership with Pinebrook Family Answers and United Way of the Greater Lehigh Valley. In the rural region, the Rural Health Center LCSW provides services on the Mobile Health Van and in the District. This service is offered in four different school districts (Allentown, Bethlehem, Bangor and Panther Valley). These programs are offered in conjunction with the schools and guidance counselors who are an integral part of care delivery.

Additionally, efforts have begun across SLUHN to increase the proportion of primary care facilities that provide mental health treatment through a collaborative care model or medical home/case management model. We have also increased depression screenings by primary care providers for adolescents and adults and are working towards building capacity for community-wide approaches to addressing mental health needs in the local communities served by SLUHN through a psychiatric residency program. We are also working towards the incorporation and support of mental health counseling services within the HeartsLink.

**National Prescription Drug Takeback Days:** This past year all St. Luke's Campuses participated in the DEA's 17th National Prescription Drug Take Back Days. The National Prescription Drug Take Back Day addresses a crucial public safety and public health issue by providing everyone with a safe method

to dispose of unwanted, prescription medications.

According to the 2015 National Survey on Drug Use and Health, 6.4 million Americans abused controlled prescription drugs. The study shows that a majority of abused prescription drugs were obtained from family and friends, often from the home medicine cabinet. The majority of teenagers abusing prescription drugs get them from family and friends – and the home medicine cabinet. In addition to overdose and abuse, unused or expired prescription medications are also a leading cause of accidental poisoning. Too often, unused prescription drugs find their way into the wrong hands and can lead to dangerous and tragic situations. Pharmaceutical drugs can be just as dangerous as street drugs when taken without a prescription or a doctor's supervision. The non-medical use of prescription drugs ranks second only to marijuana as the most common form of drug abuse in America.

Unused prescription drugs thrown in the trash can be retrieved and abused or illegally sold. Unused drugs that are flushed contaminate the water supply. Proper disposal of unused drugs saves lives and protects the environment. National Drug Take Back Day provides everyone an opportunity to do your part to help prevent drug addiction and overdose deaths. It is also a method for everyone to clean out your medicine cabinet and safely and anonymously turn in your old prescription drugs.

In 2018, all St. Luke's campuses participated in the both the spring and fall Take Back Days and collected 612 pounds of unwanted medications.

### **Research & Partnerships**

Collaborations with area institutions of higher education to build a strong provider base continue to grow and develop with Lehigh University, DeSales University and the Lewis Katz School of Medicine at Temple University. CHPM and Behavioral Health at SLUHN have been actively involved in county and health bureau suicide and opioid task forces to combat the opioid epidemics currently being faced by our communities. There are opioid task forces in communities serving Bethlehem, Allentown, Anderson, Gnadon, Quakertown, Miners, Monroe, Warren, and Quakertown campuses. The intent is to build better collaboration between systems, particularly the county and the hospi-

tal, to ensure people seeking care are referred to and connected to recovery services and integrate the Warm Hand Off (WHO) process, that has proven success in Lehigh county.

According to Lehigh County Drug and Alcohol, the 2015 Opioid Death Rate Data, Lehigh County SCA and all of the Hospitals in Lehigh County recognized that additional support for people struggling with addiction during the critical moment when someone has experienced a medical emergency could save lives. In response, the Lehigh County SCA and all Lehigh County based hospitals partnered on the HOST (The Hospital Opioid Support Team) program which provides that additional support for people struggling with addiction when they are at the hospital for an emergency. HOST services began on January 1, 2017. Since that time, 841 referrals have been made! By comparison, in 2016 – a combined 39 referrals were made for the year. The HOST is an example of what can occur when positive collaborations in our community are made. Funding for the HOST program is made possible by the Lehigh County Department of Drug & Alcohol Abuse Services: <https://home.lehighcounty.org/DrugAndAlcohol/Response>. This past year, CHPM attended regional WHO meetings sponsored by the PA Department of Drug and Alcohol and the Department of Health to strengthen and operationalize our network opioid response planning and implementation.

Work is also under way to develop Trauma Sensitive Programs. This United Way led effort would allow partnerships with community organizations to implement trauma sensitive programs in partner schools and provide training for SLUHN department and service line staff to provide trauma sensitive care to patients. Mindfulness initiatives are being strategically built within the Adopt a School model to address resiliency within the community schools using the Trauma Informed Care Model.

In September 2018, St. Luke's Miners (SLM) was awarded a U.S. Department of Health and Human Services Health Resource and Service Administration (HRSA) Federal Office of Rural Health Policy (FORHP) Rural Pennsylvania Community Consortium Opioid Response Plan Grant. Through this grant, community partners developed a regional response including OUD/SUD gap analysis, comprehensive strategic, workforce and sustainability plans that fo-

cus on prevention, treatment and recovery efforts for Carbon and Schuylkill Counties as part of the Surgeon General's Call to Action spotlight on Opioids. Stigma, transportation and cost of treatment prevent most from accessing treatment and recovery. The multi-sectoral consortium is led by SLM CHPM and rural health centers and includes Panther Valley (PVSD), Tamaqua Area School Districts (TASD), Child Development, Inc. (Schuylkill Head Start program), PathStone Corporation (Carbon Head Start program, Schuylkill County's VISION and several local and grassroots organizations and partners. *"This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$200,000 with 43% percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government."*

In addition to OUD/SUD response planning, collaboration with county Opioid Task Forces and improving the Warm Hand Off programs at each campus, St. Luke's is working with county drug and alcohol offices, department of drug and alcohol, regional center of excellence treatment centers and other state and local partners to further improve prevention, treatment and recovery programs such as stigma reduction and naloxone education and distribution, integrative Medically Assisted Treatment, counseling services and evidence based practices and trainings such as Mental Health First Aid and SBIRT (Screening, Brief Interaction and Referral to Treatment).

# 3

SECTION

## **Health For All: Improving Access to Care & Reducing Health Disparities**

The Health For All initiative addresses CHNA goals related to Improving Access to Care and Reducing Health Disparities, Preventing Chronic Disease, Improving Mental and Behavioral Health, Improving Child and Adolescent Health and Improving Elder Health.

### **3.1 Prevention & Wellness:**

#### **Dental Initiative**

The Dental Program continues to experience growth and exciting new changes. Effective January 1, 2019, all six existing dental sites transitioned to Star Wellness Center Inc, along with several other community sites. The dental locations are striving to become a Federally Qualify Health Center (FQHC). The operations service goal for Star Wellness is to be able to provide better access to availability for our patients, regardless of their ability to pay. One significant benefit of becoming an FQHC is the ability to offer patients who are uninsured or underinsured our sliding fee scale program. By utilizing this program, patients are billed according to their family's size and income level. Since the transition, our dental offices have experienced an influx of patients who are all very excited at the opportunity for affordable dental care. Patients

who previously may have elected to extract a tooth due to it being the most effective option in past, are now choosing alternative options to save and re-store their tooth. See attached graphs for dental.

|                     | <b>FY19 Visits</b>   | <b>FY18 Visits</b>   | <b>Increase</b>    |
|---------------------|----------------------|----------------------|--------------------|
| <u>Fowler</u>       | 7,704                | 6,735                | 14%                |
| <u>Sigal</u>        | 5,582                | 4,634                | 20%                |
| <u>Easton</u>       | 4,205                | 4,142                | 1.5%               |
| <u>D1</u>           | 1,752                | 1,786                | -1.9%              |
| <u>D2</u>           | 1,597                | 1,891                | -15.5%             |
| <u>D3</u>           | 1,169                | 1,297                | -9.9%              |
| <b><u>Total</u></b> | <b><u>22,009</u></b> | <b><u>20,485</u></b> | <b><u>7.4%</u></b> |

|                     | <b>FY19 Production</b>  | <b>FY18 Production</b>  | <b>Increase</b>     |
|---------------------|-------------------------|-------------------------|---------------------|
| <u>Fowler</u>       | 1,472,106               | 1,136,988               | 29%                 |
| <u>Sigal</u>        |                         |                         |                     |
| <u>Easton</u>       | 913,986                 | 756,217                 | 20.8%               |
| <u>D1</u>           | 529,010                 | 469,251                 | 12.7%               |
| <u>D2</u>           | 417,631                 | 399,625                 | 4.5%                |
| <u>D3</u>           |                         |                         |                     |
| <b><u>Total</u></b> | <b><u>3,332,733</u></b> | <b><u>2,762,081</u></b> | <b><u>20.6%</u></b> |

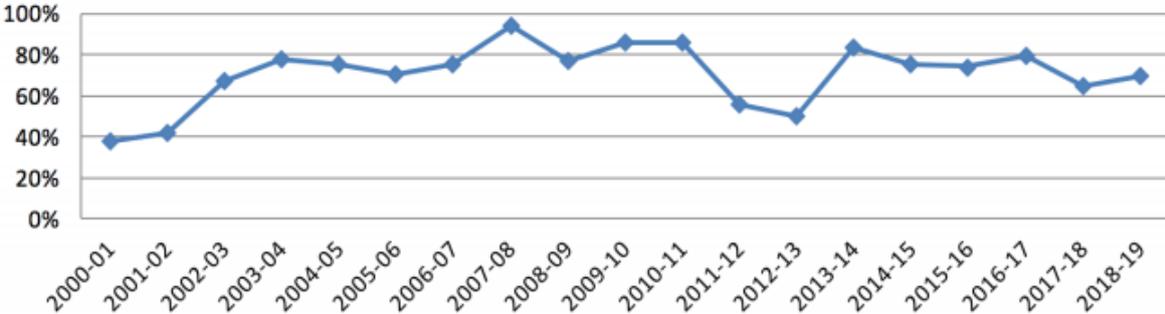
**Adolescent Career Mentoring Initiatives**

Adolescent Career Mentoring Initiatives provide career mentoring programming for in-school and out-of-school youth in Lehigh (PA), Northampton (PA), and Warren (NJ) Counties, through a combination of hospital rotations, professional development sessions, and/or work experience. Initiatives include the School-To-Work Program, Health Career Exploration Program, Next Step, and the CareerLinking Academy programs in Bangor, Bethlehem, Allentown, and Phillipsburg (NJ). The programs focus on increasing graduation rates in high risk populations, improving English language skills for English as a Second Language Learners. This is done by providing work experience for high school students and graduates in the healthcare field, while teaching

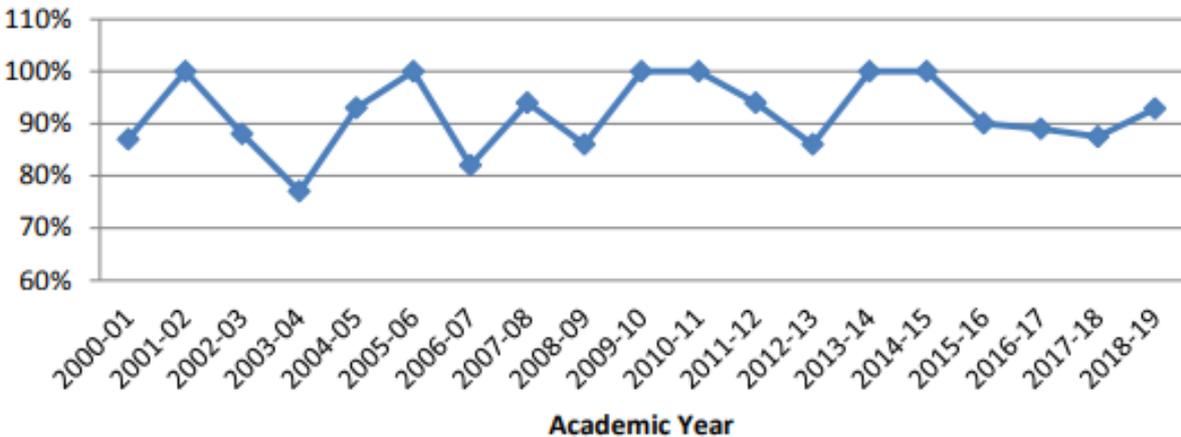
job keeping and job seeking skills, further diversifying the healthcare workforce.

*School-To-Work Program (STW):* In collaboration with the Bethlehem Area School District, the STW Program was created to improve graduation rates, lower absenteeism, and encourage students toward post-secondary education. The STW Program provides English as a Second Language students the opportunity to explore healthcare careers. Its intent is to engage at-risk students to remain in school by exposing them to health careers, to offer support and guidance as they work to achieve fluency in English, and to obtain valuable career and life skills. The St. Luke’s School-To-Work Program completed twenty-two years since inception and has served 335 students with a high school graduation rate of 92%. The average enrollment in post-secondary education is 72%.

**School to Work  
Enrollment in Post-Secondary Education**

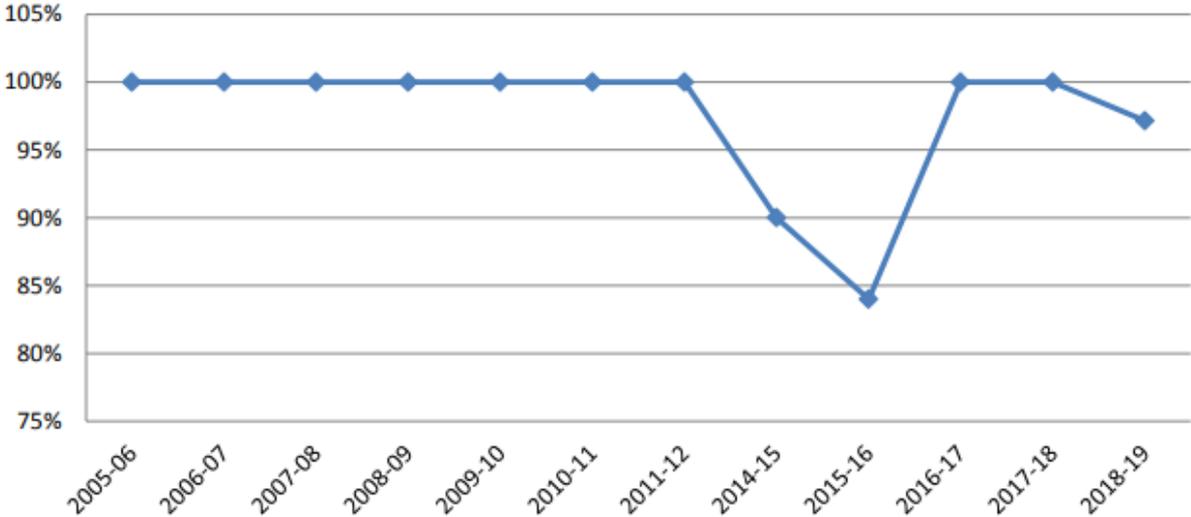


**School to Work Graduation Rate**

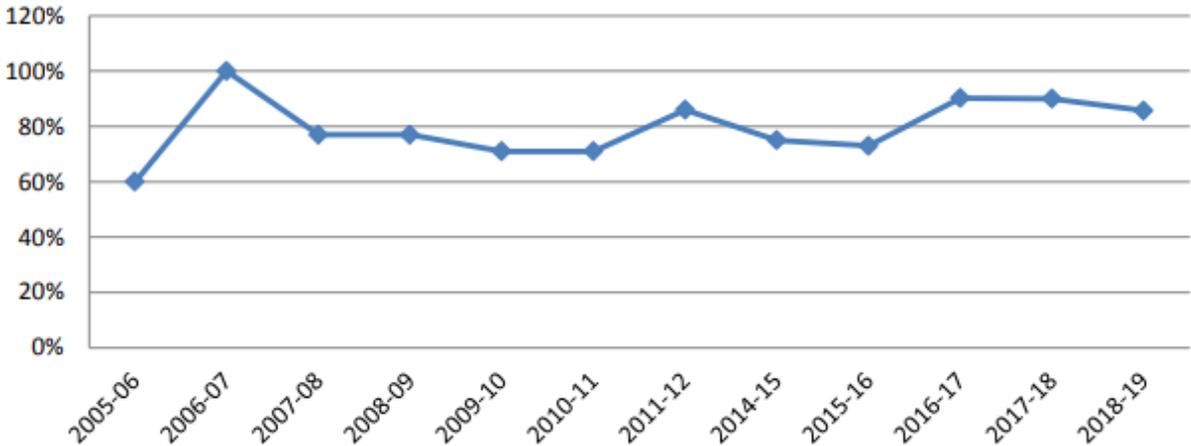


*Health Career Exploration Program (HCEP):* In collaboration with the Bethlehem Area School District, Allentown School District and the Workforce Board Lehigh Valley, the HCEP program provides employability skills training and unsubsidized work experiences at St. Luke’s Bethlehem, Allentown, Anderson and Sacred Heart Campuses for high school seniors during the summer and academic year. This year we served 35 students, of which 34 graduated from high school. Some of the colleges the students will be attending during the 2019-2020 academic year include: Northampton Community College, Lehigh Carbon Community College, Temple University, LaSalle University – Allentown Campus, Cedar Crest College, Penn State – Lehigh Valley, Kutztown University and Thomas Jefferson University.

**HCEP Graduation Rate**



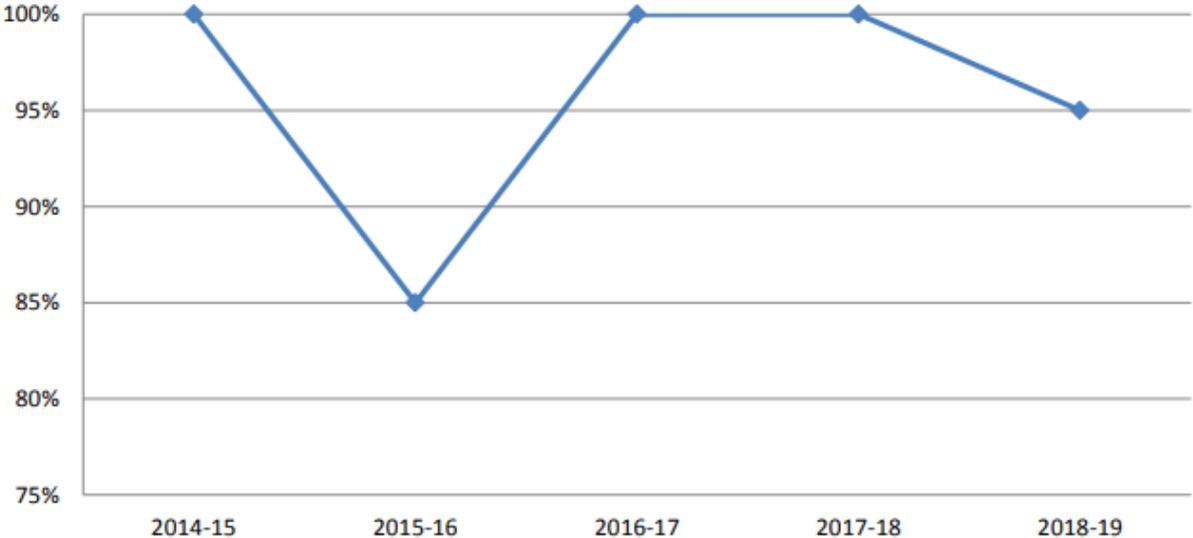
**HCEP Enrollment in Post-Secondary Education**



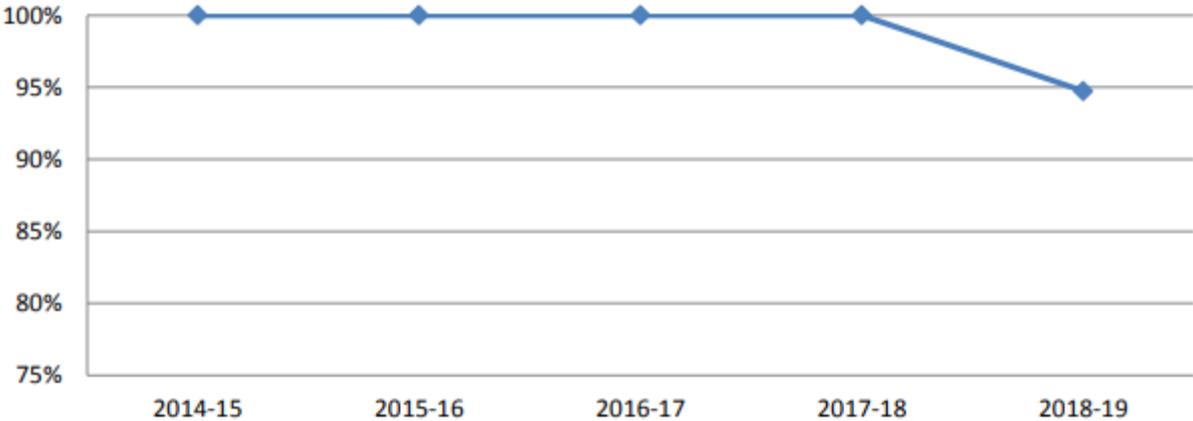
*CareerLinking Academy Program (CLA)* In collaboration with the Bethlehem

Area School District, Allentown School District, Bangor Area School District and Phillipsburg School District, the CLA program combines observational learning experiences and professional development sessions focusing on exposure to healthcare careers with job readiness skills training. This program served 45 students this year and 88% (40) of the youth were seniors. Ninety-five percent (38) of the seniors graduated high school and 36 of them will attend college while one student is joining the military. In the past five years, 150 students from four different school districts have participated in the CareerLinking Academy Programs.

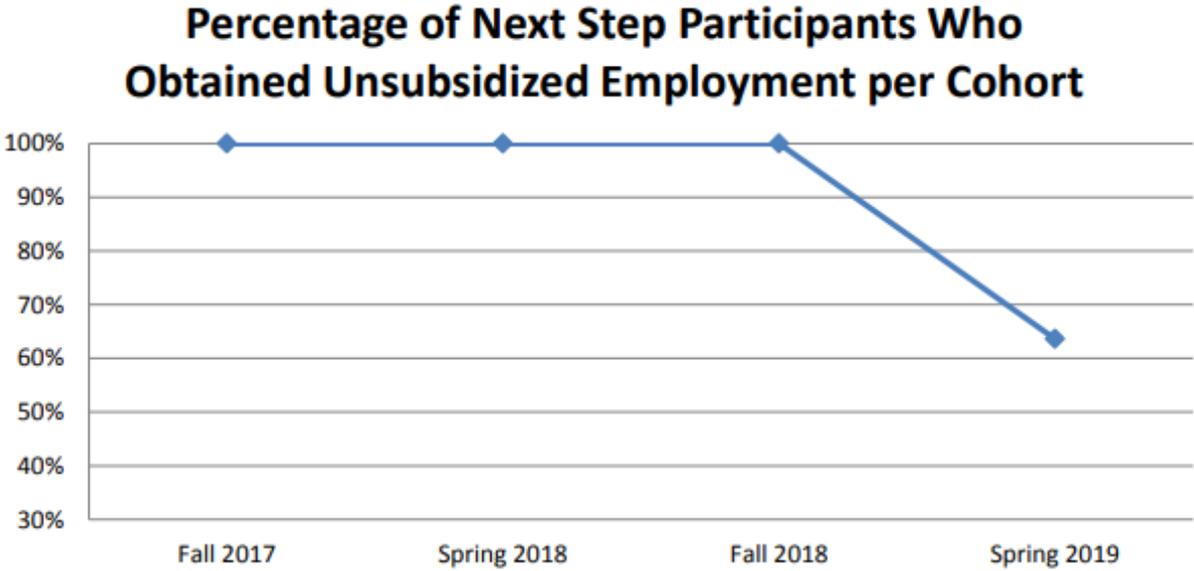
**CareerLinking Academy Graduation Rate**



**CareerLinking Academy Enrollment in Post-Secondary Education**



*Next Step Program (NSP):* In collaboration with Workforce Board Lehigh Valley and the St. Luke's Nurse Family Partnership, the NSP provides employability skills training and subsidized work experience for out-of-school youth aged 17 to 24 years old at the Bethlehem & Allentown Campuses, and various St. Luke's Physician Group locations. This program places youth in entry-level positions available at St. Luke's University Health Network (SLUHN) for a total of 520 hours of work experience. This year 20 youth were enrolled in the program and 80% (16) completed it. Seventy-five percent (12) of the youth participating in this program were gainfully employed at the end of the program, with 58% employed at St. Luke's.



*Quakertown Campus Mentoring Program:* Medical Career Pathways Program served 24 students from Quakertown High School and Palisades High School. The program included lectures and interactive sessions with health care professionals and clinical rotations.

### **Success of the Programs**

In the fiscal year 2018-19, we served 89 high school seniors from a total of 150 youth. We have an overall graduation rate of 96% (85/89) and 88% (75/85) of the seniors will enter post-secondary education. Schools the students will be attending include: Lehigh Carbon Community College, Northampton Community College, LaSalle University (Allentown campus), Kutztown University, Penn State Lehigh Valley and Harrisburg, Thomas Jefferson University, Cedar Crest College and Moravian College, Franklin and Marshall College, Arcadia University, and Fairfield University in Connecticut. Most of the students are on a science track to pursue careers in medicine. Additionally, six seniors who participated in our programs from the Bethlehem Area School District received scholarships during the District's Minority Awards Ceremony. Every one of our CareerLinking Academy students served as the Mistress of Ceremony. Furthermore, the out-of-school youth program served 20 youth. Eighty percent (16) graduated from the program and 75% (12) of those who graduated were gainfully employed.

## **3.2 Care Transformation**

### **Community Outreach**

*Parish Nursing* is a subspecialty of nursing that works with individuals and groups on the path to optimal health for all through body, mind, spirit and social aspects of each person's life. The foundation for this work is that each person has intrinsic beauty, dignity and value. The Parish Nursing/Community Outreach Department staff works primarily with those residents in the urban core of Allentown who are impoverished and/or either at risk for homelessness or are homeless. The Parish Nursing Department has been working in the urban core of Allentown since 2003.

The department goal is to assist 1,000 unique (unduplicated) individuals in Lehigh County in the creation of their self-determined wellness goals; walk

beside them in the pursuit of their goals; give them the resources and education to become independent in their own health and wellness care; and finally reduce health care costs for the clients and the community. The staff works to connect each person to their choice of primary care physician and then continues to follow them, if they allow, so that they can meet their health-care goals.

The process with which we engage the clients is as follows:

1. Meet the client in their safe space
2. Build a relationship
3. Assist the individual in creating their self (client) – determined health-care goals
4. Walk beside them offering opportunities (resources) to meet established goals
5. Encourage the client to become self-sufficient
6. Never re-traumatize the client
7. Remember the client can refuse our care at any point

In FY 2019 statistics revealed the following:

| <b>Category</b>                            | <b>Productivity</b>            |
|--|--------------------------------|
| Unique Individuals (including new)         | 1,964                          |
| New Individuals (in 10 months)             | 824                            |
| 7-site Encounters made face to face        | 5,552                          |
| Contacts by text, phone or email           | 5,755                          |
| Resources/ referrals given (approximately) | 2,855                          |
| Formal health education programs offered   | 81 programs for 1,712 learners |

We provided referrals, advocacy and/or funding for:

1. 74 state IDs for clients so that they could enter into the queues for housing, employment, and healthcare.
2. 64 clients to obtain medication, prior to having medical insurance, in order to maintain stability.
3. 4 clients' housing needs; also connected 100 people/ families to housing queue
4. 255 clients with transportation assistance to get to work and healthcare appointments.
5. 84 clients connected to mental health treatment
6. 193 clients to obtain insurance
7. 7 individuals to obtain employment

Parish Nursing, in collaboration with the Parish Nurse Coalition of the Greater Lehigh Valley's Councils on Education and Spirituality, has been educating nurses in the subspecialty of Parish Nursing since 1999. In the twenty years that we have offered this education, over 800 people, primarily registered nurses have participated in this education. We continued to offer *Foundations of Faith Community Nursing Education* annually with the cooperation of St. Luke's Staff Development after the unification of Sacred Heart Hospital and St. Luke's University Health Network in FY 2019. The number of nurses educated has grown. In FY 2019, 99 people took advantage of the education offered through *Foundations* as well as three free seminars, all of which were offered to nurses in the SLUHN and beyond. SLUHN is quickly becoming the network of choice to receive parish/faith community nursing focused education.

### **3.3 Research & Partnerships**

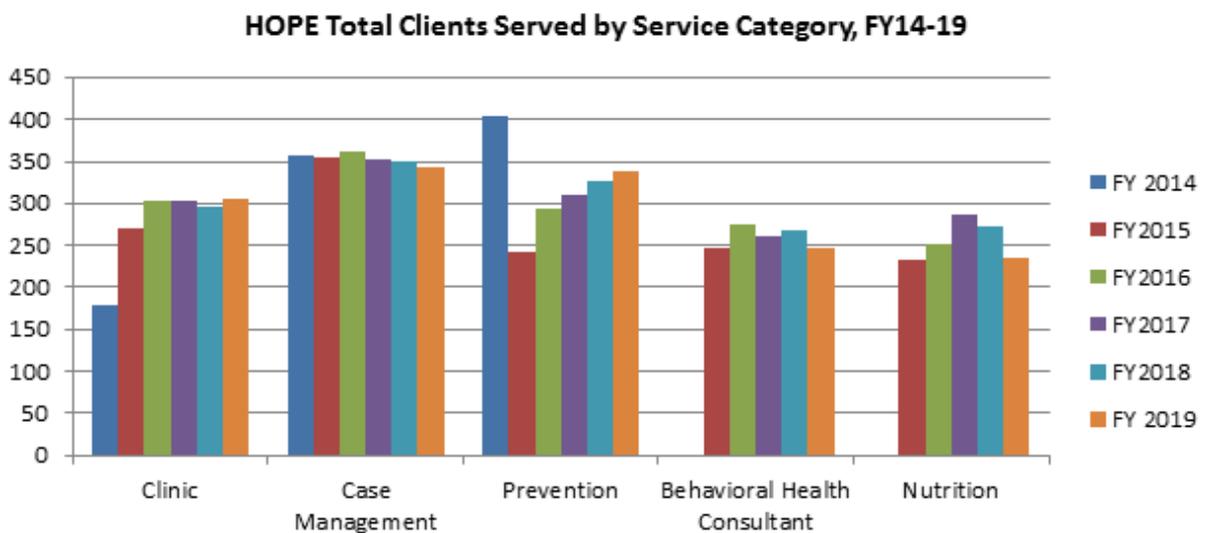
*The HOPE Program:* The National HIV/AIDS Strategy has four primary goals:

1. Reduce new HIV infections.
2. Increase access to care and improve health outcomes for people living with HIV.

3. Reduce HIV-related disparities and health inequities.
4. Achieve a more coordinated national response to the HIV epidemic.

The new vision of the strategy states that the United States will become a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

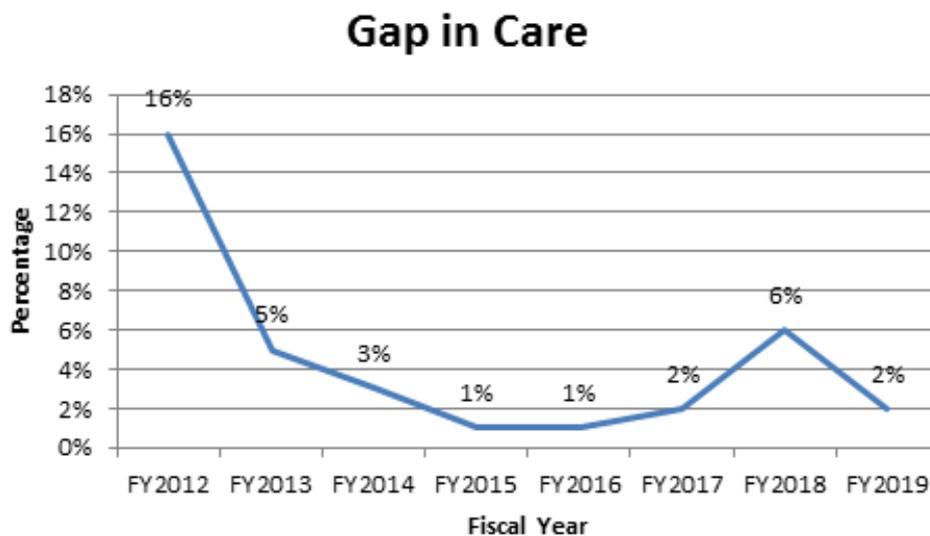
At St. Luke’s AIDS Service Center (ASC), staff strives to meet the national vision by providing rapid HIV testing and prevention services, comprehensive primary and specialty care, case management and social support services, housing case management services and integrated behavioral health services to HIV+ or high-risk individuals. This past year, services were funded by the U.S. Department of Health and Human Services through its Health Resources and Services Administration (HRSA) Ryan White grant program, AIDSNET, and the PA Department of Health.



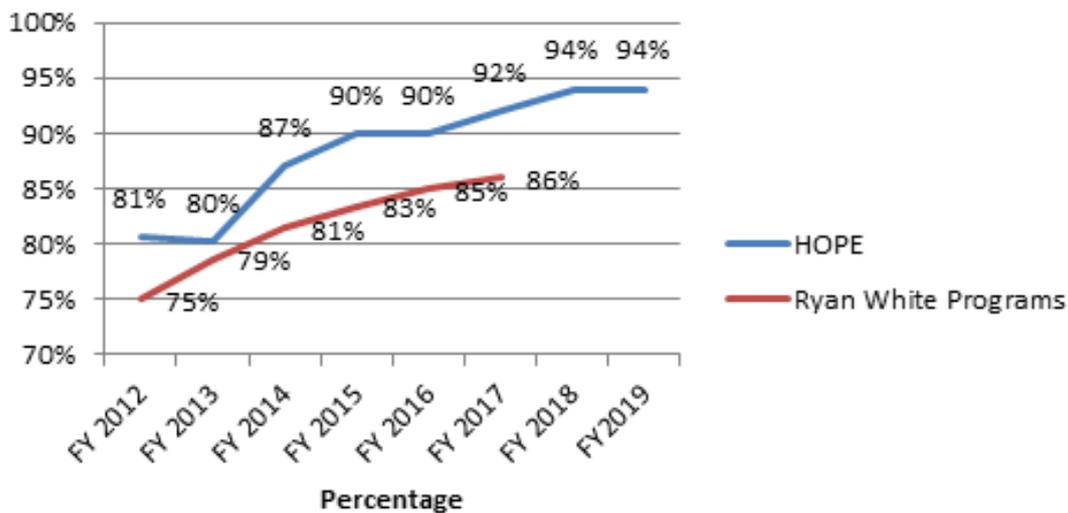
FY 19’ has been a year of growth for HOPE at St. Luke’s Hospital. HOPE initiated a new quality improvement project, Provider-Initiated Opt-Out HIV Testing to increase HIV testing rates among family medicine, internal medicine, and pediatric practices in the St. Luke’s network. The current testing rate for the outpatient network is 3.14%. HOPE provided comprehensive clinical care and case management services to a total of 400 unduplicated patients. The Ryan White Part C grant funding was extended until March 2021 to support

our clinics in Bethlehem and Easton. Moreover, economic benefits of moving patients from unsuppressed to suppressed viral loads in the past year indicate total medical costs averted due to HOPE care was \$293,243. 47 new patients enrolled in our comprehensive HIV clinical services – 23 in Easton and 24 in Bethlehem.

Overall, 94% of our patients have a suppressed viral load, and only 2% of patients were viewed as out of care (no visit in the past 6 months) as of the end of FY18. Additionally, 86% of our patients were considered to be retained and appropriately receiving HIV and primary care services at least every 6 months over the previous two years. Tobacco cessation counseling was at 82%. Success continued for the ARTAS program (a program to reconnect people living with HIV/AIDS to clinical care) with 86% of patients linked during FY19 being retained in their medical care. Considering all 4 quarters of the fiscal year, Partnership for Health completed 99% of eligible prevention sessions during HIV appointments.



## Viral Load Suppression



### 3.4 Hispanic Center Lehigh Valley

On May 31, 2019, the Hispanic Center Lehigh Valley opened the Fowler Community Wellness center. Since its opening, families and adults with limited resources have received services that build the health and wellness of young children, assist adults with becoming financially stable through career planning and employment, and provide mental & physical health and wellness care. With thanks to the generous support of donors, HCLV’s aging Southside facilities have been extensively renovated, and programs and services have also been expanded and more people are receiving help than ever before.

#### **Basilio Huertas Senior Center**

The center provides seniors 60 years of age and older access to resources that help them stay active and independent, such as social activities, health screenings, educational activities, and assistance navigating health and human services. The program includes a healthy breakfast and lunch daily. – *87 unduplicated seniors served.*

#### **Food Pantry**

Each month, four opportunities to receive a three-day emergency supply of food are provided to individuals residing in zip codes 18015 and 18020 through the food pantry. Users who are experiencing broader needs are encouraged to use, and connect with, HCLV’s case management services. – *755 undupli-*

*cated clients served from 277 households*

### **Haggerty, Goldberg, Schleifer, & Kupersmith, (HGSK) P.C. Law**

The HGSK legal team provides free legal consultation on personal injuries, workers' compensation, car accidents, slip & fall, Social Security, disability, and medical malpractice.

### **Bethlehem Employment and Training Center**

BETC provides services such as information sessions, workshops in resume writing, online job research, and interviewing skills to community members.<sup>364</sup> *unduplicated clients served, secured 137 jobs, and provided 1,970 information sessions on jobs seeking & keeping skills.*

### **Community Empowerment Program (CEP)**

CEP provides resources to stabilize individuals and families in crisis, enable educational success, and promote financial independence. For employment needs, staff works closely with the co-located Bethlehem Employment and Training Center. All services are designed to help clients improve their self-sufficiency. *794 unduplicated clients served*

In addition, the Community Empowerment Program served 425 unduplicated individuals affected by Hurricane Maria. Services included:

|   |    |
|---|----|
| # Connected to the LV Outreach Depot for Furniture            | 37 |
| #Connected to Salvation Army                                  | 12 |
| #Served by the HCLV Food Pantry                               | 31 |
| # Winter coats distributed                                    |    |
| # Provided rental assistance ranging from 300 to 100,000      | 11 |
| # Provided rental assistance through FEMA grant (\$38,283,32) | 9  |

### **Pinebrook Family Answers (PFA)**

PFA offers individual, group, and family therapy for children, adolescents and adults that incorporates knowledge about the impact of trauma and recovery. Additionally, education on behavioral health and self-care supplements therapeutic approaches.

### **Women, Infants, and Children Services**

WIC helps pregnant women, new mothers, and children up to age 5 learn about nutrition, make healthy food choices, and improve overall health. Participants receive education on infant and child feeding, child development information and assessments, and vouchers to purchase healthy foods at grocery stores and local farmers markets that help support proper growth and development. *20,150 encounters serving women and children in the area.*

### **H.O.P.E. Clinic at St. Luke's Bethlehem**

H.O.P.E. clinic is fully-funded by the Ryan White grant program, and provides comprehensive care to mostly uninsured and/or underinsured individuals living with or affected by HIV/AIDS. Services include primary and specialty care, treatment and disease prevention, case management, 10 advocacy and stigma reduction, counseling and education, and legal referrals. All services are confidential and provided by bilingual and bicultural staff. *See HOPE Clinic report.*

### **HEARTS Clinic**

The HEARTS (Health, Education, Advocacy and Resources at Temple-St. Luke's) Clinic is a free health & wellness clinic that serves uninsured and underinsured members of the community. The clinic operates on the third Saturday of each month. *167 unduplicated clients served. Other Services Provided.*

# 4

SECTION

## Healthy Kids, Bright Futures

The Healthy Kids, Bright Futures initiative addresses CHNA goals related to Improving Access to Care and Reducing Health Disparities, Preventing Chronic Disease, Improving Mental and Behavioral Health and Improving Child and Adolescent Health.

### **4.1 Maternal Child Health Programs**

The Maternal Child Health initiatives consist of two distinct programs: the Nurse-Family Partnership (NFP) and the Visiting Nurse Advocates of the County (VNAC). These community health programs are implemented through collaboration with the Visiting Nurse Association of St. Luke's and CHPM. The initiative addresses child health issues by working with families in their home and community.

*Nurse-Family Partnership Program (NFP):* The NFP program is an evidence-based, nurse (RN) lead, home visitation program for first-time low income mothers less than 28 weeks gestation. It is rooted in a foundation of prevention, and focuses on multi-generational change as a means to transform health and wellness across the lifespan. This national program is based on over 40 years of research and has been implemented by the VNA of St. Luke's since 2001. The program works to obtain 3 main goals:

1. Improve birth outcomes
2. Improve childhood health and development
3. Improve the economic self-sufficiency of the Mother/family

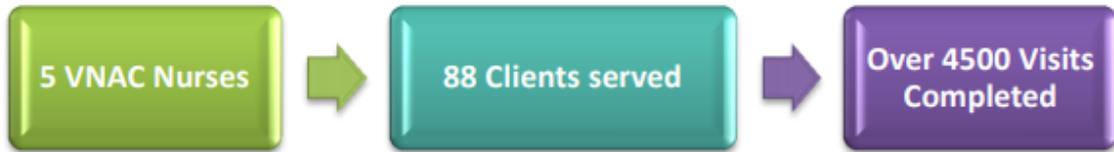
Our highly trained NFP nurses give our clients valuable knowledge and support throughout pregnancy up until their child reaches two years of age. Through education, mentorship, clinical assessment, care coordination, and empowerment, this program can create lasting health and behavioral change for both mother and baby. At any one time, we have the capacity to serve 250 families with a rolling admissions and discharge. See the total number of families served and visits for the year below.



*The Visiting Nurse Advocates of the County (VNAC)* VNAC is an intervention program that works with families currently involved with the county children and youth system. The VNAC RN's work as an advocate for the child, while educating the families on how to provide a safe, nurturing, and healthy environment that will allow their child to thrive and develop. Interventions are designed to prevent future instances of abuse, neglect, or childhood maltreatment. The VNAC program works in tandem with the Lehigh and Northampton County Office of Children and Youth to meet the following 4 goals with the families they are serving:

1. Parent will provide a safe environment for the child
2. Parent and child will have safe and positive interactions
3. Parent will increase knowledge of parenting and improve parenting skills
4. Parent will meet the child's health/ medical needs

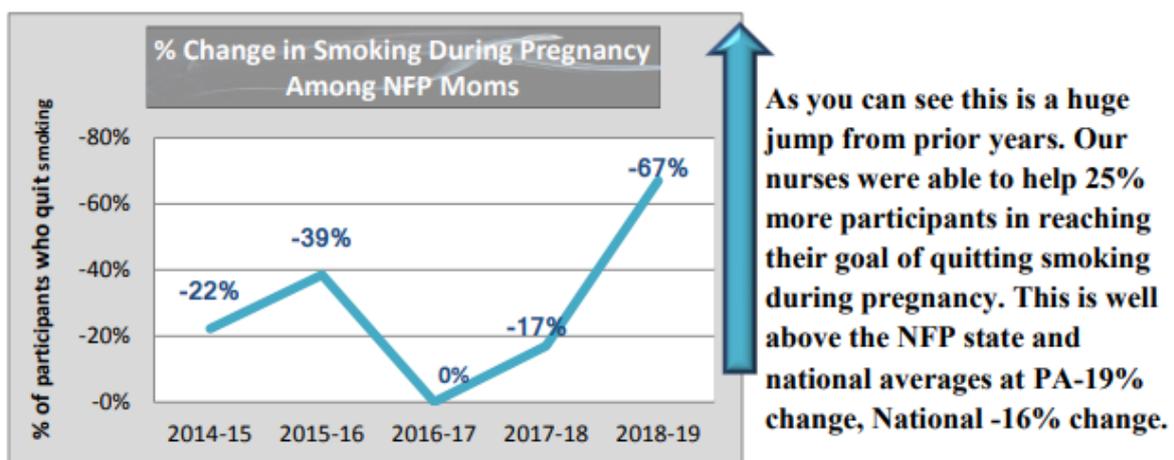
VNAC nurses work to meet these goals by providing intensively focused services aimed at family support, life skills development, parenting education, case management services, and acting as an advocate for the child.



## Prevention and Wellness

The MCH programs both seek to prevent future illness, disease, and childhood trauma. The NFP program is, at its core, a prevention program aiming to prevent childhood health issues starting in pregnancy. Low-income families are extremely vulnerable to health system inequities and often face multiple social determinants of health such as homelessness, food insecurity, poor living and working environments, educational and literacy disparities, and poor social supports and coping skills. These social determinants play a huge role in attaining positive health behaviors when compared to society as a whole. Programs like NFP and VNAC work to help reduce these disparities by providing support and education while tracking our outcomes on health, wellness, and life course development outcomes. Below you can see some general statistics on prevention based measures for our programs in FY18-19.

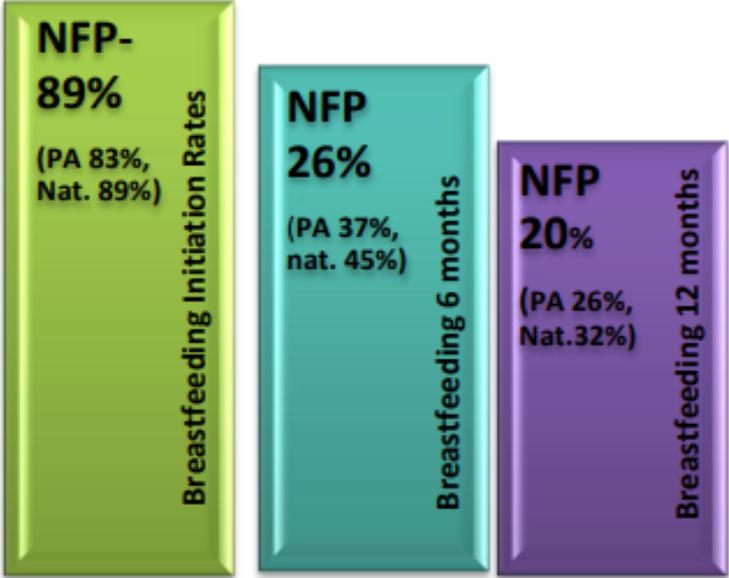
## NFP Smoking Cessation Statistics



## Breastfeeding Education

Breastfeeding is the best source of nutrition for most infants. It can also reduce the risk for some short and long-term health conditions for both infants

and mothers. That is why our highly trained NFP nurses educate and encourage participants to breastfeed. According to the CDC, breastfeeding has been linked to reduced risk of pediatric obesity, asthma, ear infections, SIDS, and GI illnesses in babies. For mothers, breastfeeding can reduce the risk of developing high blood pressure, type two diabetes, ovarian cancer, and breast cancer.



The Visiting Nurse Advocates spend a great deal of time on prevention education, promoting a safe environment, and helping individuals to use health care appropriately.

**VNAC Outcomes On Discharge:**

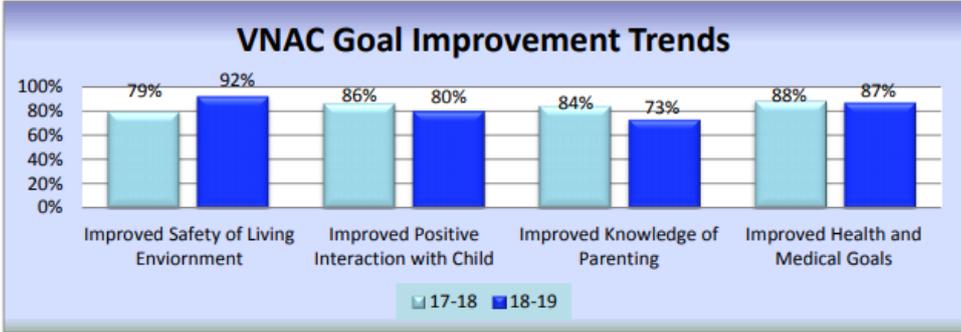
97% of children seen in VNAC program had a safe sleep environment.

95% of VNAC families were using the ER appropriately

**Care Transformation**

The MCH programs serve as community facing care coordination models that act as an extension to the traditional system of primary care. The MCH nurses can assist traditional health care providers with care coordination,

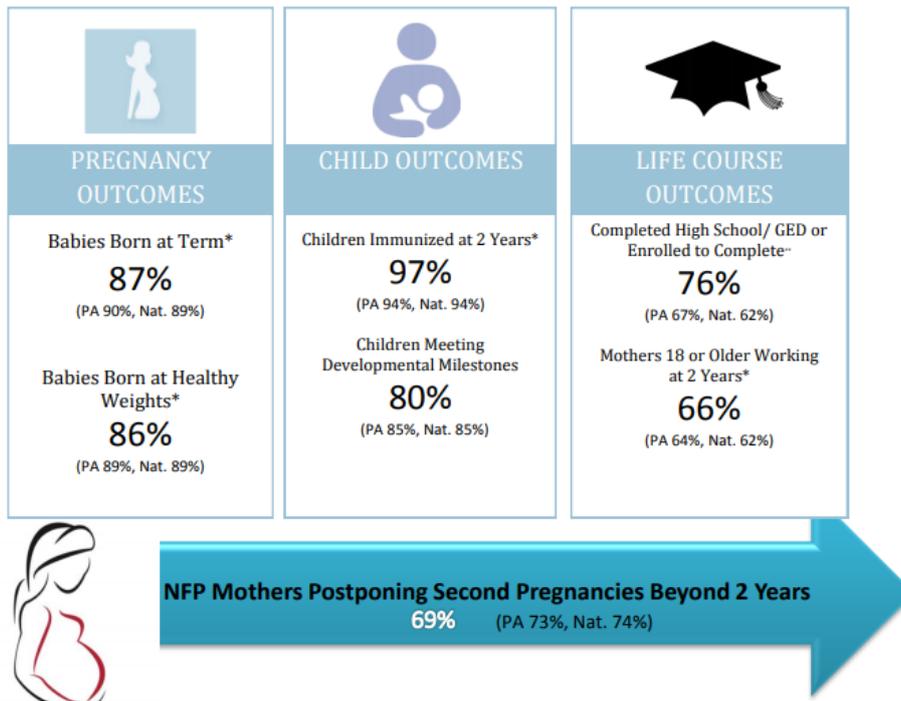
community connection, and clinical assessment in the home. In both of the MCH home visitation programs, nurses work to help families overcome barriers to obtaining insurance, medical homes, and maintain preventative & specialty care appointments with their doctors. They are often called upon to obtain weights, blood pressures, and basic assessment that can be relayed back to their health care provider if needed. Additionally, nurses provide education on a variety health & safety issues in an attempt to reduce unintentional injuries and preventable illness. The assessment of the home environment provides nurses with a holistic view point that allows them to create a meaningful care plan that address both physical health issues while maintaining a focus on the social determinants of health that may be impeding the attainment of true health and wellness. Below you can see some of our outcomes related to care transformation FY 18-19.



| VNAC Outcomes (On Discharge)    | 2017-18 | 2018-19 |
|---------------------------------|---------|---------|
| Connection to Immunizations     | 96%     | 98%     |
| Up to date on Well-Child Checks | 94%     | 100%    |
| Connection to Insurance         | 100%    | 96%     |
| Connection to Medical home      | 100%    | 96%     |

**Research & Partnerships**

The MCH programs are designed to be holistic and community focused. The programs could not be successful without our many partners. It takes a village to care for a village and without the support of our partners we would not be able to address the complex needs of the clients we are serving. The NFP program works with: OBGYNS, pregnancy testing centers, schools, homeless shelter, and other community organizations for referrals. We refer families to various agencies for support to connect them with housing, IPV assistance, insurance, education, early intervention, career development, food, and education. The NFP program also works closely with our Next Step Career Men-



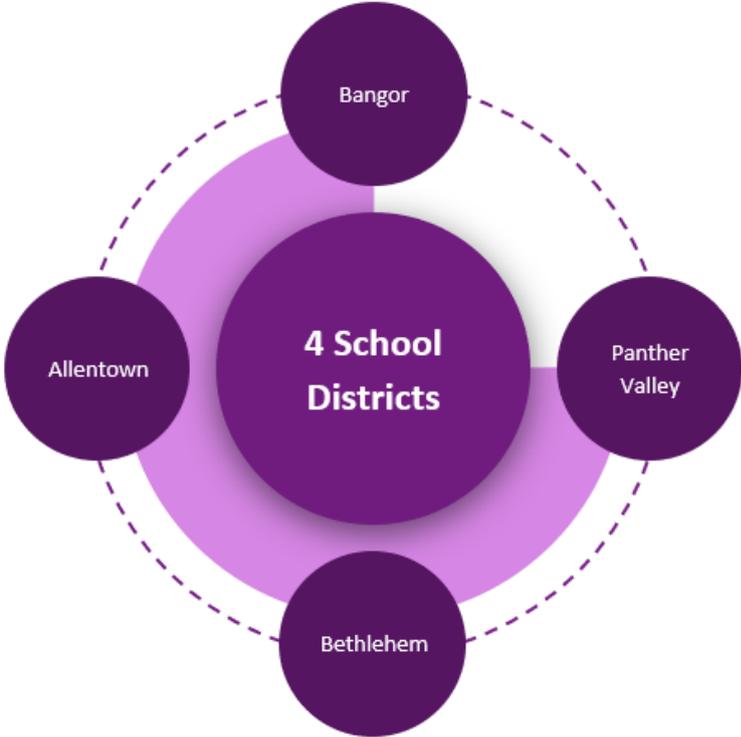
toring program housed in St. Luke’s Department of Community Health and Preventive Medicine department and in collaboration with Lehigh Valley Workforce Development Board. This year we were fortunate enough to have 19 of Nurse-Family Partnership clients enroll in the Next Step program with 15 graduates. The Next step program worked with a total of 20 women and 16 total graduates making NFP mothers 95% of the total participants.

The VNAC program works closely with: county caseworkers, specialty physicians, primary care physicians, dental health providers, schools, homeless shelters, the Lehigh County Child Advocacy Center, Northampton and Lehigh County Court System, and other social service and community focused organizations. Collaboration with the community and health care partners is essential in creating safety nets for vulnerable populations. A collaborative approach is the only way we can make strides in combating the social determinants of health. Access to quality health care only accounts for 20% of a population’s total health and wellness. This is why a transformative approach is needed to address the physical environment, socio-economic factors, and health behaviors in our community. Programs like those detailed in this report go beyond traditional health care meeting to start addressing these factors with families. It is our goal to create holistic care starting form birth so we can make lasting multi-generational change, thereby creating a brighter, healthier future.

## 4.2 School-age and Adolescent Health

### Health Van

The Districts We Serve



*Youth Succeeding in School (YSS) Program* Our YSS program aims to reduce chronic absenteeism for at-risk students in grades K-3 at Donegan Elementary School through wrap-around case management services. The Family Development Specialist (FDS) works with families of students who have or are at risk of having chronic absenteeism, to identify attendance barriers and work to address them. During the 2018-2019 academic year, our FDS worked with 72 students’ families. Of those 72 students, 64 (89%) improved their attendance.

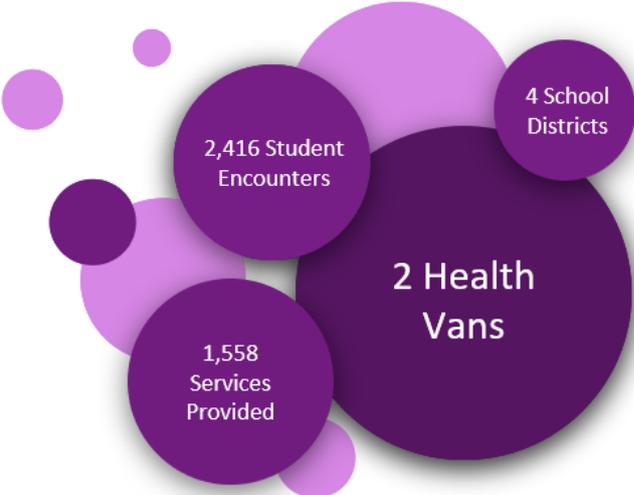
#### Care Transformation

*MYHC Mobile Vans & Adopt-A-School Initiative:* Our department’s Mobile Youth Health Center (MYHC) and Adopt-A-School Initiative are two of our primary, community-based programs addressing issues related to our Care Transformation priority. Since 1994, St. Luke’s University Health Network (SLUHN) has been providing medical, vision, and dental care on board our MYHCs. In FY 2018-2019, our MYHC dental services became a part of the Star

Wellness FQHC system. Additionally, our vision program has begun transitioning from a mobile model (i.e. services provided on a van) to a model based upon the provision of vision vouchers for students who meet the program's eligibility requirements. Through the exploration of an alternate service model, our vision program is able to connect students to care while making it possible for our MYHC health vans to visit our schools more frequently. The goal of our MYHC health van and vision program is to increase access to care for students who are uninsured while focusing on the connection of students who have Medicaid to primary care providers and services available to them in our communities. Care Transformation is not realized strictly through the provision of care but through the efforts taken to connect students to the care they would be receiving in an equitable healthcare system.

## Health Van

By the Numbers

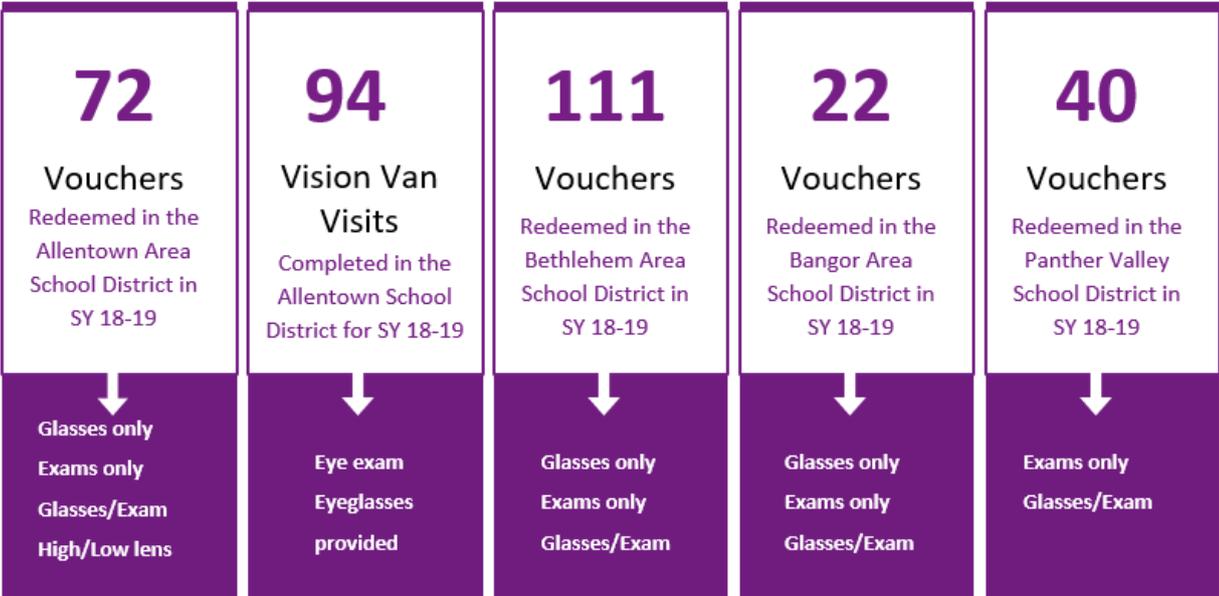


For FY 2018-2019 and moving forward, our MYHC health vans had and will have a behavioral health specialist on board each time they visit one of our schools. Through a partnership with Pinebrook Family Answers (PbFa), students who are evaluated by our provider can be referred to behavioral health services provided in a secure and trusted environment. Our partnership with PbFa is another example of the work we are doing to satisfy our Care Transformation priority through the facilitation of convenient mental health services. SLUHN is also both a lead and corporate partner to two United Way of the Greater Lehigh Valley (UWGLV) Community Schools. Working alongside UWGLV, SLUHN serves as a lead partner for the Community School initiative and employs 2 full-time Community School Coordinators (CSC). Our CSCs

focus on the facilitation of programs and the coordination of social services in their schools to improve students’ chances of being successful academically and personally.

As SLUHN continues to grow as a network, so too does the Adopt-A-School Initiative and in FY 2018-2019, our partnership with the Pocono Mountain School District (PMSD) became official. Through a grant secured by the UWGLV and funds raised by the SLUHN Monroe campus, we were able to initiate a vision voucher program and literacy programs within the PMSD. The graphs below provide a breakdown of our vision and health van programs’ connection rates.

### Vision Program - By the Numbers



## Health Van - Connection Rates

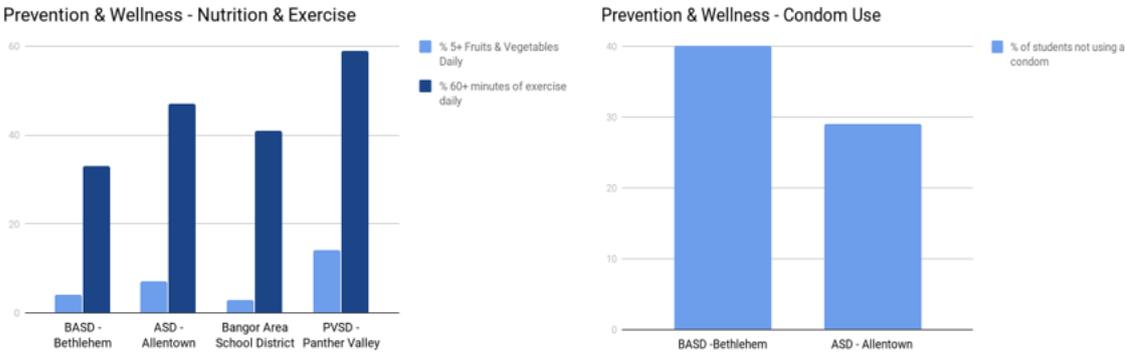
| Bethlehem Area School District                    | Allentown School District                         | Panther Valley School District                    | Bangor Area School District                       |
|---|---|---|---|
| <b>43%</b><br>Connected to insurance              | <b>48%</b><br>Connected to insurance              | <b>14%</b><br>Connected to insurance              | <b>13%</b><br>Connected to insurance              |
| <b>77%</b><br>Connected to medical                | <b>76%</b><br>Connected to medical                | <b>100%</b><br>Connected to medical               | <b>20%</b><br>Connected to medical                |
| <b>68%</b><br>Connected to vision                 | <b>78%</b><br>Connected to vision                 | <b>81%</b><br>Connected to vision                 | <b>50%</b><br>Connected to mental health services |
| <b>89%</b><br>Connected to mental health services | <b>99%</b><br>Connected to mental health services | <b>86%</b><br>Connected to mental health services |   |

### Prevention & Wellness

*MYHC Mobile Vans & Adopt-A-School Initiative:* Our MYHC health vans visit four school districts and eleven schools. In FY2018-2019, our health vans provided 1,558 total services and completed 2,416 encounters for 966 students on 213 days. In order to address our Prevention & Wellness priority, our outcome measurements are determined by student answers to the questions posed by the Adolescent Health Assessment (AHA). The AHA is performed on each student one time per school year and is derived from the Center for Disease Control's (CDC) Healthy People 2020 leading health indicators. The AHA assesses risky and unhealthy behaviors that may be present in the lives of our students and, as a result, our MYHC health van teams are able to provide services and resources that may help prevent chronic diseases and ensure overall wellness. For example, if a student indicates on the AHA that he or she has had unprotected sex, our health van teams are able to perform STI and pregnancy testing on board the van. For FY 2019-2020, our MYHC health van serving the Bethlehem Area School District (BASD) will pilot a Family Planning Van (FPV) at Liberty High School on the first Monday of every month and both our BASD and Allentown School District (ASD) MYHC health vans will extend their STI testing panel to include rapid HIV testing. These two ini-

tiatives are just two examples of our MYHC health vans’ efforts to satisfy the requirements set forth by the Prevention & Wellness priority. Additionally, in order to address the unhealthy behaviors affecting student nutrition and the lack of daily exercise indicated by the AHA, our MYHC health vans have updated our Healthy Steps tool (self-management tool based upon motivational interviewing and coaching) and our clinical team members are pursuing health coach certifications for FY 2019-2020.

The graphs below provide a snapshot view of our AHA metrics pertaining to condom use in the BASD and the ASD, as well as nutrition and exercise data gleaned from our FY2018-2019 school year.



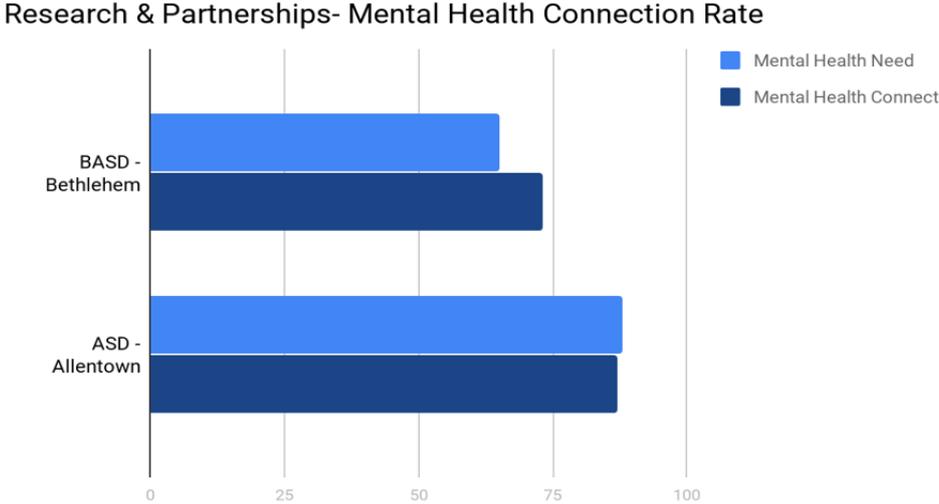
Our Adopt-A-School Initiatives’ efforts to facilitate Prevention & Wellness can be identified in our employment of the Penn State PRO Wellness model for the completion of state mandated health screenings at the start of each school year. In partnership with our school districts, marathon screening events are performed at our elementary, middle, and high schools so as to ensure that screenings are not delayed, thereby limiting timely access to care and contributing to poor academic performance.

**Research & Partnerships**

*MYHC Mobile Vans & Adopt-A-School Initiative:* Our department continues to address the needs determined by our CHNA through collaborative partnerships at the local, regional, state, and national levels. In FY 2018-2019, the MYHC health van serving the BASD partnered with the Bethlehem Health Bureau (BHB) and the BASD to create the framework for a Family Planning pilot at Liberty High School for FY 2019-2020. A need for reproductive health counseling as well as family planning services was expressed by our partners

working within the BASD and a need for greater connection to the adolescent population of Bethlehem was expressed by the BHB. Working in partnership with both the school district and the health bureau, a process was created which will allow the BHB to provide family planning services on board our MYHC health van the first Monday of every month beginning in October 2019.

In order for our health vans to provide consistent and timely mental health services to the students of the school districts we serve, an existing partnership with Pinebrook Family Services (PbFa) was strengthened. A behavioral health specialist was on board our health vans each time they visited one of our schools thereby improving our connection rate for mental health services for FY 2018-2019 on board our MYHC health vans in the ASD and BASD.



### 4.3 Literacy Initiatives

A multitude of research has linked low literacy to poorer outcomes related to health and life course development. Literacy and exposure to books needs to occur early, as a child’s brain develops rapidly with approximately 80% of an individuals brain architecture set by the age of three. Reading interactions affect children’s cognitive, language, and social-emotional development. The American Academy of Pediatrics reported that fewer than half (48%) of young children are not read to daily, and that minority, low-income children are less likely to be read to daily compared to non-minority, higher income peers. This inequity impacts a child’s school success, and long term health as social determinates have a major role in both a person’s quality and length of

life. Early positive parental influences, reading interaction, access to books, and heard vocabulary all have a lasting impact on learning and school success. Those children not exposed to books are missing opportunities, and our low-income children are at a disproportionate disadvantage.

In an effort to close this literacy gap, SLUHN has taken on strategies to promote access to books, reading interactions, and community partnerships to help promote literacy throughout the community and across the lifespan.

### **Prevention & Wellness-Access To Books**

*Book Drive:* Each year SLUHN conducts a Network-wide book drive to obtain new and used books from employees and community members. These books are then distributed to the community through our pediatric practices, placed in our Little Free Libraries, and given to community partners in an effort to get books into the hands of our most vulnerable populations. This year SLUHN employees donated 12,711 books and distributed 10,561 books back to our community. This is a 20% increase in donations and an 11% increase in our total distribution over last year's outcomes.

*Little Free Libraries:* With the help of community partners, SLUHN has in place 6 Little Free Libraries on our spread across our SLUHN campuses and 7 partner little free libraries located at schools in the Allentown, Bethlehem, Bangor, Panther Valley, and Phillipsburg. The SLUHN Book dive helps to provide us with the books to keep these free libraries stocked and to keep our community reading.

### **Care Transformation**

*Reach out and Read (ROR) and Brush, Book and Bed (BBB) Literacy Initiatives in Carbon County:* The ROR program address the literacy needs of pediatric patients in Carbon County by training doctors, nurses and staff through online courses on how to educate and engage parents in reading aloud to their children and the importance of making reading part of daily life. The program provides age-appropriate books and guidance for parents including: how to enjoy looking at board books and naming pictures with infants, the importance of rhyme and repetition to toddlers, and open-ended questions

to ask when reading with preschoolers. The interaction and distribution of books takes place during each well visit up until age five. The four participating Carbon County practices include Palmerton Pediatrics, Lehighon Family Practice, Nesquehoning Primary Care and Nesquehoning Health Center.

Carbon County is located in a Health Provider Shortage Area (HPSA) for Dental. This federal designation means access to dental care and services is more challenging for local Carbon County Residents. St. Luke's partners to improve literacy while integrating oral health education through ROR and the Pennsylvania American Academy of Pediatrics (AAP) Brush, Book, Bed (BBB) programs and messaging. BBB provides a simple and clear message for parents: Each night, 1) help your children to brush their teeth, 2) Read a favorite book (or two), and 3) Get to bed at a regular time each night to improve literacy and oral health outcomes while promoting healthy routines. ROR and BBB is sponsored by a generous donation from the Carbon County Community Foundation where staff trainings and over 1400 ROR and BBB books, along with educational materials, have been provided to the practices to engage families in these interactive literacy initiatives.

*Dr. Seuss Day:* During Read across America week, SLUHN helps to celebrate the importance of reading through Dr. Seuss day. SLUHN employees volunteered to read to students K-5 in classrooms in schools districts across all SLUHN Network campuses. In FY18-19 the Dr. Seuss day event brought together 155 SLUHN employee volunteers who helped to reach 3,528 students.

*Reading Rocks:* Reading Rocks is a 6 week reading mentor program held at Union Terrace and Cleveland Elementary Schools in the Allentown School District. Through SLUHN coordination, volunteers from SLUHN and the community work with students in 1st and 2nd grade to help improve reading skills. In the FY18-19 fall cohort, Union Terrace had 20 students and 20 volunteer reading mentors. In the spring cohort, Union Terrace had 16 students & mentors and Cleveland had 10. Outcomes measured at Union Terrace show that 87.5% of the first graders and 75% of the second graders had improved reading scores at the end of the program.

## **Research Community Partners**

*Literacy Calendars:* In an effort to promote literacy skills across the valley, a partnership was created with St. Luke's Community Health and Preventive Medicine, the Bethlehem Public Library, PBS, Barnes & Nobel and SLUHN & Star Wellness Bethlehem Pediatric practices. This partnership helped to create a calendar of free literacy events happening every month in Bethlehem for families to enjoy and attend. Encouraging families to engage in these free literacy events can help to close literacy gaps that exist, allow children to experience fun and exciting opportunities to explore books and reading, and offer parent role modeling so reading experiences and books can be enjoyed at home. Literacy calendars are printed each month and distributed through our ABW pediatric practices, Star Wellness Kids Care Bethlehem site, and our Star Wellness Family Practice location on Easton Avenue in Bethlehem.

*Lehigh Valley Reads and United Way:* Lehigh Valley Reads is a regional organization dedicated to having all children reading at grade level by the end of Grade 3. Through the support of the United Way of the Greater Lehigh Valley community awareness campaigns and organizational partnerships have been formed to encourage literacy skills, and on target reading scores for all children by grade three. Through this initiative and posters created by "Too Small to Fail", the United Way has committed to printing posters that were placed in pediatric practices and distributing information on the importance of talking, reading, and signing to children to practices all over the valley and including SLUHN. Over the course of FY 19-20 you will see additional posters in practices, community advertising, and billboards promoting talking, reading, and singing to your child.

# 5

SECTION

## Allentown and Sacred Heart Campus Specific Report

St. Luke's University Health Network partners with local schools and communities to improve the health of students through our Adopt a School Program. The St. Luke's Adopt a School program supports the Community Health Needs Assessment priority areas which are identified at each campus by collecting and analyzing data and community input. Based on the identified needs and priorities, each campus develops plans and programs to improve the health of those in the communities. Through our efforts and initiatives, we have partnered with the school districts and local organizations to Improve Access to Care and Reduce Health Disparities ( Parish Nursing, Partnership with Workforce Lehigh Valley), Prevent Chronic Disease (Diabetes Education Program, Walk with a Doc, Tail on the Trail, and School Gardens), Improve Mental and Behavioral Health (Behavioral Health Specialists on MYC vans, Partnership with PNLV with their Zero Youth Violence Initiative, Warm Hand off in EDs) and Improve Child & Adolescent Health (We are the lead and corporate sponsor at Raub Middle School, we have our Mobile Youth Clinics, Adolescent Career Mentoring, Reading Rocks and Dr. Seuss Day, and Summer Feeding Program at Sacred Heart). Our initiatives are continually assessed and evaluated in order to provide measurable and effective health outcomes.

Priority areas include:

- Improving Access To Care
- Preventing Chronic Disease
- Improving Mental and Behavioral Health

## **5.1 Highlights**

### **Allentown**

- 991 students were seen on the Mobile Health Clinics in the Allentown School District during the 2018-2019 school years.
  - 48% of students were connected to insurance
  - 76% were connected to a medical home
  - 78% of students were connected to vision services
  - 99% of students were connected to mental health services
- The Mobile Health Clinic has extended their STI testing panel to include HIV rapid testing. In addition, there was a Behavioral Health Specialist on the van every day it was out and 99% of students who were referred were connected.
- Raub Middle School has a new full time After School Coordinator as a result of the Full Service Community School federal grant secured by the United Way. The After School Coordinator is a St. Luke's employee and reports to the Network of School & Neighborhood Based Initiatives.
- 600 students were visited by SLUHN and Community Volunteers in 2019 to promote literacy for Dr. Seuss Day. 30 volunteers tutored 1st and 2nd graders at Union Terrace and Cleveland Elementary during the Fall and Spring 2018-2019 school year for Reading Rocks. The students and volunteers worked on literacy skills. 1st graders saw an 87% improvement and second graders saw a 75% improvement in reading and literacy skills.

## **Sacred Heart**

- Parish Nurses connected 1,964 unique patients 2019
- Parish Nurses made 2,855 referrals to outside partners
- In collaboration with the Bethlehem Area School District, Allentown School District and the Workforce Board Lehigh Valley, the St. Luke's Health Career Exploration Program provided 20 high school students employability skills training and subsidized work experiences at the Bethlehem, Allentown, Sacred Heart and Anderson Campuses. Out of the 20 students enrolled in the program, 4 students were from the Allentown School District, and worked at the Mother Baby Unit, PACU, Business Office, Medical ICU.
- SLUHN SH campus partnered with Workforce LV to open a new Career Link site on the SH campus. Career Link opened its doors on June 30th .
- SH was one of the pilot campuses for the Summer Feeding Program. SH campus served 765 meals in 12 weeks and provided 154 CSA shares & 197 backpacks with non-perishable food items for children between the ages of 0-18. Lehigh County Drug and Alcohol has granted SLUHN CHPM \$23,000 in fees for service to educate the community on Naloxone and distribute the life saving drug. Family Medicine Residents at SH will be working this project for the 2019-2020 FY

## **5.2 Challenges & Next Steps**

### **Allentown**

- Community Health and Preventive Medicine will continue working in the schools and the communities to address access to care, preventing chronic disease and improving mental and behavioral health. In the coming year SLUHN, Allentown Health Bureau, Allentown School District and LVHN will be working in true partnership to work on a vaccine campaign for students to ensure they can be enrolled in school. SLUHN and Promise Neighborhoods of the LV have established a partnership to address violence amongst youth in the community. SLUHN,

ASD and Computer Aid Incorporated have also established a partnership to bring quality after school tutoring to students at Raub Middle School in an effort to help raise math scores to state averages.

- Improving a Continuum of Care for Patients presenting with a SUD diagnosis
- Connecting patients identified as being high utilizers to the ED with our Parish Nurse team and other social services

### **Sacred Heart**

- Community Health and Preventive Medicine will continue working in the schools and the communities to address access to care, preventing chronic disease and improving mental and behavioral health. In September 2019, Sacred Heart Campus hosted its inaugural Social Determinants of Health Symposium. National and local leaders on the SDOHs spoke about the importance of partnership. As a follow up from the symposium the Community Health Initiatives Committee established five action groups that will work on priorities identified in the CHNA; Housing, Workforce, Education, SUD prevention/treatment/recovery and Chronic Disease Prevention. The action committees are comprised of community leaders, community residents and SLUHN staff and will establish achievable, measurable goals for the first year.
- Connecting patients identified as being high utilizers to the ED with our Parish Nurse team and other social services.
- Continue to improve the Warm Hand of Process and Continuum of Care for patients who present with Substance Use Disorder Diagnosis.

# 6

SECTION

## Anderson Campus Specific Report

St. Luke's Anderson Campus (SLRA) partners with the Bangor Area School District and surrounding communities to improve the health of students through our Adopt-a-School Program and to improve the health of all residents through other community programs and collaborations. These programs support the Community Health Needs Assessment priority areas that were identified at SLRA through collecting and analyzing data from community input and other reliable aggregate sources. Based on the identified needs, priorities, and local resources, SLRA and community partners developed plans and programs to improve the health of those in the community. Through our partnerships with the local schools and organizations, we have helped provide health services, such as medical, mental health, vision, and dental, healthy living programs, such as Get Your Tail on the Trail, Walk with a Doc, and school gardens, literacy programs such as Little Free Libraries and Dr. Seuss Day, and youth development programs, such as our adolescent career mentoring programs. Our initiatives are continually assessed and modified in order to provide measurable and effective health outcomes, including the social determinants of health.

The five priority areas were:

1. Improving access to care and reducing health disparities
2. Reducing chronic disease and promoting healthy living
3. Improving mental and behavioral health
4. Improving child and adolescent health
5. Improving elder health

The priority areas and their associated programs and projects are funneled into three initiatives:

1. Health For All: Ensuring the priority areas are applied to all community members
2. Fit For Life: Promoting healthy living to reduce chronic disease
3. Healthy Kids, Bright Futures: Projects and programs targeted specifically at children

## **6.1 Highlights**

### **HOPE Easton Wellness Center**

This community wellness center provides free programming on the topic of healthy living. Such programs include yoga classes, strength training classes, and our Farm to Fork program where participants volunteer at a local urban farm and then enjoy a cooking class based on the plants they harvested. The total number of unique individuals for the year was 40 with an average of 15 per month, for a total of 1,061 visits for the year, averaging 88 per month.

### **Adolescent Career Mentoring**

Our Career Linking Academy program at the Bangor High School connected 15 students to a year-long program which consists of general job skills training (e.g. resume writing & practicing employment interviews) and job shadowing (including two rotations at St. Luke's hospital in areas such as surgery, radiology, and pharmacy). 100% of the students graduated and went on to pursue post-secondary education or military roles.

## **School-based Health Services**

The mobile medical van visited Bangor schools seven times and saw 35 students over 76 encounters. On the van, three students were also provided with mental health services. Our vision program provides vouchers that students can redeem for an eye exam and glasses, if needed, at a local partnering optometrist. A total of 22 vouchers were redeemed this year.

## **Community Fitness Programs**

As a network, our Get Your Tail on the Trail program encourages community members to get out and get active by rewarding physical activity with small, outdoor-friendly incentives such as hats, gloves, and safety items. This past year 1,102 people completed the 165-mile challenge logging a combined 491,328 miles, and 872 people completed the winter mini-challenge logging a combined 57,592 miles. The total miles accumulated over the life of the program also went over four million total miles. SLRA also hosts a Walk with a Doc program every week between April and September, where a St. Luke's provider gives a short educational talk, followed by a group walk, open to all community members. A total of 36 unique providers led or participated in 28 events, where a total of 170 unique individuals came to an average of 2.1 events each.

## **Older Adult Meal**

The SLRA campus offers an affordable, healthy meals for seniors every weeknight in the hospital cafeteria, often featuring produce from the SLRA-Rodale Institute Organic Farm. The program is designed to promote both healthy eating and social connectedness. The cafeteria is run by our partner in Metz Culinary Management using St. Luke's employees. In the past fiscal year, a total of 5,601 meals were served, for an average of 21.5 meals per day. The daily average rose fairly steadily from 12.2 meals in July 2018 to 33.6 in June 2019, credited to a referral program (receive a future free meal for bringing a friend) and ongoing relationship building among the staff and guests.

## **Community and School Gardens**

The SLRA campus supports school gardens with our partner Kellyn Foundation at two of the Bangor schools, including eight raised beds at Five Points

and three at Washington school. These gardens are part of a larger program designed to teach valuable nutrition information to all students in grades three through five, including strategies to make the best choices and produce tastings. A total of 450 students from 18 different classrooms received programs.

### **Employee Wellness**

Our Caring Starts with You employee wellness program aims to target the health and wellness outcomes of our employees and their families. Our CSA program (Community Supported Agriculture) allows employees to buy fresh, local produce each week through payroll deduction and pick up the produce right at the hospital. This past year, 70 people participated, which was the max allowed, and has grown every year since inception. An added benefit is that the roughly \$26,564 total cost went to local farmers.

### **Lifestyle Medicine Residency Program and Medical Practices**

SLRA is at the leading edge of the new Lifestyle Medicine medical specialty, in which we prepared for the arrival of the first cohort of 16 medical residents who will be trained in Lifestyle Medicine in partnership with the American College of Lifestyle Medicine, and who will practice in both Family Medicine and Internal Medicine office settings.

## **6.2 Successes**

### **New Liaison**

With the expansion of the St. Luke's network, the former liaison for SLRA shifted focus to cover our four rural hospitals, and the liaison for the St. Luke's Monroe Campus expanded his role to include SLRA. This is an exciting development because as our network ability to ensure improved health outcomes increases, our relationships and partnerships grow through the work of the campus liaisons.

## **Dr. Hans Diehl, National Walking Day, and the Lifestyle Medicine Symposium**

To kick off the SLRA Walk with a Doc program, we were fortunate enough to have Dr. Hans Diehl from Loma Linda University lead the walk on National Walking Day: the first Wednesday in April set aside by the American Heart Association to promote the heart benefits of walking. Dr. Diehl is a pioneer in Lifestyle Medicine and created the Complete Health Improvement Program (CHIP), one of the most successful public health healthy living programs in existence. Dr. Diehl then spoke at the first ever Lehigh Valley Lifestyle Medicine Symposium, sponsored by St. Luke's.

## **Hike For Health**

The SLRA Walk with a Doc program launched an offshoot program in partnership with the Pennsylvania Department of Conservation and National Resources (DCNR) called Hike for Health. Like the regular Walk with a Doc, a St. Luke's provider gave a short educational talk, followed by a walk with community members. In contrast to Walk with a Doc, the walk was a hike through the beautiful woods of Jacobsburg State Park. A total of 10 providers led and participated in the eight walks. Roughly 20 to 40 community members attended each event. In addition, there were four presenters, the first two of whom are billable providers: Dr. Bonnie Coyle, Registered Dietician Tammy Zalokar, school-based athletic trainer Jeff Timlin, and Todd Nemura.

## **Provider Engagement in the Community**

In an effort to promote improved community health outcomes, we have been working to increase participation in community efforts by St. Luke's providers. For example, the number of providers leading Walk with a Doc nearly doubled over the previous year. In addition, our Sports Medicine department and many medical residents came out to volunteer significant time in our school and community gardens.

## **2019-2021 Community Health Needs Assessment (CHNA)**

Much work went into the next round of our CHNA, with a total of 10,234 surveys completed by community members across our network, 3,423 coming

from the SLRA service area. In addition, a community stakeholder meeting and multiple key informant meetings were held.

### **6.3 Challenges & Next Steps**

#### **Anderson Expansion into Easton**

With the SLRA campus opening three new practices to support the Lifestyle Medicine residency program, it is imperative that we build even stronger relationships and partnerships with the agencies in Easton. Lifestyle Medicine relies on strong community partnerships so that patients can live healthy every day and not just on days they see their healthcare provider. In order to make this a reality, significant time and effort is required. In addition, the practice of Lifestyle Medicine and the existing models are so new that continuous monitoring and improvement of operational flow is necessary.

#### **Opioids, Substance Abuse, and Mental Health**

The rise of opioid-related issues, vaping, especially among teens, substance use disorder in general, and many other behavioral and emotional health indicators all point to the need for more concerted mental health efforts. We are working both network-wide and at SLRA to implement a strategy that addresses the prevention, treatment, and successful recovery from substance use disorder, including a warm handoff from the hospital to community care settings, stigma reduction training, and other programs.

# Miners, Lehighton and Geisinger Campus Specific Report

St. Luke's conducts a Community Health Needs Assessment (CHNA) every three years to remain a tax-exempt organization under section 501(c)(3) of the Internal Revenue Code. The goal of the assessment is to identify critical health disparities faced by residents within St. Luke's University Health Network (SLUHN) service areas. The 2019 Community Health Needs Assessment revealed three health priority areas. We aim to address these priorities using a three bucket approach: 1. Prevention & Wellness 2. Care Transformation and 3. Research & Partnerships. The following are the five CHNA health priorities:

## 1. Improve Access to Care and Reducing Health Disparities

- *Adopt a School Program at Panther Valley School District (PVSD):* includes School Based Master's level Community Health Worker and part time school based coordinators to consistently connect students, staff and families to programs, resources and connections to care with demonstrated improved outcomes. Such outcomes include reductions in PAYS (PA Youth Survey) data risk factors and improvements in protective factors.
- *Oral Health Planning:* working with local, state and national part-

ners to plan for improved value & access to oral health and dental resources & care.

- *Head Start Partnership in Coaldale and Lehighton*: student connection to provider, physicals, and lead testing (28 students with barriers screened for lead in 2017 & 18)
- Literacy Promotion

## 2. Promoting Healthy Lifestyles and Preventing Chronic Disease

- PVSD health improvement project outcomes: includes school walking loops, bathroom checks, PV Community Elementary School Playground Build, Vegetable Gardens and Nutrition Education.
- Healthy Lifestyle PVSD Staff In Service; 56% (2017) and in 60% (2018) staff engaged
- Tail on the Trail (TOT) and Walk with a Doc (WWAD) at the Panther Valley Track and in Tamaqua: over 80 unduplicated staff, students and community members have walked 10k miles within 24 community walks; of those, 14 TOT and WWAD walks were offered in 2017-18
- *Community Supported Agriculture*: 1200lbs of local farm fresh produce to Cancer & Diabetes, RHC patients, Community & School event for twelve weeks from July to September 2018
- *Diabetes Self-Management Training Program* accredited through the American Association of Diabetes Education
- *Kid Zone Car Seat Safety Clinics*: formerly known as PA Safe Kids

## 3. Improving Mental and Behavioral Health

- Panther Valley Adopt a School Program Licensed Clinical Social Worker on and off the medical van
- Social and Emotional Learning curriculum and trainings offered to staff and students grades K - 8
- Schuylkill and Carbon Drug & Alcohol Partnership in assessment, Opioid Task Force, Opioid & Substance Planning Committees and implementing Hospital Warm Handoff Programs

- Valor Veterans Quarterly Clinics: CHW & Nurse Navigator attend for connection to care and resources

## **7.1 Highlights**

### **Rural Oral Health Planning**

Oral health is an identified unmet need in our rural areas including Carbon and Schuylkill counties, designated as Medically Underserved and Dental Health Provider Shortage Areas (DHPSA). In 2017-18, St. Luke's Miners received a Network Planning and Development Grant to develop partnerships and programs to improve oral health value and access in the rural region. *"This program was sponsored in part and supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$99,237.00 with 50% percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government."*

**Vision:** We visualize a healthy and responsive environment where our neighbors will access and value a quality dental home.

**Mission:** The mission of the Dental Planning Network is to collaboratively assess the dental needs of Schuylkill and Carbon counties by engaging residents (professional and lay people) and exploring, building upon and expanding our existing relationships, infrastructure, and evidence-based resources to improve oral health awareness, prevention and access in the region.

### **Improving Oral Health Value and Access**

Dr. Seuss Read Across America is implemented at 12 local schools in Carbon and Schuylkill counties, reaching over 1300 students per year. The program promotes literacy and oral health through the Dr. Seuss "Tooth Book" and the PA AAP Brush, Book and Bed messaging & bookmarks.

Reach out & Read (ROR) and PA American Academy of Pediatrics Brush, Book, Bed (BBB) evidence based national programs impact 1,500 children ages 6

months to 5 years in Carbon County at Palmerton Pediatrics, Lehighon Family Practice, Nesquehoning Primary Care and Nesquehoning & Lansford Rural Health Center (RHC's). ROR and BBB Program are sponsored through a generous donation by the local Carbon County Community Foundation.

PA Coalition for Oral Health Rural Health Center Dental Unit agreement for preventive services through the Hometown Rural Health Center in May 2019 and hospital agreement to integrate medical oral health services through a Public Health Dental Hygiene Practitioner (PHDHP) beginning October 2019.

### **Rural Community Response for Substance Use Prevention, Treatment and Recovery Services**

In September 2018, St. Luke's Miners (SLM) was awarded a U.S. Department of Health and Human Services Health Resource and Service Administration (HRSA) Federal Office of Rural Health Policy (FORHP) Rural Pennsylvania Community Consortium Opioid Response Plan Grant. Through this grant, community partners developed a regional response including OUD/SUD gap analysis, comprehensive/ strategic workforce and sustainability plans that focus on prevention and treatment & recovery efforts for Carbon & Schuylkill counties as part of the Surgeon General's Call to Action spotlight on opioids. Stigma, transportation and cost of treatment prevent most from accessing treatment and recovery.

The multi-sectoral consortium is led by SLM CHPM and rural health centers, including Panther Valley (PVSD), Tamaqua Area School Districts (TASD), Child Development, Inc. (Schuylkill Head Start program), PathStone Corporation (Carbon Head Start program, Schuylkill County's VISION and several local and grassroots organizations & partners. *"This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$200,000 with 43% percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government."*

Vision: Our vision is a safe, supportive and healthy community that cultivates

a continuum of care for opioid and substance use disorder including prevention, treatment and recovery.

**Mission:** The mission of the Rural Community Opioid Response Consortium is to assess regional needs, expand life skills, provide evidence based resources and to improve comprehensive treatment services in an environment that supports and values recovery

**Scope:**

- Prevention: Reduce the occurrences of OUD/SUD.
- Treatment: Implement evidence based practices (EBP's), reduce cost to then un/underinsured and recovery.
- Recovery: Treatment options to help start/stay in recovery

**Focus Groups**

Primary data focus groups were lead and held by each MOU Rural Planning Partners in 2018-19, thereby engaging community members with lived experience in our target population. Focus Group consents and questions were approved by the St. Luke's Institutional Review Board. The six focus groups included 51 parents, students age 18 and older, staff, teachers and community members with lived experience from Head Start, PVSD and T ASD Public Schools, a satellite college campus and faith based organization including 21 men, 29 women and one "rather not say".

Barriers discussed included: transportation, stigma, perceived normalization and local social acceptance of drug use, lack of community support, connections and education, lack of treatment coverage and financial resources needed to seek treatment and stay in recovery.

**Advisory Council**

*April 9th Advisory Council Meeting:* 75 adults; 15 students attended. 85 community leaders and members, including those with lived experience, completed a pre meeting survey to identify priority needs as determined by key

community members. When asked, what do you think are the three most important area/topics that the planning committee should address during the grant period, the top responses included:

- Addressing Barriers to accessing services, such as transportation: 48%
- Trauma Informed Care (improving mental and behavioral health services): 41%
- Warm Hand Off processes (improving connection to care): 38%
- Expanding Recovery efforts and visibility (recovery community centers, transitional housing, etc.): 36%
- Evidence Based social/emotional learning programs for schools such as Life Skills Trainings: 33%
- Stigma reduction efforts (address negative community opinions): 31%
- Treatment options: 29%
- Workforce development (training and recruiting additional and existing providers for our area): 27%
- Harm Reduction (Narcan, drug take back, drug disposal): 16%

## **7.2 Successes**

Improving visibility while building partnerships and rural capacity to meet identified need:

- Carbon County Community Foundation Collective Impact to Improve Local Outcomes Panel Presentation, January, 2018
- Senator Yudichak Roundtable Presentation: Senator Yudichak, Senator Baker Roundtable Discussion on Lead Exposure and Testing, February, 2018
- Health Resource Service Administration (HRSA) Strategies for Success: Strengthening Rural Partnerships Poster Presentation, February 2018
- Rural Residency Training Track in Family Medicine, Spring 2018

- Carbon County Carbon County Interagency Collaborative Board “Building Access to a Stronger Health System in Carbon County”, April 2018
- Health Resource Service Administration (HRSA) Rural Community Opioid Response Planning Grant Award, September 2018
- Pathstone Head Start Mary Mailey Power of Partnerships Memorial Award, October 2018
- Schuylkill County Chamber of Commerce Rural Community Opioid and Substance Response Panel Presentation, March 2019
- PA Department of Health, Public Health 3.0, Adverse Childhood Experience and Trauma Community Response, May 2019
- PA Department of Health, Oral Health Stakeholder Meeting, Building Capacity to Improve Oral Health Access and Value in Rural Underserved PA Community, May 2019
- Carbon County Education Association Friend of Education Award, May 2019
- Health Resource Service Administration (HRSA) Rural Community Opioid Response Implementation Grant Award, September 2019

### **7.3 Challenges & Next Steps**

Improving access to care, chronic disease prevention & management and mental health & substance use disorder prevention, treatment and recovery services:

- Improving transportation solutions and connection to care
- Evidence-based Practices and Trainings: Motivational Interviewing, Community Health Worker, Screening, Brief Intervention, Referral to Treatment, Stigma Reduction trainings, Warm Hand Offs, Naloxone Education & Distribution, and Mental Health First Aid (Question, Persuade, Refer, Trauma Informed Trainings, etc.).
- Evidence Based Practices and Programs: Diabetes Prevention and Self-Management, physically activity and nutrition, tobacco cessation, Medication Assisted Treatment (MAT) with Counseling services

- Improved electronic health records that assist health care to understand the social determinants of health and to connect to appropriate services, ensuring connection and follow up
- National Health Service Corps (NHSC) Rural Communities Loan Repayment Program to recruit and retain rural providers

# 8

SECTION

## Monroe Campus Specific Report

St. Luke's Hospital Monroe Campus (SLMC) partners with Pocono Mountain School District, especially the West side, and surrounding communities to improve the health of students through our Adopt-a-School Program and the health of all residents through other community collaborations. These programs support the Community Health Needs Assessment priority areas that were identified at SLMC through collecting and analyzing data from community input and other reliable aggregate sources. Based on the identified needs, priorities, and local resources, SLMC and community partners developed plans and programs to improve the health of those in the community. Through our partnerships with local schools and organizations, we have provided health services such as medical, vision, and dental, healthy living programs, such as Get Your Tail on the Trail, Walk with a Doc, and school/community gardens, and literacy programs such as Little Free Libraries and Dr. Seuss Day. Our initiatives are continually assessed and modified in order to provide measurable and effective health outcomes, including addressing the social determinants of health. The SLMC Community Health & Preventive Medicine program is now in its second full year as the hospital is finishing its third full year in operation.

The five priority areas are:

1. Improving access to care and reducing health disparities
2. Reducing chronic disease and promoting healthy living
3. Improving mental and behavioral health
4. Improving child and adolescent health
5. Improving elder health

The priority areas and their associated programs and projects are funneled into three initiatives:

1. Health For All: Ensuring the priority areas are applied to all community members
2. Fit For Life: Promoting healthy living to reduce chronic disease
3. Healthy Kids, Bright Futures: Projects and programs targeted specifically at children

## **8.1 Highlights**

### **The Mountain Center**

This community center was recently opened and quickly became a hub for residents to overcome many of the social determinants of health all under one roof. This converted elementary school saw an estimated five- to seven thousand unique individuals in the 2018 calendar year across the numerous agencies that both reside in the building and utilize the facility for programs. SLMC has identified this as a key partner due to its geographic location within a lower socio-economic area and due to the potential to create a comprehensive Community Centered Health Home.

### **Adopt-a-School Launched**

SLMC looked at the four school districts in the area and chose to work with Pocono Mountain School District based on several factors including third grade reading levels, the percentage of students on free and reduced-price school lunches, and other related indicators. Some successes of the first full year are noted below.

## **Community Fitness Programs**

SLMC hosted a Walk with a Doc program at the campus where local providers gave a short educational talk and then joined community members for a walk on the beautiful wooded walking trail at the hospital. A total of 15 unique providers led or participated in 16 events, where a total of 103 unique individuals came to an average of 2.2 events each. As a network, our Get Your Tail on the Trail program encourages community members to get out and get active by rewarding physical activity with small, outdoor-friendly incentives such as hats, gloves, and safety items. This past year, 1,102 people completed the 165-mile challenge, logging a combined 491,328 miles, and 872 people completed the winter mini-challenge logging a combined 57,592 miles. The total miles accumulated over the life of the program also went over four million total miles.

## **Older Adult Meal**

SLMC offers affordable, healthy meals for seniors every night of the year including weekends and holidays. A total of 2,247 meals were served for an average of 6.2 meals per day, designed to promote healthy eating and social connections.

## **Employee Wellness**

Our Caring Starts with You employee wellness program aims to target the health and wellness outcomes of our employees and their families. Our CSA program (Community Supported Agriculture) allows employees to buy fresh, local produce each week through payroll deduction and pick up the produce right at the hospital. This past year, 48 people participated, which was the max allowed, and has grown every year since inception. An added benefit is that the roughly \$18,216 total cost went to local farmers.

## **8.2 Successes**

### **New Provider at Brodheadsville Family Practice**

Dr. Margaret Mintus completed her residency with St. Luke's and was successfully recruited to stay at St. Luke's where she chose to work in the Monroe area as part of our Brodheadsville Family Practice. Dr. Mintus will also be

spending one full day per week as part of the Community Health & Preventive Medicine department, providing community-based services.

### **Literacy Initiatives**

After several snow delays, eleven SLMC staff dressed in red and white while wearing Cat in the Hat hats and read *The Tooth Book* by Dr. Seuss to over 225 first grade students at Clear Run Elementary Center to promote literacy and good dental hygiene. In addition to another successful Dr. Seuss Day, two additional, sustainable literacy-promoting programs were started, including a Little Free Library at the hospital and a free library book shelf. The Little Free Library was conceived as part of the Eagle Scout requirements for Zach Brinker, son of our own Dr. John Brinker. He is organizing his troop-mates to build both the library and bird houses along the campus walking trail. At one of our adopted schools, Clear Run Elementary Center, we created a process to provide books for the students as they wait for the nurse or sit through medical treatments.

### **Launch of Vision and Dental Services**

Through a grant provided by the Pennsylvania Department of Health, in conjunction with State Representative Maureen Madden, we were able to begin both a vision and dental program. The vision program provided the school with vouchers they could give qualifying families. The vouchers can be used for vision exams and eyeglasses, if needed, at one of three local partnering optometry offices. Through the vouchers, increased notifications to parents, and individual phone calls to help parents navigate the care system, 75 students had their vision needs met, which reduced the unmet need to nearly half of the rate from the prior school year. For dental services, our Star Wellness partner dental van made seven trips and provided care to 28 students during 64 total appointments.

### **Community and School Garden Build**

Through a grant provided by Pocono Mountains United Way, SLMC, Pocono Mountain School District, and The Mountain Center partnered to implement a community & school garden and nutrition education program. At The Mountain Center, over 50 individuals from 12 different agencies and families, in-

cluding roughly half children and half adults, all came together to build eight extra tall, raised bed gardens as an addition to the existing four raised beds already there through a previous grant to St. Luke's and The Mountain Center. The garden was designed to serve both young and old alike by encouraging programs that combine the students from Head Start with the seniors from the Monroe County Area Agency on Aging adult day center.

### **Wellness Program at Clear Run Elementary Center**

The school wellness committee and SLMC partnered to conduct the School Health Index (SHI): a tool developed by the Centers for Disease Control and Prevention (CDC) to help schools assess where they fall in terms of the Whole School Whole Child model of school wellness. This required a significant amount of work by the committee but resulted in a comprehensive baseline index. From this, the committee chose three of the eleven modules to work on over the remaining school year. Progress was made in all three target modules, especially Nutrition Education and Services which saw a 38-point increase from a 48 to 86% rating. School Health services saw a 5-point increase and Family Engagement saw a 13-point increase.

### **NEPA Chapter of Get Your Tail on the Trail**

The network healthy living program, Get Your Tail on the Trail (TOT), expanded outside of our network through a new chapter program. Due to numerous requests from other health networks and outdoor groups, we launched the first chapter where Geisinger Health acted as the health partner, and the Pennsylvania Environment Council acted as the outdoor agency, to create the Northeast PA (NEPA) chapter of TOT. The program officially launched right before the winter mini challenge in 2019. In this first year, 70 people completed the winter mini-challenge, logging a combined 3,971 miles. We look forward to seeing this chapter grow and to establishing new chapters across the country.

### **2019-2021 Community Health Needs Assessment (CHNA)**

Much work went into the next round of our CHNA, with a total of 10,234 surveys completed by community members across our network, and 1,029 of

those surveys coming from the SLMC service area. In addition, a community stakeholder meeting and multiple key informant meetings were held.

### **8.3 Challenges & Next Steps**

#### **Medical Literacy and Social Isolation**

It became clear during the launch of the vision and dental programs that local residents needed more navigation support than charity programs. In other words, most residents had insurance but were unsure how or where to use it. In addition, the county has one of the lowest social connection index ratings of all the counties St. Luke's serves, so the sense of community and shared resources is not as strong as it could be. As a result, we are working to secure funding for a Community Health Worker, perhaps as a Community School Coordinator, who can bridge these gaps and better connect families with the care they need and the resources they have access to already.

#### **Opioids, Substance Use, and Mental Health**

Across our county, but especially in some states, including PA, there is an epidemic in substance use disorder and the associated mental health issues. The symptoms and causes can be seen in hospital emergency room data, the PA Youth Survey data, and through the data of various agencies that serve people with mental health-related issues. We are working with numerous local partners to address the issues, especially implementing a warm handoff process and medically-assisted treatment procedures to better prevent and treat substance use and mental health issues, and then maintain the resulting healthy behaviors.

## Quakertown Campus Specific Report

St. Luke's Quakertown Campus (SLQ) partners with local organizations to improve the health of all residents through community programs and collaborations. These programs support the Community Health Needs Assessment priority areas that were identified at SLQ through collecting and analyzing data from community input and other reliable aggregate sources. Based on the identified needs, priorities, and local resources, SLQ and community partners developed plans and programs to improve the health of those in the community. Through partnerships with the local schools and organizations, unique services have been provided to the community. These initiatives, which incorporate the Social Determinants of Health (SDOH) are continually assessed and modified to provide measurable and effective health outcomes. The five top priority areas identified:

1. Improving access to care and reducing health disparities
2. Reducing chronic disease and promoting healthy living
3. Improving mental and behavioral health
4. Improving child and adolescent health
5. Improving elder health

Three categories for strategic initiatives:

1. Health for All: Ensuring the population has access to resources and services; addressing the social determinants of health.
2. Fit for Life: Promoting healthy living for disease prevention and chronic disease management; Improving Mental and Behavioral Health
3. Healthy Kids, Bright Futures: Projects and programs targeted specifically at maternal and child health programs.

## **9.1 Highlights**

### **Medical Careers Pathway Program**

Adolescent Mentoring Program for high school students interested to pursue a career in the health care field. There were 24 students from Quakertown and Palisades High Schools who participated in Monday lectures/interactive sessions and Wednesday Clinical Site Rotations. Several students from The Perkiomen School (Medical Distinction) attended sessions in the 2018-2019 school year.

### **Summer Food Service Program (SFSP)**

The Quakertown campus served as an open site for the United States Department of Agriculture's (USDA's) program to provide summer meals for children in Quakertown. In addition to a healthy meal, the program was created to provide activities, crafts, education sessions, CSA shares and backpacks with food for week-end meals. The program began in FY 19 on June 17, 2019.

### **Oral Health Services/Dental Van**

Waiting for info from stacie

### **Community Fitness Programs**

The Fit for Life Strategy supports the promotion of a minimum of 150 minutes of exercise per week. The two programs designed to promote community engagement in physical activity include **Get your Tail on the Trail** (a program in partnership between SLUHN and the D&L) and **Walk with a Doc.**

Across the network communities, the total miles accumulated under this program surpassed four million total miles. Families within Quakertown Elementary School received free Lehigh Valley Zoo passes and were invited to take a walk to observe the five Healthy Living Tips displayed throughout the zoo as part of the Get your Tail on the Trail Program. The Walk with a Doc program was initiated at the Quakertown Campus in November of 2018 with a total of seven providers participating for the first seven- month period.

### **Nutrition**

Nutrition and healthy eating presentations including Diabetes Education. Dieticians presented at Upper Bucks and Upper Perk YMCA and at Walk with a Doc Programs. Presentation at Quakertown Elementary School for students and families during national Nutrition Month.

### **Older Adult Meal Program**

SLQ offers a senior meal program to community members. For a flat rate of \$5.00, participants can obtain a meal in the cafeteria. Periodically, there are information sessions and activities to supplement the program. For FY19, there were 83 participants.

### **Literacy Programs**

A book drive was completed at the Quakertown Campus and employees were encouraged to bring books for donation to local community members. A total of 612 books were collected and distributed to Quakertown Head Start, The Child Development Program, The Quakertown Christian School, Upper Bucks YMCA, Upper Perk YMCA, Quakertown Free Library and the Maternal Child Health Cart at SLUHN's Community Health & Preventive Medicine's Department.

### **Employee Wellness**

The Caring Starts with You Program for employees and spouses is a wellness program established to promote wellness and to help reduce the risk for chronic disease. Screenings and health coaching are key components for the program. Promotion of the Community Supported Agriculture (CSA) Pro-

gram was offered at Quakertown Campus sites. In addition to the employee wellness benefits, the program provided revenue to our local farmers.

| 2019 CSA           | People Signed Up | Reg Completed | 1/2 Share | Full Share | Total Shares | Total Dollars |
|--------------------|------------------|---------------|-----------|------------|--------------|---------------|
| SLQ - Bone & Joint | 4                | 4             | 4         | 0          | 2            | 1440          |
| SLQ - Upper Perk   | 5                | 5             | 5         | 0          | 2.5          | 1800          |
| SLQ                | 17               | 17            | 15        | 2          | 9.5          | 6800          |
| <b>SLQ Totals</b>  | <b>26</b>        | <b>26</b>     | <b>24</b> | <b>2</b>   | <b>14</b>    | <b>10040</b>  |

**Warm Hand Off Processes (BCARES)**

SLQ partnered with The Penn Foundation to provide Restorative Specialists for initial patient connection. A total of 78 patients were referred for FY 19.

**9.2 Successes**

**Community Health Needs Assessment Survey**

For the 2019 CHNA Longitudinal Study, there were 10,234 respondents for the network; 1,327 surveys for the Quakertown Campus.

**Bucks County Health Improvement Partnership (BCHIP) Collaboration**

Many of the strategic initiatives for St. Luke’s are congruent with the key priorities for BCHIP.

**Nature-Based Placemaking Executive Committee**

The Quakertown Community Health Liaison is a member of this committee representing St. Luke’s University Health Network. This committee provides structure and leadership for the grant provided by the Pennsylvania Downtown Center aimed to “create a total quality experience and support local community and economic development”. This committee supports the Walk with a Doc, Tail on the Trail and CSA Programs.

**Upper Bucks Chamber of Commerce**

The Quakertown Community Health Liaison serves on the Executive Board as Vice President.

## **Upper Perkiomen YMCA**

The Quakertown Community Liaison serves on the Advisory Board as a member.

### **Provider Engagement in the Community**

Increasing provider engagement in community activities has been a goal. This year there has been participation in Summer Feeding, Walk with a Doc, Tail on the Trail and additional marketing/community events.

### **Community/ Business Support**

Generous support was provided to the Summer Food Program from Penn Community Bank as well as individual donors.

## **9.3 Challenges & Next Steps**

The service area for the Quakertown Campus covers several counties including Bucks, Lehigh, and Montgomery.

Substance abuse including alcohol remains a dominant problem throughout the community and surrounding areas.

Mental Health concerns remain a priority and establishing effective and consistent resources exists as a challenge.

Additional financial resources to expand programming would be beneficial.

# 10

## SECTION

### Warren Campus Specific Report

St. Luke's conducts a Community Health Needs Assessment (CHNA) every three years to remain a tax-exempt organization under section 501(c)(3) of the Internal Revenue Code. The goal of the assessment is to identify critical health disparities faced by residents within St. Luke's University Health Network (SLUHN) service areas. The 2019 Community Health Needs Assessment revealed three health priority areas. We aim to address these priorities using a three bucket approach: 1. Prevention & Wellness 2. Care Transformation and 3. Research and Partnerships. The following are the three CHNA health priorities:

1. Improve Access to Care, Reducing Health Disparities
2. Promoting Healthy Lifestyles/Preventing Chronic Disease
3. Improving Mental and Behavioral Health

#### **10.1 Highlights**

##### **Improving Access to Care, Reducing Health Disparities**

*Partnering with Lyft:* We looked into partnering with Lyft as a result of our last CHNA findings in 2016 which showed transportation was (and currently con-

tinues) to be a barrier to accessing care. We started working with Lyft in 2018 and piloted in Warren Campus at Coventry Family Practice.

*Integrative Medicine Program:* a new program at Coventry Family Practice, is a comprehensive lifestyle change and wellness programs with aspects involving quality improvement, research, clinical care, patient education, and physician wellness. It also includes planned group visits, a physician burnout prevention program, community outreach and health fairs.

### **Oral Health Services:**

- St. Luke's Warren Campus teamed up with Adaptive Dental Associates by providing funding support for screenings and other dental services to Philipsburg School district students and developmentally challenged patients.
- Dental Van Services are provided every month during the school year at the local adopt a school.
- The dental residency program started in September 2018.

### **Literacy Initiatives:**

- To help improve literacy rates, we sponsored and oversee the use of the Little Free Library at our local adopt a school.
- On Dr. Seuss Day, hospital staff members and volunteers read to students at one of the local schools.

### **Promoting Healthy Lifestyles/Preventing Chronic Disease**

*Walk with a Doc Program:* is led by the Coventry Family Practice residents and it helps encourage people to get out and move as well we develop relationships with local providers.

*School Gardens:* To help promote healthy eating and living, St. Luke's sponsored a school garden at the local adopt a school in Philipsburg.

## **Improving Mental and Behavioral Health**

We work with local partners to help address our health priority areas and provide services to the community in our Warm Hand-Off process.

### **10.2 Successes**

By working collaboratively with local partners and institutions, we were able to develop the following successes:

- Since working with LFYT, we currently provide about 750 rides a month to help patients get to their medical appointments.
- The Walk With A Doc program is led by nine residents and they have led the walks in different areas of Philipsburg to help work with different age populations. The walks previously took place at the local mall, at a local park, and now at a local youth center.
- By teaming up with community partners, a fence was built to help protect the garden beds from being eaten by local deer. The school teachers helped motivate and encourage their colleagues to get their students involved in the garden. St. Luke's partnership with the Kellyn Foundation helped to engage about 625 students from the school and held 52 classroom program visits.
- In 2018, the Dental Van program helped provide 125 students with cleanings, fillings, extractions, and sealings.
- On Dr. Seuss Day, 27 books were donated and 406 bookmarks so that every classroom in the local school received a book and each student received a bookmark

### **10.3 Challenges and Next Steps**

We will continue to look for ways to partner and collaborate to help address the health priority areas identified. We want to develop programs in collaboration with local partners to help address gaps and challenges. In addition, we are looking for ways to help increase the number of participants in the Walk With A Doc program, develop and ensure implementation of the warm

hand-off process, and increase consumption of healthy produce in the local community.

## **10.4 Conclusion**

Currently, the Department of CHPM at SLUHN is wrapping up our 2016-2019 cycle with the completion of the 2019 CHNA. We are moving into our 2019-2022 cycle and will complete our next CHNA in 2022. In the previous cycle, we focused on five priorities: (1) Improving Access to Care and Reducing Health Disparities, (2) Preventing Chronic Disease and promoting Healthy Lifestyles, (3) Improving Mental and Behavioral Health, (4) Improving Child and Adolescent Health and (5) Improving Elder Health.

In the coming cycle, we will focus on three main priorities: (1) Improving access to care & reducing health disparities, (2) Preventing chronic disease & improving healthy lifestyles and (3) Improving mental & behavioral health. Topics that are lumped together under one priority are done so because they are interrelated and contingent upon the other: for example, a healthy lifestyle is a prerequisite for preventing chronic disease.

On behalf of everyone at CHPM, we would like to humbly thank our national, state and local partners for their continued support in allowing us to expand the impact SLUHN is able to have in our shared community.